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CHAPTER 1: BACKGROUND

Maria Neary NMBI

COMMISSION ON NURSING

In 1998 the Report from the Commission on Nursing: A Blueprint for the Future, recommended the establishment of the National Council for Nursing & Midwifery (NCNM) with one of its functions being the development of advanced nursing & midwifery posts & persons.

The Commission recommended a three step clinical career path in nursing and midwifery, one of which was advanced practice. It further recommended that t to use the title of "advanced nurse or midwife practitioner", a nurse or midwife must be appointed to a particular post. It also recommended that programmes intending to prepare nurses and midwives for the role of ANP should have a large component of clinical practice (competency being assessed during the programme).

NATIONAL COUNCIL FOR NURSING & MIDWIFERY

Over a ten-year period 2001 to 2010, the NCNM approved (or deemed criteria to have been met) 154 Advanced Practice Posts and accredited (or deemed criteria to have been met) 95 Advanced Nurse/Midwife Practitioners.

AN BORD ALTRANAIS: NOW NMBI

In 2010, the Department of Health transferred the area of advanced practice from the NCNM to An Bord Altranais through the Statutory Instrument S1 3 of 2010 Refer: http://www.irishstatutebook.ie/2010/en/si/0003.html

In order to operationalize this transfer, SI 689 of 2010, Nurses Rules 2010 were written Refer: www.nursingboard.ie publications/current.

When advanced practice transferred from NCNM to NMBI (previously An Bord Altranais) application was made by the healthcare agencies to have the advanced practice posts accredited by NMBI via Registration Department assessment only. To date no application has been received in regard to 13 posts. One post lost funding prior to the transfer.
93 of the 95 NCNM Advanced Practitioners applied for An Bord Altranais registration via Registration Department assessment only. Of the other two, 1 post lost funding & 1 person moved to another post & required full educational assessment & was subsequently registered
COMMITTEE OF ADVANCED PRACTICE & REGISTRATION COMMITTEE

A Committee of Advanced Practice (CAP) was established by An Bord Altranais to deal with matters pertaining to advanced practice. At its meeting on 05 August 2010, the Board of An Bord Altranais delegated to CAP the authority to make a determination in accordance with S.I. No 3 of 2010 to recommend to the CEO accreditation of an ANP or AMP post, which meets the criteria, set down by the National Council. The Board delegated to CAP the authority to make a determination in accordance with S.I. No 3 of 2010 to recommend to the CEO registration of an applicant in the ANP or AMP Division of the Register, who meets the criteria, set down by the National Council. Between 01 September 2010 & 18 September 2012, there were 10 meetings of CAP

Following the first meeting of the newly elected Board under the Nurses & Midwives Act 2011, a committee known as the Registration Committee was formed and among other functions, the Registration Committee took over the functions of CAP. Between July 2013 & July 2014 there were seven meetings of the Registration Committee.

Using the NCNM criteria, the Nursing and Midwifery Board of Ireland (NMBI) and formerly An Bord Altranais:

Accredits Advanced Practice Posts through a rigorous assessment process including a full site visit and presentation to the Registration Committee (RC) of NMBI (formerly Committee of Advanced Practice of An Bord Altranais: ABA CAP)

Assesses applications from nurses and midwives for registration as Advanced Nurse Practitioners (RANP) and Advanced Midwife Practitioners (RAMP)

Since transfer to NMBI December 2010 (An Bord Altranais) to 31 July 2014, the Committees (CAP & Registration Committee) activity has been as follows:
New Posts x 56 (including 12 duplicates)
New Persons x 60
Other x 5 (including re-accreditation due at time of transfer & site visit of with NCNM approved post)
There are currently nine new Posts at educational assessment stage.
There are over 70 new Posts at different stages of development in the healthcare facilities with possible submission to NMBI between 01 October 2014 & end June 2015.

OVERVIEW AT 01 OCTOBER 2014	
POSTS NMBI ACCREDITED	193
PERSONS NMBI REGISTERED	146 (including 5 on leave of absence)
√ PIN = Person in Post	141
(B) RANP/RAMP on leave of absence	5
(C) RANP/RAMP moved to another post	2
(D) RANP/RAMP has resigned/retired from the Post	5

POSTS & PERSONS PER DIVISION OF REGISTER AT 01 OCTOBER 2014		
Division of NMBI Register	POSTS	PERSONS
Nursing Children's	9	8 (including 1 leave of absence)
Nursing General	153	116 (including 4 leave of absence)
Nursing ID	2	1
Nursing Psychiatric	20	13
Nursing Public Health	2	2
Midwifery	7	6
TOTAL	193	146

DIVISIONS OF THE REGISTER PROFILE AT 01 OCTOBER 2014											
Register	Total	Female	Male	RGN	RCN	RPN	RNID	RPHN	RNP	RNT	RM
Total Register	93,234	85,948	7,284	77,239	5,730	13,550	5,762	3,375	742	859	18,090
Inactive Register	29,343	27,004	2,339	24,311	1,472	5,001	1,133	1,030	13	239	7,056
Active Register	63,891	58,944	4,945	52,928	4,258	8,549	4,629	2,345	729	620	11,034
RANPs	140	113	27	130	15	20	2	2	114	10	24
RAMPs	6	6	0	6	1	0	0	0	4	0	6

FOR FURTHER STATISTICS REFER TO APPENDIX A

CHAPTER 2: REVIEW OF NCNM CRITERIA

Maria Neary NMBI

A project was set-up to review the NCNM criteria and to develop standards and requirements regarding ADVANCED PRACTICE and a team was established known as: Working Group Advanced Practice (WGAP). In February 2014 a review of the NCNM criteria commenced in order to develop revised standards & requirements for advanced practice. Until these standards & requirements are satisfactorily operational, the assessment of advanced practice Posts & persons will continue as at present.

To advise & assist with the development of standards & criteria, a working group was established called: Working Group Advanced Practice Cross Functional Team 7 (WGAPXFT7). The project team charged with development of the draft standards and requirements for advanced practice was established from expertise from within and outside NMBI. An invitation was extended to staff within NMBI to be part of the team and expert representation was sought from a number of different key stakeholders as follows:

Representing	How Decided	Rationale
President or Vice President	Board Meeting	Governance Structure
Public Representative on Reg Comm	Reg Committee	Importance of public involvement
Chairperson Registration Committee	Reg Committee	Involvement in Advanced Practice Issues
HEI Offering Specific MSc/Post Graduate Diploma in Advanced Practice	Nursing/Midwifery Heads HEIs	Involvement in development of programmes approved by NMBI
DON/DOM with history of advanced practice posts	IADNMS	Clinical involvement with posts and the person to whom ANP/AMP is professionally accountable
Consultant with experience of clinical supervision of ANPs/AMPs	Letter to Irish Hospital Consultants Association	Involvement with clinical supervision, and the person to whom the ANP/AMP is clinically accountable
Office of Nursing and Midwifery Services Director ONMSD	Letter to Director	Financial and other involvement with advanced practice
Quality and Patient Safety Directorate	Letter to Director	Directorate promotes greater involvement of patients and the public in designing and delivering health services
Clinical Indemnity Scheme CIS	Letter to Director	Ensuring indemnity of profession
IAANMP	Letter to Chair	Advanced Practice Professional Organisation
ANP/AMP Forum RCSI	Letter to Chair	Specific Education Forum
ANP of long standing	Invite to V Small	Experience of development of Advanced Practice
ANP involved in NMBI Site Visits	Decided by Education Officer when above agreed	Experience in Site visit process and emerging issues
Subject Matter Expert	Invitation from CEO	Subject Matter Expert
NMBI Staff	Self-interest declared	

REFER APPENDIX B FOR WGAP MEMBERS

Project Parameters

To develop Standards and Requirements for Advanced Practice
for presentation to the Board of NMBI for its consideration
in line with Nurses and Midwives Act 2011
to facilitate the Commencement Order/s pertinent to Advanced Practice.

Person Parameters

To develop standards and requirements for use by the Higher Education Institutions and prospective employers regarding Advanced Nurse Practitioners (ANPs) and Advanced Midwifery Practitioners (AMPs) in order that a nurse/midwife may apply for registration with NMBI.

Post Parameters

To develop governance criteria for facilities where there are ANP/AMP Posts.

Governance Structure

Working Group Advanced Practice established to advise Education Officer Regulation NMBI

Education Officer Regulation NMBI reports to Chief Education Officer, NMBI, who works within the Senior Management Team of NMBI.

Education Officer Regulation presents to Registration Committee for its consideration.

Interim Report/s from Registration Committee to the Board of NMBI for its deliberation.

Final Draft Report from Registration Committee to the Board of NMBI for its decision.

Where relevant and appropriate, liaise with Rules Team.

Project Sponsor

Chief Education Officer, NMBI

Project Lead

Education Officer Regulation NMBI

Administrator

Rose Lindsay rlindsay@nmbi.ie

Methodology

The methodology being used comprises:
In-Depth Literature Review by Prof Carney on behalf of NMBI

Information sharing through: all NMBI Advanced Practice Presentations; NMBI website; NMBI Regulation Matters

Consultation: Each WGAP member consults with persons in the structure/s that she/he is representing

Survey: Via Survey Monkey (including a Pilot Questionnaire)

Focus Groups

Purposive discussions when draft Standards & Requirements are written

Provisional Timeline for WGAPXFT7
10 month period: 11 FEBRUARY 2014 to 11 DECEMBER 2014

11 February 2014 √	1st meeting WGAPXFT7
03 March 2014 √	NMBI issues Literature Review and Suggested Pilot Questions to WGAPXFT7
03 March to 21 March √	WGAP devise Survey Questions and return with comments on Literature Review to NMBI
11 April 2014 √	NMBI issues Pilot Questions to WGAPXFT7
11 April to 24 April 2014 √	WGAPXFT7 Pilot Survey Questions
May 2014 √	Section on the Project placed on NMBI website
May 2014 √	Overview placed in NMBI Regulation Matters
20 May 2014 √	Survey plus Literature Review on NMBI web
21 May 2014 √	Email issued re Survey to WGAP members; DONs/DOMs; HEIs; NMPDUs; RANPs/RAMPs
03 June 2014 √	Reminder Email issued re Survey to WGAPXFT7 members; DONs/DOMs; HEIs; NMPDUs; RANPs/RAMPs
20 May to 09 June 2014 √	Survey
23 June 2014 √	2nd meeting WGAPXFT7
16 July 2014	Invitation to Focus Groups to WGAP members; DONs/DOMs; HEIs; NMPDUs; RANPs/RAMPs
31 July 2014 √	Detailed update to Registration Committee
08 August 2014 √	Issue Half-Way Report to WGAPXFT7 Members
08 August 2014 √	Reminder re Focus Groups to WGAP members; DONs/DOMs; HEIs; NMPDUs; RANPs/RAMPs
August 2014 √	Plan Focus Groups. Plan Purposive Consultation Meetings.
02-29 September 2014 √	Focus Groups
By 15 September 2014 √	WGAP members submit Core Competencies & Guidelines re Specific Competencies
September/October 2014 √	Analysis of Focus Groups Complete Interim Report
13 October 2014 √	Issue Interim Report to WGAPXFT7
20 October 2014	3rd meeting of WGAPXFT7 Having considered the Interim Report, devise Draft: Standards & Requirements Core Competencies Guidelines for the Development of Specific Competencies
From 21 October 2014 to 11 December 2014 Write Standards & Requirements based on work to date Purposive Groups (REFER APPENDIX C) Item to Registration Committee 13 November 2014 4th Meeting of WGAPXFT7 Submit Standards & Requirements to Acting Chief Education Officer for follow-on	

CHAPTER 3: SUMMARY LITERATURE REVIEW

Prof Marie Carney

For full literature review refer: http://www.nursingboard.ie/en/join_register.aspx

Summary

A literature review was undertaken to explore the national and international role of the advanced nurse/midwife practitioner (ANP/AMP) in the context of the Nurses and Midwives Act (2011). Search engines Cinahl, Cinahl Plus and Full Text, EBSCO Support Site (2014), MedLine, PubMed and Search Mode-Boolean were utilised. The search encompassed advanced nurse/midwife practice, OECD data, university web sites and regulatory body reports relating to nursing regulation across 19 countries, educational preparation in 30 countries and to advanced practice in 6 countries: Australia, Canada, Ireland, New Zealand, United Kingdom and the United States of America, where advanced nurse practice is developed. Searches which took place from August-October 2012 and from April-May 2014 resulted in a total of 48,714 relevant articles published between 1994 and 2014. The final search was narrowed to 2063 journal articles relating specifically to ANP/AMP/APN. Qualitative analyses were undertaken on Full Texts from 1953 articles and a further 2,800 Abstracts. The aims of the study were to review and analyse the literature relating to advanced nurse and midwife practice including definitions, role, scope of practice, extended role, regulation, education, outcomes and organisational structures.

Definitions and Titles

Definitions for advanced practice were identified in 12 countries (Cronenwett et al. 2011; Pulcini et al. 2010). 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 (ANA 2010; An Bord Altranais 2008; ICN 2008). Titles and nomenclature used to describe advanced practice also vary with up to 13 different titles having been adopted (Pulcini et al. 2010). These include for example: *Australia*: Advanced Practice Nurse and Nurse Consultant (ANMC 2006); *Canada:* Clinical Nurse Specialist, Nurse Practitioner in Primary Care and Acute Care-neonatal, Paediatric and Adult (CNA 2008); *Ireland:* Advanced Nurse Practitioner, Advanced Midwife Practitioner (NCNM 2008a, c); *Singapore:* Acute Care Nurse, Medical/Surgical Nurse, Community Nurse and Mental Health Nurse; *United Kingdom:* Advanced Nurse Practitioner, Clinical Nurse Specialist, Nurse Consultant, Modern Matron, Community Matron (RCN 2012; DOH 2009, 2004); *United States*: Advanced Practice Registered Nurse (in Certified Registered Nurse Anaesthetist, Nurse Midwife and Nurse Practitioner) (APRN 2012; NCSBN 2012) and in *New Zealand:* Nurse Practitioner Specific Area of Practice (Delamaire and Lafortune 2010; Pulcini et al. 2010; NCNZ 2009; Schober 2007).

Historical Development

The term advanced practice nurse (APN) was first used in the United States, in 1965 (Ruel and Motykca 2009) and continues to be used there. APN has been used as an overarching concept to signify nurses practicing at a higher level than that of traditional nurses (Brook and Rushforth 2011; Morgan 2010; Sheer and Wong 2008). The APN role is now well established in 30 countries (Fagerstro¨m 2009; Schober and Affra 2006 c) and defined to varying degrees in Australia, Belgium,

Canada, Cyprus, Denmark, Finland, France, Ireland, Norway, Scotland, Spain, Singapore, Switzerland, Japan, New Zealand, United Kingdom and the United States. Countries are at different stages in implementing more advanced roles for nurses (OECD 2012; Delamaire and Lafortune 2010). The United States, United Kingdom and Canada have longstanding experiences of recognising nurses in APN roles with variations existing in the regulation of, level of knowledge, scope of practice, skills, competencies and categories utilised by APN's (Delamaire and Lafortune 2010). In the United Kingdom, Nurse Practitioners have been part of the National Health Service since the early 1970s with their role consolidated at the end of the 1990s (Royal College of Nursing, 2005). The growth pattern and trajectory is difficult to access because many of those 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 (Buchan et al. 2008). Role confusion exists that is caused by 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' (Currie et al. 2011). New roles are attributed mainly to cost containment by healthcare managers in an effort to delegate tasks away from more expensive doctors and provide continuity of care, thus developing new and more advanced roles for physician assistants, clinical nurse specialists and APN's. The realisation that APN's improve access to care in the face of a limited or diminishing supply of doctors, such as in Australia and Canada contributes to APN's taking on responsibility for aspects of patient care that were previously undertaken by doctors (Currie et al. 2011).

Extension to the Role

Extension to roles, that were traditionally the preserve of doctors, such as medication prescribing and patient assessment, is being taken on by advanced practice nurses. Alternative approaches to health care delivery has developed due mainly to legislative, policy and economic changes affecting health care leading to extension to the role of nurses' (Currie et al. 2011; Institute of Medicine 2011; American Nurses Association 2010; APRN 2008; Buchan et al. 2008; ICI 2008). The APN role in nursing and midwifery expanded in rural and remote areas of Australia and Canada in the mid 1960's in order to provide primary care to populations underserved by doctors, with further development in the 1990s, due to limited resources and the will to develop primary care (Institute of Medicine 2011). The Report of the Commission on Nursing (Government of Ireland 1998) recommended that registered advanced nurse practitioners (RANP) and registered advanced midwife practitioners (RAMP) should be appointed In Ireland. The role was first introduced in 2001 and ANP's/AMP's are now working in acute, chronic and primary care settings due mainly to 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 in Ireland (NCNM) and An Bord Altranais (ABA) and to changes taking place in advanced practice in other countries (Jacobs and Boddy 2008; NCNM and ABA 2005; Small 1999). The total number of advanced nurse and midwife practitioners registered with NMBI in May 2014 is 184. In the United States and Canada APN's and acute care practice nurses (ACPN's) have taken on roles in acute and primary care settings (DiCenso et al. 2009) with positive results (Meyer and Miers 2005) and Magnet hospitals report positive patient outcomes, nurse autonomy and good working relationships between nurses and doctors (Brook and Rushforth 2011; Aiken et al. 2008; Laschinger et al. 2003). The new role of community matron overlaps to a large extent with the traditional role of general practitioners as coordinators of patient care (American Nurses Association 2010). Role substitution remains problematic in, for example the Netherlands, where the role was recently introduced (Zwijnenberg and Bours 2012).

Regulation of Advanced Practice

Regulation was explored in relation to 19 countries: Australia, Canada, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, Norway, New Zealand, Singapore, Spain, Sweden, Switzerland, United Kingdom and the United States. Regulation for advanced nurse practice occurs in 10 countries: Australia, Canada, Hong Kong, Ireland, Netherlands, New Zealand, Singapore, Spain, United Kingdom and United States (APRN 2012; NCNM 2008 c). There is a lack of consistency in regulatory systems (Delamaire et al. 2010; Pulcini et al. 2010). Sweden, United Kingdom and Australia do not differentiate between regulation of nurses and regulation of advanced practice (Gardner and Duffield 2014; Gardner et al. 2010). Regulation in Ireland is through Legislation via Nursing and Midwifery Board of Ireland (NMBI Nurses Act 2011); in Japan through Legislation and Certification by the Japanese Nurses Association (Japanese Nursing Association 2010, 2006), in New Zealand through Legislation via the Nursing Council of New Zealand (Nursing Council of New Zealand 2012a, b, 2008, 2007; Moore 2005); in Singapore through Legislation (Singapore Nursing Board 2012); in the United Kingdom by the Nurses Act (1919) and the Midwives UK (1902) through the UKCC (CHRE 2009; D0H 2007) and in the Netherlands regulation of 8 health professions takes place through Legislation termed WET BIG (OECD 2012). 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 (CNA 2005). Legislation through Licensure via Boards of Nursing takes place in the United States with revamping of advanced practice nursing planned for all states by 2015 (APRN 2012; NCSBN 2012). Regulation in Sweden is through the National Board of Health and Welfare and in Spain through the Ministry of Education and General Council of Nursing (OECD 2012). Separate Regulation of Midwifery occurs in Ireland, United Kingdom, Spain, Sweden and New Zealand.

The 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 Nursing and Midwifery Board of Ireland (ABA 2010 c) 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 and that accountability and taking responsibility for individual actions are integral to professional practice www.nmc.com/regulation,but are particularly so for advanced practice. The purpose of regulation 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 (Delamire et al. 2010). Regulators in the United States argue that nurses prepared at master's level and above should be unencumbered by additional licensure requirements (APRN 2012) and 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 (Morgan 2010; CHRE 2009). Regulation of advanced practice has been described as essential for the United Kingdom (Brook and Rushforth 2011), yet, Pearson (2011) believes that regulation will hinder the progress of nursing innovation amongst all grades of nursing.

