

LITERATURE REVIEW

International perspectives on Advanced Nurse and Midwife Practice, regarding advanced practice, criteria for posts and persons and requirements for regulation of Advanced Nurse /Midwife Practice. Undertaken for Nursing and Midwives Board of Ireland (NMBI) (*An Bord Altranais agus Cnáimhseachais na hÉireann*) 2014.



Prof Marie Carney 2012
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Glossary of Terms

ABA: An Bord Altranais is the regulatory body for nursing and midwifery in Ireland and is responsible for the development of requirement and standards for educational programmes in nursing and midwifery. An Bord Altranais is now re-named the Nursing and Midwifery Board of Ireland (NMBI) (*An Bord Altranais agus Cnáimhseachais na hÉireann*)

ACPN: Acute Care Practice Nurses work mainly in the USA and take on advanced practice roles in acute care and in primary care settings

Added Value Content: In the context of nursing programmes, delivered by Universities, this is the additional value offered by the programme that is unique or different to that offered by other colleges

AMP: Advanced Midwife Practitioner

ANP: Advanced Nurse Practitioner

ANA: American Nurses Association

ANP: Advanced Nurse Practice is used as a concept that incorporates a number of advanced practice roles such as nurse practitioner (NP), nurse consultant (NC) clinical nurse specialist (CNS), nurse anaesthetist (NA) and certified nurse-midwife. The definition put forward by the National Council for the Professional Development of Nursing and Midwifery in Ireland (NCNM) is: "Advanced nursing practice promote wellness, offer healthcare interventions and advocate healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines ... "(NCNM 2008a)

APN: Advanced Practice Nurse was first used in the United States, in 1965 and is being used as an overarching concept to signify nurses practicing at a higher level than that of traditional nurses

APRN: Advanced Practice Registered Nurse is a term used in the United States to denote a registered nurse who is practicing at advanced practice level

Assessment of Domains of Competence: This is the assessment tool used in Ireland to define competencies for advanced practice. There are five domains, with each domain incorporating three dimensions: performance criteria, defined standard(s) and evidence of successful performance to meet this standard. The five domain's are: Professional /Ethical Practice; Holistic Approaches to Care and Integration of Knowledge; Interpersonal Relationships; Organisation and Management of Care and Personal and Professional Development

Benchmarking: A continuous process of measuring and comparing care and services with similar service providers

Best available evidence: Systematic identification, analysis and selection of data and information to evaluate options and make decisions in relation to a specific question or area of practice

Capability: Capability is based on the theory of how adults learn and develop and differs from competence. Competence describes what individuals know or are able to do in terms of knowledge, skills and attitudes at a particular point in time while capability includes the ability to meet future demands by developing further competencies (NHS Scotland 2007).

Capability Frameworks: Capability frameworks focus on realising an individual's full potential, developing the ability to adapt and apply knowledge and skills learning from experience, being able to envisage the future and helping to make it happen (NHS Scotland 2007)

Casemix: The types of patients and complexity of their condition treated within a healthcare service

Clinical audit: A quality improvement process that seeks to improve patient care and outcomes through collection and monitoring processes

Clinical Governance: A system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding CHRE: Commission for Healthcare Regulatory Excellence (CHRE 2009). CHRE states that practitioners are always accountable to their regulatory body whatever the level or context of practice and the core focus of regulatory bodies is the professional's fitness to practice and the safety of the public

Clinical Criteria for Advanced Practice: Regulatory bodies and professional organisations have laid down criteria for advanced practice, which vary across countries. These criteria include: registration as a nurse; acquisition of expert knowledge base, complex decision-making skills and clinical competencies for extended practice

CM: Community Matron: The new role of community matron overlaps to a large extent with the traditional role of general practitioners as coordinators of patient care, particularly in the United States

CNA: Canadian Nurses Association (CNA)

CNM: Certified Nurse-Midwife

CNS: Clinical Nurse Specialist. Clinical nurse specialists undertake some or all of the advanced practice nursing roles but do not normally or officially discharge patients and in many countries the role is a specialist one

Competencies for Advanced Practice: Competencies are a central tenant of the advanced nurse or midwifery practice roles. Competence is the effective and creative demonstration and deployment

of knowledge and skill in human situations. Competence draws on attitudes, emotions, values and sense of self-efficacy of the learner as well as knowledge of procedures

CRE: Council for Regulatory Excellence in Britain provided advice on advanced practice to the Department of Health, in 2008 with the underlying purpose of examining whether 'advanced practice' is a regulatory matter or if it is an extension of the role of the nurse or midwife

Educational Qualifications and Training Requirements for Advanced Practice: These vary across countries and within countries and range from diploma to masters to PhD with a masters degree in nursing recommended or required to qualify as an advanced practice nurse/midwife/advanced nurse practice nurse/midwife in most countries where the role is recognised

EU Directive 2005/36/EC of the European Parliament and Council refers to nursing and midwifery legislation as set out in the Directive

Extension to the Role of Nurse and Midwife: Extension is resulting in roles that were traditionally the preserve of doctors, such as medication prescribing and patient assessment, now being taken on by advanced practice nurses and midwives

Governance Structures: Governance differs by country. In the United Kingdom governance in the creation of advanced practice nurses/midwives dwells with the health care system and with individual health care organisations rather than with regulatory bodies, as in some countries

Government of Ireland (1998) Report on the Commission on Nursing formed a blueprint for future nursing and midwifery in Ireland and recommended the extension of the nurses' and midwives roles

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centered care for the benefit of the public. Currently The Authority's mandate extends across the quality and safety of the public, private (within its social care functions) and voluntary sectors

ICN: International Council of Nurses

JNA: Japanese Nursing Association

LACE: The LACE Consensus Model was developed in the United States to clarify the roles of advanced practice nurses (APN's) and aims to standardise education, licensure and certification. LACE is the operational framework component of APRN (Advanced Practice Registered Nurse) and is made up of four components: Licensure, Accreditation, Credentialing and Education

Levels of Regulation: Levels of regulation of advanced practice exist in the United States.

- Level 1, the least restrictive approach corresponds to Designation or Recognition
- Level 2, corresponds to Registration and requires advanced practice nurses to apply to have their names added to an official roster maintained by the Board

- Level 3, corresponds to Certification, which recognises the professional competence of a nurse who has met pre-determined qualifications
- Level 4, corresponds to Licensure and includes the pre-determination of qualifications necessary to perform a unique scope of practice safely and legally by licensed individuals. Licensure is the preferred method of regulation for advanced nursing practice in the United States

MP: The term denotes Midwifery Practice or the practice of midwifery. Legislative and regulatory practices and mechanisms for midwifery vary between countries, with some countries legislating separately for nursing and midwifery practice while some make no distinction between the two and in some countries midwifery is subsumed under nursing

NA: Nurse Anesthetist

NCNM: National Council for the Professional Development of Nursing and Midwifery. The Council was set up by the government to establish the role of the advanced nurse and midwife practitioner in Ireland. The functions of the NCNM are now under NMBI formerly An Bord Altranais

NC: Nurse Consultant

NP: Nurse Practitioner. Two broad categories of Nurse Practitioner currently co-exist in Canada: Primary Care NPs and Acute Care NPs (working in hospitals). In the United Kingdom, NPs have been part of the National Health Service since the early 1970s

National Clinical Guidelines: Guidelines that meet specific quality assurance criteria and are mandated by the National Clinical Effectiveness Committee in Ireland

Needs Assessment: Identification of the needs of an individual or population to determine the appropriate level of care or services required

Nurses and Midwives Bill (2010) was announced by the Minister for Health and Children, Mary Harney TD. The Bill provides for a modern statutory framework for the regulation of the nursing and midwifery professions

Nurses and Midwives Act (2011): This is the new Act for Nursing and Midwifery in Ireland, referenced in this text only when discussing new legislation into the future

Nurses Rules SI 639 of 2010: Developed by An Bord Altranais to implement SI No 3 of 2010 In order to operationalise SI 689 of 2010, Nurses Rules 2010 were written. SI No 3 of 2010 was developed by the Department of Health and Children to confer additional responsibility to An Bord Altranais. In 2010, the Department transferred the area of advanced practice from the National Council for the Professional Development of Nursing and Midwifery (NCNM) to An Bord Altranais through the statutory Instrument SI 3 of 2010

Nursing and Midwifery Board of Ireland (NMBI) (*An Bord Altranais agus Cnáimhseachais na hÉireann*), formerly called An Bord Altranais, is responsible for the development of requirement and standards for educational programmes in nursing and midwifery in Ireland

Nurse Practitioner/Advanced Practice Nurse: “A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master’s degree is recommended for entry level” (ICN, 2008 a, b)

OECD: Organisation for Economic Co-operation and Development. Countries within the OECD are at different stages in implementing more advanced roles for nurses. Development and formal recognition of APN’s is still in its infancy and some unofficial practices may already exist

Prescribing of Medication in Advanced Practice: Certain categories of nurse are now authorised to prescribe medication within a nurses’ scope of practice and national legislation, either independently or only under the supervision of a doctor

Regulation: Regulation of Nursing and Midwifery is undertaken mainly by regulatory nursing bodies such as An Bord Altranais in Ireland

Scope of Practice: A profession’s scope of practice encompasses the activities its practitioners are educated and authorised to perform. The overall scope of practice for the profession sets the outer limits of practice for all practitioners and may also be influenced by the settings in which the nurse or midwife practices, the requirements of the employer and the needs of patients

Scope of Advanced Practice in Ireland: Defined by the NCNM (2008a) as promoting wellness, offering healthcare interventions and advocating healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines

Scope of Practice in Scotland: Allows the cognitive, integrative and technical abilities of the qualified nurse to put into practice ethical and safe acts, procedures, protocols and practice guidelines. The clinical practice of ANP’s/AMP’s is scientifically based and applies to health care in all settings. The role also includes leadership, mentorship, peer education and research practice

SI No 3 of 2010: See above

SNB: Singapore Nursing Board

WET BIG: The Wet Big law regulates eight health care professions in the Netherlands, from 1995

Executive Summary

A literature review was undertaken to explore the national and international role of the advanced nurse/midwife practitioner (ANP/AMP) from the perspectives of the requirement for regulation, persons and posts. The review is undertaken in the context of the Nurses and Midwives Act (2011) that replaces all previous legislation related to nursing and midwifery in Ireland.

Countries are at different stages in the development of legislation, scope of practice, roles, responsibilities, education and clinical preparation for the advanced nurse/midwife practitioner role. The United States, Canada, Ireland and the United Kingdom have had advanced nurse practitioner roles for many years, while Australia, New Zealand and Singapore have developed the role in more recent years and Finland, Hong Kong, Sweden and Cyprus are in the developmental stage.

Ambiguity surrounds the title, definition, role, scope and function of the ANP/MP/APN. Interest in the role has been gaining ground in recent years, yet confusion exists in relation to where the title advanced practice nurse sits due mainly to the proliferation of titles and roles. Variations also exist in the level of knowledge, educational qualifications, scope of practice, competencies, role outcomes and job and organisational specification required. Mandatory standards for nurse practitioners to ensure public protection are called for. Ambiguity is further compounded by how nursing is regulated internationally. Ireland is at the forefront of advanced practice regulation, development and implementation through powers granted in The Nurses and Midwives Act (2011). This regulatory confusion extends to regulation of title where title protection and regulatory mechanisms for practice extend beyond first level nurses' regulated scope of practice as in Australia, Ireland, New Zealand, Canada and the USA.

Titles: The titles adopted by countries where advanced practice is in place are varied. These include in *Australia:* Advanced Practice Nurse and Nurse Consultant; *Canada:* Clinical Nurse Specialist, Nurse Practitioner in Primary Care and Acute Care-neonatal, paediatric and adult; *Ireland:* Advanced Nurse Practitioner, Advanced Midwife Practitioner; *Singapore:* Acute Care Nurse, Medical/Surgical Nurse, Community Nurse and Mental Health Nurse; United Kingdom: Advanced Nurse Practitioner, Clinical

Nurse Specialist, Nurse Consultants, Modern Matron, Community Matron: *United States*: Advanced Practice Registered Nurse (in Certified Registered Nurse Anaesthetist, Certified Nurse Midwife and Nurse Practitioner); *New Zealand*: Nurse Practitioner Specific Area of Practice.

Regulation: Regulations for advanced nurse practice currently occur in 11 countries. These countries are Australia, Canada, Hong Kong, Ireland, Netherlands, New Zealand, Scotland, Singapore, Spain, United Kingdom and United States. Criteria relating to practice in specialist or generalist areas occur in 8 of the 19 countries studied in this research. These countries are: Australia, Canada, Ireland, New Zealand, Scotland, Singapore, United Kingdom and United States. The remaining countries do not have clearly defined criteria in this area. It is important to note that regulation is evolving over time and other countries may regulate nurses in the future.

Some countries regulate advanced practice but others do not. Sweden, United Kingdom and Australia do not differentiate between regulation of nurses and regulation of advanced practice. Regulation of Nursing and Midwifery in Ireland is through Legislation via Nursing and Midwifery Board of Ireland (NMBI); in Japan through Legislation and Certification by the Japanese Nurses Association (JNA); in New Zealand through Legislation via the Nursing Council of New Zealand; (NCNZ); in Singapore through Legislation; in the United Kingdom by the Nurses Act (1919) and the Midwives UK (1902) through the UKCC. A similar but distinct regulation of 8 health professions takes place through Legislation termed WET BIG in the Netherlands. State regulation occurs in Australia where each state has its own regulatory authority. In Canada, Provincial regulation occurs through separate acts in each of the 10 provinces and 2 territories. Legislation through Licensure via Boards of Nursing takes place in the United States. Regulation in Sweden is through the National Board of Health and Welfare, in Spain through the Ministry of Education and General Council of Nursing and In Norway through the Ministry of Education and Research. Separate Regulation of Midwifery occurs in Ireland, United Kingdom, Spain, Sweden and New Zealand. Regulations for advanced nurse practice occur in 11 countries. These countries are Australia, Canada, Hong Kong, Ireland, Netherlands, New Zealand, Scotland, Singapore, Spain, United Kingdom and United States. (Scotland is presented separately to the UK in this study due to the advanced level of knowledge development originating in Scotland).

Almost all of the American State Boards have regulations to govern three types of advanced practice registered nurses (Certified Registered Nurse Anesthetist, Certified Nurse Midwife and Nurse Practitioner) which set out scope of practice, regulation and requirements for legal recognition (NCSBN 1993) and to protect public health, safety and welfare (See Appendix 3 for Levels of Regulation in the USA). Licensure is the preferred method of regulation for advanced nursing practice in the United States. The LACE Consensus Model is a Consensus Model for advanced nurse practice regulation with its aim of providing leadership to advance regulatory excellence for public protection and which was adopted by The National Council of State Boards of Nursing in the United States to provide guidance to Member Boards in the regulation of advanced nursing practice. The LACE Model adopts designation/recognition as the preferable method of regulating advanced practice nursing (APRN 2008, 2012). Plans are underway to revamp advanced practice nursing in all states of the United States by 2016, from the current single-state licensure model to a mutual recognition model (See Appendices 1 and 4 for Regulation of Advanced Practice Nursing –LACE Consensus Model).

Education: Educational developments and qualifications for advanced nurse practice in 24 countries are presented. As advanced nurse practice is not officially recognised in many European countries –Finland, France, Germany, Netherlands, Switzerland, Spain, Italy there are no specific requirements laid down. Some countries do not provide advanced practice programmes as yet and details of the educational requirements for nursing, specialist, post graduate and master’s programmes are briefly provided in order to provide overview of advanced practice nursing education development that is occurring. These countries are: Australia, Belgium, Canada, Czech Republic, Cyprus, Denmark, France, Finland, Germany, Ireland, Italy, Japan, Netherlands, Norway, New Zealand, Scotland, Singapore, United Kingdom (excluding Scotland) and the United States. Six selected countries, Australia, Canada, Ireland, Scotland, United Kingdom and United States are explored in detail and taken as examples of advanced educational programmes.

In most countries, a master’s degree in nursing is now recommended or required to qualify as an advanced nurse practitioner but this is not always the case. Education level required for registration and practice varies and ranges from Bachelors degree to PhD. Education for advanced practice is at master’s level in Ireland, New Zealand, Singapore, and Sweden. The United States is also at master’s level although the trend is toward PhD level. Post Graduate Diploma in a relevant

area of practice is required in Australia, Canada, Finland, Japan, Norway, United Kingdom including Scotland, Czech Republic, Cyprus. Masters degree is also available in Australia. Additional qualification required by Japan is the JNA Certificate Nurse Expert Examination (JNA). Wider title is defined by the UK and Cyprus as both require post graduate certificate or post graduate diploma or clinical masters. Denmark requires a specialist nurse master's degree and the masters degree in New Zealand is clinically focused. See Appendix 7 for details of the Education level for nurses in advanced practice roles that are required or recommended by regulation, licensure or otherwise in 24 countries.

University Delivery: Within countries, education for advanced practice may be delivered in multiple universities, in a few, or in one, as in Singapore-the National University of Singapore. Different approaches to programme title and content occurs with focus on the added-value a university programme in advanced practice can offer, thus providing a competitive advantage over this offered by competitors. A total of 12 educational programmes for advanced nurse practice developed by universities in Australia (2), Canada (1), Ireland (4), United Kingdom (2) and the United States (3) are provided as examples of best practice and innovation in advanced practice education in countries where the role of advanced practice nurse is established. See Appendix 7 for details of universities offering advanced practice programmes. See Section 7.22 for discussion on programme content of selected universities. It is demonstrated that varying programmes and content are offered by universities with some adopting different approaches to course content offered thus minimising duplication of content and titles within countries. Out-reach and distance learning programmes are also offered. It is also demonstrated that universities provide innovation and distinction in subject and programme content and appear to work hard at defining the distinctive advantages of their university over another.

Advanced Practice study is offered by four universities in Ireland-University College Dublin, Trinity College Dublin, National University of Ireland, Galway and Royal College of Surgeons in Ireland. Added value in the University of Newcastle, Australia where the Master of Nursing –Nurse Practitioner programme is delivered provides additional Clinical Practicum hours, normally 500 and increased to 658 while In the Australian Catholic University the Master of Clinical Nursing degree offers added value through its outreach and remote rural area programme and is unique in the range of areas where graduates may seek employment. In Canada, In the University of

Toronto, a range of Certificates of Completion for a Graduate-level Course are offered with added value being provided by the multidisciplinary approach taken that is holistic in nature and contains outcomes that are focused on improving healthcare.

In the University of Singapore added value is offered in the make-up of modular components, with four specific advanced practice modules included. In Ireland approaches taken to add-value to advanced practice programmes offered are mainly subject content. University College Dublin offers added-value in disease management and colorectal screening. The Royal College of Surgeons offers added-value through specific programmes in neonatology and epilepsy, and Trinity College Dublin offers added-value in its emergency nursing programme, National University of Ireland, Galway has title distinction- Master of Health Sciences (Advanced Practice Nursing and Midwifery).

In Australia, the Master of Clinical Nursing by Degree (by coursework) is offered by the Australian Catholic University, Sydney and may be undertaken for outreach and remote rural areas. A similar approach is taken by some universities in Canada. A different approach is taken by the University of Canterbury, United Kingdom where the MSc Advanced Practice (Nursing, Midwifery and Occupational Therapy) offers added-value through nine pathways designed to meet the needs of the NHS, through its delivery to a profession outside of nursing-Occupational Therapy and by offering an inter-professional approach to healthcare education. Kings College, London, also offers a different approach through mapping of module content to the “Knowledge and Skills Framework” and lectures are provided in a multi-faculty environment.

In the USA different approaches to those adopted in Ireland are also offered, whereby nurses holding the MSc. Nursing in a specific area of nursing may obtain a Post Masters Certificate Option in another area for example in Adult Gerontology: Acute Care Nurse Practitioner. A similar programme is offered by the University of Pennsylvania through its post masters option in Woman’s Health. Cedars –Sinai Medical Centre, California offers a unique programme by providing specialist education for complex situations where patients have undergone highly sensitive procedures. The programme is based on interventions to obtain better healthcare outcomes. A similar approach is taken by University College, Los Angeles.

Criteria for Practice: Specific criteria for advanced practice incorporate broadly similar concepts in countries where advanced practice is established. These concepts relate to education level, that is mainly master’s level. Attainment of optimal outcomes is obtained through critical analysis and

synthesis of knowledge, problem solving, interpretation and application of advanced nursing theory and research, accurate, high-level decision making and autonomy to practice. Concepts also include the ANP/APN demonstrating a vision and commitment for developing nursing practice beyond the current scope of practice and attainment of advanced competencies for practice and having a minimum number of years of practice in the specialist area, ranging from 3-5 years, prior to taking up the role of advanced nurse or midwife practitioner.

Scope of Practice: There is no uniform method of describing scope of advanced nursing practice and scope differs across countries where advanced nurse practice roles are established. The scope of practice of the nursing and midwifery professions is broader than that of the individual nurse or midwife. The outer limits to advanced practice are set by legislation, policy and guidelines within which individuals need to make decisions about their own level of competence and take personal responsibility and accountability for their practice. Scope of Practice documents exist, with differing titles. Limited evaluation or research would appear to have taken place on the effect on practice of scope of practice frameworks. See Appendix 2 for Criteria for advanced practice posts in Ireland.

New Zealand has placed 10 areas of practice onto 12 defined practice areas. For example Emergency is placed on Nurse Practitioner Lifespan Acute Care; Intensive Care is placed on Nurse Practitioner Adult Acute Care and Nurse Practitioner Child; General or Orthopaedics Surgical is placed on Nurse Practitioner Adult; and Respiratory Conditions on Nurse Practitioner Youth/Adult Health Conditions and Nurse Practitioner Lifespan Primary Health. See Appendix 6 for a complete overview of defined practice areas.

Healthcare organisations need to establish service parameters for advanced practice nursing/midwifery and to differentiate operationally between advanced practice and practitioner nursing and midwifery roles. This distinction is not taking place in all countries where advanced nurse practice is established. Studies undertaken in Australia support the Strong Model of Advanced Practice as best representing the clinical experiences of participants in defining service parameters and as an operational framework for advanced practice nursing roles. Countries are seeking to improve the quality of health care delivered by reviewing the roles of health professionals, including nurses and midwives, and as a result the expertise of advanced practice

nursing and midwifery is being recognised and resulting in ANP/s taking responsibility for new service areas not previously provided by nurses such as chronic disease management.

ANP/MP/CNS/Physicians: Research into the differences in outcomes by ANP/AMP and CNS's is taking place. Findings indicate that ANP/AMP's provide a higher level of care than CNS's and that this is more evident at a strategic level. Results indicate that a clear difference exists between CNS and ANP in providing improved service delivery, greater clinical and professional leadership, developing education curricula, undertaking and publishing research with clear governance and accreditation structure. Studies exploring the differences in outcomes between APN's and Physicians indicate comparable results from APN/APRN's and Physician/doctor care in the areas of diagnostic assessment and diagnoses and similar results in post-discharge management by APRN's in the USA where they influenced the level of hospital re-admission rates for heart failure in a positive manner.

Research on outcomes to clinical care is mainly focusing on patient satisfaction, communication with patients, length of stay, access to care, comparisons between care provided in acute care and primary care settings, emergency nursing and that provided to vulnerable patients and older persons. More research is needed in medication management, community care, primary care facilities, mental health, diabetes, midwifery, intellectual disability and outcomes from multidisciplinary care teams.

Competencies for advanced practice are continually being changed and updated in order to meet changing healthcare need. Therefore It is essential that all competencies are well articulated, with indicators that are specific to each area of practice, post and speciality of practice, thus ensuring that local governance arrangements, risk factors and patient outcomes have been identified and are monitored.

Mentorship: An important component of competency development relates to mentorship or clinical supervision. Different models of supervision exist. Senior clinical nurses, a clinical nurse manager in the specialist area of practice or a medical mentor are the supervisory models used across different countries. Candidate advanced nurse/midwifery practitioners in Ireland are mentored mainly by a medical mentor. This mentorship model is consultant led and may need

further consideration when Standards and Requirements for advanced practice are being developed. Some flexibility in relation to a relevant mentor could utilise a model other than the medical model such as mentoring by a registered nurse or midwife practitioner, relevant clinical facilitator or liaison facilitator. See Appendix 8 for further information.

Job Description and Site Preparation: Research into job description and site preparation for advanced practice are being researched to a limited extent, mainly because clinical practice is governed by clinical organisations and not regulatory bodies, thus leading to inconsistent organisational preparation for the role. Currently Site Visits in Ireland, one of the few countries where Site Visits take place, are undertaken by NMBI. This method may change in the future to one governed by the health service organisation because it may be argued that responsibility for job description and site preparation could lie with the service provider and that service requirements could lead in defining the need for the development of advanced practice posts.

Currently Re-registration for advanced practice in Ireland takes place every 5 years post registration and this appears to be the international norm. Singapore has adopted a different approach that is time graduated. To re-register in Ireland RANP/RAMP should be practicing and be able to produce evidence of Continuous Professional Development (CPD), Clinical Exposure, Clinical Supervision and Competence.

Ireland is in key position to lead advanced nurse and midwife practice internationally. The RANP/RAMP roles need to be clearly defined and articulated to peers, other healthcare professionals, health care organisational staff and the wider community and from that of other roles such as Clinical Nurse Specialist (CNS), Nurse Consultant and undefined advanced practitioners, otherwise the confusion that is visible elsewhere will become evident in Ireland, particularly as health services come under pressure to reduce costs.

A summary of each area of advanced practice is presented in Chapter 1 and further details are presented in subsequent chapters. It is necessary to note that as advanced nurse and midwife practice is evolving over time and developing in many countries around the world that future research into the areas presented in this research are likely to evolve also.

CHAPTER 1

1.1 SUMMARY

Information provided here is derived from an extensive review of the relevant literature relating to advanced nurse/midwife practice, OECD data, university and national web sites and regulatory body reports relating to nursing regulation across 19 European and OECD countries and to advanced nurse and midwife practice in 6 countries: Australia, Canada, Ireland, New Zealand, United Kingdom and the United States of America, where advanced nurse practice is in place. A summary of the aims of the study, role aspects, definitions for advanced practice, historical development of the role at advanced practice level including extension of the role, regulation of advanced nurse practice, education for advanced practice, scope of practice and differences between the role of the advanced practitioner and other professionals such as clinical nurse specialists and physicians/doctors are presented. Criteria and competencies for practice are introduced. An overview of organisational structures surrounding the development of roles and posts and introduction to medication management and midwifery are presented. These areas are presented in further detail in subsequent chapters.

1.2 SEARCH METHODS AND RESULTS

The literature review was undertaken through an extensive search of the relevant literature using search engines CINAHL, CINAHL Plus and Full Text, EBSCO Support Site (2014 and 2016) (EBSCO Industries) Search Engine, MedLine, Search mode-Boolean. Search 1, yielded a total of 12,000 articles published between 1994-2010 relating to advanced practice, advanced nurse practice, advanced practice nurse, clinical nurse specialist, regulation of advanced practice, governance of practice, clinical outcomes from ANP/AMP/APN/ care and other relevant articles. Search 2 yielded a total of 36,714 articles, published between 2004-2014, including 2,473 relating to Nurse Consultants, 26,972 to advanced practice nurses and 11,042 to advanced nursing practice. Combining Search 1 which took place from July-October 2012 with Search 2 undertaken in April-

May 2014 the final search was narrowed to 2063 journal articles relating specifically to relevant areas of ANP/AMP/APN. Full Texts were read from 1,953 articles and Abstracts from a further 2,800 articles. This literature review was again updated in April 2016 by a review of a further 80 peer reviewed journal articles relating to nursing and midwifery advanced practice. Survey Monkey was sent to 50 nurses in April 2014 seeking their views on advanced practice, posts and organisational site visits and to provide further direct evidence regarding advanced practice in Ireland, seek information to inform a further Survey undertaken in late 2014 with a wider group, as well as informing questions for Focus Groups that took place in 2015.

1.3 STUDY AIMS

The aims of this study are to:

1. Review the literature relating to the development of advanced nurse and midwife practice.
2. Review how nursing and midwifery in general and advanced nurse practice specifically is regulated in countries where advanced practice is in place.
3. Examine the salient aspects of the role including scope of practice, extended role of the advanced practice nurse/midwife and outcomes from practice delivered by ANP/AMP/APN's.
4. Identify and discuss the educational developments and clinical criteria and posts required for regulation and for practice at advanced practice level.

1.4 ROLE ASPECTS

The aspects of the role presented in this review relate to:

- Definitions of advanced practice in 12 countries
- The history and development of advanced practice roles
- The extended role of the advanced nurse/midwife practitioner with particular reference to 5 countries
- Regulation of Nursing and midwifery and of advanced practice in 19 countries
- Development of advanced practice nurses and midwives in 16 countries
- Educational development and qualifications for the advanced nurse practitioner in 24 countries

- Scope of Practice of advanced nurse and midwife practice in 7 countries where the scope is defined
- Criteria for advanced practice in 9 countries where criteria are defined
- Competencies for advanced practice in 5 countries where competencies are defined
- Outcomes from advanced nurse and midwife practice found in recent publications
- Medication management, taking cognisance of the role of nurse and midwife prescriber in Ireland, Canada and elsewhere where criteria are available
- Midwifery in advanced practice.

1.5 DEFINITIONS OF ADVANCED NURSING PRACTICE

Definition of advanced practice varies across countries, therefore causing confusion amongst the public and other professions (Pulcini et al. 2010; Cronenwett et al. 2011). There are as many definitions of advanced practice as there are names of titles dedicating advanced practice. Confusion also occurs due to new categories of health personnel, such as “physician assistant” or “medical assistant” emerging, in for example the United States and the United Kingdom. Difficulties in providing a concise definition of “*advanced practice*” stems from the fact that definition’s encompass a growing and wide range of competencies and practices and because “*advanced practice nursing*” roles are at different stages of development and implementation in many countries. Further details are provided in Chapter 2.

1.6 HISTORICAL DEVELOPMENTS OF ADVANCED NURSING PRACTICE

The history and development of advanced practice is defined from the perspective of 17 countries: Australia, Belgium, Canada, Cyprus, Denmark, Finland, France, Ireland, Norway, Scotland, Spain, Singapore, Switzerland, Japan, New Zealand, United Kingdom and the United States. Exploration of the main factors motivating the development or hindrance of advanced practice roles in these countries is discussed.

The term advanced practice nurse (APN) was first used in the United States, in 1965. Since then the role has developed to varying degrees around the developed world. APN has been used as an

overarching concept to signify nurses practicing at a higher level than that of traditional nurses. Titles are also different and confusing across countries and up to 13 different titles have been adopted. Ireland and a few other countries use the designated title of “advanced nurse practice” (ANP). This concept incorporates a number of advanced practice roles such as nurse practitioner (NP), nurse consultant (NC) clinical nurse specialist (CNS), nurse anesthetist (NA) and certified nurse-midwife (Morgan 2010, Brook and Rushforth 2011). OECD countries are at different stages in implementing more advanced roles for nurses. In other countries, such as Belgium, the Czech Republic, France, Japan and Poland the development and formal recognition of APN’s is still in its infancy.

The United Kingdom and Canada have longstanding experiences of recognising nurses in APN roles, however variations exist in the regulation of, level of knowledge, scope of practice, skills, competencies and categories utilised by APN’s. The United States recently developed the “LACE Consensus Model” which clarifies the roles of advanced practice nurses (APN’s) and aims to standardise education, licensure and certification.

Confusion relating to the role is caused by many factors including the emergence of the role of “physician assistants” who are carrying out a number of clinical and administrative tasks, some of which may overlap with those of advanced practice nurses. The main reasons put forward for the growth of these assistant roles are related to cost containment by healthcare managers in an effort to delegate tasks away from more expensive doctors, thus developing new and more advanced roles for nurses, particularly in the United States, United Kingdom and Canada. A further cause is the realisation by managers that APNs improve access to care in the face of a limited or diminishing supply of doctors, such as in Australia and Canada. As a result, in some countries, advanced practice nurses (APN’s) have taken responsibility for patient care that was previously undertaken by doctors, in an effort to reduce doctors’ workload and provide continuity in health care delivery. Also, as more health care services are consumed by the growing elderly population this growth has fed into the proliferation of advanced practices nurses. Research undertaken, particularly in the United States, has demonstrated that outcomes from care delivered by advanced nurse practitioners has enhanced patient care in relation to level of satisfaction, quality and access. Further details are provided in Chapter 3.

1.7 EXTENSION OF THE NURSES ROLE

The extended role of the advanced nurse /midwife practitioner is presented with particular reference to countries where the extended role is most defined. These countries are Australia, Canada, Ireland, Britain and the United States. Extension to the role of the nurse and midwife is resulting in roles that were traditionally the preserve of doctors, such as medication prescribing and patient assessment, now being taken on by advanced practice nurses (Currie et al. 2011; Farrelly 2014). There has been an increasing recognition of the overlap between medical practice and that of nurse practitioners. Additionally, increased interest in alternative approaches to health care delivery has developed first in the United States and latterly across the world, due mainly to legislative, policy and economic changes affecting health care leading to extension to the role of professionals, especially nurses' (United States Institute of Medicine 2011; Dreher et al 2014; Nursing and Midwifery Board of Ireland 2015d). In Australia, nursing and midwifery expanded in rural areas in order to provide primary care to populations underserved by doctors. Today nurses and midwives in these remote areas are often the first health care provider.

In Canada, Nurse Practitioners were introduced in the mid-1960s, also as a response to the general healthcare care needs of rural and remote areas where doctors were in short supply and due to the absence of provincial legislation and regulation. The APN role developed further in the 1990s, due to "health system renewal", combined with limited resources and the will to develop primary care. Two broad categories of NPs currently co-exist in Canada: primary care NPs and acute care NPs working in hospitals.

The Report of the Commission on Nursing (1998) recommended that registered advanced nurse practitioners (RANP) and registered advanced midwife practitioners (RAMP) should be appointed in Ireland. Advanced nurse and midwife practice was first introduced in 2001 and since then numbers have grown each year. ANP's/AMP's are now working in acute, chronic and primary care settings. The total number of advanced nurse and midwife practitioners registered with NMBI in May 2014 is 184. This growth has occurred mainly due to Report recommendations to extend the

nurses' role. Increases in health care costs, reduction in junior doctors' hours, support in the development of the role from the National Council for the Professional Development of Nursing and Midwifery and An Bord Altranais and to changes taking place in advanced practice in other countries.

In the United Kingdom, NPs have been part of the National Health Service since the early 1970s, but their role was consolidated at the end of the 1990s with numbers increasing significantly since then. It is difficult to assess precisely the growth pattern and trajectory because many of these new appointments and roles are not based on a registerable qualification and local differences often exist between job titles and grades as well as varying levels of educational qualification, leading to reported levels of role dissatisfaction. Ingram (2014) discusses this dilemma in relation to advanced nurse practitioner registration in the area of cardiac nursing.

In the United States, the nurses' role has continued to expand with advanced practice nurses (APN's) and acute care practice nurses (ACPN's) taking on more and more roles in acute care and in primary care settings with positive outcomes such as a reduction in length of stay by 2 days, being reported. The new role of community matron (CM) overlaps to a large extent with the traditional role of general practitioners as coordinators of patient care. Further details are provided in Chapter 4.

1.8 REGULATION OF ADVANCED PRACTICE

Regulation of advanced nurse practice is discussed in relation to 20 European and OECD countries. These countries are: Australia, Canada, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, Norway, New Zealand, Scotland, Singapore, Spain, Sweden, Switzerland, United Kingdom and the United States.

Legislative and regulatory practices vary between and within countries. Regulation differs by country with some countries legislating separately for nursing and midwifery practice, some make no distinction between the two while in some countries midwifery is subsumed under nursing. All European countries have legislation to determine the practice of health professions, yet regulation

of advanced practice does not occur in most EU countries, even if the role exists in some form. Ireland is in the minority in regulating advanced practice at national level.

Regulation of advanced practice is difficult to establish as some countries: Ireland, Scotland, Singapore, Spain, and New Zealand have clearly defined laws regulating advanced practice. The United States and Canada have recently introduced new legislation. Australia, Japan and European countries such as Denmark, Finland, Germany, Italy, Norway, Switzerland, Sweden and the United Kingdom do not regulate advanced nurse practice. Also, there is no legally protected specialist nurse title in Denmark, Finland, Japan, Switzerland and Sweden and in the Netherlands nursing is neither legally defined nor protected in law. Midwifery is regulated as an entity in its own right in Ireland, Netherlands, Japan, Singapore, Spain, United Kingdom and the United States.

Regulation takes several forms due in part to the fact that the evolution of nursing practice has produced an increasing body of knowledge leading to the extended role of the nurse, as well as multiple levels of nursing practice, titles, grades, skills and competencies. There is a lack of consistency in regulatory systems and professional awards and as a result there is confusion for the public, legislators, regulators, nurses and other health care providers regarding titling, credentialing, scope of practice, development of new posts and education relating to advanced nursing practice (Delamaire et al 2010; Pulcini et al. 2010; Ingram 2014; Carney 2015). Professional nursing organisations have recognised advanced nursing practice by regulation in some countries and by voluntary certification in others. It is acknowledged that these systems have evolved mainly because of the difficulty inherent in applying professional nursing certification requirements to regulatory systems, including legal regulations as these are the responsibility of legislators and Boards of Nursing. Licensure is the preferred method of regulation for advanced nursing practice in the United States, and even though licensure is intended to protect the public, it is often viewed as a barrier, a limitation on professional development.

It has been argued in the United States that nurses prepared at master's level and above should be "unencumbered" by additional licensure requirements. Regulators in the United Kingdom argue that advanced practice roles are an extension to the role of the nurse and should not require additional regulation. However, another view is that, in addition to protecting the public, the authorisation for advanced practice provided by licensure or regulation affords protection for individual patients. The first legislation relating to nursing in Ireland was the Nurses Registration Act, 1919, which established the General Nursing Council for Ireland. The first legislation relating

to midwifery in Ireland was the Midwives Act, 1918. The Nurses and Midwives Act (2011) replaces all other acts for nursing and midwifery and is the current statutory framework for the regulation of Nursing and Midwifery. Further details are provided in Chapter 5.

1.9 SCOPE OF ADVANCED PRACTICE

The Scope of Practice of advanced nurse and midwife practice in 8 countries where the scope is defined is discussed: Australia, Canada, Ireland, Scotland, Singapore, New Zealand, United Kingdom (excluding Scotland) and the United States. There is no uniform method of describing a nursing activity or the scope of advanced nursing and midwifery practice. The scope of advanced practice differs across countries and criteria for practice are broadly similar where advanced nurse practice roles are established.

Individually nurses and midwives must consider their own accountability and duty of care as they practice and make decisions with regard to their scope of practice. The ANP/APN role is perceived as being critical to the delivery of acute and chronic diseases and in balancing inequalities in healthcare delivery. Many countries and states published scope of practice documents throughout the 1990's in order to augment or clarify legislation. Canada, Ireland, New Zealand, Thailand and the Canadian states of Alberta and Saskatchewan did so. Role ambiguity exists in relation to the role and scope of the ANP/APN.

There is a trend towards broad, enabling scope of practice frameworks, which empower nurses and midwives as professionals to make decisions about their scope of practice and thus a general shift away from an emphasis on certification for tasks. Empowering frameworks, such as that of the UKCC are perceived as having a positive influence on practice by providing liberation for practitioners in relation to role development and enabling the development of skills. In general, such scope of practice documents have been developed and published by nursing regulatory bodies, and some originate from professional organisations. The documents vary in their orientation. Some are restrictive, outlining lists of practices, while others are more flexible and are presented as decision-making frameworks (Nursing and Midwifery Council 2015; Nursing and Midwifery Board of Ireland 2015 d).

Research into the scope of nurses work indicates anomalies whereby in one study nurse practitioners undertook 30 individual activities with direct care accounting for 36%, indirect care for 32% and service related care for 32%, thus raising concerns by the researchers of the best use of nurse practitioners time. Other studies into the role report that the pattern of the nurse practitioner's role as described in this study is inconsistent with the role of the advanced nurse practitioner elsewhere where the role is reported as primarily a clinical service role with individual patients and communities and thereby demonstrating role variances and understanding of the role.

In *Australia*, there is no uniform method of describing a nursing activity or scope of nursing practice. The Nursing Board of Tasmania (1997); Queensland Nursing Council (1998) and the Nursing and Midwifery Board of Ireland (2015 c) have produced scope of practice documents or frameworks to augment nursing acts and to define scope of practice.

In *Canada*, there is no uniform method of describing a nursing activity or scope of nursing practice. The Canadian Nurses Association (CNA) states that a profession's scope of practice encompasses the activities its practitioners are educated and authorised to perform and the overall scope of practice for the profession sets the outer limits of practice for all practitioners. CNA also say that the scope for individual practitioners is influenced by the settings in which they practice, the requirements of the employer and the needs of their patients or clients.

In *Ireland*, The scope of advanced practice roles, defined by the NCNM 2008a and revised and rewritten by the Nursing and Midwifery Board of Ireland in 2015 (Nursing and Midwifery Board of Ireland 2015c) is enshrined in legislation and is defined as promoting wellness, offering healthcare interventions and advocating healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines. The scope of nursing/midwifery practice is further defined as the range of roles, functions, responsibilities and activities, which a registered nurse or midwife is educated, competent, and has authority to perform in the context of a definition of nursing and midwifery.

In *Scotland*, The Scope of Practice developed for Scotland (Skills for Health 2006) is developed at Bachelors level 7 and includes key nursing areas: level of knowledge, competence, clinical skills and patient care, organisational skills and autonomy to act, planning, financial, human resources and research. The scope is applicable across all clinical contexts and professionals including advanced level practitioners. Scotland has also developed the key scope of practice themes for advanced practice roles that are underpinned by key principles. These are clinical and professional leadership; facilitating learning; research and development and advanced clinical practice.

In *Singapore*, the Scope of Practice is enshrined in the Regulations for Nursing (2012) and allows the cognitive, integrative and technical abilities of the qualified nurse to put into practice ethical and safe acts, procedures, protocols and practice guidelines. The clinical practice of ANP/AMP's is scientifically based and applies to health care in all settings. The role also includes leadership, mentorship, peer education and research practice.

In *New Zealand*, the Nursing Council of New Zealand (2008) specify that applicants who have successfully completed an approved programme of study in New Zealand can apply for registration as a nurse in the scope of practice for which his/her qualification is prescribed. The Scope allows for expert nurses who are practicing independently and collaboratively while also providing assessment and interpreting diagnostics. Certain conditions are placed on a nurse's scope of practice that describes the specific area of practice he or she may work in.

In the *United States*, the scope of practice in each of the advanced roles of a nurse practitioner, nurse anesthetist, nurse-midwife, or clinical nurse specialist is distinguishable from the others and while there is overlapping of activities within these roles, there are activities which are unique to each role. Further work was undertaken in the United States in 2003 in defining the acute care nurse practitioners (ACNP) role or scope of practice and competencies through a consensus undertaken by the ACNP organisation. The competencies identified are in the areas of health, patient relations, professional, teaching, quality and culture. Recently, the knowledge, skills and abilities identified in the LACE Consensus Model as being essential for safe and competent advanced nursing practice are beyond those attained by an individual prepared in a basic nurse registration education programme. Through graduate level education, a nurse can further

develop abstract and critical thinking, the ability to assess at an advanced level, as well as advanced nursing and other essential therapeutic skills.

Advanced practice nursing roles are developing globally, and opportunities for advanced practice nursing (APRN) are expanding due to the need for expert nursing care at an advanced level of practice (Kleinpell, Scanlon, Hibbert et al. 2014). APRN is a term used to encompass certified nurse midwife, certified registered nurse anesthetist, clinical nurse specialist, and nurse practitioner. The Institute of Medicine (IOM) Report on the future of nursing has highlighted the importance of promoting the ability of APRNs to practice to the full extent of their education and training and to identify further nurses' contributions to delivering high-quality care (IOM, 2010). It is recognised that barriers exist that hinder APRN's practicing to the full extent of their capabilities. Global characteristics of the nurse practitioner role include the right to diagnose, authority to prescribe medication and treatment, authority to refer clients to other professionals and authority to admit patients to hospital. Metzger and Rivers (2014) in exploring organisational leadership by advanced practice registered nurses (APRN's) say there is a lack of structure in place for appropriate APRN supervision and recommend an advanced practice nursing organisational leadership model that includes a Chief of Advanced Practice Officer and APRN supervisors. Gardner, Duffield, Doubrovsky and Adams (2016) in an Australian study, advise Nurse Practitioners (NP's) on the need to define the standards of excellence in patient care for the entire health care community: many working in isolation without appropriate leadership or management from another peer provider thus negatively impacting on patient care outcomes. See Chapter 6 for further details.

1.10. EDUCATIONAL DEVELOPMENTS FOR ADVANCED PRACTICE

Educational programmes for advanced nurse and midwifery practice continue to grow. This growth is taking place in tandem with a confused scope of practice, the need for healthcare cost containment, different educational and training criteria and qualifications as well as fragmentation of educational programmes leading to challenges for all concerned in education and regulation. The most recent significant initiative in the field is the development of the "LACE Consensus Model" (2008) in the United States which aims to standardise education for advanced practice nurses. It is recognised that the education, expertise and experience of APN's can result in differing patient outcomes and costs particularly where standardisation in educational programmes does not exist.

Educational developments and qualifications for advanced nurse practice in 24 countries, including the requirements or recommendation for the ANP role as set down by regulatory or national bodies or nursing associations are presented. Some of these countries do not provide advanced practice programmes as yet and details of the educational requirements for nursing, specialist, post graduate and master's programmes are briefly provided in order to provide clarity in relation to the educational development for advanced practice occurring around the world. These countries are: Australia, Belgium, Canada, Czech Republic, Cyprus, Denmark, France, Finland, Germany, Ireland, Italy, Japan, Netherlands, Norway, New Zealand, Scotland, Singapore, United Kingdom (excluding Scotland) and the United States. Six selected countries, Australia, Canada, Ireland, Scotland, United Kingdom and United States are explored in detail and taken as examples of advanced educational programmes. A total of 12 educational programmes for advanced nurse practice developed by universities in Australia (2), Canada (1), Ireland (4), United Kingdom (2) and the United States (3) are provided as examples of best practice and innovation in advanced practice education.

Educational qualifications and training requirements vary across countries and within countries and range from diploma to masters and PhD level. Whilst the goal is to bring APN/ANP/AMP education to master's level not all countries have reached this goal. In most countries a masters degree in nursing is now recommended or required to qualify as an advanced practice nurse. This is the educational requirement that has been established in Ireland, and for instance, in Australia, as new university-based programmes are set up to produce advanced practice nurses. In the United States, preparation for advanced nursing practice is typically at doctoral level. In some countries a post graduate diploma is the norm as in for example Canada and Finland. In the United Kingdom, including Scotland, a first-level university degree (for example a Bachelor's degree) is still sufficient to become a nurse/midwife practitioner or a clinical nurse/midwife specialist. Having relevant work experience and on-the-job training are important criteria in determining the suitability of candidates to move to more advanced posts in these areas.

The National Council for the Professional Development of Nursing and Midwifery in Ireland was instrumental in the development of practice for clinical nurse/midwife specialists and advanced practice (2001, 2002, 2004a, 2004b, 2008a, 2008 b). An Bord Altranais, now NMBI, is responsible

for the development of Requirements and Standards for educational programmes in nursing, midwifery, nurse prescribing, advanced practice and post graduate education (ABA 1998, 2005 a ,b ,c; 2007 a, b; 2008; 2010 f; Bord Altranais agus Cnáimhseachais na hÉireann 2016a, b; Bord Altranais agus Cnáimhseachais na hÉireann 2015a, b) in addition to development in other areas including psychiatric/mental health, learning disability and children's nursing.

The RANP/RAMP in Ireland must be a registered nurse/midwife on the active register maintained by the NMBI and have held a post-registration qualification in the specialist area of nursing/midwifery for longer than 26 weeks. Many candidates have been in a specialist role for much longer. The candidate must hold a master's degree in nursing/midwifery or a higher degree which should contain substantial modules related to advanced practice in the candidates specific area of practice. Clinical components must be relevant to the area of practice. Currently the NMBI has laid down a minimum of 7 years' post-registration experience of which 5 years must be in the candidates chosen nursing/midwifery specialty. Registered nurse and midwife prescribing of medicinal products are desirable and are required by some educational institutions for awarding of the masters degree, but not by all. Nurse/Midwife prescribing of medical ionising radiation (X-ray's) is desirable but not compulsory and is obtained by a minority of candidates. See Chapter 7 for further details.

1.11 CLINICAL CRITERIA FOR ADVANCED PRACTICE ROLES

Regulatory bodies and professional organisations have laid down criteria for advanced practice. Criteria vary across and in some instances within countries. Criteria from 10 countries are presented. These countries are: Australia, Canada, Finland, Ireland, New Zealand, Scotland, Spain, Singapore, United Kingdom (excluding Scotland) and the United States, and are identified as providing examples of best clinical practice in the development of advanced practice roles. These countries have all put forward similar criteria for practice. These criteria include: registration as a nurse/midwife; acquisition of expert knowledge base, complex decision-making skills and clinical competencies for extended practice. In Ireland the required period of specialist clinical experience is currently a minimum of five years but in other countries this ranges from 2-5 years. Completion of advanced education to master's degree level, trained in the assessment of complex situations,

diagnosis and management of medical and surgical conditions and being able to provide a broad range of healthcare services, whilst working collaboratively, are typical requirements.

A further set of criteria for the advanced practice role relates to legislation. Legislation in many jurisdictions, including the United States, Australia and New Zealand, has made attempts to differentiate between the role of the advanced practice/nurse practitioner and the role of other nurses including registered nurses. The main points of differentiation are legislative title protection. This is viewed as an essential step in differentiating between roles and demonstrates that APN's/NP meet the extended standards required by the registering or regulatory authority, and through this process, the APN/NP operates within the scope of practice of the registered nurse. Thus the title nurse practitioner is protected and applies to the registered nurse who meets local jurisdiction requirements for advanced nurse practitioner authorisation. In Australia and in other jurisdictions nurse practitioners practice is authorised through legislation to provide patient service that incorporates nurse prescribing of medication, requesting of diagnostic tests and referral of patients. These are three well differentiated legislative parameters. See Chapter 8 for further details.

1.12 Prescribing Medication in Advance Practice

In many countries, including Ireland, Australia, United States, United Kingdom, Canada and New Zealand, certain categories of nurse are now authorised to prescribe medication. The United States was the first country to introduce the right for nurses to prescribe prescription medication in the mid-1970s, followed at the beginning of the 1990s by the United Kingdom and Australia. Certain provinces in Canada began to authorise this role at the end of the 1990s, and this right has progressively been extended since then. Nurses and midwives In Ireland obtained the right in 2007. An important distinction regarding the rights for nurses to prescribe drugs is whether they can prescribe independently or only under the supervision of a doctor. Countries vary in this regard. The range of medication that nurses and midwives may prescribe is dependent on legislation and on the practitioners' scope of practice. Some countries such as Ireland and Singapore require the advanced practice nurse to have completed a certified programme in

nurse/midwife prescribing and others incorporate the subject into educational programmes. See Chapter 11 for further details.

1.13 Competencies for Advanced Practice

Competencies for advanced practice are a central tenant of the advanced nurse practice/advanced practice roles. Competence is the effective and creative demonstration and deployment of knowledge and skill in human situations. Competence draws on attitudes, emotions, values and sense of self-efficacy of the learner as well as knowledge of procedures. Competencies are defined in different ways around the world leading to confusion and meaning of the word. Definitions include domains of competence, core concepts, criteria, indicators or standards. Assessment of Domains of Competence is the tool used in Ireland to define competencies for advanced practice. There are five domains in number, with each domain incorporating three dimensions: performance criteria, defined standard(s) and evidence of successful performance to meet this standard. The five Domains of Competence are: Professional /Ethical Practice; Holistic Approaches to Care and Integration of Knowledge; Interpersonal Relationships; Organisation and Management of Care and Personal and Professional Development. Scrutiny of the competencies defined for practice by other countries, identifies competencies in broad outline for some countries but does not identify a competency tool of such detail, complexity or application to practice as that used in Ireland.

While the Irish competency tool may lack application to specific specialty areas of practice, in some instances, it is an excellent example of a competency assessment tool. Ireland and New Zealand have clearly defined competencies for advanced practice. Competencies for advanced practice in New Zealand are similar to Ireland in terms of structure: three main competencies and indicators. The framework used in Ireland has an additional component to the structure: that of behaviors to indicate when a competency has been met. The Domains of Competence adopted by Ireland are capable of capturing achievement of competency, which other frameworks may not. The tool used in Ireland is presented in Appendix 10 for benchmarking comparisons.

With the number of advanced practitioners increasing a greater interest in the role, activities, potential benefits and outcomes is being generated. Studies have demonstrated the value of

APN/APM's in clinical settings and of positive outcomes such as patient satisfaction, less readmissions, in cost of care delivery and lower mortality rates. Equal or better clinical outcomes as doctors in the primary care setting have been demonstrated. There is scant literature published in relation to the advanced nurse practitioner's role in Mental Health areas of practice. Fung, Chan and Chien (2014) in their systematic review on the role performance of psychiatric nurses' in advanced practice undertaken in HongKong, in 14 studies from the literature found that mental health advanced practice nurses can potentially develop collaborative partnerships with non-mental health service providers, perform multifaceted roles and provide mental health-care services in various contexts. In a pilot study on advanced practice psychiatric nurses' outcomes of care Parrish, Peden, Staten et al. (2013) identify similar issues in mental health.

Sastre-Fullana et al. (2014) identified common traits specific to competency development in their literature review. Findings from 119 relevant publications indicate that 17 essential core competency domains pertaining to the role development of international advanced practice nursing can be found in most national frameworks. These domains may be used to further develop instruments to assess the perceived competency of advanced practice nurses and related outcomes from care delivered. Kilpatrick, Lavoie-Tremblay, Ritchie and Lamothe (2014) in their study of team effectiveness of advanced practice nursing roles and health care teams recommend that these two concepts, which have been studied separately, need further research into their association linkage so that APN roles in health care teams may be better utilised thus improving delivery of health care services to patients and families.

Capability Frameworks

The capability framework devised in Scotland is aimed at nurses working in or towards an 'advanced practitioner' role in community health nursing teams, in Scotland. This framework builds on the capabilities, practice learning achievements and key content in the capability framework for community health nursing (NHS Scotland 2007; NES, 2007a) and outlines the focus, level of practice and generic knowledge, skills and approaches needed by the advanced practitioner nursing in the community: equating to the senior level of practice in the careers development framework. Capability frameworks focus on realising an individual's full potential, developing the ability to adapt and apply knowledge and skills learning from experience,

envisaging the future and helping to make it happen. This set of skills generally arises from achievement of a specialist practice qualification, experience or through transitional education for community health nursing (NHS Scotland 2007). Advanced practice, in this model, is viewed as a particular stage on a developmental continuum between 'novice' and 'expert' practice. This framework is underpinned by the idea of capability, which goes beyond the idea of competence. Capability is based on the theory of how adults learn and develop, and includes the notion of complexity. Capability differs from competence, in that competence describes what individuals know or are able to do in terms of knowledge, skills and attitudes at a particular point in time while capability includes the ability to meet future demands by developing further competencies (NHS Scotland 2007). A capability approach fits well with the NHS Knowledge and Skills Framework (NHS KSF) (DH, 2004b), the overarching framework for reviewing the development of most staff groups in the NHS.

Following on from this notion of capability, the NHS Scotland Nursing Practice Competence and Capability Toolkit was updated in 2012 with the aim of moving towards the position where capability at advanced practice level may be evident through a portfolio of learning and competence assessment. The portfolio needs to reflect the key elements of advanced practice and the breadth of clinical and settings within which they can be demonstrated (NHS Scotland 2012). Not every Advanced Nurse Practitioner, for example Scotland, the United Kingdom and Australia will have undertaken a Masters level course. For individuals currently working in advanced practice posts and not having a formal Masters level qualification, compiling a portfolio of learning and competence assessment can help them to demonstrate their competence and capability. Education programmes supports the development and recognition of advanced practice 'capability' and prepares a practitioner to be able to fulfill the requirements and expectations of an advanced practice role, but does not grant the practitioner advanced practitioner 'status'. This requires them to achieve and demonstrate competence, confidence and expertise in practice and the required level of knowledge (NHS Scotland 2012).

