Policy, Politics, & Nursing Practice
2015, Vol. 16(1–2) 27–37

DOI: 10.1177/1527154415584233
ppn.sagepub.com
SAGE

Development of the Nurse Practitioner Standards for Practice Australia

Andrew Cashin, RN, MHN, NP, Dip App Sci, BHSC, GCert PTT, GCert Hpol, MN, PhD, FACNP, FACMHN, FCN[1], Thomas Buckley, RN, BSc (Hons), MN, PhD[2], Judith Donoghue, PhD, BA (Hons), DNE, CN, CM[3,4], Marie Heartfield, PhD, RN[5], Julianne Bryce, RN, BN Dip App Sci, Grad Dip Adult Education and Training[6], Darlene Cox, BA, DipEd, Grad Dip AppECE, Bed[7], Donna Waters, RN, PhD MPH (Sydney), BA (Macquarie), Paed Cert FCN[2], Helen Gosby, RN, NP, BA, Grad Dip Appl Sc, MN[8], John Kelly, AM, RN, BA (Hons), LLB, Grad Dip Leg Prac, FACN, AFAIM, MAPS, MAICD[3,9], and Sandra V. Dunn, RN, PhD, FACN[10]

Abstract

This article describes the context and development of the new Nurse Practitioner Standards for Practice in Australia, which went into effect in January 2014. The researchers used a mixed-methods design to engage a broad range of stakeholders who brought both political and practice knowledge to the development of the new standards. Methods included interviews, focus groups, surveys, and work-based observation of nurse practitioner practice. Stakeholders varied in terms of their need for detail in the standards. Nonetheless, they invariably agreed that the standards should be clinically focussed attributes. The pillars common in many advanced practice nursing standards, such as practice, research, education, and leadership, were combined and expressed in a new and unique clinical attribute.

Keywords

advanced nursing practice, certification/accreditation, regulation of nursing practice

In July 2010, Australia moved to a national registration process for all health practitioners under the auspices of the Australian Health Practitioner Regulation Agency (AHPRA) and encompassing several regulatory boards, including the Nursing and Midwifery Board of Australia (NMBA). The NMBA commissioned the drafting of the second version of the Standards for Practice for the Nurse Practitioner (*NP)* in 2012, with the aim of revising the standards to reflect contemporary and actual practice. The authors of this article constituted the team involved in the development of the NP standards. We present it here as an example of policy formation in which policy makers (NMBA) translated their visions of NP practice into a format that guides delivery of care to achieve desired population outcomes (Smith-Merry, Gillespie, & Leeder, 2007).

[1]School of Health and Human Sciences, Southern Cross University, Lismore, NSW, Australia
[2]Sydney Nursing School, University of Sydney, NSW, Australia
[3]University of Technology, Sydney, NSW, Australia
[4]Nurse Practitioner Standards Review Project, Sydney Nursing School, University of Sydney, NSW, Australia
[5]Flinders Human Behaviour & Health Research Unit, Flinders University, Adelaide, South Australia, Australia
[6]Australian Nursing and Midwifery Federation, Melbourne, Victoria, Australia
[7]Health Care Consumers' Association, Canberra, ACT, Australia
[8]Australian College of Nurse Practitioners, Sydney, NSW, Australia
[9]Aged and Community Services Australia, Sydney, NSW, Australia
[10]Faculty of Engineering, Health, Science and the Environment, Charles Darwin University, Darwin, Northern Territory, Australia

Corresponding Author:
Andrew Cashin, School of Health and Human Sciences, Southern Cross University, Rifle Range Road, Lismore, NSW, 2480, Australia.
Email: andrew.cashin@scu.edu.au

Policy making can be framed as a drama that includes a synthesis of evidence to make plausible arguments (Greenhalgh & Russell, 2006). The evidence required to form effective policies includes, but is not limited to, results of empirical studies (Bernier & Clavier, 2011). Successful policy formation can also be based on synthesis of evidence developed through the three lenses of political knowledge, research-based knowledge, and field experience (Head, 2008). This article draws from evidence in each of these lenses. The evidence that guided our development of the NP standards included a review of the literature, interviews with policy stakeholders, focus groups with consumers, public consultation, and work-based observation of NP practice. We first analyzed findings from these different sources of evidence and then synthesized the findings with a focus on revising the NP standards.