Scope of Practice

There is no uniform method of describing the scope of advanced nursing and midwifery practice. Canada, Ireland, New Zealand, Thailand and the Canadian states of Alberta and Saskatchewan published scope of practice documents throughout the 1990's to augment or clarify legislation (CNA 2008). Research indicates that 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 (Chang et al. 2010; CHRE 2009) and Brook and Rushforth (2011) argue for mandatory standards to ensure public protection for a role that they say is distinct from all other nursing roles.

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Confusion remains internationally in regard to the scope of practice of the APN/AMP. The evolvement of advanced nursing and midwifery roles requires careful benchmarking against best practice internationally thus ensuring that best practice is endorsed and maintained (Pulcini et al. 2010; Gardner and Gardner 2005). Roles need to be defined within a framework of nursing and midwifery practice (Chang et al. 2010) 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 (Gardner and Duffield 2014). Scope of Practice Frameworks need to keep pace with changing patient need and expanded according to the speciality (Pulcini et al. 2010).

In *Australia and Canada* there is no uniform method of describing a nursing activity or scope of nursing practice (Gardner and Duffield 2014). The Canadian Nurses Association (CNA 2005) 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. In *Ireland,* the scope 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 (NCNM 2010, 2009 a, b, 2008 a, b, 2005 a, b, 2004 a, b; An Bord Altranais 2010 c, d, e, 2007; 2005). In *Singapore*, the Scope of Practice is enshrined in the Regulations for Nursing (SNB 2012). New Zealand has placed 10 areas of practice onto 12 defined practice areas. For example Emergency is placed on Nurse Practitioner Lifespan Acute Care; (Gardner and Duffield 2014; NCNZ 2009). 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 an overlapping of activities within these roles, there are activities which are unique to each role (NCSBN 2012; Sheer and Wong 2008) and are beyond those attained by an individual prepared in a basic nurse registration education programme (APRN 2012). Scotland has developed the key scope of practice themes for advanced practice roles that are underpinned by key principles (Farrelly 2014; Department of Health 2010, 2004).

Clinical Criteria

Regulatory bodies and professional organisations have laid down criteria for practice (Gardner et al. 2010; Gardner et al. 2007; ANMC 2009, 2006; CNA 2009; NCNM 2008 a, b; NCNZ 2008 a, b; Kleinpell 2005). 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. Registration as a nurse or midwife, master's degree level education, trained in the assessment, diagnosis and management of complex situations and being able to provide a broad range of healthcare services, whilst working collaboratively, are typical requirements (NCNM 2008 c). The Strong Model of Advanced Practice in Australia is regarded as best representing the clinical experiences of participants in defining service parameters and as an operational framework (Chang et al. 2010).

Outcomes to Care

Research into outcomes to care delivered by CNS's, ANP's and Physicians has been undertaken. Uncertainty remains between those roles *(*Begley et al. 2013; Begley et al. 2010; Gardner et al. 2007). Findings indicate a clear difference existing between CNS's and ANP's with ANP's providing improved service delivery, greater clinical and professional leadership, developing education curricula, undertaking and publishing research with clear governance and accreditation structure (Begley et al. 2013)   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 primary care settings

(Koskinen et al. 2012, Potera 2011; Boontong et al. 2007; Kleinpell and Gawlinski, 2005), diagnostic assessment and in post-discharge management by APRN's in the USA where APN's influenced the level of hospital re-admission rates for heart failure in a positive manner (Koskinen et al. 2012; Potera 2011; Lindblad et al. 2010). Studies have demonstrated the value of APN/APM's in clinical settings and of positive outcomes such as patient satisfaction (Bergman et al. 2013), less readmissions, reduction in cost of care delivery and lower mortality rates (Koskinen et al. 2012; Institute of Medicine 2011). 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 care provided to vulnerable patients and older persons (Potera 2011; Brown and Grimes 2005). More research is needed in medication management, community care, primary care facilities, mental health, diabetes, midwifery, intellectual disability and outcomes from multidisciplinary care teams (Koskinen et al. 2012), where individual research with other health care professionals will validate clinical outcomes. Communicating the aspects of the role that are clearly nursing, those that overlap with other professionals will ensure that these professions have an awareness of the roles, leadership and quality aspects being undertaken by ANP/AMP's (Koskinen et al. 2012)

Competencies

Competence is the effective and creative demonstration and deployment of knowledge and skill in human situations which draws on attitudes, emotions, values and sense of self-efficacy of the learner as well as knowledge of procedures (Gardner et al. 2006). Competencies are defined in different ways around the world (HIQA 2014; APRN 2012 (LACE); An Bord Altranais 2010, c, d, e, 2007; DOH 2010: ANMC 2009; CNA 2008, 2005; ACNP 2003). Domains of Competence the tool used in Ireland to assess competencies for advanced practice, is made up of five domains with each domain incorporating three dimensions: performance criteria, defined standard(s) and evidence of successful performance to meet this standard (NCNM 2010, 2009a, 2008 b, 2004 a; ABA 2010 b, 2007, 2005). Competencies for advanced practice in New Zealand are similar to Ireland in terms of structure (NCNZ 2012 b, 2008 b). Competencies for advanced practice are continually being updated in order to meet changing healthcare need hence 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 (RCN 2012; NCNM 2010, 2009a, 2008 b, 2004 a; ABA 2010 b, 2007, 2005; NCNZ 2012 b, 2008 b; ANMC 2006; ACPN 2003). Refer to www.nursingboard.ie/literaturereview.
An important component of competency development relates to mentorship or clinical supervision. Candidate advanced nurse practitioners in Ireland require a mentor to supervise practice that up to now is generally a Medical mentor, who signs the ANP/AMP as competent. 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) (NMBI Survey 2014).

Educational Developments

Educational programme development was explored in 19 countries: Australia, Belgium, Canada, Czech Republic, Cyprus, Denmark, France, Finland, Germany, Ireland, Italy, Japan, Netherlands, Norway, New Zealand, Singapore, Sweden, United Kingdom, and the United States. Five selected countries: Australia, Canada, Ireland, United Kingdom and United States were explored in detail and taken as examples of advanced educational programmes in advanced practice. Educational qualifications and training requirements vary and range from diploma to masters and PhD level. Whilst

the goal is to bring advanced practice education to master's level not all countries have reached this goal (Sheer and Wong 2008). Masters level is the educational requirement that has been established in Ireland (ABA 2010 c, 2008, 2007, 2005). Preparation is typically at doctoral level in the United States (APRN 2012-LACE Model). Post Graduate Diploma in a relevant area of practice is required in Australia, Canada, Finland, Japan, Norway, United Kingdom, Sweden, Czech Republic and Cyprus (Nursing Council of New Zealand 2012 a, 2007; OECD 2012, 2006; JNA 2010, 2006; ABA 2010 c; Australian Nursing and Midwifery Council 2009; Fagerström 2009; CNA 2008; CHRE 2009; APRN 2008). Refer to www.nursingboard.ie/literaturereview.

University Delivery

Education, expertise and experience of APN's can result in differing patient outcomes and costs particularly where standardisation in educational programmes does not exist (Christiansen et al. 2013; Schober and Affara 2006a, b). Educational requirements for advanced practice vary (Cronenwett et al. 2011). 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 (Perraud et al. 2006; Delaney 2005). This bias may be due to individual preferences for areas of advanced practice or to lack of educational programmes in place to develop these areas further. Different approaches to programme title and content occur with focus on the added-value a university programme in advanced practice can offer. Twelve educational programmes for advanced practice developed by universities in Australia (2), Canada (1), Ireland (4), United Kingdom (2) and the United States (3) provide examples of best practice, innovation, choice, flexibility, pathways to entry and progression. See NMBI Literature Review (2014) www.nursingboard.ie/literaturereview for further details. Curricula for advanced practice would benefit from broadening of the content taught including 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 needs to include a substantial clinical modular component(s) pertaining to the relevant area of specialist practice. Universities in Ireland provide tailored programmes in defined practice areas such as emergency, neonatology, epilepsy and colorectal screening thus defining advanced practice in each university rather than each offering the same programme/subject content. The University of Canterbury delivers the MSc Advanced Practice (Nursing, Midwifery and Occupational Therapy) http://www.canterbury.ac.uk/courses/prospectus/programmes/courses/advanced -practice-nursing-idwifery.asp/.com to an occupation outside nursing, that of Occupational Therapy, through an inter-professional healthcare education approach. 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 / Cedars Sinai University: www.cedars-sinai.edu/ and University College, Los Angeles www.losangeles.edu/ provide specialist education for complex situations where patients have undergone highly sensitive procedures and are based on interventions to obtain better healthcare outcomes.

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 (Schober 2007). Curricula needs to include innovative 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. Education for midwifery needs consideration in relation to accountability and autonomy, competence, supervision, continuing professional development, delegation and community practice. Advanced midwifery practitioners need the Requirements and Standards for the Education of Midwifery to be flexible enough to accommodate RGN/RM's and cognisance taken of the emerging competencies of direct entry midwives in the creation and titles of advanced posts (NMBI 2014, Survey).

Prescribing of Medication

In Ireland, Australia, United States, United Kingdom, Canada and New Zealand certain categories of nurse are authorised to prescribe medication. The United States was the first country to introduce this right in the mid-1970s, followed at the beginning of the 1990s by the United Kingdom, Australia and some provinces of Canada. 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. Ireland and Singapore require the advanced practice nurse to have completed a certified programme in nurse/midwife prescribing (SNA 2012; NCNZ 2008 a; NCNM 2005). Specific programmes in Nurse Prescribing of medication and ionising radiation (X-ray) are offered by a small number of universities and other incorporate the subjects into advanced practice programmes www.facultyofnursingandmidwifery/rcsi/programmes.ie. Barriers exist in Sweden in relation to inability to prescribe medication (Bergman et al. 2013; Altersved et al 2011).

Organisational Structures for Advanced Practice

There remains confusion on how posts should be constructed, limits to the role, differentiation of roles, organisational structures needed to support the role, the role of nursing services and the governance structure needed for effective utilisation of advanced nurse and midwife practice roles across populations and commnities, in hospitals and in primary care (Gardner 2010). 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 (Begley et al. 2013; Gardner et al. 2010, 2007; Jones 2005). There is also, 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 (Cerinus and Wilson 2009; Nazareth et al. 2008; Nhan and Zuidema 2007; Roberts 1996). This has caused difficulties for nurses who are striving to expand their roles mainly due to failure to clarify the boundaries of advanced practice and has led to role curtailment in some countries (Kilpatrick et al. 2012, Zwijnenberg and Bours 2012; Middleton et al. 2011), but conversely 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 (Begley et al 2013). Australia has sought a generic description of the core features of the practice of advanced nursing (Nhan and Zuidema 2007; ANMC 2006; Roberts 1996). Scotland has developed a framework that establishes how advanced practice posts should be established in the NHS (CHRE 2009). The guiding principle is that such posts 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 (DOHC, 2011; Gardner et al. 2010, 2007; Furlong and Smith 2005).

Governance Models

The role of health care organisations in the governance and structure of advanced nurse and midwife practice poses challenges as governance models vary and often conflict. Ireland is one of few counties to have clear documentation relating to the development of the ANP/AMP (NCNM 2009 b, 2005 b) but 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. In the United Kingdom the governance structure for nurse practitioners dwells within the health care sysyem 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 will see organisational divisions purchasing 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 and areas likely to include ANP/AMP's. 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 throughout newly configured directorates and organisations. See www.nursingboard.ie/literaturereview (2104) for further details.

Job Description and Site Preparation

Inconsistent organisational preparation for the role exists (Wilson et al. 2004). Currently Site Visits in Ireland, one of the few countries where Site Visits take place, are undertaken by NMBI. It is argued that responsibility for job description and site preparation should lie with the service provider and that service requirements should lead in defining the need for the development of advanced practice posts (NMBI Survey 2014; Gardiner 2010). Currently re-registration for advanced practice takes place every 5 years post-registration and this appears to be the international norm. To re-register in Ireland RANP/RAMP should be practicing and be able to produce evidence of Continuous Professional Development, Clinical Exposure, Clinical Supervision and Competence (NMBI 2014). Refer to http://www.nursingboard.ie/en/apply_registration.aspx for registration details. 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 (APRN 2008).

Conclusion

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

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CHAPTER 4: SURVEY RESULTS

Prof Marie Carney

Summary:

This paper refers to the Working Group Advanced Practice (WGAP) Survey for Advanced Practice sent to nurses and midwives by NMBI in May 2014 and presents a summary of results obtained. Survey Monkey was used. The sample size was 250 and 193 replies were received. The survey was comprised of 32 questions. SPSS analyses of data were undertaken. Typical comments were extracted from the detailed SPSS analysis of qualitative data and the coded number of each respondent's comment is provided after each comment.   Participant confidentiality and ethical guidelines were adhered to in the development, implementation and analysis of data.

Criteria for Post

When asked if the criteria for the post should include the job description the response was: Yes 98%, No 2% with no qualitative comments made. When asked if criteria for post should include Site Preparation the response was: Yes 94%, No 6%. Typical responses made by respondents included:

"There should be no ambiguity around role description and site preparation and office space and administration support must be taken into account" (no 8)
*"NMBI should provide support to ANP/AMP when needed" (*no 9)
"External review by NMBI ensures that the nurse has the skill and resources to provide safe care for patients" (no 10).
 "If defined area is established for the need for ANP/AMP … it should be the responsibility of the employer that criteria are met and maintained" (no 12)

Responsibility for Maintaining Criteria

When asked if responsibility for maintaining criteria should rest with the employer the response was: Yes 86%, No 14%. Comments provided related to:
- Responsibility lying with the NMBI
- NMBI oversight is needed to ensure compliance
- A joint approach to responsibility is needed
- ANP's should ensure compliance
- Employers should maintain responsibility once NMBI has laid down criteria for practice and site responsibility and post creation should be the role of the organisation
- Responsibility should be maintained through conjunction with colleges and governing bodies
- A collaborative approach with senior hospital nursing managers was required
- Employer and other independent bodies should assume responsibility and ensure compliance.

Typical comments made included:

"The NMBI has an excellent system in place. This should be maintained" (no 18)
"Responsibility should be with NMBI. Otherwise those posts may not be used for what they were intended for and nurses may be compromised by their employers" (no 1)
"*There should be dual responsibility between NMBI and employer"* (no 66)

"Post development and governance must rest with the employer. The regulator should set the standard and ensure compliance of the employer through "… Statutory Declaration of Compliance" (no 10)
"Responsibility should be with the employer and regulated and reviewed by NMBI "(no's 23, 33)
"A formal structure such as job description and site preparation ensures the process is considered and the necessary governance … in place" (no 30)
" A national job description and site preparation standards could be developed for high capacity ANP roles for example Endoscopy with the onus on the employer to ensure these standards are in place to ensure site approval " (no 44).

Regulation of Advanced Practice

When asked if advanced nursing/midwifery practice should be regulated by NMBI the response was: Yes 98%, No 2% with just one comment made.

"If the individual candidate meets the criteria for a specific ANP/AMP role they should be eligible to register on the division of the register (similar to RGN, RCN, RM). This would allow the RANP RAMP to move more freely from one hospital to another but keeping the same role/discipline" (no 2)

Registeration of ANP/AMP

When asked if the ANP/AMP should be registered as a RANP/RAMP with NMBI the response was: Yes 96%, No 4% and no comments made. When asked if there should be an offer of a post before an ANP/AMP can be registered as a RANP/RAMP with NMBI the response was mixed: Yes 56%, No 44% with just one relevant comment made:

"Yes, but with fixed time to becoming registered" (no 10)**.** When asked if there should there be a defined start rate before an ANP/AMP can be registered as a RANP/RAMP with NMBI the response was: Yes 56%, No 44%. Typical comments made were:

"Yes, often people are registered but not in post" (no 10),
"Job offers by an organisation should be sufficient criteria for registration as an ANP/AMP if the employer is compliant with the requirements for the post then start dates and other specific criteria should remain within the remit of the employing organisation" (no 13)
"Start date should be defined by registration date similar to nurse prescribing "(no 18)

The question asking if the ANP/AMP should be linked to a specific post before being registered as ANP/AMP elicited Yes 59%, No 41%. There were a large number of responses with comments being shared equally between those agreeing with the question and those that did not. Comments related to:

- Movement between posts (being allowed to move between posts)
- Linkage (linked to a post on completion of training otherwise deskilling)
- Offer of post (nurse should have the offer of a post for service needs)
- Flexibility (when moving to a new anp/amp post rather than starting from scratch).
- Limiting linkage (So … linking to a specific post could be limiting for the scope that a midwife should have)
- Differences (Can be a RN with NMBI without having a defined post so don't see why RANP would be any different)

- Person Accreditation (accreditation and registration should be for the person, not the post)"
- Re-Applying (they must re-apply through NMBI for a position that they already had)
- Dual Responsibility (The regulation and registration responsibility (NMBI) and organisational (job/org) side should be separated with the oversight being maintained by NMBI to ensure quality is maintained)
- Title (ANP title is awarded to an individual and they can apply for any post)
- **Collaboration with DoN for service need if post in place**
- Competence (the anp is only an autonomous practitioner within specific parameters... she is either competent or not)
- "The ANP is not a "post".

Typical Comments made included the following:

"*The RANP should be allowed to move between posts where site preparation has already been approved*" (no 5) and
"*it makes no sense for a nurse to train as an ANP/AMP unless they are linked to a post on completion of training otherwise deskilling would be an issue*" (no 6)
"*The need for an anp/amp should be driven by service need, The nurse should have the offer of a post, and once completed the criteria there should be no delay on the part of the employer to ensure that the qualified p/amp takes up the post*" (no 7)
"*There should be no delay on the part of the employer to ensure that the qualified anp/amp takes up the post*" (no 7)
"*While I do not think that registration should be linked to the post, I feel there needs to be criteria for ongoing competence related to registration* "(no 9)
"Yes*, but with flexibility when moving to a new anp/amp post. If the job description is similar and the anp's portfolio demonstrates competence for the new post it should be more straightforward transferring rather than starting from scratch*" (no 10)
"*There needs to be more flexibility to allow the movement of ANP's between posts in a given network o hospitals.*
"*Due to current financial difficulties it is unfair to request that a post be available prior to registering with NMBI as RANP/MP*" (no 11)
."*ANP posts can be specific i.e. minor injuries etc where as the AMP can be broad. A midwife should have knowledge of all aspects of women's care in pregnancy and be able to detect deviations ... and act appropriately. So ... linking to a specific post could be limiting for the scope that a midwife should have*" (no 12)
"*Can be a RN with NMBI without having a defined post so don't see why RANP would be any different* "(no 16)
"*While registration is very important, we would not treat doctors in the same way, and say they cannot register to be a n orthro-surgeon because there is not a specific post*" (no 17)
"*Once education on programme is undertaken, accreditation and registration should be for the person, not the post*" (no 22)
"*Linking a specific post to the registration of an ANP means that should the anp move to another clinical setting to take up a similar role, they must re-apply through NMBI for a position that they already ha*d..." (no 30)
"*The regulation and registration responsibility (NMBI) and organisational (job/org) side should be separated with the oversight being maintained by NMBI to ensure quality is maintained*" (no 32)
"*It happened that if RANP's on one site are unavailable to work... an RANP from another site was unable to provide cover due to the specific post stipulation*" (No 34)

"Currently, *the anp is only an autonomous practitioner within specific parameters… she is either competent or not. It is like saying that a physiotherapist or teacher that they can only practice in one place* "(no 37)

"The *anp is not a "post". The title should be recognised as reflecting academic/clinical practice/knowledge achievement and competence. Skills should remain transferable*" (No 52)

"*In keeping with international ANP the title is awarded to an individual and they can apply for any post* "(No 55).