From Competence to Capability

From 'competence to capability' was explored by Gardner, Hase, Gardner et al. (2007) using a capability framework in an effort to determine the level and scope of practice of the nurse practitioner in Australia and New Zealand. The original study, from which the present paper was

developed, sought to identify competency standards for the extended role of the nurse practitioner in these countries and In doing so became aware that while competencies described many of the characteristics of the nurse practitioner but not the complete scope that the concept of capability appeared to provide a useful construct to describe the attributes of the nurse practitioner (Gardner, Hase, Gardner et al. 2007). A secondary analysis of data obtained from interviews with 15 nurse practitioners working in Australia and New Zealand was undertaken that investigated whether or not the components of capability would adequately explain the characteristics of the nurse practitioner. Findings indicate that capability and its dimensions is a useful model for describing the advanced level attributes of nurse practitioners. Nurse practitioners described elements of their practice that involved: using their competences; being creative and innovative; knowing how to learn; having a high level of self-efficacy and working well in teams. This study suggests that both competence and capability need to be considered in understanding the complex role of the nurse practitioner (Gardner, Hase, Gardner et al. 2007; 2008). O' Connell, Gardner and Coyer (2014) describe competencies as being appropriate for practice in advanced nurse practice where stable environments exist and identify capability as the combination of skills, knowledge, values and self-esteem which enables individuals to manage change and move beyond competency. In presenting a discussion paper exploring '*capability*' as a framework for advanced nursing practice standards they note that leading researchers into 'capability' in health care state that traditional education and training in health disciplines concentrates mainly on developing competence and that there is a need to embrace 'capability' as a framework for advanced practice and education. Further work is needed in this area to establish if and how competence and capability are intertwined in advanced nurse practice.

1.14 ESTABLISHING ADVANCED NURSE PRACTICE POSTS

There are no agreed criteria for advanced practice posts as some posts are regulated by law as in Ireland, Singapore and New Zealand and others are governed by health care organisations or professional bodies as in the United Kingdom and Canada. In countries where advanced practice is well established there remains confusion on how posts should be constructed, limits to the role, differentiation of roles and on the governance structure needed for effective utilisation of advanced nurse practice roles across populations and communities, in hospitals and in primary care.

Little consensus on the organisational structures needed to support the role or on the role of nursing services is available. Many international publications relating to advanced practice nursing highlight the confusion and ambiguity remaining over roles and nomenclature. The title of advanced practice nurse may be losing its currency due to ambiguity and lack of consensus of the role. This is occurring mainly as a result of lack of organisational structures for health service delivery and resource planning and to an inability by health service managers to differentiate the advanced practice role from that of other nurses, such as the registered nurse and clinical nurse specialists, and also in making decisions as to how advanced practice roles may be more effectively utilised.

There is also in some countries, particularly the United Kingdom and Australia, a call for nursing practice that does not extend beyond the legislative framework of the registered nurse but that seeks to incorporate higher roles into practice and as a result a scope of practice has evolved and is continuing to evolve that seeks to fill gaps in the existing service. This has also caused difficulties for nurses who are striving to expand their roles mainly due to failure to clarify the boundaries of advanced practice in relation to roles, autonomy and decision making. Studies from Australia sought a generic description of the core features of the practice of advanced nursing. Findings indicate that the APN/NP perceives caring as being integral to direct care in advanced practice and that ANP nurses provide innovative patient care when supported by their organisation's culture and by nursing services. Scotland has developed a framework that establishes how advanced practice posts should be established, in Scotland and in the NHS as a whole (NHS 2007). The guiding principle is that such roles should be based upon demonstrable patient outcomes and service user need in order to promote good governance structures that are underpinned by consistent benchmarking of advanced practice roles at recognised levels of practice.

In the light of the requirements of the Statutory Instrument SI 3 of 2010 and likely changes to the current governance structure existing in Ireland for creation of new posts and following review of the literature a framework is presented that explores organisational structure and governance including culture and the senior nurses role in developing and supporting the advanced role. See Chapter 10 for further details.

1.15 ORGANISATIONAL STRUCTURES FOR ADVANCED PRACTICE

MIDWIFERY PRACTICE

Legislative and regulatory practices and mechanisms for midwifery vary between countries. Regulation differs by country with some countries legislating separately for nursing and midwifery practice while some make no distinction between the two and in some countries midwifery is subsumed under nursing. Midwifery is incorporated into each section of this document where relevant. Definitions and scope of practice for the role also differ across countries where midwifery exists. Education for midwifery practice differs across countries and ranges from 6 months to four years for a professional midwifery qualification, highlighting variances in type and recognition of midwifery educational and clinical programmes. Advanced practice programmes in midwifery remain at the developmental stages in most countries apart from Ireland, Canada, New Zealand and Australia. In Ireland direct entry to the Bachelor of Science in Midwifery is a 4 year programme that was introduced in 2005. Access is also through the post graduate diploma in nursing, which is of one year duration following the bachelors programme.

Changes are likely to take place in midwifery regulation, governance, education and creation of new posts as a result of new legislation. The Department of Health (2016) published "*Creating a better future together: National Maternity Strategy 2016-2026*" that focuses on health and well being with safety and normalisation of pregnancy and delivery as overriding principles. See Chapter 12 for further details.

1.16 CONCLUSION

Definition of advanced practice varies across countries, therefore causing confusion amongst the public and other professions. The proliferation of the role mainly due to nurses taking on more advanced roles, extension to the role to meet individual patient need, organisational and population need have all contributed to the growth in advanced practice and to advanced practice midwives to a lesser extent. Countries are reviewing the roles of health professionals including nurses in seeking to improve the quality of health care and to reduce the costs of health care delivery and consequently the expertise of advanced practice nursing is being acknowledged worldwide, particularly in areas such as chronic disease management, primary care, emergency

nursing and cancer care. Advanced practice nurses are taking on roles that were traditionally the preserve of doctors.

Educational qualifications and training requirements vary across countries ranging from diploma to PhD level, raising ambiguity regarding the level needed for advanced practice, which the majority of countries where advanced practice exists, agree should be master's level, yet some maintain that education should remain at the level of registered nurse.

Confusion also exists in relation to the Scope of Practice for advanced practice due to differences across countries and while some countries have developed documents, frameworks and guidelines for practice others have none. Even so there is evidence that similar criteria for advanced practice exist. It is also recognised that the competencies required for advanced practice are a central tenant of the advanced nurse practice/advanced practice roles, yet competencies are defined in different ways around the world and include domains of competence, core concepts, criteria, indicators or standards. There are no agreed criteria for establishing advanced practice posts as some posts are regulated by law and others are governed by health care organisations or professional bodies and little consensus exists on the organisational structures needed to support the role or on the role of organisations and regulatory bodies or professional organisations.

What is recognised is that the evolvment and development of advanced nursing and midwifery practice and posts must be managed in such a way that national standards are adhered to, this requires careful benchmarking against best practice internationally, thus ensuring that the role is defined within a framework of nursing and midwifery practice and best possible practice is endorsed and maintained. Scope of Practice frameworks need to keep pace with changing patient need and expanded according to the speciality.

CHAPTER 2 DEFINITIONS OF ADVANCED NURSE PRACTICE

2.1 SUMMARY

Definition of advanced practice varies across countries thus causing confusion amongst the public and other professions. Difficulties remain in providing a concise and clear definition of “advanced practice(s)”, due to the fact that definitions encompass a wide variety of practices and competencies. Internationally, achieving a broad consensus on the definition of “advanced practice nursing” is difficult as countries are at different stages in developing and implementing these advanced roles. In countries that are just now beginning to consider extensions to the traditional roles of nurses, some new practices being introduced may be considered “advanced”, while these same or broadly similar practices may no longer be considered “advanced” in those countries that introduced the role earlier.

2.2 DEFINITIONS OF ADVANCED NURSE PRACTICE

The term “advanced practice nurse” first appeared in the nursing literature in the mid 1980’s (Ruel and Motykca 2009). The International Council of Nurses (ICN) in proposing the following definition for advanced nurse practice recognises the level of confusion existing and in an attempt to give meaning to the role the organisations description relates mainly to the characteristics of the nurse practitioner role rather than to a complex blending of attributes of senior nurse clinicians (ICN 2008 b).

“A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master’s degree is recommended for entry level” (ICN, 2008 a, b).

In the United Kingdom, the Royal College of Nursing defines an ANP as a registered nurse who had studied an ANP programme at graduate or postgraduate level, with domains of competence mapped against the NHS Knowledge and Skills Framework (DoH 2004; RCN 2012).

Current national definitions of advanced practice nurses are generally consistent with this broad ICN definition, although they are adapted to each national context. National definitions of advanced practice nursing were developed by Australia, Canada, Ireland and the United States. The definition provided by the Australian Nursing and Midwifery Board (ANMB) is:

“Advanced practice nursing defines a level of nursing practice that utilise extended and expanded skills, experience and knowledge in assessment, diagnosis, planning, implementation and evaluation of the care required...” (ANMB 2014, 2006)

The definition put forward by the Canadian Nurses Association (CNA) is:

“Advanced nursing practice’ is an umbrella term describing an advanced level of clinical nursing practice that maximises the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations” (CNA 2008).

In Scotland the Career Framework for Health defines advanced practitioners as:

“Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas.” (Career Framework for Health 2006)

The definition put forward by the National Council for the Professional Development of Nursing and Midwifery in Ireland (NCNM) is:

“Advanced nursing practice [roles] promotes wellness, offer healthcare interventions and advocate healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines...” (NCNM 2008a)

The definition put forward by the Advanced Practitioner Registered Nurse Group (APRN Consensus Work Group) and the National Council of State Boards of Nursing (APRN Advisory Committee 2008), in the United States is:

“An Advanced Practice Registered Nurse” (APRN) is a nurse who: has completed an accredited graduate-level education programme preparing him/her for one of the four recognised APRN roles; Has passed a national certification examination that measures APRN role and competencies and who maintains continued competence as evidenced by re-certification; Has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients as well as a component of indirect care....” (APRN 2008)

A further definition contained in the LACE Model in the United States is that the advanced practice nurse has:

“Advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions and management of health care” (APRN 2008).

2.3 DISCUSSION

Interest in the NP/APN role has been gaining ground (Pulcini et al 2010; Morgan 2010; Brook & Rushforth 2011; Farrelly 2014), but is not universally accepted (Pulcini et al. 2010), thus, ambiguity exists in relation to where the title advanced practice nurse sits. This ambiguity is due mainly to the proliferation of titles and roles (Gardner and Duffield 2014; Cronenwett et al. 2011; Pulcini et al. 2010; ANA 2009; An Bord Altranais 2008) thus causing confusion amongst relevant stakeholders. Kleinpell, Scanlon, Hibbert et al. (2014) address issues impacting on advanced nursing practice worldwide. Koskinen, Mikkonen, Graham et al. (2012) examine advanced practice nursing in managing enduring health needs management from a global perspective.

Titles such as ‘nurse practitioner’, ‘nurse consultant’ and ‘advanced practice nurse’ and the more commonly ‘clinical nurse specialist’ (Coster et al. 2006; Sheer & Wong 2008) are now in existence. A recent National Survey of a nursing workforce carried out by Gardner, Duffield, Doubrovsky and Adams (2016) to identify advanced practice, was sent electronically to 5662 registered general

nurses (RGN) across all states and territories in Australia, using the validated advanced practice roles delineation tool that is based on the Strong Model of Advanced Practice. Findings indicate that even though there are numerous models of definitions of advanced practice nursing there is scant published research of significant scope that supports existing models. The authors call to stabilise nomenclature and say organisations are confused on how best to optimise advanced nurse practitioner's. The survey tool identified position titles where nurses were practising at advanced level had high mean scores across domains of the Strong Model of Advanced Practice and had significant differences for all other nurse practitioners including RGN's and Nurse Practitioners indicating what is advanced practice and what is not advanced practice. Findings from this study if replicated elsewhere could lead to standardisation of nomenclature and role definition.

Consensus on the characteristics of advanced practice nursing does not appear to have been reached. A meta-summary of the existing literature to identify the specific characteristics of advanced practice was undertaken by Hutchinson, East, Stasa and Jackson in 2014, in Australia. These authors say that there has been considerable research and debate about essential features of advanced nursing practice and of the differences among various categories of advanced practice nurses. Fifty manuscripts from studies undertaken internationally were included and seven domains of advanced nursing practice were identified: (1) autonomous or nurse-led extended clinical practice; (2) improving systems of care; (3) developing the practice of others; (4) developing/delivering educational programs/activities; (5) nursing research/scholarship; (6) leadership external to the organisation and (7) administering programs, budgets, and personnel (Hutchinson, East, Stasa and Jackson 2014). Domains were similar across categories of advanced nursing practice suggesting that advanced practice role categories are less distinct than often argued and that a more integrated and consistent interpretation of advanced practice nursing is needed (Hutchinson, East, Stasa and Jackson 2014; Carney 2016).

Titles also vary across countries, often raising confusion amongst the public and other healthcare professions (Schober 2007; Delamaire and Lafortune 2010). Pulcini et al. (2010), in a review of titles across countries, identified 13 different titles that advanced practice nurses may have and summarised their main tasks, and the educational level required or recommended to hold these positions.. Titles include "nurse practitioner", "advanced nurse practitioner", "nurse consultant",

“clinical nurse specialist” and others. Lafortune (2011) explored the development of advanced nursing titles in 32 European and non-European countries with 91 respondents. He identified the most common titles as Nurse Practitioner (44%); Advanced Practice Nurse (17%) and Advanced Nurse Practitioner (10%). The study does not include the category of “nurse midwife”, which in many countries is considered as an advanced role for nurses. Not included are a variety of nursing specialties which may also be considered as advanced roles (for example psychiatric/mental health nurses, nurse anesthetists or emergency nurses). Tasks described are not exhaustive, as advanced practice nurses may also carry out other tasks to those identified in the study (Delamaire and Lafortune 2010; Pulcini et al. 2010. See Appendix 8 for categories of nurses in advanced practice roles.

2.4 CONCLUSION

Difficulty lies in the broad interpretation of the concept as used in a number of advanced practice roles mainly because variations exist in the titles used, level of knowledge for advanced practice, educational qualifications for practice, scope of practice and criteria for practice, skills, competencies, role outcomes and job and organisational specification required. In countries that are just now beginning to consider extensions to the traditional roles of nurses, some new practices being introduced may be considered “advanced”, while these same or broadly similar practices may no longer be considered “advanced” in those countries that introduced the role earlier.

CHAPTER 3 HISTORICAL DEVELOPMENT OF ADVANCED PRACTICE ROLE

3.1 SUMMARY

The APN role is now well established and working in 30 countries. The title suggests that of a nurse working at a higher level than that of the registered or first level nurse. Yet, ambiguity remains surrounding the title, definition, role and function of the RANP/MP. Advanced nurse practitioners are required to demonstrate higher levels of autonomy, decision making, skills and accountability than registered nurses and midwives. Whilst research indicates that a number of nursing roles

under the generic title of advanced nurse practice, do demonstrate these competencies some do not. Resistance to the role remains in some countries.

3.2 HISTORICAL DEVELOPMENT OF ADVANCED PRACTICE ROLE

The APN role is now well established working in 30 countries (Schober & Affra 2006 c, Fagerström 2009) Advanced nurse practice (ANP) was first introduced in the United States in 1965 and since then ANP has been used as an overarching concept to signify nurses practicing at a higher level than that of traditional nurses (Sheer and Wong 2008; Farrelly 2014). Lafortune (2011) explored the development of advanced nursing roles in 5 countries and identified the percentage of advanced practice nurses amongst the total registered nurses in Australia (0.2%); Canada (0.9%); Ireland (3.8% which included CNS' and ANP's and midwives); England (0.2%) and United States (6.5%). He identified a number of titles: NP's, CNS's; ANP's, NC's s making up the study highlighting the role confusion that exists. The United Kingdom and Canada have longstanding experiences of recognising nurses in APN/ANP roles, however variations exist in the level of knowledge, scope of practice, skills, competencies and categories utilised by APN's. In Australia, the first ANP programme was introduced in New South Wales, in 1990, under the titles of clinical nurse specialist (CNS) and clinical nurse consultant (CNC) (Appel et al. 1996). Countries within the Organisation for Economic Co-operation and Development (OECD) are at different stages in implementing more advanced roles for nurses. In Belgium, Czech Republic, France, Japan and Poland, the development and formal recognition of APN's is still in its infancy, although some of these countries have already carried out pilot studies to test new APN roles and some unofficial practices may already exist (OECD 2006; Delamaire and Lafortune 2010). In the United Kingdom, the first nurse practitioner (NP) programme was introduced by the Royal College of Nursing (RCN) in the 1970's and in Ireland the first "advanced nurse practitioner" was accredited in 1996 (Sheer and Wong 2008). Numbers have grown since then, albeit slowly in many countries. There were just 400 Nurse practitioners in Australia in 2010, accounting for about 0.2% of all registered nurses, although numbers are growing worldwide (Delamaire and Lafortune 2010). There are 184 NMBI accredited posts in Ireland in 2014. The "LACE Consensus Model", developed in the USA, clarifies the roles of advanced practice nurses (APN's) and aims to standardise education, licensure and certification (Stanley et al. 2009). New Zealand's first Nurse Practitioner was approved by the

Nursing Council of New Zealand in December 2001, the centenary year of New Zealand nursing registration, but less than a decade after the commencement of New Zealand's first pre-registration nursing degrees (Jacobs and Boddy 2008).

3.3 DISCUSSION

Early research into the role of APN's, particularly in the United States, centered on comparing outcomes from APN delivered primary care and care provided by doctors in practices (Brown and Grimes 1995, Potera 2011). Later research focused on care provided in hospitals by acute care nurse practitioners (ACNP) compared to that provided by doctors in the same environment (Kleinpell and Gawlinski, 2005, Lindblad et al. 2010, Potera 2011) and on outcomes from care delivered to vulnerable or high cost patients (Cowan et al. 2006). Later research focused on the APN role (Bonsall and Cheater 2008; Lindblad et al. 2010; Farrelly 2014). These studies are important in providing clarity around the roles of APN/ANP's in countries where the role is ill defined or underdeveloped (Boontong et al. 2007; Koskinen et al. 2012). In a national census undertaken by Middleton et al (2011) on the status of Australian nurse practitioners, findings indicated the importance of the advanced practitioner role. Results from studies carried out in the United States indicate that patients are very satisfied with the care provided by APN's, particularly in primary care (Knudson 2000; Green and Davis 2005 Cole and Ramirez 2002) and in mental health (Reasor & Farrell 2005) in relation to the effectiveness of advanced practice registered nurses as psychotherapists.

In many countries, more and varied health care services are being consumed by the growing elderly population resulting in the growth of advanced practice nurses in this area (Donato 2009). Countries are seeking to improve the quality of health care delivered by reviewing the roles of health professionals, including nurses and midwives, and as a result the expertise of advanced practice nursing and midwifery is being recognised worldwide and ANP's/AMP's are increasingly taking responsibility for new service areas not previously provided, by nurses such as chronic disease management (Koskinen et al. 2012).

3.4 DEFINED AREAS OF PRACTICE

Many countries have defined areas of advanced practice which confirms the title differences existing, of which there are several, particularly in New Zealand. These are presented in Table 1 below.

Table 1 Defined Areas of Advanced Nurse Practice

Country	Defined Areas of Advanced Nurse Practice
Australia	Advanced Practice Nurses (Clinical Nurses, Consultants) Nurse Practitioners
Canada	Clinical Nurse Specialists Nurse Practitioner in Primary Care and Acute Care – Neonatal, Paediatric, and Adult
Ireland	Advanced Nurse Practice Advanced Midwife Practice Clinical Nurse Specialist
New Zealand-Areas of Practice	New Zealand-Defined Practice Areas
Emergency	Nurse practitioner Lifespan Acute care
Intensive Care	Nurse Practitioner Adult Acute Care Nurse Practitioner Child
Sexual and Reproductive Health	Nurse Practitioner Youth/Adult Health Condition
General or Orthopaedic Surgery	Nurse Practitioner Adult
Renal	Nurse Practitioner Adult/Older Health
Pain Management	Nurse Practitioner Lifespan

Occupational Health	Nurse Practitioner Adult
Adolescent Addiction	Nurse Practitioner Youth Mental Health
Forensic Mental Health	Nurse Practitioner Adult Mental Health
Respiratory Conditions	Nurse Practitioner Youth/Adult Health Conditions Nurse Practitioner Lifespan Primary Health

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> Pg 7 July 23 2012

3.5 DISCUSSION

Role ambiguity remains confusing. One reason why role confusion exists was highlighted in a survey and workshop study undertaken in Hong Kong by Christiansen et al (2013). The sample was 120 ANP's working in nurse-led out-of-hours clinics. Findings indicated that the factors ANP's perceived as the greatest challenge in hindering the development of the ANP role in Hong Kong was acceptance of the role by other health professionals and the public's attitude to the traditional methods of delivering health care in the region that did not include ANP's. On a positive note, it was found that the advent of the introduction of ANP's in Hong Kong provides more benefits than challenges by improving the quality of care delivered. Christiansen et al (2013) recommend that more extensive education of other healthcare professionals and the public be undertaken.

Standards for practice do exist in some countries. Standards related to description of the core role, education standards, generic competencies and role authorisation of advanced nurse practitioners in Australia and New Zealand are in place (Gardner et al. 2006; Carryer et al. 2007; Gardner and Duffield 2014). Practice standards for midwives were developed in Ireland (Nursing and Midwifery Board of Ireland 2015d). Brook and Rushforth (2011) argue for mandatory standards for nurse practitioners to ensure public protection and say that the role, which they define as hybrid, combining skilled nursing with medical skills, is distinct from all other nursing roles.

Studies undertaken in Australia support the Strong Model of Advanced Practice (Chang et al. 2008) as best representing the clinical experiences of participants in defining service parameters and as an operational framework for advanced practice nursing roles (Gardner 2007). The need to

establish service parameters for advanced practice nursing and to differentiate operationally between advanced practice and practitioner nursing roles is required as uncertainty surrounding how the roles of clinical specialists and advanced practitioners differ exists (Gardner et al. 2007, 2016; Hutchinson, East et al. 2014). For example eleven grades of nurse exist in the United Kingdom each with varying domains and a similar number in the United States. To substantiate this level of confusion and uncertainty, a cross-sectional, descriptive web-based survey undertaken by Pulcini et al (2010), in the United States, presents a snapshot of education, practice, and regulation for NP/APNs. Respondents were 174 key informants and active members of the International Nurse Practitioner-Advanced Practice Nursing Network of the International Council of Nurses. Ninety-one nurses from 32 countries responded. Thirteen titles were identified for the NP-APN and 23 countries had formal recognition of the NP-APN role. NP/APN education was available in 71% of the 31 countries responding to this item, with 50% identifying the master's degree as the most prevalent credential. Of these, 48% had licensure maintenance or renewal requirements for the NP/APN, with most requiring continuing education or clinical practice. Support from nurses (70%) and nursing organisations (92%) was positive while responses from physicians (83%) and their organisations (67%) were mainly negative. In order to counter this level of negativity, the study authors recommend that NP/APN's undertake greater International networking, more extensive communication of the role amongst physicians and peers and the provision of more formalised support from networks and professional bodies for NP/APN's.

3.6 CONCLUSION

Role ambiguity remains due to the differing perceptions of the role that exists mainly amongst other healthcare professionals and the public. Researchers advocate more extensive education of other healthcare professionals and the public be undertaken. Research has demonstrated that the factors ANP's perceive as the greatest challenge in hindering the development of the ANP role are acceptance of the role by other health professionals, resistance by the medical professional to the introduction of the role and in some countries the public attitude to the traditional cultural methods of delivering health care in that country that did not previously include ANP's. On a positive note findings indicate that advanced practitioners provide more benefits than challenges

by improving the quality of care delivered. Defined areas of advanced practice which confirms the title differences existing in countries are presented.

CHAPTER 4 EXTENSION OF THE NURSES' ROLE

4.1 SUMMARY

Extension to the role of advanced nurse practitioner has developed as a result of many factors. In the United States the role evolved due to legislative, policy and economic changes affecting health care. Different factors influenced extension to the nurses' role in Australia and Canada where APN's was introduced in rural or remote regions to provide primary care to populations who were underserved by doctors and absence of provincial and/or territorial legislation and regulation.

Extension in Ireland is due mainly to due to recommendations in the Report of the Commission on Nursing (1998) to role extension and to increases in health care costs, reduction in junior doctor hours and support in the development of the role from the National Council for the Professional Development of Nursing and Midwifery and An Bord Altranais (NMBI). Sweden is a recent entry to advanced practice and thus far has had mainly positive experiences to introduction of the role. In the United Kingdom, NP' s role was consolidated at the end of the 1990s with numbers increasing significantly, it remains difficult to assess their number because many of these new jobs and roles are not based on a registerable qualification, and there are sometimes local differences between job titles and grades. The nurses' role has continued to expand in the United States with advanced practice nurses taking on more and more roles in acute and primary care settings with positive outcomes. Magnet hospitals have also reported positive patient outcomes, nurse autonomy and good working relationships between advanced nurse practitioners and doctors

4.2 EXTENSION OF THE NURSES' ROLE

Increased interest in alternative approaches to health care delivery has developed first in the United States and latterly across the world (Institute of Medicine 2011), due mainly to legislative, policy and economic changes affecting health care including concerns regarding cost, quality and access to care. As a result nurse practitioners carry out a range of activities that may otherwise be

performed by doctors including diagnostics, screenings, prescribing of medication or medical tests, health prevention and education and the monitoring of patients with chronic illnesses. ANP's may undertake the roles autonomously or in consultation with doctors (Delamaire and Lafortune 2010). This has led to the overlap between the doctor's role and that of nurse practitioners, and others (APRN 2008). Nursing roles have extended as a result in the United States (American Nurses Association 2010) and worldwide (Currie et al. 2011; Carney 2016). In the extended roles of advanced nurse practitioners there are generally two main categories: the "*nurse practitioners*" (or advanced nurse practitioner) and "*clinical nurse specialist*" and differences may exist between these two categories. Clinical nurse specialists undertake some or all of the APN's roles but do not normally or officially discharge patients. The extended role of the nurse in Canada, Australia, Britain, United States and Scotland is explored.

Periods of growth in mental health nursing took place first the 60's and 70's with the introduction of mental health nursing programmes (Perraud et al 2006). Programmes were designed for CNS's in the first instance with emphasis on nurse-patient relations, psychiatric nursing, empathy, therapeutic relationship and education. The creation of PMH programmes in advanced practice commenced in the early 2000's with great change in nursing practice that was called a decade that unsettled a speciality by Delaney (2005). Advanced practice roles have recently been introduced in the Netherlands. Zwijnenberg and Bours (2012) in their study of nurse practitioners and physician assistants in Dutch hospitals on their role, extent of substitution and facilitators and barriers experienced in the reallocation of tasks found that barriers remained in relation to some areas of substitution.

4.3 EXTENSION OF THE NURSES' ROLE IN AUSTRALIA

Similar to Canada, nurses in advanced roles were first introduced in rural or remote regions in Australia to provide primary care to populations who were underserved by doctors and today nurses in these areas are often the first health care provider. Roles and tasks for these nurses include: assessing, diagnosing, treating and monitoring a variety of health problems; initiating, ordering and interpreting pathology and radiology; counseling and referring patients for depression through the development of close networks with area psychologists; organising out-of-area transfers for patients requiring complex acute care and providing preventative health and

education, and family childcare. The midwifery role has also extended as a result (Australian Nursing and Midwifery Council 2009, 2014; Nurse Practitioner Core Competencies Content, USA 2014).

4.4 EXTENSION OF THE NURSES' ROLE IN CANADA

Nurse Practitioners were first introduced in Canada in the mid-1960s as a response to the general healthcare care needs of rural and remote areas where doctors were in short supply and financial incentives for nurses to take on these positions without recognition was lacking. Other reasons for the extension of the role included the absence of provincial and/or territorial legislation and regulation, little public awareness of the role, and weak support from other health professionals (DiCenso et al 2009). In the 1990s, due to the "*health system renewal*", combined with limited resources and the will to develop primary care, renewed interest in nurse practitioners took place (DiCenso et al 2009).

Two broad categories of NPs currently co-exist in Canada: primary care NPs and acute care NP's, working in hospitals. While the number of all NP's in Canada doubled between 2003 and 2008, they still account for only 0.6% of all registered nurses. Now registered nurses in extended roles work in some rural and remote regions to carry out systematic assessment and diagnosis and treatment of patients with relatively minor health problems, accounting for half of all cases visited by NP's (British Columbia Ministry of Health 2002), and in transfer to doctors in complex emergencies (Jaatinen et al. 2002). Nurse practitioners in primary care and acute care nurse practitioners also emerged in hospitals at this time in order to address gaps in service delivery traditionally performed by doctors and residents whose numbers had continued to decline (Canadian Nurses Association (CAN) 2005; Nurse Practitioners' Association of Ontario 2010).

4.5 EXTENSION OF THE NURSES' ROLE IN IRELAND

Advanced nurse and midwife practice was first introduced in 2001. The Health Service Executive in 2008, supported innovative nursing and midwifery practice including role expansion. This expansion resulted from the deliberations and subsequent recommendations from the nursing and midwifery expert group that was set up in 2004 to advise on, and coordinate the involvement

of nurses' and midwives in any future extension to roles in Ireland that may arise as a result following implementation of the European Working Time Directive (EWTD) for non consultant hospital doctors. Since the introduction of advanced practice in Ireland, numbers have grown steadily. By May 2014 there were 140 persons registered with NMBI and 184 NMBI accredited posts of which 7 are in Midwifery (RAMP); 9 are in Children's Nursing; 144 are in General Nursing; 2 are in Intellectual Disability Nursing; 20 are in Psychiatric Nursing and 2 are in Public Health Nursing. See Appendix 15. RANPs are now working in acute, chronic, emergency, midwifery and primary care settings. This growth has occurred mainly due to recommendations in the Report on the Commission on Nursing (1998) to extend the nurses' role. Extension to the role is also due to increases in health care costs, reduction in junior doctor hours, supports in the development of the role from the National Council for the Professional Development of Nursing and Midwifery, An Bord Altranais and now NMBI and to changes taking place in advanced practice in other countries.

4.6 EXTENSION OF THE NURSES' ROLE IN SWEDEN

In 2003, the University of Skövde, Sweden, was the first Nordic university to introduce an APN programme into primary health care (Hallman & Gillsjö (2005). Education for advanced practice commenced with an Advanced Specialist Nurse master's degree programme that met the requirements of the Swedish National Board of Health and Welfare and that met ICN standards was developed in collaboration with Skaraborg Primary Health Care, Sweden. APN's are permitted by the Board to make medical decisions, order diagnostic tests (laboratory and x-rays), diagnose and make referrals but are not permitted to prescribe medication in related to the diagnoses they make. Registered nurses in Sweden are permitted to prescribe medication from a limited formulary, mainly over the counter drugs, following a supplementary pharmacology course (Bergman et al 2013). A further extension to the role into primary care occurred in Sweden. In an evaluation study of the role of the four first APN's in primary care teams, undertaken in 2010 with 81 respondents, results indicated mostly positive experiences of the role. Access to care, cooperation amongst team members and increased patient flow were found although barriers were limited autonomy and inability to prescribe medication (Altersved et al 2011).

4.7 EXTENSION OF THE NURSES' ROLE IN THE UNITED KINGDOM

In the United Kingdom, NPs have been part of the National Health Service since the early 1970s, and their role was consolidated at the end of the 1990s with numbers increasing significantly since then (Royal College of Nursing, 2005). It remains difficult, however, to assess precisely their number because many of these new jobs and roles are not based on a registerable qualification, and there are sometimes local differences between job titles and grades (Buchan et al. 2008) and role dissatisfaction exists in some areas as a result. In a survey of 3096 nurse practitioners in the United Kingdom, undertaken by Buchan et al. (2008), dissatisfaction with the role was found with half reporting that their posts were unique in their organisations thus leading to a sense of isolation. A further cause of concern reported by 44% of respondents was difficulty in referral to other professionals, including X-Ray referrals, being refused, mainly due to lack of understanding and awareness by these clinicians of their role (Ball 2006). NP's are mainly working in the primary care sector, some with little or low levels of autonomy, particularly in hierarchical situations with general practitioners. Some nurse practitioner posts have also emerged recently in hospitals (RCN 2008).

4.8 EXTENSION OF THE NURSES' ROLE IN THE UNITED STATES

The nurses' role has continued to expand in the United States with advanced practice nurses taking on more and more roles in acute and primary care settings with positive outcomes. Meyer and Miers (2005), in research relating to patient outcomes and mortality rates undertaken in the acute care setting, found that advanced care practice nurse's (ACPN's), caring for post-operative cardiac surgery patients generated a reduction in length of stay by 2 days per patient. Also, in Magnet hospitals positive patient outcomes, nurse autonomy and good working relationships between nurses and doctors exist (Laschinger et al. 2003; Aiken et al. 2008; Brook and Rushforth 2011; Leigh 2014). A new advanced nursing role has emerged in primary health care in relation to chronic disease management (Nurse Practitioner Core Competencies Content 2014). This new role was inspired by the approach used by certain Health Maintenance Organisations (HMOs) and is titled Community "Matron", who usually manages a group of patients with severe conditions. Community matrons assume responsibility for the planning, coordination and provision of care, as well as the ongoing monitoring of care quality and outcomes. The role of community matron overlaps to a large extent with the traditional role of general practitioners as coordinators of patient care in the primary care setting (American Nurses Association 2010).

4.9 CONCLUSION

Extension to the nurses' role has resulted in mainly positive outcomes to care being delivered by advanced nurse practitioners reported. Extension to the role has been mainly due to increases in health care costs. A new advanced nursing role has emerged in primary health care in relation to chronic disease management and managed by a Community "Matron", who usually manages a group of patients with severe conditions and assume responsibility for the planning, coordination and provision of care, as well as the ongoing monitoring of care quality and outcomes, and overlapping to a large extent with the traditional role of general practitioners as coordinators of patient care in the primary care setting. Whilst positive outcomes were achieved this is not always the case.

In the United Kingdom it remains difficult to assess precisely the numbers of advanced nurse practitioners in place because many of these new jobs and roles are not based on a registerable qualification, and there are sometimes local differences between job titles and grades. Research has indicated that role dissatisfaction exists in some areas as a result with nurses' reporting that their posts were unique in their organisations thus leading to a sense of isolation and respondents having difficulty in referral to other professionals, mainly due to lack of understanding and awareness by these clinicians of their role. It is evident that extension to the role has heralded in new practice possibilities for some nurses but is also posing challenges for nurses working at advanced practice level in some areas. These difficulties will require attention in the future.

CHAPTER 5 REGULATION OF ADVANCED PRACTICE

5.1 SUMMARY

Countries around the world have adopted different regulatory systems for nurses and for advanced practice. Some regulate advanced practice but others such as Sweden, United Kingdom and Australia do not differentiate between regulation of nurses and regulation of advanced practice. Regulation of Nursing and Midwifery in Ireland is through Legislation via Nursing and Midwifery Board of Ireland (NMBI); in Japan through Legislation and Certification by the Japanese Nurses Association (JNA); in New Zealand through Legislation via the Nursing Council of New Zealand; (NCNZ); in Singapore through Legislation; in the United Kingdom by the Nurses Act (1919) and the Midwives UK (1902) through the UKCC. A similar but distinct regulation of 8 health professions takes place through Legislation termed WET BIG in the Netherlands. State regulation occurs in Australia where each state has its own regulatory authority. In Canada, Provincial regulation through separate acts in each of the 10 provinces and 2 territories occurs. Regulation in Germany and Switzerland is through Federal State law. Regulation of nursing in Italy takes place through Colleges of Nursing. Legislation through Licensure via Boards of Nursing takes place in the United States. Regulation in Sweden is through the National Board of Health and Welfare, in Spain through the Ministry of Education and General Council of Nursing and In Norway through the Ministry of Education and Research. Separate Regulation of Midwifery occurs in Ireland, United Kingdom, Netherlands, Spain and Sweden. Regulations for advanced nurse practice occur in 11 countries. These countries are Australia, Canada, Hong Kong, Ireland, Netherlands, New Zealand, Scotland, Singapore, Spain, United Kingdom and United States.

5.2 REGULATION OF ADVANCED PRACTICE

Regulatory systems are in place to authorise advanced practice. Authorisation normally includes educational preparation and the protection of titles and systems for licensing or registration. Even though regulation and regulatory authority must work to protect public safety there is a lack of consistency in regulatory systems and professional awards around the world resulting in confusion for the public, legislators, regulators, professional nursing and midwifery organisations, nurses and midwives and other health care providers in most areas related to advanced nursing practice (Delamire et al 2010), regarding tiding, credentialing, and scope of practice, educational requirements and costs related to advanced nursing practice.

Legislative and regulatory practices and mechanisms vary between and within countries. Regulation differs by country with some countries legislating separately for nursing and midwifery practice, some make no distinction between the two while in some countries midwifery is subsumed under nursing. All European countries have legislation to determine the practice of health professions yet regulation of advanced practice takes several forms due in part to the fact that the evolution of nursing practice has produced an increasing body of knowledge as well as multiple levels of nursing practice. The United States and Canada have regulatory powers in place for advanced practice nursing (NCSBN Position Paper, 1993). Licensure is the preferred method of regulation for advanced nursing practice in the United States.

The Council of the European Union produces directives from time to time, which have direct implications for nursing and midwifery practice. These relate to mutual recognition of qualifications, training of nurses and midwives, knowledge and clinical experience necessary for nursing and midwifery practice and the activities of a midwife. The scope of midwifery practice is outlined within 2005/36/EC (An Bord Altranais 2005). This directive concerns the coordination of provisions laid down by law and regulation or administrative action in respect of the activities of midwives. The directive outlines the minimum knowledge and clinical experience necessary for midwifery and outlines the activities that midwives are entitled to take up and pursue.

Professional nursing organisations have supported the recognition of advanced nursing practice through the mechanism of regulation in some countries and through voluntary certification in others. These systems have evolved mainly due to the difficulty inherent in applying professional certification requirements to regulatory systems including legal regulations as these are the responsibility of legislators and Boards of Nursing (APRN 2008). The purpose for any government or regulatory body when regulating advanced practice is the protection of public health, safety and welfare. Premises surrounding regulation of advanced practice are similar across countries where advanced practice is regulated. The criteria for regulation should reflect minimum requirements for safe and competent practice and should be the least burdensome criteria consistent with public protection (Delamire et al 2010). Regulation of advanced nurse practice in 19 European and OECD countries is presented in outline in Appendix 1. See table 2 for a summary of premises surrounding the regulation of advanced practice.

Table 2 Premises Surrounding Regulation of Advanced Practice

- Professional nursing standards as embodied in voluntary certification programmes should encompass more than essential criteria
- Clear and specific legislative mandate will strengthen the Board's authority to promulgate rules relating to advanced nursing practice
- The public has a right to the access to health care, and to make informed choices regarding selection of health care options, through knowledge of the area of expertise, qualifications and credentials of individuals who provide health care
- The public has a right to rely on the credentials of health care providers in making choices and decisions regarding health care.

(Adapted from LACE Consensus Model 2012)

5.3 REGULATION OF NURSING IN AUSTRALIA

In Australia Nurse the ANP practitioner is protected by legislation and the role is defined by national standards. A regulatory framework and extended practice is supported by legislation. Conversely the ANP sits within the Registered Nurse scope of practice and with no requirement for additional regulation (Gardner et al 2010, Gardner and Duffield 2014). In 2006, the Australian

Nursing and Midwifery Council adopted standards nationally that had been developed collaboratively through a research project undertaken in 2004 by the Australian Nursing Council and the Nursing Council of New Zealand. Standards related to description of the core role, education standards, generic competencies and standards for authorisation of advanced nurse practitioners in both Australia and New Zealand (Gardner et al. 2006, Carryer et al. 2007; Gardner and Duffield 2014, Nursing and Midwifery Board of Australia 2014). Other advanced practice roles in Australia and internationally remains undifferentiated from the nurse practitioner role and poorly defined with a multitude of different titles creating confusion in and outside the nursing profession (Gardner and Duffield 2014; Gardner, Duffield, Doubrovsky and Adams (2016) Identify advanced practice in a National Survey of a nursing workforce.

Historically, there are two levels of nurses in Australia, the registered nurse and the enrolled nurse. The Australian Nursing and Midwifery Council Inc. (ANMC 2009) published competency standards for registered and enrolled nurses that are core competencies which all nurses must possess. These assist in indicating the scope of nursing practice. Each of the six states and two territories in Australia has a nurse regulatory authority, which maintains its own register of registered and enrolled nurses. It is a legal requirement under the Nurses' Acts of each state and territory that nurses are registered or enrolled in the state or territory in which they intend to practice. Requirements across states may vary. Once registered in one state or territory, mutual recognition laws in Australia provide for recognition of certain categories of registration across state boundaries and nurses may be eligible for registration provided there is a similar registration category in that state (ANMC 2009). Current legislation is in the process of harmonising the scope of practice of all professionals. The Great Southern Managed Health Network demonstrates a web based management system that is supporting the work of professionals across the country and particularly in rural areas. Collaborative processes are being put in place to advance this further. See Appendix 1.

5.4 REGULATION OF NURSING IN CANADA

In the late 1990s, nurse practitioner regulation was supported by doctors in order to have guarantees of appropriate skills and the role is now recognised in the legislation of all ten provinces and three territories. Professional legislation governing nursing practice in Canada is a

provincial rather than a federal responsibility and regulation is via separate acts in each of the ten provinces and two territories. Regulation defines self-governance, scope of practice and mechanisms for registration and quality assurance. Licensing examinations are nation-wide and conducted under the auspices of the Canadian Nurses Association (CNA) Testing Service. Licensing is therefore reciprocal between the ten provinces and two territories. See Appendix 1 for further details (CNA 2005; Nurse Practitioners' Association of Ontario 2010).

5.5 REGULATION OF NURSING IN DENMARK

There is no legally protected specialist nurse title except that of home visiting nurse and therefore there is no regulation for advanced practice in Denmark (Danish Nurses Organisation 2005). The Bachelor degree in Nursing is regulated by the Ministry of Education. Registration is the responsibility of the National Board for Health which authorises the right to practice and which holds registers for 17 professional groups including nurses and midwives. The Board follows up and evaluates reforms, legislation and activities conducted by municipalities, county councils and other organisations (Regulation of Nursing in Denmark OECD 2006; Nursing Education in Denmark 2006). See Appendix 1.

5.6 REGULATION OF NURSING IN FRANCE

There is no regulation for advanced practice nursing in France. The nursing profession is seeking to expand advanced nursing practice and the development of new advanced programmes were reported in 2006 (ICN 2006). Regulation of first level nurses is the State certification as approved by the Ministry of Health. There is one first level nurse provided through hospital-based schools of nursing, includes three years of study, exiting with the state diploma. General training is followed by specialisation at post registration level. Nursing is classified as a paramedical profession and midwives are classified as a medical profession (OECD 2005, 2006) See Appendix 1.

5.7 REGULATION OF NURSING IN FINLAND

Specialist nurses are not recognised through separate registration. Development of new advanced practice programmes were introduced in 2006 as reported by the ICN (2006). These are the titled Masters degrees in Health Care. Regulation of first level nurses is through the Ministry of Education who approves degree programmes. One of the three national boards of the National Authority for Medico-Legal Affairs deals with registration/authorisation to practice for both levels of nurse and keeps a register of all health care personnel (OECD 2006; Workgroup of European Nurse Researchers 2001; EU 2000). There are two levels of nursing in Finland: registered and practical. The Registered nurse/registered public health nurse receive similar training but are regarded as separate professions. Exit qualification is the Bachelor in Health Care. The public health nurse is qualified as a nurse and a public health nurse (OECD 2006, ICN 2006). See Appendix 1.

5.8 REGULATION OF NURSING IN GERMANY

There is no recognised advanced nurse practice in Germany. Post-basic education and specialisation is regulated by the federal states (OECD 2006). There is no national system of registration or a regulatory nursing body and responsibility for registration is devolved to the regions. The National Nursing Act and Ordinance of 1985 regulates general nurse education on a legal basis at national level and defines the professional competence and responsibilities of nurses. The National Nursing Act regulates the education of pediatric nurses and nurse assistants whereas federal state laws regulate the education of branch nurses for care of the elderly (OECD 2006). There are two levels of nurse in Germany: first and second level. As there is no registration system in Germany, the term registered nurse is not used (OECD 2006; German Nurses Association 2006). See Appendix 1.

5.9 REGULATION OF NURSING IN IRELAND

In Ireland the process of Regulation is undertaken in accordance with criteria set down by the National Council for the Professional Development of Nursing and Midwifery (NCNM, 2008),

whereby a successfully registered RANP/RAMP is placed on a separate division of the Register held by the NMBI. NMBI has legislative responsibility for registration and re- accreditation of individuals who have met the criteria and standards. The NMBI registration committee meets four times each year and may also remove accreditation from any RANP/RAMP post that no longer meets the criteria set by the NMBI.

The review of the literature suggests that Ireland is at the forefront of advanced practice regulation, development and implementation. The Nurses and Midwives Act (2011) replaces all other acts for nursing and midwifery in Ireland and is the current statutory framework for the regulation of nursing and midwifery. Advanced nurse practice is also regulated under the Act. The Nursing and Midwifery Act (2011) was preceded by Nurses Rules 2010 under which SI 3 of 2010 (An Bord Altranais) (Additional Functions Order) will introduce advanced practice into law for the first time. The additional functions assigned under SI 689 of 2010 Nurses Rules, 2010 (Extracts) to the Board under the Act, gives An Bord Altranais additional functions in relation to the accreditation of advanced nurse practitioner posts and advanced midwife practitioner posts, and the registration of advanced nurse practitioners and advanced midwife practitioners in accordance with criteria set by the National Council for the Professional Development of Nursing and Midwifery (ABA 2007 a; 2010 b, c; Bord Altranais agus Cnāimhseachais na hÉireann 2016a, b; Bord Altranais agus Cnāimhseachais na hÉireann 2015 a).

In preparation for the Commencement Orders pertaining to Advanced Practice, An Bord Altranais will facilitate the development of Requirement and Standards. Underpinning any requirement or standard will be the protection of the public. Education and training models will be developed that may include changes from the existing models. Within the Act, the meaning of “advanced nurse practitioner” is a person for the time being registered in the division of the register on which are registered the names and particulars of advanced nurse practitioners. This new divisions of the register is known as the Advanced Nurse Practitioner Division and the Advanced Midwife Practitioner Division of the Register. See Appendix 2 for the Criteria for Advanced Practice Posts in Ireland (ABA 2005 a, b, c; 2007 a, b; 2008; 2010 f; g).

The nursing and midwifery professions in Ireland are self-regulated meaning that certain responsibilities for regulation are granted by the state through legislation to An Bord Altranais (NMBI), the professional regulatory body. It is the legal definition of nursing and midwifery practice, which is included in professional legislation, that establishes the legal basis for the scope

of practice in which a registered nurse or midwife may engage, while fulfilling relevant European Union Directives (EU Directive 2005/36/EC of the European Parliament and the Council). The function of An Bord Altranais is to provide for the registration, control and education of nurses and to provide for other matters relating to the practice of nursing and the persons engaged in such practice. The general concern of NMBI is to promote safe practice, high standards of professional education and training and professional conduct among nurses (NMBI 2015b, c). There are currently seven divisions of the register: general nurses, psychiatric nurses, sick children's nurses, intellectual disability nurses, midwives, public health nurses and nurse tutors. A separate register for advanced nurse and midwife practice was introduced under new legislation in 2010. Many nurses have more than one qualification registered (An Bord Altranais 1998). NMBI, through detailed accreditation process, ensures protection of the public from RANP/RAMP practice and ensures competencies for safe practice are maintained. See Appendix 1.

5.10 REGULATION OF NURSING IN ITALY

Advanced nurse practice is not yet introduced in Italy hence there is no regulation in place. Registers for nurses are kept by colleges of nursing in each province and allow practice throughout Italy. According to the law, the aims of the provincial colleges are to protect the public and support and guarantee the professionalism of nurses. There is no central control/validation of degree courses. General nursing is a three year programme, takes place in universities and is based in faculties of medicine. Specialty training is undertaken at post-registration level and midwifery is a separate 3 year course (Workgroup of European Nurse Researchers 2001; European Commission 2000; OECD 2006). See Appendix 1.

5.11 REGULATION OF NURSING IN JAPAN

There is no regulation of advanced practice in Japan as the role does not exist. Two levels of Nursing exist in Japan: registered and licensed practical nurse and there is regulation of first and second level nurses. The Public Health Nurse, Midwife and Nurse Law defines the terms and scope of duties for registered nurses, midwives and public health nurses and licensed practical nurses. Registration is obtained by: qualifying from the course, passing the government examination and

obtaining a license from the Ministry of Health, Labour and Welfare. Licensed practical nurses obtain a license from prefecture (regional) governors; this enables them to work in any prefecture but they require instruction from doctors, dentists, or registered nurses to perform nursing duties. There are no state level qualifications for specialized. Various organisations and academic societies offer their own certification systems including the Japanese Nursing Association (JNA) (OECD 2006) All JNA certificates are renewable 5-yearly on the basis of performance reports (Japanese Nursing Association (2006). See Appendix 1.

5.12 REGULATION OF NURSING IN THE NETHERLANDS

Development of new advanced practice programmes were reported in the ICN a network press release for 2006. Specialist training programmes are specified by both nursing associations and employers. These include intensive care nursing of adults; children; neonatal; cardiac care; post – basic training; higher professional education (ICN 2004). Midwifery is not as a specialism of nursing and is regulated as a separate entity to nursing. The Diploma Van Verpleegkundige² regulated nursing practice since the 1921 Act (OECD 2006). The 1993 Wet BIG (the individual Health Care Professions Act removed the ban on the unqualified practice of medicine thus paving the way for alternative medicine (OECD 2006). The WET BIG regulates eight health care professions and states that only those registered as *Verpleegkundige* can use the title and such registration only takes place once the registrar is informed that the candidate has an appropriate diploma. This system came into force in 1995.

Nurses must register on the BIG-Register. This is a division of the Central Information Centre for Professional Practitioners in Health Care which is an executive agency of the Ministry of Health, Welfare and Sport. Periodic renewal of registration is required in order to ensure that the knowledge and skills of those included in the BIG-register still meet the minimum standards of quality required. Theoretically anyone can practice some types of nursing as it is neither legally defined nor protected in law. The *Wet BIG (1993)* designates certain activities as reserved and nurses can undertake these procedures under orders from a professional (i.e. doctor, dentist). The law however does not indicate that only registered nurses can undertake such acts based on the relevant professional's order. Anyone competent can commit such an act, the onus being on

the primary professional to make sure that the person so ordered is in fact competent to perform the procedure (OECD 2006). Since the introduction of the Wet BIG, no specialist nurse training is legally regulated. Under article 14 of the Wet BIG regulation can be made defining the legal title of Nurse Specialist (OECD 2006). See Appendix 1.

5.13 REGULATION OF NURSING IN NEW ZEALAND

In 2005, the Nursing Council of New Zealand published a framework for post-registration education in support of its continuing competence requirements. The nurse practitioner is one of the four parts of the register and up to 5% of nurse practitioners are being audited each year. The Nursing Council of New Zealand is the statutory authority governing the practice of nurses. In 2003, the Health Practitioners Competence Assurance Act established a common and consistent framework across health professions, while retaining separate registering bodies, including a new separate Midwifery Council. The Council is also responsible for professional conduct matters including setting and monitoring standards, keeping a register and issuing annual practicing certificates.

In 2004, nursing registers were replaced by four scopes of practice for registered nurse, nurse practitioner, nurse assistant and enrolled nurse. There are 48.000 active registered nurses and 2903 midwives in New Zealand. Midwives are registered separately. The principle purpose is: “to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are compliant and fit to practice their profession” (Competence Assurance Act HPCA Act, 2003).

Standards of competence are assured by The Nursing Council of New Zealand by four methods: recertification audit, evidence of practice, professional development and assessment of competence. The National Council states that if a person has the responsibilities of a nurse as defined by the Nursing Council Scopes of Practice and is using nursing knowledge in a direct relationship with clients, a practicing certificate must be in force (Nursing Council of New Zealand 2008, 2012a, b, 2014). The Council’s role and responsibilities are outlined in the Health Practitioners HPCA Act Competence Assurance Act 2003; Moore 2005; Nursing Council of New Zealand 2008, 2012a, b) See Appendix 1.

5.14 REGULATION OF NURSING IN NORWAY

The Ministry of Education and Research regulates advanced practice. Development of new advanced practice programmes is reported in the ICN apnetwork press release for 2006. Masters and doctoral programmes are offered, including the masters in advanced nursing practice (ICN 2006). Regulation of first level nurses is provided by the Ministry of Education and Research which also regulates nurse education. The Ministry of Health and Care Services issues the license for practice as a Registered Nurse after an approved Bachelor Degree. There is one registered nurse qualification. Specialist post-graduate courses of at least 1 year in length are available in a wide range of areas (Workgroup for European Nurse Researchers 2001; Nursing in Norway OECD 2006). See Appendix 1.

5.15 REGULATION OF NURSING IN SCOTLAND

Regulation of Nursing and Midwifery in Scotland is through the United Kingdom Central Council (UKCC). According to the Commission for Healthcare Regulatory Excellence (CHRE 2009) practitioners are always accountable to their regulatory body whatever the level or context of practice. The core focus of regulatory bodies is the professional's fitness to practice. The primary responsibility for the governance of advanced level practice should rest with employers and commissioners (CHRE 2009). This position is supported by each of the four UK Health Departments (Do H 2007).

Risks to patient safety arise when professionals take on roles and responsibilities for which they lack the competence to do so or where they practice without adequate safeguards. The activities that professionals undertake at advanced level practice must not lie beyond the scope of existing regulation unless the nature of their practice changes to such a significant extent that their scope of practice is fundamentally different from that at initial registration (Commission for Healthcare Regulatory Excellence CHRE 2009). According to the Commission, advanced level practice reflects a set of responsibilities, competencies and capabilities which act as an indicator of a particular stage on the nursing career development ladder (CHRE 2009). Well developed specialized governance arrangements surrounding all types and levels of practice, including advanced nurse practice, is necessary in order to control for risks to patient safety from an individual professional's

practice without unnecessary recourse to an additional formal regulatory framework and also to support good governance at advanced level nursing (CHRE Scottish Report 2009). See Appendix 1.

5.16 REGULATION OF NURSING IN SINGAPORE

Nursing and midwifery in Singapore is regulated through the Singapore Nursing Board (SNB). The Board is entitled to regulate advanced practice nurse through the Nurses and Midwives Act (2012), under sections 32 (8) and 44, which came into effect on April 1st 2012. The Board maintains a register called the Advanced Practice Nurses Register. The Board with the approval of the Minister has powers to regulate, certify and re-certify advanced practice nurses and to regulate the conduct and titles of APN's and to publish the names of advanced nurse practitioners in the Gazette. The Board regulates standards for the education and preparation of nurses, registered midwives and advanced practice nurses (APN's) to ensure that nurses are prepared and competent to practice. The SNB also sets standards and accredits and monitors nursing and midwifery programmes delivered in Singapore. The standards and criteria for accreditation are defined in the Standards for Nursing Education and Standards for Advanced Practice Nurse Education. The SNB also monitor accredited programmes and will undertake regular site visits to educational institutions and clinical sites to monitor compliance with regulations and standards. If considerable changes are made to a curriculum that may affect the continued accreditation of the programme these changes must be submitted to the SNB two months prior to implementation of the changes (Singapore Nursing Board 2012). See Appendix 1.