"*There needs to be more flexibility to allow the movement of ANP's between posts in a given network o hospitals. Consideration should be given to freeing ANP registration from being tied to a post. It would be similar to RGN registration and subject to evidence of CPD and competence maintenance. This would allow ANP's be more responsive to service and patient need*" (no 57)

Years of Practice

The question asking if the ANP/AMP should have a minimum of 7 years post-registration experience generated a response of Yes 91% No 9% with no comments made. When asked if the ANP/AMP should have a minimum of 5 years post registration practice in the chosen area of specialist practice the response was Yes 94%, No 6%. A typical comment made was:

"*It is quite clear from the literature that 5 years experience in the specialist areas of practice is needed before registering as ANP/AMP. I would see some flexibility in relation to the years of practice since registration as a nurse maybe 6 years rather than seven years*" (no 12)

Educational and Clinical Preparation for Practice

The question asking if the ANP/AMP should have obtained a master's degree or higher in nursing/midwifery, or in a relevant area to practice elicited a response of Yes 91%, No 9% with just one comment made which was "Yes".When asked if educational preparation should include a substantial clinical modular component relevant to a specialist area of practice the response was Yes 99%, No 1%. There was no qualitative comment made to this question. The question asking if the clinical modular component should be preceptor/mentored the response was Yes 98%, No 2%**.** Comments made were mixed with preference for mentoring by RANP/RAMP or joint mentorship with medical colleague. **Typical comments made were:**

"Mentorship *to* be medical or other AN/MP *or similar*" (no 3)

"*Partial. Needs to be similar to ANP in neonates whereby, person works with registrar for a number of shifts prior to assuming the role alone. Or to work similarly to junior/senior registrars who work together until deemed competent*" (no 5)

" *.. The mentoring should be provided by the* relevant clinical lead *who as part of the organisational commitment rather than being linked to the masters academic programme*" (no 6)

"*Mentors should be allowed for all disciplines" (no 10*)

"An *RANP should be involved in the mentoring process. Several examples have occurred where the mentoring has been provided solely by a medical doctor who has little understanding of ANP philosophy or ultimate role" (no 13)*

"*By an ANP/AMP" (*no 17)

"*Ideally by an AMP/ANP/ANNP"* (no 17)

"Or *clinically supervised to use the preferred term in mental health 2* (no 22)

Competency for Practice

When asked should the clinical modular component be competency based with competency sign off the response was: Yes 97%, No 3%. Typical comments made were:

"Some *form of competency tool is required to ensure candidate is meeting the clinical practice requirements of the role*" (no 1)
"*Depends on the area of practice.. Some practices will require competency sign-off. Others will not*" (no 6)
"*… Should be portfolio with evidence of competencies in it as opposed to just the competency tool*" (no 10)
"*Competency sign-off by a recognised mentor or supervisor" (no 12)*
"An *RANP should be involved in the mentoring process* (no 13)
"Clinical *proficiency determined by the lead clinician*" (no 3)
"*Reflective practice is more consistent and gives better insight to the nurse's attitude to practice" (no 15)*
"*Be assessed by a clinician and not university based*" (no 7)

When asked if the ANP/AMP should be signed off as competent by inter-professional colleagues, the following break down was provided: 36%, RANP/RAMP 27%, Medical colleague 23%, DoN/DoM 14%. Overall there were contradictory messages regarding who should sign-off the ANP/AMP as competent. Typical comments made included:

"*Competencies should be signed off by any of the above (the examples provided in question)or RAMP/interprofessional colleagues depending on the individual role may be ANP/AMP work closely with medical colleagues more than nursing colleagues and visa versa, so again options should be specific to the individual ANP.AMP*" (no 1)
" *Competency sign off should be by the DON /M and the medical consultant to whom the RANP will be responsible to*" (no 3)
"*In the event of a well established RANP in a speciality he/she could mentor an ANP candidate*" (no 4)
"*Signing off as competent should be a grade above the ANP candidate that is either a qualified ANP of at least I year or DON/M or a Medical Consultant. Should not include NCHD or any other allied health professional for example physio*" (no 6)
" *… An interdisciplinary team approach is required at present where we have limited AMP's*" (no 8)
"*… In some cases a medical colleague will not be the best placed to sign off nursing practice… there isn't always an ANP/AMP colleague available to sign-off*" (no 10)
" *… By a team of health professionals as opposed to one group*" (no 16)
" *…by a collaborative approach between medical doctor, director of nursing/midwifery, RANP/MO and relevant inter-professional colleague for example radiology…*" (no 19)
" *… more than one sign-off for example in mental health a psychologist may be appropriate …Should be carried out by the most appropriate clinical supervisor depending on the area of expertise and clinical practice case load*" (no 13).

When asked how many hours of supervised clinical hours are required respondents who replied placed their preference within the following ranges.

<100	<250	300-400	500	600-750	>1000	Difficult to say	None	Until competent	No opinion
6	6	8	42	5	10	35	0	1	36

Comments offered included:

It is *"difficult to specify 550 hours"* and *"the question is "difficult to answer as each h speciality has different components so number should be set by the competency framework for the speciality"* (no 16)
"500 approx with flexibility to meet uncertain situations" (no 63)
" some flexibility as circumstances of post and person may vary. I would think that a minimum of 20 hours per week in ANP role would maintain competence" (no 71)
"*Ratio of 1 hour clinical supervision to 30 hours clinical practice"* (no 73)

When asked what are the core competencies needed before taking up an advanced practice post a wide range of competencies were presented, most of which corresponded to the NMBI (ABA) and the National Council for the Professional Developments of Nursing and Midwifery (ABA 2010 a, b, c; 2007; NCNM 2008, 2005a, b, 2004 a, b, c, 2002, 2001) requirements for advanced nurse and midwife practice. Competencies mentioned included NMBI domains of practice and those identified as core for the speciality as per site preparation and dictated by the scope of practice for a specific post.

Professional and Clinical Responsibility

When asked if the RANP/RAMP should be professionally responsible to the DoN/DoM the response was: Yes 96%, No 4%. Comments provided were mixed.

"The *RANP may be accountable to other senior RANP in future*" (no 2)
"Should *be accountable to unit/area managers, medical consultants and DON/M"* (no 3)
"To NMBI … yes there will be a reporting relationship with DON as for any RN/RM. … Should have a collegial relationship rather than a reporting on" (no 4)
"Must not report to a similar grade" (no 14)
"Should not be responsible to a manager with no nursing background or accountability themselves" (no 15)
"Anp should be same grade as DoN but clinically more specialised, and needs autonomy to do role (no 16)
"Anp must be professionally accountable to themselves, the patient, NMBI and other regulatory bodies" (no 22)

When asked if the RANP/RAMP should be clinically responsibility to a consultant or a relevant person the response was: Yes 82%, No 18%. Comments were varied. Typical comments included:

"Should be no ambiguity regarding clinical accountability to a consultant or an appropriate clinical lead that they are clinically responsible to" *(no 11)*
"Yes, except where the ANP/AMP works in an autonomous role where this reporting would not be appropriate "(no 11)
" "ANP's are not employed by consultants and they should not be their manager otherwise the ANP will lose the core nursing attributes of the role…" (no 17)
"The ANP will have greater expertise in the specified field than the DON /DOM and should not be professionally accountable to DON/DOM. …They should work closely with consultants but not be accountable to them. They should be accountable to the NMBI" (no 23)

"… Should not be clinically accountable to a consultant as many work in the community setting ….facilitate team decision making, being respectful of individual professional backgrounds and the role each plays in determining optimum standards of patient/client care" (no 37)
"Should be a collaborative relationship with medical colleague" (no 18)
" This is a nursing role and should stay with nursing" (no 41)

Demographic Responses

Questions 25- 32 related to demographics. Survey results demonstrated that participants were overwhelming female (Female 90%, Male 10%). The age profile was in the 40-59 age brackets (40-49, 43%, 50-59, 37%). Profe qualification of respondents was broad with registered nurses predominating (Nurse 67%, Midwife 17%, HEI Educa Other 8% (other professional). Respondents were working in different grades (25% as RANP/RAMP, 17% as CNM 1, 2, DoN/ DOM, ANP/AMP 10%, Other 14% (Nurse lecturers, organisational managers) in a wide range of organisations (acute hospital, 15% in maternity hospital, older persons 9% other 17% (mental health, intellectual disability, private). AN posts established in respondents' organisation were identified as being in place in 69% and 31% responding in the nega 58% saying they had less that 5 posts and 25% had none (17% did not specify). In response to the question a respondent had experienced a healthcare episode delivered by an ANP/AMP 50% said Yes and the same number replie negative.

Conclusion

Responses and comments to the Survey have elicited a range of questions which will be discussed in six Focus Grou relevant stakeholders that are scheduled to take place around Ireland in September 2014. Findings from the NMBI Group for Advanced Practice, Literature Review, Survey Monkey and Focus Groups will form the basis for the Requi and Standards for Advanced Nurse and Midwifery Practice in Ireland in compliance with the Nurses Act 2012.

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CHAPTER 5: FOCUS GROUPS

Hilary Dunne & Rachel Dardis & Shane Dunne ISQSH; Maria Neary NMBI

Focus Groups took place nationally in September 2014 to further inform the development of standards and requirements for advanced practice. The NMPDUs supplied the venue for the Focus Groups. A request for Focus Group participants was made nationally by the NMBI. This invitation was sent to WGAP members; DONs/DOMs; HEIs; NMPDUs; AP contact list; and RANPs/RAMPs. An invitation was also placed on the NMBI website; in the NMBI Regulation Matters Publication and on the NMBI Ezine. Eight venues were organised in collaboration with the NMPDUs. These included venues in Cork; Waterford; Sligo; Limerick; Offaly; Louth; Dublin North and Dublin South.

Respondent Profile
A variety of respondents replied to the invitation to attend the Focus Groups. This included; Directors of Nursing/Midwifery (DONs/DOMs), Advanced Directors of Nursing (ADONs), Registered Advanced Nurse Practitioners (RANPs), Registered Advanced Midwife Practitioners (RAMPs), Advanced Nurse Practitioners (ANPs), Advanced Nurse Practitioner Candidates, Staff Nurse/Midwife, Nursing and Midwifery Planning and Development Units including Co-ordinators, Officers, and Directors, Clinical Nurse Managers, Director and Acting Assistant Director of Public Health Nursing, Clinical Nurse Specialists across all nursing disciplines and representing diverse practice settings, Public Health Nurse/Midwife, Professional Development Co-ordinator, Operational Manager, Emergency Department Co-ordinators across different hospitals throughout the country, a Clinical Risk Advisor and Administration for Advanced Practice (NMBI). Many different universities, institutes and hospitals from around the country were also represented in the Focus Group Sessions. Focus group sessions were held at eight different locations throughout Ireland, with some locations holding both a morning and afternoon session.

PARTICIPANTS IN THE FOCUS GROUPS	
Designation	**% of total attendance**
NMPDU	7.9%
Third Level	3.6%
DON/DOM & ADON/ADOM	11.5%
RANP/RAMP & ANPc/AMPc	32.4%
Nurse Practice Development Co-ordinator	3.6%
Clinical Specialist	15.8%
Clinical Manager	2.2%
Staff Nurse/Midwife	8.6%
Other	14.3%
Total	100%
Ten members of WGAP also attended the Focus Groups Sessions.	

Structure of Focus Groups
Twenty-six focus groups, comprising an average of 6 participants per group, were held over an eight day period between 02 & 29 September 2014. Each Focus Group Session lasted approximately 2.5 hours, and was structured to gain an in-depth analysis into the respondents' views on ANP/AMP Standards and Requirements. At each of the Focus Group Sessions, participants were assigned to groups. Each group was assigned one of two aims to discuss in detail. The groups had approximately sixty minutes to discuss and capture the views of the group participants. A number of prompts were

provided to facilitate the discussion. Each focus group respondent attending had previously received a copy of each question and each of the 14 key points to discuss. At the start of each Focus Group, the NMBI representative gave an overview of Advanced Practice in the Republic of Ireland, tracing its history to the present day. The purpose of the Focus Groups was explained, and the prompt questions were also explained but it was clearly emphasised that they were prompts and that the group had the freedom to discuss any other relevant aspects. The NMBI representative requested that particular attention be given to the possible flow in the development of a post including its governance and emphasised that in the future it was not the intention that NMBI would be involved in the site visit of new posts. All feedback was audio recorded by a researcher from the ISQSH for verbatim transcription. In addition the groups' discussion notes were collected at the end of the session. Below is a list of the two aims and each of the 14 key points (plus OTHER as determined by each group) discussed:

FIRST AIM: TO DISCUSS THE POST INTO THE FUTURE: POSSIBLE PROMPTS
Explore the guidance to be given to employers surrounding the criteria regarding the creation of advanced practice posts, for example:
1. Description of post with its caseload & location
2. The advanced element of the post in comparison to other posts
3. Need for the post
4. Benefit of the post
5. Measuring of benefit
6. Underpinning legislation, rules, guidelines
7. PPPGs
8. Nursing/midwifery framework
9. Role content: clinical; education; research
10. MDT
11. Resources
12. Insurance arrangements
13. Possible flow in the development of a post
14. Governance structures
Other

SECOND AIM: TO DISCUSS THE PERSON INTO THE FUTURE: POSSIBLE PROMPTS
Explore the Person Specification, for example:
1. Need for separate division of the NMBI Register
2. Need for Person and Post to be linked
3. Experience including specific experience
4. General education at third-level
5. Specific education at third-level
6. Substantial specific clinical modular component
7. Hours at supervised practice level with competency sign-off
8. Clinical supervision prior to commencement of the Post
9. Clinical supervision following commencement of the Post
10. Accountable professionally to
11. Accountable clinically to
12. Competencies: Global and specific
13. Demonstrating on-going competence
14. Governance Structures
Other

Methodology
The methodological approach applied to this analysis involved a qualitative research method using content theory analysis. Sources of information provided for this analysis included the results of Focus Group Sessions undertaken by the NMBI. This final report is based upon the feedback from 26 Focus Groups. This included 13 feedback sessions on the Post and 13 feedback sessions on the Person. Each Focus Group session was analysed by entering the data into QSR NVivo 9; a research software for qualitative analysis.

When analysing any qualitative data there are a number of challenges of relevance; namely, keeping track of all the data as it is coded into the various categories, and managing the categories. To this end the use of QSR NVivo software is beneficial as it allows for a flexible coding system. Text can be retrieved within its context, and there are powerful search facilities and methods to keep track of the analysis.

Focus Group Framework
The following framework was utilised when undertaking this research.
Content analysis was used to analyse the data with the use of NVivo Software Programme. The use of NVivo allows for the analysis of qualitative data in a systematic manner. While the time involved in using this software package is not insignificant, it is, nonetheless, a worthwhile exercise as it ensures that all views are recorded, and that the emphasis placed on themes is representative of the views of all those involved in the research. Analysis has involved the following steps:

Reading through all the data. Once all the transcripts were prepared for entry in NVivo, they were read to obtain a general sense of the information gathered and to reflect on its overall meaning.

Beginning the detailed analysis using content analysis. The ISQSH used the software programmes NVivo to code the data. Coding the data has involved attaching codes or labels to chunks of the data. This was done line by line, sentence by sentence or paragraph by paragraph. Initially, a starting list of codes was developed based on the fieldwork. This is often developed in association with the discussion or moderators' guide and provides a conceptual framework.

Use of the coding process to generate a description of the participants e.g. service users, service providers.

Advance of the coding through the development of additional codes, and examined the data for main thematic areas.

Developed the narrative for the respective themes. Emphasised the findings through the use of quotations.

The last step in the analysis involved producing a final interpretation of the data.

FIRST AIM: TO DISCUSS THE POST INTO THE FUTURE. EXPLORE THE GUIDANCE TO BE GIVEN TO EMPLOYERS SURROUNDING THE CRITERIA REGARDING THE CREATION OF ADVANCED PRACTICE POSTS:

DESCRIPTION OF POST WITH ITS CASELOAD AND LOCATION

A number of different discussions took place regarding the description of the post including its caseload and location. Some groups identified the need for clear guidance for employers where a service is developing an ANP/AMP post for the first time. One group suggested that this function could be provided by the NMBI.

> *"If a service is developing an advanced practice post for the first time it needs to be a step-by-step approach."*

While other groups suggested the development and use of a national or regional template for the site post description. This could be pre-populated where appropriate in terms of the post description but would leave an area for specific content to be added in.

> *"We would like to see a generic job description and a generic site preparation."*

> *"The template could be generic or regional and addendums identifying specific requirements for sites."*

It was also suggested by respondents that role definition needs to be clearer particularly in relation to ensuring a strong differentiation for both advanced nursing practice and advanced scope of practice between *"the staff nurse role, clinical nurse specialist role and the advanced nurse practitioner role."* Respondents suggested that this can be done through caseload management where a clear definition of the scope of practice should be outlined under the core concepts of the role. Respondents also identified the need to acknowledge the diversity of posts and the fact that changes may occur over time to meet patient's needs particularly as "more subsets of conditions em*erge*".

"There is a need for clarity around upper levels for case load but also the need for fluidity and an acknowledgement of diversity of posts and changes within posts to meet patient need."

"The description of the post should also be very explicit about the roles of the practitioner, including research, autonomy and practice, clinical leadership, and expert practitioner."

"The location should be fluid but the post case load needs to be very well described to get a good match."

In relation to transferability of location, several groups stated that the post should be specific to the individual thus allowing them to move sites if needed and allowing more rotation of these individuals outside of their current location.

Working across various sites did raise the issues of accountability, registration and regulation where the RANP/RAMP was working in different locations. However, it was stated that given the high level of education and training required for an ANP/AMP, that suitable arrangements including governance should be made available to those who worked across a number of sites especially considering that medical colleagues were also working across several sites. Groups suggested that the post should be linked to the *"hospital structure and should be set up in relation to that structure with appropriate governance arrangement.*

"We discussed that the post associated with the site and we acknowledged that there's issues around accountability and support when the AMP is working out of several sites."

Respondents also highlighted the role of the ANP/AMP with respect to teamwork. This was based on the fact that the role of an ANP/AMP post is one that will impact on the entire medical team, and that when an employer is designing the description of the post that he/she would need to examine the entire

medical team, how they work as a whole and how the new role will affect that team. It was recommended by these respondents that the whole service team should be analysed before the caseload can be determined. Furthermore, respondents suggested that in determining the post description, consideration should be given to the hospital group, trust structures, clinical care programmes and new PCCC structures. Finally, it was considered important that service needs analysis be undertaken as part of the decision for a post.

"Our group also discussed the fact that an advanced practitioner post or requirement for one cannot be examined individually. One would need to look at the entire team and how one role impacts another and how the team would work as a whole."

"Job and site description to be at national level rather than a hospital focus or sort of area focus."

THE ADVANCED ELEMENT OF THE POST IN COMPARISON TO OTHER POSTS

With regard to the advanced element of the ANP/AMP in comparison to other posts, respondents stated that role clarity was very important and that there was a need for measurable competencies to be outlined in the post description and these should be geared towards the ANP/AMP level. The advanced element should take into consideration research, education and clinical practice but there was also a need for some recognition around the administrative elements of the post.

Role clarity and differentiation was also discussed as groups stated that the role between staff nurse, the CNS and the ANP/AMP should be included in the post description. Differentiation between the ANP and the medic was also discussed as they stated that the debate is around the creation of the roles to fulfil gaps in other professional roles.

The role of leadership within the ANP/AMP role was also discussed. One group stated that as the ANP/AMP role was primarily concerned with the clinical component, that a lack of leadership on behalf of the AMP/AMP caused a "disadvantage in advancing and expanding in relation to more ANPs/AMPs coming on board".

Respondents discussed the need for recognisable autonomy and higher levels of decision making in relation to the advanced element of the post, stating *"that the ANP/AMP should be able to take caseloads alone from admission to discharge without reference to other professional people."*

> *"The advanced element of the RANP post should emphasise high levels of decision making, even though some parts of the role may overlap with medical and other healthcare professional roles."*

NEED FOR THE POST

In relation to the need for the post, groups stated that there was a requirement for specific guidance to be given to employers when creating the ANP/AMP post. Respondents mentioned the requirement for a needs assessment to be undertaken. This could be undertaken by the new group Directors of Nursing or the Department of Health. The needs assessment should include areas such as future projections of illness, sub sets of health conditions, population demand, and a review of national and international evidence.

> *"We would need, we still need a needs analysis to be done with regards to the need for the post."*

It was suggested that in the future the need for the post might be determined using a step by step structure. This included an initial step of the hospital or healthcare facility adoption of the idea, and then incorporation of national and international evidence to develop the business case, leading to the identification of the service need and its place in the service plan for an organisation.

Respondents also explored the fact that the need for the post could be reflected through caseloads, audits, service gaps and through patient and staff satisfaction levels. It was recommended that after the identification of the need of the post, that a strategy for the ANP/AMP development should be created by the chief director of nursing/midwifery in each hospital and/or the lead nurse/midwife who will be appointed to the hospital groups when they are developed. It was also suggested that specific

investigation should be placed on the employer before the development of the need for the post in relation to being able to provide continuous support for the person and the necessary resources.

Cost of care was also explored by groups in relation to the need for the post. Respondents specifically highlighted the importance of the establishment of finances and the resolution of any financial issues that arise with the development of the post.

More refined management of defined subsets was regarded as significant by groups in relation to the need for the post. Respondents stated that there is a need for definition and clarity of subsets of disease conditions and that they need to be further developed in relation to the need for the post. Respondents also questioned whether there are currently enough advanced nurse/midwife practitioners. These respondents believed that this will *have huge implications for budgets and for future planning."*

BENEFIT OF THE POST

A number of elements were explored in relation to the benefits associated with the post. These included organisational benefit, patient benefit including improved quality and safety, meeting local service needs, clinical programmes benefits and perceived future benefits. Organisational benefit was discussed in relation to the organisation outcomes i.e. decreased waiting lists, increased services delivered and increased education regarding both teaching and receiving education.

Patient benefit was discussed in relation to improved patient outcomes through enhanced clinical continuity of care. In relation to the comparison between patient benefits and healthcare workforce benefits, it was stated that the focus on nursing and midwifery advanced practice should be made apparent and not used to substitute or fill in the gaps of other roles.

> *"One of the benefits we want to clearly articulate is the holistic approach that advanced nurse practitioners and midwife practitioners bring to their care."*

Groups mentioned the difficulty that can be experienced in relation to articulating the financial benefits of the post. While the clinical benefit is evident it can prove difficult to demonstrate the financial benefits when developing the business case. In these instances, perceived benefits may need to be stated.

MEASUREMENT OF BENEFIT

Groups identified a number of benefits and provided examples of how these could be measured including patient centred benefits and patient satisfaction and experience measurement. Other benefits included audits on service outcomes, measurement of satisfaction levels, clinical audits, shorter hospital stays and reduction in outpatient waiting lists were also suggested along with the implementation and adoption of the Health Information and quality Authority (HIQA) recommendations. Organisational outcomes and KPIs were also discussed as important measurements of benefit. It was recommended by one group that KPI's are not only important in terms of clinical outcomes but also in "terms of targets for the employer, national KPI's and local/regional KIP's that the employer has to meet".

The possibility of streamlining the care pathway for patients was also discussed. This offered the possibility to increase patient satisfaction, improve the care pathway and reduce unnecessary appointments, all of which would ultimately result in a more efficient service. Management of care was also considered a measurement of benefit within groups specifically in relation to the amount of time dedicated to each patient.

> *"We need to be able to articulate the time that we give to the patient and how useful it is and that we give a complete episode of care and that a patient isn't in a hospital all day having to be exposed to fragmented care and meeting different people and everybody reviewing what care package that they gave. So in essence a complete management of care."*

A number of groups also discussed clinical and professional benefits, including education and research, as a measurement of benefit. This was discussed as being part of the ANP/AMP role and how the post needs to be developed to expand on the potential development of education and research and to teach others. The need to increase the educational element was specifically stated by groups as looking at part of the role of the ANP/AMP as an educator was greatly expressed.

> *"There needs to be a clinical bridge as well from the time somebody is actually a candidate right through to the time that they're actually in the post. Not just specific to the clinical component or placement."*

UNDERPINNING LEGISLATION, RULES AND GUIDELINES

A number of groups stated that the current legislative rules and guidelines were clear, essential, necessary and robust, stating that they are also integral to the post. Respondents discussed the need for the post to be protected, funded and supported. They stated that there was also a need for time to be allocated equally to education, clinical practice, competency development and audits.

While underpinning legislation, rules and guidelines are extremely important, there was a clear request for the NMBI to continue with site visits. Respondents stated that this ensured that ANP/AMP's were kept abreast of all requirements. Over regulation was a key point discussed by respondents in relation to this post criterion. They stated that caution not to over regulate the post was required. Over regulation could result "in the person in the post becoming stifled because their autonomy and flexibility" may be restricted. Respondents stated that in light of the new CPD Scheme developed by NMBI, the reaccreditation system should be phased out.

Respondents also expressed the importance of general legislation where there could be a central repository of resources that could be used for all posts. They also stated that there would also be a need for a section which would include specific guidelines for a specific post.

Particular reference to supporting autonomous practice in particular employer autonomy and the need for development of autonomous practice were discussed by groups as they felt there was no existing legislation around this area. While there is legislation to support the register, a query was made by respondents on whether this should be linked to clinical supervision by a medic or be autonomous practice in terms of supervision by a nurse. The future use of a forum of advanced practitioners developing guidelines was also suggested by respondents. It was suggested by these respondents that this would *"reduce variability, increase standardisation and increase the transferability across services in the future."*

POLICIES, PROCEDURES, PROTOCALS AND GUIDELINES (PPPGs)

When regarding PPPGs, one group specifically stated that they are essential and the employer needs to be assured that the ANP/AMP is practicing within these.

"PPPGs have an important play to play and they should be clearly linked to job description which will relate to the caseload and the location of the post."

A number of groups suggested that these could be standardised and developed regionally or nationally. The example of an ANP/AMP within the Emergency Department was provided, where standardised PPPG's could be used and amended locally if there were specific differences in the individual site. Respondents made a suggestion in relation to this, stating that a possible community involving sub-groups of advanced nurse practitioners experts could lead on the development of such regional/national PPPGs.

"The PPPGs aim for registered advanced nurse practitioner level should probably be externally reviewed and nationally standardised. It is sufficient that they are internally reviewed and approved."

"Standard data base of core PPPG's that can be adopted or adapted just to avoid replication. It's not going to work in every case but it would avoid a lot of time wasting in sites and site prep."

"Move away from a more local sort of hospital based guideline. The protocols or guidelines can be more generic and then again if it was based al local level, they can then be sort of developed upon."

A separate group also discussed the amount of effort and time that goes into the development of PPPG's in relation to site accreditation. They suggested that site accreditation can be too prescriptive and this may distract from the real objective of developing the site and candidate.

"The amount of effort and time that has to go into actually developing these when you're trying to develop the candidate and develop the site. It perhaps distracts from the real purpose of what we're trying to do. And that once somebody is actually qualified to participate in the role

that really its guidelines they should be working towards which are evidence based as opposed to being prescriptive SOPs around how you do the work on a daily basis."

NURSING/MIDWIFERY FRAMEWORK

A number of groups felt that the nursing and midwifery framework should remain as it currently stands in relation to employer guidance when creating the advance practice post. Groups also suggested that the framework could be pre-populated with samples and references appropriate to specific areas such as nursing in the ED or chronic disease management.

"The nursing and midwifery framework we felt should remain the same. We felt it was very robust and that the decision making frameworks and scope of practice framework remain as the guide."

The need for a uniform national framework was clearly articulated by one group.

"The one very strong view of the group was that we have one national framework for advanced nurse practitioner posts in the country, and whatever happens in the future, to continue one uniform national framework. It's the strength of the system here."

A number of separate groups explored a number of key points. One group of respondents discussed the fact that as the nursing framework guides the direction of nursing there is a need for more formal and established links to the chief nursing officer and the new directorates. This would provide the ANP/AMP with a real voice at the point of decision making. They also suggested that having a quarterly, biannual or annual report on ANP/AMP activity or concerns may result on more timely solutions to concerns raised. One group queried whether having one explicit framework may constrain the ANP/AMP post. They suggested as did another group that it might be better approached using a philosophy of nursing rather than a specific framework. The need to maintain either a framework or a philosophy was considered important.

ROLE CONTENT: CLINICAL; EDUCATION; RESEARCH

In relation to role content a number of points were discussed by the groups particularly in relation to the clinical element. It was considered important that the employer was aware of the standard expected from the ANP/AMP as this would provide assurances that the ANP/AMP was practicing safely and effectively. The composition of the clinical element would need to be worked out but it should include the appropriate clinic hours, competencies, and skills. Other aspects of importance included *"clinical supervision, clinical exposure, the maintenance of competency, the accountability and responsibility and support."*

Clinical supervision was discussed by one group in terms of both receiving supervision and giving supervision. They stated that there was a need for clarity for the ongoing role development particularly as it related to supervision by a senior ANP/AMP to a more junior candidate.

In relation to the education element of the role content, CPD was believed to be an essential component. There was also a discussion around the CPD scheme where respondents stated that as the CPD scheme became embedded it offers the possibility of eliminating the need for reaccreditation. A desire for the scope of practice to be reviewed annually was also discussed as this could also provide assurance to the employer that the "maintenance of competence is achieved by the RANP/RAMP and also that clinical supervision is adhered to".

The lack of support to attend clinical education days was also discussed and while respondents stated that most of the time they "attended under their own steam and are happy to do that" they felt that there should be a commitment given with regard to the time involved particularly as employers should see the value of it. Some respondents stated that the delivery of structured formal teaching by ANP/AMP's along with the future development of more encompassing relationships between the relevant practitioner and their local academic institution is of high importance. In addition, some respondents stated that the educational element could be increased and the ANP/AMP could become an educator in their own right.

In relation to the research element, respondents agreed that there is a need for "standardised protected time". The benefits of the time committed to research and audit need to be made clear to the employer, as they will benefit from the publication of papers and presentations at conferences.

Enhanced linkages and collaborations with the Health Research Board (HRB), other hospital sites and third level organisations were also discussed. Greater collaborative arrangements were seen as a

means of eliminating replication of research and as a means of reinforcing the research component through education.

MULTIDISCIPLINARY TEAM (MDT)

Multidisciplinary team interaction was considered "crucial" as they provided a means of support from fellow health professionals and allied health professionals. Links should be developed from the start as a means of supporting the implementation of the post and also become a part of the MDT in terms of research.

When new ANP/AMP posts came into effect a lot of work was required in terms of referrals particularly as some healthcare professionals and patients had no real experience of this type of service. Now that they are established they are considered a valuable part of the service provision and as such they should be considered as part of the MDT.

"We are part of the puzzle and we should all work together."

"Something that could be expanded within the document in the future, how those referral pathways are actually activated in relation to for example memorandums of understanding, and that might be something that needs to be structured more within the role in the future."

It was considered extremely important that the ANP/AMP's would have a dedicated space within the clinical area. It was also suggested that a commitment in terms of administrative support and office space would be appreciated.

RESOURCES

There was a view that standard resources should be allocated with the post and that these resources should be mandatory as the lack of resources was perceived to be a "*barrier to role development currently*".

The most explored area regarding resources was administrative issues where a number of groups specifically expressed the need for more administrative support in terms of both a dedicated work area and clerical support. The dedicated clinical area was considered very important by one group who stated that having a dedicated clinical area was important to ensure that "*we are safe and that we have time to think about the care we are providing*".

INSURANCE ARRANGEMENTS

Insurance was considered very important and it was deemed necessary that all arrangements should be made to ensure that the occupant of the role was indemnified when the post was being approved. This was particularly important in relation to the private sector as only those in the public/hospital setting were covered by vicarious liability.

"There should never be any concern about insurance and there is a feeling that at the moment that's adequate. It's not on anyone's radar particularly."

"In terms of insurance, the Clinical Indemnity Scheme (CIS) of the hospital should cover it."

"In relation to insurance and the development of the post the group were unanimous in saying the absolute imperative of being very clear on how the occupant would be indemnified when the post is being approved."

"Insurance is extremely important for this particular group. Clinical indemnity I think covers advanced practitioners in the public but in the private sector the advanced nurse and midwifery practitioners must have specific indemnity cover for their practice."

The need for the transferability of the CIS in relation to satellite clinics and job transfers was suggested by respondents. Respondents also discussed the issue of nurses working independently where they have to have their own insurance, while issues of constraint in relation to scope or role development due to insurance arrangements was also explored.

POSSIBLE FLOW IN THE DEVELOPMENT OF A POST

A number of different issues and suggestions were also explored in relation to this key point. One group stated that "*retrospective reviewing of the scope of practice*" was important as was the participation of the ANP/AMP in relevant specialist groups.

A number of different issues and suggestions were also explored in relation to this key point. These included a suggested accreditation inspection specifically in relation to a re-accreditation process by the person themselves through an updated portfolio submission, the issue of different sites having different numbers of ANPs/AMPs, and the lack of financial approval including automatic protection and ongoing inclusion in relation to year on year budgets that focus on role development and ANP/AMP participation in relevant specialist groups at national level.

Respondents also stated that the patient journey needs to be followed in terms of ensuring the development of further ANPs/AMPs within the primary care setting.

"You know the patient journey begins in primary care……and we hope that there would be support …for more ANP's and AMP's in primary care, in primary care teams and the networks in public health and community."

Respondents queried whether it would be beneficial for the RANP/RAMP candidate to have a contact person from the NMBI specifically in relation to providing support during the development stage of the post and shortly after the post is accredited. The issue of site visits was then questioned, and if deemed necessary queried who would carry them out in the future.

GOVERNANCE STRUCTURES

Groups identified a number of different examples of guidance in relation to governance structures that can be used as employer guidance when creating the post. Although groups agreed on a national governance structure, offered areas of guidance included governance arrangements that are specifically supported by the organisational structure chart, where it was suggested that this could be addressed regionally rather than locally resulting in a outlined organisational structure for all ANP/AMP posts which can be agreed upon and signed off by the consultant, the Director of Nursing, and operational directors etc. It was suggested that after a life span of five years, organisational structure of that post can then be reviewed as long as nothing within the structure has changed. In relation to re-accreditation, the structure was suggested to be "*less onerous*" when updating an existing ANP/AMP portfolio.

Shared governance in relation to the professional nursing and midwifery reporting structure was also suggested specifically in relation to the governance structures of the ANP/AMP role and the lack of

decision making when creating the role. It was discussed that this was a significant issue regarding ANP/AMP roles sitting in one area, for example a regional hospital, leaving the ANP/AMP only in particular area.

"There is a need to look at the shared governance, and what it actually means for an ANP that's maybe developed within an acute sector but is looking at going out to outreach centres across all different disciplines. There needs to be an agreement and an awareness of what that really means for everyone."

The change of a supporting clinical consultant was also discussed by a number of groups in relation to this criterion. Concern was raised regarding a dedicated clinical supervisor who provides support to the ANP/AMP in advancing and developing their role having to move on. Respondents queried whether when this occurs is there a scope for the HR to begin with or for the consultant, to allow and to ensure that the new supervisor doesn't have any choice but to ensure that the role of the ANP/AMP is continuously supported.

"You may have an ANP in a post who is being supported by collaborating medical practitioners. Collaborating medical practitioners may change and there may be a difference from a governance perspective then for the individual in the post. So is there a nursing governance structure that can be wrapped around that in the future."

It was also suggested by respondents that the development of posts into the future following registration may need to be monitored at a national level.

"Governance wise, while there is a local responsibility, there should be an accountable officer in each service where an ANP is based."

It was suggested by these respondents that an annual report of assurance that consists of adhered to requirements and standards of the development of the post be provided to both the HSE and a national regulator. Respondents believe that while the regulator would focus on the professional issues of the post and the HSE focus on the benefits, key performance indicators and outcomes etc., allows the advanced practitioner a form of feedback and to be assured.

OTHER

In relation to OTHER, groups discussed a number of different areas including the need for more support and encouragement for the development of the nurse including posts that are outside of an acute setting, the need for more funding from specific places that will guarantee funding and not turn away the candidate who is seeking the funding, the need for continuous support from the NMBI specifically in relation to the maintenance of competencies regarding the preparation and regulation of sites, the need to explore the future possibility of nurse consultant posts, unrelated to clinical medicine, but just *"from the point of view of the nursing and midwifery framework"* and the need for future ANP/AMP clinical accountability.

SECOND AIM: TO DISCUSS THE PERSON INTO THE FUTURE. EXPLORE THE PERSON SPECIFICATION:

NEED FOR SEPARATE DIVISION OF THE NMBI REGISTER

In relation to whether there is a need for separate division of the NMBI register, a large number of groups agreed believing that there is a need for a separate division. Respondents stated that it should stay with the NMBI for recognition of qualification and advanced scope of practice only. The element of protection that a separate division offers was also discussed by respondents in relation to the protection of the patient, the protection of the nurse and the protection of the advanced practice.

"There certainly needs to be a separate division, it's necessary for continual development."

"The need for separate division of the NMBI, we all agreed to that. It gives authority and power to be connected in a separate register. It's linked to professional development and it donates the standard of practice and it's very much linked to patient safety."

"The majority felt that it is important to have an identity. It is important for research and audit and also for linking with other colleagues."

"We said Yes there should be a separate division, for the ANP to be recognised as an ANP. But this should identify the specialist area."

"This keeps the standards and mentioned standards for advanced practice and within that it dictates the scope of the registered advanced practitioners, i.e. the educational requirements and standard. It provides a clear demarcation of the roles from RGN, clinic and nurse specialists and ANP."

A number of different elements in relation to the need for separate division of the NMBI register were discussed including the need for the identification of different specialities amongst ANP/AMP roles. Using a United Kingdom example, respondents compared that they use a separate SPQ system in the division to name different speciality areas.

A query was raised in relation to the implications of a separate division suggesting that a separate division may contribute to the regulation of the role. A separate query was raised regarding whether having a separate division was just an administrative issue. Separate respondents simply questioned if there was a mechanism for identifying RANPs/RAMPs if there was no register, and if so, they felt that there was no need for a separate division.

NEED FOR PERSON AND POST TO BE LINKED

In relation to whether there is a need for the person and post to be linked, a large number of groups said that there is no need for the two to be linked. However respondents stated that there is a need to use robust structures to support the post, support the ANP/AMP and to support clinical competencies.

> *"We don't think in our group that they should be linked. It shouldn't be essential as the individual is working at a higher professional level. This then restricts appropriate timely response to service needs."*

> *"We felt that it should be separate, that the person traditionally was identified first however we feel strongly that it should be needs based and standardised with a focus on the budget, the service, a national need and with local context, but very much identified by the Department of Health initiatives and clinical care programs."*

> *"We felt the person and post should not be linked so to allow freedom of global travel for people who are registered,"*

> *"The person in post we felt that if a registered ANP/AMP role are the same as an ANP/AMP working somewhere else, they should be able to work in other hospitals in the same service, within the same scope of practice."*

Separate respondents also stated that there is a need for the person and post to be linked, believing that it should be linked but not restricted, specifically in relation to where once the ANP/AMP has attained and maintained her or his registration that it is not lost if the post becomes obsolete. This was also agreed upon by other groups where the need for the site should be changed to the need for speciality specific qualification.

> *"We thought that the post needs to be linked to the speciality so that the person needs to be able to expand or move within that speciality."*

> *"We felt that from an experience point of view that an RANP speciality needs to maintain competence in a certain field. For example ANPs that have had their training and have done adult and paediatrics and work only in an adult hospital, that if they want to maintain their paediatric experience they should be able to rotate into another ED to keep up their paediatric competencies and then go back to the work."*

Groups also discussed issues around the area of the vacancy of the post. These issues include how the service need should identify whether there is a need for an ANP/AMP post instead of an ANP/AMP looking for a site to practice in. Respondents also stated that if a post is vacant through retirement that the right ANP/AMP with the required qualifications should be able to apply for it after it has been advertised ethically.

EXPERIENCE INCLUDING SPECIFIC EXPERIENCE
Groups stated that seven years post registration with five years within a speciality experience was sufficient regarding experience including specific experience.

"We agreed with what is in place at the minute, 7 years is required and that 5 years specifically within specialist area is required because we're working at such an advanced level of care."

"We felt that 7 years post registration with 5 years' experience in the area sufficient."

"We agreed that it should be 7 years experience and 5 years in the area and that recent practice should continue."