5.17 REGULATION OF NURSING IN SPAIN

In Spain regulation of first level nurse's education is regulated by the Ministry of Education. In 2001, registration became the responsibility of the General Council of nursing which is responsible for the regulation of nursing and advanced nurse practice. The midwifery qualification is pecialize in law. All nurses must be registered with their local Provincial College of Nurses. There is one level of nurse: the registered nurse. Post-registration courses are available in midwifery (2 years), mental health (1 year), care of the elderly, pediatrics', community health, and special care nursing and nursing management. All nurses must be registered with their local provincial college. A move

towards regulation of advanced nurse practice occurred in 2006 and graduate-level advanced programmes leading to a Master of Nursing Science, have been developed at several universities. The programme includes nursing research, teaching, management and advanced care. Following agreement with the Ministry of Education and Science, doctoral programmes were introduced in 2006 by some regional governments (European Commission 2000; Workgroup of European Nurse Researchers 2003; Moreno-Casbas 2005; OECD 2006; Zabalegui A et al. 2006). See Appendix 1.

5.18 REGULATION OF NURSING IN SWEDEN

Advanced nurse practice is not regulated in Sweden. The Swedish nurse is regulated and the title “nurse” is protected as a person who is a general care nurse. Regulation is as set out in law in the Act (1998: 531 chapter 3 paragraphs 2) deals with specialism relating to professional activities within the health care system. All nurses in Sweden are general care nurses and must register with the National Board of Health and Welfare. The scope of nursing activity is not legally defined but the National Board of Health and Welfare (*Socialstyrelsen*) has issued general recommendations describing the skills required of the nurse in various fields of nursing as set out in general guidelines. Post basic courses for nurses are not regulated by national law. Midwifery is regulated in law. The practice of the specialist activities are not regulated in law. Essentially the employment market sorts out the demand for nurses in various areas of practice (European Commission 2000; OECD 2006). See Appendix 1.

5.19 REGULATION OF NURSING IN SWITZERLAND

There is no national accrediting body for specialist programmes and therefore advanced practice is not regulated (OECD 2006). University programmes in advanced practice are offered in several universities (OECD 2006). Regulation of first level nurses was through the Red Cross; but is now at Federal level through various mechanisms. There is one level; the registered nurse. Currently nursing is in a period of transition by two routes: the 3 year diploma based in a school of nursing (higher vocational training) and the 3 year Bachelor’s degree in a University of Applied Science (higher education). With the introduction of the Bologna system, nursing education is now at bachelor level (OECD 2006). See Appendix 1.

5.20 REGULATION OF NURSING AND MIDWIFERY IN THE UNITED KINGDOM (excluding Scotland)

Nurses became regulated via the Nurses Registration Act, 1919. Midwives were first regulated in England through the United Kingdom 1902 Act. Discussion is taking place on the regulation of advanced nurse practice in the United Kingdom and in a report from the Prime Minister's Commission on the future of nursing in England he points out that The Nursing and Midwifery Council must regulate advanced nursing practice, ensure that advanced practitioners are recorded as such on the register and that they have the required competencies. He also advised that stakeholders need to consider how to reduce and standardise the proliferation of roles and job titles in nursing (Prime Minister's Report Commission 2010).

There is no formal regulation of advanced nursing practice in the United Kingdom with less distinction between advanced practice roles and no separate regulatory mechanism for nurse practitioners (Morgan 2010, Skills for Health 2009). Regulation of advanced practice has been described as 'essential' for the United Kingdom (Brook & Rushforth 2011), yet, Pearson (2011) expressed disquiet over regulation of the role believing that regulation will hinder the progress of nursing innovation amongst all grades of nursing. The regulation of advanced nurse practice in Britain remains unclear due to disquiet being expressed by the DoH in relation to roles being taken on by professionals that were not traditionally associated with their profession. Concern that this practice, without additional qualifications, could pose a potential risk to public protection particularly if initial qualifications for entry to the register and experience through the professionals career alone, do not adequately prepare them for undertaking these roles. As a result, in 2008, the Department of Health asked the Council for Regulatory Excellence in Britain to provide advice on advanced practice. The purpose of the study was to examine whether 'advanced practice' is a regulatory matter. Findings indicate that regulation for advanced practice is not deemed to be necessary because registered nurse regulation is sufficient and all nurses are responsible for their practice including advanced practitioners. CHRE viewed advanced practice as the normal extension of the role of the nurse and said it is career development that is governed by existing regulation (CHRE 2009). See Table 3 and Appendix 1

Table 3 Council for Regulatory Excellence Guidelines for Advanced Practice

- Identify the current approaches of the regulators to ‘advanced’, ‘specialist’ and ‘expanded practice’
- Identify any additional risks to the safety of patients from these roles
- Determine the contribution of post-registration qualifications and defined scopes of practice to ensuring patient safety
- Establish the appropriate roles of regulators and employers in identifying and controlling for any additional risks
- Identify if there are wider regulatory implications from these roles

(Adapted from CHRE Council for Healthcare Regulatory Excellence 2009)

5.21 REGULATION OF NURSING AND MIDWIFERY IN THE UNITED STATES

In 1938, New York State passed the first mandatory Nurse Practice Act, a law which established two levels of nursing: licensed registered nurse and licensed practical nurse. Other states followed. States now recognise expanded nursing roles (NCSBN 1993). The National Council of State Boards of Nursing, Inc. (NCSBN Inc.) is made up of the boards of nursing in the 50 states, the District of Columbia, and five United States territories. The National Council tests entry-level nursing competence of candidates for licensure as registered nurses and as licensed practical/vocational nurses (NCSBN Position Paper, 1993). Plans are underway to revamp nursing regulation in the USA, from the current single-state licensure model to a mutual recognition model, as proposed by the NCSBN Inc. (NCSBN 1993; American Nurses Association 2010). Most Boards of Nursing are authorised to develop regulations pertaining to the practice of nursing in the jurisdiction. Laws governing individual health care providers are enacted through state legislative action. Regulatory authority is derived from legislative action. The delegation of regulatory authority allows the legislature to use the expertise of the agencies in the implementation of statutes.

Almost all of the American State Boards have regulations to govern three types of advanced practice registered nurses -Certified Registered Nurse Anesthetist, Certified Nurse Midwife and Nurse Practitioner-which set out scope of practice, regulation and requirements for legal recognition (NCSBN 1993) and to protect public health, safety and welfare. Current nursing

practice statutes and administrative rules range from no provision addressing advanced nursing practice to entire chapters of statutes and detailed regulations. In a 1991 survey, 47 jurisdictions addressed advanced nursing in either nursing practice statutes, administrative rules, or both. Leigh (2014) addressed the importance of using the full scope of practice of Certified Registered Nurse Anaesthetists as Advanced Practice Registered Nurses (APRN).

Licensure is the preferred method of regulation for advanced nursing practice in the United States. Safe and competent advanced nursing practice requires licensure as the method of regulation necessary to protect the public. Key elements of licensure are provided in Table 3. The LACE Consensus Model is a Consensus Model for advanced nurse practice regulation with its aim of providing leadership to advance regulatory excellence for public protection (APRN Group 2008, 2012). The LACE Position paper was adopted in 1986 by The National Council of State Boards of Nursing in the United States in order to provide guidance to Member Boards in the regulation of advanced nursing practice. Nurses considered to be advanced nurse practitioners are titled nurse practitioners, nurse anesthetists, nurse-midwives and clinical nurse specialists in the United States. Broader titles exist in other countries. The LACE Model addressed advanced nursing practice as a concept varying in interpretation and regulation and defined the educational preparation to be at least a master's degree in nursing. The Model concluded that the preferable method of regulating advanced nursing was designation/ recognition (APRN 2008, 2012). See Appendix 4 for further details on Regulation of Advanced Practice Nursing –LACE Consensus Model (USA).

The LACE Consensus Model makes certain recommendations for the regulation of advanced nurse practice and states that since regulation may limit entry into advanced nursing practice, consideration must be given to possible legal challenges. Two possible areas of challenge would be infringement of constitutional rights and constitutional delegation. Individuals have the right to pursue employment of their choosing but this individual right to seek employment must be balanced with the state responsibility to protect the health, safety and welfare of the public. Thus, Boards of Nursing seek to justify the relationship between the restrictions imposed by regulations and the public health, safety and welfare and to give attention to assuring guarantees of procedural due process, such as notice and an opportunity to be heard in an effort to protect against charges of proceeding with arbitrary, discriminatory or unreasonable regulations (APRN 2008, 2012).

Table 4 Key Elements of Licensure in the United States (LACE Consensus Model)

- an identifiable and unique scope of practice is a key element of licensure
- the scope of practice, as defined in state nursing practice acts is usually written in broad language and identifies boundaries of practice
- nurses' working in advanced roles, with additional education and experience practice beyond traditional nursing
- medical diagnosis and prescription of medications are good examples of acts that have been viewed as traditional medical acts or as overlapping areas of practice with advanced practitioners
- additional professional education is necessary for registered nurses' to perform these functions
- the core of skills and abilities required for advanced practice are identified
- definition of advanced nursing practice are presented
- specific practice characteristics of each advanced nursing category must be identified in order to create distinguishable scopes of practice for advanced nursing practice roles

(Adapted from LACE 2008; Delamaire and Lafortune 2010)

Table 5 Advanced Practice Registered Nurses (APRN) Regulation

- Programmes leading to Licensure will meet established educational requirements
- A core nurse practitioner licensing examination required for licensure as APRN
- A separate clinical practice component to a recognised APRN programme
- Fully licensed practitioner will be independent practitioners
- No regulatory requirement for supervision following licensure
- The Advanced Practice compact will be the regulatory model used to effect mutual recognition
- Do not support evidence of continued competency being required for licence renewal
- Redefine the role of clinical nurse specialist

(Adapted from Comment on Recommendations Proposed by the NCSBM over Redefinition of Advanced Practice Nursing 2012)

In California a report presented at the eighteenth annual update on legislative issues affecting advanced practice registered nurses (APRNs) across the United States has become highly regarded by regulatory agencies, state legislators, nurse practitioner's, state nurse practitioner associations and healthcare administrations (Phillips 2006).

5.22 DISCUSSION

Due to lack of conformity relating to the level of regulation of RANP/MP/APN's worldwide there is an emerging body of literature calling for regulation and delineation of the nurse practitioner role (Cashin, Buckley, Donoghue et al. 2015). This confusion is caused by national governments and nursing bodies and professional organisations adopting differing mechanisms for regulation of advanced practice, such as regulation, voluntary certification and licensure. In some countries regulation of nursing does not exist. This lack of conformity is in part due to the inherent difficulty in applying advanced practice professional certification requirements to regulatory practice and legal regulations, as these are the responsibility of legislators and Boards of Nursing.

The regulation of advanced nursing practice has potential for unduly limiting the practice of nurses who do not meet the specified requirements and because of this care is needed in the drafting of regulations so that the practice of registered nurses' is not limited and the evolution of nursing practice at all levels is assured (APRN 2012). There are four levels of regulation in the United States: designation and recognition; regulation; certification and licensure. In the United States most Boards of Nursing are authorised to develop regulations pertaining to the practice of nursing in the jurisdiction (APRN 2012). The National Council of State Boards of Nursing (NCSBN 2012) issued a draft vision paper titled '*The future of regulation of advanced practice nursing*' which proposed that over the next ten years all 50 states should change their nurse practice acts to require that all APN's pass a single competency examination that the association would approve and that would supercede all current assessments being undertaken by other American professional nursing bodies. An important feature is that APN's would be educated as generalists and not specialists and that the CNS title would be eliminated. Regulation would remain under the state Boards of Nursing in individual states. NCSBN, a member organisation of the state board of

the 50 states, does not have regulatory authority and its role is to develop NCLEX examinations papers (Torre 2006).

Ambiguity is also evident, particularly in the United Kingdom where there is less distinction between nurse practitioner and nurse consultant and advanced practice roles and no separate regulatory mechanism for nurse practitioners in place (Morgan 2010, Scottish Government 2010). A study undertaken in the UK by CHRE (2009) to examine whether 'advanced practice' is a regulatory matter or if regulation of the registered nurse is enough for advanced practice also (DOH 2008, CHRE 2009) indicated that what is termed 'advanced practice' across many health professionals, does not make additional statutory regulations necessary but that what is termed 'advanced practice' is career development that is governed by existing regulation. The CHRE report does caution that all professionals are responsible for their practice and must not practice outside their scope of practice. However, they also say that if the standards for practicing proficiency in these expanded roles are significantly different to those assessed against at initial registration and are beyond the professional's scope of practice and could potentially pose a risk to the patient, then regulatory bodies may need to consider if additional regulation is required (CHRE 2009). In Australia, a regulatory framework and extended practice is supported by legislation but conversely the ANP sits within the Registered Nurse scope of practice with no requirement for additional regulation (Gardner et al 2012). Other advanced practice roles in Australia and internationally remains undifferentiated from the nurse practitioner role with limited definition and a multitude of different titles, thus continuing to create confusion in and outside the nursing profession (Gardner et al 2007, 2012, 2014).

5.23 CONCLUSION

Ambiguity relating to title, role and scope is compounded by how nursing is regulated internationally. Ireland is at the forefront of advanced practice regulation, development and implementation through powers granted in The Nurses and Midwives Act (2011). This situation does not always exist elsewhere. An emerging body of literature calling for regulation and

delineation of the nurse practitioner role is evident. This confusion is caused by national governments and nursing bodies and professional organisations adopting differing mechanisms for regulation of advanced practice, such as regulation, voluntary certification and licensure or in some countries where regulation of nursing does not exist. This is in part due to the inherent difficulty in applying advanced practice professional certification requirements to regulatory practice and legal regulations as these are the responsibility of legislators and Boards of Nursing (APRN 2008). This regulatory confusion extends to regulation of title where title protection and regulatory mechanisms for practice extend beyond first level nurses regulated scope of practice as in Australia, Ireland, New Zealand, Canada and the USA.

CHAPTER 6 SCOPE OF PRACTICE AND CRITERIA FOR POSTS, PERSON AND QUALIFICATIONS

6.1 SUMMARY

There is no uniform method of describing a nursing activity or the scope of advanced nursing practice. The scope of advanced practice differs across countries and criteria for practice are broadly similar where advanced nurse practice roles are established. The scope of practice of the nursing and midwifery professions is broader than that of the individual nurse or midwife. The outer limits to practice are set by legislation, policy and guidelines within which individuals need to make decisions about their own level of competence take personal responsibility and accountability for their practice. There is also a need for healthcare organisations to establish service parameters for advanced practice nursing and to differentiate operationally between advanced practice and practitioner nursing roles. Scope of Practice documents exist but limited evaluation or research would appear to have taken place on the effect on practice of scope of practice frameworks.

6.2 SCOPE OF PRACTICE AND CRITERIA FOR POSTS, PERSON AND QUALIFICATIONS

The ANP role is perceived as being critical in the care of patients with chronic diseases and in balancing inequalities in healthcare delivery Sciamanna et al. (2006). Many countries and states including Canada, Ireland, New Zealand, Thailand and the United States published scope of practice documents throughout the 1990's in order to augment or clarify legislation (Canadian Nursing Association 2006, 2012; Leigh 2014). There is a trend towards broad, enabling scope of practice frameworks that instead of placing emphasis on certification for task's, empower nurses and midwives as professionals to make decisions about their own scope of practice. Studies suggest that empowering frameworks, such as that of the UKCC are perceived as having a positive influence on practice by providing liberation for practitioners in relation to role development of skills and promotion of confidence, reflection and self awareness (Fitzpatrick 2009).

In general, these scopes of practice documents have been developed and published by nursing regulatory bodies, and some originate from professional organisations (Nurses Board of South

Australia 2006; Nursing Council of New Zealand 2012; Canadian Academy of Health Sciences 2014; Nursing and Midwifery Board of Australia 2014; Bord Altranais agus Cnáimhseachais na hÉireann 2015c d). Documents vary in their orientation. Some are restrictive, outlining lists of practices, while others are more flexible and are often presented as decision-making frameworks. Certain issues emerge that are common to many of the documents published. These include a definition for the term *scope of practice* and of nursing and midwifery practice and health. National legislation that governs nursing and midwifery practice in the determination of the scope of practice is included as well as local policies and the relevance of the code of conduct that exists to guide practice. Determining a scope of practice includes the level of accountability of the nurse or midwife, education for the role, competencies for practice and approval for the advanced practice post (NCNM 2008). Krautscheid (2014) defined professional nursing accountability in a literature review and Mueller and Vogelsmeier (2013) explored nurses' understanding of responsibility, authority and accountability in undertaking effective delegation.

6.3 ROLE AMBIGUITY TO ROLE OF APN/ANP AND SCOPE

Role ambiguity and confusion in relation to the role and scope of the ANP/APN exists (Lloyd Jones 2005; Gardner et al. 2007; Cashin, Buckley, Donoghue et al. 2015) and is often perceived as a barrier to the introduction of APN roles (Chang et al. 2010). A study undertaken in Australia in 2007 to inform a model of service parameters and an analysis framework for advanced practice roles (Gardner et al 2007) offered support for the Strong Model of Advanced Practice and also cautioned the need for healthcare organisations to establish service parameters for advanced practice nursing and to differentiate operationally between advanced practice and practitioner nursing roles (Gardner et al. 2007).

Eleven grades of nurse exist in the United Kingdom each with varying domains. For example Consultants undertake expert clinical practice, leadership and consultancy, practice and service development and education and development. Advanced Nurse Practitioners undertake some of those functions but with a wider scope that is similar to that undertaken in other countries where advanced practice is in place (Cerinus and Wilson 2009) A study undertaken in Hong Kong in 2013 identified the extended role of the ANP in nurse-led out-of-hours clinics as improving the quality

of healthcare delivered (Christiansen et al. 2013). In an attempt to understand the ambiguous role and scope and activities undertaken by the advanced nurse practitioner an international study was undertaken by Chang et al. (2008) which validated The “Strong Model of Advanced Practice Role Delineation Tool” and identified dimensions of the role that included assessment, diagnosis, ordering diagnostic tests, education, seeking funding and research (Chang et al. 2010). However, a study undertaken in Australia, by Gardner et al. (2010) with nurse practitioners, found less positive results indicating administration and providing clinical care as the main activities of the ANP role. Scope of Practice framework documents from Australia, Canada, Ireland, Scotland, New Zealand and United States are presented.

6.4 SCOPE OF PRACTICE FOR NURSES AND MIDWIVES IN AUSTRALIA

There is no uniform method of describing a nursing activity or the scope of nursing practice. The Nursing Boards of Tasmania and Queensland Nursing Council (1998) produced scope of practice documents to augment nursing acts and to define of scope of practice. Roche, Duffield, Wise, Baldwin, Fry and Solman (2013) identified domains of practice and the characteristics of advanced practice nursing in Australia. According to the Nursing and Midwifery Board of Australia (2014) NP’s in Australia have the capability to provide clinically focused nursing care to a high level in a variety of contexts and to people with varying complexities and that their scope of practice is built upon the scope of practice of the registered nurse and meets competency standards for this level of practice. The core standards presented in the Nursing and Midwifery Board of Australia document “*Nurse practitioner standards for practice*” (2013 effective from 1st January 2014) are:

“the minimal Standards that are applicable across diverse practice settings and patient/client populations for both beginning and experienced NP’s” (Nursing and Midwifery Board of Australia p. 1).

These Nurse standards relate to Nurse Practitioner’s ability in the following areas: Assesses by using diagnostic capability; Plans care and engages others; Prescribes and implements therapeutic interventions and Evaluates outcomes and improves practice. The Scope of Practice for ANP’s in Australia defined by the Australian Nursing and Midwifery Council (ANMC) is one:

“That utilises extended and expanded skills, experience and knowledge in assessment, diagnosis, planning, implementation and evaluation of the care required...” (ANMC 2006)

As existing service structures were proving inadequate to meet existing demands, the nurse practitioner’s role emerged in Australia as an innovative response to unmet health service need due to dispersed populations and variations in health outcomes (Roberts 1996; Nhan and Zuidema 2007). The nurse practitioner’s role was introduced in order to improve access to care for such populations (Nazareth et al. 2008). An observational study was undertaken by Gardner et al. (2009) to describe variations in the pattern of nurse practitioners working in a range of clinical areas. The study involved 12,189 individual observations. Results indicated that nurse practitioners undertook 30 individual activities with direct care accounting for 36%, indirect care for 32% and service related care for 32%, thus raising concerns by the researchers of the best use of nurse practitioners time. The authors note that just 1.6% of the nurse practitioners time was taken up with research or evidence based activity even though research is an integral part of advanced nurse practice and of nurse practitioner practice internationally (Ruel and Motyka 2009; Gardner et al. 2010), and is explicit in the Australian nurse practitioner competency standards (ANMC 2010). The authors also report that the pattern of the nurse practitioner’s role as described in this study is inconsistent with the role of the advanced nurse practitioner elsewhere where the role is reported as primarily a clinical service role with the nurse practitioner working with individual patients and communities (Furlong and Smith 2005; Gardner et al. 2006c, 2007; CNC 2014), thus demonstrating role variances. The scope of practice in Australia is centered on 5 dimensions: expertise, independent practice, assessment, intervention and treatment and partnerships and participation. See Table 4 for Scope of Practice in Australia.

Table 6 Scope of Practice in Australia

Expert Nurses	Nurse practitioners utilise extended skills, experience & knowledge in assessment, implementation and the care required in advanced practice
Independent Practice	Practice independently and in collaboration with other health care professionals to promote health and to prevent disease
Assessment Interventions and treatments	Diagnose, assess and manage care Provide a wide range of assessment and treatment interventions

Active partnerships & participation	Work in partnership with individuals and communities across a range of settings Participate in professional activities, and in local and national policy development.
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Adapted from ANMC 2006

6.5 SCOPE OF PRACTICE IN CANADA

There is no uniform method of describing a nursing activity or scope of nursing practice in Canada. The Canadian Nurses Association (CNA) states that a profession's scope of practice encompasses the activities its practitioners are educated and authorised to perform. The scope for individual practitioners is influenced by the settings in which they practice, the requirements of the employer and the needs of their patients (CNA 2006 a, b, 2010, 2014). Nurse Practitioners are in practice in acute care hospitals and in rural areas providing enhanced care to communities. The Canadian Academy of Health Sciences (2014) recommended optimising scopes of practice and propose new models of care for new health care systems. The definition for advanced practice put forward by the Canadian Nurses Association is:

“Advanced nursing practice is a term used to describe an advanced level of clinical nursing practice that maximises the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and population” (CNA, 2008).

6.6 SCOPE OF NURSING AND MIDWIFERY PRACTICE IN IRELAND

The scope of advanced practice roles, defined by the National Council for the Professional Development of Nursing and Midwifery in Ireland, promote wellness, offer healthcare interventions and advocate healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines (NCNM 2008a). Bord Altranais agus Cnaimhseachais na

hÉireann published the Scope of Nursing and Midwifery Practice (2015c) for registered nurses and midwives which all nurses and midwives must comply with. Reference is made to the scope of nursing and midwifery practice in the *Report of the Commission on Nursing* (1998). The Commission highlights the need for a framework that will enable nurses and midwives to develop their practice within safe parameters and considers that nurses need to be empowered to a greater extent to make professional decisions, rather than having narrowly focused prescriptive guidelines in certain areas.

The scope of nursing/midwifery practice is defined as the range of roles, functions, responsibilities and activities, which a registered nurse or registered midwife is educated, competent, and has authority to perform in the context of a definition of nursing and midwifery (DoHC, 2011: 28; Fealy, Casey, Brady et al. 2014; Nursing and Midwifery Board of Ireland. Bord Altranais agus Cnáimhseachais na hÉireann 2015c). Fealy, Casey, Brady et al. (2014) undertook a National Review of the Scope of Nursing and Midwifery Practice in Ireland and their findings are presented and referenced in the Scope of Nursing and Midwifery Practice Framework (2015 c).

Scope of Practice in Ireland is currently defined by legislation, social policy, national and local guidelines, education, individual levels of competence, International developments and EU directives. Legislation specifically relating to nurses and midwives is via the Nurses Act (1985) and Nurses and Midwives Act (2011) as well as other acts that define practice parameters (Bord Altranais agus Cnáimhseachais na hÉireann 2015c). Social policy relates to documents and strategies developed on a national basis which may have implications for nursing and midwifery practice. *Health in Ireland Key Trends* (2007) and *Guidelines for the Safe Administration of Cytotoxic Medical Preparations in the Treatment of Patients with Cancer* (Department of Health 1996) are important when defining the boundary of scope of practice. On a regional basis, locally defined policies, protocols and guidelines outline care within a particular setting. Nurses may expand their scope of practice provided they have undertaken the appropriate education and training, and are prepared to be accountable for their practices (An Bord Altranais, 2000a; Bord Altranais agus Cnáimhseachais na hÉireann 2015c). Nurses and midwives should be proactive in identifying areas where expansion in their scope may lead to improved outcomes for patients (Health Service Executive 2012).

Registration education programmes allow nurses and midwives to register in a particular division of the register maintained by NMBI and thus practice in that discipline. Post-registration education programmes provide nurses and midwives with in-depth knowledge and skills for particular practice fields. Nurses and midwives are advised by the NMBI to practice within the limits of their training, education and competence and within their scope of practice (An Bord Altranais 2000). The scope of advanced practice in Ireland is developed around four concepts: advanced knowledge, clinical skills, competencies and practice. See Table 7 for an outline of the criteria for the Scope of Practice for ANP/AMP's in Ireland.

Table 7 Criteria for Scope of Practice of Advanced Practice in Ireland

Category	Characteristics
Advanced Competencies	<ul style="list-style-type: none"> Advanced nursing/midwifery practice [roles] promote wellness, offer healthcare interventions and advocate healthy lifestyle choices for patients/clients, their families and carers in a wide variety of settings in collaboration with other healthcare professionals, according to agreed scope of practice guidelines
Advanced Knowledge	<ul style="list-style-type: none"> ANP/AMP's utilise advanced clinical nursing and midwifery knowledge and critical thinking skills to independently provide optimum patient/client care through caseload management of acute and/or chronic illness Advanced nursing and midwifery practice is grounded in the theory and practice of nursing and incorporates nursing and midwifery and other related research, management and leadership theories and skills in order to encourage a collegiate, multidisciplinary approach to quality patient/client care ANP/AMP is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice
Advanced Clinical Skills	<ul style="list-style-type: none"> ANP/AMP's are highly experienced in clinical practice ANP/AMP's are educated to master's degree level (or higher) The postgraduate programme undertaken for advanced practice must be in nursing or an area which is highly relevant to the specialist field of practice and educational preparation must include substantial clinical modular component(s) pertaining to the relevant area of specialist practice
Advanced Practice	<ul style="list-style-type: none"> ANP/AMP roles are developed in response to patient/client need and healthcare service requirements at local, national and international levels ANP/AMP's must have a vision of areas of nursing and midwifery

practice that can be developed beyond the current scope and a commitment to the development of these areas (NCNM, 2008).

Adapted from National Council for the Professional Development of Nursing and Midwifery (2008)

6.7 SCOPE OF PRACTICE IN SCOTLAND

Scotland is mentioned, separately from the United Kingdom in this section, due to its leadership role in the development of a scope document. The Scope of Practice developed for Scotland is developed at level 7. The Scope includes skills developed in the Skills for Health (2006) document. See Table 8 for Scope of Practice in Scotland and Appendix 5 for further detail. Advanced nursing practice roles are applicable across all clinical contexts/professionals including advanced level practitioners. This Skills for Health document contends that there are many nurses who function at an ‘advanced’ level’ but who may not be working in a specifically ‘clinical’ role and the authors say that ‘advanced practice’ should be viewed as a ‘level of practice’ rather than a specific role but also that ‘advanced practice’ is not exclusively characterised by the clinical domain but may also include professionals working in research, education or managerial/leadership roles (Callaghan 2008).

The Advanced Practice Toolkit (SGHD 2008) draws together the body of work around advanced level practice and states that this level of practice reflects a particular benchmark above ‘Senior’ level and below ‘Consultant’ level on the career development ladder, as exemplified in the NHS Career Framework (SGHD 2008). The Toolkit sets out a consensus position on this level of practice and offers tools and resources to support implementation of these roles. The Chief Nursing Officer (CNO) for Scotland, the CNO’s for England, Wales and Northern Ireland and the UK Modernising Nursing Careers Coalition have all endorsed the Advanced Practice Toolkit and believe it is now time for clear guidance on advanced level nursing practice to be disseminated. They say that a clear operational model for advanced practice roles and posts needs to be established across the NHS Scotland through dialogue with relevant stakeholders (Do H 2007, 2010).

Table 8 Criteria for Scope of Practice in Scotland

Criteria	Description
Knowledge	<ul style="list-style-type: none"> Utilises highly developed specialist knowledge covering a range of

	<p>procedures and underpinned by relevant broad based knowledge, experience and competence</p> <ul style="list-style-type: none"> • Uses highly specialised theoretical and practical knowledge some of which is at the forefront of knowledge in the work area. This knowledge forms the basis for originality in developing and/or applying ideas • Demonstrates critical awareness of knowledge issues in the work area and at the interface between different work areas • Creates a research based diagnosis to problems by integrating knowledge from new or interdisciplinary work areas and makes judgments with incomplete or limited information • Develops new skills in response to emerging knowledge and techniques
Supervision	<ul style="list-style-type: none"> • Demonstrates leadership and innovation in work contexts that are unfamiliar, complex and unpredictable and that require solving problems involving many interacting factors • Reviews strategic impact/outcome of the work or team
Professional and Vocational Competence	<ul style="list-style-type: none"> • Demonstrates autonomy in the direction of practice and a high level understanding of development processes • Solves problems by integrating complex knowledge sources • Demonstrates experience of managing change within a complex environment • Responds to social, scientific, clinical and ethical issues that are encountered
Analytical/Clinical Skills and Patient Care	<ul style="list-style-type: none"> • Provides specialist or highly specialist clinical, technical and/or scientific services • Makes complex judgments
Organisational Skills and Autonomy/Freedom to Act	<ul style="list-style-type: none"> • May be responsible for work area, specialist services or clinical pathways • May be accountable for direct delivery of part of service
Planning, Policy and Service Development	<ul style="list-style-type: none"> • May formulate strategy, propose changes to practices or procedures and plan and/or organise a range of complex activities or programmes

<p>Financial, Administration, Physical and Human Resources</p>	<ul style="list-style-type: none"> • May be responsible for purchasing and maintenance of assets • May undertake supervision and/or teaching and training • May devise training or development programmes • May hold a budget. • Manages staff and/or services ranging in size and complexity
<p>Research and Development</p>	<ul style="list-style-type: none"> • May evaluate equipment, techniques and procedures. • May undertake straightforward or complex audit or assist with clinical trials or research projects • May regularly undertake clinical trials or research projects and R&D programmes

Adapted from Scope of Practice Level 7 Role Descriptors (Skills for Health, 2006) Scotland

Scotland has also developed the key scope of practice themes and core principles for advanced practice roles that are underpinned by key four principles that will be of interest to Directors of Nursing and hospital managers in the United Kingdom and elsewhere when new roles and posts for advanced practice nursing are being developed. It is proposed by the working group in Scotland that all advanced nursing practice posts will be structured around these central themes (SGHD 2008; DoH 2010). The themes are Clinical and Professional Leadership, Facilitating Learning, Research and Development and Advanced Clinical Practice. See Table 9 for information relating to the advanced practice themes and core principles for advanced practice.

Table 9 Advanced Practice Themes and Core Principles -Scotland

Clinical /Professional Leadership	Facilitating Learning	Research and Development	Advanced Clinical Practice
<ul style="list-style-type: none"> • Identifying need for change, developing and leading change • Innovation • Clinical Governance • Equality and diversity • Ethical decision-making • Negotiation and influencing values based skills and practice • Networking 	<ul style="list-style-type: none"> • Principles of teaching and learning • Supporting others to develop knowledge and skills • Promotion of learning/creation of learning environment • Service user teaching and information giving • Developing service user education materials • Mentorship and coaching • Building capability and capacity and team development 	<ul style="list-style-type: none"> • Ability to access research Use information systems and audit • Critical appraisal/evaluation skills • Ability to implement research findings into practice- including use of and development of policies/protocols and guidelines. • Conference presentations • Publications 	<ul style="list-style-type: none"> • Decision making/clinical judgments and problem solving • Critical thinking and analytical skills incorporating critical reflection • Managing complexity • Assessment, diagnosis referral, discharge • Developing higher levels of autonomy • Assessing and managing risk • Prescribing (where required). • Developing confidence • Developing therapeutic nursing to improve patient outcomes • Higher level communication skills • Patient Focus/Public Involvement

Adapted from SGHD 2008; Do H 2010

6.8 SCOPE OF PRACTICE IN SINGAPORE

Singapore is one of the few countries in the world that has set out its defined Scope of Practice in the Regulations for Nursing (2012). The Scope of Practice, adapted from the ICN definition of Scope of Practice, allows the cognitive, integrative and technical abilities of the qualified nurse to put into practice ethical and safe acts, procedures, protocols and practice guidelines. The clinical practice of ANP's is scientifically based and applies to health care in all settings. The role also includes leadership, mentorship, peer education and research practice (Singapore Nursing Board 2012).

6.9 SCOPE OF PRACTICE IN NEW ZEALAND

The Nursing Council of New Zealand (2008) specify that applicants who have successfully completed an approved programme of study in New Zealand can apply for registration as a nurse in the scope of practice for which his/her qualification is prescribed. The Scope of Practice of the Nurse Practitioner in New Zealand allows for expert nurses who are practicing independently and collaboratively. Nurse practitioners are expert nurses who work within a specific scope of practice. See Table 10 for the criteria for the Scope of Practice developed by the National Council of New Zealand for advanced practice nursing.

Table 10 Criteria for Scope of Practice New Zealand

Expert Nurses	Nurse practitioners are expert nurses who work within a specific area of practice and incorporate advanced knowledge and skills
Independent Practice	<ul style="list-style-type: none"> • They practice independently and in collaboration with other health care professionals to promote health and to prevent disease
Systematic Assessment, Interventions and Treatments	<ul style="list-style-type: none"> • Diagnose, assess and manage people’s health needs. • Provide a wide range of assessment and treatment interventions, including differential diagnoses; ordering, conducting and interpreting diagnostic and laboratory tests • Administer therapies for the management of potential or actual health needs • May choose to prescribe medicines within their specific area of practice.
Partnership Approaches Including Leadership	<ul style="list-style-type: none"> • Work in partnership with individuals, families, Whanau and communities across a range of settings. • Demonstrate leadership as consultants, educators, managers and researchers
Active Participation	<ul style="list-style-type: none"> • Participate in professional activities, and in local and national policy development.

Adapted from Nursing Council of New Zealand (2008, 2012a, b; New Zealand Council 2008)

Certain conditions are placed on a nurse’s scope of practice that describes the specific area of practice he or she may work in. These conditions may apply to nurse practitioners, registered nurses or enrolled nurses. The common class conditions applied to nurses registered under the Nurses Act 1977 are included in Table 9. The Council can also place other conditions in a nurse’s scope of practice to ensure competence or safety of the public. These conditions include the requirement to complete professional development hours or to practice under supervision. All conditions are shown on a nurse’s practicing certificate.

The Nursing Council of New Zealand has defined the broad areas of practice using population groups for identifying the population groups (and practice areas) as child and youth; family; Adult; Older adult; Maori; Pacific peoples and other cultural groups. Also designated are areas of practice. The advanced nurse practitioner must define the population group and practice areas. These areas are in acute care, primary practice, health/general; heart conditions specific; mental health; palliative care; public health and women’s health. Registration under the Nurses Act translates to the new scopes of practice and how nurses were transferred into the new scopes (Nursing Council of New Zealand 2008). See table 11 which demonstrates how advanced practice nurses should place their practice onto defined practice areas.

Table 11 Conditions placed on Scope of Practice in New Zealand- Registration under Nurses Act (1977)

Registration (Under the Nurses Act 1977)	Scope of Practice (Effective: 18 Sept. 2004)	Conditions
Registered Comprehensive Nurse	Registered Nurse	
Registered General & Obstetric Nurse	Registered Nurse	May practice only in general and obstetric nursing
Registered Psychiatric Nurse	Registered Nurse	May practice only in mental health nursing
Registered Psychopaedic Nurse	Registered Nurse	May practice only in settings which provide services for consumers with intellectual disabilities
Registered General Nurse	Registered Nurse	May practice only in general nursing
Registered Obstetric Nurse	Registered Nurse	May practice only within a maternity setting under the direction of a midwife or a medical practitioner
Nurse Practitioner	Nurse Practitioner	May practise (and prescribe) only within a specific designated area of practice

Nursing Council of New Zealand, 2008

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> accessed 6 July 2012

6.10 SCOPE OF PRACTICE IN USA

In the United States, the scope of practice in each of the advanced roles of nurse practitioner, nurse anesthetist, nurse-midwife, or clinical nurse specialist is distinguishable from the others. While there is an overlapping of activities within these roles, there are activities which are unique to each role. The legal scope of practice should reflect the uniqueness of each. The granting of prescriptive authority should be specific to the practice area, for example, a pediatric nurse practitioner is not responsible for prescribing medications for older clients. Further work was undertaken in the United States in 2003 in defining the nurse practitioners role or scope of practice in relation to Acute Care Nurse Practitioner (ACNP) competencies through a consensus undertaken by this group. The competencies identified by the ACNP are in the areas of health, patient relations, professional, teaching, quality and culture (Nurse Practitioner Core Competencies Workgroup (2014)).

The knowledge, skills and abilities identified in the LACE Consensus Model as being essential for safe and competent advanced nursing practice are beyond those attained by an individual prepared in a basic nurse registration education programme. Participants identify criteria for Scope of Practice that is consistent with the nurses’ area of practice. The Scope of Practice defined for advanced practice roles include those defined in the LACE Consensus Model as presented in Table 12.

Table 12 Criteria for Scope of Practice - United States of America

Criteria	Main Scope of Practice or Main Skills Permitted
Education Level	A nurse who has completed an accredited graduate-level education programme preparing him/her for one of the four recognised APRN roles and has passed a national certification examination that measures APRN role and competencies and who maintains continued competence as evidenced by recertification Is educationally prepared to assume responsibility and accountability for health promotion

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	<p>and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions</p>
<p>Knowledge and Competencies</p>	<p>Has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients as well as a component of indirect care</p> <p>Builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and more autonomous roles</p>
<p>Clinical Experience</p>	<p>Has clinical experience of sufficient depth and breadth to reflect the intended license</p> <p>Has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS) or certified nurse practitioner (CNP)(<i>Source: APRN Consensus Work Group et al., 2008</i>).</p>
<p>Criteria defined by LACE Consensus Model</p>	<p>Knowledge and skills acquired in basic nursing education</p> <p>Demonstration of minimal competency in basic nursing as evidenced by licensure as a Registered Nurse</p> <p>Graduate degree with a major in nursing or a graduate degree with a concentration in an advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions and management of health care</p> <p>Skills and abilities essential for an advanced practice registered nurse within the designated area of practice</p> <p>Assessing clients, synthesising and analysing data, and understanding and applying nursing</p> <p>Providing expert guidance and teaching at advanced practice level</p> <p>Working effectively with clients, families and other members of the health care team</p> <p>Managing clients' physical and psycho-social health-illness status</p> <p>Utilizing research skills</p> <p>Analysing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment</p> <p>Making independent decisions in solving complex client care problems</p> <p>Performing acts of diagnosis and prescribing therapeutic measures consistent with the area of practice</p>

	<p>Recognising limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate</p> <p>Acting in an autonomous manner. Each individual who practices nursing at an advanced level does so with substantial autonomy and independence and accountability</p> <p><i>(USA Definition in LACE Model 2008).</i></p>
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Source: APRN Consensus Work Group (2008)

6.11 DISCUSSION

Further confusion remains internationally in regard to the scope of practice of the RAPN/RAMP. The evolution of advanced nursing/midwifery roles need to be managed in such a way that national standards are adhered to, and this requires careful benchmarking against best practice internationally thus ensuring that best practice is endorsed and maintained. To ensure that roles are based on the philosophical underpinnings of Nursing/Midwifery, it is essential that the role be defined within a framework of nursing and midwifery practice. It is important to demonstrate the value of the role in monitoring and enhancing patient responses to their disease process, not simply replacing the diagnostics and treatments hitherto prescribed by other members of the multidisciplinary team. Scope of practice should only be expanded following research that indicates a clear need to keep pace with changing patient need and that adheres to best practice internationally but also that scope is being extended to improve access, quality of care and outcomes for patients and not to replace another discipline or organisational management need. Research demonstrates that the RAPN/RAMP is ideally positioned to promote self-care management strategies for those with complex care needs within their agreed caseload and Scope of Practice. The RCN identified that most ANP's provide nursing care in GP surgeries, out-of-hours and walk-in services and in personal medical services (Duke 2012).

6.12 CONCLUSION

Scope of practice may be expanded but research needs to be undertaken that clearly demonstrates that this is being done in order to improve clinical outcomes and not simply to replace another discipline on foot of working time directives. Often new roles are introduced to meet service and organisational need, as occurred in Australia and Canada where existing service

structures were proving inadequate to meet existing demands. The role is often introduced to remedy variations in health outcomes. Research indicates that the RANP/MP is taking on responsibilities for new clinical services, where appropriate, however it is not essential or appropriate that they should take on every new service (CAN 2010, 2014)..

In New Zealand the advanced nurse practitioner must define the population group and practice areas they practice in unlike in other countries where the practice area only is required. Nurse practitioner roles are evolving and it is envisaged that in the future the nurse practitioner title will be broadened to indicate the population group the nurse practitioner works with. Applicants will need to identify the area of practice for registration as a nurse practitioner. This is usually defined by a population group and may include practice areas (NCNZ 2012 a, b).

CHAPTER 7 EDUCATIONAL DEVELOPMENTS FOR ADVANCED PRACTICE

7.1 SUMMARY

In most countries, a master's degree in nursing is now recommended or required to qualify as an advanced practice nurse but this is not always the case. Through graduate level education, a nurse can further develop abstract and critical thinking, the ability to assess at an advanced level, as well as advanced nursing and other essential therapeutic skills. Educational preparation should encompass both knowledge and the clinical components unique to the specific advanced nursing role. According to the LACE Consensus Model, Boards of Nursing should acknowledge and consider the current education, practice and health care environment by providing for "phasing in" educational requirements when developing regulations for the jurisdiction.

Education level required for registration and practice varies and ranges from Graduate Diploma level to PhD. Education is at master's level in Ireland, New Zealand, Singapore, and Sweden. The United States is also at master's level although the trend is toward PhD level. Post Graduate Diploma in a relevant area of practice is required in Australia, Canada, Finland, Japan, Norway, United Kingdom including Scotland, Czech Republic, Cyprus. Additional qualification required by Japan is the JNA Certificate Nurse Expert examination (JNA). Wider title is defined by the UK and Cyprus as both require post graduate certificate or post graduate diploma or clinical masters. Denmark requires a specialist nurse master's degree and the masters degree in New Zealand is clinically focused.

Within countries, education for advanced practice may be delivered in multiple universities, in a few, or in one, as in Singapore -the National University of Singapore. Different approaches to programme title and content are provided with focus on the added value a university programme in advanced practice can offer, thus providing a competitive advantage over this offered by competitors.

7.2 EDUCATIONAL DEVELOPMENTS FOR ADVANCED PRACTICE

The first known programme in advanced practice nursing education was established in 1965 in the United States, at the University of Colorado, with the development of a nurse practitioner (NP) certificate programme (Pearson 1999). Programmes have been set up around the world since then. Lafortune (2016) explored the development of advanced nursing roles in 12 European and non-European countries and found concerns about the need to re-define doctors and nurses roles in the context of skills mix (OECD 2016). This OECD study also explored nurse education and healthcare from the perspective of advanced practice nursing and is available on: <http://www.oecd.org/health/health-workforce-policies-in-oecd-countries-97892642395.17-en.htm/>

The growth in both education and practice at advanced practice level is occurring in tandem with a confused scope of practice, the need for health care cost containment, different educational and training criteria and qualifications as well as fragmentation of educational programmes leading to challenges for all concerned in the delivery of health care (Schober and Affara 2006a, b). A significant development is the development of the “LACE Consensus Model”(2008) which clarifies the roles of advanced practice nurses (APN’s) and aims to standardise education, licensure and certification of advanced practice nurses in the United States. It is recognised that the education, expertise and experience of APN’s can result in differing patient outcomes and costs (Schober 2007; Brooten et al. 2012; NMCA 2014; Carney 2016), particularly where standardisation in educational programmes does not exist. Education levels for nursing and the requirements either in place or recommended for advanced practice roles including title of category in advanced practice role are presented by country in Appendix 7.

Educational qualifications and training requirements vary and range from diploma to masters and PhD level. Whilst the goal is to bring APN/ANP education to master’s level not all countries have reached this goal (Sheer and Wong 2008). In most countries, a graduate degree in nursing (for example a master’s degree) is now recommended or required to qualify as an advanced practice nurse. This is the educational requirement that has been established in Ireland, and for instance,

in Australia, as new university-based programmes are being set up to educate advanced practice nurses.

Education level required for practice in the United States ranges from Graduate diploma level to PhD. Masters education is the required level for registration in Ireland, New Zealand, Singapore, and Sweden. The master's degree in New Zealand is clinically focused. Post Graduate Diploma in a relevant area of practice is required in Australia, Canada, Denmark, Finland, Japan, Norway, United Kingdom, Czech Republic, Cyprus, Denmark, Finland, and Japan. Some countries require further qualifications for example Japan requires the JNA Certificate Nurse Expert examination (JNA). Canada, Australia, United Kingdom accept either Post graduate diploma or masters. Scotland, UK, Cyprus require post graduate certificate or post graduate diploma or clinical masters. Denmark requires a specialist nurse master's degree. In Singapore the master's degree undertaken is at a single university, the National University of Singapore. As advanced nurse practice is not officially recognised in many European countries—Finland, France, Germany, Netherlands, Switzerland, Spain, Italy there are no specific requirements laid down. Details of a range of advanced practice programmes from representative universities in countries where the role of advanced practice nurse is established are presented in Appendix 14. An exploration of education for advanced practice and programme development in 24 countries is presented.

In Ireland, NMBI approves all education programmes leading to Registration in a Division of the Register of Nurses maintained by An Bord Altranais, now NMBI, including continuing professional development and post registration nursing and midwifery education programmes (Nursing and Midwifery Board of Ireland 2015a, b; 2016a, b) The Board sets requirements and standards for professional programmes and approval is based on the programme satisfying these requirements. Requirements for post-graduate education are contained within the Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes (An Bord Altranais 2010 f re-issued Oct 2015). NMBI state that the purpose of the document is to “provide guidance for the development of flexible and innovative programmes/units of learning for educational providers (Third Level Institutions, Health Care Institutions, Regional Centres for Nurse (Midwifery) Education) and other stakeholders for the development of post-registration nursing and midwifery education programmes/units of learning, within the context of the regulations of An Bord

Altranais and the National Framework of Qualifications” (An Bord Altranais 2010 f, re-issued Oct 2015)

7.3 EDUCATION FOR ADVANCED PRACTICE IN AUSTRALIA

Education for advanced nurse practice exists in Australia with several universities and colleges offering programmes in advanced practice at mainly master’s level. A Master’s degree of post graduate degree is required for advanced practice. See Appendix 7 for further details on the education level required and Appendix 14 for educational requirements in the Australian University of Newcastle and the Australian Catholic University, Sydney. Added value offered in the University of Newcastle where the Master of Nursing–Nurse Practitioner programme is offered, is through its additional Clinical Practicum hours. Normally, clinical requirements for advanced practice nursing are 500 hours-in this case it is 658 hours. In the Australian Catholic University where the Master of Clinical Nursing degree is offered, added value is through its outreach and remote rural area programme and also the range of areas where graduates may seek employment-in government and/or private health care facilities, rural and remote retrieval services, management, research or in health promotion (ANMC 2009).

7.4 EDUCATION FOR ADVANCED PRACTICE IN CANADA

Education for advanced nurse practice is available in Canada. There has been a gradual increase in the educational requirements of nurse practitioners and clinical nurse specialists and a master’s degree is now becoming the norm, although in some Canadian provinces, a post-baccalaureate certificate is still sufficient to become a nurse practitioner. In the 1990s, many provinces introduced university-based education programmes and legislation to support a renewal of nurse practitioners, with the objective of improving access to primary care. In 1995, in Ontario, educational programmes were introduced to support these initiatives. See Appendix 7 for further details on the education level required and Appendix 14 for educational requirements in the University of Toronto. The Certificate of Completion for graduate level course in Advanced Practice in Oncology is offered. The University of Toronto provides a range of Certificates of

Completion for a Graduate-level Course, including Advanced Practice in Oncology. Added value relates to the programmes' multidisciplinary approach that is holistic in nature and contains outcomes that are focused on improving healthcare (CNA 2008, 2009, 2010, 2014).

7.5 EDUCATION FOR ADVANCED PRACTICE IN DENMARK

Education for advanced nurse practice is not yet available. Masters degrees in clinical nursing are available at some university colleges and several offer a Master of Nursing Science that is equivalent to a master's degree at university level (referred to as candidate programmes). A PhD in nursing is available at some universities. There is one level of undergraduate nursing degree: Bachelor degree in Nursing. This is provided by higher education institutions that are grouped into the: college sector which provides professionally oriented higher education, and the university sector. Nursing education is based in the former and is undertaken in schools or departments of nursing which form part of centers of higher education. The exit qualification is that of the Professional Bachelor's degree in Nursing and the level corresponds to that of University Bachelor's programmes. In February 2008, a new national curriculum was introduced leading to a Bachelor Degree in Nursing Science. Specialist education programmes are available at diploma or masters level in the college sector leading to a qualification as anesthetic nurse; Intensive care nurse; psychiatric nurse; hygienic nurse (Infection Control) and the diploma in education for qualification as a Home Visiting Nurse (OECD 2006). See Appendix 7 for further details (Danish Nurses Organisation 2005; Moreno-Casbas, 2005; Nursing Education in Denmark OECD 2006).

7.6 EDUCATION FOR ADVANCED PRACTICE IN FINLAND

Specialist nurses are not recognised through separate registration in Finland. New advanced practice programmes were introduced in 2006 as reported in the advanced practice network press release for 2006 and leading to the Masters degree in Health Care. Four universities have Departments of Nursing and Caring Sciences and offer masters and doctoral programmes (European Commission 2000; Workgroup of European Nurse Researchers 2001; Ministry of Education 2006; Regulation Nursing in Finland, OECD; 2006; Personnel Communications 2007). Since 2005, a number of post-registration programmes were introduced in specialties such as

nursing older people, mental health nursing, family nursing, medical-surgical nursing and health promotion, and offered at masters level. Midwifery is a 4.5 year programme consisting of general nurse training followed by one-year midwifery, to exit with a dual qualification (OECD 2006). The Finnish higher education system consists of two parallel sectors: polytechnics of which there are 28 and twenty universities. Nurse education is based in the polytechnic sector which trains professionals in response to labour market needs (Ministry of Education 2006). The duration of general nurse education is 3.5 years and 4 years for public health nursing. Exit qualification is the Bachelor in Health Care. See Appendix 7.

7.7 EDUCATION FOR ADVANCED PRACTICE IN FRANCE

Masters, and doctoral programmes are delivered by several universities but advanced nurse practice is not yet available. Three recognised specialist career pathways are available in France: Child care nurses: one year course in schools of nursing recognised by the prefect of the administrative region concerned.; Nurse anesthetist: 2 years of prior professional experience required prior to 24 month training in approved schools for nurse anesthetists; operating room nurse (2 years professional experience required prior to 18 month training in approved school). Some specialist career pathways exist such as mental health nurses and clinical nurse specialists but these are described as 'non-official'. Emphasis is placed on the importance of continuing training (OECD 2006). The nursing profession is in discussion with government about reforming nurse education and hopes to see the introduction of an academic, higher education based approach to training with greater emphasis placed on evidence-based practice. Post-graduate level study is available in some universities but is undertaken within other disciplines as there is no specific nursing discipline in France. Nurses can access medical and paramedical training programmes in healthcare which are aimed at professionals seeking to improve their knowledge but do not give access to specific occupations (OECD 2006). Throughout France, universities may be authorised to grant licenses (the French equivalent of the Bachelors degree) or even Masters, to students in paramedical training programmes (Moreno-Casbas 2005; OECD 2006; International Council of Nurses 2006; Debout 2007; Personal Communication 2007). See Appendix 7.

7.8 EDUCATION FOR ADVANCED PRACTICE IN GERMANY

There is no recognised advanced nurse practice in Germany and advanced nurse practice are not available. Post-basic education and specialisation is regulated by the federal states (OECD 2006). More than 50 universities of applied science offer bachelor programmes (BA or BSc) in Nursing for nurses who already hold their registration and these courses focus mainly on management and education but also nursing science. Post-registration education is available in intensive care, psychiatric care, theatre nursing, oncology nursing, community nursing and infectious diseases control. Most courses are 2-year hospital based programmes (OECD 2006; German Nurse Association 2006; Personal Communication 2007). There are two levels of nurse in Germany: first and second level. As there is no registration system in Germany, the term registered nurse is not used. The first level is based on a 3 year course based in a school of nursing attached to a hospital and organised comparably to an apprenticeship. This is the route by which all but a very small proportion of nurses qualify and is described as regular nurse education and regarded as further not higher education. Entry qualification is completion of 10 years general schooling, age 17. Exit qualification is a nursing diploma. A Bachelor's degree in nursing was first awarded in 2004 by several universities for nurses who already hold registration through regular nurse education (OECD 2006). See Appendix 7.

7.9 EDUCATION FOR ADVANCED PRACTICE IN JAPAN

There is no regulation for advanced practice in Japan as the role does not exist and there are no advanced practice programmes offered. There are no state level qualifications for specialisation. Various organisations and academic societies offer their own certification systems, including the Japanese Nursing Association (JNA) (OECD 2006; JNA 2010). Masters, doctoral programmes in nursing are now provided at 70 universities, 26 of which also offer doctoral courses (JNA 2006, JNA 2012; OECD 2006). As at May 2005, the JNA were actively lobbying for the government to legislate mandatory clinical training after graduation for nurses, midwives and public health nurses, instead of relying on voluntary training offered at individual hospitals (JNA 2006). There are 3 routes to registration as a registered nurse and the Bachelor degree in Nursing is a 3-4-year university based course. All qualifiers have to pass the Registered Nurse National Board Examination to gain a license to practice. The registered nursing course is generic. Certified specialisation is at post-

registration level. Midwifery and public health can be undertaken as a 4-year degree programme or as a 1-year course after a 3-year nursing course. All JNA certificates are renewable 5-yearly on the basis of performance reports (JNA 2006, 2012; OECD 2006). See Appendix 7.

7.10 EDUCATION FOR ADVANCED PRACTICE IN IRELAND

Changes to nurse education were recommended in the *Report of the Commission on Nursing* (1998). Quality and Qualifications Ireland (QQI) is responsible for the external quality assurance of further and higher education and training and validates programmes and makes awards for certain providers in these sectors. QQI is also responsible for the maintenance, development, and review of the National Framework of Qualifications (NFQ). The NFQ is designed for the development, recognition and award of qualifications based on standards of knowledge, skills, and competence acquired by learners (Department of Health Report on the Review of Undergraduate Nursing and Midwifery Degree Programmes 2012). The Framework consists of 10 levels, from basic learning to Doctoral awards. Refer www.qqi.ie.

The National Framework of Qualifications (Framework of Qualifications) was developed by the National Qualifications Authority of Ireland (NQAI) in partnership with national stakeholders and arose from the Qualifications (Education and Training) Act, 1999. This is a learner-centred Framework that relates all education and training awards to each other, thus providing coherence to the awards system by defining standards about what a learner can be expected to achieve for each award. The Framework recognises learning outcomes, what a person with an award knows, can do and understands rather than time spent on the programme.