Five years generic was suggested as essential by other respondents, while including the two years waiting to be registered to be counted as specific experience, as they stated that a lot of specific experience is gained during waiting to be registered with NMBI. Three years working in a speciality equivalent area was also suggested by some groups, while competency based experience instead of years required was also suggested, in relation to ongoing experience in the ANP/AMP specific area of practice.

"Others felt to reduce it to five years post qualification experience with three years in the specific area would be more appropriate. There was some question whether it might be dependent on the person but there was no consensus reached."

GENERAL EDUCATION AT THIRD-LEVEL

In relation to general education at third-level, a level 9 Masters qualification was thought of as essential, with a PhD as a professional choice stated by respondents. Using a Higher Diploma to gain entry into a Master's programme was also explored in relation to where one might not necessarily have a Bachelor of Nursing to apply for Masters level but do have a Higher Diploma.

"In terms of education we felt that it should be obviously hugely focused nurse led, clinical role and that it should be to master's level."

> *"We agree that it needs to be master's level but not necessarily elevating to PhD level. So not necessarily bachelor of nursing before you get to you master's level, that if a person does have a higher diploma the university will obviously decide if they're allowed on to master's level at that stage."*

> *"We agreed that advanced practice was to be a minimum of master's level. However, it could be higher than that to PhD, but minimum of master's level."*

A professional doctorate instead of a PhD was also suggested and expressed as being more beneficial to the ANP/AMP while the need for a research element, specifically a research module, to be made available with the third level was also discussed.

> *"We feel that it needs to be at Masters Level. PhD can be a professional choice if the ANP decides to go and do that. Higher diploma if available as well, again a professional choice. We feel that something going forward maybe if there was a professional doctorate available it would be beneficial as opposed to a PhD if available."*

> *"We thought maybe the research element for the ANP could be available within the third level, so that you'd actually take on a research module specific."*

SPECIFIC EDUCATION AT THIRD LEVEL

In relation to specific education at third level, respondents agreed that it was essential that there is a clinical component with one or two modules to be specific to the speciality including the need for a level 9 Master's qualification. The need for more flexibility was suggested as it is dependent on the type of courses completed in the past.

"We felt that the Master's should incorporate an area that was specific to the post."

An issue was raised by respondents in relation to the availability of third level speciality programmes. Respondents stated that specialities such as dermatology are unavailable and difficult to gain experience and specialist experience in.

SUBSTANTIAL SPECIFIC CLINICAL MODULAR COMPONENT

Groups expressed a large amount of agreement in relation to the need for a specific clinical modular component. They suggested that it should stay at 500 clinical hours, stating that it was integral to the courses that the students or the ANP/AMP is attends.

"Substantial specific clinical modular component is essential and is key to advanced practice in you speciality."

"The clinical modular component, we thought it was substantial. Yes for third level academic recognition."

The need for continuous recognition of the nursing element of the modular component was also discussed as a necessity. The need to examine clinical accreditation, specific practice experience, CPD and live competency documents, and the need for more flexibility in relation to the availability of the specific modular component was also explored by respondents.

"There had to be speciality obviously components, but also that we didn't lose the nursing part of that somewhere, that potentially you could do a lot on the speciality but not actually looking at how in advanced nursing, what was special about advanced nursing or what was different or what were the components of it ."

"We felt that the need to look at clinical accreditation, specific practice experience, CPD and live competency documents."

"We felt that there needed to be possibly some flexibility. Looking into the past that sometimes the modular component wasn't always available in Ireland and people did have to go overseas. Now an awful lot of the actual specific modular components are built into advanced practice courses at third level. But maybe with certain new ANP posts there may still need to be a bit of flexibility."

HOURS AT SUPERVISED PRACTICE LEVEL WITH COMPETENCT SIGN-OFF

Hours at supervised practice level with competency sign-off was agreed upon by the groups. Respondents agreed with the current 500 hours at supervised practice believing it to be an essential component that should occur before initial registration. Separate respondents agreed on fewer hours including 200 hours and 250 hours at competency sign-off along with self-competency as part of the process.

"Hours at supervised practice level with competency sign-off is currently 500 hours and we felt that this was a requirement."

We agree to the 500 hours clinical supervision. Need to be there prior to the initial registration as an advanced nurse midwife practitioner."

"Clinical supervision is essential and it's as important in the role if not more important than the college education when it comes to pre-registration. We felt that the minimum should be 55 hours of competence."

"The 200 came up as a number of hours that would be signed off."

"In terms of the number of hours we agreed it was a minimum of 250 hours was needed but that self-competency should be part of the process, and that a formalised competency document/logbook, again they should be ongoing."

One issue that was discussed by groups related to the difficultly an ANP/AMP might have getting signed off by a consultant or by a supervisor that is not working in the same generic area. It was discussed that this may cause the ANP/AMP to take longer in getting these hours. It was also suggested that ANP/AMP supervision and sign-off may be an area that could be examined in the future so as to avoid issues such as these from occurring.

"Some people think that this might be hard to get signed off by consultants. So it may take longer to get these hours."

"We feel that working at a higher level as the ANP does, with the level of autonomy that's involved, our question really would be does it need to be a clinician or an experienced ANP that would sign-off."

"In the past it depended on your supervisor, some people got signed off maybe quicker than others. It depends who the site supervisor was and within that specific generic area. We had a big discussion around are we now moving towards other ANPs supervising other ANPs? We need to be probably more future orientated. That maybe down the line that may be written into the requirements and standards around advanced practice, prescribing is probably going in that direction and with other areas within the nursing field."

Annual sign-off instead of the current 5 year system was also suggested by respondents; this would result in a continuous ongoing update and possibly identify future needs. The need for completed competency recognition and sign-off if the ANP/AMP completed overseas recognisable courses was also expressed. Respondents also stated that they disagree with the current re-registration system of the ANP/AMP producing 500 clinical supervision hours.

"And for re-registration we don't agree to the requirement for the advanced nurse/midwife practitioner to produce 500 hours clinical supervision as the advanced nurse practitioner is already practicing clinically on a daily basis."

CLINICAL SUPERVISION PRIOR TO COMMENCEMENT OF THE POST

Groups specifically agreed to this stating that it is highly essential for clinical supervision to take place prior to commencement of the post. Respondents believed that it should involve a learning contract with the consultant and that it should be formal and protected.

"We thought that it's essential that that's already in place and then you build on that post commencement of the post."

"We agree with the structures that are already in place and the need for clinical supervision to be in place."

"We feel that as in the case of applying for third level credit should be given within evidence of clinical supervision, be it a clinician, or an ANP/AMP. It's important going forward to have supervision and evidence of all that."

A number of different suggestions and guidance were made in relation to clinical supervision prior to commencement of the post. One suggestion included the need to explore different models and certain

topics within clinical supervision as depending on the area of practice, the need for the ANP/AMP supervision needs to be more conjoined including different team members, for example within midwifery, a director of midwifery, a consultant and a director of nursing and the ANP/AMP may all be involved in the supervision role. Other suggestions included the need for a portfolio development and to explore the area of peer supervision and allowing ANP/AMP clinical group supervision from different areas and specialities.

CLINICAL SUPERVISION FOLLOWING COMMENCEMENT OF THE POST

Groups agreed with the need for clinical supervision following the commencement of the post and the mention of a lead consultant monthly meeting where any practice issues can be discussed was given specific acknowledgement and recommendation by respondents. "*Something more specific*" was also suggested by respondents as a system for achieving clinical supervision following the commencement of the post. It was believed it may prove beneficial in the future, while the need for continuous support from a mentor was also recommended.

"Clinical supervision following commencement of the post we felt was important. We felt that once somebody qualified as an RANP/RAMP they should still continue to get some level of clinical supervision for the post."

It was also suggested by separate respondents that clinical supervision following the commencement of the post should involve a yearly portfolio for RANP/RAMP accreditation every year. It was suggested that this could be an alternative to the use of the accreditation process every 5 years.

"It should be involved in our yearly portfolio really for RANP/RAMP accreditation every day, not the 5 year accreditation, that's different but that we should have our CPDs and all that every year."

A group of respondents suggested the opposite, stating that there is currently no need for clinical supervision following the commencement of a post. These respondents recommended the use of one hour case presentations every three months.

"Clinically supervision following commencement of post, the group decided that we wouldn't, they didn't need that as much. That the case presentations maybe one hour every three months. There was an example of an ANP doing this and that may vary."

ACCOUNTABLE PROFESSIONALLY TO

The director of nursing and the director of midwifery or the advanced director of nursing/midwifery were described as the professional that ANPs/AMPs are accountable to professionally. Respondents also stated that they are also professionally accountable to the NMBI in relation to community services. Respondents also stated that there may be cases where an ANP/AMP may not have a director of nursing/midwifery and in those cases that they should be accountable professionally to an equivalent nurse/midwife of an identical grade.

"Accountable professionally to our director of nursing which is the way it currently is."

Patients and their family members were also discussed as being accountable professionally to, along with respondents stating that they are also accountable to a named specialist consultant.

"We are accountable professionally to the director of nursing and to the patients."

"Accountable professionally to the DON and to the named specialist consultants."

Professional accountability to the line manager and line management were also discussed along with respondent confusion in relation to the issue of grading and the lack of a managerial component within in it. It was recommended that a specific grade might be more beneficial.

> *"Most of the time we are managing people and clients and patients but not necessarily other midwives, and that maybe a specific grade might need to be set up for advanced practice going forward."*

An issue was also raised regarding community posts and who the ANP/AMP should be professionally accountable to. Respondents stated that in the future more and more posts may move out into the community where there are two or three directors of nursing/midwifery and that there would need to be one specific person designated to be professionally accountable to.

ACCOUNTABLE CLINICALLY TO

A number of professionals were debated upon by the groups in relation to who the ANP/AMP is clinically accountable to. These include the director of nursing, the patient, the consultant, the clinical supervisor specifically a registered ANP/AMP, a GP with regard to a community setting, and the medical lead or the head of the team.

> *"In terms of the clinical professional and who we are accountable to we felt that it should be the lead of the team and that this could be a rolling position and not necessarily a consultant.*

> *"Accountable clinically to patients and your consultant."*

> *"Clinically we have to be accountable to the consultant because that is the standard in this country. No matter what speciality you work in, the consultant has overall responsibility for the patient. So until that changes we should be answerable to the consultants."*

> *"Clinically we felt that we should be accountable to a named consultant or whoever has responsibility for the patient that we are looking after."*

It was considered important that the professional to whom the ANP/AMP is clinically accountable should be able to provide a source of resources to advanced midwifery and nursing and to provide clinical professional responsibility to each ANP/AMP.

"Clinical accountability was two-fold. If you are going to be clinically accountable to your director of nursing, that she or he equally had to put something in place that allowed you to maintain clinical accountability and professional accountability."

COMPETENCIES: GLOBAL AND SPECIFIC

In relation to competencies, both global and specific, groups were in general agreement with how they are currently measured. Respondents also acknowledged the necessity for the ANP/AMP to gain new skills, education and competence when new developments in a site occur.

"We felt that competencies both global and specific were very relevant to the post."

"We agree with what is in place should move forward to the future as they are at the moment and demonstrating ongoing competencies, we have no issues here."

Respondents also discussed specific competencies and how they should relate to the ANP/AMP post.

"Specific competencies obviously need to be specific to the ANP post. That's fairly obvious I guess."

"Each area should have specific competencies to their area for example adult/paeds or their specific area such as diabetes, epilepsy etc."

Separate global competency elements and issues were explored in relation to respondents agreeing to *"maintain the current core competencies with the national council, which are the 4, which is assert leadership, expert, autonomy and practice."* Time management and the issue of managing work load when taking on the research component of the post was discussed as a possible problem in relation to this criterion. Communication and being a good communicator, taking part in audits, and teaching and educating were also discussed and acknowledged as global competencies.

A number of concerns regarding competencies were also discussed by the groups. These included concerns over changing competencies. Respondents expressed concern in relation to job description and the role development of a post, and how their competencies may change over periods of time.

An issue regarding the wording was also explored by respondents, stating that the wording within the job description needs to be examined more specifically in relation to competencies, while a query was raised by respondents in relation to the absence of an ANP/AMP in their post for a period of time due to an illness or leave of absence and whether their competencies should be re-evaluated when they return.

> *"We had a little debate around the wording because advanced practice looks at concepts. So you have the concept of we'll say clinical leadership, our expert practice, your research, and the competencies comes out of that. But when you are demonstrating to the NMBI it's the concepts that you are looking at."*

A recommendation was made by respondents in relation to the RANP/RAMP keeping a log of the own competencies. It was suggested that these would be signed-off specifically like CPD allowing them to be linked in with all ANP/AMP future plans.

> *"They would be professionally responsible to keep up their own portfolio and instigate their own continued professional development with their clinical supervisor and that we might have a national template that could be used to guide that."*

DEMONSTRATING ON-GOING COMPETENCE

CPD, research and audit were discussed by respondents in relation to areas of demonstrating on-going competence.

"It's important to provide evidence of CPD and research five yearly as is required at the moment and it's important to continue to submit CEUs every year."

Suggestions made by respondents included an annual review, or annual performance appraisal, with directors of nursing and consultants to allow the need of the ANP/AMP speciality role to be examined. A yearly CPD requirement for all registered ANP/AMPs was also recommended by respondents in relation to the demonstration of competencies for reaccreditation. A recommendation on the use of an E Portfolio was also suggested. This was suggested to be an annual process where the ANP/AMP can continuously submit information to the NMBI on procedures, audits and research that have been undertaken. Other respondents questioned the complete re-evaluation process suggesting that there is no need for it as it is already put in writing in the job description of the post that undergoing CPD is something that is essential.

"We did discuss that the ANP/AMP would keep their own personal portfolio and that they would need to demonstrate the work that they do, that had been outlined in their scope of practice initially."

The need for specialty meetings where the ANP/AMP must be in attendance, the need for services that support the ANP/AMP role for example peer support and clinical supervision and the need to look into the possible use of other models to demonstrate competencies were also recommended by respondents. It was suggested that learning from overseas models may be beneficial in relation to demonstrating on-going competence. For example respondents explained that in the United States they are examining whether a level 10 should be a requirement for ANPs/AMPs to move forward in their

career and that the use of a coach or mentor in these circumstances may be necessary within these leadership roles.

GOVERNANCE STRUCTURES

In relation to governance structures, groups agreed with the necessity of clinical governance and were in agreement with the current system in relation to the use and involvement of the multidisciplinary team. The need for policies and guidelines to continue and be specified to the post was emphasised, along with the need for referral pathways to support the ANPs/AMPs governance. Respondents also acknowledged the importance of the involvement of the NMBI and questioned the future involvement of the NMPDU.

"That goes without saying, that clinical governance should be a prerequisite for advanced nursing and advanced midwifery practitioners. That sometimes the ability to see problem areas through and to get support, that clinical governance sometimes can be the last voice on it if you are actually struggling."

"In relation to governance structure the clinical lead, and perhaps it should be a single person that we report to, that it's a rolling governance and that the structure is very much based around team work."

"*Our governance structures, we wanted to remain registered with the NMBI for regulation, and we wanted the NMPDU for governance structures."*

"We discussed the NMPDU and their involvement and we are not sure about the role in the future of the NMPDU in the RANP/RAMP."

Groups also discussed the necessity of linking in with various different governance groups throughout the hospital to allow for a more national or generic governance.

"It is important that we link in with other various different governance groups. For example radiology etc. within the hospitals. We feel it may be beneficial to have some national governance over radiology and prescribing and that, and have local agreements based on that because a lot of ANPs/AMPs are having difficulties with things like radiology when it comes to adults and paeds."."

The changeable roles of the multidisciplinary team were also suggested as an important issue as respondents stated that as practice develops and the team develops into different roles, the post of the ANP/AMP may evolve thus resulting in different governance structures. Respondents stated that this is an area within governance structures that may need attention in the future.

OTHER

The role of the ANP/AMP was discussed in relation to the other criterion. This included the need for the ANP/AMP to be viewed as independent practitioners towards the future.

"I suppose we'd like to see the role of the ANP. That they become independent practitioners within their own right, and I suppose that would be our vision for the future for the ANP."

Questions were also raised by respondents specifically in relation to the future supports to the RANP/RAMP and in relation to the future progression of a senior RANP/RAMP post and their eventuality.

SUMMARY

FIRST AIM: TO DISCUSS THE POST INTO THE FUTURE. EXPLORE THE GUIDANCE TO BE GIVEN TO EMPLOYERS SURROUNDING THE CRITERIA REGARDING THE CREATION OF ADVANCED PRACTICE POSTS:

DESCRIPTION OF POST WITH ITS CASELOAD AND LOCATION

- Groups agreed that there was a need for a national or regional template for the site post description. This template could be pre-populated where appropriate in terms of the post description but could be adjusted to suit local requirements where necessary.

- A clear role definition was also considered important particularly in relation to demonstrating both the advanced nurse practice and the advanced scope of practice for ANP/AMP's compared to other nursing roles.

- There was a recommendation that the post should be specific to the individual thus allowing them to move sites if needed. However, the case load must be clearly defined.

- ANP/AMP's should also be facilitated to rotate across sites but governance arrangement must be very clear.

THE ADVANCED ELEMENT OF THE POST IN COMPARISON TO OTHER POSTS

- With regard to the advanced element of the ANP/AMP in comparison to other posts, respondents stated that role clarity was very important and that there was a need for measurable competencies to be outlined in the post description and these should be geared towards the ANP/AMP level. The advanced element should take into consideration research, education and clinical practice but there was also a need for some recognition around the administrative elements of the post.

NEED FOR THE POST

- In relation to the need for the post, groups stated that there was a requirement for specific guidance to be given to employers when creating the ANP/AMP post. Respondents suggested that a step by step approach should be undertaken whereby the initial step was adoption of the idea, followed by a review of the need or evidence to support the decision, leading to the identification of the importance of the role within the service plan.

- A needs assessment should be undertaken and it was suggested that this function could be fulfilled by the new group Directors of Nursing or the Department of Health. As part of the

needs assessment, areas to be considered included future projections of illness, sub sets of health conditions, population demand, and a review of national and international evidence.

BENEFIT OF THE POST

- While a number of elements were explored in relation to the benefits associated with the post, one of the main areas related to the benefit to patients of the ANP/AMP role. Patient benefits were outlined in terms of improved quality and safety and improved patient outcomes through enhanced clinical continuity of care.

- Other benefits discussed included meeting local service needs, clinical programmes benefits and organisational benefit specifically in relation to organisation outcomes i.e. decreased waiting lists, increased services delivered and increased education regarding both teaching and receiving education.

- Groups while accepting that it was important to demonstrate the financial benefits when building the business case, found it very difficult to articulate the financial benefits of the post.

MEASUREMENT OF BENEFIT

- In terms of patient benefits the main methods of measurement discussed by the groups were patient satisfaction and experience measurements, improvement in the care pathway and length of time dedicated to patients.

- Other measurement tools included the use of audits e.g. clinical or service outcomes, length of stay, reduction in outpatient waiting lists and implementation of relevant HIQA recommendations.

- Organisational outcomes and KPIs were also discussed as important measurements of benefit. It was recommended by one group that KPI's are not only important in terms of clinical outcomes but also in "terms of targets for the employer, national KPI's and local/regional KIP's that the employer has to meet".

- A number of groups also discussed clinical and professional benefits, including education and research, as a measurement of benefit.

UNDERPINNING LEGISLATION, RULES AND GUIDELINES

- A number of groups stated that the current legislative rules and guidelines were clear, essential, necessary and robust, stating that they are also integral to the post. Respondents discussed the need for the post to be protected, funded and supported. They stated that there

was also a need for time to be allocated equally to education, clinical practice, competency development and audits.

- While underpinning legislation, rules and guidelines are extremely important, there was a clear request for the NMBI to continue with site visits. Respondents stated that this ensured that ANP/AMP's were kept abreast of all requirements. There was an acknowledgment amongst some groups that while the NMBI may not be continuing with this role there was a clear need for some organisation operating at a national level to undertake this task.