Nursing and Midwifery Board of Ireland (NMBI) is the regulatory authority and the designated competent authority for nurses and midwives in the Republic of Ireland. There is a Register of Nurses and Midwives maintained by NMBI that comprises 10 divisions. Pre-Registration education and training is at honours degree and is placed at level 8 on the NFQ (Refer Appendix 7). The current undergraduate education registration information is contained in the Nurse Registration Programmes Standards and Requirements 4th edition (An Bord Altranais agus Cnáimhseachais na hÉireann 2016 a) and the Midwife Registration Programme Standards and Requirements 4th edition (An Bord Altranais agus Cnáimhseachais na hÉireann 2016 b). Two of the ten divisions of

the Register pertain to advanced practice and in order to work as an advanced nurse/midwife practitioner a person must be registered with NMBI. The RANP is a registered advanced nurse practitioner and the RAMP is a registered advanced midwife practitioner.

The Requirements and Standards for Post-Registration Nursing and Midwifery Education Programme -Incorporating the National Framework of Qualifications (1st edition) (2010) contains NMBI post registration education and training. The updated Bord Altranais agus Cnāimhseachais na hÉireann (2015a) Post Registration Nursing and Midwifery Programmes (Re issued October 2015) contains current post registration standards and requirements.

Nursing and Midwifery Registration education is located in Higher education and Registration programmes are placed at level 8 on the NQAI framework of qualifications and the Board's Domains of Competence are also at level 8. This document includes the NQAI level 7 to 9 standards which were developed in conjunction with HETAC and from contributions from stakeholders involved in nursing and midwifery education in Ireland. Setting standards of education for in-service education, specialist education and continuing education are included. Category 2 specialist programmes, such as those developed for advanced nurse and midwifery practice, are post registration programmes designed, developed and conducted with reference to a specific body of knowledge and experience in an area of nursing and midwifery (An Bord Altranais 2010 f).

To become a Registered Advanced Nurse/Midwife practitioner with NMBI, an applicant must hold a Masters (level 9 on NFQ) or higher. Advanced practice programmes are offered in universities in the Republic of Ireland at Masters or Post Graduate certification/diploma in advanced practice levels for post masters. Currently (March 2014) there are four universities offering programmes pertaining to Advanced Practice (See Appendix 14 for an outline of the universities.)

National University of Ireland Galway (NUIG) www.nuig.ie; Royal College of Surgeons in Ireland (RCSI) www.rcsi.ie; University of Dublin Trinity College (TCD) www.tcd.ie; University College Dublin (UCD) www.ucd.ie. For an up-to-date of the available NMBI approved programmes refer to: http://www.nursingboard.ie/en/professional_practice.aspx

7.11 EDUCATION FOR ADVANCED PRACTICE IN ITALY

Advanced nurse practice is not yet introduced in Italy. There is no regulation in place. Masters and doctoral programmes are provided in management and education. The aims of the provincial colleges offering higher level programmes in nursing are to protect the public and support and guarantee the professionalism of nurses (European Commission 2000; OECD 2006; OECD Health Data 2012). General nursing is a three year programme which takes place in universities and is based in faculties of medicine. Entry qualification is 18 years of age, leaving examination and a multiple choice entry examination. Specialty training is undertaken at post-registration level. Midwifery is a separate 3 year course. Specialist education courses include intensive care, palliative-oncology, wound care, and mental health. Such courses are provided by universities, healthcare institutions and continuous education agencies (OECD 2006). See Appendix 7.

7.12 EDUCATION FOR ADVANCED PRACTICE IN THE NETHERLANDS

A relatively new ANP role has commenced in the Netherlands. Masters education for Nurse Practitioner is in place at Rotterdam University focusing on the role of the nurse practitioner (NP) with emphasis on leadership development. Twenty master's ANP students were surveyed in Rotterdam University before and after participating in an international exchange programme, which is compulsory within the NP programme. Students reported positive outcomes from the international exchange (Ter Maten & Garcia-Mass 2009). The impact of the Bologna Agreement on colleges and students in the Netherlands were explored by Ter Maten and Garcia-Mass (2009 a, b). The agreement established a transferable degree system across European countries. Outcomes from the study indicated the need for internationalisation within the curriculum to ensure advanced nurse practice students maximise personal and educational outcomes from placements.

Education is regulated by the Ministry of Education, Culture and Science. Education is divided into several streams. The general secondary educational system has three main options, the MAVO (four years), the HAVO (five years) and the VWO (six years), the latter being the entry requirement to university degrees. Professional education has two main options: the MBO (secondary professional education) and the HBO (higher professional education). Only the “nurse”,

Verpleegkundige, is currently recognised in law. There is now a new “nurse profile” but it still treats the Dutch nurse as a single entity. Article 14 of the BIG Wet will be used to designate new post-basic specialist nurses. Specialist nurse training is aimed at obtaining extra competencies and qualifications on professional specific skills in intensive care nursing of adults, children’s, neonatal and cardiac nursing (OECD 2006). See Appendix 7.

7.13 EDUCATION FOR ADVANCED PRACTICE IN NEW ZEALAND

Education for advanced nurse practice is available. In 2005 the Nursing Council of New Zealand published a framework for post-registration education in support of its continuing competence requirement. The New Zealand’s National Council’s role and responsibilities are outlined in the Health Practitioners Competence Assurance Act 2003 (HPCA Act) and the Council is responsible under the Act HPCA Act for the registration of nurses in New Zealand. Nurse practitioners are one of the four parts of the register. Its primary function is to protect the health and safety of members of the public by ensuring that nurses are competent and fit to practice (Nursing Council of New Zealand (2007, 2012 a. b). See Appendix 7.

7.14 EDUCATION FOR ADVANCED PRACTICE IN THE NORWAY

There is as yet no dedicated advanced nurse practice education programme in Norway. However, masters and doctoral programmes in nursing are offered. A master’s degree in nursing or equivalent degree is required for entry to the 3 year doctoral programme, which comprises 1 year theoretical studies in nursing science and methods and 2 years for a dissertation. Nurse education is provided at university or college (28 in total) and most colleges are managed by state education authorities, although some are privately owned. Entry qualifications are 13 years general education. The nursing programme is of 3 years duration (Workgroup for European Nurse Researchers 2001; Krykjebo, Mekki and Hanestad 2002; Moreno-Casbas 2005; ICN 2006; Personal Communication 2007). See Appendix 7.

7. 15 EDUCATION FOR ADVANCED PRACTICE IN SCOTLAND

Education for advanced practice is available. In Scotland, dating from 2010, the educational qualification required for advanced practice is successful completion of a clinical master's programme, or an equivalent qualification including academic transcripts and course content, if internationally educated. This qualification must be approved by the Nursing Council or the Education Committee (Scottish Report 2008). When assessing educational equivalence, evidence is required of the applicant's ability to integrate theory, research and practice; to demonstrate the application of nursing frameworks to practice and the application of critical thinking and evidence as the basis of clinical decision making. See Appendix 7 for further details.

7.16 EDUCATION FOR ADVANCED PRACTICE IN SINGAPORE

Advanced nurse practice is available in Singapore and is registered under a separate division of the register held by the Singapore Nursing Regulatory Body. Education programmes for advanced practice are offered in Singapore. A programme leading to the certification of advanced practice nurses is offered through the Master of Nursing in the National University of Singapore which commenced in 2003. Programmes in advanced practice nursing are accredited by the Singapore Nursing Board. Advanced nurse practice is at master's level. ANP's are certified in four distinct areas of practice: acute, medical/surgical care, community and mental health and education and provided at just one college in Singapore. The Alice Lee Centre for Nursing Studies in the National University of Singapore is accredited by the Singapore Nursing Board to deliver the advanced nurse practice master's programme (Singapore Nursing Board 2012). See Appendix 7.

The commencement of advanced nursing practice in Singapore took place, in a manner similar to other countries, as a result of rising health care costs, increased technology, an ageing population and resultant chronic diseases in this population. The desire to maintain clinically competent nurses at the bedside was a further impetus to the Ministry of Health to introduce the first master's programme in advanced practice. The title "Advanced Practice Nurse" is restricted to registered nurses authorised by the Singapore Nursing Board to practice as APN's and the 1999 Nurses and Midwives Act was amended in 2005 to include the regulation and registration advanced nurse practice. The role and specifications are presented in Table 13. APN generally work in four adult specialties with scope for delivery of further specialties.

Table 13 Advanced Nurse Practice in Singapore: Role and Specifications

Regulation	Requirements	APN Competencies through collaborative practice	Recognition of Overseas Masters of Nursing APN
Nurses and Midwives Act amended in 2005 to include the regulation and registration of APN's	Recognised Masters degree in nursing education	Conduct comprehensive health assessment & physical examination	Complete 4 modules: Advanced Health Assessment Pharmacology 1 and 2. (general principles and concepts and systems) Advanced Practice 1 and 2
Maintenance of Register of APN's	Completion of internship	Diagnose, treat and manage acute and chronic illness	
Act stipulates Scope of Practice	Verification of core APN competencies in relevant speciality	Exercise clinical judgment through advanced decision making skills	
Specialties where APN practice is permitted	Completion of 12 case studies	Plan and manage care in consultation with physician	
	Recommendation from Clinical Head of Department and Director of Nursing in the employing organisation	Interpret diagnostic and laboratory tests Administer medications with protocols and scope of practice	
		Educate , council and advocate patients	
		Initiate and make changes in response to need Perform advanced procedures and evaluate quality practice	

		Educate nursing staff Initiate and coordinate research	
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Adapted from Kannusamy (2007) Development of advanced practice nursing in Singapore

7.17 EDUCATION FOR ADVANCED PRACTICE IN SPAIN

Advanced nurse practice education is not yet available in Spain. There are 110 Universities with 85% being managed by the state education authorities. Entry qualification to nursing is the leaving certificate and a university access examination. The nursing course is of 3 years duration with the diploma as the exit qualification. By 2006, 47 universities were offering the bachelor of nursing science. Generalist or specialist education occurs following general nurse education which is followed by specialisation at post-registration level (OECD 2006). See Appendix 7 for further details.

7.18 EDUCATION FOR ADVANCED PRACTICE IN SWEDEN

The MSc Nursing Advanced Practice in Primary care is offered in the Department of Health Sciences in the University of Skovda. After obtaining 90 ECT credits, nurses obtain competence as an advanced nurse practitioner in primary health care, a further 90 credits leads to a masters degree. Clinical nurse specialist roles are in place since the late 1990's. Masters courses include those focusing on research. The minimum length of the doctoral programme is four years. Advanced practice is not regulated or officially recognised in Sweden. Post basic courses are offered in universities in the areas of: primary health care; paediatrics; ophthalmology; intensive care; operating room; psychiatric; geriatrics; radiology; oncology treatment and nursing. Colleges also provide courses in health administration teaching and research training. As there are no legally defined and protected specialist nurses no special difficulties arise and specialist diplomas are awarded (Fagerström 2009). All nurse qualifications in a speciality hold 120-160 credits, the duration of programmes ranges from 38-52 weeks with the Swedish nurse registration as the entry qualification and 2 years experience since registration required. Exit is a post graduate certificate or diploma (European Commission 2000; Bergman et al 2013). See Appendix 7.

7.19 EDUCATION FOR ADVANCED PRACTICE IN SWITZERLAND

There is no national accrediting body for specialist nursing programmes and therefore advanced practice is not regulated (OECD 2006). However, the development of advanced practice programmes was first reported in the ICN apnetwork press release in 2006. University programmes in advanced practice are offered in several universities. For example the University of Basle, which is German speaking, offers advanced nursing practice leading to the Master of Science in nursing and doctoral degrees. Lausanne University, which is French speaking, commenced a degree in advanced practice in 2008. Various post degree programmes are being offered in the Universities of Applied Science (OECD 2006; Personal Communication 2007). With the introduction of the Bologna system, nursing education is being introduced in most universities at Bachelor of Science level. From 1991, all nursing education became generalist with specialisation at post-registration level, and duration is usually one and a half to two years in training (OECD 2006). See Appendix 7.

7. 20 EDUCATION FOR ADVANCED PRACTICE IN THE UNITED KINGDOM (EXCLUDING SCOTLAND)

Education for advanced practice is available. In the United Kingdom, a first-level university degree (for example a Bachelor's degree) is still sufficient to become a nurse practitioner or a clinical nurse specialist. Having relevant work experience and on- the- job training are important criteria in determining the suitability of candidates to move to more advanced posts. Specific training programmes of short duration have been set up for all registered nurses, not just advanced practice nurses, interested in extending their scope of practice in certain areas, such as drug prescribing (Delamaire and Lafortune 2010; Nursing & Midwifery Council 2014; RCN 2012, 2014; RCM 2015).

The MSc Advanced Practice (Nursing, Midwifery and Occupational Therapy) is offered in the University of Canterbury (2012). This programme meets the needs of the National Health Service (NHS) in the UK. Nine pathways are included that prepare practitioners for roles within their speciality of practice. These pathways are in adult acute nursing; cancer nursing; community

nursing; child nursing; midwifery; mental health nursing; end of life; public health nursing and occupational therapy and is unique as it is also delivered to a profession outside nursing-occupational therapy- that provides for an inter professional approach to healthcare education (Appendix 14).

The MSc Advanced Practice (Nursing) offered in Kings College, London (2012) was developed to meet the needs of the National Health Service and modules are mapped against the Knowledge and Skills Framework so that NHS practitioners can identify the relevant learning required to support career development. Access is available to extracurricular seminars and lectures provided by healthcare leaders from around the world in a multi-faculty environment. The programme draws from world leading experts for a number of world leading schools and hospitals that are providing inter-professional learning experiences See Appendix 7 for further details and Appendix 14 for details of programmes offered in the University of Canterbury and Kings College, London.

7.21 EDUCATION FOR ADVANCED PRACTICE IN THE UNITED STATES

Education for advanced practice nursing is available. Preparation for advanced nursing practice in the United States is at doctoral level (Koskinen et al. 2012). The first practice-focused doctoral degree programme in nursing was established at Case-Western Reserve University in 1979 and since this time doctor in nursing practice (DNP or DrNP) programmes have existed with the aim of improving health care systems through developing advanced practice roles. In 2008, 88% of nurse practitioners held at least a master's degree (American Nurses Association 1995a; American Association of Colleges of Nursing 1996). This figure is up from 62% in 2000 (Cronewett et al. 2011). See Appendix 7 for further details and Appendix 14 for details of University programmes in advanced practice from the University of Pennsylvania (2012), Cedars-Sinai Medical Centre (2012) and the University of Los Angeles (2012). In 1994 the first education programme carrying the Emergency Nurse Practitioner (ENP) title commenced at the University of Texas health science centre in Houston (Cole and Ramirez 1997) and this was not followed until 2001 at Loyola University in Chicago. Other colleges in the United States now offer the ENP programme.

The Advanced Clinical Nurse Practitioner (ACNP) in Gerontology is offered in Pennsylvania. This programme was one of the first in the United States to prepare acute care nurse practitioners for the management of patients with specialised health care needs and focuses on populations of specialist interest through a collaborative, inter-professional team approach. Students are offered wide choice in clinical experiences. Some focus on the marketability of the programme to the US health care system through the provision of the dual qualifications of Nurse Practitioner and Clinical Nurse Specialist in order to meet the demands of diverse and often rural communities (University of Pennsylvania 2012).

The Post Masters Certificate option in Adult Gerontology is also offered and is designed for nurses holding a Masters of Science in Nursing in another area of nursing who wish to obtain a specialised Adult Gerontology Acute Care Nurse Practitioner qualification/degree and thereby adding additional skills and competencies to their initial masters. Focus is also placed on governmental issues such as cost containment.

The third programme chosen in the University of Pennsylvania is the Post Masters Certificate option in Women's Health Care Nurse Practice (ACNP). This programme is designed for independent practitioner graduates of the Women's Health Care Nurse Practitioner programme who will have the autonomy to play a unique role in advancing the well being of women. Students may exit with the dual qualification of Women's Health Nurse Practitioner and as Certified Nurse-Midwives, and be certified as such (University of Pennsylvania 2012) (See Appendix 14).

In Ceders-Sinei Medical Centre, California, the MSc Advanced Practice Nursing (Specialist) is offered and aims to equip advanced practice nurses to care for patients with complex conditions who have undergone sensitive and highly technical procedures, thereby focusing on implementing intervention procedures that improve health outcomes. Additional added value is provided through Community Outreach Programme that are designed for vulnerable and under served populations (Ceders-Sinei 2012) (See Appendix 14). University College Los Angeles (UCLA) is one of the foremost Schools of Nursing in the United States, providing a wide range of nursing programmes at advanced practice level. The focus is on differences in relation to advanced nursing interventions that are focused on improving healthcare outcomes across populations (UCLA 2012) (See Appendix 14).

7.22 DISCUSSION

Educational requirements for advanced practice vary across countries and states. Within the advanced nurse practitioners community there appears to be a bias toward practicing in some areas of nursing such as medical, surgical and emergency nursing or in a sub-set of these areas of practice. Clinical areas of mental health/psychiatry, intellectual disability, midwifery, community care and care of the older person remain underdeveloped. This may be due to individual preferences for areas of advanced practice or to lack of educational programmes in place to develop these areas further. See Appendix 15 for the number of RANP in specialties in Ireland. Advanced practice requires special educational content that must include specialist content as well as generic content.

Advanced practice programme content varies with focus on added -value offered. Added value is offered in the University of Newcastle, Australia where the Master of Nursing –Nurse Practitioner programme is delivered through offering additional Clinical Practicum hours, normally 500 and increased to 658. In the Australian Catholic University the Master of Clinical Nursing degree added value through its outreach and remote rural area programme and is unique in the range of areas where graduates may seek employment-in government and/or private health care facilities, rural and remote retrieval services, management, research or in health promotion. In Canada, in the University of Toronto, a range of Certificates of Completion for a Graduate-level Course, including Advanced Practice in Oncology are offered with added value being provided by the multidisciplinary approach taken that is holistic in nature and contains outcomes that are focused on improving healthcare. In the University of Singapore added value is offered in the make -up of modular components, with four specific advanced practice modules included: Advanced Health Assessment; Pharmacology 1 and 2, General principles and concepts and systems; Advanced Practice 1 and 2 and 12 course assignments based on clinical practice needed.

In Ireland approaches taken to add- value to advanced practice programmes offered are mainly subject content. University College Dublin offers added-value in disease management and colorectal screening. The Royal College of Surgeons offers added-value through specific programmes in neonatology and epilepsy, and Trinity College Dublin offers added- value in its emergency nursing programme, the first emergency nursing programme in advanced practice,

offered in Ireland. NUIG, National University of Ireland, Galway is unique in its title of Master of Health Sciences (Advanced Practice Nursing and Midwifery) that is designed to meet the needs of the Irish health care system.

The Master of Clinical Nursing by Degree (by coursework) offered by the Australian Catholic University, Sydney, may be undertaken for outreach and remote rural areas and is designed for rural areas where education is difficult to access. A similar approach is taken by some universities in Canada.

A different approach is taken by the University of Canterbury, United Kingdom where the MSc Advanced Practice (Nursing, Midwifery and Occupational Therapy) offers its added value through nine pathways designed to meet the needs of the NHS, through its delivery to a profession outside of nursing-Occupational Therapy and by offering an inter- professional approach to healthcare education. Kings College, London, also offers a different approach through mapping of module content to the “Knowledge and Skills Framework” thus supporting career development. Lecturers are provided in a multi-faculty environment delivered by world leading experts from a variety of excellent schools and hospitals.

In the USA different approaches to those adopted in Ireland are also offered, whereby nurses holding the MSc. Nursing in a specific area of nursing may obtain a Post Masters Certificate Option in another area for example in Adult Gerontology: Acute Care Nurse Practitioner. The additional added value offered is the additional education, skills and competencies developed by the nurse as a result. A similar programme is offered by the University of Pennsylvania through its post masters option in Woman’s Health. Cedars–Sinai Medical Centre, California offers a unique programme by providing specialist education for complex situations where patients have undergone highly sensitive procedures. The programme is based on interventions to obtain better healthcare outcomes. This is also accessed by outreach. A similar approach is taken by University College, Los Angeles.

Educational development for advanced nurse practice in the community is underdeveloped (Dreher, Clinton and Sperhac 2014). Community educational development is influenced by the complexity of healthcare problems and patients need and demands. Thus curricula developed for

public health nursing need innovative vision and content. A position paper sponsored by the Association of Community Health Nursing Educators in the United States (Levin et al. 2008) challenges nurse educators to apply strategies in preparing public health nursing (PHN) professionals to meet current demands. Curricula needs to include content on demographic shifts in communities, changing social structures including family make up, child protection and the legislative factors impacting on community health care practices. Aranda and Jones (2008) present their views on the modernisation of the NHS, in their proposed curriculum design that includes a range of clinical, legal, social policy and sociological perspectives.

Nurse practitioners in private healthcare facilities such as general practice and in nurse managed health centres and clinics provide a range of services to the public including primary care services, specialised mother and child clinics, all requiring differing curricula and education approaches but due to funding resources ANP's are often unable to access this education when required (American Academy of Nurse Practitioners; Nursing & Midwifery Council 2014; RCN 2012, 2014; RCM 2015). A further area of specialist nursing at advanced practice level requiring specialist educational curricula refers to RANP's working in Care of the Older Person facilities. This category of patient are likely to become more numerous in the future particularly as legislation is increasing in countries as in Ireland (HIQA 2012), United Kingdom (Dept of Health 2010; Nursing & Midwifery Council 2014; RCN 2012, 2014) and Australia (Australian Commission on Safety and Quality in Healthcare 2010) to protect the elderly population from risk and harm. Bakerjian (2012) discussed the leadership opportunities relating to quality assurance, performance improvement, quality of care and quality outcomes that need to be provided through educational programmes so that RANP nurses can achieve optimal care outcomes from care delivered. Other areas requiring further curriculum development are in the areas of mental health/psychiatry, intellectual disability and midwifery. It is recognised that if those specialist areas of practice continue to be underdeveloped clinically focused roles such as CNS and advanced practice roles in these areas will remain underdeveloped (Bakerjian 2012).

Competencies for the delivery of safe practice need to be incorporated into education programmes. Education and clinical criteria for the role include leadership, governance and management, setting, implementation, monitoring and complying with standards internationally including in Ireland with NMBI and HIQA standards, quality and safety in healthcare, responsibility

and accountability for quality and safety of services, evidence based practice, planning and management of health services from strategic and operational levels, auditing health services, measuring improvements in health care delivery by identifying dimensions such as patient-centredness, safety, effectiveness, efficiency, access, equity and promoting better health, promotion of quality and safety culture and identifying and addressing gaps and deterioration in services (HIQA 2012) and management of information services including service users records. All legislative frameworks need to be provided through education programmes. These include legislation relating to health and safety of the public, including Health Acts 1947 to 2007, Child Care Acts 1991 and 2001, the Children Act 2001 and nursing home services as defined in section 2 of the Health (Nursing Homes) Act 1990 (HIQA 2014).

7.23 CONCLUSION

Educational preparation must include a substantial clinical modular component (s) pertaining to the relevant area of specialist practice with the clinical modular component focused on the specialist area of practice rather than a generic programme. This can sometimes be difficult to obtain depending on where the candidate ANP/AMP undertook their master's degree and to the range and quality of supports available in organisations and clinical sites for supervising and mentoring the candidates.

Areas of practice requiring targeted education programmes for advanced nurse and midwifery practice are in the community, private healthcare facilities such as general practice and in nurse managed health centres and clinics provide a range of services to the public including primary care services and RANP's working in Care of the Older Person facilities. Other areas requiring further curriculum development are in mental health/psychiatry, intellectual disability and midwifery. It is recognised that if those specialist areas of practice continue to be underdeveloped advanced practice roles in these areas will remain low and undermined. Educational programmes need to be quality focused so that RANP/RAMP's achieve optimal care outcomes from care delivered.

The literature demonstrates that curricula for advanced practice would benefit from additional content in two areas. Firstly, broadening the content taught and secondly delivering a higher level of content that is specific to the advanced practice programme. Examples of content not being

universally taught include: comprehensive physical assessment; current health issues and solutions; community outreach initiatives; coaching; diagnostic tests relevant to the programme; disease management solutions; developing interventions to improve patient/client outcomes; healthcare developments, logistical models for practice delivery; inter-professional approaches; incorporation of medicinal prescribing and ionising radiation (x-rays); mentorship models; nursing specific programmes based on a bio-psycho-social-spiritual model, public policy; technology advances and outcome measurements.

CHAPTER 8 CLINICAL CRITERIA FOR ADVANCED PRACTICE

8.1 SUMMARY

Regulatory bodies and professional organisations have laid down criteria for advanced practice. Criteria vary across and in some instances within countries. Criteria in this report are provided from countries where advanced practice is in place. These countries are: Australia, Canada, Finland, Ireland, New Zealand, Scotland, Spain, Singapore, United Kingdom (excluding Scotland) and the United States, and are identified as providing examples of best clinical practice in the development of advanced practice roles. These countries have all put forward similar criteria for practice. These criteria include: registration as a nurse; acquisition of expert knowledge base, complex decision-making skills and clinical competencies for extended practice. In Ireland the required period of specialist clinical experience is a minimum of five years but in other countries this ranges from 2-5 years. Completion of advanced education to master's degree level, trained in the assessment of complex situations, diagnosis and management of medical and surgical conditions and being able to provide a broad range of healthcare services, whilst working collaboratively, are typical requirements.

8.2 CLINICAL CRITERIA FOR ADVANCED PRACTICE

Regulatory bodies and professional organisations have laid down criteria for advanced practice. Legislation in many jurisdictions, including North America, Australia and New Zealand, has made

attempts to differentiate between the role of the advanced practice/nurse practitioner and the role of other nurses including registered nurses. The main points of differentiation are legislative title protection. This is viewed as an essential step in differentiating between roles and demonstrates that APN's/NP meet the extended standards required by the registering or regulatory authority, and through this process the APN/NP operates within the scope of practice of the registered nurse but the title nurse practitioner is protected and applies to the registered nurse who meets local jurisdiction requirements for advanced nurse practitioner authorisation. In Australia, New Zealand and Ireland nurse practitioners practice is authorised through legislation to provide patient service that incorporates nurse prescribing of medication, requesting of diagnostic tests and referral of patients. These are three well differentiated legislative parameters for advanced practice roles (Gardner and Gardner 2005; Gardner et al. 2006, 2007; Nursing Council of New Zealand 2012 a, b; CNA 2010, 2014).

8.3 CRITERIA FOR ADVANCED PRACTICE IN AUSTRALIA

The Australian Nursing and Midwifery Council (ANMC) stipulate that “nurses practicing at advanced practice level in Australia are educationally prepared at post-graduate level and may work in a specialist or generalist capacity”. The basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision-making (Kleinpell 2005; ANMC 2006, 2009, 2014). There are two categories of nurses working in advanced practice in Australia—Advanced Practice Nurses (APN) working as clinical nurses and consultants and Nurse Practitioner (NP). The same clinical skills are required for both with additional skills required by the NP including vaccinating, prescribing medication and ordering and interpreting diagnostic test (Dixon 2006; ANMC 2009, 2014). Education for skills development and prescribing details are presented in Appendix 8.

8.4 CRITERIA FOR ADVANCED PRACTICE IN CANADA

The Canadian Nurses Association (CNA) stipulates that ANP's are involved in analysing and synthesising knowledge; understanding, interpreting and applying nursing theory and research

and developing and advancing nursing knowledge in nursing and in the profession as a whole (CNA 2009, 2010, 2014). There are two categories of nurse at advanced practice level: Clinical Nurse Specialists and Advanced Practice Nurses working in two categories: Primary care, acute care adult pediatric and neonatal areas (CNA 2000, 2006c, 2009, 2014). The skills required for both categories are similar. Master's level education is required for acute care NPs and Master's level for Primary Health Care. Nurse Prescribing education is included in the programme for both. Both can prescribe under medical directives through indirect medical supervision. Nurse practitioners in primary care (community) can prescribe drugs without medical supervision. See Appendix 8.

8.5 CRITERIA FOR ADVANCED PRACTICE IN FINLAND

In Finland, there is a tradition of cooperation between doctors and nurses in primary care centers with nurses undertaking a number of advanced roles. Advanced nursing consultations take place in special reception facilities in health centers, with support provided by doctors as requested. Such consultations may also involve an approach whereby nurses and doctors work in tandem in a health centre (Delamaire and Lafortune 2010). Finland has also developed nursing reception facilities in smaller health stations in remote areas, which are supported by e-consultations with doctors working in main health stations when necessary. Nurses can manage up to 70% of the service needs in these remote health stations (Jaatinen et al. 2002). See Appendix 8.

8.6 CRITERIA FOR ADVANCED PRACTICE IN IRELAND

In Ireland, the National Council for the Professional Development of Nursing and Midwifery defined the criteria for advanced practice in nursing and midwifery as:

“Promoting wellness, offering interventions and collaborating with other healthcare professionals in a variety of settings while utilising advanced knowledge and critical thinking skills that is grounded in advanced theory. They lead and implement healthcare at advanced practice level” (NCNM 2008a).

Criteria for advanced practice posts are presented in Table 1 and relate to the application of, accreditation of, registration of advanced nurse and midwife posts as well as conditions for removal of the nurse or midwives name from the Register held by An Bord Altranais. Further

information is provided in Appendix 8, where details of the categories of nurses in advanced practice roles, their main tasks, the education and clinical skills requirement for advanced practice and mentorship. There are two categories of advanced practitioner in Ireland: Advanced Nurse Practitioner and Advanced Midwife Practitioner. A masters degree is required as well as a minimum of 5 years experience in the relevant area of practice. Mentorship by a medical practitioner is currently required for advanced practice and nurse prescribing. Nurses may prescribe medication within their scope of practice (NMBI 2005 a, c; 2007 e; 2010 g). See Appendix 8. Well-defined pathway toward final registration as an RANP/AMP exist in Ireland which encompasses level 9 masters education, minimum 500 hours of specific clinical practice in a specific area of practice, preparation of the site where the RANP/RAMP is working and creation of the job description for the role. See Appendix 13.

8.7 CRITERIA FOR ADVANCED PRACTICE IN UK incl. SCOTLAND

In Scotland, the Skills for Health developed the Career Framework for Health in 2006. This framework was enhanced by the Scottish Government guidance on the Career Framework (2008). The framework provides steps on a structured career ladder that can be characterised as level 'benchmarks' that supports consistency.

The framework places the 'Advanced Practitioner' at Level 7, defining advanced practitioners as:

"Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard" They are empowered to make high-level clinical decisions and will often have their own caseload. Non-clinical staff at Level 7 will typically be managing a number of service areas."

The framework incorporates a wide range of professional roles and can be seen as an over-arching practice which crosses professional groups and practice contexts, such as education and management/leadership. The Career Framework for Health (2008) document stipulates that from 2010, all candidate advanced practitioners should have a clinical masters and those who do not have a clinical masters will need to contact an approved programme provider in order to identify entry requirements. This is usually a postgraduate certificate or post-graduate diploma.

Candidates will need to supply transcripts and course descriptors for the assessment. When assessing educational equivalence, evidence is required of the candidates' ability to integrate theory, research and practice, and application of critical thinking and evidence as the basis for clinical decision making. Application of nursing frameworks to his/her practice is also required. Nurses in practice roles may prescribe medication under supervision (Scottish Government Career Framework 2008).

In the UK nurses are normally practicing at level 7 or 8 but many are now practicing at master's level 9. Extensive experience in the field of practice with continuing professional practice orientated toward medical consultation is required. Nurse prescribing and ionising radiation (x-ray) administration may be undertaken, depending on training and competency level. ANP's may interpret x-rays, a competency not permitted in Ireland. Practitioners may administer medication as delegated by the doctor (RCN 2012, 2014). See Appendix 8 for categories of nurses in advanced practice roles, main tasks and educational experiences in the UK and Scotland.

8.8 CRITERIA FOR ADVANCED PRACTICE IN SINGAPORE

Criteria for advanced nurse practice were laid down by the National Board in Singapore in 2012. These criteria are comprehensive and mirror criteria set out by the National Nursing and Midwifery Council in Ireland except that criteria for entry is three years, which is less than the five years needed in Ireland and prescribing of medication is not permitted for all APN's. Similar criteria include registration as an APN with the National Board and having acquired the expert knowledge base, complex decision-making skills and clinical competencies for extended practice. Criteria also include the completion of advanced practice education to master's level and training in the diagnosis and management of common medical conditions. A common criterion is that of working collaboratively with doctors and other healthcare professionals to provide complex nursing care to patients and using advanced assessment and clinical skills to anticipate and manage complex situations in this process. Advanced practice nurses in Singapore administer therapies for managing actual and potential health issues and participate in the development of evidence based practice by integrating theory and practice-based knowledge in order to influence nursing development at local and international levels, as in Ireland.

8.9 CRITERIA FOR ADVANCED PRACTICE IN SPAIN

As advanced nurse practice is not yet available in Spain criteria for advanced practice are not yet available. However, with the recent introduction of the Master of Nursing Science (Advanced Care) and other graduate level advanced programmes in several universities in 2006, progress is likely in the area of advanced nurse practice. The programmes currently being delivered include nursing research, teaching, management and advanced care.

8.10 CRITERIA FOR ADVANCED PRACTICE IN NEW ZEALAND

The Nursing Council of New Zealand is the regulatory authority responsible for the registration of nurses. The National Council is required to define practicing at the appropriate level and to establish if a nurse should hold a practising licence for advanced practice nursing. Criteria for advanced practice as defined by the National Council are similar to those defined in Ireland (NCNZ 2012 a, b). Criteria include the maintenance of the required standard of continuing competence, hold a practicing certificate, have the responsibilities of a nurse as defined by the scope of practice as set down by the National Council of New Zealand and are in direct relationship with clients (National Council of New Zealand 2008, 2012 a, b). Information published in 2014 states that to become a nurse practitioner, nurses must be registered with the Nursing Council of New Zealand in the registered nurse scope of practice and have a minimum of four years of experience in a specific area of practice and have successfully completed a clinically focused Master's degree programme approved by the Nursing Council, or an equivalent qualification. Further information is provided in Appendix 8, where details of the categories of nurses in advanced practice roles, their main tasks, the education for clinical skills for advanced practice and the mentorship provided. Advanced practitioner may prescribe medication under his/her scope of practice and must undertake a recognised prescribing programme.

8.11 CRITERIA FOR ADVANCED PRACTICE IN THE UNITED STATES

In the United States criteria for advanced practice were established by the United States APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee in 2008. Criteria for advanced practice are governed by the title Advanced Practice Registered Nurse" (APRN). The APRN is a nurse working in one of the four recognised APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner.

Criteria for the APRN role for advance practice is broadly similar to Ireland and includes masters level or beyond educational preparation, possessing advanced clinical practice specifically for the role and is capable of demonstrating a greater depth of knowledge, critical thinking and decision-making to the registered nurse and is undertaking autonomous roles in advanced practice and in nurse prescribing. Different criteria required include having passed a national certification examination that measures competencies (Nure Practitioner Core Competencies 2014). There are two categories of advanced practice nurse in the United States: Clinical Nurse Specialists and Advanced Nurse Practitioner. Masters or a higher degree is required in an accredited graduate-level education programme for one of the four recognised APRN roles. Nurses may prescribe drugs under medical supervision and in some states APRN's may prescribe without supervision. Skills for the role are as provided in the LACE Model in Appendix 8.

8.12 DISCUSSION

Research undertaken by Delamaire and Lafortune in the Autumn of 2009, reviewed the development of advanced practice nurses (APN) in 12 countries (Australia, Belgium, Canada, Cyprus, Czech Republic, Finland, France, Ireland, Japan, Poland, United Kingdom and United States). The study explored the main factors motivating the development or hindrance of APN roles in these countries. A survey was sent to designated national experts in participating countries and the results provided for use within the OECD. Findings indicated that using advanced practice nurses can improve access to services and reduce waiting times. It was also found that APN's are able to deliver the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up, and that the level of patient satisfaction was high due to ANP's spending more time communicating with and providing information to patients (Delamaire and Lafortune 2010). Kilpatrick (2009) recommends praxis as a

means to inform practice. The primary objective of praxis is to integrate theory, practice and art, and facilitate the recognition and valuing of different types of knowledge through reflection. Within this role the acute care nurse practitioner assumes a dual role of practice clinician and researcher.

The US Institute of Medicine Report (2010) relating to the future of nursing, state that advanced practice nurses play an important role in mentoring and supervising nurses and promoting interdisciplinary, collaborative relationships between all health care disciplines and community support programmes (Ellerbe and Regen 2012; Scott and Lindsey 2014). The Institute of Medicine (2010) has called for transformation of the nursing profession to lead the redesign of health care in the United States and recommends change in advanced practice education in order to expand access to care, improved quality, and reduction in cost. Dreher, Clinton and Sperhac (2014) in response to the IOM's article say that although the IOM provides validation of nursing's significant role, most of the recommendations have been advocated by nurse educators and what has historically kept the nursing profession from realising its full potential in advanced practice nursing is continuing preference for experience over education, belief that only nurses can teach nurses and hegemony of the research doctorate. Countries have led the way forward in competence development. The Nurse Practitioner Core Competencies Content Work Group (2014) in the United States identified the core competencies needed for advanced practice. The Nursing and Midwifery Board of Australia (2013) identified Nurse Practitioner Standards for practice. The Nursing and Midwifery Council (2014) United Kingdom made proposals on regulation and revalidation. The Nursing and Midwifery Board of Ireland Working Group for Advanced Nurse Practice (2014) developed the competencies needed for advanced nurse practice. See Appendix 8 for further information.

CONCLUSION

Criteria for practice differ and are mainly dependent upon the stage countries are in regulation and scope of practice development. The Australian Nursing and Midwifery Council (ANMC) stipulate that "nurses practicing at advanced practice level in Australia are educationally prepared at post-graduate level and may work in a specialist or generalist capacity while The Canadian Nurses Association (CNA) stipulates that ANP's are involved in analysing and synthesising

knowledge; understanding, interpreting and applying nursing theory and research and developing and advancing nursing knowledge in nursing and in the profession as a whole. Finland adopt a different approach where there is a tradition of cooperation between doctors and nurses in primary care centers with nurses undertaking a number of advanced roles. Ireland adopts a focused set of criteria that encompasses collaborating with other healthcare professionals in a variety of settings whilst utilising advanced knowledge and critical thinking skills that are grounded in advanced theory thus leading and implementing healthcare at advanced practice level. In Scotland *advanced* nurse practitioners are empowered to make high-level clinical decisions and will often have their own caseload. *In Singapore* registration as an APN with the National Board is dependent upon having acquired the expert knowledge base, complex decision-making skills and clinical competencies for extended practice. The broad criteria adopted in the United States ensures that APN's are capable of demonstrating a greater depth of knowledge, critical thinking and decision-making compared to the registered nurse and are undertaking autonomous roles in advanced practice and in nurse prescribing. These criteria demonstrate the complexity of criteria required for the role.

CHAPTER 9 COMPETENCIES FOR ADVANCED PRACTICE

9.0 SUMMARY

Competencies are defined in different ways around the world: some as domains of competence, core concepts, criteria, standards, competencies and competences in recent times. Greater interest in the role, activities, potential benefits and outcomes, than that experienced before is being generated, due mainly to the increasing number of advanced nurse practitioners in practice, healthcare demands and financial considerations that seek efficiencies and greater effectiveness in health care management and delivery. Studies have demonstrated the value of ANP/APN's in clinical settings and of positive outcomes such as higher patient satisfaction, less readmissions, lower costs and lower mortality rates. Equal or better clinical outcomes as doctors in the primary care, and other setting have been demonstrated.

9.1 COMPETENCIES FOR ADVANCED PRACTICE

Competencies for advanced practice are a central component of the role. Competence is the effective and creative demonstration and deployment of knowledge and skill in human situations. Such situations could comprise general social and civic ones, as well as specific occupational ones. Competence draws on attitudes, emotions, values and sense of self-efficacy of the learner, as well as on declarative and procedural knowledge. Competence outcomes can thus be stated as follows "In a specified range of circumstances, a learner will be able to ..." and incorporates context, role, learning to learn and insight (An Bord Altranais 2010 pg 25).

Research presented by Sastre-Fullana, De Pedro-Gómez, Bennasar-Veny et al. (2014) identified competency frameworks for advanced practice nursing. Scott and Lindsey (2014) identified the importance of collaboration and supervision in advanced practice nursing. Gardner, Duffield, Doubrovsky and Adams (2016) in an Australian study, advocate the use of an advanced practice nursing organisational leadership model to improve supervision. Taylor (2014) in her study undertaken in the United Kingdom to identify the effects of a clinical supervision group on the practice of bio-feedback therapists found that clinical supervision in a group was found to enhance effectiveness and professional and personal development. Taylor (2015) discusses Person-Centred Care in Practice and The King's Fund (2015) presented Midwifery Regulation in the United Kingdom. The Parliamentary and Health Service Ombudsman (2013) proposed new midwifery supervision and regulation and made recommendations for change.

9.2 COMPETENCIES FOR ADVANCED PRACTICE IN CANADA

Due to an aging population, rising costs, difficulty in accessing care and a shortage of professionals the need for collaborative healthcare is increasing and the advanced nurse practice is well positioned to respond to these changes and contributing to a sustainable and effective health care system. To address these needs a National Framework for Advanced Nursing Practice was developed in 2008 by the Canadian Nurses Association (CNA 2008). The framework describes advanced nursing practice and allows for a coordinated national approach which allows flexibility among provinces and territories and allows new roles to develop (CNA-A National Framework 2008). Prior to this, in 2005, the CNA organised and invited stakeholders in health care to the

Dialogue on Advanced Nursing Practice in order to discuss and advise on what could be learned from the existing advanced nursing practice roles and on how the role should be evolved. The advanced nursing practice roles in Canada are the clinical nurse specialist and the nurse practitioner, both roles having evolved through different routes-clinical nurses grew as patient care became more complex and advanced practitioner's were needed to serve the care needs of rural populations (CNC 2010, 2014). Currently, the only advanced nursing practice role with additional regulation and title protection in Canada is the nurse practitioner, although specific titles varies among the provinces and territories.

Core competencies for advanced practice are based on appropriate depth, breadth and range of nursing knowledge, research and clinical experience are cut across speciality lines and used by all advanced practitioners. There are four categories: clinical, research, leadership and consultation and collaboration. Clinical competencies include developing multiple advanced assessment and intervention strategies within a client focused framework; using research when making clinical decisions; analysing complex interactions; guiding decision-making and developing client focused care and education programmes (Canadian Nursing Council 2010, 2014; CNA-National Framework 2008).

9. 3 COMPETENCIES FOR ADVANCED PRACTICE IN IRELAND

Assessment of Domains of Competence is the tool used in Ireland to define competencies for advanced nurse practice. There are five Domains in number, with each domain incorporating three dimensions: performance criteria, defined standard(s) and evidence of successful performance to meet this standard. The five Domains of Competence are: Professional /Ethical Practice; Holistic Approaches to Care and Integration of Knowledge; Interpersonal Relationships; Organisation and Management of Care and Personal and Professional Development. Scrutiny of the competencies defined for practice by other countries, identifies competencies in broad outline for some countries but does not identify a competency tool of such detail, complexity or application to practice as that used in Ireland. While the Irish competency tool may lack application to specific specialty areas of practice in some instances, it is an excellent example of a

competency assessment tool (NCNM 2008b). Benchmarking of concepts contained within competency tools is provided in Appendix 10.

The Health Information and Quality Authority (HIQA) Model will support best practice for advanced nurse and midwife practitioners, following introduction of the Nurses and Midwives Act (2011), by ensuring that care is provided through a model of service that will drive high quality, safe and reliable healthcare (HIQA 2014, Standard 2.6). The Model provides the main components of a quality service that healthcare organisations in Ireland will be required to meet. A key component of HIQA's role is in ensuring that healthcare organisations support the RANP/RAMP in the development of competencies in clinical practice through mentorship and provision of resources (Quality and Qualifications Ireland 2014).

The Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes-Incorporating the National Framework of Qualifications (1st edition) (2010 updated October 2015) contains current NMBI continuing and post registration education and training.

Clinical practice experience provides learning opportunities that enable the achievement of competence in clinical nursing and midwifery practice and the stated learning outcomes (An Bord Altranais 2010 g, h). Clinical placements are based in health care institutions that satisfy An Bord Altranais (NMBI) requirements and standards. Post-registration learner allocation to clinical placements is based on the need to integrate theory and practice and to facilitate the progressive development of clinical skills and competencies by the RANP/RAMP. Requirements for practice required by the NMBI also include mechanisms to support interdisciplinary team working and to involve service users in the development and review of healthcare provision;

Maintaining competence is needed for continuation of the RANP/RAMP role. Competence is maintained through dedicated clinical mentorship/supervision, reflection-on-practice (Johns 1995:24), case-based discussion, evidence of continuing professional development (CPD) and maintenance of Portfolio for re-accreditation. Table 14 provides detail of the Level 9 competencies currently required by NMBI for post graduate nursing. Competencies include knowledge, know-how, skills and competency development across a range of standards.

Table 14 Level 9 Competencies for Post Graduate Nursing Education

(All cognate areas within the discipline of nursing must be at level 8).

<p>Knowledge Breath</p>	<p>A systematic understanding of knowledge, at, or informed by, the forefront of a field of learning</p>	<p>The graduate should:</p> <ol style="list-style-type: none"> 1. know how knowledge is created and changed within the profession. 2. be able to demonstrate a knowledge base that exercises higher levels of judgment, discretion and decision making Within nursing practice. 3. be able to demonstrate the value of nursing through the generation of nursing knowledge and innovative clinical practice, nursing education and management.
<p>Knowledge kind</p>	<p>Critical awareness of current problems and/or new insights, generally informed by the forefront of a field of learning</p>	<p>The graduate should:</p> <ol style="list-style-type: none"> 1. demonstrate the synthesis and integration of knowledge from various domains showing a breadth and depth 2. demonstrate the synthesis and integration of knowledge from a broad range of disciplines that inform and develop nursing practice 3. demonstrate the synthesis and integration of the major research methodologies appropriate to his/her professional domain
<p>Know How and Skill range</p>	<p>Demonstrate standard and specialised research or equivalent tools and techniques of enquiry</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. make critical choices in the selection of approaches to research problems 2. synthesise different approaches to research and justify their use in practice 3. systematically gather, interpret and evaluate evidence drawn from a diverse range of sources that are chosen independently 4. conduct a comprehensive health needs assessment as the basis for independent nursing practice within a specified area 5. demonstrate expert skill in providing care for individuals and groups in communities, within the scope of practice framework and multidisciplinary team. 6. demonstrate advanced clinical decision-making skills to manage a patient/client caseload 7. evaluate and critique current evidence base to set standards for best practice
<p>Know How and Skill selectivity</p>	<p>Select from complex and advanced skills across a field</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. critically evaluate with discrimination the complex theories and

	of learning; develop new skills to a high level, including novel and emerging techniques	<p>concepts underpinning professional practice</p> <ol style="list-style-type: none"> 2. utilise advanced knowledge and critical thinking skills to directly and indirectly provide optimum nursing care 3. develop and apply critical faculties to practice through advanced reflection skills 4. demonstrate vision of professional practice that can be developed beyond current scope of practice 5. act proactively as an educational resource for healthcare professionals 6. apply critical faculties to professional practice through analysis of the underlying epistemology of its knowledge base
Competence context	Act in a wide and often unpredictable variety of professional levels and ill defined contexts	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. demonstrate autonomy, experience, competence, accountability, authority and responsibility in nursing practice 2. demonstrate leadership in nursing practice 3. use knowledge to autonomously identify, resolve and evaluate intellectual issues and practical problems that appear in practice 4. identify and integrate research into areas of health care that can incorporate best evidence based practice 5. use advanced skills to conduct an in-depth research study relevant to the field of professional nursing
Competence role	Take significant responsibility for the work of individuals and groups; lead and initiate activity	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. co-ordinate evidence based practice audit and research to develop and evaluate practice 2. actively contribute to the professional body of nursing knowledge 3. demonstrate the value of nursing & midwifery through the generation of nursing knowledge and innovative nursing education and practice 4. teach others from a broad and in-depth knowledge base, derived from reflection on nursing practice and expertise 5. Critically review the working of teams and demonstrate skills in negotiation and the management of conflict
Competence learning-to-learn	Learn to self evaluate and to take responsibility for	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. identify personal learning needs and the steps needed to meet them

	continuing academic and professional development	<ol style="list-style-type: none"> 2. reflect critically on practice in order to improve it in self and others 3. undertake complex and sustained analysis of subject matter and provide a balanced, logical and coherent conclusion 4. continually evaluate personal contribution to current body of knowledge in practice 5. utilise life-long learning skills to continue to develop knowledge applied to nursing practice 6. explore beyond scope of practice, developing effective and innovative nursing practice 7. demonstrate commitment to advancing the body of knowledge in nursing practice
Competence insight	Scrutinise and reflect on social norms and relationships and act to change them	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. identify and implement action to improve practice and initiate change 2. identify and critically evaluate ethical issues and work with others towards their resolution 3. develop the ability to be political within and outside of his/her employing organisation 4. challenge assumptions and question values, beliefs and policies underpinning care at individual, team and organisational level 5. actively contribute to the quality of care through research that can advance nursing and health care knowledge 6. develop advanced communication skills in order to present balanced arguments <ul style="list-style-type: none"> - present structured, rational and evidenced coherent arguments using appropriate strategies - engage confidently in academic and multiprofessional debate

Adapted from: *Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes - Incorporating the National Framework of Qualifications • First Edition An Bord Altranais • June 2010 pg 30-38.*

9. 4 COMPETENCIES FOR ADVANCED PRACTICE IN NEW ZEALAND

Competencies for the nurse practitioner scope of practice were approved by the Nursing Council of New Zealand in September 2008. There are four domains of competence for the nurse

practitioner scope of practice in New Zealand. Competencies are similar to Ireland in terms of structure: three main competencies and indicators. The framework used in Ireland has an additional component to the structure: that of behaviors to indicate when a competency has been met. There are three main competencies divided into sub-competencies. Ireland identifies five main domains of competence. In New Zealand, the main areas are competencies related to advanced practice in the provision of diverse health care services (NCNZ 2012 a, b). The second demonstrates advanced comprehensive client health assessment skills and diagnostic decision making relevant to specific areas of practice. The third establishes therapeutic relationships by recognising the client in context and respecting cultural identity and lifestyle choices. The four domains are (1) Professional Responsibility; (2) Management of Nursing Care; (3) Interpersonal and Inter-professional Care and Quality Improvement and (4) Prescribing Practice. The Model is represented in the Ireland Model as running through several domains and also separately in the Domains of Competence as set out for the Certificate in Nurse and Midwife Prescribing. The Model places emphasis on quality outcomes from interventions undertaken by the advanced practice nurse and on competencies that apply a model of nursing to practice; demonstrate accountability for practice; demonstrate nursing leadership; utilise comprehensive health assessment skills; demonstrate advanced practice in client care in a range of settings; involve client decision making; demonstrate independent practice; establish therapeutic relationships; contribute to clinical collaboration and is actively involved in quality assurance (NCNZ 2012 a, b). See Appendix 9 for details of Competencies for Advanced Practice in New Zealand.

9. 5 COMPETENCIES FOR ADVANCED PRACTICE IN THE UNITED KINGDOM

Competencies developed for advanced practice in the United Kingdom vary across roles and titles. The RCN (2012; 2014) and RCM (2015) have commented on competences at advanced practice level. In response to the dramatic changes taking place in health and social care, a Department of Health (2010), position paper sets out advanced practice competencies that differs significantly to those in place for the registered nurse. The paper is intended for use as a benchmark to enhance patient safety and the delivery of high quality care (Prime Minister's Report Commission on the Future of Nursing and Midwifery in England 2010). Benchmarks developed are made up of 28

elements clustered under four themes. The themes are: clinical /direct care practice; leadership and collaborative practice; improving quality and developing practice and developing self and others. The document authors recommend that all registered nurses should be engaged in developing their practice and advanced nurse practitioners should be engaged in developing their practice beyond the registered nurse threshold (DoH 2010). The four themes and 28 elements are broadly similar to competencies utilised in Ireland, New Zealand and Singapore. See Table 15 for a summary of nationally agreed competencies.

Table 15 Summary of Elements of Advanced Practice –United Kingdom (Nationally Agreed Competencies)

Elements	Description
Clinical /Direct Care Practice	Nurses working at advanced practice level will: <ul style="list-style-type: none"> • Practice autonomously • Assess individuals and populations • Draw on a diverse range of knowledge which usually includes prescribing medication • Assess risk factors • Plan and manage complete episodes of care • Use professional judgement in managing complex and unpredictable care events • Draw on relevant agencies and professionals when appropriate • Define boundaries to practice
Leadership and Collaborative Practice	<ul style="list-style-type: none"> • Demonstrate the impact of advanced level nursing to the healthcare team and to the wider health and social care sector • Provide consultancy services • Demonstrate leadership in unfamiliar contexts • Use high level negotiating and influencing skills • Work across professional organisations and system boundaries • Develop practice roles through application of demographic metrics • Identify the need for change
Improving Quality and Developing Practice	<ul style="list-style-type: none"> • Be proactive in developing strategies and undertaking activities to monitor and improve healthcare • Strive to improve health outcomes that exceed international standards • Continually evaluate and audit self and others • Monitor risk and challenge others about wider risk factors • Synthesise the outcomes of relevant research • Generate new knowledge to their own and others' practice • Alert others to gaps in service • Use financial acumen to enhance quality and value-for -money

Developing Self and Others	<ul style="list-style-type: none"> • Seek and participate in peer review • Enable patients to learn through various approaches • Develop robust governance systems by contributing to developmental processes • Work in collaboration with others • Use high level communication skills and disseminate their work widely
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Department of Health (2010) Advanced Level Nursing: A Position Paper. CNO Directorate, United Kingdom.

9. 6 COMPETENCIES FOR ADVANCED PRACTICE IN THE UNITED STATES

Competency assessment methods-tool and processes differ across countries and domains (Butler, Cassidy, Quillinan et al. 2011). Competencies were identified by Cooke at al. (2008) in a USA study involving APN’s as “intervention nurses” by exploring a patient journey through a post-hospital discharge. Competencies identified in this study are direct clinical practice, expert coaching and advice, consultation, research skills, clinical and professional leadership, collaboration and ethical decision making (Cooke and Grant 2008). Brown (1998) also identified similar competencies. The European Federation of Nurses Associations (2015) proposes the EFN Competency Framework and Guidelines to implement Article 31 into national nurses’ education programme that is an important development in the area. Competencies for advanced practice in the United States are mainly based on the LACE Consensus Model (2008). The six core competencies identified for practice in the United States are similar to the Core Concepts identified by the National Council for the Professional Development of Nursing and Midwifery in Ireland (Nursing and Midwifery Board of Ireland 2014) and Working Group for Advanced Nurse Practice NCNM 2008 b; 2014). Competencies differ to the Domains of Competence developed for the Ireland Model (NCNM 2005) in terms of structure, assessment methods and focus. It is acknowledged that the competencies developed for the USA Model are included in different form in the Domains of Competence, Ireland Model. In the USA Model, Domains of Competence are not utilised and emphasis is placed on a staged or tiered approach to competency development. Entry level competencies are designed for graduate nurses and are designed to build upon the core

competencies identified for all nurse practitioners (ANMC 2006a, b). Scope for the nurse practitioner to develop more advanced specific-to-the-role competencies is provided for.

Acute Care Nurse Practitioner (ACNP) Competencies were developed in the United States in 2004, by the National Panel of ACNP's Competencies. Endorsements of the competencies were provided by 15 organisations. The validation panel was made up of 54 nursing experts from universities, associations, healthcare systems, American colleges of nursing, national associations, societies, nursing certification boards and the American organisation of nurse executives. The competencies describe entry-level competencies of graduates of master's and post-master's programmes preparing acute care nurse practitioners for practice. Competencies are intended to build upon the core competencies identified for all nurse practitioners. The group acknowledges that as the nurse practitioner's grow into their roles practice may then include more advanced skills and competencies. These entry level competencies are related to the following areas of practice: Health promotion, health protection, disease prevention and treatment, diagnosis of health status, plan of care and implementation of treatment, nurse practitioner patient relationship, teaching-coaching function, professional role, managing and negotiating health care delivery systems, monitoring and ensuring the quality of health care practice and cultural and spiritual competencies. Many of those concepts are contained within the Domains of Competence (Ireland) but with a different focus. From this initial competency development work, core competencies applicable to the six areas for acute care nurse practitioners were developed. See Table 16 for further details.

In 2014, The Nurse Practitioner Core Competencies Content Workgroup in the United States suggested curriculum content for the development of of the nurse practitioner population-focused competencies. The NP's core competencies presented are based on the 2011/12 edition of the work of the NP Core Competencies task force working group. In the 2014 document suggested curriculum content to support the NP core competencies is included. The NP Core Competencies identified relate to the development of NP core competencies in the following areas: Scientific Foundation; Leadership; Quality; Practice Inquiry; Technology and Information Literacy; Policy; Health Delivery Systems; Ethics and Independent Practice. The document contains a delineation of suggested content that was developed by the Work Group (Nurse Practitioner Core Competencies Content Workgroup 2014).

Benchmarking of core concepts for advanced practice between Ireland and 6 other countries that have introduced advanced practice: Australia, Canada, New Zealand, United Kingdom, United States and Singapore, are presented in Appendix 10. Competencies are broadly similar across the six countries although with core concepts have different titles and orientation in some areas of practice.

Table 16 Competencies –Acute Care Nurse Practitioners Entry –Level Competencies –USA

Level	Competencies
Acute Care Nurse Practitioners (ACNP) United States	<ul style="list-style-type: none"> • Health Promotion, health protection, disease prevention and treatment • Diagnosis of health status • Plan of care and implementation of treatment • Nurse practitioner patient relationship • Teaching-coaching function • Professional role • Managing and negotiating health care delivery systems • Monitoring and ensuring the quality of health care practice • Cultural competence <p>From the development of these competencies and domains, core competencies in relation to these concepts were developed in areas that acute care nurse practitioners are involved in:</p> <ul style="list-style-type: none"> ○ Delivery of acute care health care ○ Education of acute care nurse practitioners ○ Credentialing of nurse practitioners ○ Regulation of advanced practice nursing ○ Accreditation of graduate nursing education programmes or ○ Employment of acute care nurse practitioners (Acute Care Nurse Practitioner 2003)

Adapted from: National Panel for Acute care Nurse Practitioner Competencies (2004). *Acute Care Nurse Practitioner Competencies*. Washington, D.C. National Organisation of Nurse Practitioner Faculties; (Apple 2010; NCSBN 2006; Delamaire, M. and G. Lafortune 2010) <http://dx.doi.org/10.1787/5kmbrcfms5g7-en>

9.7 DISCUSSION

Studies have demonstrated the value of APN's in clinical settings and of positive outcomes such as increased patient satisfaction, less re-admissions, reduced costs and lower mortality rates (Cunningham 2004). Equal or better clinical outcomes as doctors in the primary care setting has been demonstrated by Lenz et al. (2004) in a two year follow-up study and by Mundinger et al. (2000) in a randomised control trial. Further evidence of APN's ability to meet the care needs of children create a safe and trustful relationship with patients and enhanced collaboration with colleagues, was provided In a qualitative study with 26 APN's working in paediatric medical and surgical units in a Scandinavian country by Nieminen, Mannevaara and Fagerstrom (2011), findings indicate that the care provided by APN's is characterised by responsibility and competence in making autonomous decisions as well as the creation of safe and trustful relationships within the exchanges made (Cunningham 2004). Farrelly (2014 in the United Kingdom concurs. Loescher, Harris and Curiel-Lewandrowski (2011) in a systematic review, explored advanced practice nurses' skills level in areas relating to cancer assessment barriers, skin lesion recognition skills and skin cancer training activities and reported continuing progress in advanced practice nursing skills and competencies in these areas.

Competencies defined for practice, in countries where competencies are used, are presented in broad outline in Appendix 8. The competencies required by the advanced practitioner in Canada are similar in structure: three main competencies and indicators, and content to those of Ireland and New Zealand although not contained within a specific Domains of Competence. The framework used in Ireland has an additional component to the structure: that of behaviors to indicate when a competency has been met. In Canada, there are three main competencies divided into sub-competencies. Ireland identifies five main domains of competence. Core competencies for advanced practice in Canada are based on appropriate depth, breadth and range of nursing knowledge, research and clinical experience. These are used by all advanced nurse practitioners and are based on the APN's specialist of practice. Four categories: clinical, research, leadership and consultation and collaboration are used. Clinical competencies include assessment and intervention strategies, using research when making clinical decisions, analysing complex interactions, guiding decision-making and developing client focused care and education programmes (CNA-National Framework 2008; CNC 2010, 2014).

There are four domains of competence for the nurse practitioner scope of practice in New Zealand as opposed to five domains utilised in Ireland. Applicants must meet the competencies within four domains. These domains are (1) Professional Responsibility; (2) Management of Nursing Care; (3) Interpersonal and Inter-professional Care and Quality Improvement and (4) Prescribing Practice. In benchmarking against the Ireland Model: (1) Professional Responsibility in the New Zealand Model, corresponds to the Domain of Professional and Ethical Practice and the Domain of Personal and Professional Development in the Ireland Model. Domain (2) Management of Nursing Care corresponds to the Domain of Holistic Approaches to Care and Integration of Knowledge in the Ireland Model. Domain (3) Interpersonal and Inter-Professional Care and Quality Improvement correspond to the Domain of Organisation and Management of Care in the Ireland Model. Domain (4) Prescribing Practice in the New Zealand Model is represented in the Ireland Model as running through several domains and also separately in the Domains of Competence as set out for the Certificate in Nurse and Midwife Prescribing.

The New Zealand Model places more emphasis on outcomes from interventions undertaken by the advanced practice nurse and to a higher focus on quality by the advanced practice nurse compared in Ireland. Similar to the Ireland Model, the New Zealand Model places emphasis on competencies that apply a model of nursing to practice; demonstrate accountability for practice; demonstrate nursing leadership; utilise comprehensive health assessment skills; demonstrate advanced practice in client care in a range of settings; involve client decision making; demonstrate independent practice; establish therapeutic relationships; contribute to clinical collaboration and is actively involved in quality assurance (NCNZ 2012 a, b). See Appendix 9 for details of Competencies for Advanced Practice in New Zealand.

In the United Kingdom a different approach is used that focuses on 4 themes and 28 elements. The themes are: clinical /direct care practice; leadership and collaborative practice; improving quality and developing practice and developing self and others. The four themes and 28 elements are broadly similar to competencies utilised in Ireland, New Zealand and Singapore.

Competencies for advanced practice in the United States are mainly based on the LACE Consensus Model (2008). The six core competencies identified for practice in the United States are similar to the Core Concepts identified by the National Council for the Professional Development of Nursing and Midwifery in Ireland (NCNM 2008 b; NMBI 2014). Competencies for the USA differ to the

Domains of Competence developed for the Ireland Model (NCNM 2005) in terms of structure and focus, although these competencies are included in different form in the Domains of Competence, Ireland Model. In the USA Model, Domains of Competence are not utilised and emphasis is placed on a staged or tiered approach to competency development with scope for the nurse practitioner to develop more advanced specific-to-the-role competencies provided for.

There is scant literature published on Mental Health Advanced Nurse Practice. Fung, Chan and Chien (2014) in their systematic review on the role performance of psychiatric nurses in advanced practice undertaken in HongKong, in 14 studies from the literature found that mental health advanced practice nurses can potentially develop collaborative partnerships with non-mental health service providers, perform multifaceted roles and provide mental health-care services in various contexts. In a pilot study on advanced practice psychiatric nurses' outcomes of care Parrish, Peden, Staten, Hall and Danner (2013) identify similar issues in mental health.

Sastre-Fullana et al. (2014) identified common traits specific to competency development in their literature review. Findings from 119 relevant publications indicate that 17 essential core competency domains pertaining to the role development of international advanced practice nursing can be found in most national frameworks. These domains may be used to further develop instruments to assess the perceived competency of advanced practice nurses and related outcomes from care delivered. Kilpatrick, Lavoie-Tremblay, Ritchie and Lamothe (2014) in their study of team effectiveness of advanced practice nursing roles and health care teams recommend that these two concepts, which have been studied separately, need further research into their association linkage so that APN roles in health care teams may be better utilised thus improving delivery of health care services to patients and families.

The capability framework devised in Scotland is aimed at nurses working in or towards an 'advanced practitioner' role in community health nursing teams in Scotland. This framework builds on the capabilities, practice learning achievements and key content in the capability framework for community health nursing (NHS Scotland 2007; NES, 2007a) and outlines the focus, level of practice and generic knowledge, skills and approaches needed by the advanced practitioner nursing in the community: equating to the senior level of practice in the careers development framework and focus on realising an individual's full potential, developing the ability to adapt and apply knowledge and skills learning from experience, envisaging the future and helping to make it

happen (NHS Scotland 2007). Capability at advanced practice level may be evident through a portfolio of learning and competence assessment, The portfolio needs to reflect the key elements of advanced practice and the breadth of clinical and settings within which they can be demonstrated (NHS Scotland 2012). From 'competence to capability' was explored by Gardner, Hase, Gardner et al. (2007) using a capability framework in an effort to determine the level and scope of practice of the nurse practitioner in Australia and New Zealand found that the concept of capability provided a useful construct to describe the attributes of the nurse practitioner but not the complete range (Gardner, Hase, Gardner et al. 2007) and the study suggests that both competence and capability need to be considered in understanding the complex role of the nurse practitioner (Gardner, Hase, Gardner, Dunn and Carryer 2007; 2008). O'Connell, Gardner and Coyer (2014) describe competencies as being appropriate for practice in advanced nurse practice where stable environments exist and identify capability as the combination of skills, knowledge, values and self-esteem which enables individuals to manage change and move beyond competency.

9.8 CONCLUSION

Comparisons are made between competencies developed by six countries with those of Ireland. Competencies defined for practice, in countries where competencies are used, are presented in broad outline in Appendix 8 and do not identify a competency tool of such detail, complexity or application to practice as that used in Ireland. Assessment of Domains of Competence is the tool used in Ireland to define competencies for advanced nurse practice. While the Irish competency tool may lack application to specific specialty areas of practice in some instances, it is an excellent example of a competency assessment tool (NCNM 2008b). It is essential that all competencies are well articulated, with indicators that are specific to each post. This will help to ensure that local governance arrangements, risk factors and patient outcomes have been identified and are monitored. Respondents to NMBI Survey (2014) indicate that candidates should maintain a clinical log book to identify clinical skills undertaken and a Portfolio of Practice that incorporates all competencies.

CHAPTER 10 CLINICAL OUTCOMES FROM ADVANCED PRACTICE

10.1 SUMMARY

Research undertaken on clinical care outcomes delivered by emerging roles has not yet produced significant patient improvements, other than level of satisfaction with care delivered, over established ANP/APN's., mainly due to the length of time these roles are in existence and the main focus of research outcomes focusing on advanced nurse practitioners. Clinical outcomes from advanced practice nursing are mainly focused on research related to patient satisfaction, communication with patients, length of stay, comparisons between care provided in acute care and primary care settings and that provided to vulnerable patients and older persons. Research is also focused on cost of care and outcome differences from care provided by doctors/physicians and that provided by advanced practice nurses.

10.2 CLINICAL OUTCOMES FROM ADVANCED PRACTICE

Research is taking place on outcomes to clinical care around the world, mainly focusing on patient satisfaction and on cost of care (Cunningham 2004; Rhodes, Fusilero and Williams 2010, Yeo et al. 2011; Bergman, Perhed, Eriksson, Lindblad and Fagerström 2013). Yeo et al.2011 and Brooten, Youngblut, Deosires et al. 2012 place emphasis on the area of oncology. Research being provided by ANP's and physicians demonstrates comparable care being provided (Fisher and Vaughn-Cole 2003; Potera 2011, Begley, Devane, Clarke et al. 2011; Begley, Murphy, Higgins and Cooney 2014). More research is needed in medication management (Goldman et al 1998, Parrish et al 2013). Community care requires further and faster development. Development of primary care facilities and models of care being used in Hong Kong (Twinn et al. 2005) are being delivered in hospitals but little advanced practice is taking place in primary care. International research undertaken has evaluated the effectiveness of advanced practice in some nursing specialties, such as on the role and scope of practice of emergency nurse practitioners in the emergency department (Small 1999), heart failure (McCauley et al. 2006), cardiac care (Ingram 2014), mental

health and psychotherapy (Reasor and Farrell 2005) and critical care (Fairley and Closs 2006) but limited evaluation of advanced midwifery practice has taken place (Alexander et al. 2002).

Ritz et al. (2000), in exploring the effects of advanced nursing care on quality of life and cost outcomes of women newly diagnosed with breast cancer, found that these patients had improved quality of life compared to breast cancer patients receiving standard care. In Canada advanced nurse practice is an integral part of health care delivery (Kilpatrick 2008) and similar to Finland, ANP's provide care in remote areas (CNA 2006, Jaatinen et al. 2002). Studies are now being undertaken in relation to mental health in the United States with positive outcomes from care delivered by Advanced Practice Psychiatric Nurses (APPN's) in patients with major depression (Parrish et al, 2013). The authors did find that barriers to education were found and that education and training for APN's to address this area were not easily available (Loescher et al 2011). Feldman et al (2003) using survey methods explored APPN 's as a treatment resource found similar results indicating that APPN's are highly effective in treating clients with depression and that clients were very satisfied with this care.

10.3 DISCUSSION

Many studies report positive outcomes form care delivered by ANP/APN/AMP. Koskinen et al. (2012) identified that advanced nurse practitioners were taking on responsibility for new service areas not previously provided by registered nurses, such as chronic disease management where reduction in length of stay by 2 days is reported. In the United States early research into the role of the advanced practice nurse centered on comparing outcomes from care delivered by advanced practice nurses in primary care areas and care provided by doctors/physicians in medical practices (Brown and Grimes 1995), and latterly on care provided in hospitals by acute care nurse practitioners (ACNP) compared to that provided by doctors in the same environment (Kleinpell and Gawlinski 2005), with positive results reported in relation to the care provided. Equal or better clinical outcomes as doctors in the primary care setting has been demonstrated by Lenz et al. (2004) in a two year follow-up study and by Mundinger et al. (2000) in a randomised control trial. In a study, undertaken by Ingersoll McIntosh and Williams (2006), also in the area of primary care,

it was found that the APN's knowledge of patients and family were enhanced and that collaboration among care providers was observed (Sidani et al. 2006). It was also found that APN's engage in more informal co-ordination activities, encourage more patient involvement in care and provide more education to patients and families (Sidani et al. 2006; Plager and Conger 2006), Sidani et al. 2000). Bergman et al (2013) concurs with this finding. The importance of providing information to patients prior to survey research is indicated in a recent study undertaken in Sweden. Bergman et al (2013) explored patients' satisfaction with the care offered by 340 advanced practice nurses and findings indicated a high level of satisfaction with APN led care but also that patients provided with information on the APN role prior to completing the survey were significantly more satisfied than those who did not highlighting the importance of communication

Outcomes are not always positive. Reserch undertaken by Loescher et al (2011) in Tuscon, Arizona via a systematic review of advanced practice nurses working in the area of dermatology, with specific reference to skin cancer assessment, found negative outcomes from care. Out of 136 articles meeting criteria for selection 12 were selected for further review. These researchers found that skin cancer examinations by APN's were infrequently and inconsistently measured because of limited time available to undertake the skin assessments. Also, the APN's abiliuty to consistently diagnose and to refer on suspicious lesions to physicians or pathologists was inconsistent. Following education the APN's demonstrated improvement. Barriers to education were found even though education and training for APN's to address this area were not easily available (Loescher et al 2011).

Willens et al (2011) acknowledges that strategies need to be developed in the area of diabetes multidisciplinary care teams in relation to the extension of the role to APN's and clinical pharmacists. Care was previouslt provided by physicians and now extended to primary care teams. Strategies to mprove clinical outcomes and cost efficiencies by the teams are recommended. Inconsistent results are often obtained. Recent research undertaken by Duangbubpha et al. (2013) In a community in Thailand amongst 210 patients who were receiving care for COPD found inconsistent results from care delivered by teams containing ANP's and teams that did not. Results indicated that the strategic and self help dimensions of care delivery were higher in ANP teams and functional care was higher in non ANP care teams, highlighting the strategic importance of ANP delivered care. Drennan and Goodman (2011) recommend sustaining innovation in the

health care work force in a case study of community nurse consultant posts in the United Kingdom.

10.4 CONCLUSION

Research undertaken on clinical care outcomes delivered by emerging roles has not yet produced significant patient improvements, other than level of satisfaction with care delivered, over established ANP/APN's, mainly due to the length of time these roles are in existence and the fact that the main focus of research outcomes has been focused on care provided by advanced nurse practitioners. Outcomes are not always positive and in some cases are inconsistent. More research is called for by Pulcini et al (2010). Research is increasing in some areas but much more is needed in relation to chronic disease, community care, mental health and in specialist areas of practice.

Chapter 11 DIFFERENCE IN CARE DELIVERED BY ANP AND CNS/CNM'S

11.1 SUMMARY

Much discussion and dissention has arisen over the boundaries between the CNS and ANP roles in recent years and also between ANP roles with that of physicians. Research into the differences between ANP's and CNS/CMS's has taken place. Some experts see them as overlapping and others do not. Results indicate that a clear difference exists between CNS and ANP care. ANP's were perceived as providing improved service delivery, greater clinical and professional leadership, developing education curricula, undertaking and publishing research with clear governance and accreditation structure. It is evident from published studies that further research is needed into the outcomes and activities undertaken and comparisons made between CNS and ANP roles.

11.2 DIFFERENCE IN CARE DELIVERED BY ANP AND CNS/CNM'S

Role confusion is evidenced by a proliferation of terms such as ‘nurse practitioner’, ‘nurse consultant’ and ‘advanced practice nurse’ and the more common ‘clinical nurse specialist’ (Coster et al. 2006, Sheer & Wong 2008; Donald et al. 2010; Roche et al. 2013) leading to uncertainty surrounding how the roles of clinical nurse specialists and advanced nurse practitioners differ. In the UK, there is less distinction between advanced practice roles (Morgan 2010, Skills for Health 2011). Some educational programmes now prepare nurses for blended CNS and NP roles (Cole 2003). Cole found that the boundaries of NP practice intersect with medicine and that CNS practice does not. He contends that the NP role is direct care giving providing a combination of nursing and medical care.

11.3 DISCUSSION

Begley et al (2013), utilising mixed methods non-participant observation, interviews and survey of 154 service users compared the roles and perceived outcomes of Clinical Nurse Specialists (CNS), Clinical Midwife Specialists (CMS) and ANP’s in Ireland. Interview guides used in the study were informed by issues identified in the Delphi study undertaken prior to this study (Begley et al. 2010). Findings indicated that ANP/AMP’s provide a higher level of care than CNS’s and that this is more evident at a strategic level. Results indicated that a clear difference existed between CNS and ANP care. Domains of practice were studied. In Begley et al. (2013, 2014), ANP’s were perceived as providing improved service delivery, greater clinical and professional leadership, developing education curricula, undertaking and publishing research with clear governance and accreditation structure. This study concurs with others undertaken in Australia and New Zealand (Carryer et al. 2007) and in Finland (Fagerström 2009) in the area of clinical leadership where ANP’s were viewed as being positive role models in committee involvement, facilitating education for all team members, research and audits.

However, an American study undertaken in California involving 947 Californian CNS’s indicated that even though CNS’s spent some time on clinical leadership and research, they preferred expert clinical practice (Mayo et al. 2010). In Begley et al (2013) CMS’s were more involved in co-ordination of the multi-disciplinary team, integrated care planning and development of information resources for patients than were CNS’s or ANP’s. It is recognised that many CNS/CMS’s continue to further develop their clinical leadership roles in teaching, consultancy, and

practice development, all areas that have been identified as part of the role of ANP/AMPs (NCNM 2005, Elliott et al 2012).

Further research that is at variance with these studies relates to a recent study undertaken in Australia by Roche et al (2013), exploring the work of advanced nurse practitioners and other grades of CNS. This study explored domains of practice for advanced practice nursing in Australia and evaluated one APN role-the Clinical Nurse Consultant. All 56 CNC's working in a tertiary hospital were studied through observation, on-line questionnaire, working activity, interviews and a 50 point measurement tool to score the level of practice of each CNC against five domains: Clinical Service and Consultancy; Clinical Leadership; Research; Education; Clinical Services and Management. Results indicated that domains of practice did not appear to have featured significantly in the original design of the CNC role even though it is defined in legislation and linked to the CNC's salary structure in Australia. Findings indicated significant differences in job content and variability in levels of practice in the CNC role and across the 3 grades within the role but that all grades were mainly involved in direct patient care with little time for undertaking the other four domains of leadership, research, education or strategic management. Roche et al. (2013) maintains that the CNC role is equivalent to the Clinical Nurse Specialist role in the UK and in the USA and at the time of publication the CNC role was regulated by the Public Hospital Nurses ' Award ("the award") (NSW Department of Health, 2000). The "Award", in Australia, sets minimum employment standards for an occupation, such as nursing. It is evident from these studies that further research is needed into the outcomes and activities undertaken and comparisons made between different specialists.

11.3.1 Nurse Consultant

The Nurse Consultant is viewed as an advanced nurse practitioner in some countries. The role of Nurse and Midwife Consultant is ill defined and perceived by the profession, organisations and patients in a variety of ways. Lee, Chow Choi, Chan et al. (2013) discussed the impact on patient health and on service outcomes of introducing nurse consultants in Hong Kong. The role was introduced by the Hospital Authority in January 2009. Seven Nurse Consultant's (NC) were appointed in five clinical specialties: diabetes, renal, wound and stoma care, psychiatrics, and continence. This was a pilot initiative. A total of 280 patients participated in the study: 140 in each

cohort under NC or non-NC care. The patient health and service outcomes of both cohorts were evaluated and compared in relation to accident and emergency visits, hospital admissions, length of hospital stays, number of acute complications, number of times treatment or regimen altered by nurses' according to patient's condition and blood tests in relevant areas. A patient satisfaction instrument was also used to assess the NC cohort. Findings indicated that patients under NC care had favourable patient health and service outcomes compared with those under non-NC care. The NC cohort also reported a high level of patient satisfaction. The study demonstrates that the introduction of NCs in specialty units may have a positive impact on patients' health and service outcomes. The high level of patient satisfaction scores indicates that patients appreciate the care they are receiving with the introduction of NCs.

Drennan and Goodman (2011) explored the role of a Community Nurse Consultant in the United Kingdom from the perspective of recruiting, retaining and meeting increasing demand for experienced, qualified nurses for all health care systems. Their study considers the factors that sustain or curtail workforce innovations through the case example of a cohort of nurse consultants established in one community health service in England over a three year period, using interviews, observations, documentary analysis and questionnaires. Ten nurse consultant posts were created over a period of two years (2002-2004). Within two years only five posts remained and within five years (2009) only two part time posts with the original appointees remained and no replacements took place. Three factors identified as influential in the demise of the posts were the extent to which a) there was support for individual nurses rather than the post, b) there was an unambiguous and uncontested clinical service requirement for a nurse consultant and c) finances for the post were judged as being used to best effect in a service setting. Drennan and Goodman (2011) point to the importance of normalising clinician and managers' beliefs in the relevance and need for the NC role.

Giles, Parker and Mitchell (2014) say that lack of role clarity is highlighted extensively in international and Australian studies examining the role of the Nurse Consultant and studies up to now have failed to adequately examine the role in the context of integrated and complex health services. These authors explored the role from contextual and recognition of differences perspectives in metropolitan and rural New South Wales (NSW) Australia. Findings indicate that the advanced practice role of the Nurse Consultant is unique in its capacity to provide clinical

leadership across a range of contexts. Within health care organisations, across contexts, the NC role has suffered through lack of clarity over function and appropriateness for purpose. These researchers say there is an urgent need for evidence of how Nurse Consultant's contribute to health care outcomes in ever changing contexts.

Wilkes, Luck and O'Baugh (2015) explored the role of Clinical Nurse Consultant (CNC) in an Australian Health District: through on-line survey methods. This study replicates previous research undertaken in 2013 that explored the role of the CNC in a metropolitan health district in Sydney, Australia. Findings indicate that CNC's are well informed about the domains and functions of their role and able to identify clinical service and consultancy as the areas in which they predominantly practice yet, despite the clarity of the domains and functions as outlined in the relevant legislated award, the activities undertaken by these clinical nurses are institutionally, individually and contextually constructed.

In a study of domains of practice and advanced practice nursing in Australia, Roche, Duffield, Wise et al. (2013) explored the Clinical Nurse Consultant (CNC) role which they say is one ANP role in Australia. The study sample was all 56 CNCs employed in a tertiary hospital in New South Wales. Demographic and work activity data were collected by an online questionnaire and face-to-face interviews included the administration of a 50-point tool to score the level of practice of each CNC against five domains. Findings indicated that domains of practice did not play a central role in the design of the role and there was wide variability in the level of practice both within and between the CNC grades as well as significant differences in job content. Few CNCs managed to achieve a moderate level of practice across all five domains suggesting that the distinctive features of the CNC roles as articulated in the domains of practice are often not realised in practice.

11.3 CONCLUSION

Guided by scope of practice, departmental policies procedure, protocols and guidelines the RANP/RAMP can initiate an investigation and management plan and complete an episode of care leading to discharge or referral to an appropriate service/clinician as agreed in the scope of practice, in contrast to a CNS. While the role of the CNC has been investigated by many there is still no agreement as to what the major functions of the role of these nurses should be. The UK has been creating clinical career structures for nurses that include innovative posts known as Nurse Consultants (NC). While the numbers overall appear to have grown over the last eleven years,

there is evidence that in some specialities and regions the numbers are decreasing. Findings from Australian studies indicated that domains of practice did not play a central role in the design of the role. Strategies to ensure continued support of CNS/CMS and ANP/AMP roles need to be implemented in Ireland that are in keeping with the Government's new framework for role expansion (Government of Ireland 2011). Begley et al (2013) recommends that health service policy-makers support existing Clinical Nurse Specialists to become Advanced Nurse or Midwife Practitioners in order to give higher level service, particularly in the areas of community care and long-term illness. The RANP/RAMP is a positive role model for advanced nursing practice and thus needs to provide evidence of active participation in the development and delivery of education for the multidisciplinary team by acting as an advocate for expert nursing practice.

CHAPTER 12 DIFFERENCES IN CARE DELIVERED BY ANP/APRN'S AND PHYSICIANS

12.1 SUMMMARY

Research indicates that similar results and similar outcomes from care are being obtained from care delivered by ANP/APRN's and Physicians. Equivalent care in assessment and diagnostic accuracy were maintained and reduced re-admission rates were found.

12.2 DIFFERENCES IN CARE DELIVERED BY ANP/APRN'S AND PHYSICIANS

Research into ANP roles, undertaken in primary care, found that NP's and physicians provide equivalent care in relation to assessment and diagnostic accuracy and achieve similar outcomes (Brian and Grimes 1995; Horrock et al. 2002). Sidani et al. (2006) explored the process of care. in making comparisons between nurse practitioners and physician residents in acute care, and identified positive outcomes from ACNP care. Delgado-Passler and McCaffrey (2006), in a study undertaken in the United States on the influence of post-discharge management by nurse practitioners on hospital re-admission rates for heart failure, found there was a reduced re-

admission rate for patients who had post-discharge care delivered by advanced nurse practitioners. Findings also indicate that advanced practitioners are undertaking a range of activities that doctors previously performed including diagnostics, screenings, prescribing of medication or medical tests.

12.3 DISCUSSION

Research has taken place into the differences in outcomes between APN's and Physicians. Positive findings by physicians and ANP's were obtained in OECD studies relating to improved access to care and quality of care delivered in minor illnesses and follow-up procedures (Delamaire and Lafortune 2010). In an Australian study, ANP led care resulted in higher patient satisfaction, decreased waiting times and equal quality of care when compared to mid-grade residents (Carter and Chochinov 2007). Findings from a study undertaken for the OECD by Delamaire and Lafortune (2010) indicated that using advanced practice nurses can improve access to services and reduce waiting times, and deliver the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up. Delamaire and Lafortune (2010) in their OECD study identified that advanced nurse practitioners were carrying out a range of activities that doctors previously performed including diagnostics, screenings, prescribing of medication or medical tests, health prevention and education and the monitoring of patients with chronic illnesses. In a systematic review undertaken with nurse practitioner's, on the impact of nurse practitioners on cost, quality of care, satisfaction and wait times in the emergency department, Carter and Chochinov (2007), in an Australian study, found that nurse practitioners lead care that resulted in higher patient satisfaction, decreased waiting times and equal quality of care when compared to mid-grade residents. In a study, undertaken in the United States by Horrock et al. (2002) to explore if nurse practitioners working in primary care can provide equivalent care to doctors, it was demonstrated that patients are very satisfied with primary care provided by APRN's.

12.3 CONCLUSION

The Institute of Medicine (2010) in the United States, state that APRN's are recognised as being in the domain of medicine and in integrating skills from holistic nursing and other disciplines,

although opposition from other medical organisations differ and some resistance to the role is expressed (Villegas and Allen 2012). According to Cronenwett (2012) nurses and physicians share many aspects of care delivery and critical aspects of the same patient mission and therefore it is time for nurses to drop the rhetoric of advanced nurses versus medical models of care and the defensive positions adopted, because due to the nature of the doctor and nurses' roles there will also be collaboration needed. Carney (2006) in a study of 860 health care clinician managers in Ireland, using survey methods, found that involvement, commitment and collaboration in care delivery resulted in greater consensus of roles and a shared mission of excellence in patient care delivery.

CHAPTER 13 CRITERIA FOR DEVELOPMENT OF ADVANCED PRACTICE POSTS

13.1 SUMMARY

International publications relating to advance practice nursing highlight the ambiguity surrounding the establishment of, and need for, posts, roles and nomenclature (Jones 2005; Gardner et al. 2007). Confusion remains on how posts should be constructed and on the governance structures, clinical, organisational, community and professional needed for effective utilisation of ANP/APN roles in hospitals and in primary care (Gardner 2010). This ambiguity is compounded by the views expressed by nursing and government experts, mainly in the United Kingdom, and Australia who query if regulation for the role is needed and that advanced practice is an extension of the role of the nurse that would occur organically with experience. Regulation is not needed in their view as advanced practice should not extend beyond the legislative framework of the registered nurse that incorporates the higher skills and competencies needed for advanced practice into existing roles (Wilson et al. 2004). Jones (2005) says that lack of clarity surrounding the boundaries of advanced practice roles is compounding this view.

There are no agreed criteria for advanced practice posts as some posts are regulated by law as in Ireland, Singapore and New Zealand and others are governed by health care organisations or

bodies such as in the United Kingdom and Canada. In countries where advanced practice is well established there remains confusion on how posts should be constructed, limits to the role, differentiation of roles and on the governance structures needed for effective utilisation of advanced nurse practice roles across populations and communities, in hospitals and in primary care, with little consensus on the structures needed to support the role. The focus in this review is on the future development of advanced practice posts and on best practice governance structure of such posts.

13.2 CRITERIA FOR DEVELOPMENT OF ADVANCED PRACTICE POSTS

Publications relating to advanced practice nursing highlight the confusion and ambiguity from an international perspective of posts, roles and nomenclature (Jones 2005; Gardner et al. 2007, 2010). The title of “advanced practice nurse” may be losing its currency due to ambiguity and lack of consensus on the role (Gardner et al. 2007), mainly because of a lack of organisational structures for health service delivery and resource planning. Ambiguity also surrounds the difficulty in differentiating the advanced practice role from that of other nurses such as the registered nurse and the clinical nurse specialist and as a result there is confusion by health service managers in utilising and optimising advanced practice roles (Gardner 2010). In their study from the Specialist Clinical and Advanced Practitioner Evaluation study undertaken in Ireland, Elliott, Higgins, Begley et al. (2012) identified clinical and professional leadership activities of advanced practitioners:.

There is also, in some countries particularly in the United Kingdom, Australia and Canada, a call for nursing practice that does not extend beyond the legislative framework of the registered nurse but that seeks to incorporate higher skills and competencies into existing roles, and as a result a scope of practice has evolved that seeks to fill gaps in the service (Wilson et al. 2004). This confusion has also caused difficulties for nurses who are striving to expand their roles and this is mainly due to failure to clarify the boundaries of advanced practice in relation to roles, autonomy and decision making (Jones 2005; Gardner et al. 2007). Recent communication into the role of the advanced nurse practitioner has dismissed this view.

ANP/AMP practice has been curtailed in some countries including Australia and Holland (Middleton et al. 2011, Kilpatrick et al. 2012, Zwijnenberg and Bours 2012). Similar curtailment has been reduced in Ireland due to deliberate and relevant site preparation and development of ANP posts in order to meet population and service needs. This conscious preparation leads to consistent practice by ANP's thus enhancing role clarity and leading to a reduction in such barriers as have occurred in other countries (Begley et al 2013).

13.3 JOB DESCRIPTION

It is argued that the job description for a particular POST cannot reflect the complete clinical decision making requirements/situations of that post that arise in all situation (NMBI Survey 2014). A contra view is that responsibility for job description and site preparation lie with the service provider and that service requirements lead in defining the need for the development of advanced practice posts. The job description should incorporate a degree of flexibility to meet changing health service needs and the role and function of the role should be clear enough to recognise all the elements, components and requirements of the post. If a job description or role is so ill defined or broad so as to place an added workload burden on the RANP/RAMP the value of having an advanced practitioner in post may be negated or minimised. NMBI have a role in defining criteria, framework, and advice for such development.

13.4 CONCLUSION

Currently some nurses see pathways to advanced practice as a significant challenge and organisations may encounter challenges from within nursing and medicine due to limited resources. These barriers once identified remain future challenges. Evaluation of the role is also in the transition stage as evaluating the work of the RANP/RAMP in terms of the number of patients seen in one day is a crude evaluation of the care provided. The complexity of the assessment and care of patients with complex medical backgrounds, profound social needs and personal issues are time consuming but necessary for positive care outcomes (NMBI 2014 Survey).

CHAPTER 14 ORGANISATIONAL SERVICES FRAMEWORK TO SUPPORT EXISTING APN/MP ROLES IN CLINICAL SITES

14.1 SUMMARY

There is need for organisational structures to support the APN/NP title and roles. Many factors influence the development of advanced practice at national and international level that may be outside the control of the advanced practitioner or the regulatory body. These include structures, environments, local healthcare conditions and services, culture, government policy and nursing needs and recently reduction in junior doctors working hours. Parameters and frameworks for advanced practice nursing roles have been developed. Researchers have found that there is a need for nursing services to incorporate expanded levels of skills, autonomy and decision roles and for organisations to set out the service parameters for advanced practice and to differentiate operationally between the roles of advanced practice and other nursing roles.

14.2 ORGANISATIONAL SERVICES FRAMEWORK TO SUPPORT EXISTING ANP/AMP ROLES IN CLINICAL SITES

The framework for the accreditation of advanced nurse or midwife posts in Ireland is as set out in Framework for the Establishment of Advanced Nurse Practitioner and Advanced Midwife Practitioner Posts (NCNM 2008). The roles of clinical nurse specialists (CNS) and registered advanced nurse practitioner (RANP) are separate and distinct. Each of those roles must be articulated within the scope of practice for each role (Ingram 2014). The RANP role is defined by four competencies:

1. Individual patient/client outcomes
2. Outcomes specific to other health-care staff
3. Outcomes specific to the health service,
4. Barriers to implementing the role

Studies have identified the readiness of health care organisations in the development of new APN's posts (Manley 1997; Bryant et al. 2004). Roles and concepts have been identified and some

researchers' have expressed the opinion that concepts such as clinical practice, education, research, organisational leadership and professional development are better indicators of APN roles than titles alone (CNA 2000; ICN 2003; ANC 2008; AANP 2009; ANA 2010; APRN 2012; Begley et al 2013). The Health Information and Quality Authority (2012, 2014) identified the components of a quality service that healthcare organisations in Ireland will be required to meet and the National Standards needed for safer better healthcare.

There is increasing interest in health service research emerging in relation to the workforce and work activity of nurse practitioners, particularly in Canada and Australia (Hurlock-Chorostecki et al. 2008, van Socren et al. 2009; Gardner et al. 2010, 2012). Environmental structural factors influencing the development of advanced practice at national and international level may be outside the control of the advanced practitioner or the regulatory body. A study undertaken by the Centre for Nursing Studies in Canada explored environmental factors relating to primary care nursing, in the context of examining government policies and stakeholders perception of the ANP role. Findings indicate that at organisational level often the development of a new APN post is an afterthought. The authors recommend that a needs based assessment be undertaken prior to introduction of the role, in order to define performance indicators. Defining the responsibilities of other health care professionals, required to support role implementation, is also needed. This process should include collaborative, systematic evidence based strategies to provide sufficient data to support the need for the post and identify goals for defined roles (Marsden et al. 2003; Bryant et al 2004). Gardner et al. (2008, 2012) advise that a research model that investigates organisational and service influences on the role is needed. Mayo, Omery, Agocs-Scott et al. (2010) discussed clinical nurse specialist practice patterns and found variations across domains of practice. Nieminen, Mannevaara and Fagerström (2011), in a Scandinavian study, explored advanced practice nurses' scope of practice in a qualitative study of advanced clinical competencies.

The most recent document emphasising the positive outcomes of CNS and RANP/AMP practice in Ireland was published in 2010, as part of the SCAPE project (NCNM, 2010a). This document provided evidence of the benefits of CNS and RANP/AMP roles. Begley et al. (2013) presented ANP/AMP roles in Ireland under 4 headings. These are: clinical practice, clinical leadership, and professional leadership and research. Similar clinical leadership roles were identified in Australia

and New Zealand (Carrier et al. 2007) and Finland (Fagerström 2009). Models of best practice in collaboration and supervision need to be developed between physicians and APN's in acute, chronic, primary care and long term care facilities (Mayo et al. 2010). Even though organisations have promoted such collaborative models this has not occurred in the nursing home setting. The American Medical Directors Association has formed a work group to address collaboration and supervision relationships in order to best define the role of both professionals in this setting (Institute of Medicine 2011).

Lalor, Casey, Elliott, et al. (2013) evaluated the impact of specialist and advanced practice roles on clinical outcomes. In a two phased approach, the authors used the SCAPE Study (Begley et al. 2013) on specialist Clinical and Advanced Practitioner Evaluation in Ireland to illustrate how case study was used to strengthen a sequential explanatory design. Data were collected through observation on CS's or ANP's, documentary analysis, 115 interviews with clinicians and managers and 279 service users completed a survey based on the components of CS and AP practice as identified in Phase 1. Interviews with policy-makers to set the findings in context were then undertaken. Findings indicate that the role of the clinical nurse/midwife specialist and advanced nurse/midwife practitioner is complex not least because of the diversity in how the roles are operationalised across health settings and within multidisciplinary teams.

Research undertaken in Australia examined practice and organisational supports to enhance practice. A qualitative study by Gardner et al. (2007), undertaken in Australia in 2006, examined practice through in-depth interviews, in an attempt to develop parameters and a framework for advanced practice nursing roles. Researchers found that there is a need for nursing services to incorporate expanded levels of skills, autonomy and decision roles and for organisations to set out the service parameters for advanced practice and to differentiate operationally between the roles of advanced practice and other nursing roles. Results support the "Strong Model of Advanced Practice" (Ackerman et al. 1996), as the authors seek a generic description of the core features of the practice of advanced nursing. Findings indicate that the APN/ANP consider caring as being integral to direct care in advanced practice as well as providing innovative patient care when supported in, for example, the domains of support systems in discharge planning. The APN operational framework is based on direct comprehensive care that allows the APN to use highly developed skills and knowledge to inform care and direct care. The APN also draws on support

systems that optimise patients' utilisation of services and progression through services. The APN also utilises education supports and research that creates and supports a culture of enquiry and dissemination of relevant research based knowledge through professional leadership. Whilst these skills are inherent in competencies for advanced practice that have been developed by nursing organisations and regulatory bodies, confusion remains (NCNZ 2012 a, b).

In July 2010, Australia moved to a national registration process for all health practitioners under the auspices of the Australian Health Practitioner Regulation Agency (AHPRA) that included several regulatory boards, including the Nursing and Midwifery Board of Australia (NMBA). The NMBA commissioned the drafting of the second version of the Standards for Practice for the Nurse Practitioner (NP) in 2012, with the aim of revising the standards to reflect contemporary and actual practice. Cashin, Buckley, Donoghue et al. (2015) constituted the team involved in the development of the NP standards and in this paper by Cashin et al. (2015) they describe the context and development of the new Nurse Practitioner Standards for Practice in Australia, which went into effect in January 2014. A mixed-methods design was used and a range of stakeholders brought political and practice knowledge. Agreement was reached that the standards should be composed of clinically focussed attributes with areas of practice, research, education, and leadership included.

MENTORSHIP

An important component of the development for advanced practice is mentorship of Candidate advanced nurse practitioners. Mentorship/supervision of candidate ANP/AMP has generated little research internationally (Scott and Lindsey 2014). Supervised advanced practice is not reflected in the literature except in Ireland and New Zealand. In Ireland Candidates require a mentor to supervise and up to now it is generally a Medical mentor who signs the ANP/MP as competent. There is an assumption amongst stakeholders involved in the development of advanced practitioners that there is a medical mentor available to supervise. Respondents from the (NMBI) (2014) Pilot Survey sent to 40 nurses indicated that In some midwifery roles, such as AMP in normal midwifery, there may not be an obstetrician as a mentor as they are experts in complicated obstetrics and therefore a clinically competent consultant or relevant other working in the specialty may be needed. Requiring a medical mentor is likely to pose a barrier only to candidates in areas who do not use a medical model of care. Respondents also indicated that some flexibility in relation to a relevant mentor is needed in the future and this could incorporate

mentorship utilising a model other than, as well as a medical model, such as relevant Clinical Facilitator/Liaison Facilitator/Director of Nursing/Midwifery/RANP/RAMP Models of Mentorship.

Requirements for mentorship and the length of time a RANP/RAMP needs to be supervised following registration are needed in order to allow the distinction between supervision of RANP/RAMP and candidate ANP/AMP to be made. Survey respondents (NMBI 2014) indicated that a RANP/RAMP would be of greater assistance to Candidates and to the service if regularly engaged in mentorship or clinical supervision of Candidate practitioners by covering supervised practice of existing scope and developing new scope. The LACE Model in the USA recommends that RANP's do not require any supervision of RAPN's after registration.

The area of mentorship or clinical supervision and who should mentor the ANP/AMP is an important one. This is particularly so when the ANP/AMP is working in an out-reach area of practice. Survey respondents (NMBI 2014) indicated that there could be dual responsibility between the parent organisation and out-reach site with the Candidate ANP/AMP reporting to both the Director of Nursing in the parent site and to another relevant mentor in the outreach site. The Director of Nursing of the parent site would maintain principle professional governance of the Candidate thus ensuring that the scope of the role is fully comprehended and supported at the parent site and even though clinical responsibility is assigned to the outreach consultant, there could be a mechanism in place whereby this process is agreed by the consultant at the parent site. Clinical mentoring needs to be clearly articulated within the site and in job description documents and endorsed by the organisation (Carney 2015). Table 17 presents the RANP/RAMP current and proposed roles, in Ireland, following the introduction of the 2011 Nurses' Act. Some RANP's are already undertaking the proposed future roles indicated here, but according to Begley et al (2013), in the SCAPE study, many are not.

Table 17 Summary of RANP/AMP Roles in Ireland: Current and Proposed Future

Current Roles	Future Roles
1. Provides Strategic advantages	As ANPs have greater autonomy to make clinical decision they could therefore process patients through the system more efficiently by: Taking referrals from other clinicians

	Making referrals to doctors including GP, orthopaedic registrar and plastic surgeons
2. Improved service delivery	Provide reduction on waiting times
3. Greater clinical leadership	Update guidelines regularly Use service-user surveys to measure satisfaction
4. Greater professional leadership	Sit on committees
5. Increased research output	Undertake greater service planning
6. Clear governance in place	Educate the multidisciplinary team
7. Accreditation structure in place.	Undertake research individually and as part of the multidisciplinary team Make contribution to national and international research
8. Provides good communication skills In Interviews and observation	Implement evidence-based practice locally Make contribution to development of national and international evidence based practice and guidelines
9. Practices at a higher level by providing more holistic care:	Make contribution to national and international clinical leadership
10. Provides a full detailed physical assessment	Make contribution to national and international professional leadership
11. Provides Clinical decision-making.	Be active in teaching and developing educational modules nationally and curricula Be active in teaching and developing educational modules nationally and curricula and at international level occasionally Teach at Master's level
12. Acts as a resource and consultant for other members of the multidisciplinary team	Network and sit on high-level national, and some international committees
	Manage patients x-ray/radiology needs

Adapted from: BEGLEY et al (2013) Differences between clinical specialist and advanced practitioner clinical practice, leadership, and research roles, responsibilities, and perceived outcomes (the SCAPE study). Journal of Advanced Nursing 69(6), 1323–1337

In Australia structures to support advanced practice are based on the Strong Model of Advanced Practice (Ackerman et al. 1996). This Model places governance for advanced practice on nursing services and on the development of organisational support structures that promote a strong culture. Carney (2015, 2006) in her study of 850 clinicians in 65 health service organisations in Ireland, identified culture as being a critical factor in the promotion of organisational commitment and consensus by senior managers, thus concurring with the Australian authors. The Australian framework designed to support advanced practice nursing in Australia is presented in table 18. The framework identifies the nursing services and organisational cultural supports needed.

Table 18 Framework of Organisational Support Structures for APN’s in Australia

Organisational Structures	Framework Parameters
Nursing Services	Nursing services: <ul style="list-style-type: none"> • sets out service parameters for advanced practice • incorporates expanded ANP level of skills, autonomy and decision roles • Differentiates operationally between the roles of advanced practice and other nursing roles
Organisational Culture Supports	The organisation will support the APN/NP in:: <ul style="list-style-type: none"> • Valuing caring as being integral to direct care in advanced practice • providing innovative patient care • providing a range of support systems such as discharge planning models • consulting with others • enhancing the ANP’s care giving through dissemination of current scientific knowledge • facilitating and supporting a wide range of teaching roles • utilising research through evidence based practice • undertaking assessment and evaluation across the APN spectrum • providing professional leadership

(Based on Strong Model of Advanced Practice Ackerman et al. 1996)

14.3 CONCLUSION

Advanced practice should be patient led as well as service led and focus on quality care and not on cost saving's alone. Costs may increase in certain cases because patients may receive appropriate interventions that they previously did not, thus, the focus should not merely be on cost, rather should focus on cost effectiveness and efficiency in relation to clearly articulated outcomes. Research has indicated that the extension of the role occurs but caution is needed to ensure that RANP/RAMP's take on activities previously undertaken by doctors only if they are within a nursing/midwifery domain, scope of practice and are clinically appropriate.

Researchers have recommended a needs based assessment be undertaken prior to introduction of the RANP/RAMP role in order to define performance indicators. Defining the responsibilities of other health care professionals, required to support role implementation, is also needed. This process should include collaborative, systematic evidence based strategies to provide sufficient data to support the need for the post and identify goals for defined roles.

CHAPTER 15 FRAMEWORK FOR ORGANISATIONAL STRUCTURE ASSESSMENT FOR NEW ANP POSTS

15.1 SUMMARY

Structures and environments influence the development of ANP roles at international level and these factors include local conditions, culture of health care systems, government policy, nursing needs and healthcare services. Other factors influencing the development of the APN role are related to fluctuations in supply and demand, demand for new care providers, economic factors affecting delivery such as cost containment through shorter length of stay, improved medical treatment and technology and the move into ambulatory and community care. Recent factors in Europe are reduction in junior doctor's hours of work, improved primary care and palliative care service requirements. Many barriers to APN practice could be avoided through better planning

and efforts to address environmental factors, structure and resources that are necessary for advanced nursing practice to take place.

15.2 FRAMEWORK FOR ORGANISATIONAL STRUCTURE ASSESSMENT FOR NEW ANP POSTS

Ireland is one of the few countries in the world that has clearly defined documentation relating to the development of the ANP/MP. In countries where advanced practice posts are in place, most posts are not subject to regulatory body accreditation or oversight and posts appear to have developed on an ad-hoc basis, mainly in response to service need. Consequently, the role has developed in different directions. In Ireland, the job description for the ANP/MP was devised by the National Council for the Professional Development of Nursing and Midwifery (2008a) and new criteria were introduced by An Bord Altranais (2010).

Documents contain advanced practice role specification, job description and site preparation details that are currently required by NMBI for the accreditation of new advanced nurse practice posts. Requirements include criteria for job title, title use, registration details, reporting relationships, location, background and purpose of the post. The second area relates to responsibilities which cover clinical practice, level of autonomy and expert practice. A survey undertaken in 1995, in Canadian hospitals, found that ANP roles were set up in response to physician replacement rather than to provide a patient centered health focused service. Nursing roles and intervention should complement the service already being delivered by doctors and not replace it (Dunn and Nicklin 1995).

A total of 140 persons were registered with NMBI in May 2014 and there are a total of 184 NMBI accredited posts per division of the Register. This figure is expected to expand in the next year. See Table 19. A comprehensive list of the areas of practice of the registered advanced practitioner is presented in Appendix 15.

Table 19

PERSONS: REGISTERED WITH NMBI	
Registered Advanced Midwife Practitioners: RAMPs	06
Registered Advanced Nurse Practitioners: RANPs	134

Total PERSONS with NMBI Registration	140
NMBI ACCREDITED POSTS PER DIVISION OF REGISTER	
RAMP: Midwifery (M)	007
RANP: Children’s Nursing (CH)	009
RANP: General Nursing (G)	144
RANP: Intellectual Disability Nursing (ID)	002
RANP: Psychiatric Nursing (P)	020
RANP: Public Health Nursing (PH)	002
Total NMBI Accredited Posts	184

The majority of advanced practitioners are working in emergency nursing followed by cardiology, diabetes, neonatology and oncology. The title, location of the post and division of the Register in which the RANP/MP are registered are provided in Appendix 15. The Nursing and Midwifery Planning and Development Units (NMPDUs) work with Healthcare Facilities (except Private Healthcare Facilities) in the development of Advanced Practice Posts. Each NMPDU works with the Healthcare Facilities in a geographical area per County.

<http://www.hse.ie/eng/about/Who/ONMSD/NMPDUU>

15.3 FRAMEWORK OF ORGANISATIONAL SUPPORT STRUCTURES FOR RANP, RAMP’S IN IRELAND

Frameworks of organisational support structures for RANP/NM in Ireland are discussed. Following introduction of the Nurses and Midwives Act (2011) and the development of Requirements and Standards for advanced nurse and midwife practice to comply with the Act there may be changes made to the current procedures. There is a need for collaborative, systematic evidence-based processes that are designed to provide data to support the need and goals for clearly defined APN roles in addition to the support of a strong nursing orientation to advanced practice (Bryant Lukosius et al. 2004).

The Director of Nursing seeking post approval will present information on the post requirements, case load and referral pathways to and from the ANP/MP, scope of practice, working relationship, decision making autonomy and how competence is maintained. A further area relates to professional and leadership roles and includes identification of areas of nursing requiring development. The final section submitted relates to the current scope of practice and on how the

role will be supported and developed and on organisational need. How the candidate will undertake and develop research is presented. Creating Person Specification for the post of ANP/AMP, where accreditation is being sought for a post, will include applicant details including qualifications, skills and competencies. Site preparation details are identified that includes healthcare needs and service plans. Guidance on the application process is also submitted. See Appendix 13 for details of the application processes currently required by An Bord Altranais before a person, post and healthcare site are approved.

15.4 DISCUSSION

In developing posts there is a need to be responsive to service need and to practitioner need and to acknowledge that some learning is core and other learning will develop within new Scope of Practice criteria. Currently a Scope of Practice is linked to the post and posts are currently linked to a particular post. Consideration will be given into the uncoupling of the post and to ending of the post, because it is argued that advanced practice is related to the education and experience of the nurse and need not be related to a specific "post". The link to a specific post may be seen as necessary by some organisations however, as more posts are developed, there will be scope for movement between areas of employment. If an RANP/RAMP wishes to move to another similar post, guidance on facilitating this move is required. This guidance will include the requirement of the RANP/RAMP to demonstrate competence in any additional clinical components of the Scope of the role, or caseload. Requirements also include support with data base development, report access and statistical analysis.

Restriction of movement occurs when the RANP/MP is linked to a specific post in a defined specialist, area of work, or organisation, whereas a link with a specific post ensures that the employer who supported the candidate ANP/AMP during their education, training and transition to the role will benefit from the appointment (NMBI Survey 2014). Placing restriction on the length of time a practitioner must remain in post following appointment is likely to hinder advanced practice development nationally.

A further area is related to how the Scope of Practice of the ANP/AMP will appear when a practitioner moves from one specialist area of practice to a different one, for example oncology

nursing to breast care nursing. Consideration will be required in relation to how the ANP/MP may develop Scope of Practice further when changing responsibilities and practices. Consideration will also be given to the requirements if an ANP/MP moves from one practice area to another in the same organisation or moves to an organisation or community area in a different location. A further complicating factor requiring attention is that the new location may be under the care of a different health service provider.

Identification of service need is the initial step in creating an RANP/RAMP post and incorporates several areas. In order to obtain site approval for a RANP/RAMP an environment analysis incorporating a comprehensive needs analysis is undertaken by the RANP/RAMP or candidate by information gathering and collaboration with other site personnel. The Scope of Practice for the new role must be defined. The role of the RANP/AMP is comprehensive in responding to and implementing change in health care delivery (Furlong and Smith, 2005) and a plan for implementation is needed when setting up a nurse-led service.

Research undertaken in Australia, in 2009, during which 12,189 individual observations were recorded, demonstrated that the work of nurse practitioners is related to direct and indirect care and to service-related activities. The latter consumed 32% of the ANP's time. This research is likely to impact on the role in relation to the service-related activities undertaken by the RANP/RM and on the nurses' position and on service effects of these positions. This service related area may in the future influence new posts being created in advanced practice as examination of the work activities of such nurses can provide detailed information on how they contribute to the provision of health care and on patient outcomes (Gardner et al. 2010) and thus ensure that RANP/RAMP's assume responsibility for clinical leadership, introducing quality initiatives, risk management and research including review of protocols and clinical guidelines (Begley et al. 2013). The advanced practitioner will present the clinical leadership (Begley et al 2013), research and education initiatives proposed and will identify how best evidence-based practice to meet patient client or service need are integrated (Ingram 2014).

The candidate obtains written agreement to work as a candidate advanced nurse/midwife practitioner in the organisation. The educational requirement to practice is masters level (level 9) education with required clinical components. The candidate must obtain financial agreement for

funding, obtain agreement with clinical mentor/supervisor and commence clinical supervision and clinical competency attainment. The candidate will commence site preparation and job description documentation utilising the expertise of the nursing midwifery planning development units (NMPDU) who will on completion submit the candidate's application to NMBI. Following this the Site Visit will be undertaken by NMBI and will include recommendation for approval of site. An important dimension to the success of role implementation is readiness of directors of nursing and midwifery in the preparation of sites, nurses and midwives for the role. Rhodes, Fusilero and Williams (2010) advised on the development of the new role of director of advanced practice nursing to ensure readiness for the role.