POLICIES, PROCEDURES, PROTOCALS AND GUIDELINES (PPPGs)

- Overall the groups agreed with the need for PPPGs, it was suggested that they could be standardised and developed regionally or nationally. The example of an ANP/AMP within the Emergency Department was provided, where standardised PPPG's could be used and amended locally if there were specific differences in the individual site.

- Respondents made a specific suggestion in relation to this, stating that a possible community involving sub-groups of advanced nurse practitioners experts could lead on the development of such regional/national PPPGs.

NURSING/MIDWIFERY FRAMEWORK

- The consensus among groups was that the nursing and midwifery framework should remain as it currently stands in relation to employer guidance when creating the advance practice post. Groups also suggested that the framework could be pre-populated with samples and references appropriate to specific areas such as nursing in the ED or chronic disease management.

- A number of separate groups explored a number of points including the fact that as the nursing framework guides the direction of nursing there is a need for more formal and established links to the chief nursing officer and the new directorates. This would provide the ANP/AMP with a real voice at the point of decision making. Another group queried whether having one explicit framework may constrain the ANP/AMP post. They suggested as did another group that it might be better approached using a philosophy of nursing rather than a specific framework. The need for either a framework or a philosophy was considered important.

ROLE CONTENT: CLINICAL; EDUCATION; RESEARCH

- In relation to role content it was considered important that the employer was aware of the standard expected from the ANP/AMP as this would provide assurances that the ANP/AMP was practicing safely and effectively.

- With reference to education, CPD was believed to be essential component which could reduce or remove the need for reaccreditation as the CPD scheme became more embedded.

- In relation to the research element, respondents agreed that there is a need for protected time. The benefits of the time committed to research and audit need to be made clear to the employer, as they will benefit from the publication of papers and presentations at conferences.

MULTIDISCIPLINARY TEAM (MDT)

- While the need for more support and awareness for ANP/AMP's was considered a major issue for a number of groups, the referral pathway was a significant key point for other respondents. As the advanced nurse practitioner role is becoming more and more established and regarded as a valuable element in relation to service provision, these groups feel that the ANP role should involve effective communication to have clear pathways of referrals to and from other specialist roles within the team.

RESOURCES

- Groups that discussed the need for resources stated that there should be mandatory standard resources that would include a dedicated clinic area, office space and clerical support.

INSURANCE ARRANGEMENTS

- Insurance was considered very important and it was deemed necessary that all arrangements should be made to ensure that the occupant of the role was indemnified when the post was being approved. This was particularly important in relation to the private sector as only those in the public/hospital setting were covered by vicarious liability.

POSSIBLE FLOW IN THE DEVELOPMENT OF A POST

- A number of different issues and suggestions were explored in relation to this key point. These included a suggested accreditation inspection specifically in relation to a re-accreditation process by the person themselves through an updated portfolio submission, the issue of different sites having different numbers of ANPs/AMPs, and whether it would be beneficial for the RANP candidate to have a contact person from the NMBI specifically in relation to providing support during the development stage of the post and shortly after the post is accredited. The

issue of site visits was then questioned, and if deemed necessary queried who would carry them out in the future.

GOVERNANCE STRUCTURES

- In relation to governance the groups felt that the post should continue to be registered as part of the governance process.

- There was also agreement in terms of the need for one national governance framework for ANP/AMP's in the future which could be reviewed in a set time period e.g. five years.

- There was also concern in relation to the governance structures as the posts developed in the future and the question was posed as to whether this should continue to be the consultant or if there another structure that could be used such as a nursing structure that would address this challenge in the future.

- Succession planning was also considered important so that when a post holder leaves the service there is not a gap in the service provision.

- The approval of posts should continue with the NMBI or another national agency and changes to the post should be notified to the NMBI.

SECOND AIM: TO DISCUSS THE PERSON INTO THE FUTURE. EXPLORE THE PERSON SPECIFICATION:

NEED FOR SEPARATE DIVISION OF THE NMBI REGISTER

- The consensus among the groups was that there is a need for separate division of the NMBI Register.

- The element of protection was recognised by respondents as an important benefit of having a separate division of the NMBI Register. Examples of such protection included the protection of the patient, the protection of the nurse and the protection of the advanced practice.

- The need to identify the different specialities amongst the ANP/AMP roles was also considered highly important by respondents.

NEED FOR PERSON AND POST TO BE LINKED

- The majority of respondents agreed that there is no need for the person and post to be linked.

- A small amount of respondents stated that there is a need for the person and post to be linked but not restricted. Respondents stated that when a post becomes obsolete, the ANPs/AMPs registration should not be lost.

- The service provider being able to identify the need for the post was also an important issue discussed by respondents, instead of having the ANP/AMP search for a site to practice in.

EXPERIENCE INCLUDING SPECIFIC EXPERIENCE

- The majority of respondents agreed that seven years post registration with five years within speciality experience was sufficient.

- Separate suggestions included, five years generic with two years waiting to be registered to be counted as specific experience, with others suggesting three years working in a speciality equivalent area.

- Competency based experience was also suggested by respondents instead of using years required, when the ANP/AMP is developing ongoing experience in a specific area of practice.

GENERAL EDUCATION AT THIRD-LEVEL

- The majority of respondents recommended that a level 9 Masters qualification was essential, with a PhD qualification offered as a professional choice.

- A professional doctorate was suggested by respondents instead of a PhD and suggested as being more beneficial to the ANP/AMP by respondents.

- The use of a Higher Diploma was also suggested as a way of entry into a level 9 Masters if the candidate did not necessarily have a Bachelor of Nursing.

SPECIFIC EDUCATION AT THIRD LEVEL

- The majority of respondents agreed that specific education at third level is essential, with a need for a clinical component with one or two modules to be specific to the AMP/AMP speciality.

- Respondents also discussed an issue in relation to the lack of availability of third-level speciality programmes.

SUBSTANTIAL SPECIFIC CLINICAL MODULAR COMPONENT

- A significant number of groups agreed with the need for a substantial specific clinical modular component. This included 500 clinical hours integral to the course that the students or the ANP/AMP is attending.

- The need for continuous recognition of the nursing element within the modular component was also discussed as a necessity by respondents.

HOURS AT SUPERVISED PRACTICE LEVEL WITH COMPETENCT SIGN-OFF

- The majority of groups agreed the necessity of hours at supervised practice with competency sign-off, stating that 500 hours is essential.

- Separate groups recommended shorter hours including 200 hours and 250 hours as competency sign-off with self-competency as part of the process.

- An issue was raised by respondents in relation to the difference between getting signed off by a consultant or by a supervisor who may not be in the same speciality and how it can cause some ANPs/AMPs to take longer in gaining their hours.

CLINICAL SUPERVISION PRIOR TO COMMENCEMENT OF THE POST

- Clinical supervision prior to the commencement of the post was perceived as essential and necessary to take place.

- Peer supervision and allowing the ANP/AMP clinical supervision from different areas of speciality were suggestions made by respondents in relation to future clinical supervision prior to the commencement of the post.

CLINICAL SUPERVISION FOLLOWING COMMENCEMENT OF THE POST

- Clinical supervision following the commencement of the post was agreed upon by the majority of the groups.

- Separate groups stated that there was no need for clinically supervision following the commencement of the post, as they suggested that the use of one hour case presentations every three months may be more beneficial.

- The use of a yearly portfolio for RANP/RAMP accreditation was suggested by respondents instead of a five year accreditation process.

ACCOUNTABLE PROFESSIONALLY TO

- The majority of groups stated that they are accountable professionally to the Director of Nursing or the Director of Midwifery.

- Respondents also stated that they are accountable professionally to the NMBI, patients and their family members and the line manager or line management.

- Community posts where there may be two or three Directors of Nursing/Midwifery were seen as an issue of concern for respondents as there was confusion over who exactly the ANP/AMP was professionally accountable to.

ACCOUNTABLE CLINICALLY TO

- There was a lot of debate over who the ANP/AMP should be accountable clinically to. Many respondents discussed different professionals including the consultant, the Director of Nursing/Midwifery, the patient, the RANP/RAMP, the GP, and the medical lead or head of the team.

- It was strongly emphasised by respondents that the professional to whom the ANP/AMP is accountable clinically should provide a strong support system for the ANP/AMP including clinically professional responsibility to each ANP/AMP.

COMPETENCIES: GLOBAL AND SPECIFIC

- Respondents were in general agreement on how global and specific competencies are currently measured.

- Respondents discussed how specific competencies should be specific to the ANP/AMP post, while they also acknowledge certain global competencies such as communication, taking part in audits, learning and teaching.

- An issue of concern was raised by respondents in relation to changing competencies as the ANP/AMP role develops and how this might affect their initial role description.

DEMONSTRATING ON-GOING COMPETENCE

- The majority of respondents acknowledged that CPD, research and audit were areas of demonstrating on-going competence.

- Recommendations made by respondents on how to demonstrate on-going competence included an annual performance appraisal, a yearly CPD requirement, the use of an E Portfolio, speciality meetings where the ANP/AMP must be in attendance, and the need to compare and learn from overseas models.

GOVERNANCE STRUCTURES

- The majority of groups agreed with the necessity of clinical governance and agreed with the current system in relation to the use and involvement of the multidisciplinary team.

- Respondents also agreed with the need for policies and guidelines to continue and to be specified to the post, and agreed with the need for referral pathways to support the ANPs/AMPs governance.

- The changeable roles of the multidisciplinary team including the development of the ANP/AMP's role was discussed as an issue by respondents in relation to the need for their governance structures to be changed. This is an area that may need attention in the future.

This report reflects the findings on the analysis of ANP/AMP Standards and Requirements Project. The purpose of the research was to highlight issues raised regarding ANP/AMP standards and requirements from a wide range of perspectives. The information gathered will assist the Nursing and Midwifery Board's further development of these standards and requirements by exploring ANPs/AMPs views. In total, the views of 139 respondents were recorded on dealing with the Post into the future and dealing with the Person into the future. The findings highlighted a number of guidelines to be considered in relation to developing the standards and requirements. The thematic analysis in Chapter 2 forms the basis for these considerations.

While sufficient guidance and discussion were provided by all of the groups in relation to the first and second discussion aims, a number of significant issues were greatly emphasised by respondents. In relation to the first aim, while the majority of respondents agreed on a number of key points for example the current legislative rules and guidelines, the current nursing and midwifery framework, the current role content of the ANP/AMP and the need for PPPGs, separate emphasises took place regarding

certain areas of other key points. These included a national or regional template requirement for site post description, the need for the ANP/AMP to rotate across different sites, role clarity, the use of a step by step approach when identifying the need for the post, acknowledging and measuring patient benefits and satisfaction, and acknowledging the significance of the role of the ANP/AMP in the multidisciplinary team.

When considering the second aim, the consensus of agreement was seen amongst groups throughout the majority of the key points, for example, many groups were in agreement in relation to the need for a separate division of the NMBI Register, experience including specific experience, specific education at third level, substantial clinical modular component, hours at supervised practice with competency sign-off, clinical supervision including prior and following the commencement of a post, global and specific competencies and governance structures. When considering who the ANP/AMP is accountable to professionally and clinically, the majority of groups agreed on the Director of Nursing/Midwifery and the consultant or Director of Nursing/Midwifery. When asked to explore demonstrating on-going competence, groups were in consensus with CPD, audit and research. Groups also expressed agreement in relation to the need for the person and post to be linked when the majority believed they should not be linked.

CHAPTER 6: PRINCIPLES NEEDED TO SUPPORT ADVANCED PRACTICE

Prof Marie Carney

Summary
Principles needed to support advanced nurse and midwife practitioners and advanced practice are based on ethics, particularly clinical ethics that arise within the context of caring for patients/clients. Ethics is defined as enquiry into the principles of right and wrong conduct (Meleis 2006). Professional values form the basis of ethical behaviour and provide the foundation for nursing and midwifery practice. Professional practice standard holds that moral conduct is determined by the customs and practices of professional bodies such as advanced practitioners (Beauchamp & Bowie1993). Values guide the nurses' interaction with patients, colleagues and society. Principles are needed to support advanced practice.
:
Professional values include:
Altruism: defined as the nurses' concern for the well being of patients and reflected in advocating for patients, particularly those most vulnerable
Autonomy: defined as the right to self-determination and demonstrated by the nurse in respecting the right of patients to make their own decisions about their care.
Uniqueness: defined as the nurse respecting human dignity and reflected in preserving patient's dignity and confidentiality.
Integrity: defined as acting in accordance with the Nurses Code of Conduct and reflected in the nurse providing care that is ethically based (Taylor 1993).

Nonmaleficence: defined as avoiding causing harm
Beneficence: defined as benefiting the patient while balancing benefits against risks (ICN 2000).
Culture: defined as observed behavioural regularities between individuals-for example- the language used, rituals, customs and traditions or in terms of standards, values and group norms (Deal & Kennedy 1982).
Values: defined as the goals, shared values, norms, beliefs and philosophies of organisational members (Carney 2006).

Accessibility: defined as access to services in a timely manner. The nurse will endeavor to adhere to the principles of accessibility and transparency that in health care administration in Ireland are supported by legislation such as the Freedom of Information Acts, the Ombudsman Act and The Data Protection Act (ABA 2000).

Accountability: defined as an obligation or willingness to accept responsibility or to account for one's actions. Accountability is based on the following concepts:
Scope of Practice: Scope of Advanced Nurse Practice in Ireland is defined by the NCNM (2008) 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. Differences between the role of the advanced practitioner and other professionals exist with variations in regulation, level of knowledge, scope of practice, skills, competencies and titles (An Bord Altranais 2000*;* American Nurses Association 2010).
Criteria for Practice: Specific criteria for advanced practice incorporate concepts that relate to education level and experience. Optimal outcomes are attained 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.

Assessment Tools for Practice: The aim of clinical practice learning is to enable nurses' develop the domains of competence and become safe, caring, competent decision-makers willing to accept personal and professional accountability for evidence-based advanced practice care (ABA 2000).

Competency: defined as the ability of the nurse or midwife to practise safely and effectively fulfilling their professional responsibility within their scope of practice (ABA 2000). 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. Moral principles as set out in the Code of Professional Conduct for Each Nurse and Midwife (2000) underpin professional practice (ABA 2000, 2014).

Domains: defined as broad categories that represent the functions of the Registered Advanced Nurse Practitioner in contemporary practice (ABA 2000)

Domains of Competence: the assessment tool used in Ireland to define competencies. 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.

Performance Criteria: statements of selected actions or behaviours that identify how achievement of competence is demonstrated (ICN 2000).

Indicators: provide evidence of competence. They may be further sub-divided into critical elements.

Critical Elements: defined as the set of single, discrete, observable behaviours that are mandatory for the designated skill at the target level of practice (ABA 2000), in this case advanced practice.

Competencies for Advanced Practice: Competencies for advanced practice are a central tenant of the advanced nurse practitioner roles and are continually being updated to meet changing healthcare need. Competencies should be 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.

Consistency: defined as adhering to the same view including harmony of conduct in actions and always acting or behaving in the same manner with the same quality and standard each time. The nurse will provide greater consistency across organisations by ensuring that regulations, policies and procedures applicable to advanced practice are mutually consistent. Consistency in work processes is important as it gives a degree of predictability and legal certainty to advanced nurse practitioners (Government White Paper 2004).

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Differences in Delivery Systems: Different approaches taken by health care organisations or individuals in delivering health care. These include:

Service needs analysis models: identify the operational needs of the organisation within a defined time frame and include Strategic Analysis and Strategic Development Models, both of which include situational analysis of the strengths and weaknesses of the organisation and the opportunities and threats existing in the environment that have the potential to harm the organisation in some way, Case mix that identifies the types of patients and complexity of their condition treated within a healthcare service and Integrated Care Pathways that group patients by illness (Carney 2006). Service needs analysis is based on needs assessment: defined as identification of the needs of an individual or population to determine the appropriate level of care or services required (Sheer & Wong 2008).

Service Parameters: Healthcare organisations need to establish service parameters for advanced practice nursing/midwifery and to differentiate operationally between advanced practice and the

registered practitioner nursing and midwifery roles. Countries are seeking to improve the quality of health care delivered by reviewing the roles of health professionals,   and as a result the advanced nurse practitioner is taking responsibility for new service areas.

Compliance: identified as doing what has been asked or ordered including conforming to regulations. In terms of ensuring better compliance and enforcement, the advanced nurse practitioner will implement better consultation processes to inform and involve stakeholders.

Effectiveness: defined as obtaining or producing the intended result. The advanced nurse practitioner will ensure, as far as is possible, that care is delivered in an effective and efficient manner to the highest standards whilst utilising evidence based practice. Efficiency is the ability to do something without waste of resources. Effectiveness in care delivery is based on the following principles:

Partnership: defined as developing a partnership approach between the patient/client and the advanced nurse practitioner that is based on mutual trust, support and collaboration, which facilitates informed choice and decision-making and the empowerment of both the individual and the advanced nurse practitioner (Government of Ireland 2011).

Advocacy: defined as the act or process of supporting patient/client cause. Advanced nurse practice involves advocacy for the individual patient/client and family.

Standards: defined as authoritative statements that are developed, monitored and enforced by the Nursing and Midwifery Board of Ireland to describe the responsibilities and conduct expected of registered nurses and midwives. The standards are based on the principles and values that underpin professional practice (ABA 2000).

Benchmarking: defined as a continuous process of measuring and comparing care and services with similar service providers and clinical audit which is defined as a quality improvement process that seeks to improve patient care and outcomes through collection and monitoring processes

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 (American Nurses Association 2010).

Evidence-based practice: defined as the use of the best available evidence together with the nurse or midwife's expertise and a patient's values and preferences in making healthcare decisions (ABA 2000). Best available evidence includes the 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.

Quality of practice: defined as evidence-based professional standards that are balanced against patient needs, patient satisfaction and organisational efficiency (ABA 2000). Decisions about an individual advanced nurse practitioner's scope of practice should always be made with the patient/client and family's best interests foremost and in the interest of promoting and maintaining best quality advanced practice services that are based on the best available evidence (ABA & NCNM 2005).

National clinical guidelines: defined as guidelines that meet specific quality assurance criteria and are mandated by the National Clinical Effectiveness Committee in Ireland

Integrity: defined as upholding the values of the profession and the accepted standards of practice. Acting with integrity is acting honestly and behaving as expected under the Code of Professional Conduct and Ethics (ABA 2000). *Professional mis-conduct occurs because the professional is negligent and standards of care have fallen below that which is acceptable to the profession (Beauchamp & Bowie 1993)

Codes of practice: Awareness of codes of professional practice as set out by the NMBI (ABA 2000) including The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives and the Scope of Nursing and Midwifery Practice. Nurses and midwives need to understand

the importance of the Board's most *current version* of standards and guideline documents and apply them in any professional setting. The portfolio of Board publications (ABA 2010) is available online www.nmbi.ie/portfolio

Governance: defined as the way that health care is managed and controlled by the people who are in charge of running it.

Clinical governance: defined as the system of authority to which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver (ABA 2000).

Pathways to entry to advanced practice
Different pathways to entry exist that are based on level of education, experience and competence for practice and include:

Curriculum design and development should reflect current, evidence-based educational theory and healthcare practice, including education models for advanced nurse practice (ABA & NCNM 2005). Curricula needs to be dynamic and flexible to allow for changes in advanced practice, the delivery of advanced practice services and the development of evidence-based practice. The curriculum should permit progression to a higher or different programme and be sufficiently flexibility to offer choice to students. Advanced clinical practice needs to reflect consistency, linkages and effectiveness in planning and delivery models and approaches used. Self-directed learning skills, clinical reasoning/problem solving and decision-making skills will form the foundation for maintaining competence and continuing professional development (ABA & NCNM 2005). Educational preparation must include a substantial clinical modular component(s) pertaining to the relevant area of specialist practice.

Educational qualifications and training requirements: These vary across countries and range from diploma to masters to PhD with a masters degree in nursing recommended or required to qualify as an advanced nurse practitioner. Clinical components must be relevant to the area of practice (Furlong & Smith 2005). Registered nurse and midwife prescribing of medicinal products and medical ionising radiation (X-ray's) are desirable **(**NCNM 2008, 2005)

University Delivery: Advanced practice programme titles and content differ and there is evidence of innovation in course content that serves to minimise programme duplication.   Progression is offered through varying levels of study. Some universities adopt multidisciplinary approaches with outcomes that are focused on improving healthcare.