15.5 ENVIRONMENTAL SITE ANALYSIS

RANP/AMP care must meet NMBI registration Requirements and Standards, comply with Scope of Practice and adhere to the Health Service Executive (HSE) *National Service Plan (2012)*. This means that patients receive informed individual high-quality treatment that is based on best international practice and delivered with respect and dignity in a safe environment (Health Service Executive (HSE), 2012).

Before a post is created there is a need for an assessment of the environmental factors that are likely to affect role implementation. These factors include educational preparation for the role as well as barriers to role implementation (Marsden et al. 2003). Evaluation of organisational structure includes physical and social structures, culture, management structure, consensus level, commitment to staff and costs of delivering care (Brooten et al 2011). An addition is ANP/AMP dose effect which evaluates if there are sufficient staff numbers and staff time available in an organisation at a given time to provide the required care (Brooten et al 2011). DiCenso added "host" and "host responses" which is the effectiveness of ANP/APN's and their practice which depends on autonomy and acceptability to the host. The host may include the organisation, health service provider, regulatory body or government in addition to the patient and family (DiCenso et al. 2010). A business plan will include staffing, financial and patient safety considerations and clinical risk level. Cost-effectiveness is a critical component of a needs analysis. Evidence of the RANP/AMP role demonstrating cost-effectiveness includes earlier access to care, admission avoidance and utilising evidence-based practice (NCNM, 2010a).

Before a clinical site is recognised as suitable for advanced practice by NMBI an environmental analysis is undertaken by the proposed ANP/AMP who will provide details of the designated site including the framework of advanced practice and the role and scope of practice for the ANP/AMP in the site. The ANP/AMP will produce evidence of health-care need for the clinical site as well as guidelines for clinical practice that have been developed collaboratively with stakeholders. The candidate ANP/AMP will present to NMBI the relevant legislation required for advanced practice in Ireland and the Nursing philosophy for advanced practice being utilised. The benefits to having a RANP/AMP role in the defined site will be articulated as well as the resource implications for the role and practice. Ensuring that service insurance arrangements are in place is also required (Ingram 2014). In Ireland, the organisation covers RANP/RAMP insurance with the role incorporated into the standard insurance arrangements of medical malpractice indemnity under the terms of the clinical indemnity scheme in place. Caution is needed in relation to clarifying that this is the case with the local risk management department or authority (Ingram 2014).

15.6 SITE RECOGNITION BY NMBI

Currently Site Visits are undertaken by NMBI. This method may change in the future to regulation by the health service organisation. NMBI are essential in ensuring patient safety through rigorous evaluation of the job description and Site, ensuring that the nurse can practice safely in a safe site, thus protecting the public. The integration of quality assurance into the regulatory mechanism for site visits must continue.

Similar criteria to those existing in Ireland also pertain to the undertaking of a Site visit by the regulatory bodies in Singapore including the criterion that advanced practice nurses must have the support of the director of nursing and clinical nurse manager's in the specific area of practice. The latter criteria are not common to those laid down in other countries. In Singapore, the three stage process for certification of the advanced practice nurse is at variance with this employed in Ireland. The process involves application for certification, internship and APN certification panel interview (Singapore National Council 2012).

15.7 NMBI 'S ROLE FOLLOWING SITE VISIT

The process currently in place is that following completion of the Site Visit the NMBI education officer presents relevant documentation to NMBI Registration Committee. Agreement is reached by the Registration Committee and the CEO of NMBI. Following this a Letter of site approval, with required changes or modifications, is sent to the director of nursing in the proposed site. The ANP/AMP completes the individual application form, obtains funding agreement signature from the organisation and sends full site preparation and job description with required changes back to NMBI. The ANP/AMP completes a personal portfolio that demonstrates proof of 500 hours clinical mentorship; professional achievements; scope of practice; proof of competencies signed by relevant mentor/supervisor; copy of study days attended and certificates obtained. Documentation is notarised by Notary/Public Commission for Oaths (Adapted from An Bord Altranis Framework for the Development of ANP posts 2010, c, d: Ingram 2014)

15.8 ACCREDITATION OF REGISTERED ADVANCED NURSE/MIDWIFE PRACTITIONER

The candidate ANP/AMP sends the required registration fee to NMBI. The NMBI education officer presents this documentation to the registration committee of NMBI who recommend approval (or further requirements if needed). The CEO of NMBI agrees the registration of the RANP/RAMP. The ANP/AMP then receives the Registration Certification from NMBI (Adapted from An Bord Altranis 2010 c; Ingram 2014).

Currently Re-registration occurs in Ireland every 5 years post registration and this appears to be the international norm (Furlong and Smith 2005). To re-register RANP/RAMP should be practicing and be able to produce evidence of CPD, Clinical Exposure, Clinical Supervision and Competence. However, as this appears to be a grey area for some health care services the five year re-registration requirements needs to be incorporated into Standards and Requirements. Re-registration, if a RANP/RAMP remains off the Register for a period of time needs to be clarified.

In Singapore, a different approach to re accreditation is in place. (SNB 2012) in order for the ANP to renew accreditation a minimum number of clinical hours in practice are required. This amount is dependent upon the number of years since first initial ANP certification and varies according to the length of time that has elapsed since accreditation. In summary this means that in:

- Year 1 post-certification requires 1040 clinical hours at advanced beginner level
- Year 2 post-certification requires 800 clinical hours at competent level
- Year 3 post-certification requires 560 clinical hours at proficient level

Year 4 post-certification requires 330 clinical hours at expert level

To comply with the Nursing and Midwives Act (2011) new standards are required. These will be incorporated into registration Requirements and Standards for the education and training of advanced nurse and midwife practitioner's. A suggested model of practice is presented in 15.9, the purpose of which is to allow the regulator, advanced practice nurses and midwives and clinical managers to identify criteria for registration. The Model is derived from the literature in the area of advanced practice.

15.9 Model of Advanced Practice-Future Criteria for Practice

Criteria	Details
Regulation	RANP/RAMP are regulated by NMBI under Nurses and Midwives Act (2012)
Accreditation	The nurse/midwife is registered as RANP/RAMP with NMBI accreditation Meets NQAI National Framework of Qualifications
Division of Register	Be a registered nurse/midwife with NMBI in the Division(s) of NMBI Register for which the application is being made (criterion may not apply in exceptional circumstances)
Title	Advanced Nurse Practice (ANP) Advanced Midwifery Practice (AMP)
Registration	The nurse/midwife is registered as RANP/RAMP with NMBI
Education	Masters degree level or higher in an area which is highly relevant to the specialist field of practice for ANP/AMP – Major Award representing a significant volume of learning

	outcomes
Education provider	University education University committed to providing advanced practice education. Due regard taken in relation to evolving public and service need, clinical/practice audit, patient safety (Government of Ireland, 2008), educational and clinical quality (HIQA 2009) and student access.
Clinical Modular Component	Educational preparation must include a substantial clinical modular component (s) pertaining to the relevant area of specialist practice
Title or Category in Advanced Practice Roles	ANP AMP
Years experience as a registered nurse	Have a minimum of 7 years post-registration experience
Years experience as a registered nurse in the specialist area	The 7 years post-registration experience must include 5 years recent experience in the chosen area of specialist practice
Specialist area years of Practice	Minimum of 5 years working in specialist area of practice
Education providers Compliance with Standard	Education providers comply with section 4.1 Standards for the Approval of Educational Providers and Health Care Providers (An Bord Altranais/NMBI 2010).
Curriculum design	Curriculum design and development reflect research and evidence based educational theory and health care theory, policy and practice and is informed by national and International benchmarks. Meets 4. 2 Programmes/Units of Learning Design and Development (An Bord Altranais/NMBI 2010)
Scope of Practice	A scope of practice framework specifically for RANP/RM is developed
Link to Post	The RANP/MP is not linked to a specific post
Offer of Post prior to registration with NMBI	The advanced nurse/midwife need not have an offer of a Post before applying for registration with NMBI
Start date for the Post	There need not be a start date for the Post before the nurse/midwife can be registered as an ANP/MP
Hours of practice per week	The nurse/midwife must work a minimum of 19.5 hours per week in advanced practice.

Organisational structures	Organisational structures supporting the management of the educational programmes/units of learning are explicit.
Clinical Practice Experience	Clinical practice experience provides learning opportunities that enable the achievement of competence in clinical nursing/midwifery practice and the stated learning outcomes. and meets all 4.3, 4.4, 4.5 Clinical practice experience standards (An Bord Altranais June 2010)
Clinical accountability	Clinical accountability to medical consultant or relevant other
Professional accountability	Professional accountability to DON/DOM
Supervised advanced practice	Have substantive hours (500 hours) at supervised advanced practice level prior to applying for registration
Supervised advanced practice following registration	Must continue to engage in supervised advanced practice level following registration
Competency sign-off	Have evidence of competency sign off, both global (core)and specific
Re-Registration requirements	When applying for re-registration as RANP/RAMP the nurse/midwife must have been working as an advanced nurse/midwife for at least 3 years in the most recent last 5 years
CPD	Engage in maintenance of professional competence prior to applying for re-registration as RANP/RM
Maintenance of professional competence	Minimum requirements must be attained in each 3 year period following registration to ensure maintenance of professional competence for RANP/RM

Model devised by Carney M. (2014) from published literature in the areas of advanced nurse and midwifery practice

15.10 CONCLUSION

There is often a lack of clarity around the multi-dimensional nature of the role. Nursing orientation, characterised by patient centred care, is needed as well as the promotion of full use of the ANP's knowledge, skills and expertise in all role domains and scope of practice. Research is indicating the positive outcomes resulting from RAPN/RANP interventions, yet evidence is also

suggesting that ANP skills and competencies are under utilised. The nurse practitioner role has been implemented internationally mainly as a service reform model that is aimed at improving the access and timeliness of health care for populations.

The value of the nursing contribution as a distinct profession must be safeguarded and articulated in the development of new ANP/AMP posts. There is a danger that in the present climate, they may be seen as an economical alternative to the enactment of the Working Time Directive (HSE 2008). While this may be the case in expanding practice, it needs to be demonstrated that this is so in order to improve access, quality of care and outcomes for patients (NMBI 2014 Survey). Enhancing patient responses to their disease process is the role of the RANP/RAMP and not simply replacing the diagnostics and treatments hitherto prescribed by other members of the multidisciplinary team. There is a dearth of RANPs in the areas of ID, Psychiatry, Public Health, and also Midwifery. Barriers to the development of advanced practice roles in these areas require investigation. There is evidence emerging of the impact of the role of advanced nurse practitioners on service models and on how different service models influence the advanced practitioners work, which is directed mainly to direct and indirect patient care and to service related activities. (Gardner et al. 2010; 2014).

CHAPTER 16 GOVERNANCE MODELS

16.1 SUMMARY

Even though Ireland is at the forefront of advanced practice regulation challenges lie ahead in relation to further expansion of the role, how governance will be structured following the introduction of the Nurses and Midwives Act (2011) legislation and the role of health care organisations in the governance and structure of advanced nurse and midwife practice are likely to pose challenges. Other areas requiring structural changes for advanced nurse practice are around the organisation of care including primary care, chronic disease and care of the older person as

well as perceived overlapping of roles with other grades of nurse including clinical nurse specialist and with other health care professionals

Governance models for advanced practitioners vary and often conflict. Ireland is one of few countries to have clear documentation relating to the development of the ANP/AMP. In countries where advanced practice posts are in place, most posts are not subject to regulatory body accreditation or oversight and posts appear to have developed ad-hoc, mainly in response to service need. Consequently, the role has developed in different directions.

In Ireland, the job description for the ANP/AMP was devised by the National Council for the Professional Development of Nursing and Midwifery (2008a) and new criteria were introduced by An Bord Altranais in 2010. In the United Kingdom the governance structure for nurse practitioners dwells with the health care system and with individual health care organisations, rather than with regulatory bodies. The Department of Health (2010) in the UK set out a position paper for advanced level nursing that is intended for use as a benchmark to enhance patient safety and delivery of high quality care by advanced practitioners, that puts in place local governance structures and national standards. In contrast, Scotland has developed a framework that establishes how posts should be established with criteria that are linked to the development of the Advanced Practice Toolkit2 (SGHD 2008). In their report on advanced practice, the Council for Healthcare Regulatory Excellence in the UK confirmed the need for a set of nationally agreed standards for advanced level practice in nursing to support employers and commissioner's to establish good governance arrangements (Beasley CNO, UK 2009).

16.2 GOVERNANCE MODELS

Varying Governance Models exist. In the *United Kingdom* the RCN has developed clinical governance guidelines. The key elements in clinical governance are continuous professional development, re-validation and licensing to practice, finding and using evidence EBP, patient and public involvement, accountability, performance, under performance, risk management, audit effectiveness and coding, patient safety and significant event, audit, data security and

confidentiality (RCN 2014). Nursing programmes in Clinical Governance being delivered in Irish colleges include modules in clinical governance, clinical decision-making, assessing and managing risk, quality assurance and practice development. Such content modules are required by senior management in health care and by advanced nurse practitioners in order to supplement ANP competencies and skills. The RCN also places new focus on its role in supporting the development of guidelines through agencies such as NICE and in supporting the implementation of clinical governance through on-line methods. RCN will endorse externally produced professional standards as being fit for national/UK practice and that they conform with RCS's quality criteria for professional standards (www.rcn.org.uk).

In the United Kingdom the governance structure for nurse practitioners dwells with the health care system and with individual health care organisations, rather than with regulatory bodies. Thinking is advancing in this area mainly through a paper developed by the Department of Health (2010), in response to the dramatic changes taking place in health and social care. The paper sets out a position paper for advanced level nursing that has as its focus best practice guidance and that is intended for use as a benchmark to enhance patient safety and delivery of high quality care. This aim will be supported by putting in place structures such as local governance, assisting good employment practices and providing consistency in nursing titles at advanced level. The authors say that even though the position paper was developed for nursing, recommendations may also be relevant to midwifery, health visiting and allied health professionals. This position paper follows a report on advanced practice by the Council of Healthcare Regulatory Excellence (2009) (Scottish Government 2010, Royal College of Nursing 2010). The position paper confirmed the need for a national set of standards for advanced level practice in order to support good governance structures and consistency in care delivered either by matching to an existing national profile or local evaluation system.

Comparisons are made in the document between the standards expected of the registered nurse or midwife with those expected from the advanced nurse or midwife practitioner. Benchmarks developed by the authors of the report are made up of 28 elements clustered under four themes. The themes are: clinical /direct care practice; leadership and collaborative practice; improving quality and developing practice and developing self and others. The authors further recommend that all registered nurses should continue to develop their practice and that advanced nurse

practitioners should develop beyond the registered nurse levels. They further recommend that the organisation should identify and support learning and development in the advanced level nurse through performance appraisal, regular individual reviews and re-validation requirements, thus placing responsibility on organisations as well as on individual nurses for governance. The processes through which advanced practice posts should be established and governed in the future was set out. Roles should be based upon demonstrable patient outcomes and service user needs and should promote good governance structures that are underpinned by consistent benchmarking of advanced practice roles at recognised levels of practice (NHS Scotland Career Framework Guidance¹ (2009), Scotland Career Framework Guidance 2009). The role of the ANP is defined in Singapore by the nurses' employing institution, supported by the director of nursing and clinical head of department.

The Magnet hospital initiative has led the way in hospital accreditation. The first UK hospital to seek Magnet Accreditation was Rochdale NHS Trust that explored the Magnet accreditation process through a multidisciplinary Pilot Study, with 11 senior managers. This was built on previous work undertaken by the Magnet group in the areas of governance and clinical leadership and on the effect on existing systems and resources of this work. This Magnet study enables care areas to identify examples of best practice and of sharing information throughout the organisation. Issues arising relate to costs incurred in developing the Magnet work, interpretation of terminology and limited engagement of medical and allied professionals in the process.

Scotland: has developed a framework that establishes how posts should be established in Scotland, and in the NHS as a whole. The NHS in Scotland has developed criteria for the creation of advanced practice posts that are linked specifically to the development of the Advanced Practice Toolkit² (SGHD 2008) and associated guidance on Consultant NMAHP roles. This new guidance sets out for NHS Boards the context for advanced practice nursing roles and the processes through which they should be established and governed in the future. Following the release in early 2009, of the NHS Scotland Career Framework Guidance¹, (CNO Directorate and Health Workforce) colleagues were keen to support the consistent and sustainable implementation of advanced level nursing roles across NHS services in Scotland. The guiding principle is that such roles should be based upon demonstrable patient outcomes and service user needs and should promote good governance structures that are underpinned by consistent benchmarking of advanced practice

roles at recognised levels of practice. The desired level of competence, educational preparation and rewards are emphasised. Little guidance is available in relation to the creation of posts or to the clarification of a mechanism for the development of posts. NHS Boards will determine where these posts should be established in the light of service needs and Boards will undertake the responsibility of developing job and person specifications that are linked to the identified clinical competencies required for the role. This means that, when considering whether the development of an advanced nurse practice role is the best fit to meet the needs of patients and service, directors of nursing, clinical service leads and planners will take into consideration several service needs. These include undertaking a service needs assessment, including local and national service drivers; undertaking an educational needs assessment and anticipating the impact of the role on the existing workforce and identifying key deliverables and how these will be delivered and measured. Evidence of support from key stakeholders; governance and service and individual accountability arrangements should be identified and put in place (Scotland Career Framework Guidance 2009).

USA: In the United States, advanced nurse practitioners practice with a high level of autonomy, independence and accountability and must seek information about the regulatory requirements in the proposed practice jurisdiction as each jurisdiction establishes the process for regulation (LACE Consensus Model 2008). The role of the ANP is defined in Singapore by the nurses' employing institution, supported by the director of nursing and clinical head of department.

16.3 CONCLUSION

Corporate, financial and clinical governance are interconnected. Clinical Governance systems which HSE service providers are accountable for continuous improvements in the quality of clinical practice and high standards of care by creating environments where excellence in care can flourish along with accountability www.hse.ie/clinical governance. The advanced nurse practitioner has a major role in delivering these high standards of care to the population. The meaning of governance in advanced practice from an organisational perspective is difficult to define due to the newness of the role in some institutions, roles not introduced in primary care and conflict between different grades of nursing in relation to role content and outcomes. Supporting

governance in the creation of new ANP/AMP posts and best practice criteria for supporting governance in clinical sites are presented in Appendix 11. These are based on criteria used in six countries where the role is well developed. Benchmarking against the Competency Assessment Tool for ANP/AMP Core Concepts for Advanced Practice utilised in Ireland and criteria for accreditation of posts and person developed by An Bord Altranais, are presented in Appendix 10.

Chapter 17 FUTURE GOVERNANCE STRUCTURES IN IRELAND

17.1 SUMMARY

In 2011, the Irish Government has decided on the structure of health care systems following the dissolution of the Health Service Executive (HSE). These new governance structures will impact on the role of the advanced nurse/midwife practitioner's and on their function and purpose because health care and primary care organisational structures will change. The government has approved the drafting of legislation involving significant changes in the governance of the HSE. The legislation when implemented will replace the current HSE Board/CEO with a Directorate of Transitional Governance Structure and will also allow for the introduction of Universal Health Insurance. Management in Nursing and Midwifery, in Ireland, is preparing for these structures through involvement in Clinical Governance.

17.2 FUTURE GOVERNANCE STRUCTURES IN IRELAND

Ryan (2009) has proposed the implementation of formal clinical governance structures in Irish Hospitals as a matter of urgency to protect the patient. New governance structures are currently

being implemented in Ireland. This new structure means (a) that healthcare functions will be transferred elsewhere (b) A Childrens and Families Support Agency will be set up, (c) organisational divisions will purchase health/social services, (d) money- will- follow the patient system will be implemented and (e) providers will be paid on the basis of services delivered. Prior to the introduction of the newservices, New Directorate Systems will identify clear areas of priority and the responsible directors for the service lines. There will be 7 Directors appointed in the areas of hospital care, primary care, mental health, children and family services, social care, public health and Corporate (shared services) and one over seeing Director General. The Minister of Health will determine the functions of the Directors <http://healthupdate.gov.ie>.

Management in Nursing and Midwifery, in Ireland, is preparing for these structures through involvement in Clinical Governance. The Health Service Executive (HSE) (2014 a) presented guidance for healthcare managers and organisations on Clinical Governance and introduced a National Lead Midwife (2014 b) to develop midwifery services further. The Clinical Strategy and Programme Division of the Health Service Executive developed guidelines for the critically ill women in obstetrics, Obstetrics and gynaecology, anaesthetic and critical programmes (Health Service Executive (2014 c). The DoH (2016) proposed a National Maternity Strategy 2016-2026 to map maternity and neonatal services.

The ONMSD appointed a senior nurse to work with the National Director of Quality and Patient Services on the development of systems for clinical governance implementation alongside the Project Manager. Clinical Governance is a system where health care teams are accountable for the quality, safety and satisfaction of patients through excellence in care delivered by applying evidence based practice initiatives. So, to do this, ANP's must specify clinical standards and develop measurements to demonstrate what has been done. Each ANP must know what is required in each case. Working groups across services were set up in 2013 www.hse.ie/clinicalgovernance to support this work.

The main driving force behind delivery of health care in Ireland that will impact on how organisations provide care, including care provided by RANP/MP's, will be The Health Information and Quality Authority (HIQA). HIQA is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public. According to

Standards of care are provided through a model of service that will drive high quality, safe and reliable healthcare. HIQA's remit includes services provided or funded by the Health Service Executive (HSE). This remit does not include mental health services (which are regulated by the Mental Health Commission) or private healthcare providers. Also, HIQA does not have a remit for individual healthcare professionals such as RANP/MP who are regulated through NMBI or relevant professional bodies. However, regulators do have a common purpose to protect the public and to drive improvements in the quality and safety of services provided to them. Consequently, National Standards have been designed to complement the work of other healthcare regulators, such as NMBI for nursing and midwifery, to meet this aim. HIQA Standards were developed through a national public consultation, with 200 submissions, which was carried out from September to November 2010 (available as a Statement of Outcomes on www.hiqa.ie).

17.3 The Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) will support best practice following introduction of the Nurses and Midwives Act (2012) by ensuring that care is provided through a model of service that will drive high quality, safe and reliable healthcare (HIQA 2014, Standard 2.6). The Standard provides the main components of a quality service that healthcare organisations in Ireland will be required to meet in the future.

- Clear description of how the service will be delivered and communication of the scope, objectives and intended quality outcomes of the service through a publicly available statement of purpose.
- Delivery of care using high quality, safe and reliable models of service delivery that have the required clinical services, meet legislative requirements and take into account best available evidence, national policies, National Clinical Guidelines if available, local population health needs and available resources.

- Necessary arrangements in place for transfer of care to the appropriate service when the service user's healthcare needs cannot be met within the model of service provided. This transfer process involves clear consultation with the service user throughout.
- Regular review of the services provided and evidence that the defined model of service can be delivered safely. This review should include the:
 - assessed needs of the population being served
 - size, complexity and specialties of the service being provided
 - interdependencies of internal and external clinical and non-clinical services and support arrangements
 - national and international evidence regarding the model of service or type of service being provided
 - relevant legislation and Government policy
 - findings from consultation with key stakeholders
 - number of staff required to deliver the service
 - skill mix and competencies required to deliver the service" (*Section 2.6, HIQA 2014*)

The RANP/MP will have an important role in ensuring that many of those criteria are met. The Candidate ANP/AMP will already have demonstrated that some of these criteria are in place through the needs and environmental analysis undertaken on application for NMBI registration. The Candidate will demonstrate how the service that incorporates their scope of practice will be delivered and in the process will communicate the quality outcomes that are expected from this practice. They will indicate how they will utilise evidence from national and international best practice, and appropriate legislation, when delivering a safe model of care.

Organisations, hospital or community, will also have to ensure that organisational supports are in place to permit safe care to be delivered by RANP/MP's as well as by all professional involved in care delivery. Some of those supports are currently indicated in the Candidates application to NMBI, for example environmental factors such as the defined population, service type, interdependencies and collaborative models in place, staff numbers, skills mix and competencies

necessary to deliver safe and reliable care. In addition to the information currently being provided by advanced nurse/midwife practitioners, organisations will need to take a collaborative approach alongside RANP/MP's, Directors of Nursing, Directors of hospital care, primary care, mental health, children and family services, social care, public health and Corporate (shared services), ONMSD and The National Director of Quality and Patient Services, in ensuring that Standard 2.6 is complied with and to ensure on-going compliance.

Organisations must also comply with Standard 2.7 in ensuring that health care is delivered in a safe physical environment that complies with relevant legislative requirements and is designed to ensure the safety, both physically and psychologically, of its workforce. RANP/RAMP's have a role in managing risk in normal, complex and changing circumstances and organisations will be required to support them in the role. Ensuring that health care is monitored, evaluated and improved (Section 8) in order to ensure best quality outcomes, must also be complied with. The RANP/RAMP's role in maintaining this standard relates to using national performance indicators and benchmarks or developing such indicators if not already in place by evaluating clinical outcomes from their practice, seeking patient or client experiences and seeking feedback from the multidisciplinary team. The Australian Commission on Safety and Quality in Healthcare in their guide relating to improvements in clinical handover discussed the importance of obtaining feedback and collaborating with the multidisciplinary teams to ensure quality outcomes from care are obtained (Australian Commission on Safety and Quality in Healthcare 2010).

Professional organisations, including NMBI and other relevant expert bodies will be involved in this Governance Model by ensuring that RANP/RAMP's are able to maintain their skills and competencies to deliver specialist advanced practice that is evidence based and that they receive sufficient support to deliver this care in managing normal, complex and rare conditions and complications.

17.4 FUTURE PROOFING FOR OPTIMISATION AND CONTINUATION OF THE ANP/AMP ROLE

In the light of ambiguity inherent in the optimisation of ANP/AMP existing role skills and competencies and in the creation of new posts, taking cognisance of accessible published

research, components of best practice models from countries where existing and new posts are being established, are presented in Table 19. Criteria presented below are either not normally taking place or are taking place in some form, while other criteria are not in focus. Details include how organisations, nursing, service need, regulatory body and ANP/AMP’s may look to examples of best practice that are currently not well established. Criteria for Advanced Practice Posts in Ireland are presented in Appendix 10 and details of the development of new posts in advanced practice are presented in Appendix 13.

Table 14 Future Proofing Framework for Advanced Practice Posts/Roles (country roles)

Future Frameworks	The organisation will:	
<p>Future Organisational Agenda for ANP/APN/AMP</p>	Set out the context for advanced practice nursing roles and the processes through which they should be established and governed in the future	NHS Scotland & UK
	Undertake needs based assessment prior to introduction of the role and in order to define performance indicators, Identify the responsibilities of other health care professionals and how to support role implementation.	Canada
	Analyse environmental factors that may affect role implementation. This includes educational preparation by the ANP and others as well as governance and organisational structures and barriers to role implementation	Canada
	Identify the multi-dimensional nature of the new service and the ANP’s role in this	Canada
	Set out the service parameters for advanced practice	Australia
	Focus on best practice guidance that is intended for use as a benchmark to enhance patient safety and the delivery of high quality care by supporting local governance and assisting good employment practices	UK, Scotland
	Differentiate operationally between the roles of advanced practice and other nursing roles.	Australia, Canada
	Seek a generic description of the core features of the practice of advanced nursing.	Australia, USA
	Provide innovative patient care by ensuring that the domains of support systems are put in place	Australia, UK
	Undertake a job evaluation exercise to ensure consistency by matching to an existing national profile	UK and Scotland

Future Do N & Service Need Agenda for role	Identify and support learning and development in the advanced level nurse through performance appraisal	UK
	Optimise patients utilisation of services and progression through services	Australia
	Create and supports a culture of enquiry and dissemination of relevant evidence-based knowledge through professional leadership	Australia, UK, USA, Ireland
	Provide good supports for ANP's to improve the access and timeliness of health care for populations	Canada, Australia
	Promote caring as being integral to direct and indirect comprehensive care in advanced practice through highly developed skills and knowledge	Australia, Ireland
	Focus on improving quality and developing practice and developing self and others	UK
	Incorporate expanded levels of skills, autonomy and decision roles	Australia, Ireland
	Continually assess the impact of the ANP on different service models	Canada
	Assess how different service models influence the work of the ANP	Canada
	Ensure that new ANP roles are introduced in response to patient and health care needs and well defined goals resulting form systematic assessment of need and having a clear understanding of ANP roles	Australia
	Co-operate in development of a research model that investigates organisational and service influences on the ANP role	USA, Australia
	Develop guidelines for good practice and continually update these to patient/client and ensure these are collaboratively developed between APN and clinical directors	Ireland
	Develop guidelines and benchmarks for best practice on a collaborative basis between ANP and DoN & others	Ireland
	Regulatory Body/Education Office	Assess ANP candidates application and portfolio, following strict guidelines
Develop a national set of standards for advanced level practice in order to support good governance structures		Ireland and UK
ANP's should:	Benchmark self against elements of care under, for example: clinical /direct care practice; leadership and collaborative practice; improving quality in care delivered and developing practice and developing self & others	UK

	<p>Strive to develop advanced practice beyond the registered nurse threshold.</p> <p>Hold regular individual reviews and re-validation requirements, thereby placing responsibility on organisations as well as individual nurses for governance.</p>	<p>Australia, UK, Canada.Ireland (already does)</p> <p>UK</p>
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To support the best practice criteria presented in table 19 further criteria for supporting governance in clinical sites are presented. These are based on criteria used in six countries where the role is well developed. Benchmarking against the Competency Assessment Tool for ANP/AMP Core Concepts for Advanced Practice, utilised in Ireland (NCNM 2008 b), criteria for accreditation of posts and person developed by An Bord Altranais and research findings in the area are presented in Appendix 10.

17.5 CONCLUSION

The introduction of clinical governance is designed to ensure efficient delivery of healthcare in a safe environment. Conflict can arise where clinical governance, as defined by regulators and advanced nurse practitioners, conflicts with an organisations’ view that control over nursing practices is defined as organisational autonomy or the freedom to define the roles of advanced nurse practitioners. Professional organisations, including NMBI and other relevant expert bodies will be involved in the introduction of a Governance Model by ensuring that RANP/RAMP’s are able to maintain their skills and competencies to deliver specialist advanced practice that is evidence based, and that they receive sufficient support to deliver this care in managing normal, complex and rare conditions and complications.

CHAPTER 18 MEDICATION PRESCRIBING

18.1 SUMMARY

In many countries, including Ireland, Australia, the United States, the United Kingdom, Canada, New Zealand and Singapore, certain categories of nurses are now authorised to prescribe pharmaceutical drugs. The United States was the first country to introduce the right for nurses to prescribe drugs in the mid-1970s, followed at the beginning of the 1990s by the United Kingdom and Australia. Certain provinces in Canada began to authorise this role at the end of the 1990s, and this right has progressively been extended since then.

18.2 MEDICATION PRESCRIBING

In May 2006, primary legislation-the Irish Medicines Board (Miscellaneous Provisions) Act allowed for the introduction of independent nurse and midwife prescribing in Ireland. Following the deliberations of a National Steering Group the Medicinal Products (Prescription and Control of Supply (Amendment) Regulations 2007 and the Misuse of Drugs (Amendment) Regulations 2007, were signed into law in May 2007. The Act specified the conditions for the prescribing of medicinal products by registered nurse prescriber's (RNP's). These conditions, together with the Irish Nursing Board's Nursing Rules (2007), form the basis on which nurses and midwife prescribing came into force in Ireland (An Bord Altranais, 2007a; Irish Medicines Board 2006, 2007; Adams et al. 2010). Following completion of the Certificate in Nurse/Midwife Prescribing, nurses must register with An Bord Altranais before practicing as a nurse prescriber. The regulatory framework for nurse and midwife prescribing in Ireland is established through the Irish Nursing Boards'

Nurses Rule (2007), which allowed for the setting up of a division of the register for nurse prescriber's (An Board Altranais 2005 a, c; 2007 e; 2008; 2010 g)

18.3 AUTHORISATION FOR NURSES TO PRESCRIBE

The authorisation for nurses to prescribe medications has required legislative changes in countries where nurse prescribing is permitted. See Appendix 1 for regulation of advanced practice nurses in 12 European and OECD countries. An important distinction regarding the rights for nurses to prescribe drugs is whether they can prescribe independently or only under the supervision of a doctor. See Appendix 8 which indicates the categories of nurses allowed to prescribe drugs without the supervision of a doctor or are restricted in different countries. Some countries, such as the United States, grant authorisation to prescribe drugs to all categories that are defined as advanced nurses, while others are more restrictive and grant prescribing to some categories only. For instance, in Canada, only nurse prescriber's working in primary care is allowed to prescribe drugs without supervision by doctors. In some countries, such as the United Kingdom, Ireland, Singapore or New Zealand, this authorisation may be granted to all nurses, provided they complete appropriate training (Delamaire and Lafortune 2010).

In Sweden, APN's are authorised by the Swedish national Board of Health and Welfare to diagnose and make referrals but are not permitted to prescribe medication in relation to the diagnoses they make. Registered nurses in Sweden are permitted to prescribe medication from a limited formulary, mainly over the counter drugs, following a supplementary pharmacology course (Altersved et al 2011; Bergman et al 2013).

Prescribing practices by APPN's IN THE United States have been reviewed to a limited extent. Beldman, Bachman, Cuffel, Friesen and McCabe (2003) in a study of 595 APPN's with prescriptive authority, working in private practice or in psychiatric behavioural clinics, found there was no difference in the prescribing patterns of APRN's and psychiatrists prescribing patterns. A recent study by Parrish et al (2013) reported similar findings.

18.4 RANGE OF DRUGS PERMITTED

The range of drugs nurses can prescribe, in countries where prescribing is permitted, is broad and includes antibiotics, antiviral drugs, anticoagulants, ant cholesterols and others. Variations exist across countries concerning the right for nurses to prescribe “controlled drugs” in particular narcotics and strong pain killers. Australia, Ireland and the United Sates allow certain categories of nurses to prescribe drugs for palliative care and narcotics, Canada does not authorise nurses to prescribe those controlled substances. The United Kingdom authorises nurses to prescribe controlled drugs for palliative care, including strong opiates, but not other controlled drugs such as narcotics. In Finland, a number of steps have been taken to extend the rights of nurses to prescribe pharmaceutical drugs. For many years, nurses have been entitled to prescribe contraceptive pills there. Since 2000, many health centers have defined local guidelines on collaborative prescribing thus allowing nurses to propose a limited number of prescriptions to certain patient groups, but these prescriptions still require the approval of doctors. In early 2010, the government proposed new legislation to allow nurses to prescribe a limited number of drugs (Delamaire and Lafortune 2010).

18.5 NURSE PRESCRIBING IN NEW ZEALAND

In New Zealand, guidelines for requirements for registration as a Nurse Prescriber were first published in 2002 and updated in 2009, and include registration with the Nursing Council of New Zealand in the registered nurses scope of practice. Nurse practitioner applicants seeking registration with prescribing rights are required to have an additional qualification to this required for registration as advanced nurse practitioner. Successful completion of an approved prescribing component of a clinical Masters programme relevant to their specific area of practice is required (Nursing Council of New Zealand 2012, 2014).

Nurse Practitioners are able to prescribe under the Medicines Act (1981) and the Medicines Regulations (2005). This domain describes the competencies to be achieved by those applicants seeking prescribing rights. Competencies and indicators are utilised. The Competencies for the nurse practitioner scope of practice (2012) provides examples of the indicators that will be used by

the expert panel who will be assessing the applicant's competence. The Council recognises that nurse practitioners work in a variety of clinical contexts, thus indicators provide transparency to applicants to assist them in the preparation of evidence for their clinical contexts. Third party evidence must be from a registered prescriber in an appropriate scope of practice before a nurse may register as a nurse prescriber. See Appendix 12 for competencies and Indicators utilised for nurse prescribing in New Zealand. Competencies for nurse prescribing are similar to those utilised in Ireland and include the registered nurse being able to prescribe.

18.6 CONCLUSION

The Certificate in Nurse and Midwife Prescribing is delivered in Ireland for registered nurses and midwives wishing to undertake prescribing of medication under a defined scope of practice. Advanced nurse and midwife practitioners may undertake this programme. A few universities have incorporated this certificate programme into the master's in nursing in advanced practice programmes. RANP/MP's are required to prescribe medication and therefore universities will be required to make decisions around how they will deliver this programme to advanced practitioners following implementation of the Nurses and Midwives Act (2012).

A national study undertaken in 2009 in Ireland has indicated positive results from the programme. National evaluation on nurse/midwife prescribing was undertaken by Drennan et al. (2009) in order to establish if the model adopted for implementation in Ireland had met its objectives. The group found that there were considerable advantages to nurses and patients from the initiative. They found that nurses and midwives with prescriptive authority were highly satisfied with the level of support they received for their role and that their role had a positive impact on patient care. Concurrence with this view occurred in a study undertaken in the United States by Zych (2012), through a policy evaluation of the statutory limitations of advanced practice registered nurses' prescriptive authority. This study found that there is little research available examining violations of laws governing the practice of APRN's. This study explores such violations during two major expansions of the prescribing laws occurring in 1996 and again in 2003. Data was obtained from the Licensing Board of Nursing in a southern state. A significant increase in violations was found in the seven years following the 1996 change of law. But no significant increase was noted in the 7 year period after the 2006 change indicating APRN's contribution to quality care delivery

in the area of nurse prescribing was positive. The study also concurs with a study undertaken in a mental health facility the USA by Fisher et al 2009, who identified the similarities and differences in clients treated and in the medication prescribed by APRN's and psychiatrists. Positive outcomes were identified.

CHAPTER 19 MIDWIFERY PRACTICE

19.1 SUMMARY

Legislative and regulatory practices and mechanisms for midwifery vary between countries. Regulation differs by country with some countries legislating separately for nursing and midwifery practice while some make no distinction between the two and in some countries midwifery is subsumed under nursing. Midwifery is incorporated into each section of this document where relevant. Definitions and scope of practice for the role also differ across countries where midwifery exists. Midwifery education has gone through periods of change in Ireland that are expected to continue. Change occurred following the introduction of nurse registration programmes within third level institutions, leading in 1995 to Schools of Midwifery establishing links with third level institutions. Recent developments in midwifery expansion are discussed in the areas of re-validation for midwifery practice, student supervision, home birth, normalisation of the midwifery process, managing risk ethically and clinically and models of maternity care.

19.2 MIDWIFERY PRACTICE

NMBI has a remit to promote high standards of professional education and professional conduct among midwives thus promoting protection of the public (An Bord Altranais 2005). The International Confederation of Midwives (ICM) (2013) presented the essential competencies for basic midwifery practice (2010 Revised 2013). The International Confederation of Midwives ICM (2003) offered the following definition of a midwife:

“A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery” (ICM 2003).

The midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, take responsibility for conducting deliveries and caring for the new-born and the infant. This care includes preventative measures, detecting abnormal conditions in mother and child, procuring medical assistance and the execution of

emergency measures in the absence of medical help. The midwife has an important task in health counseling and education for the woman and family and within the Community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child-care, and the midwife may practice in hospitals, clinics, health units, domiciliary conditions or in any other service (ICM 2003).

19.3 EDUCATION FOR MIDWIFERY

Education for midwifery practice differs across countries and ranges from 6 months to four years for a professional midwifery qualification, highlighting variances in type and recognition of midwifery educational and clinical programmes. Advanced practice programmes in midwifery remain at the developmental stages in most countries apart from Ireland, Canada, New Zealand, Sweden, Finland, Japan, Netherlands, Spain and Australia. In Canada in 1985, midwifery practice was legal in just one province- Newfoundland. However, by 1992 several provinces in Canada were in the process of, or had obtained midwifery legislation designed to strengthen, support and legalise the practice of midwifery (CNA 2005).

In Ireland direct entry to the Bachelor of Science in Midwifery: a 4 year programme was introduced in 2006. The BSc. Midwifery is being offered by six third level institutions in partnership with seven health care institutions. Access to midwifery education is also through the Post Graduate Diploma in Midwifery (An Bord Altranais 2005 b; NMBI 2010 h).

In Finland general nurse training is followed by a one-year midwifery programme (4.5 years leading to dual exit qualification of both nursing and midwifery). In Germany and Italy, midwifery is a separate 3 year course to nursing. In Japan, education programmes for midwifery are of 5 years duration. In the Netherlands, midwifery is not a specialisation of nursing and is an entity in its own right. In Spain post-registration courses available in midwifery are of two year duration and midwifery qualifications are recognised in law (OECD 2006). In the United Kingdom, midwives were first regulated in England through the UK 1902 Act. Nurse midwifery emerged in the USA in the late 1920's as traditional midwifery declined. In the USA, almost all of the American State Boards have regulations to govern three types of advanced practice registered nurses: Certified

Registered Nurse Anesthetist, Certified Nurse Midwife and Nurse Practitioner, which sets out scope of practice, regulation and requirements for legal recognition.

According to Gardner and Duffield (2014) Australia is preparing for a major study into advanced practice and midwifery. Confusion remains in Australia regarding the roles and competencies for advanced nurse and midwifery practice. This proposed study, commencing in early 2014, will survey all Australian registered nurses and midwives through a national census in order to achieve clarity for the professions and will seek to reduce the sense of ambiguity and confusion that remains around the roles. The role of Nurse Prescribing does have clarity regarding level, practice type and is defined by legislation. Identifying advanced practice roles from registered nurses, clinical nurse consultants and the advanced extended practice of the nurse practitioner is the aim of the study. New models of midwifery care based on continuity of care are being developed in Australia and currently privately practicing midwives are delivering care in New South Wales (Gardner and Duffield 2014).

19.4 LEGISLATION FOR MIDWIFERY IN IRELAND

Midwifery in Ireland will undergo change at advanced practice as a result of the Nurses and Midwives Act 2011. Midwifery education and practice is regulated by A Bord Altranais under a separate register for midwives. Under the new legislation the meaning of “advanced midwife practitioner” is a person for the time being registered in the division of the register on which are registered the names and particulars of advanced midwife practitioners. An “advanced midwife practitioner post” means a post accredited by the Board as advanced midwife practitioner post (An Bord Altranais 2010). The Bill recognises midwifery as a separate and distinct profession and provides for the establishment of a Midwives Committee to advise An Bord Altranais in relation to all matters pertaining to Midwifery practice.

19.5 MIDWIFERY IN IRELAND CURRENT AND FUTURE MIDWIFERY PRACTICE

The Department of Health in Ireland acknowledges that Irish maternity services compare well with those in other countries (Department of Health 2016). The recently published “*Creating a better*

future together: National Maternity Strategy 2016-2026 maps out how maternity and neonatal services in Ireland can be improved to ensure safe, standardised care that offers a better experience and more choice to women, families and parents. The focus is on health and well being and on the normalisation of pregnancy and birth.

In the Final Report published by An Bord Atlantis (2000) midwives support the proposed legislative changes to the 1985 Nurse's Act as recommended by the Report of the Commission on Nursing (1998) that the profession of midwifery as a profession remains distinct from nursing. The Minister for Health and Children set up an Expert Group on Midwifery and Children's Nursing Education with the primary objective to develop a comprehensive strategy for the future of midwifery and children's education. An Bord Altranais were represented on this group. Fifty one recommendations were made regarding both areas, including Recommendation No 34 which states that "... the post-registration midwifery programme be changed to one of 18 months duration ...", a reduction of 6 months on the current programme at that time (Department of Health and Children 2004, pg 13).

19.6 SCOPE OF MIDWIFERY PRACTICE IN IRELAND

Bord Altranais agus Cnāimhseachais na hÉireann published a Scope of Nursing and Midwifery Practice Framework (2015d) that replaced the Scope of Nursing and Midwifery Practice Framework (2000). Scope of Practice is a concept that several professions use in the context of professional regulation, and sets out the procedures, actions and processes that the registered or licensed practitioner is allowed to perform (pg 3). Bord Altranais agus Cnāimhseachais na hÉireann also published Practice Standards for Midwives (2015d) in order to set out the standards of midwifery care which would be expected from someone who practices as a registered midwife in Ireland and to make registered midwives aware of the legislation and guidelines defining their role and describing their scope of practice. These practice standards are aligned with the Code of Professional Conduct and Ethics for registered nurses and registered midwives (Bord Altranais agus Cnāimhseachais na hÉireann (2015 c) and are based on five Principles: Respect for the Dignity and of the Person; Professional Responsibility and Accountability; Quality of Practice; Trust and Confidentiality and Collaboration with Others (pg 6). The Scope of Midwifery practice as set out in

Article 42 of the EC Directive of 2005 is set out in the Practice standards (pg. 10) as well as Midwifery Philosophy and Midwifery Values (pg. 12).

In September 2004, the Minister for Health and Children set up an Expert Group on Midwifery and Children's Nursing Education with the primary objective to develop a comprehensive strategy for the future of midwifery and children's education. An Bord Altranais were represented on this group. Fifty one recommendations were made regarding both areas, including Recommendation No 34 which states that "... the post-registration midwifery programme be changed to one of 18 months duration ...", a reduction of 6 months on the current programme at that time (Department of Health and Children 2004, pg 13. Throughout the consultation process, midwives clarified that their scope of practice was already outlined within the definition presented above and in the EEC Council Directive 80/155/EEC of 1980. However, many felt that a major difficulty with their scope of practice was that although their scope was outlined in both the EEC directive (1980) and the definition of a midwife, they found themselves unable to practice at this level because they felt that currently their scope of practice decision-making was centered on the way in which health services in Ireland are delivered. Findings identify a number of important concepts to consider in relation to the expansion and further development of the scope of practice of the midwife. Other areas for consideration include specialist and advanced practice, accountability and autonomy, competence, supervision, continuing professional development and delegation. The main issues raised by midwives in the report were that some midwives believed that a midwife who is functioning as defined by the WHO/ICM 1992 definition are working within the EEC Directive (1980) and are practicing at advanced practice level, yet other participants felt that to practice as defined by the EEC Directive was a requirement for all midwives at the point of registration and this was normal practice for the midwife. Concern was expressed that midwives should be providing more holistic care rather than becoming specialised, for example as a labour ward midwife or a postnatal ward midwife. Some participants were concerned that such specialisation could lead to loss of skills and reduced continuity of care, and others did not. In general, the participant midwives felt that pregnancy and childbirth should be considered normal which is contrary to the present medical model of childbirth. Midwives stated that currently many policies are obstetric led and not midwifery led and they recommended future developments including outlying clinics, DOMINO (Domiciliary Care In and Out of Hospitals) schemes, team midwifery, home deliveries and more independent midwives.

The midwife participants said that the Misuse of Drugs Regulations (1988) outlines the regulations relating to the possession or administration of any medical preparation, which contains pentazocine or methadone, but that regulations do not allow midwives practicing in a hospital setting to administer these medications without prescription. The legislation also prevents midwives from administering over-the-counter non-prescription medications without a prescription from a medical practitioner. They believe that there are certain prescription-only medications that in the course of their practice they need to be able to prescribe and administer without reference to a medical practitioner. Midwife participants in the study believe that greater professional guidance is needed to allow them to fulfill their roles and scope of practice under the legislation. They also recommend that appropriate, timely, referenced, enabling local policies and guidelines (midwife-led) and educational strategies need to be in place to guide and support scope of practice decisions (An Bord Altranais 1998b; Nursing and Midwifery Council 2015; RCM 2015).

19.7 Competencies for Education and Practice in Midwifery

Competencies for post graduate midwifery education were developed by An Bord Altranais (2010) It will be necessary for new Requirements and Standards to be developed in Midwifery in order to comply with the Nurses and Midwives Act (2011). The current competencies for midwifery were developed at level 9. See Table 20 for details.

Table 20 Level 9 Competencies for Post Graduate Midwifery Education

(All cognate areas within the discipline of nursing must be at level 8).

<p>Knowledge breath</p>	<p>A systematic understanding of knowledge, at, or informed by, the forefront of a field of learning</p>	<p>The graduate should:</p> <ol style="list-style-type: none"> 1. Know how knowledge is created and changed within the midwifery profession. 2. be able to demonstrate a knowledge base that exercises higher levels of judgment, discretion and decision making Within midwifery practice. 3. be able to demonstrate the value of midwifery through the generation of midwifery knowledge and innovative clinical practice, midwifery education and management.
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<p>Knowledge <i>kind</i></p>	<p>Critical awareness of current problems and/or new insights, generally informed by the forefront of a field of learning</p>	<p>The graduate should:</p> <ol style="list-style-type: none"> 1. demonstrate the synthesis and integration of knowledge from various domains showing a breadth and depth of knowledge of midwifery 2. demonstrate the synthesis and integration of knowledge from a broad range of disciplines that inform and develop midwifery practice. 3. demonstrate the synthesis and integration of the major research methodologies appropriate to midwifery
<p>Know How and Skill <i>range</i></p>	<p>Demonstrate a range of standard and specialised research or equivalent tools and techniques of enquiry</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. make critical choices in the selection of approaches to research problems. 2. synthesise different approaches to research and justify their use in midwifery practice. 3. systematically gather, interpret and evaluate evidence drawn from a diverse range of sources that are chosen independently. 4. demonstrate expert skill in providing care for women and groups in communities, within the scope of practice framework and multidisciplinary team. 5. demonstrate advanced clinical decision-making skills to manage a midwifery practice caseload. 6. evaluate and critique current evidence base to set standards for best practice
<p>Know How and Skill <i>selectivity</i></p>	<p>Select from complex and advanced skills across a field of learning; develop new skills to a high level, including novel and emerging techniques</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. critically evaluate with discrimination the complex theories and concepts underpinning professional midwifery practice. 2. utilise advanced knowledge

		<p>and critical thinking skills to directly and indirectly provide optimum midwifery care.</p> <p>3. develop and apply critical faculties to midwifery practice through advanced reflection skills.</p> <p>4. demonstrate vision of professional midwifery practice that can be developed beyond current scope of practice.</p> <p>5. act proactively as an educational resource for healthcare professionals.</p> <p>6. apply critical faculties to professional midwifery practice through analysis of the underlying epistemology of its knowledge base</p>
<p>Competence context</p>	<p>Act in a wide and often unpredictable variety of professional levels and ill defined contexts</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. demonstrate autonomy, experience, competence, accountability, authority and responsibility in midwifery practice. 2. demonstrate leadership in nursing practice. 3. use knowledge to autonomously identify, resolve and evaluate intellectual issues and practical problems that appear in midwifery practice. 4. identify and integrate research into areas of health care that can incorporate best evidence based midwifery practice. 5. use advanced skills to conduct an in-depth research study relevant to the field of professional midwifery
<p>Competence role</p>	<p>Take significant responsibility for the work of individuals and groups; lead and initiate activity</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. co-ordinate evidence based practice audit and research to develop and evaluate midwifery practice. 2. actively contribute to the professional body of midwifery knowledge.

		<p>3. demonstrate the value of & midwifery through the generation of midwifery knowledge and innovative midwifery education and practice.</p> <p>4. teach others from a broad and in-depth knowledge base, derived from reflection on midwifery practice and expertise.</p> <p>5. Critically review the working of teams and demonstrate skills in negotiation and the management of conflict</p>
<p>Competence <i>learning-to-learn</i></p>	<p>Learn to self evaluate and to take responsibility for continuing academic and professional development</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. identify personal learning needs and the steps needed to meet them. 2. reflect critically on midwifery practice in order to improve it in self and others. 3. undertake complex and sustained analysis of subject matter and provide a balanced, logical and coherent conclusion. 4. continually evaluate personal contribution to current body of midwifery knowledge in practice. 5. utilise life-long learning skills to continue to develop knowledge applied to midwifery practice. 6. explore beyond scope of practice, developing effective and innovative midwifery practice. 7. demonstrate commitment to advancing the body of knowledge in midwifery practice
<p>Competence <i>insight</i></p>	<p>Scrutinise and reflect on social norms and relationships and act to change them</p>	<p>The graduate should be able to:</p> <ol style="list-style-type: none"> 1. identify and implement action to improve midwifery practice and initiate change. 2. identify and critically evaluate ethical issues and work with others towards their

		<p>resolution.</p> <p>3. develop the ability to be political within and outside of his/her employing organisation.</p> <p>4. challenge assumptions and question values, beliefs and policies underpinning care at individual, team and organisational level.</p> <p>5. actively contribute to the quality of care through research that can advance midwifery and health care knowledge.</p> <p>6. develop advanced communication skills in order to present balanced arguments.</p> <ul style="list-style-type: none"> - present structured, rational and evidenced coherent arguments using appropriate strategies. - engage confidently in academic and multiprofessional debate.
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Adapted from: *Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes - Incorporating the National Framework of Qualifications • First Edition An Bord Altranais • June 2010 pg 39-46.Re- issued October 2015*

Notes within the *Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes: Pre-registration midwife education programmes are at Level 8.*

- the use of the word ‘woman’ should be taken to include her fetus/baby where appropriate.
- the use of the word ‘family’ refers to any significant others, identified by the woman, and not necessarily blood relatives.

19.8 DISCUSSION

New dimensions in midwifery practice include re-validation for practice and supervision of midwifery practice. The process of re-validation is now an issue in the United Kingdom due to new legislation in this area and career misconceptions about the new systems of re-validation is currently being reviewed (Kolyva 2016). Baker (2015) discusses NMC Renewal and advises midwives not to “get caught out” by omitting to re-validate. The Nursing and Midwifery Council

(2015) are accepting revalidation on line and they caution nurses and midwives to confirm they have read the guidelines.

Research on new models of maternity care in health service provision is complex, as is the implementation of such models. Normalisation Process is explored by Forster, Newton, McLachlan and Willis (2011) who advise that positive research findings are only one factor in whether a new model s of care will be implemented. These authors discuss sustainability of models of care in which they use two case studies where new models of maternity care were implemented and evaluated via randomised controlled trials (RCTs). Comparison is made using two case studies – one where a theoretical framework was used, the other where it was not, in relation to outcomes for women and sustainability in the organisational setting. A model of maternity care –Team Midwifery (where women have a small group of midwives providing their care) – was implemented and tested in an RCT but was not continued after the RCT’s conclusion, despite showing the same or better outcomes for women in the intervention group compared with women allocated to usual care. These authors also explored aspects of implementation of a Caseload Midwifery Model (where women are allocated a primary midwife for their care). Findings indicate that when midwives and organisations are exploring implementation and sustainability of models of care awareness of the importance of education and experience is needed and they propose the Normalisation Process Model as a suitable theoretical framework. The Department of Health (2016) places the normalisation of maternity care to the fore in its new strategy.

19.9 Normalisaton

Normalisation of midwifery care is questioned by Healy, Humphreys and Kennedy (2016) who ask in discussing if maternity care can move beyond risk say that due to increased interventionist care and a threatening Medical Model of Maternity Care midwives believe that there is a need to reclaim their role in promoting normal birth, whilst balancing consideration of risk with the principle of women-centred care. Healy et al. (2016) discuss the implication for midwifery as a profession and its inherent risk factors and Diamond (2013) in her book on Legal aspects of Midwifery Care discusses the legal aspects in this context. Guidelines relating to risk, ethical behaviour, legal aspects and professionalism are discussed by several regulatory bodies including: Nursing and Midwifery Board of Australia (2013) Nurse Practitioner standards for practice; Code of Professional Ethics and Conduct (NMBI 2014); The UK Nursing and Midwifery Council (2015) in The

Code: Professional standards of practice and behaviour for nurses and midwives; The King's Fund (2015) on Midwifery Regulation in the United Kingdom and The Royal College of Midwives (RCM) State of Maternity Services Report (2015) that provides the professional and policy requirements in providing individualistic women's care.

In a study undertaken in Norway (2016), an innovative approach to empowering mothers in pregnancy and normalising the process of childbirth is promoted by Helberget, Fylkesnes, Crawford and Svindseth (2016). The study explores midwives perceptions of alternative birth care in that country. Using in-depth interviews, findings indicate that shared common opinions of important factors empowering women in pregnancy and in promoting the best possible health for mother and baby during pregnancy, birth and in the post-natal period was possible when utilising an alternate birth clinic that promotes a shared philosophy between midwives and mothers.

19.10 Supervision

Recommendations for change in the areas of midwifery supervision and regulation are published by the Parliamentary and Health Service Ombudsman (2013). Statutory supervision is a feature of midwifery practice in the United Kingdom since 1902 and all midwives meet with a named supervision of midwifery (SOM) to review practice over the previous year and to confirm their competence to practice in the coming year (Lavery, Wolfe and Darra 2016). A future proofing Model of Supervision was introduced in Wales in August 2014 that is based on action learning approach in midwifery care (Machin and Pearson 2014) and that replaces one- to- one supervisory meeting with group supervisory meeting. This Model of Supervision is expected to herald the impending withdrawal of statutory supervision of midwifery in the United Kingdom. Supervisory agreements are not universal as risk factors are often at issue. Taylor (2015) explores supervision of midwives through a Person-Centred Care (PCC) lens and says that the current framework of supervision supports midwives in a way that reflects the principles of PCC through its models and concepts. Scott and Lindsey (2014) argue that mandated collaborative or supervisory agreements are a restriction to practice for nurse practitioners (NPs) in the United States but that progress toward autonomy is being made in many states, as advocated by Pearson (2012), even though there remains opposition from the American Medical Association (AMA). Concern for patient safety and the educational preparation NPs receive are cited but according to Scott and Lindsey (2014) this is not supported by current data.

The number of midwives in practice in the future may influence the type and level of midwife supervision undertaken. Retention of midwives will remain an important factor in workforce policy and planning and the motivations of people to continue in their current job. A study undertaken by Warmelink, Wiegers, de Cock et al. (2015) in the Netherlands, explored the career plans of primary care midwives and their intentions to leave the current job. All 108 primary care midwives of 20 selected midwifery care practices responded via written questionnaire to their career plans and intentions to leave. Findings indicate that the majority of primary care midwives intended to stay in primary care but the absence of job satisfaction, in midwives aged between 30 and 45 years old is associated with primary care midwives' intention to leave their current job. The authors recommend future ongoing monitoring.

19.11 Risk Management in Midwifery

Risk consideration is also being discussed in the literature. Evidence based decision making is proposed by Ménage (2016 a,b) in a two part published series where a new fit-for-purpose Model for evidence-based decision making in midwifery care in the United Kingdom is proposed. She proposes a radical broad definition of evidence-based decision making that includes information from several sources including the role of guidelines in midwifery care and the impact of risk culture on decision making. Ménage found that national and local health care policies, along with professional standards and guidelines require midwives to play a key role in delivering evidence-based safe professional care in partnership with women but advises that tools to guide such interactions are missing. Her proposed Model addresses a gap in theory and practice by using evidence from women, midwives, research and resources in an environment context in order to redress this imbalance.

Home births remain a difficult choice for mothers in many countries with the exception of the Netherlands. Available birth settings have diversified in Canada since the integration of regulated midwifery. Midwives are required to offer eligible women choice of birth place and consequently 25-30% of midwifery clients plan home births. Canadian provincial health ministries have instituted reimbursement schema and regulatory guidelines to ensure access to midwives in all settings. Evidence from well-designed Canadian cohort studies demonstrates the safety and efficacy of midwife-attended home birth. However, national rates of planned home birth remain low, and many maternity providers do not support choice of birth place. Home births are explored by Vedam, Stoll, Schummers et al. (2014) in a National Canadian birth place study which examines

maternity care provider attitudes and interprofessional conflict around planned home birth. In this 17 item survey on Provider Attitudes to Planned Home Birth Scale (PAPHB-m) to assess attitudes towards home birth among maternity providers, favourability scores were very low among obstetricians (33.0), moderately low for family physicians (38.0) and very high for midwives (80.0). Concerns about perinatal loss and lawsuits, inter-professional consultations, and preference for the familiarity of the hospital correlated with less favourable attitudes to home birth. Among all providers, favourability scores were linked to beliefs about the evidence on safety of home birth, and confidence in their own ability to manage obstetric emergencies at a home birth. The authors recommend increasing the knowledge base among all maternity providers about planned home birth to increase favourability.

In a different but related area of maternity care the risk of deliberately unassisted births in Ireland is discussed in an effort to reach understanding of why such a choice is made by mothers. A professional and quality risk is discussed by O'Boyle (2016) in the context of unattended births. Four individuals who were unattended at birth due to inability to access a midwife had home births so were dependent on Emergency Services for hospital transfer. The individuals had chosen unattended birth in order to avoid criticism of themselves or their lay attendant's. He concludes that the current Health Service Executive homebirth provision does not adequately address demand for homebirth and as a result women may birth alone.

In a similar vein freebirthing is discussed. Free birthing is a radical childbirth choice, which has potential morbidity and mortality risks for mother and baby (Feeley and Thomson 2016). Feeley and Thomson (2016) in a study undertaken in the United Kingdom ask why some women choose to freebirth. They say that while a number of studies have explored women's freebirth experiences, there has been no research undertaken in the UK. Freebirthing or unassisted birth is the active choice made by a woman to birth without a trained professional present, even where there is access to maternity provision. The aim of this study was to explore and identify what influenced women's decision to freebirth in a UK context. Three main influencing factors to freebirth are participants' backgrounds (personal and/or childbirth); experiences of childbirth and maternity care and validation of decision to freebirth by self-directed research, enlisting the support of others and conceptualising risk. These authors say that the UK based midwifery philosophy of woman-centred care that tailors care to individual needs is not always carried out,

leaving women to feel disillusioned and opting out of professional care for their births. Maternity services need to provide support for women who have experienced a previous traumatic birth. Midwives need to help restore relationships with women even when they challenge normative practices and to jointly create birth plans that enable women to be active participants in their decision making whilst making childbirth a quiet birthing space.

19.12 Birthplaces

There is worldwide debate regarding the appropriateness and safety of different birthplaces and Models of Care for well and women at high risk. The Department of Health in Ireland (2016), state in its National Maternity Strategy, that the four stand alone maternity hospitals should be re-located to new state-of-the-art hospitals in adult campuses. They recommend that choice of a maternity care pathway will be available based on risk. The Strategy proposes care pathways: Supported Care for normal risk mothers and babies delivered by midwives as part of the multidisciplinary team; Assisted Care delivered by the obstetrician and midwife as part of a multidisciplinary team and Specialised Care intended for high risk mothers and babies delivered by the obstetrician and midwife as part of a multidisciplinary team. In determining the Model of Care being used patient safety is the overriding principle. Guidelines will be developed through the National Clinical Effectiveness Committee process.

Little is known about how women experience having to change their birthplace plans during the antenatal period or before admission to a primary unit, or transfer following admission (Grigg, Tracy, Schmied et al. 2015). Grigg et al. explore women's experiences of transfer from a primary maternity unit to a tertiary hospital in Christchurch, New Zealand as part of the prospective cohort Evaluating Maternity Units study. The study's objectives were to compare clinical outcomes for well women intending to give birth in either a tertiary level maternity hospital or a freestanding primary level maternity unit and to explore women's experiences of these changes. This paper used the six week postpartum survey data, from the 174 women from the primary unit cohort affected by birthplace plan change or transfer (response rate 73 %). The 702 study participants were well, pregnant women booked to give birth in one of these facilities, all of whom received continuity of midwifery care, regardless of their intended or actual birthplace. Findings indicate that women's experience of transfer in labour was generally positive, and none expressed stress

with transfer. The Continuity of Midwifery Care Model in New Zealand appears to mitigate the negative aspects of women's experience of transfer and facilitates positive birth experiences.

In a randomised trial comparing midwife led and consultant led care of healthy women at low risk of childbirth complications, in the Republic of Ireland by Begley, Devane, Clarke et al. (2011) all women booking prior to 24 weeks of pregnancy at two maternity hospitals, with 1,300-3,200 births annually, were assessed for trial eligibility and 1,653 consenting women were centrally randomised on a 2:1 ratio to Midwifery Led Unit (MLU) or Consultant Led Unit (CLU) care. 'Intention-to-treat' analysis was used to compare 9 key neonatal and maternal outcomes. No statistically significant difference was found between MLU and CLU in the 9 key outcomes of caesarean birth; relative risk; induction; episiotomy; instrumental birth; Apgar scores; postpartum haemorrhage and breastfeeding initiation. Findings indicated that women were significantly less likely to have continuous electronic fetal monitoring or augmentation of labour. Midwife-led care, as practised in the study, is as safe as consultant-led care and is associated with less intervention during labour and delivery (Begley et al. 2011).

A further study that may have relevance in Ireland was undertaken by Monk, Tracy, Foureur, Grigg Tracy(2014) on evaluating Midwifery Units (EMU) in New South Wales, Australia with the aim of comparing maternal and neonatal birth outcomes and morbidities associated with the mother's intention to give birth in two freestanding midwifery units and two tertiary-level maternity units . Sample included 494 women who intended to give birth at freestanding midwifery units and 3157 women who intended to give birth at tertiary-level maternity units. Participants had low risk, had single pregnancies and less than 28+0 weeks gestation at the time of booking. Findings indicate that women who planned to give birth at a freestanding midwifery unit were significantly more likely to have a spontaneous vaginal birth and less likely to have a caesarean section. There was no significant difference in the Apgar scores and babies from the freestanding midwifery unit group were significantly less likely to be admitted to neonatal intensive care or special care nursery. Analysis of secondary outcomes indicated that women planning to give birth in a freestanding midwifery unit were associated with similar or reduced odds of intrapartum interventions and similar or improved odds of indicators of neonatal well-being. The results of this study support the provision of care in freestanding midwifery units as an alternative to tertiary-level maternity units for women with low risk pregnancies at the time of booking.

Rogers, Jay, Yearley and Beeton (2015) in a national survey, explored the level of compliance with recommendations and standards for the newborn and infant physical examination (NIPE) in an effort to identify which professionals were complying with NIPE and current practice standards when screening at-risk babies. The survey was undertaken in 2014, in the United Kingdom via on-line questionnaire to a sample size of 154 heads of midwifery. Findings indicate that the professionals mainly undertaking the HIPE examination were paediatricians, midwives and neonatal practitioners, with 80% rating NIPE Screening as good or excellent. Midwives responses indicate that 50% were undertaking NIPE screening. The authors recommend more training and education for midwives and parents.

19.13 CONCLUSION

Midwives have difficulty with the medicalisation of maternity services. They view the function of the midwife in maternity care as the normal care of women throughout pregnancy, labour and the postnatal period and they believe that the current care they deliver is in contrast to their defined role and function. This can create differences of opinion between midwives and obstetricians. The midwife feels that at times his/her role is only to facilitate, or is perceived as being only to facilitate, the obstetrician. Recent research is also included in this updated version in the Discussion pages --. Midwife-led care was found to be as safe as consultant-led care and is associated with less intervention during labour and delivery (Begley et al. 2011). Comparing maternal and neonatal birth outcomes and morbidities associated with the mother's intention to give birth in freestanding midwifery units and tertiary-level maternity units will remain a research study and cause for concern as will the Normalisation Process (Healy, Humphreys and Kennedy 2016) and Free Birthing, a radical childbirth choice, which has potential morbidity and mortality risks for mother and baby (Feeley and Thomson 2016). Available birth settings have diversified in Canada since the integration of regulated midwifery. Midwives are required to offer eligible women choice of birth place and consequently 25-30% of midwifery clients plan home births. New dimensions in midwifery practice include re-validation for practice and supervision of midwifery practice. This process is currently being reviewed in the United Kingdom and will be required in countries where midwifery is recognised as a separate profession (Baker 2015; The Nursing and Midwifery Council 2015; Kolyva 2016).

An Bord Altranais in the Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes - Incorporating the National Framework of Qualifications (2010) developed competencies for post graduate midwifery education. Respondents from the NMBI Pilot Survey (2014) believe that Requirements and Standards for the Regulation of Midwifery for advanced midwifery practitioners be flexible enough to accommodate RGN/RM's and take cognisance of the emerging competencies of, for example, direct entry midwives in the creation and titles of advanced practice midwifery posts. Continued compliance with recommendations and standards for the newborn and infant physical examination (NIPE) will remain of importance to midwives.

To facilitate introduction of the Nurse and Midwives Act (2011) a National Lead in Midwifery Service was appointed by the ONMSD to ensure standardisation of midwifery practice across maternity services and to develop evidence-based maternity practice in Ireland. The Lead Midwife will provide leadership, support, provide expert practice and promote initiatives to support choice for mother's www.hse.ie/nationalleadmidwife. Available birth settings have diversified in Canada since the integration of regulated midwifery and Midwives are required to offer eligible women choice of birth place (Vedam, Stoll, Schummers et al. 2014).

CHAPTER 20 CONCLUSION

Ireland is leading advanced nurse and midwife practice internationally and for this leadership to be developed further we need to articulate the dimensions of the role to the wider healthcare professionals, management and community, otherwise the confusion around the role and its concepts, that are evident in many countries, will lead to further splintering of the advanced practitioner title, roles, functions and responsibilities.

Even though Ireland is at the forefront of advanced practice regulation challenges lie ahead in relation to further expansion of the role, how governance will be structured following the introduction of the Nurses and Midwives Act (2011) legislation and the role of health care organisations in the governance and structure of advanced nurse and midwife practice are likely to pose challenges, due in part to the inherent difficulty in applying advanced practice professional certification requirements to regulatory practice and legal regulations, as these are the

responsibility of legislators and Boards of Nursing (APRN 2008; NCNZ 2012 a, b; NMCA 2014). This regulatory confusion extends to regulation of title where title protection and regulatory mechanisms for practice extend beyond first level nurses regulated scope of practice as in Ireland, New Zealand, Canada and the USA.

Regulation principles in place in each country must be adhered to by the RANP/MP. The NMC (Nursing and Midwifery Council 2014) in the UK state that nurses and midwives must apply their professional judgment when putting regulation principles into practice. The NMC (2014) and the NMBI (2012) state that professional nurses at every level are personally accountable for their actions and for any omissions in practice and must be able to justify the decisions they make. Accountability and taking responsibility for individual actions are integral to professional practice www.nmc.com/regulation but are particularly so for advanced practice. What is often forgotten is that the purpose for any government or government department, regulatory body or professional organization, when regulating advanced practice, is the protection of public health, safety and welfare so that no harm may arise from the clinical activity of the advanced practitioner. Harm may occur through the absence of regulation, lack of organisational structures in place where advanced practice is carried out or inadequate educational preparation for the role.

RANP/MP's must be able to articulate to organisational management the advantages of having an advanced nurse practitioner on site. The importance of the RANP/MP undertaking individual research with other health care professionals in order to validate the role, competencies and benefits, including the clinical outcomes from the role is needed. Importance is communicated through defining the aspects of the role that are clearly nursing, those that overlap with other professionals, such as doctors and other therapists thus ensuring that these professions have an awareness of the roles, elements, leadership and quality aspects being undertaken by RANP/MP. A special function of the role is the protection of the public.

Educational requirements for advanced practice vary across countries and state. Even within the advanced nurse practitioners community there is clear bias toward practicing in some areas of nursing such as medical, surgical and emergency nursing or in a sub-set of these areas of practice. Clinical areas of mental health/psychiatry, intellectual disability, midwifery, primary care community care and care of the older person remain underdeveloped. This may be due to

individual preferences for areas of advanced practice or to lack of educational programmes in place to develop these areas further. The proliferation of clinical titles in place for advanced nurse practitioners will need refinement. The New Zealand Model of practice areas linked to titles may be a model that Ireland could consider.

Advanced practice requires special educational content. Curricula for advanced practice would benefit from additional content broadening of the content taught and in delivering a higher level of content that is specific to the advanced practice programme. Examples of content not being universally taught relate to: comprehensive physical assessment; current health issues and solutions; community outreach initiatives; coaching; diagnostic tests relevant to the programme; disease management solutions; developing interventions to improve patient/client outcomes; healthcare developments, logistical models for practice delivery; inter-professional approaches; incorporation of medicinal prescribing and ionising radiation (x-rays); mentorship models; nursing specific programmes based on a bio-psycho-social-spiritual model, public policy; technology advances and outcome measurements.

Educational preparation must include a substantial clinical modular component(s) pertaining to the relevant area of specialist practice. The clinical modular component needs to be focused on the specialist area of practice rather than on a generic programme. It is demonstrated that universities adopt different approaches to course content offered thus minimising duplication of content and titles within countries. Universities provide innovation and distinction in subject and programme content and appear to work hard at defining the distinctive advantages of their university over another. This distinctive approach includes differing masters title's; providing significant advanced practice modular content; increasing the normal clinical practicum from 500 to 658 hours; providing out-reach and remote rural area programme; focusing on employment areas for advanced practice; offering Certificates of Completion for a Graduate-level Course and adopting multidisciplinary approaches with outcomes that are focused on improving healthcare.

In Ireland, distinction is made by providing tailored programmes in defined practice areas such as emergency, neonatology, epilepsy and colo-rectal screening thus defining advanced practice in each university rather than each offering the same programme/subject content. Offering the Master of Clinical Nursing by Degree (by coursework) is offered in the Australian University, Sydney, and the provision of the MSc Advanced Practice (Nursing, Midwifery and Occupational

Therapy) offered in the University of Canterbury extends advanced practice to an occupation outside nursing, that of Occupational Therapy, through an inter- professional approach to healthcare education. In the USA, nurses holding the MSc. Nursing in a specific area of nursing may obtain a Post Masters Certificate Option in another area thus broadening their knowledge and competency base. Cedars –Sinai Medical Centre, California and University College, Los Angeles provide specialist education for complex situations where patients have undergone highly sensitive procedures and are based on interventions to obtain better healthcare outcomes. The innovative nature of these programmes could be replicated in Ireland by universities providing distinctive approaches to advanced practice education while meeting the Requirements and Standards for advanced nurse and midwife practice as set down by the NMBI. Pathways to entry also need further consideration.

Educational development for advanced nurse practice in the community is underdeveloped. Community educational development is influenced by the complexity of healthcare problems and patients need and demands. Thus curricula developed for public health nursing need innovative vision and content. A position paper sponsored by the Association of Community Health Nursing Educators in the United States challenges nurse educators to apply strategies in preparing public health nursing (PHN) professionals to meet current demands. Curricula needs to include content relating to demographic shifts in communities, changing social structures including family make up, child protection and the legislative factors impacting on community health care practices, thus providing a range of clinical, legal, social policy and sociological perspectives.

Confusion remains internationally in regard to the scope of practice of the RAPN/RAMP. The evolvement of advanced nursing/midwifery roles need to be managed in such a way that national standards are adhered to, and this requires careful benchmarking against best practice internationally thus ensuring that best practice is endorsed and maintained. To ensure that roles are based on the philosophical underpinnings of Nursing/Midwifery, it is important that the role is defined within a framework of nursing and midwifery practice, thus demonstrating the value of the role in monitoring and enhancing patient responses to their disease process and not simply replacing activities undertaken by other members of the multidisciplinary team.

Competencies for advanced practice are continually being changed and updated in order to meet changing healthcare need. Therefore, it is important that all competencies are well articulated, with indicators that are specific to each area of practice, post and speciality of practice. Through this process, local governance arrangements, risk factors and patient outcomes are identified and monitored. An important component of competency development relates to mentorship or clinical supervision. Candidate advanced nurse practitioners in Ireland require a mentor to supervise practice. In Ireland up to now it is generally a Medical mentor who signs the ANP/AMP as competent. This mentorship model is consultant led and may need further consideration when Requirements and Standards for advanced practice are being developed. Some flexibility in relation to a relevant mentor could incorporate mentorship utilising a model other than, or in addition to the medical model such as the registered advanced nurse or midwife practitioner, relevant clinical facilitator or liaison facilitator model(s).

Governance Models: Regulation challenges lie ahead in relation to further expansion of the ANP/MP role, how governance will be structured following the introduction of the Nurses and Midwives Act (2011). The role of health care organisations in the governance and structure of advanced nurse and midwife practice will also pose challenges. Governance models for advanced practitioners vary and often conflict. Ireland is one of few countries to have clear documentation relating to the development of the ANP/AM but in countries where advanced practice posts are in place, most posts are not subject to regulatory body accreditation or oversight as in Ireland, and posts appear to have developed ad-hoc, mainly in response to service need. In the United Kingdom the governance structure for nurse practitioners dwells within the health care system and with individual health care organisations, rather than with regulatory bodies.

New governance structures are currently being implemented in Ireland that will include healthcare functions being transferred elsewhere and organisational divisions will purchase health and social services which are likely to impact on the creation of advanced nurse and midwife posts. New Directorate systems will identify clear areas of priority and the responsible directors for hospital care, primary care, mental health, children and family services, social care, public health and Corporate (shared services) and one over seeing Director General, also areas likely to include RANP/RAMP. Centres of Excellence including the Magnet approach would assist organisations in identifying examples of best practice, identifying new advanced practice posts and in sharing information advanced practice throughout newly configured directorates and organisations.

Site Visits are currently being undertaken by NMBI. This method may change in the future to regulation by the health service organisation. This change will pose challenges in relation to development of advanced practice posts. While it is argued that the job description for a particular post cannot reflect the complete clinical decision making requirements of the role health service organisations will need to take responsibility for defining the need for the development of advanced practice posts in individual organisations.

A future challenging area relates to environmental factors that must be assessed and developed prior to the introduction of new advanced practice posts that are likely to affect role implementation. Those challenging areas are presented in a Model of Future Criteria for practice in Section 15.9 of this report. The model offers criteria that may be considered and will act as guidance for role development and for areas that need to be included in Standards and Requirement and for the role of advanced nurse and midwife practice. Medication management needs to be extended to all RANP/AMP's and include ionising x-ray prescribing. Mechanisms for the inclusion of those areas into the curriculum need to be defined.

A number of important concepts need consideration in relation to the expansion and further development of the scope of practice of the midwife. Areas for consideration include specialist and advanced practice, accountability and autonomy, competence, supervision, continuing professional development, delegation and community practice. Midwifery practice is expanding and new models of care and birth choices for women are being developed internationally. Requirements and Standards for Post-Registration Nursing and Midwifery Education Programmes - Incorporating the National Framework of Qualifications (2010) present competencies for post graduate midwifery education. Respondents from the NMBI Pilot Survey (2104) indicate that advanced midwifery practitioners need the Requirements and Standards for the Regulation of Midwifery to be flexible enough to accommodate RGN/RM and cognisance taken of the emerging competencies of for example direct entry midwives in the creation and titles of advanced posts.

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Appendices

Appendix 1 Regulation of Advanced Practice Nursing in 19 European and OECD Countries

Country	Regulation	Summary of Criteria for Regulation
Australia	<ul style="list-style-type: none"> Nurse practitioner is protected by legislation and the role is defined by national standards A regulatory framework and extended practice is supported by legislation ANP sits within RN scope of practice and with no need for additional regulation (Gardner et al 2012) Each of the six states and two territories in Australia has a nurse regulatory authority, which maintains its own register of registered and enrolled nurses (Australian Nursing Council Inc. 2000) 	<ul style="list-style-type: none"> Australia (Australian Nursing and Midwifery Council, ANMC) Nurses practicing at this level are educationally prepared at post-graduate level May work in a specialist or generalist capacity The basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision-making" (ANMC, 2006).
Canada	<ul style="list-style-type: none"> Professional legislation governing nursing practice is a provincial rather than a federal responsibility Regulation is via separate legal acts in each of the ten provinces and two territories. 	<p>Criteria involves being able to:</p> <ul style="list-style-type: none"> Analyse and synthesise knowledge Understand, interpret and apply nursing theory and research Develop and advance nursing knowledge, and the profession as a whole. (CNA 2008).
Denmark	<ul style="list-style-type: none"> No regulation of Advanced Nurse Practice No legally protected specialist nurse titles except that of home visiting nurse 	<ul style="list-style-type: none"> Requirement is minimum of 3 years relevant work experience after completion of first degree
Finland	<ul style="list-style-type: none"> Specialist nurses are not recognised through separate registration. 	Not applicable

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France	<ul style="list-style-type: none"> No regulation of Advanced Practice Nursing 	Not applicable
Germany	<ul style="list-style-type: none"> There is no national system of registration or a regulatory nursing body Responsibility for registration is devolved to the regions. 	Not applicable
Ireland	<ul style="list-style-type: none"> Advanced Nurse Practice and all nursing programmes are regulated by An Bord Altranais, the nursing regulatory body. 	<p>Advanced nurse practitioners must be:</p> <ul style="list-style-type: none"> Highly experienced in clinical practice Educated to master's degree level (or higher) Postgraduate programmes must be in nursing or an area which is highly relevant to the specialist field of practice Educational preparation must include substantial clinical modular component(s) pertaining to the relevant area of specialist practice Have a vision of areas of nursing practice that can be developed beyond the current scope of nursing practice and a commitment to the development of these areas (NCNM, 2008a).
Italy	<ul style="list-style-type: none"> No regulation for advanced practice. Registers for nurses are kept by colleges of nursing in each province and allow practice throughout Italy. There is no central regulation in place (OECD 2006) 	Not applicable
Japan	<ul style="list-style-type: none"> There is no regulation. There are no state level qualifications for specialisation. Various organisations and academic societies offer their own certification systems, including the Japanese Nursing Association (JNA) 	<p>Eligibility criteria for nurses at the equivalent of advanced nurse practice level include:</p> <ul style="list-style-type: none"> Clinical experience above the defined standard in the specific area of nursing and (for midwifery at least 5 years Either have completed a regulated curriculum of 6 months or passed a JNA Certified Nurse Expert examination (midwifery requires both) (JNA 2006).
Netherlands	<ul style="list-style-type: none"> Nurses must register on the WET BIG-Register. 	<ul style="list-style-type: none"> Specialist nurse training is aiming at obtaining extra competencies and

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	<p>Since the introduction of the Wet BIG, no specialist nurse training is legally regulated. Most specialist nurse training programmes are recognised by both the nursing associations and the employers.</p>	<p>qualifications on professional specific skills</p> <ul style="list-style-type: none"> • A substantial theoretical and clinical training is necessary. • The recognised specialist nurse training is aimed on a specific category of clients
New Zealand	<ul style="list-style-type: none"> • Advanced Practice and all nurses are regulated by The National Council. The Council's role and responsibilities are outlined in the Health Practitioners Competence Assurance Act 2003 (HPCA Act). (Council of New Zealand 2007). 	<p>Applicants who have successfully completed an approved programme of study in New Zealand can apply for registration as a nurse in the scope of practice for which his/her qualification is prescribed</p> <ul style="list-style-type: none"> ○ If a person has the responsibilities of a nurse as defined by the Nursing Council scopes of practice and is using his or her nursing knowledge in a direct relationship with clients he or she should hold a practicing certificate (Nursing Council of New Zealand 2007, 2012) ○ Registration with the Nursing Council of New Zealand in the Registered Nurse Scope of Practice ○ A minimum of four years experience in a specific area of practice ○ Successful completion of a clinically focused Masters Degree programme approved by the Nursing Council of New Zealand, or equivalent qualification ○ A pass in a Nursing Council assessment of Nurse Practitioner competencies and criteria. Nurse Practitioners seeking registration with prescribing rights are required to have an additional qualification ○ Successful completion of an approved prescribing component of the clinically-focused master's programme relevant to their specific area of practice.
Norway	<ul style="list-style-type: none"> • The Ministry of Education and Research regulates advanced practice 	<p>Criteria include:</p> <ul style="list-style-type: none"> • Masters degree required for entry to the three year doctoral programme

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		<ul style="list-style-type: none"> • Programme comprises 1 year of theoretical studies in nursing science and methods and 2 years for a degree programme • Clinical experience and a postgraduate speciality qualification needed.
Scotland	<ul style="list-style-type: none"> • Regulated by the UKCC and strong organisational governance is in place • Scope of practice for advanced practice is not defined in specific legislation. 	<p>Criteria:</p> <ul style="list-style-type: none"> • Be experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard and applied nursing frameworks to practice • Empowered to make high-level clinical decisions and will often have their own caseload • All candidate advanced practitioners should have a Clinical Masters or a postgraduate certificate or post-graduate diploma • Show evidence of ability to integrate theory, research and practice and application of critical thinking as the basis for clinical decision making .
Singapore	<ul style="list-style-type: none"> • Nursing and midwifery in Singapore is regulated through the Singapore Nursing Board (SNB). The SNB undertakes regular site visits to educational institutions and clinical sites to monitor compliance with regulations and standards. 	<ul style="list-style-type: none"> • Masters level study • Appropriate clinical experiences • Support of Director of Nursing
Spain	<ul style="list-style-type: none"> • Education is regulated by the Ministry of Education and registration of advanced practice nursing is the responsibility of the General Council of Nursing. All nurses must be registered with their local Provincial College of Nurses. 	No official criteria established
Sweden	<ul style="list-style-type: none"> • Advanced nurse practice is not regulated in Sweden. Regulation of nursing is as set out in law and deals with authorisation relating to professional activities within the health care system. All nurses must register with the National Board of Health and Welfare 	No official criteria established

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<p>Switzerland</p>	<ul style="list-style-type: none"> • Regulation is now at Federal level through various mechanisms. • There is Regulation of advanced practice • There is no national accrediting body for specialist programmes and therefore advanced practice is not certified (OECD 2006). 	<p>No official criteria established</p>
<p>United Kingdom</p>	<ul style="list-style-type: none"> • Nurses became regulated via the Nurses Registration Act, 1919 and Midwives through the United Kingdom 1902 Act. Discussion is taking place on the regulation of advanced nurse practice in the United Kingdom. Organisational governance is in place. <p>http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_0_65946 and Scottish Report</p>	<p>Criteria include:</p> <ul style="list-style-type: none"> • Bachelors or masters degree or post Graduate Cert depending on category of nurse being registered as nurse practitioner/specialist nurse or advanced nurse practitioner • Have extensive clinical experience in specialist area of practice.
<p>United States</p>	<p>Almost all of the American State Boards have regulations to govern three types of advanced practice registered nurses (Certified Registered Nurse Anaesthetist, Certified Nurse Midwife and Nurse Practitioner, which set out scope of practice, regulation and requirements for legal recognition (NCSBN Inc. 1997, NCSBN 2012).</p> <p>Plans are underway to completely revamp nursing regulation in all states of the USA by the year 2015, from the current single-state licensure model to a mutual recognition model, as proposed by the NCSBN Inc. (Chaffee 1998, American Nurses Association 1995).</p>	<p>Criteria include:</p> <ol style="list-style-type: none"> 1. the specialised education, skills and abilities required for the professional practice 2. the level of autonomy 3. the scope of practice <p>(NCSBN (2012) Regulation of Advanced Nursing Practice; NCSBN Position Paper 1993).</p> <p>Identifiable and unique scope of practice is a key element of licensure.</p> <ul style="list-style-type: none"> • Additional education and experience, practice beyond traditional nursing for example in medical diagnosis and prescription of medications. • The core of skills and abilities as set out by LACE • Specific practice characteristics of each advanced nursing category which creates distinguishable scopes of practice for the advanced nursing practice roles.

Delamaire & Lafortune (2010) *OECD Health Working Papers*, No. 54

Appendix 2 Criteria for Advanced Practice Posts in Ireland –Regulation-SI No 3 of 2010

1. to determine, in accordance with criteria set by the National Council:
 - (a) applications for the accreditation of posts as advanced nurse practitioner posts
 - (b) applications for the accreditation of posts as advanced midwife practitioner posts
 - (c) applications for the registration of nurses as advanced nurse practitioners
 - (d) application for the registration of midwives as advanced midwife practitioners
2.
 - (a) to accredit, as an advanced nurse practitioner post, a post which has been determined to meet criteria set by the National Council for the Professional Development of Nursing and Midwifery, under Statutory Instrument, SI. No 3 of 2010
 - (b) to accredit, as an advanced midwife practitioner post, a post which has been determined to meet criteria set by the National Council
 - (c) to register, as respects a specified advanced nurse practitioner post, in the advanced nurse practitioner division of the register, any nurse-
 - (i) who has been determined to meet the criteria referred to in paragraph (1) and
 - (ii) who has received an offer of employment in respect of the advanced nurse practitioner post concerned
 - (d) to register, as respects a specified advanced midwife practitioner post, in the advanced midwife practitioner division of the register, any nurse-
 - (i) who has been determined to meet the criteria referred to in paragraph (1) and
 - (ii) who has received an offer of employment in respect of the advanced midwife practitioner post concerned
3. To remove, from the advanced nurse practitioner division of the register, the name and particular of a person whose name and particulars are registered on the advanced nurse practitioner division of the register-
 - (a) where that person no longer complies with the criteria referred to in paragraph (1), or
 - (b) upon the cessation of that person's employment in the advanced nurse practitioner post concerned,
4. To remove, from the advanced midwife practitioner division of the register, the name and particular of a person whose name and particulars are registered on the advanced midwife practitioner division of the register-

- (a) where that person no longer complies with the criteria referred to in paragraph (1), or
- (b) upon the cessation of that person's employment in the advanced midwife practitioner post concerned.

Notwithstanding Article 3 Nurses Act 2011 www.nursingboard.ie/publications/current

Appendix 3 Levels of Regulation in USA

There are four levels of regulation in the United States

1. Level 1, the least restrictive approach, typically corresponds to designation and/or recognition
2. Level 2, typically corresponds to registration, and requires advanced practice nurses to apply to have their names added to an official roster of individuals who provide advanced nursing practice, maintained by the Board. Registration does not involve state inquiry into competence and the scope of practice is not generally defined
3. Level 3, corresponds to certification which does not include a defined scope of practice but does recognise the professional competence of an individual who has met the pre-determined qualifications specified by that agency or association. Boards of Nursing have also used the term certification to authorize advanced nursing practice, However the potential for confusion exists when this term is used by both professional organisations and regulatory boards
4. Level 4, corresponds to Licensure. This regulatory method is used when regulated activities are complex; require specialised knowledge and skill, and independent decision-making. The licensure process includes the predetermination of qualifications necessary to perform a unique scope of practice safely and an evaluation of licensure applications to determine that the qualifications are met. Licensure provides that a specified scope of practice may only be performed legally by licensed individuals LACE Consensus Model (2009).

Appendix 4 Regulation of Advanced Practice Nursing –LACE Consensus Model (USA)

Requirements for Licensure	Requirements for Accreditation of APRN Education Programme	Requirements for Certification	Requirements for Education
The Boards of Nursing (Licensure) will:	Accreditors will:	Certification programme will:	APRN educational programmes will:
License APRN's in one of four roles with a population focus	Evaluate APRN graduate degree and post-graduate certificate programmes	Follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure	Follow established educational standards and ensure attainment of the APRN core, role core and population core competencies
Be solely responsible for licensing (exception exist in relation to states where midwifery is regulated)	Assess APRN programme in light of the APRN core, role core and population foci core competencies	Assess the APRN core and role competencies across at least one population focus of practice	Be accredited by a nursing accrediting organization that is recognized by the US dept of Education and or the Council for Higher Education Accreditation
Only license graduates of accredited graduate programmes	Establish a pre-approval, pre-accreditation or accreditation process prior to student enrollment for new educational programmes	Assess speciality competencies separately from the APRN core, role and population focused competencies	Be pr-approved, pre-accredited, or accredited prior to the acceptance of students , including all developing AORN education programmes and tracks
Require completion of a national certificate examination that assesses APRN core, role and population competencies	Include an APRN on the visiting team when reviewing an APRN programme	Be accredited by a national certification accreditation body	Ensure that graduates of programmes are eligible for national certification and state licensure
Only license an APRN when reduction and certification are congruent	Monitor the APRN education programme throughout the accreditation period		
Independent practice: no supervision of collaboration			

Adapted from LACE CONSENSUS MODEL, 2009; Apple K. 2010).

Appendix 5 M-Strong AP Model Domains and Domains 1 and 2 Activities

Domain of Practice	Domain Title	Activities
Domain 1	Direct Comprehensive Care	Procedures, hands –on activities: care giving, assessing, data interpretation
		Progression of patient through system, role advocacy
		Dissemination & provision of current knowledge and student education
		Generation of knowledge & integration of research findings into clinical practice
		Sharing knowledge at national & international levels
Domain 2	Support of Systems	Assess, develop, implement & evaluate quality improvements
		Provide Leadership in practice areas
		Mentor students
		Advocate the nurses’ role
		Spokesperson for nursing when networking
Domain 3	Education	
Domain 4	Research	
Domain 5	Publications/Professional Leadership	

(NP Model) by Gardner et al. (2012) which was first adapted from Mock & Ackerman 2000

Appendix 5 Criteria for Scope of Practice in Scotland

Country	Main Scope of Practice or Main Skills Permitted
Knowledge	<ul style="list-style-type: none"> • Utilises highly developed specialist knowledge covering a range of procedures and underpinned by relevant broad based knowledge, experience and competence • Uses highly specialised theoretical and practical knowledge some of which is at the forefront of knowledge in the work area. This knowledge forms the basis for originality in developing and/or applying ideas • Demonstrates critical awareness of knowledge issues in the work area and at the interface between different work areas • Creates a research based diagnosis to problems by integrating knowledge from new or interdisciplinary work areas and make judgments with incomplete or limited information • Develops new skills in response to emerging knowledge and techniques.
Supervision	<ul style="list-style-type: none"> • Demonstrates leadership and innovation in work contexts that are unfamiliar, complex and unpredictable and that require solving problems involving many interacting factors • Reviews strategic impact/outcome of the work or team.
Professional and Vocational competence	<ul style="list-style-type: none"> • Demonstrates autonomy in the direction of practice and a high level understanding of development processes • Solves problems by integrating complex knowledge sources that are sometimes incomplete and in new and unfamiliar contexts • Demonstrates experience of managing change within a complex environment • Responds to social, scientific, clinical and ethical issues that are encountered in work or study.
Analytical/clinical skills and patient care	<ul style="list-style-type: none"> • Provides specialist or highly specialist clinical, technical and/or scientific services • May be accountable for direct delivery of part of service. • Makes complex judgments

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Organisational skills and autonomy/freedom to act	<ul style="list-style-type: none"> • May be responsible for work area, specialist services or clinical pathways • May be accountable for direct delivery of part of service.
Planning, policy and service development	<ul style="list-style-type: none"> • Proposes changes to practices or procedures which impact beyond own work area. • May plan and/or organise a broad range of complex activities or programmes with formulation of strategies.
Financial, administration, physical and human resources	<ul style="list-style-type: none"> • May be responsible for purchasing and maintenance of assets. • Undertakes supervision and/or teaching and training • May devise training or development programmes • May hold a budget. • Manages staff and/or services ranging in size and complexity.
Research and development	<ul style="list-style-type: none"> • May evaluate equipment, techniques and procedures • May undertake straightforward or complex audit or assist with clinical trials or research projects • May carry out R&D as a major activity. • May regularly undertake clinical trials or research projects. In addition to above, may initiate and develop R&D programmes.

Scope of Practice Level 7 role descriptors (Skills for Health, 2007) Scotland

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012

Appendix 6 Placing Areas of Practice onto Defined Practice Areas –New Zealand

EXAMPLES OF PLACING YOUR AREA OF PRACTICE ONTO ONE OF THE DEFINED PRACTICE AREAS	
Emergency	Nurse Practitioner Lifespan Acute Care
Intensive Care	Nurse Practitioner Adult Acute Care Nurse Practitioner Child
Sexual and Reproductive Health	Nurse Practitioner Youth / Adult Health Condition
General or Orthopaedics Surgical	Nurse Practitioner Adult
Renal	Nurse Practitioner Adult/ Older Adult
Pain Management	Nurse Practitioner Lifespan
Occupational Health	Nurse Practitioner Adult
Adolescent Addictions	Nurse Practitioner Youth Mental Health
Forensic Mental Health	Nurse Practitioner Adult Mental Health
Respiratory Conditions	Nurse Practitioner Youth / Adult Health Conditions Nurse Practitioner Lifespan Primary Health

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> Pg 7 July 23 2012

Appendix 7 Education Level for Nurses in Advanced Nurse Practice Roles (Requirements or Recommended)

Country	Title or Category in Advanced Practice Roles	Educational Requirements
Australia	1 Advanced Practice Nurses (clinical nurses, consultants) 2 Nurse Practitioner	Graduate Diploma or Master's degree Master's degree
Belguim (Advanced Practice not recognised)	Registered Nurses	Some nurses hold a Bachelor's or Master's degrees or one year specialist programme
Canada	1 Clinical Nurse Specialists 2. Nurse Practitioner in Primary Care and Acute Care -Neonatal, Paediatric and Adult	Master's degree Master's degree for three areas in Canada except for Ontario, Saskatchewan, Newfoundland. (NP education in Canada by 2015, should be at graduate level)
Czech Republic (Advanced Practice not yet recognised)	1.Registered Nurse (with specialisation) 2. Registered Nurse in a clinical discipline	2-3 years specialisation following registration as a nurse and attestation examination Master's degree
Cyprus	1. Community Mental Health Nurse 2. Community Nurses including Health Visitors 3. Mental Health Nurses 4 Diabetic Nurses 5 Clinical Nurse Specialist	Specialisation through short-term educational programmes or post graduate programmes of 12-18 months duration 3, 4 .5 Same entry requirements.
Denmark (Advanced Practice not yet recognised)	Specialist Home Visiting Nurse	Diploma in Education for Home Visiting Specialist Nurse Masters degrees offered in Anesthetist Nurse, Psychiatric and Infection Control nursing Professional Bachelor degree in Nursing and some specialist diplomas.
France (Advanced Practice not formally recognised. A number of pilot projects in place).	1 Specialist Nurses in some areas such as Nurse Anesthetist, operating theatre, and Paediatric 2. Pilots involving advanced nursing practice in areas such as primary practices, home	State Nursing Diploma Bachelors and Master's degrees introduced in some universities.

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	chemotherapy, and digestive function	
Finland (Has not formally recognised Advanced Practice)	1. Nurses (with advanced degree) 2. 2. Public Health Nurses (with advanced degree)	1. Post-Graduate Diploma or Master's degree for both categories
Germany (Advanced Practice not recognised)	Not applicable	Apprenticeship System
Ireland	1. Advanced Nurse Practitioner (ANP) 2. Advanced Midwifery Practitioner (AMP)	1. Masrer's degree
Italy (Advanced Practice not yet recognised)	Not applicable	Bachelors and master's degrees offered in some faculties of medicine
Japan (Advanced Practice not recognised)	1. Registered Nurses 2. Certified Nurse Specialists	Graduate programme for Nurse Practitioners in some universities Master's degree and JNA certification Five years of clinical of which 3 years is in a specialist area
Netherlands (Advanced Practice or the title "nurse" are not recognised)	Specialist nurse training is no longer legally regulated or recognised and all such nurses are currently added to the Big Register as "nurses" with no dedicated specialism.	Not applicable.
Norway	There Is one registered nurse qualification	Masters in Advanced Nursing Practice, Doctoral and Specialist post graduate programmes
Portugal (Advanced practice is not recognised)	There Is one registered nurse qualification	Diploma, Bachelors and Master's offered in some colleges
Poland (Advanced Practice not formally recognised)	Nurse Specialists Rescue Medicine Nursing Anesthetic Nurses	State Certification
Scotland	Professionals undertake roles at advanced level but may not be registered or practicing within their Scope of Practice	Bachelors or Clinical Master's degree
Singapore	ANP's are certified in four distinct areas of practice: acute, medical/surgical care community and mental health.	Masters degree in Nursing at National University of Singapore
Spain (A move towards regulation of advanced nurse	One level of Nurse recognised	Bachelors and Master's in Nursing Science and post

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practice occurred in 2006 but advanced practice is not officially recognised)		graduate diplomas introduced by some universities
Sweden (Advanced nurse practice is not yet officially recognised)	Masters degree	Masters degrees introduced by some universities.
Switzerland (There is no national accrediting body for specialist programmes and therefore advanced practice is not regulated , OECD 2006).	One level of Nurse recognised	3 year diploma or 3 year bachelor MSc Advanced Practice offered in some universities
United Kingdom	1.(Advanced) Nurse Practitioners 2.Clinical Nurse Specialists 3. Nurse Consultants 4.Modern Matron 5.Community Matron	1. Bachelors degree at a minimum (Most nurses have Master's degree 2. Bachelor's degree or Master's degree and extensive experience in specialist field of practice and continuous professional education (required or recommended) 3. Master's and Doctorate degree 4. Master's degree or extensive experience 5. Master's degree or extensive experience
United States	1. Nurse Practitioner 2. Clinical Nurse Specialist	1. Master's degree (followed by national certification examination) 2. Masters degree (followed by national certification examination)
New Zealand	Nurse Practitioner Specific Area of Practice	Master's degree generally

Delamaire & Lafortune (2010), OECD Health Working Papers, No. 54, OECD ; LACE Consensus Model 2008; (APRN Consensus Work Group et al., 2008; Scope of Practice Level 7 role descriptors (Skills for Health, 2007) Scotland; Nurse Practitioner Core Competencies Content Workgroup 2014)

<http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012; www.rcsi.ie/nursing; www.ucd.ie/nursingprogrammes

Appendix 8 Categories of Nurses in Advanced Practice Roles, Main Tasks, Education and Clinical Skills Requirement and Mentorship

Country	Categories	Main Tasks	Education and Clinical Skills Requirement for Advanced Practice	Mentorship or Clinical Supervision
Australia	<p>Advanced Practice Nurses (clinical nurses, consultants)</p> <p>Nurse Practitioners</p>	<p>Clinical / technical tasks:</p> <ul style="list-style-type: none"> advanced nurse consultation and diagnosis (advanced physiological and psychological assessment) prescription of drugs with supervision of doctors triage activity to prioritise patients education and teaching professional leadership such as dissemination of expert knowledge tasks linked to improving quality of care research <p>Same clinical / technical tasks as for advanced practice nurses</p> <ul style="list-style-type: none"> -additional clinical / technical tasks: ordering and interpretation of diagnostic tests management of a range of chronic diseases (follow-up, monitoring, health education and lifestyle advice for non-acute cases) prescription of drugs without medical supervision vaccination without a doctor prescription referral of patients to specialists 	<p>Graduate diploma or Master's level</p> <p>Additional training (beyond initial training) 60-80 hours required for nurse prescribing</p> <p>ANP's are permitted to prescribe drugs under medical supervision taking cognisance of variations in prescription rights across states</p> <p>ANP's are permitted to order and interpret diagnostic tests including X-Rays and diagnostic ultrasound.</p>	<p>Both may prescribe drugs in some regions with medical supervision.</p> <p>Nurse practitioners and Advanced Practice Nurses in some regions may order and administer drugs and administer vaccinations without medical supervision</p>
Canada	<p>Clinical Nurse Specialists</p> <p>Nurse</p>	<ul style="list-style-type: none"> assess patients develop or contribute to the plan of care, and intervene in complex situations within selected clinical specialty and provide consultation provide clinical teaching and promote evidence- 	<p>Training is included in nurse practitioner education programme</p>	<p>Nurse practitioners in acute care settings can prescribe under medical directives (indirect medical supervision)</p>

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	Practitioners- 2 categories: (Primary care, acute care adult paediatric and neonatal)	<p>based practice</p> <ul style="list-style-type: none"> • review existing research evidence • lead and facilitate change in a range of areas • provide comprehensive care to clients of all ages including health promotion and disease prevention in the specialist area of practice, 		Nurse practitioners in primary care (community-based can prescribe drugs without medical supervision)
Ireland	<p>Advanced Midwife Practitioner</p> <p>Advanced Nurse Practitioners</p>	<ul style="list-style-type: none"> • make alterations in prescribed clinical options along agreed protocol guidelines • provide consultancy in education and clinical practice to nursing colleagues and the wider interdisciplinary team • Prescribe medication and Ionising radiation (with additional education, training) • Hold autonomy in clinical practice, education, leadership and research • Provide case management and follow-up, monitoring, health education and practice. 	<ul style="list-style-type: none"> • Master's level education • Minimum of 5 years working in the specialist area of practice • Additional training (beyond initial training): 6 month post registration programme at Bachelor's degree level by undertaking the Certificate in Nurse Prescribing of 6 months duration • Have undertaken a specialist clinical practicum in the specialist area of practice 	<p>Mentorship by medical consultant for both advanced practice and nurse/midwife prescribing and ionising radiation.</p> <p>Have undertaken a minimum of 500 hours of mentored clinical specialist practice</p> <p>All nurses/midwives may supply and administer drugs under medication protocol agreed and signed by the relevant medical practitioners and the health service provider after taking Cert in nurse prescribing and registering with An Bord Altranais (NMBI)</p>

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				ANP's may not interpret X-Rays.
Finland	1- Public Health Nurses PHN's (with advanced degree) 2- Nurses (with advanced degree)	<ul style="list-style-type: none"> advanced nurse consultation and diagnosis (advanced physiological and psychological assessment) ordering and carrying out diagnostic tests (including diagnostic ultrasound prescription and echography) management of a range of chronic diseases (follow-up, monitoring and health education and lifestyle advice for non acute cases) referral of patients to specialists 	Post-graduate diploma or Master's level degree	PHN's with advanced degrees are permitted to order and carry out diagnostic tests including prescribing
Scotland		As per Skills Framework	Bachelor level 7	May prescribe medication under supervision
Singapore		As for Scope of Practice	Master's level	May prescribe medication under supervision
United Kingdom	(Advanced) Nurse Practitioners (normally at level 7/8 but many are now at level 9)	<ul style="list-style-type: none"> advanced nurse consultation and diagnosis (advanced physiological and psychological assessment), dependent on training and competency level ordering and interpretation of diagnostic tests (including X-ray prescription, diagnostic ultrasound prescription and echography, laboratory test prescription) (dependent on training and competency level) management of a range of chronic diseases (follow-up, monitoring, health) education and lifestyle advice for non-acute cases), dependent on role and training triage activity to prioritise patients (dependent on training and competency level) referral of patients to specialists (dependent on training and competency level) 	<p>Minimum of Bachelors degree. Many ANP's hold Masters degrees</p> <p>Extensive experience in field of practice</p> <p>Continuing professional orientated toward medical consultation</p> <p>Nurse Prescribing and Ionising Radaition and other diagnostic tests prescribing may be undertaken and is dependent on training and competency level.</p> <p>ANP's may interpret X-Rays.</p>	<p>All nurses can prescribe medicines through a process called "patient group direction" delegated by a doctor.</p> <p>All categories subject to registration as nurse prescriber's</p> <p>Nurses can become independent prescriber's through completion of a training course and registration with the Nursing and Midwifery Council.</p>

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		<ul style="list-style-type: none"> • discharge management of a caseload • receive patients with undifferentiated and undiagnosed problems and make assessment of their health care needs • develop with the patient an ongoing nursing care plan for health, with an emphasis on preventive measures • have the authority to admit or discharge patients from their caseload and refer patients to other health care providers 	<p>Other skills may be undertaken that are dependent on training and competence such as triage management and patient referral.</p> <p>Additional training (beyond initial training) for prescription without supervision of a doctor: completion of non-medical prescribing course involving 26 days of theory and 12 days of practice supervised by a doctor.</p>	<p>Drugs may be prescribed with or without supervision of a medical doctor if nurse is registered as a non-medical prescriber</p>
<p>United States of America</p>	<p>1- Clinical Nurse Specialists</p> <p>2 Advanced Nurse Practitioners</p> <p>-</p>	<ul style="list-style-type: none"> • providing assessment, application of nursing principles at advanced level, expert guidance and teaching; • working effectively with clients, families and others • managing clients' physical and psycho-social health-illness status • utilizing research skills; • analyzing multiple sources of data, identifying alternative possibilities as to the nature of a health care problem and selecting appropriate treatment; • making independent decisions in solving complex client care problems; • performing acts of diagnosis and prescribing therapeutic measures consistent with the area of practice; and 	<p>Masters or doctoral degrees educationally prepared</p> <p>Has completed an accredited graduate-level education program for one of the four recognised APRN roles</p> <p>Graduate degree with a major in nursing or a graduate degree with a concentration in an advanced nursing practice category</p> <p>Has passed a national certification examination that measures APRN role and competencies</p> <p>Has maintained continued competence as evidenced by recertification In the Lace</p>	<p>Nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists</p> <p>Some may prescribe drugs under medical supervision and in some states APRN's may prescribe without supervision (OECD 2009)</p> <p>Nurse Prescribing Training included in Master's level education programme specific to the type of advanced practice registered nurse</p>

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		<ul style="list-style-type: none"> • recognizing limits of knowledge and experience, planning for situations beyond expertise, and consulting with or referring clients to other health care providers as appropriate. <p>is capable of demonstrating a greater depth and breadth of knowledge, more autonomy, a greater synthesis of data, increased complexity of skills and interventions and nurse prescribing (LACE Consensus Model 2008)</p>	<p>Recertification in the LACE Consensus Model based on knowledge and skills, licensure as a Registered Nurse</p> <p>Has the ability to demonstrate the Skills and abilities essential for an advanced practice registered nurse within the designated area of practice as an APRN in one of the four licensed roles (APRN Consensus Work Group <i>et al.</i>, 2008).</p>	
New Zealand	Nurse Practitioner Specific Area of Practice	<ul style="list-style-type: none"> • providing assessment, implementation and evaluation of patient needs and managing clients' physical and psycho-social health-illness in a collaborative manner • utilizing research skills • making independent decisions in solving complex client care problems and performing acts of diagnosis and prescribing therapeutic measures consistent with the area of practice • recognising limits of knowledge and experience, consulting with or referring clients to other health care providers as appropriate and .is capable of demonstrating a greater depth and breadth of knowledge, more autonomy, a greater 	<p>Registration with the Nursing Council of New Zealand in the registered nurse scope of practice.</p> <p>A minimum of four years experience in a specific area of practice.</p> <p>Successful completion of a clinical Masters programme approved by the Nursing Council</p> <p>Any conditions on the registered nurse scope of practice are appropriate to the intended area of practice for the nurse practitioner scope Possession of a current annual</p>	<p>Prescribes medication under his/her Scope of Practice in a safe and effective manner</p> <p>Nurse Practitioner applicants seeking registration with prescribing rights are required to have an additional qualification.</p> <p>Successful completion of an approved prescribing component of a clinical Masters programme relevant to their specific area of practice Prescribes medication under his/her Scope of</p>

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		synthesis of data, increased complexity of skills and interventions and nurse prescribing.	Practicing certificate. Demonstrated ability to meet the competencies for the nurse practitioner scope of Council of New Zealand	Practice in a safe and effective manner
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Adapted from Delamaire & Lafortune (2010), OECD Health Working Papers, No. 54, OECD ; LACE Consensus Model 2008; (APRN Consensus Work Group et al., 2008). www.nursingboard.ie; Scope of Practice Level 7 role descriptors (Skills for Health, 2007) Scotland; <http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012; <http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012.

Appendix 9 Competencies for Advanced Practice -New Zealand.