Flexibility: In Ireland, universities offer flexibility through the provision of tailored programmes in defined practice areas such as emergency, neonatology, epilepsy and colorectal screening as well as in other practice areas.

Choice: Within advanced practice there is 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 those areas further. Curricula would benefit from broadening of content that is specific to underdeveloped advanced practice programme.

Mentorship Models
An important component of competency development relates to mentorship or clinical supervision. Different models 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. Currently candidate advanced nurse/midwifery practitioners in Ireland are mentored mainly by a medical mentor. Some flexibility in relation to a relevant mentor could utilise a model other than the medical model such as mentoring by a relevant Clinical Facilitator, Liaison Facilitator, Director of Nursing/Midwifery,

RANP/RAMP and particularly when the advanced practitioner is working in out-reach areas of practice and reporting to both the Director of Nursing in the parent site and to another relevant mentor in the outreach site. Clinical mentoring needs to be clearly articulated within the site and in job description documents and endorsed by the organisation (An Bord Altranais 2010 a, b).

Responsibility: defined as undertaking a duty or action that is asked or required of an individual. Role responsibility includes professional responsibility and accountability: Principle 2 of the Code of Professional Conduct for Each Nurse and Midwife (ABA 2000) focuses on professional responsibility and accountability, values, personal and professional integrity, and advocacy. Nurses and midwives are expected to show high standards of professional behaviour; be professionally responsible and accountable for their practice, attitudes and actions including inactions and omissions; recognise the relationship between professional responsibility and accountability and their professional integrity; advocate for patients' rights and recognise their role in the appropriate management of health (ABA 2000). Refer to www.nmbi/standards.ie for further information on adherence to professional standards including responsibility for professional indemnity insurance (www.stateclaimsagency.ie).
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Nurse Practitioner/Advanced Practice Nurse responsibility: "An advanced nurse practitioner 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). Principle 5 of the Code of Professional Conduct for Each Nurse and Midwife (ABA 2000) focuses on collaboration, team-working, communication and documentation. This principle incorporates values that are pertinent to advanced practice. Values include professional relationships with colleagues that are based on mutual respect and trust and sharing responsibility and collaboration to achieve optimal outcomes of care. Ethical management of documentation and communication of care is an integral part of professional practice. Refer to www.nmbi/standards for further information on standards of conduct.

Regulation for 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. Regulation and regulatory authority must work to protect public safety (Delamire et al 2010). The public has a right to the access to health care, to make informed choices and to rely on the credentials of health care providers in making choices and decisions regarding health care (APRN 2012). Nursing legislation provides for procedures where the NMBI may discipline a nurse or midwife when he/she is in breach of professional standards or the code of professional conduct (O'Kelly & Ronan (1994).

Role expansion: Role extension in Ireland is due mainly to recommendations in the Report of the Commission on Nursing (1998) and to increases in health care costs, legislative changes, 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). Extension to the role is resulting in roles that were traditionally the preserve of doctors, such as medication prescribing and patient assessment, now being taken on by advanced nurse practitioners (Currie et al. 2011; Institute of Medicine 2011, ANMC 2009, 2006).

Governance Models

Corporate, financial and clinical governance are interconnected. Clinical Governance systems which HSE service providers are accountable for include continuous improvements in the quality of clinical practice and maintaining high standards of care by creating environemnts 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.

Clinical governance: A system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding the public (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.

Governance application to practice: 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). The introduction of clinical goverance 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. General information about protected disclosures and whistle blowing in the health services is available from the Patient Safety First initiative at www.patientsafetyfirst.ie.

Interdisciplinary approaches to learning
Interdisciplinary approaches to learning are based on collaboration, inter-professional, shared inter-disciplinary and multi-professional education models that are under-pinned by culture and values.

Collaboration: defined as clinicians from different disciplines working together co-operatively through sharing responsibility for decision-making, problem solving, conflict resolution and co-ordination of activities (Carney 2006).

Inter-professional education: defined as the way forward in breaking down educational and professional barriers that exist in health care. Inter-professional education centres on professionals working together, interacting together and understanding each other's roles (DoH 2004, 2007).

Multi-professional education: concerned with professionals sharing learning without any emphasis on professional interaction or team working, and the basis for shared learning is the content of the programme rather than collaboration (DoH 2004).

Shared Inter-disciplinary education: defined as shared learning across disciplines and may occur in advanced nurse practice, as in university programmes in the UK, where students are encouraged to gain greater understanding and acceptance of each others' discipline and roles in delivery of health services (Carney 2006).

Multidisciplinary and interdisciplinary models
Role confusion is evidenced by a proliferation of terms such as 'nurse practitioner', 'nurse consultant', 'advanced practice nurse' and 'clinical nurse specialist' 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, Scottish Government 2010). Dissention over the boundaries between ANP roles with that of physicians is evident. Research into the differences between ANP's and CNS/CMS's see them as overlapping and others do not (Begley et al 2013, 2010).

Safety, risk management and quality assurance structures

These are key principles for the advanced practitioner. Principle 3 Quality of Practice as set out in the Code of Professional Conduct for Each Nurse and Midwife (2000) focuses on safety, competence, kindness, compassion, caring and protection from harm in a safe environment, by aiming to give the highest quality of care to all in their professional care through using evidence-based knowledge, applying best practice standards in their work in the most cost-effective manner, upholding the quality and safety of the healthcare environment and reporting safety concerns. In HIQA 2014, (Standard 2.6),

the Health Information and Quality Authority (HIQA) supports best practice by ensuring that care is provided through a model of service that will drive high quality, safe and reliable healthcare www.healthinformation/quality assurance.ie. Information is also available on the World Health Organisation Patient Safety initiative at www.who.int/patientsafety

Trust, Confidentiality and Honesty: Trust is the belief that an individual is reliable and can be depended upon. Confidentiality means respecting privileged information and honesty means being truthful and fair. Principle 4 of the Code of Fairness and Professional Conduct for Each Nurse and Midwife (2000) focuses on these three values. These are core professional values underpinning nurses' and midwives' relationships with patients and colleagues that must be exercised with professional judgement and responsibility. Confidentiality and honesty form the basis of a trusting relationship (DoH 2007). See www.nmbi/standards.ie for further information**.**

Organisational systems and service frameworks:
Systems and frameworks support existing advanced nurse practitioner roles in clinical sites. Health service organisations are required to take responsibility for defining the need for the development of advanced practice posts in individual organisations. The principles needed to support the nurse include Reciprocity, Safety, Equity, Security, Respect, Partnership and Multi-disciplinary Teamwork.

Reciprocity: defined as a mutual exchange, doing something for each other while maintaining similar rights.

Security: defined as maintenance of social balance by ensuring reciprocity, safety and harmony between staff and others and is recognisable through equity in care provided and respect for the patient

Equity: defined as fairness in the way people are treated, free from bias or favouritism. Equity in service delivery is demonstrated through inclusiveness for all and objectivity in the approach to equity adopted (Carney 2006). These principles relate to professional status evident in the competence and expertise of the advanced nurse practitioner, professional approach to care delivery and a professional organisation.

Prior to new post creation:
Before a post is created the principles of Necessity, Effectiveness, Proportionality, Relevance and Transparency are considered.

Necessity: defined as the need to do something. It is necessary for advanced nurse practitioners to safeguard health and safety and protect citizens.

Effectiveness: defined as obtaining or producing the intended result. The advanced practitioner will ensure that guidelines for practice are straightforward, clear and as accessible as possible with guidance in plain language.

Proportionality: defined as striking a balance between the advantages a regulation/policy provides and the constraints that it imposes. Proportionality means acting in a fair manner, regulating as lightly as possible given the circumstances, and using more alternatives. The principle generates greater trust on the part of patients/clients and the advanced nurse practitioner (Government White Paper 2004)

Relevance: defined as being necessary for the role and purpose.

Transparency: defined as openness, clearness, being obvious and easy to understand. In terms of the quality of patient care delivered. The principle of transparency underpins the need for regulations, guidelines and processes to be as clear, straightforward and as accessible as possible in their drafting and dissemination. Consulting with relevant stakeholders in advance and presenting information in a clear and accessible manner will ensure transparency (Government White Paper 2004).

Environmental site analysis
Prior to appointment of the advanced nurse practitioner to post an environmental site analysis is undertaken. Principles for site analysis include: Informed Choice, Individualised Care, Respect and

Dignity. The advanced nurse practitioner must meet NMBI registration Requirements and Standards, comply with Scope of Practice and adhere to Health Service Executive National Service Plans. 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 www.hse.ie/clinical

Principles for post creation include: Evaluation of structures, culture, costs and quality. 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. 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 2012).

Conclusion
Positive organisational consequences include excellent care delivery, shared organisational goals, mission and vision, operational and clinical efficiency, positive shared value systems, partnership in decision-making /team approach and new initiative development. The advanced nurse and midwife practitioner are key to this development.

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CHAPTER 7: COMPETENCIES

NMPDU GROUP

Purpose of this response: To contribute to the NMBI 2014 Review of the Standards and Requirements for Advanced Nursing and Midwifery Practice in relation to the development of competencies.

Aim of this response: To consider the following:
1.   Current global competencies of advanced practice.
2.   Feedback on the general principles or guiding factors that should be considered when developing specific competencies.

 (Table 1) provides details of contributors to this part of the review:

Table 1: Membership of the NMPDU Group

Name	Role and place of work
Ms M F OReilly	Director NMPD – West/Mid West
Ms Christine Grandon	NMPD – HSE South (Cork/Kerry)
Ms Carmel Hoey	NMPD – HSE Mid West
Ms Raphael McMullin	NMPD – Dublin Mid-Leinster (Dublin south Kildare & Wicklow)
Ms Elizabeth Breslin	NMPD – HSE North West
Ms Eithne Coen	NMPD – South East
Ms Michelle Waldron	NMPD – Dublin North
Ms Bernie Kerri	NMPD - HSE Midland
Ms Dolores Donegan	NMPD – HSE North East

Method of collecting information from the group
The following information provides details of discussions during tele-conferences, e-mail and telephone conversations. This collaborative response is with the agreement of all members of the group detailed above. Comments from the ONMSD leadership team have also been integrated into this document.
General Comments put forward by the group and agreed
1.   The word 'concept' would benefit from being defined, used in a consistent manner, removed, or reviewed as this can cause confusion particularly in relation to identifying competencies which are core and associated. The following, as an example of suggestions, were put forward as replacement of 'core concepts', the importance of defining the terms would be beneficial within the reviewed 'standards and requirements'.
•   Core Principles
•   Attributes
•   Nursing and Midwifery Framework for Advanced Practice
•   Elements of Advanced practice
2.   The integration of a theoretical framework to guide core and specific competency development was suggested as an area for consideration and further consultation. It may be that individuals or organisations could decide on which framework is appropriate, it would be difficult to provide a mandatory one but not impossible.

3.	Furthermore, utilising an evidence informed theoretical framework has the potential to enhance the overall approach to competency identification and development at advanced practice level. Suggestions in relation to particular frameworks put forward by the group include: Requirements and Standards for Nurse Registration Education Programmes, An Bord Altranais, (2005); From novice to expert : Excellence and power in clinical nursing practice, Benner (1984); The Experiential Taxonomy, A New Approach to Teaching and Learning, Steinaker and Bell, (1979). An important consideration which should be applied to this area is that the nursing/midwifery philosophy is the underpinning foundation for the evidence informed competency framework chosen. The following is additional information in relation to the suggested content of this section of the framework document (Standards and Requirements) and that similar content could be included in a specific comprehensive section outlining nursing and midwifery competency for advanced practice. These points are pertinent to competency frameworks in general.

• 	Competency Statement *(this is a brief written description outlining the expected knowledge, skills and judgement that nurses and midwives use to provide effective care* (Whiddett et al., 2003)

• 	Behavioural Indicators *(these are the behaviours that one would expect to observe when a person demonstrates effective performance in the stated competency. Therefore each individual competency will comprise several behavioural indicators* (Whiddett et al., 2007)

• 	Competency domains/core concepts/clusters or practice standards *(A competency domain/core concept/cluster is a collection of closely related competencies which are grouped together under an overall term that represents one category or aspect of professional practice.* (Higgins et al.,2010)

Global Competencies
Global/core competencies would definitely benefit from further clarification and expansion at this review. The main purpose is to ensure they are comprehensive and fit the level of advanced practice requirements in the context of the changing health care systems both nationally and internationally. Global competencies should be based on health care progression, professional practice, legislation, standards and current thinking. The following additional themes are the suggestions in relation to additional themes which could be included. They would need further discussion and consideration in the global competency framework; the following are guiding principles which could be considered for advanced nurse/midwifery practice competency development/identification.

1.	RANP/RAMP work within the agreed scope of practice for the post as outlined in post site accreditation documents.

2.	The specific competencies for the RANP/RAMP post reflect the competencies required by the RANP/RAMP to manage the patients that fall within the agreed caseload.

3.	The specific competencies must clearly match the RANP/RAMP caseload.

4.	The practice of a RANP/RAMP is informed by clinical experience specific to the specialist area of practice e.g. Emergency Nursing.

5.	The specific skills and expertise required to manage a clinical caseload have developed during the c.ANP/c.AMP clinical and academic training.

6.	The practice of the RANP/RAMP is based on best available evidence-based practice principles and supported by developed PPPG's for the role.

7.	Clinical supervision, management and education mentorship are critical.

The review should consider expanding the global competencies/core competencies to include the following themes:

- Patient and public- safety Registration process for ANP/AMPs and all that entails (Nurses and Midwives Act 2011), demonstrating and articulating the meaning of this for advanced practice contributes to the safety agenda as a whole
- Quality – This is only an example, but the need for nurses and midwives practicing at advanced level to demonstrate how benchmarks (quantitative and qualitative) are identified, evidenced informed, implemented and evaluated into practice and organisational structure is important. The importance of evaluating practice outcomes and picking up on trends is an important part of the advanced practice role from the following: patient safety and quality perspective, developing practice, meeting organisational aims/objective and also meeting public health patient outcomes
- Governance
- Person centred care
- Patient engagement
- Acknowledge the need to clarify values and
- Nursing Professionalism Demonstrating legal, ethical and professional standards of care should be highlighted within the framework
Professional practice – leadership styles - promoting and integrating critical and reflective thinking into practice (See Careful Nursing Philosophy and Professional Practice Model -Appendix 1)
- Representing the science of nursing. The application of models of nursing and midwifery should be made more explicit within the whole advanced practice role and specifically in the competency development for the role then this would support the level of practice, the practitioner, the site development process and importantly the delivery of care
- Demonstrating how the integration of nursing and midwifery philosophical frameworks into practice is important and meaningful
- Standards of Care (example HIQA)
- Integrated care models
- Accountability
- Health Policy
- Research – This section needs more expansion the inclusion of audit, and evaluation processes. The need for the ANP/AMP to demonstrate competencies in relation to translating research, audit, evaluation and other data which is relevant in order to anticipate, predict and explain variations in practice is an important competency for the role
- The identification of Key Performance Indicators (KPI) – make specific reference to this area within the document

Autonomous Practice and Competence for Advanced Practice
It may add clarity to the role if a definition of autonomous practice is offered. i.e. *'freedom to exercise judgement about actions, accepting responsibility for them and being held to account'* NHS Education for Scotland (2007). Consideration is then given to role specific competencies and the behavioural indicators of those competencies so the RANP/RAMP demonstrates this definition of autonomy in practice, knowing that no professional is truly autonomous (Walsh 2006).
The following is an example: The ANP/AMP:

1.   Accepts responsibility and accountability for the caseload management of a cohort of specific patients within an agreed scope of practice. This includes exercising higher level clinical decision making around complex care issues for this cohort.

2.   Demonstrates an understanding of the level of authority that the RANP's/RAMP's clinical practice is governed by and what informs that authority so the RANP /RAMP decision making and clinical reasoning provides the best possible care and outcomes i.e. scope of practice, PPPG's, legislation and registration requirements (This is what gives the RANP/RAMP the freedom to practice autonomously).

3.   Autonomous clinical practice demonstrates a comprehensive framework for the protection of the patient ensuring safety and the highest quality provision of care throughout all stages of the patient journey i.e. collection of clinical and health outcomes, matrix, feedback mechanisms, etc.

4.   Acts as a clinical leader promoting and protecting autonomy through demonstrating of self awareness, empowerment, advocacy, effective communication and team working skills.

Expert Practice

It may add clarity if within the standards and requirement for advanced practice that a definition for' expert' practice is offered. Considerations are then given to role specific competencies and their behavioural indicators that allow the RANP/RAMP demonstrates expert practice. Competencies alone will not make expert practice, to this is added the educational requirement, agreed substantial experience and capability (Fraser & Greenhalgh 2001, Wilson & Holt 2001, Benner (1984) level 5 expert practitioner- See Appendix 1).

Clinical Leadership

A definition of 'clinical leadership' is included as in the other three core concepts above, *i.e. a clinical leader is a competent professional involved in providing direct and indirect clinical who influences and enables oneself and others to improve care' (*ONMSD 2010*).* Considerations are then given to role specific competencies and their behavioural indicators that will allow the RANP/RAMP demonstrates practice as a clinical leader.

All nursing/midwifery practice should be founded upon a robust philosophy, at advanced nursing/midwifery practice level; the philosophy of care should be integral to all aspects of the role. The professional contribution of nursing/midwifery to the patient's journey should be made explicit, notwithstanding the need for interdisciplinary collaboration. Another approach to developing competencies for advanced practice would be to use the four nursing concepts of the

1.   Person
2.   Environment
3.   Health
4.   Nursing

This would facilitate use of commonly known nursing theories/models. The competencies and behavioural indicators could then be developed for the four concepts.

Alternatively, a professional practice model (which is more flexible and applicable to advanced practice), could form the framework for advanced nursing practice such as the "Careful Nursing Philosophy and Professional Practice Model." Here the four main dimensions are:

1.   The Therapeutic Milieu
2.   Practice Competence and Excellence
3.   Management of Practice and Influence in Health Systems
4.   Professional Authority

There are 20 related concepts to the four dimensions See www.carefulnursing.ie   This is an Irish professional practice model derived from nursing in Ireland.
The philosophical underpinnings of the practice model in this example are inextricably linked to all aspects and permeate care at every level.

As either of these suggestions would require changing the existing Nursing Midwifery Board of Ireland (NMBI) and National Council for the Professional Development of Nursing and Midwifery (NCNM) framework significantly, they are offered as suggestions for consideration.

The example below utilises the current NMBI/NCNM framework, all of the competencies are inextricably linked to one another and are interdependent on each other. Competence is the ability of an individual to practice safely and effectively within his/her scope of practice (An Bord Altranais, 2000).
Benner's taxonomy (expert level 5 as listed below), or similar could be used for all ANP/AMP competencies with the additions on the left. These are adapted from both University College Dublin and the Royal College of Surgeons Ireland advanced practice programmes as example only. The behavioural indicators offered relate to autonomy in clinical practice and the sub headings in the first row of the table listed on the left. Behavioural indicators are also offered for the sub heading under Expert practice (MDT collaboration).   The other three elements have not been dealt with in this submission document.

ANP practice specific competencies in the assessment treatment and overall management of patients presenting to their clinics should be demonstrated at expert level as outlined by Benner level 5 (1984)

- Has a global scope of practice
- No longer relies on rules, guidelines or maxims
- Intuitive grasp of situations based on deep tacit understanding
- Cohesively integrates direct and indirect roles
- Intuitively recognises situations and applies prior knowledge and experience in decision-making process
- Facilitates innovative changes in the clinical setting using audit and research techniques
- Empowers patients, families and colleagues
- Has established strong lines of communication with the multidisciplinary team in order to promote the continued health and well-being of the client group
- Acts as a role model preceptor and consultant to nurses within and outside of the organisation
- Vision of what is possible

Benner's Taxonomy (see above for description)

Framework elements	ASSOCIATED COMPETENCIES	Behavioural Indicators
Autonomy in clinical practice		
Management of patients health illness status	• Accepts accountability and responsibility for clinical decision-making at advanced practice level through caseload management for patients/clients	• Articulates own scope of practice using the principles as laid down by the Scope of Nursing and Midwifery Practice Framework document, An Bord Altranais (2000)
Effective case management	• Performs comprehensive health assessment, plans and initiates evidence based care and treatment modalities to achieve patient/client-centred outcomes and evaluates their effectiveness, initiating and terminating a care episode	• Recognises limitations in scope and has the ability to address gaps in theoretical and practical knowledge base • Provides for safety and privacy • Takes a complete comprehensive patient health history • Performs a complete, systematic physical examination • Performs problem specific examination
Evaluation of care	• Uses professional judgement to refer patients/clients to nurses, midwives, healthcare professionals and healthcare agencies	• Demonstrates critical thinking and diagnostic reasoning in identification of both current and potential health problems
Documentation of care	• Advocates for the provision of a therapeutic environment for all service users	• Evaluates history and physical findings and generates a hypothesis about the nature, and severity of the problem the needs of the patient and family • Develops and analyses appropriate differential diagnoses for patient problems • Ensures patient and family understanding of the health problems • Adapt appropriate evidenced based decisions for individualised patient care • Develops a care plan for the patient based on this interpretation • Prioritises data collection according to the patients' immediate condition • Orders and interprets

		appropriate laboratory tests for monitoring of ongoing treatment considering: patient safety, governance invasiveness, acceptability and cost
		• The specific advanced practice tests and investigations utilised for advanced nursing diagnosis, carried out by the ANP/AMP, according to the particular patient case load. should be detailed here
		• Manages chronic and episodic illness according to collaboratively developed protocols/guidelines
		• Assesses and manages psycho–social concerns
		• Orders therapeutic modalities considering: patient safety, governance, invasiveness, acceptability and cost
		• Educates the patient and family about expected effects and potential side-effects of treatment(s)
		• Analyses and evaluates the efficiency of individual treatments
		• Modifies existing planned treatment as per protocol
		• Evaluates patients and families ability to comply with treatment
		• Identifies community resources for patient and family referral
		• Effectively instructs patients prior to diagnostic and therapeutic investigations
		• Consults and collaborates with MDT
		• Provides appropriate health promotion and disease prevention
		• Anticipate and prepares for the potential sequelae of the patient's condition in life threatening situations
		• Identifies expected outcomes of care with regard to the patient's present and potential problems
		• Modifies outcomes based on changes in condition as pre guidelines
		• Assumes a leadership role in establishing and monitoring standards of practice to improve patient care
		• Participates in efforts to avoid

		duplication of tests and prolonged lengths of stay
		• Evaluates patient assessment with regard to expected outcomes
		• Participate in clinical audit to monitor the effectiveness of patient care
		Formulates a written problem, complete history and physical examination assessment and plan of care
		Documents the rationale for diagnostic and therapeutic interventions
		Constructs concise complete notes for episodic visits
		Orally present the patient regarding;
		i. pertinent history and physical findings
		ii. laboratory tests and procedures required
		iii. a detailed plan of care
		iv. criteria for outcome evaluation
		Accurately and concisely dictates/writes letters to appropriate multidisciplinary team.
Expert practice		
Collaboration with MDT to achieve desired outcomes	• Articulates and demonstrates the concept of nursing/midwifery advanced practice within the framework of relevant legislation, The Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000), Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais 2000) and Guidelines for Midwives (An Bord Altranais 2001). Practices in accordance with the organisational governance framework in a safe and ethical manner • Demonstrates advanced clinical decision-making skills to manage a patient/client caseload • Identifies health promotion priorities in the area of clinical practice • Implements health promotion strategies for patient/client groups in accordance with the public health agenda	• Demonstrates expert skill in the diagnosis and treatment of acute and or chronic illness from within a collaboratively agreed scope of practice framework with other health care professionals • Communicates effectively with other members of the MDT • Liaises with the MDT in order to co-ordinate an effective plan of care for the patient/family • Establishes an atmosphere in which a team approach to patient care is facilitated • Discusses clinical judgements and assessment findings with the MDT • Ensures decision making processes involve all the health care professionals on the MDT
Teaching and coaching	• Identifies effective strategies for education, learning and knowledge	

	sharing among peers and the patient cohort	
Professional and clinical leadership **Patient Advocacy**	• Articulates and communicates a vision of areas of nursing/midwifery practice that can be developed beyond the current scope of nursing/midwifery practice and demonstrates a commitment to development of these areas • Develops and implements integrated services for the patient cohort • Identifies expected outcomes of care with regard to the patient's present and potential problems • Contributes to professional and health policy at local, regional and national level • Initiates and implements changes in healthcare service in response to patient/client need and service demand • Contributes to service planning and budgetary processes • Demonstrates mentorship, preceptorship, teaching, facilitation and professional supervisory skills for nurses and midwives and other healthcare professionals • Provides leadership in clinical practice and acts as a resource and a role model of advanced nursing/midwifery practice • Contributes to the professional body of nursing/midwifery knowledge and practice nationally and internationally • Identifies need and leads development of clinical standards • Procures and effectively manages resources required for service provision and development • Demonstrate a commitment to enhancing the culture of clinical governance • Ensure the implementation of patient/ service initiatives	

Research **Enhancing quality of health care**	• Identify research priorities for the area of practice • Leads, conducts, disseminates and publishes nursing/midwifery research, which shapes and advances practice, education and policy and the wider health agenda • Identifies, critically analyses, disseminates and integrates nursing/midwifery and other evidence into the area of clinical practice • Initiates, participates in and evaluates audit • Uses the outcomes of audit to improve service provision • Contributes to service planning and budgetary processes through use of audit data and specialist knowledge	

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APPENDIX A STATISTICS RE ADVANCED PRACTICE POSTS

NMBI POSTS PER COUNTY AT 01 OCTOBER 2014		
Post Title	**County**	**Division of the Register**
Emergency	Cavan x 1	G
Dementia Care	Clare x 1	P
Emergency	Clare x 3	G
Cardiology	Cork x 1	G
Colorectal	Cork x 1	G
Diabetes mellitus	Cork x 1	G
Neonatology	Cork x 1	G
Older Person Rehabilitation	Cork x 1	G
Rheumatology	Cork x 1	G
Emergency	Cork x 10	G
Psychotherapy	Cork x 4	P
Positive Behaviour Support	Cork x 1	ID
Oncology	1. Donegal x 1	G
Dementia Care	Donegal x 1	P
Child Health Parenting	Donegal x 1	PH
Emergency	2. Donegal x 2	G
Eating disorders	Donegal x 1	P
Cardiology	3. Dublin N x 1	G
Cardiology emergency	Dublin N x 1	G
Diabetes mellitus	4. Dublin N x 1	G
Heart Failure	Dublin N x 1	G
Older community	Dublin N x 1	G
Pain Management	Dublin N x 1	G
Emergency	Dublin N x 12	G
Emergency	Dublin N x 2	CH
Epilepsy	Dublin N x 2	G
Neonatology	5. Dublin N x 2	G
Diabetes mellitus	Dublin Private x 1	G
Oncology	Dublin Private x 1	G
Child & Adolescent MH	Dublin Private x 1	P
Eating disorders	Dublin Private x 1	P
Emergency	Dublin Private x 4	G
Diabetes mellitus	Dublin S x 1	M
Women's health	Dublin S x 1	M
Diabetes mellitus	Dublin S x 1	CH
Epilepsy	Dublin S x 1	CH
Haematology	Dublin S x 1	CH
Haematology oncology	Dublin S x 1	CH
Gastroenterology	6. Dublin S x 1	G
Heart Failure	7. Dublin S x 1	G
Occupational Health	Dublin S x 1	G
Ophthalmology	Dublin S x 1	G
Palliative Care	8. Dublin S x 1	G

Primary Care	9. Dublin S x 1	G
Rheumatology	10. Dublin S x 1	G
Sexual Health	11. Dublin S x 1	G
Stroke Care	12. Dublin S x 1	G
Child & Adolescent MH	13. Dublin S x 1	P
CB Psychotherapy	Dublin S x 1	P
Forensic Mental Health	Dublin S x 1	P
Older Adults Community	Dublin S x 1	PH
Emergency	14. Dublin S x 12	G
Emergency	Dublin S x 2	CH
Breast care	Dublin S x 2	G
Cardiology	Dublin S x 2	G
Cardiology emergency	15. Dublin S x 2	G
Neonatology	Dublin S x 2	G
Women's Health	Dublin S x 2	G
Cardiothoracic	16. Dublin S x 4	G
Cardiothoracic	Galway Private x 1	G
Diabetes mellitus	17. Galway x 1	G
Haematology	Galway x 1	G
Neonatology	Galway x 1	G
Oncology	Galway x 1	G
Pain Management	Galway x 1	G
Urology	Galway x 1	G
Vascular	Galway x 1	G
Liaison Mental Health	Galway x 1	P
Recovery Rehab Psy	Galway x 1	P
Women's preventive health	Galway x 2	M
Oncology Radiation	Galway x 2	G
Emergency	Galway x 7	G
Emergency	Kerry x 3	G
Cardiology emergency	Kildare x 1	G
Emergency	Kildare x 2	G
Diabetes mellitus	Kilkenny x 1	G
Emergency	Kilkenny x 1	G
CBT	Laois x 1	P
Primary Care	18. Leitrim x 1	G
Rheumatology	Leitrim x 1	G
Diabetes mellitus	Limerick x 1	M
Neonatology	Limerick x 1	M
Neonatology	Limerick x 1	G
Women's Health	Limerick x 1	G
Recovery Rehab MH	Limerick x 1	P
Emergency	Limerick x 4	G
Neonatology	Louth x 2	G
Palliative Care	Louth x 3	G
Emergency	Louth x 7	G
Diabetes mellitus	Mayo x 1	G

Emergency	Mayo x 1	G
Oncology	Mayo x 1	G
Recovery M H	Mayo x 1	P
Liaison Mental Health	Mayo x 2	P
Emergency	Meath x 3	G
Emergency	19. Monaghan x 1	G
Haematology	Offaly x 1	G
Oncology	20. Offaly x 1	G
Emergency	Sligo x 2	G
ID Co-existing MH Dis	Sligo/Leitrim x 1	ID
CBT	Sligo/Leitrim x 2	P
Emergency	Tipperary North x 1	G
Emergency	Tipperary South x 1	G
Older Person Care of	Tipperary South x 1	G
Older Person Dementia	Tipperary South x 1	G
Midwifery care	Waterford x 1	M
Ambulatory care	Waterford x 1	CH
Neonatology	Waterford x 1	G
Emergency	21. Waterford x 3	G
Emergency	Westmeath x 2	G
Emergency	Wexford x 2	G

NMBI POSTS PER NMBI DIVISION OF THE REGISTER AT 01 OCTOBER 2014	
MIDWIFERY	
Diabetes mellitus	Dublin S x 1
Diabetes mellitus	Limerick x 1
Midwifery care	Waterford x 1
Neonatology	Limerick x 1
Women's health	Dublin S x 1
Women's preventive health	Galway x 2
CHILDREN'S NURSING	
Ambulatory care	Waterford x 1
Diabetes mellitus	Dublin S x 1
Emergency	Dublin N x 2
Emergency	Dublin S x 2
Epilepsy	Dublin S x 1
Haematology	Dublin S x 1
Haematology oncology	Dublin S x 1
GENERAL NURSING	
Breast care	Dublin S x 2
Cardiology	Cork x 1
Cardiology	22. Dublin N x 1
Cardiology	Dublin S x 2
Cardiology emergency	Dublin N x 1
Cardiology emergency	23. Dublin S x 2
Cardiology emergency	Kildare x 1
Cardiothoracic	24. Dublin S x 4

Cardiothoracic	Galway Private x 1
Colorectal	Cork x 1
Diabetes mellitus	Cork x 1
Diabetes mellitus	25. Dublin N x 1
Diabetes mellitus	Dublin Private x 1
Diabetes mellitus	26. Galway x 1
Diabetes mellitus	Kilkenny x 1
Diabetes mellitus	Mayo x 1
Emergency	Cavan x 1
Emergency	Clare x 3
Emergency	Cork x 10
Emergency	27. Donegal x 2
Emergency	Dublin N x 12
Emergency	Dublin Private x 4
Emergency	28. Dublin S x 12
Emergency	Galway x 7
Emergency	Kerry x 3
Emergency	Kildare x 2
Emergency	Kilkenny x 1
Emergency	Limerick x 4
Emergency	Louth x 7
Emergency	Mayo x 1
Emergency	Meath x 3
Emergency	29. Monaghan x 1
Emergency	Sligo x 2
Emergency	Tipperary North x 1
Emergency	Tipperary South x 1
Emergency	30. Waterford x 3
Emergency	Westmeath x 2
Emergency	Wexford x 2
Epilepsy	Dublin N x 2
Gastroenterology	31. Dublin S x 1
Haematology	Galway x 1
Haematology	Offaly x 1
Heart Failure	Dublin N x 1
Heart Failure	32. Dublin S x 1
Neonatology	Cork x 1
Neonatology	33. Dublin N x 2
Neonatology	Dublin S x 2
Neonatology	Galway x 1
Neonatology	Limerick x 1
Neonatology	Louth x 2
Neonatology	Waterford x 1
Occupational Health	Dublin S x 1
Older community	Dublin N x 1
Older Person Care of	Tipperary South x 1
Older Person Dementia	Tipperary South x 1

Older Person Rehabilitation	Cork x 1
Oncology	34. Donegal x 1
Oncology	Dublin Private x 1
Oncology	Galway x 1
Oncology	Mayo x 1
Oncology	35. Offaly x 1
Oncology Radiation	Galway x 2
Ophthalmology	Dublin S x 1
Pain Management	Dublin N x 1
Pain Management	Galway x 1
Palliative Care	36. Dublin S x 1
Palliative Care	Louth x 3
Primary Care	37. Leitrim x 1
Primary Care	38. Dublin S x 1
Rheumatology	Cork x 1
Rheumatology	39. Dublin S x 1
Rheumatology	Leitrim x 1
Sexual Health	40. Dublin S x 1
Stroke Care	41. Dublin S x 1
Urology	Galway x 1
Vascular	Galway x 1
Women's Health	Limerick x 1
Women's Health	Dublin S x 2
INTELLECTUAL DISABILITY NURSING	
ID Co-existing MH Dis	Sligo/Leitrim x 1
Positive Behaviour Support	Cork x 1
PSYCHIATRIC NURSING	
Child & Adolescent MH	42. Dublin S x 1
Child & Adolescent MH	Dublin Private x 1
CB Psychotherapy	Dublin S x 1
CBT	Laois x 1
CBT	Sligo/Leitrim x 2
Dementia Care	Clare x 1
Dementia Care	Donegal x 1
Eating disorders	Donegal x 1
Eating disorders	Dublin Private x 1
Forensic Mental Health	Dublin S x 1
Liaison Mental Health	Galway x 1
Liaison Mental Health	Mayo x 2
Psychotherapy	Cork x 4
Recovery M H	Mayo x 1
Recovery Rehab MH	Limerick x 1
Recovery Rehab Psy	Galway x 1
PUBLIC HEALTH NURSING	
Child Health Parenting	Donegal x 1
Older Adults Community	Dublin S x 1

APPENDIX B: WGAP MEMBERSHIP

Representing	Agreed
President or Vice President NMBI	John Murray: Vice President
Public Representative on Registration Comm	Cathriona Molloy
Chairperson Registration Committee of NMBI	Sandra McCarthy
HEI Offering Specific MSc/Post Graduate Diploma in Advanced Practice	Eileen Savage: Head of School of Nursing and Midwifery. University College Cork, Cork
DON/DOM with history of advanced practice posts	Paul Gallagher: Director of Nursing, St James's Hospital Dublin 8
Consultant with experience of clinical supervision of ANPs/AMPs	Hugh Mulcahy: Consultant Gastroenterologist. Associate Professor of Medicine. SVUH Elm Park. D 4
Office of Nursing and Midwifery Services Director ONMSD	Christine Grandon: NMPD Officer, NMPDU, Cork
Quality and Patient Safety Directorate	Maureen Flynn: National Lead for Clinical Governance Development
Clinical Indemnity Scheme CIS	Ann Duffy: Clinical Risk Advisor. Clinical Indemnity Scheme. Treasury Building, Grand Canal St, D2
IAANMP	Bernadette Carpenter: RANP Emergency Department. Mater Misericordiae University Hospital. D7
ANP/AMP Forum RCSI	Edna Woolhead: RANP Neonatology. Rotunda Hospital. D 2
ANP of long standing	Valerie Small: RANP Emergency Department. St. James's Hospital, Dublin 8
ANP involved in NMBI Site Visits	Elizabeth Meade: RANP Oncology. Midland Regional Hospital Arden Road Tullamore County Offaly.
Subject Matter Expert	Marie Carney RCSI
NMBI Staff x 5	Deirdre Hogan D/CEO Gwen Byrne Senior Staff Officer Registration Georgina Farren Professional Officer Linda Hannigan Staff Officer Registration Mary Flynn Advanced Practice Registration Department
PROJECT SPONSOR: Chief Education Officer, NMBI: Dr Anne-Marie Ryan PROJECT LEAD: Education Officer Regulation NMBI: Maria Neary ADMINISTRATION SUPPORT: Planning and Development Directorate: Rose Lindsay	

CHANGES TO WGAP MEMBERSHIP

Ruth Maher: Head of Monitoring. Quality and Patient Safety Directorate. Quality and Patient Safety, HSE has resigned her post & has been replaced on the WGAPXFT7 by Maureen Flynn National Lead for Clinical Governance Development (April 2014)
Thomas Kearns Education Officer NMBI has resigned his post (April 2014)
Linda Hannigan Staff Officer Reg Dept has moved jobs within NMBI but will remain on the group (May 2014)
Mary Flynn has replaced Linda in the area of advanced practice in NMBI & will join the group (May 2014)
Deirdre Hogan has left NMBI on a secondment (July 2014)
Ann Duffy: Clinical Risk Advisor. Clinical Indemnity Scheme. Treasury Building, Grand Canal St, D2 has been replaced by Mary Godfrey Clinical Risk Adviser Clinical Indemnity Scheme State Claims Agency Treasury Building Grand Canal Street Dublin 2 (August 2014)
Anne-Marie Ryan left NMBI on a secondment (September 2014)
Maria Neary To leave NMBI & Last meeting (20 October 2014)
Mary Flynn To leave NMBI & Last meeting (20 October 2014)

APPENDIX C: POSSIBLE PURPOSIVE GROUPS FOR CONSULTATION

Purposive Consultation
Department of Health
Department of Education & Science
INMO
IMPACT
PNA
SIPTU
Irish Patients Association
Irish Advocacy Network
Patient Focus
National Federation of Voluntary Bodies
Inclusion Ireland
Care Pathways: • ACS • Acute Medicine • Anaesthesia • Asthma • Audiology • Blood Transfusion • COPD • Critical Care • Dermatology • Diabetes • Emergency Medicine (EMP) • Epilepsy • Heart Failure • Medicines Management Programme • Mental Health • Neurology • Obstetrics and Gynaecology • Older People • OPAT • Ophthalmology • Orthopaedics • Paediatrics and Neonatology • Palliative Care • Primary Care • Radiology • Rare Diseases • Rehabilitation Medicine • Renal • Rheumatology • Stroke • Surgery

ISSUE LIST 13/10/14

Email issued with reference to NMBI website
www.nursingboard.ie/en/join_register.aspx/en/join_register.aspx

NMBI website
NMBI Staff
Registration Committee of NMBI
WGAPXFT7 members
Persons who have left WGAPXFT7
DONs/DONs
HEIs
RANPs/RAMPs
NMPDUs Directors
NMPDUs AP Contact List
NMPDUs Focus Group Organisers
Participants in Focus Groups

PLEASE SHARE LINK WITH ANYONE WHO MIGHT BE INTERESTED & NOT ON ABOVE LISTS