Competencies for Advanced Practice	Indicators
<p>Competency 1.1</p> <p>Practices within a nursing model to apply advanced nursing practice in the provision of health care services to client/population groups</p>	<p>Indicator: Describes the nursing model/framework identifying the values and beliefs that underpin and guide practice</p> <p>Indicator: Defines area of nursing practice in relation to client/population group including activities of health promotion, maintenance and restoration of health, preventative care, rehabilitation and/or palliative care</p> <p>Indicator: Articulates a coherent and clearly defined nurse practitioner area of practice that is characterised by advanced practice, evidence based nursing knowledge and skills</p> <p>Indicator: Demonstrates autonomous, interdependent and collaborative practice in relation to client care and within the health care team</p> <p>Indicator: Engages in activities at a local systems level that promote the positive contribution of nursing to health care delivery and health outcomes for population groups</p> <p>Indicator: Describes clinical decision making processes involved in response to actual and potential health needs and characteristics of the population group</p> <p>Indicator: Articulates an advanced level of knowledge and describes the evidence that underpins decision making</p> <p>Indicator: Demonstrates an advanced level of critical thinking in practice</p> <p>Indicator: Demonstrates ability to use advanced knowledge to effect equity of health outcomes for all clients</p>
<p>Competency 1.2</p> <p>Demonstrates accountability for practice in relation to the</p>	<p>Indicator: Demonstrates advanced practice competencies within a specific area of practice that is autonomous and collaborative</p> <p>Indicator: Demonstrates timely referral and consultation when an issue is outside scope of practice or level of expertise/experience</p>

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<p>population/client group and the parameters of practice within health care settings</p>	<p>Indicator: Collaborates, initiates and leads to ensure practice is informed by ethical decision making.</p> <p>Indicator: Demonstrates consideration of access and quality when making client care decisions.</p> <p>Indicator: Initiates and leads professional development processes based on professional practice standards and legal and ethical guidelines</p> <p>Indicator: Collaborates, initiates and/or leads professional development processes based on peer supervision and review of currency of practice</p>
<p>Competency 1.3 Demonstrates nursing leadership that positively influences the health outcomes of client/population group and the profession of nursing</p>	<p>Indicator: Takes leadership roles in complex situations across settings and disciplines</p> <p>Indicator: Considers the impact of the wider determinants of health including emerging health policy and funding and modifies practice accordingly</p> <p>Indicator: Promotes opportunities to achieve equity of health outcomes across the population group</p> <p>Indicator: Takes leadership roles in community and professional groups to achieve positive outcomes for client or population group</p> <p>Indicator: Shows leadership in professional activities such as research, scholarship and policy development</p> <p>Indicator: Demonstrates skilled mentoring, coaching and teaching of health care colleagues</p> <p>Indicator: Contributes to, and participates in, national and local health and socioeconomic policy development</p>
<p>Competency 2.1 Demonstrates advanced comprehensive client health assessment skills and diagnostic decision making relevant to specific area of practice.</p>	<p>Indicator: Demonstrates advanced clinical decision making processes to;</p> <ul style="list-style-type: none"> • assess the client’s health status • make differential, probable and definitive diagnoses • implement appropriate interventions based on a systematic decision making process • evaluate client response to care <p>Indicator: Orders and interprets diagnostic tests and makes decisions/interventions based on diagnostic information, current</p>

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	<p>evidence and local practice information</p> <p>Indicator: Prioritises data collection and assessment processes in complex situations according to the client’s immediate and/or ongoing needs</p> <p>Indicator: Consults and refers to other health professionals appropriately</p>
<p>Competency 2.2</p> <p>Demonstrates advanced practice in direct client care within a range of contexts and situations</p>	<p>Indicator: Anticipates situations and acts appropriately to manage risk in complex client care situations</p> <p>Indicator: Demonstrates a creative, innovative approach to client care and nursing practice</p> <p>Indicator: Decision making is justified by extensive knowledge base and contextual data</p> <p>Indicator: Uses critical thinking to plan practice according to contextual factors</p> <p>Indicator: Identifies a clear process for consultation and collaboration with client and other health professionals</p>
<p>Competency 2.3</p> <p>Consistently involves client in decision making processes and uses client information to determine management strategies</p>	<p>Indicator: Actively explores the client’s cultural preferences, health behaviours and attitudes regarding care and incorporates information into management plan</p> <p>Indicator: Actively explores client’s ability to participate in care and incorporates information into management plan</p> <p>Indicator: Ensures client has access to, and understands, relevant information and resources on which to make informed decisions regarding care</p> <p>Indicator: Documents client involvement in decision making</p>
<p>Competency 2.4</p> <p>Demonstrates confident and independent practice that is based on the synthesis of theory and practice knowledge from nursing and other</p>	<p>Indicator: Decision making is based on an advanced level of clinical judgment, scientific evidence, critical reasoning and client determined outcomes</p> <p>Indicator: Demonstrates an extensive knowledge base in specific area of practice and applies knowledge of biological, pharmacological and human sciences</p> <p>Indicator: Demonstrates advanced level skills and performance of interventions relevant to specific area of practice</p>

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disciplines.	Indicator: Provides clinical leadership in the effective use of information technologies to support practice decisions
Competency 2.5 Uses a formal approach to monitor and evaluate client responses to interventions	<p>Indicator: Provides clinical leadership in evaluating client responses to interventions and directs the modification of the care plan accordingly</p> <p>Indicator: Systematically documents and communicates evaluation process and changes to management plan</p> <p>Indicator: Demonstrates evaluation processes that measure the efficacy of practice to client outcomes, population based outcomes and the health care environment</p>
Competency 3.1 Establishes therapeutic relationships with client that recognise the client in context and respects cultural identity and lifestyle choices	<p>Indicator: Actively assesses client’s preferences and abilities and ensures clients have access to appropriate information on which to base decisions</p> <p>Indicator: Is proactive in meeting the cultural, social and developmental needs of clients</p> <p>Indicator: Demonstrates respect for differences in cultural, social and developmental responses to health and illness and incorporates health beliefs of the individual/community into assessments and plans of care</p> <p>Indicator: Promotes client’s participation in health care decision making and self management of health needs</p> <p>Indicator: Advocates for client within the health care team and with relevant agencies in a timely and respectful manner</p>
Competency 3.2 Contributes to clinical collaboration that optimises health outcomes for the client	<p>Indicator: Leads and collaborates with other health agencies/professionals to ensure timely access and smooth transition to quality services for client</p> <p>Indicator: leads case reviews and debriefing activities</p> <p>Indicator: Initiates change and responds proactively to changing systems</p> <p>Indicator: Is an effective resource and consultant for interdisciplinary clinical staff and disseminates research findings</p> <p>Indicator: Acts as an agent to foster collaboration between members of all disciplines in the health care team to work towards seamless client care</p>

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<p>Competency 3.3 Actively involved in quality assurance activities that monitor and improve the quality of health care and the effectiveness of own practice</p>	<p>Indicator: Demonstrates responsibility for quality of health care, risk management and effective resource utilisation</p> <p>Indicator: Critiques and develops clinical standards</p> <p>Indicator: Influences purchasing and allocation of resources through use of evidence based findings</p> <p>Indicator: Participates in regular formal professional supervision</p>
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<http://www.nursingcouncil.org.nz/index.cfm/1,55,html/Competencies> accessed July 23 2012 (New Zealand)

Appendix 10 Benchmarking of Core Concepts for Advanced Practice in Ireland with 6 other countries

Core Concepts for Advanced Practice Ireland	Australia	Canada	New Zealand	United Kingdom	United States	Singapore
<i>Competencies for Management of patient status: including systematic physical assessment</i>	√	√	√	√	√	√
<i>Diagnostic and therapeutic interventions</i>	√	√	√	Within certain limits	√	√
<i>Evidence based standards of care</i>	√	√	√	√	√	√
<i>Identification of actual and potential health problems including: Evaluating history and physical findings</i>	√	√	√	√ Mainly at Level 7	√	√
<i>Analysis of history, findings & diagnostic information</i>	√	√	√	√	√	√
<i>Differentiates between normal and abnormal</i>	√	√	√	√ Mainly at Level 7	√	√
<i>Manages chronic and episodic illness</i>	√	√	√	√	√	√
<i>Develops a care plan based on findings</i>	√	√	√	√	√	√
<i>Assist and encourage families and educates based on decisions made and on</i>	√	√	√	√	√	√

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<i>circumstances</i>						
<i>Competencies for effective case management</i>	√	√	√	√ In most cases	√	√
<i>Assess for patient unstable and complex health problems</i>	√	NS	√	√ In most cases	√	√
<i>Evaluate patients changing condition</i>	√	√	√	√	√	NS
<i>Order and interpret laboratory tests</i>	√	√	√	√ In some cases	√	√ In some cases
<i>Initiate timely consultation or referral</i>	√	√	√	√	√	√
<i>Collaborate with multidisciplinary team</i>	√	√	√	√	√	√
<i>Monitor and document treatment provided</i>	√	√	√	√	√	√
<i>Competencies for effective documentation</i>	√	√	√	√	√	√
<i>Formulate care plan based on findings</i>	√	√	√	√	√	√
<i>Document rationale for diagnostics</i>	√	√	√	√ In some cases	√	√ In some cases
<i>Present material to supervisor and to teams</i>	√	NS	√	√	√	√
<i>Competencies for multidisciplinary collaboration</i>	√	√	√	√	√	√
<i>Demonstrate expert knowledge and skills of diagnosis</i>	√	√	√	√ In some cases	√	√
<i>Act ethically</i>	√	√	√	√	√	√

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<i>Collaborate in a non- threatening manner including when making clinical decisions</i>	√	√	√	√	√	√
<i>Competencies for leadership in clinical practice</i>	√	NS	√	In some cases	√	In some cases
<i>Competencies for continuous quality initiatives</i>	√	NS	NS	NS	NS	NS
<i>Competencies for supervision, mentorship and teaching</i>	√	√	√	√	√	√
<i>Competencies for patient advocacy</i>	√	NS	NS	NS	√	NS

*NS (not specified) indicates that I could not find this material. The competency may be in place
Based on Core Concepts NCNM (2008)*

Appendix 11 Supporting Governance in Creation of APN Posts as Specified in Seven Countries

Criteria	Ireland	United Kingdom	Australia	USA	New Zealand	Canada	Singapore
1. Post/Role Governed by Regulation	√	Governance structures dwells with the health care sysyem and with individual health care organisations rather than with regulatory bodies	No	√ LACE Consensus Model	√	In some states	√
2. Portfolio and competencies scrutinised by Regulatory Body/National Council /Education Committee	√	Scrutinised by local bodies	Scrutinised by local bodies and National Council	√	√	√ Scrutinised by local states	√
3. Job Title specified	√	√	√	√	√	√	√
4. Specific details re job title, title use, hours of work,	√	√ Based on local situations	NS	NS	NS	NS	√

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reporting relationships, location							
5. Person Specific Post including. offer, registration with regulatory body, MSc degree, 7 years experience in which 5 is in ANP area Hours of work Competenceis CPD	√	NS	NS except for education level	Regulated by state boards	NS	Specifies level of education at PG Diploma	√ except clinica experience required is three years
6. Sets out defined areas of responsibiity, including practice parameters, level of autonomy, expert practice, work relationships, role definition sent to	√	√	√ Defined by National Council	√ Defined by State Boards	√	√ Defined By state boards	√

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regulatory body							
7. Organisational supports for APN/ANP	√	√	NS	√	√	NS	√
Promotes and values caring as being integral to direct care in advanced practice	√	√	√	√	√	√	√
Supports innovative patient care	NS	√	√	√	NS	NS	NS
Provides a range of support systems such as discharge planning models	√	√	√	√	√	√	NS
Facilitates and supporting a wide range of teaching roles	√	Some depending on roles and levels	√	√	√	√	NS
Provides support in consulting with wide range of professionals and networks	√	√	√	√	√	√	NS
Provides support in enhancing the ANP's care giving through dissemination	√	Some	√	√	√	√	√

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of current scientific knowledge							
Provides support in undertaking assessment and evaluation across the APN spectrum	√	√ At BSc Level 6/7	√	√	√	√	NS
Provides support in professional leadership in clinical practice	√	√	√	√	√	√	√
Provides supports for mentorship/supervision, teaching and CPD supports	√	√	√	√	√	√	√
Provides budgetary supports	NS	√	√	√	NS	√	NS
Authorised to prescribe medication	√	√ in some instances	In some instances	√	√	√	√
Site Preparation for ANP	√	Not yet standardised	NS	NS	NS	NS	√
Supports development of critical thinking and reasoning skills	√	√ At different levels	√	√	√	√	√
Promotes identification of actual and potential health problems	√	√	√	√	√	√	NS

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Promotes support for effective case management and documentation	√	√	√	√	√	√	√
Promotes support for a culture of continuous quality initiatives in practice	Some	√	Some	√	NS	√	NS

Criteria benchmarked against Core Concepts for Advanced Practice in Ireland (NCNM 2008); Regulatory Board Guidelines for Accreditation of Posts (ABA 2010). (Not Specified (NS) is indicated where I have not found evidence of this criteria being mentioned. This does not imply it is not taking place).

Adapted from Delamaire & Lafortune (2010), OECD Health Working Papers, No. 54, OECD ; LACE Consensus Model 2008; APRN Consensus Work Group et al., 2008; www.nursingboard.ie; Scope of Practice Level 7 role descriptors (Skills for Health, 2007) Scotland; <http://www.nursingcouncil.org.nz/download/68/guidelines-np-sept09.pdf> pg 6 July 2012.

Appendix 12 Competencies for Prescribing Medication in New Zealand

Competency 1: Understands the regulatory and legislative frameworks, contractual environment, subsidies, professional ethics and roles of key government agencies associated with prescribing

Competency 2: Prescribes and administers medications within legislation, codes, scope and specific area of practice and according to established prescribing processes and New Zealand guidelines

Competency 3: Demonstrates accountability and responsibility in prescribing practices using evidence to make risk benefit assessments

Competency 4: Collaborates, consults with and provides accurate information to the client and other health professionals about prescribing relevant interventions, appliances, treatments or medications

Competency 5: Demonstrates an understanding in the use, implications, contraindications and interactions of prescription medications and with any other medications

Competency 6: Applies knowledge of the age-related pharmacokinetic differences and the implications for prescriptive practice on clients within the specific area of practice

Competency 7: Demonstrates an ability to limit and manage adverse reactions/ emergencies/crises.

Competency 8: Recognises situations of drug misuse, under use and overuse and acts appropriately.

Competency 9: Monitors the effectiveness of the client's response to prescribing and is actively involved in pharmacovigilance and drug monitoring

Adapted from Competencies for registration as a nurse practitioner Sept (2008) Nursing Council New Zealand.

Appendix 13 Development of Advanced Practice Posts in Ireland

The first area requirements relate to the following:

Job title: This will be Advanced Nurse or Midwife Practitioner and title of speciality.

Grade: The grade which the ANP is currently appointed at is Assistant Director of Nursing/Midwifery level on the specific hospital band

Title use: While nurses or midwives may conform to the definition of, or meet the accreditation criteria for ANP/AMP they will be eligible to apply for registration as an ANP/AMP only where they have been offered an accredited ANP/AMP post subject to registration as an ANP/AMP with An Bord Altranais.

Each nurse/midwife must be registered in the ANP/AMP Division of the Register before he/she can use the title RANP/RAMP (ABA 2010)

Whole time equivalent hours: This must be at least 19.5 hours per week

Reporting relationships: These are two fold. Professional accountability is to the Director of Nursing/Midwifery and to a medical consultant and clinical accountability is to senior nurse/midwife manager or other named professional member of the healthcare team

- Location: The department, centre or unit and the name of the hospital or service organisation where the ANP is working
- Background to the post: This is a description of the service in which the post is placed
- Purpose of the post: The main aims of the post

Second area relates to:

- Submission by Director of Nursing relating to the following:
- What the post entails
- Caseload
- Referral pathways to and from the ANP/AMP
- Scope of nursing/midwifery practice including range of illnesses and conditions and therapeutic interventions that the ANP/AMP will care for
- Level of autonomous decision making attached to the role
- Range of clinical and theoretical knowledge relevant to ANP/AMP that will be required for the role
- Specific area of expert nursing/midwifery practice the ANP/AMP will provide
- Working relationships with team while using evidence-based intervention.
- How competence is maintained.

The third area of practice relates to Professional and Leadership and includes the following:

- Areas of nursing/midwifery requiring development beyond the leadership scope of practice
- Innovative development planned for the role
- How the role will facilitate service and multi-professional practice development
- How the role will develop multi agency and inter-professional relationships and networks
- How the role will promote nursing/midwifery practice at national and international level
- How the role will provide new and collaborative health services
- How the role will develop educational programmes in a variety of settings
- How the role will provide mentoring to others in the clinical area
- How the role will provide leadership

The fourth area relates to Research and includes:

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- Outline of the role will identify nursing/midwifery research to support best practice
- Identify how the role will identify research priorities
- Identify how the role will disseminate research thus advancing clinical practice
- Outline how the role will conduct research and clinical audit
- Person Specific Qualifications

Qualifications:

- The nurse/midwife must have received an offer of an ANP/AMP An Bord Altranais accredited post with a definite start date (ABA 2010)
- Registered nurse or midwife on An Bord Altranais active Register
- Be registered in the division of ABA Register for which application is being made, or if services are spanning several areas or client groups evidence of validated competencies for practice in the areas is needed
- Hold a Master's degree or higher in nursing/midwifery or an area relevant to the specialist practice.
- The postgraduate programme must be in nursing/midwifery or an area that reflects the specialist field of practice.
- Determining relevance involves a comparison between the competencies outlined for the post and the applicant's attainment of competence.
- The educational preparation must include a substantial clinical modular component(s) pertaining to the relevant area of practice (ABA 2010).
- Experience: Applicant must have at least 7 years post-registration experience of which 5 years are in the chosen speciality
- Have substantive hours at supervised advanced practice level. The appropriate number of substantive hours required by the applicant to fulfill the competencies required by the role will be approved on an individual basis by the Committee of Advanced Practice (CAP) (ABA 2010).
- Appropriate clinical supervisors must be identified. These may include nurses, midwives, and/or other healthcare professionals. The appropriateness of professionals to supervise the clinical practice should be decided with consideration of the area of advanced practice and the particular competencies required. (ABA 2010)
- Competencies: Core and specific are identified for the role and meet the requirements as set down by An Bord Altranais. The applicant must demonstrate competencies relevant to the context of practice (ABA 2010).
- Provide evidence of continuing professional development (ABA 2010)

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- Terms of Service: Are in accordance with local/organisational/ national policy
- Review criteria in place.

This area relates to the Site Preparation template and includes areas such as identification of healthcare needs and service plans

- Legislation surrounding the governance of practice
- Insurance arrangements for the post
- Guidelines for good practice, collaboratively developed
- Benefits to patient/client from ANP/AMP service
- Ensuring that service is consistent with organisation philosophy
- Show how change will meet service plan
- Rationale for optimal location of the service
- Integration of the service into the multidisciplinary teams
- Identify areas of responsibility for candidate and others
- Resource implications are set out including staff, equipment, administration, office space, diagnostic equipment, access to research facilities, professional development opportunities, audit facilities, liaison arrangements. (NCNM 2008; An Bord Altranais 2010)

Application Process:

- The central aim of the application is to demonstrate that the applicant meets An Bord Altranais criteria for registration as an ANP/AMP and that he/she can demonstrate the required competencies to perform the role.
- Documents required for registration includes the application form and fee
- The Portfolio, which requires a wide detail should be submitted on the website:
- Transcripts from the relevant Higher Education Institution is required including the number of theoretical and clinical hours contained in the education programme

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- Employers Evaluation: Must be sent directly from employer to ABA and should include how criteria and core competencies were met
- A copy of the original document must be certified as a true copy of the original by a dedicated person
- Original documents should not be sent to ABA.
- Details of the Overview of the Assessment Process undertaken on individual applications
- The Education Office Regulation will assess application and portfolio and following this strict guidelines are followed regarding notification and the outcome (approval or rejection) may be recommended to the Committee for Advanced Practice
- Committee for Advanced Practice (CAP) will consider the application and make recommendations.

Appendix 14: Outline of Selected Universities

University of Newcastle, Australia

Programme Title: Master of Nursing - Nurse Practitioner (Masters Degree -By Coursework)

Added Value Content: This programme adds value through its additional Clinical Practicum hours. Normally clinical requirements for advanced practice nursing are 500 hours-in this case it is 658 hours.

Programme Description:

This course is for registered nurses who wish to apply for endorsement with the Nursing and Midwifery Board of Australia to work as a nurse practitioner.

The focus is on clinical practice and the programme allows for specialisation in selected areas of nursing, and in-depth study of a selected topic relevant to nursing practice.

The course aims are to prepare students academically and clinically for advanced practice through research, management or practice development, and to enable students to deal with complex issues in an inter-professional and leadership approach.

The programme is made up of 120 units of study through a range of core and directed nursing modules..

Clinical Application:

Clinical Practicum is composed of a minimum of 658 hours of embedded clinical practice in the student's specialty area of nursing

Dedicated clinical supervision and guidance is provided by approved academic and clinical supervisors

Programme Outcomes: Provided at advanced practice level and relate to the specialist clinical track

Entry Requirements:

Registered nurse

Bachelor of Science in Nursing or equivalent qualification

5 years' experience (3 years as RN plus 1 year advanced speciality practice) or relevant qualification in specialty, or relevant professional activity

International applicants require English Language skills commensurate with requirements of registration as a nurse (IELTS).

Exit Award: Master of Nursing - Nurse Practitioner (Masters Degree -By Coursework)

nursing-postgrad@newcastle.edu.au

Australian Catholic University (ACU), Sydney

Programme Title:: Master of Clinical Nursing Degree (By Coursework)

Added Value Content: This programme may be undertaken for **outreach and remote rural areas**. Graduates may seek employment in government and/or private health care facilities, rural and remote retrieval services, management, research and health promotion.

Programme Description: The programme combines theory, practice and research to enable students to explore the dynamic challenges and innovative solutions in contemporary health care in Australia

Clinical Application: The programme offers professional practice, skills and knowledge in an area of speciality Clinical Practice. The programme is delivered on-line nationally and has a strong clinical practice focus.

The structure is made up 120 units of clinical practice (CP) and the Research stream or course work stream. Clinical practicum is made up of 40 clinical practicum units in Part A, 40cp clinical nursing units from Part B; 40 cp from Part c –and additionally the research stream or course work stream. Majors in a wide range of areas may be taken.

Programme Outcomes: Are set and delivered at advanced practice level in the speciality area studied.

Outcomes on Completion: (examples are provided) The student will be able to:
Synthesise theory, nursing specific knowledge based on an appropriate model of nursing
Perform comprehensive systematic physical examinations in core and specialist areas of practice

Apply critical thinking and advanced decision -making in the selection of nursing interventions

Select appropriate interventions to obtain desired outcomes

Integrate specific outcome measurements as part of advanced level practice in order to improve specific health care outcomes

Order and interpret diagnostic tests and procedures

Undertake prescribing of medication

Entry Requirements

Be a Registered nurse

Hold the Bachelor of Science in Nursing or equivalent qualification

5 years' experience (3-4 years as RN plus 1 year advanced speciality practice); or relevant qualification in specialty; or relevant professional activity

International applicants require English Language skills commensurate with requirements of registration as a nurse (IELTS).

Exit Award: Master of Clinical Nursing Degree

studentcentre@mackillop.acu.edu.au

Advanced Nursing Practice University of Toronto, Canada

Programme Title: Certificate of Completion for a Graduate-level Course in Advanced Nursing Practice in Oncology

Added Value Content: The University of Toronto provides a range of Certificates of Completion for a Graduate-level Course. The focus difference is related to a multidisciplinary approach that is holistic with outcomes focused on improving healthcare

Programme Description: Focus is on the examination of theory and research literature from medicine and includes: sociology, psychology, socio-behavioural and nursing sciences.

Clinical Application: To provide critically based interventions in advanced level nursing practice in the care of adults with cancer and their families in the context of the multidisciplinary team

Programme Outcomes: Provided at masters degree level (examples are provided) and include:

Synthesis of cancer specific knowledge that is based on an integrated bio-psycho-social-spiritual model

Selection of, and application of critical thinking and decision -making in the selection of medical and nursing interventions

Integration of nurse-sensitive outcomes measurement as part of advanced level practice in order to improve specific health care outcomes

Entry Requirements:

Bachelor of Science in Nursing

Students do not need to be clinically focused on oncology

Prior knowledge in research design, appraisal and utilisation will be an asset

Exit Award: Certificate of Completion for a Graduate-level Course in Advanced Nursing

Practice in Oncology University of Toronto: caspp.nursing@utoronto.ca accessed Oct 2 2012

University College Dublin

Programme Title: MSc Nursing (Advanced Practice)

Added Value Content: This programme is developed in order to advance nurse practice in Ireland and to meet the needs of the Irish health care system and is unique in offering programmes such as specialist advanced practice in disease management and colorectal screening.

Programme Description: Pathways are provided in nursing, midwifery, disease management and colorectal cancer screening and in other areas of practice included those that prepare practitioners for roles within their speciality of practice.

Programmes are delivered on a full or part time basis over two years to complete the master's programme and one year to complete the graduate certificate in advance practice.

The programme aims to prepare students academically and clinically for advanced practice

Clinical Application: Applicants will undertake 500 hours of mentored supervision by a medical practitioner in the designated clinical area of practice

Develop their personal portfolio as evidence to transfer knowledge and skills into the clinical practice setting and present to An Bord Altranais prior to registration as advanced nurse practitioner.

Complete the domains of competence assessment tool prior to registration

Be able to advance their practice, extend their knowledge of research and evidence-based healthcare and to develop their roles

Obtain their clinical experiences and competencies for practice in their own hospital or community environment

Programme Outcomes: Are at advanced practice level 9 and relate to advanced nurse practice. The student will (amongst other skills and competency development):

Diagnose and manage health problems and develop interventions to improve outcomes in the specialist area

Perform comprehensive physical examinations

Order medication within his/her scope of practice

Provide health promotion in the specialist areas and in other relevant areas.

Entry Requirements:

Applicants must be registered as nurses or midwives on the live Register of Nurses maintained by An Bord Altranais.

Applicants must have a primary degree in nursing or a related subject, or hold an equivalent qualification.

To undertake the MSc Nursing (Advanced Practice Prescribing Pathway) applicants must have three years recent post registration clinical experience in nursing (this must be in the past five years) with the equivalent of one year full time experience in the specific area of practice

Applicants must have a minimum of five years post registration experience

Have three years in the chosen area of specialist

Provide evidence of continuing professional development

Provide documented support from the Director of Nursing and physician in the area of specialist practice

Designate a mentor who will provide support and supervision in practice

Provide current photocopy of: Copy of Birth cert (non UCD students only)

Provide Professional reference form

Provide An Bord Altranais PIN and date of registration

Meet English language requirements

Be working in the field of practice

Exit Award:

MSc Advanced Practice (120 credits) (Level 9)
Graduate Certificate (Advanced Practice) (60 credits)
Certification Eligibility: Registered with An Bord Altranais
www.ucd.ie/nmhs/taughtgraduateprogrammes/howtoapply

Trinity College Dublin

Programme Title: MSc Nursing (Advanced Practice Emergency)

Added Value Content: This programme was specifically developed for a cohort of nurses in the specialist area of emergency nursing, in 1998, with subsequent curricula approved by ABA/NMBI in 2005 and 2011.

Programme Description: Pathways are provided in Emergency nursing and in other areas of practice included those that prepare practitioners for roles within their Emergency speciality area of practice. The most recently approved MSc in Advanced Practice (Emergency) /PG Diploma Advanced Practice (Emergency) in 2011 incorporates both prescribing of ionising radiation and medicinal products. Programmes are delivered on a full or part time basis over two years to complete the master's programme and one year to complete the PG Diploma in Advanced Practice (Emergency)

The programme aims to prepare students academically and clinically for advanced practice in Emergency Nursing. Approximately 80% of all registered ANP's in Emergency Departments nationally have been educated through this collaborative programme approach.

Clinical Application: Applicants will undertake 500 hours of mentored supervision by a medical practitioner in the designated clinical area of practice

Develop their personal portfolio as evidence to transfer knowledge and skills into the clinical practice setting and present to An Bord Altranais prior to registration as advanced nurse practitioner.

Complete the domains of competence assessment tool prior to registration

Be able to advance their practice, extend their knowledge of research and evidence-based healthcare and to develop their roles

Obtain their clinical experiences and competencies for practice in their own hospital or community environment

Programme Outcomes: Are at advanced practice level 9 and relate to advanced nurse practice. The student will (amongst other skills and competency development):

Diagnose and manage health problems and develop interventions to improve outcomes in the specialist area

Perform comprehensive physical examinations

Order medication within his/her scope of practice

Provide health promotion in the specialist areas and in other relevant areas.

Entry Requirements:

Applicants must be registered as nurses or midwives on the live Register of Nurses maintained by An Bord Altranais.

Applicants must have a primary degree in nursing or a related subject, or hold an equivalent qualification.

To undertake the MSc Nursing (Advanced Practice Prescribing Pathway) applicants must have three years recent post registration clinical experience in nursing (this must be in the past five years) with the equivalent of one year full time experience in the specific area of practice

Applicants must have a minimum of five years post registration experience

Have three years in the chosen area of specialist

Provide evidence of continuing professional development

Provide documented support from the Director of Nursing and physician in the area of specialist practice

Designate a mentor who will provide support and supervision in practice

Provide current photocopy of: Copy of Birth cert (non UCD students only)

Provide Professional reference form

Provide An Bord Altranais PIN and date of registration

Meet English language requirements

Be working in the field of practice

Exit Award:

MSc Advanced Practice (120 credits) (Level 9)

Post Graduate Diploma (Advanced Practice Emergency) (60 credits)

Certification Eligibility: Registered with An Bord Altranais

www.tcd.ie

National University of Ireland, Galway

Programme Title: Master of Health Sciences (Advanced Practice Nursing /Midwifery)

Added Value Content: This programme is developed in order to develop the educational requirements of nurses and midwives who seek to become advanced practitioners and provides the theory to support clinical development particularly in relation to physical assessment and pharmacology related to the specialist area of practice and meets the needs of the Irish health care system.

Programme Description: Pathways are provided in nursing, midwifery, and in other areas of practice included those that prepare practitioners for roles within their speciality of practice. Programmes are delivered on a full time basis over two years and part time over three years to complete the master's programme and one year to complete the graduate certificate in advance practice.

The programme aims to prepare students academically and clinically for advanced practice

Clinical Application: Applicants will:

- undertake 500 hours of mentored supervision by a medical practitioner in the designated clinical area of practice
- develop their personal portfolio as evidence to transfer knowledge and skills into practice setting and present to An Bord Altranais prior to registration as advanced nurse practitioner.
- complete the domains of competence assessment tool prior to registration
- be able to advance their practice, extend their knowledge of research and evidence-based healthcare and to develop their roles
- obtain their clinical experiences and competencies for practice in their own hospital/community environment experiences.

Programme Outcomes: Are at advanced practice level 9 and relate to advanced nurse practice. (examples are provided) The student will amongst other skills and competency development:

- Diagnose and manage health problems and develop interventions to improve outcomes in the specialist area
- Perform comprehensive physical examinations
- Order medication within his/her scope of practice.
- Provide health promotion in the specialist areas and in other relevant areas.

Entry Requirements: applicants must:

- Be registered as nurses or midwives on the live Register of Nurses maintained by An Bord Altranais.
- Be registered on the general, midwifery, mental health or learning disability nurse division of the active Registrar or hold a professional nursing qualification deemed to be equivalent by the College of Medicine, Nursing and Health Sciences or hold an appropriate active nursing registration in the country in which they practice
- have a primary degree in nursing or a related subject, or hold an equivalent qualification (at least upper second class) or
- hold a higher diploma or postgraduate diploma in nursing, midwifery studies with appropriate experience to meet the qualifying examination in the Nursing Qualifying Examination.
- have five years post registration experience
- have three years in the chosen area of specialist (exclusive of post-registration educational programmes)
- provide documented support from the Director of Nursing and physician in the area of specialist practice
- must designate a mentor who will provide support and supervision in practice

- be working in the field of practice

Exit Award:

Master of Health Sciences (Advanced Practice Nursing /Midwifery)

Certification Eligibility: Registered with An Bord Altranais

www.nuig.ie

Royal College of Surgeons in Ireland

Faculty of Nursing and Midwifery

Programme Title:: MSc Nursing (Advance Practice) or MSc Nursing (Advance Practice) (Specialist) or Post Graduate Certificate in Nursing (Advance Practice)

Added Value Content: This programme may be undertaken by registered nurses working in the areas of Epilepsy, Neonatology or in acute or chronic medical or surgical nursing.

The programme is delivered through innovative blended learning that utilises Camtasia voice over in delivery thus permitting nurses to remain in clinical practice for a longer time than if the programme were delivered via face-to-face lectures only. Lectures and seminars are provided by a range of national and international experts in the fields.

Programme Description: The programme combines theory, practice and research to enable students to explore the dynamic challenges and innovative solutions in contemporary health care and in their specialist areas of practice.

Clinical Application: The programme offers professional practice, skills and knowledge in an area of specialty Clinical Practice. The programme has a strong clinical practice focus.

Programme Outcomes: Are set and delivered at advanced practice level in the speciality area studied.

Learning outcomes on completion: (examples are provided) The student will be able to:

- Synthesise theory, nursing specific knowledge based on appropriate models of nursing
- Perform comprehensive systematic physical examinations in core and specialist areas of practice
- Apply critical thinking and advanced decision -making in the selection of nursing interventions used in the specialist area
- Select appropriate interventions to obtain desired outcomes
- Integrate specific outcome measurement as part of advanced level practice in order to improve desired specific health care outcomes
- Order diagnostic tests and procedures
- Undertake the Certificate in Nurse or Midwife Prescribing as incorporated into the programme
- Undertake a module in Diagnostic Imaging if required
- Undertake prescribing of medication

Entry Requirements

Be Registered on the live Register held by An Bord Altranais

Hold the Bachelor of Science in Nursing or equivalent qualification

Provide evidence of having 7 years' experience (5 years in specialist area of practice)

www.rcsi.ie

University of Canterbury, United Kingdom

Programme Title: MSc Advanced Practice (Nursing, Midwifery and Occupational Therapy)

Added Value Content:

This programme is developed in order to meet the needs of the National Health Service (NHS). Nine pathways are included that prepare practitioners for roles within their speciality of practice. These pathways are in adult acute nursing; cancer nursing; community nursing; child nursing, midwifery; mental health nursing; end of life; public health nursing and occupational therapy. This programme is unique as it is also delivered to a profession outside nursing, occupational therapy and provides for an inter-professional approach to healthcare education.

Programme Description:

The programme aims to prepare students academically and clinically for advanced practice through research, management or practice development, and to enable students to deal with complex issues through an inter-professional and leadership approach.

- Focus is on the four overarching themes of advanced practice as developed in the United Kingdom. These themes are: clinical practice; leadership; teaching, coaching and mentoring and research
- Focus is also on the examination of theory and research literature from medicine and includes sociology, psychology, socio-behavioural and nursing sciences.
- The specialist pathway must be chosen prior to commencement
- Students must take compulsory modules and complete one of the pathways options.
- Modules are made up of 20 (HE level 7) credits except for the research dissertation.
- Modules are compulsory, pathway specific and include a dissertation

Clinical Application:

- Students will develop their personal portfolio as evidence to transfer knowledge and skills into practice setting.
- Five hundred hours of clinical practice under the close supervision of experienced nurse practitioners and physicians or relevant specialist is undertaken.
- Students are provided with a wide range of clinical experiences in their chosen specialist area of practice

Programme Outcomes: Are at advanced practice level and relate to the highly specialist clinical track being undertaken. (examples are provided) The student will:

- Diagnose and manage health problems
- Develop interventions to improve outcomes in the specialist area
- Perform comprehensive physical examinations
- Order and interpret diagnostic tests
- Provide health promotion in the specialist areas and in other relevant areas.

Entry Requirements:

- Relevant first degree in the health and social sciences area
- Hold the relevant registration to practice in the relevant pathway
- Applicants are usually three years post qualified
- Hold a relevant clinical role
- Have obtained managerial support
- Have obtained mentorship support for the duration of the programme
- Be working in the field of practice or have sufficient access to support studies if student is from overseas.

Exit Award:

MSc Advanced Practice (Nursing, Midwifery and Occupational Therapy)(120 credits)
Post graduate Diploma in Advanced Practice (120 credits)

Post Graduate Certificate in clinical practice pathways (60 credits)

Certification Eligibility: As for the relevant NHS registration

University of Canterbury;

[http://www.canterbury.ac.uk/courses/prospectus/programmes/courses/advanced -
practice-nursing-midwifery.asp](http://www.canterbury.ac.uk/courses/prospectus/programmes/courses/advanced-practice-nursing-midwifery.asp)

Kings College London

Programme Title: MSc Advanced Practice (Nursing)

Added Value Content:

This programme is developed in order to meet the needs of the National Health Service (NHS) and modules are mapped against the "Knowledge and Skills Framework" so that NHS practitioners can identify the relevant learning required to support career development. Access is available to extracurricular seminars and lectures provided by healthcare leaders from around the world in a multi-faculty environment. The programme draws from world leading experts from a number of world leading schools and hospitals that are providing inter-professional learning experiences.

Programme Description:

Thirteen pathways are included that prepare practitioners for roles within their speciality of practice. These pathways are in cancer care; cardiac care; case management/community matron; leadership; midwifery; child health; critical care; dermatology, diabetes; gastrointestinal nursing; nurse practitioner; nurse practitioner-district nursing; neuroscience care; palliative care; primary care nurse practitioner; public health nursing and women's health care.

Structure overview:

- Includes core content in evaluation and measurement for health care practice; evidence-based decision making in healthcare and dissertation.
- For students taking either an empirical study or a service development project as part of the dissertation module, additional modules must be passed. These additional modules include issues in the conduct of healthcare research for the empirical study, and professional development and organisational change (for service development)
- Alternatively students may choose to undertake an in-depth analysis in an area of practice or to prepare three papers for publication.
- The programme aims to prepare students academically and clinically for advanced practice through research, management or practice development, and to enable students to deal with complex issues through an inter-professional and leadership approach.
- Non-core content include advanced assessment skills and clinical specialities
- Modules taken on the BSc programmes may also be incorporated into the programme through prior learning and additional BSc modules may be taken (level 7)
- Students select from modules rated at 15-30 credits and may need to take one or more practice portfolios where practice accounts/portfolio are used to demonstrate advanced practice or specialist practice.
- The duration is typically one year to complete a certificate; two years for a diploma; three years for the MSc, and up to a maximum of six years if undertaken on a part-time basis.

Clinical Application:

- The programme is structured so that options on completion include advanced practice roles, such as nurse consultant, specialist practice roles, education, research and audit.
- The programme is designed for experienced health care professionals and is built on existing skills and expertise and modelled on the Skills Framework so that NHS practitioners may be able to identify learning to support the specialist pathway being taken.
- Students will develop their personal portfolio as evidence to transfer knowledge and

skills into practice setting.

- Advanced practitioners will be able to advance their practice, extend their knowledge of research and evidence-based healthcare and to develop their roles and is suitable for practitioners who are developing autonomous practice
- Five hundred hours of clinical practice under the close supervision of experienced nurse practitioners and physicians or relevant specialist is undertaken.
- Student will be required to provide their own clinical experiences.

Programme Outcomes:

Are at advanced practice level and relate to the highly specialist clinical track being undertaken. (examples are provided) The student will:

- Diagnose and manage health problems and develop interventions to improve outcomes in the specialist area
- Perform comprehensive physical examinations
- Order and interpret diagnostic tests
- Provide health promotion in the specialist areas and in other relevant areas.

Entry Requirements:

- Relevant first degree in the health and social sciences area (minimum second class honours)
- Hold the relevant registration to practice in the relevant pathway
- Applicants are usually three years post qualified
- Hold a relevant clinical role
- Have obtained managerial support
- Have obtained mentor ship support for the duration of the programme
- Meet English language requirements
- Be working in the field of practice or have sufficient access to support studies if student is from overseas

Exit Award:

MSc Advanced Practice (120 credits)

Post graduate Diploma in Advanced Practice (120 credits)

Post Graduate Certificate in clinical practice pathways (60 credits)

Certification Eligibility: As for the relevant NHS registration

www.kingscollege.com

Post Masters Certificate Option at University of Pennsylvania, USA

Programme Title: Post Masters Certificate Option in Adult Gerontology Acute Care Nurse Practitioner

Added Value Content: This programme is designed for nurses holding a Masters of Science in Nursing in another area of nursing who wish to obtain a specialised Adult Gerontology Acute Care Nurse Practitioner qualification/degree and thereby adding additional skills and competencies to their initial masters. Focus is also placed on governmental issues such as cost containment.

Programme Design: Focus is on developing expertise in the clinical practicum in three specific clinical practicum relating to:

- **Acute Care Nurse Practitioner: Professional Role and Clinical Practicum 1**
(development of advanced clinical competencies and decision-making; current health care issues and solutions; nursing interventions)
- **Acute Care Nurse Practitioner: Professional Role and Clinical Practicum 2**
(Expansion of advanced clinical competencies and decision-making abilities; opportunities to explore the multiple social, governmental and personal resources available to acutely ill and injured adult; application of knowledge in a collaborative manner).
- **Acute Care Nurse Practitioner: Professional Role and Clinical Practicum 3**
(Refinement and expansion of advanced practice skill and competencies; physical assessment; complex decision making; diagnostic and interventional procedures; prescriptive procedures and patient care management across the adult life continuum).

Clinical Application: Students may choose a variety of clinical experiences such as oncology, trauma, internal medicine, transplant, women's health and others at advanced level nursing practice in the care of adults with cancer and their families.

Clinical Supervision by appropriate professional preceptor with relevant clinical expertise is required prior to entry.

Programme Outcomes: Provided and obtained at advanced practice level thus allowing students to meet the multifaceted needs of their patients through a collaborative team approach.

Entry Requirements:

- Masters degree in Nursing
- Submission of syllabi from previous course work undertaken that may be transferable to this programme, following which a gap analysis is undertaken on this work.
- Normally five hundred hours of clinical practice under the close supervision of appropriately experienced nurse practitioners and physicians is undertaken
- A prior Physical Assessment programme may be required. Information is provided to potential students in relation to colleges providing Advanced Practice Programs on MSN Physical Assessment Courses through out the United States of America. An example of the module titles offered includes: Introduction to Physical Assessment, Nursing Assessment of Health across the Life Span; Advanced Health Assessment; Modes of Helping; Health Assessment; Assessment Validation; Nursing Concepts and Practice; Health Assessment.

Certification Eligibility: Graduate may apply for national certification from the American Nurses Credentialing Centre or the American Association of Critical Care Nurses and to become either certified or licensed to practice.

Exit Award: Post Master's Certificate

Post Masters Certificate Options University of Pennsylvania

Programme Title: Post Masters Certificate Option in Women's Health Care Nurse Practitioner

Added Value Content: This programme is designed for independent practitioner graduates of the Women's Health Care Nurse Practitioner programme who will have the autonomy to play a unique role in advancing the well being of women. Students may exit with the dual qualification of Women's Health Nurse Practitioner and as Certified Nurse-Midwives, and be certified as such.

Programme Description: Focus is on the improving the primary health care needs of women, from adolescence to advanced years. The programme examines influences that affect women's lives such as public policy; advances in technology; on-going research; women's health specific issues such as pregnancy, alternative medicine and primary care associated with women's health.

Clinical Application: The programme focuses on promoting and maintaining women's health throughout the lifespan.

- Students will obtain clinical experiences in a range of clinical sites by working with for example, teenagers, drug addiction, immigrant communities, and public health projects.
- Normally five hundred hours of clinical practice under the close supervision of appropriately experienced nurse /midwife practitioners and physicians is undertaken

Example of a Clinical Programmes: (6 units of study)

Foetal evaluation

Well Women Health Care Clinical

Health Care of Childbearing Women Clinical

Integration 1

Integration 11-Midwifery Integration Interpartum/Postpartum/Newborn Care,

Programme Outcomes: Provided at advanced practice level and relate to the areas mentioned above thus allowing students to meet the multifaceted needs of their patients /clients in diverse settings and are marketable in the health care system.

Entry Requirements:

- MSc Nursing; Submission of syllabi from previous course work undertaken, that may be transferable to this programme, is required and following this a gap analysis is undertaken on this work.
- Advance study in research design, appraisal and utilisation will be an asset
- Advance interview held with faculty
- Advance consultation with faculty to determine the courses needed if dual certification is being undertaken

Exit Award: Post Master's Certificate Option in Women's Health Care Nurse Practitioner

Certification Eligibility: Dual certification as Women's Health Nurse Practitioner and as Certified Nurse-Midwife.

Cedars -Sinai Medical Centre, California

Programme Title: MSc Nursing (Advanced Practice Nursing) (Specialist area)

Ceders-Sinei has received its third consecutive Magnet designation for nursing excellence and it is now the longest running Magnet designation in California, first receiving Magnet status in 2002. The medical centre is committed to continued nurse training and education and provides nurses with free educational programmes and financial assistance through the Nursing Institute.

Added Value Content:

Programmes provide nurses with advanced training in highly specialised areas thus allowing advanced practice nurses to care for patients with complex conditions who have undergone sensitive and highly technical procedures, thereby focusing on implementing intervention procedures that improve health outcomes.

Additional added value is provided through Community Outreach Programme that are designed for vulnerable and under deserved populations. Advanced practice nurses may apply for entry to these programmes. The Medical Centre offers 5,300 community activities each year and screens for medical conditions, through 60 on- going programmes. The Medical Centre partners with schools, senior citizen centres and offers training to education officers working in those areas thus helping their community to grow stronger and healthier.

Programme Description: Focus is on the specific areas related to the speciality as well as the general core subjects related to advanced practice such as systematic assessment; leadership; research and health care interventions and outcomes.

Clinical Application:

- Five hundred hours of clinical practice under the close supervision of experienced nurse practitioners and physicians is undertaken.
- Students are provided with a wide range of clinical experiences in acute specialised areas of practice and in outreach programmes.
- The programme focuses on providing primary care to patients and permits the nurse practitioner to work collaboratively with physicians and other health care professionals and relevant organisations.

Programme Outcomes: are at advanced practice level (examples are provided) and relate to the highly specialist clinical track being undertaken. The student will:

- Diagnose and manage common acute and stable health problems and develop interventions to improve outcomes
- Perform comprehensive physical examinations
- Order and interpret diagnostic tests
- Provide health promotion in the areas mentioned above and in other relevant areas.

Entry Requirements: MSc Nursing or Post Graduate Diploma

Exit Award: MSc Nursing (Advanced Practice Nursing) (Specialist area) or Post Master's Certificate (Specialist area).

Certification Eligibility: As for the relevant state licensure or registration

Cedars Sinei University: www.cedars-sinai.edu accessed Oct 2 2012

University College Los Angeles (UCLA)

Programme Title: Master of Nursing Science (MNS) Advanced Practice Nursing

Added Value Content: UCLA is one of the foremost schools of Nursing in the United States, providing a wide range of nursing programmes at advanced practice level. The focus difference is in relation to advanced nursing interventions that are focused on improving healthcare outcomes across populations.

Programme Description: Focus is on the examination of theory and research literature from nursing, medicine and other relevant disciplines and includes: sociology, psychology, socio-behavioural, research, healthcare management and leadership and nursing sciences

Clinical Application:

Five hundred hours of clinical practice under the close supervision of experienced nurse practitioners and physicians.

Students are provided with a wide range of clinical experiences in acute or chronic specialised areas of practice depending on the chosen speciality, through a multidisciplinary approach

Programmes Outcomes are at advanced practice level (examples are provided). On completion the student will be able to:

- Synthesise theory, nursing specific knowledge based on an integrated bio-psycho-social-spiritual model
- Perform comprehensive systematic physical examinations
- Apply critical thinking and advanced decision -making in the selection of medical and nursing interventions
- Select appropriate interventions to obtain desired outcomes
- Integrate nurse-sensitive outcome measurement as part of advanced level practice in order to improve specific health care outcomes
- Order and interpret diagnostic tests and procedures
- Undertake prescribing of medication

Entry Requirements to MSN:

All students must have completed and passed the following undergraduate courses at higher level prior to entering the programme:

- Statistics: that includes distributions, sampling, and tests of hypotheses, estimation, types of error, significance and Confidence Interval.
- Nursing Research: with focus on planning a research project (4 quarter units).
- Human Physiology (4 course unit) that must have been undertaken within the previous five years and that covers human system physiology through cell physiology with emphasis on membrane properties (Pathos-physiology is not acceptable)
- Approved Physical Assessment course (4 quarter units). Courses may be offered during the summer for such students.
- Basic computer skills

Exit Award: Masters or Post Master's Certificate

Certification Eligibility: As for the relevant state licensure

Advanced Nursing Practice University of Pennsylvania (Penn), USA

Programme Title: Adult Gerontology Acute Care Nurse Practitioner Programme

Added Value Content: This programme was one of the first in the United States to prepare acute care nurse practitioners for the management of patients with specialised health care needs. The programme allows advanced nurse practitioners to focus on populations of specialist interest through a collaborative, inter-professional team approach. Students are offered wide choice in clinical experiences. Some focus on the marketability of the programme to the US health care system through the provision of the dual qualifications of Nurse Practitioner and Clinical Nurse Specialist in order to meet the demands of diverse and often rural communities.

Programme Design: Focus is on developing expertise in physical assessment, complex decision-making, diagnostic and interventional procedures, prescriptive procedures and patient care management across the adult life continuum.

Clinical Application: Students may choose a variety of clinical experiences such as oncology, trauma, internal medicine, transplant, women's health and others. Interventions in advanced level nursing practice are provided in the care of adults with cancer and their families, in the context of the multidisciplinary team. During clinical practicum students are paired with acute care nurse practitioners, physicians or collaborative teams.

Programme Outcomes: Provided at advanced practice level and allow students to meet the multifaceted needs of their patients and are marketable in the health care system.

Entry Requirements:

- Post Graduate Diploma in Nursing in the speciality area of practice
- Clinical Supervision by appropriate professional preceptor with clinical expertise planned in advance of commencement of the programme
- Post Masters Certificate options in the specialist area of practice are available following the Master programme
- **Certification Eligibility:** Graduate may apply for national certification from the American Nurses Credentialing Centre or the American Association of Critical Care Nurses and to become either certified or licensed to practice. A number of nurses are dual prepared as Nurse Practitioner and as Clinical Nurse Specialist (CNS) in order that may meet the multifaceted needs of their patients at both NP and CNS levels.

Exit Award of MSc Nursing

University of Pennsylvania: www.nursing.upenn.edu/academic_programs/ accessed Oct. 2 2012

Appendix 15: Summary Advanced Practice Posts and Persons in Ireland as of May 2014

PERSONS: REGISTERED WITH NMBI	
Registered Advanced Midwife Practitioners: RAMPs	06
Registered Advanced Nurse Practitioners: RANPs	134
Total PERSONS with NMBI Registration	140

NMBI ACCREDITED POSTS PER DIVISION OF REGISTER	
RAMP: Midwifery (M)	007
RANP: Children's Nursing (CH)	009
RANP: General Nursing (G)	144
RANP: Intellectual Disability Nursing (ID)	002
RANP: Psychiatric Nursing (P)	020
RANP: Public Health Nursing (PH)	002
Total NMBI Accredited Posts	184

Post Title	Post Location	Division of the Register
Diabetes mellitus	Dublin S x 1	M
Diabetes mellitus	Limerick x 1	M
Midwifery care	Waterford x 1	M
Neonatology	Limerick x 1	M
Women's health	Dublin S x 1	M
Women's preventive health	Galway x 2	M
Ambulatory care	Waterford x 1	CH
Diabetes mellitus	Dublin S x 1	CH
Emergency	Dublin N x 2	CH
Emergency	Dublin S x 2	CH
Epilepsy	Dublin S x 1	CH
Haematology	Dublin S x 1	CH
Haematology oncology	Dublin S x 1	CH
Breast care	Dublin S x 2	G
Cardiology	Cork x 1	G
Cardiology	Dublin N x 1	G
Cardiology	Dublin S x 2	G
Cardiology emergency	Dublin N x 1	G
Cardiology emergency	Dublin S x 2	G
Cardiology emergency	Kildare x 1	G
Cardiothoracic	Dublin S x 4	G
Cardiothoracic	Galway Private x 1	G
Colorectal	Cork x 1	G
Diabetes mellitus	Cork x 1	G
Diabetes mellitus	Dublin N x 1	G
Diabetes mellitus	Dublin Private x 1	G
Diabetes mellitus	Galway x 1	G

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Diabetes mellitus	Kilkenny x 1	G
Diabetes mellitus	Mayo x 1	G
Emergency	Cavan x 1	G
Emergency	Clare x 3	G
Emergency	Cork x 6	G
Emergency	Donegal x 2	G
Emergency	Dublin N x 12	G
Emergency	Dublin Private x 4	G
Emergency	Dublin S x 10	G
Emergency	Galway x 7	G
Emergency	Kerry x 3	G
Emergency	Kildare x 2	G
Emergency	Kilkenny x 1	G
Emergency	Limerick x 3	G
Emergency	Louth x 5	G
Emergency	Mayo x 1	G
Emergency	Meath x 3	G
Emergency	Monaghan x 1	G
Emergency	Sligo x 2	G
Emergency	Tipperary North x 1	G
Emergency	Tipperary South x 1	G
Emergency	Waterford x 3	G
Emergency	Westmeath x 2	G
Emergency	Wexford x 2	G
Epilepsy	Dublin N x 2	G
Gastroenterology	Dublin S x 1	G
Haematology	Galway x 1	G
Haematology	Offaly x 1	G
Heart Failure	Dublin N x 1	G
Heart Failure	Dublin S x 1	G
Neonatology	Cork x 1	G
Neonatology	Dublin N x 2	G
Neonatology	Dublin S x 2	G
Neonatology	Galway x 1	G
Neonatology	Limerick x 1	G
Neonatology	Louth x 2	G
Neonatology	Waterford x 1	G
Occupational Health	Dublin S x 1	G
Older community	Dublin N x 1	G
Older Person Care of	Tipperary South x 1	G
Older Person Dementia	Tipperary South x 1	G
Older Person Rehabilitation	Cork x 1	G
Oncology	Donegal x 1	G
Oncology	Dublin Private x 1	G
Oncology	Galway x 1	G
Oncology	Mayo x 1	G

ADVANCED PRACTICE LITERATURE REVIEW CARRIED OUT BY Prof Carney on behalf of NMBI

Oncology	Offaly x 1	G
Oncology Radiation	Galway x 1	G
Ophthalmology	Dublin S x 1	G
Pain Management	Dublin N x 1	G
Pain Management	Galway x 1	G
Palliative Care	Dublin S x 1	G
Primary Care	Leitrim x 1	G
Primary Care	Dublin S x 1	G
Rheumatology	Dublin S x 1	G
Rheumatology	Cork x 1	G
Rheumatology	Leitrim x 1	G
Sexual Health	Dublin S x 1	G
Specialist Palliative Care	Louth x 3	G
Stroke Care	Dublin S x 1	G
Urology	Galway x 1	G
Vascular	Galway x 1	G
Women's Health	Limerick x 1	G
Women's Health	Dublin S x 2	G
ID Co-existing MH Dis	Sligo/Leitrim x 1	ID
Positive Behaviour Support	Cork: COPE Foundation	ID
Child & Adolescent MH	Dublin S x 1	P
Child & Adolescent MH	Dublin Private x 1	P
CB Psychotherapy	Dublin S x 1	P
CBT	Laois x 1	P
CBT	Sligo/Leitrim x 2	P
Dementia Care	Clare x 1	P
Dementia Care	Donegal x 1	P
Eating disorders	Dublin Private x 1	P
Forensic Mental Health	Dublin S x 1	P
Liaison Mental Health	Galway x 1	P
Liaison Mental Health	Mayo x 2	P
MH and Psychotherapy	Cork x 1	P
MH Psychotherapy in PC	Cork x 1	P
Psychotherapy	Cork x 2	P
Recovery M H	Mayo x 1	P
Recovery Rehab MH	Limerick x 1	P
Recovery Rehab Psy	Galway x 1	P
Child Health Parenting	Donegal x 1	PH
Older Adults Community	Dublin S x 1	PH

NMPDUs

The Nursing and Midwifery Planning and Development Units (NMPDUs) work with Healthcare Facilities (except Private Healthcare Facilities) in the development of Advanced Practice Posts.

Each NMPDU works with the Healthcare Facilities in a geographical area per County.

<http://www.hse.ie/eng/about/Who/ONMSD/NMPDUU>

ADVANCED PRACTICE LITERATURE REVIEW CARRIED OUT BY Prof Carney on behalf of NMBI

NMPDU	COUNTIES
DUBLIN (North and North East)	Cavan; Louth; Meath; Monaghan; Dublin North (N)
DUBLIN (Mid Leinster and Midlands)	Dublin South (S); Kildare; Wicklow; Laois; Longford; Offaly; Westmeath
SOUTH (Cork/Kerry and South East)	Cork; Kerry; Carlow; Kilkenny; Waterford; Wexford; Tipperary South
WEST (North West and West/Mid-West)	Tipperary North; Clare; Galway; Limerick; Mayo; Roscommon; Leitrim; Donegal; Sligo

This figure will expand over the following years