The health policy triangle, which emphasizes the interaction of context, process, and content in forming health policy (Walt & Gibson, 1994), provides the framework for this research. Policy has multiple dimensions; this article presents the outcomes that one might use to evaluate the NP standards' success, failure, and effectiveness (McConnell, 2010).

Background

Credentialing for advanced practice nursing (APN) varies among nations. Pulcini, Jelic, Gul, and Loke (2010) surveyed 32 countries and found that 23 formally recognized the NP or APN role (Pulcini et al., 2010). Of these 23 countries, 11 (48%) had requirements for licensure maintenance, registration, or renewal (Pulcini et al., 2010). International definitions of *advanced nursing practice* (ANP) identify characteristics of advanced practice, expanded scope of practice, generality or specificity of practice, and sometimes the level of education required (e.g., master's degree; Stasa, Cashin, Buckley, & Donoghue, 2014).

Context

In Australia, *NP* is a regulated title requiring endorsement by the NMBA. Applicants who have completed an approved and required master's education programs of study and can document 5,000 hours of advanced practice are eligible to apply for endorsement as NPs. NMBA staffs assess the applications against the Australian NP Standards for Practice to determine a candidate's eligibility for NP endorsement (Nursing and Midwifery Board of Australia [NMBA], 2013).

The first National *Competency* Standards for the *NP* (*now replaced by the Australian* NP *Standards for Practice)* were commissioned by the *Australian and Nursing Midwifery Council (ANMC)* and published in 2004 (Gardner, Carryer, Dunn, & Gardner, 2004). At that time, 15 NPs participated in the research and development of the initial NP competencies. Although the number of NPs endorsed at the time of the release of the new standards is not published, as of June 2014, there were 1,087 endorsed NPs in Australia (NMBA, 2014).

In Australia, one set of NP standards is used for a range of regulatory, educational, employment, and monitoring purposes, irrespective of an NP's specialty, population focus, or geographic locale. The standards also guide the development of curricula for NP master's education programs (Australian Nursing and Midwifery Council [ANMC], 2009). Additionally, standards assist NPs in defining and validating their individual scopes of practice. Standards also enable evaluation of individual NP performance and inform other professionals and health consumers about NPs' capabilities and scopes of practice. The multipurpose NP standards in Australia mean that revision required a generic approach to content rather than a practice specialty or population focus. With this in mind, the major aim of the research project described in this article was to analyze the gap between Australia's existing 2004 National *Competency* Standards for the NP and actual NP practice. A second aim was to use a structured consultative and iterative process to develop a provisional set of revised Australian NP Standards for Practice.

The project consisted of three distinct phases: (a) literature review, consultation, and synthesis; (b) gap analysis and public consultation; and (c) validation of the revised standards (see Figure 1). Each phase had a distinct purpose and set of methods and built iteratively on the findings of the preceding one. Phases 1 and 2 encompassed ongoing engagement of stakeholders; Phase 3 was designed to ensure that the developed standards were applicable to actual NP practice. Although the research team conducted an extensive literature review to inform the process, Phases 1 and 2 largely refer to the work conducted through the lenses of political knowledge, and practical and professional field experience (Head, 2008).

The institutional Human Research Ethics committees of both the University of Sydney and Southern Cross University approved the study. The validation phase of the project was undertaken in all of Australia's six states and two territories.

Phase 1: Literature Review, Consultation, and Synthesis

The first phase—consultation and synthesis—consisted of a literature review, telephone interviews, and focus groups. The literature review covered peer-reviewed and gray literature articles published from 2004 to 2013 in Australian and international publications, with special

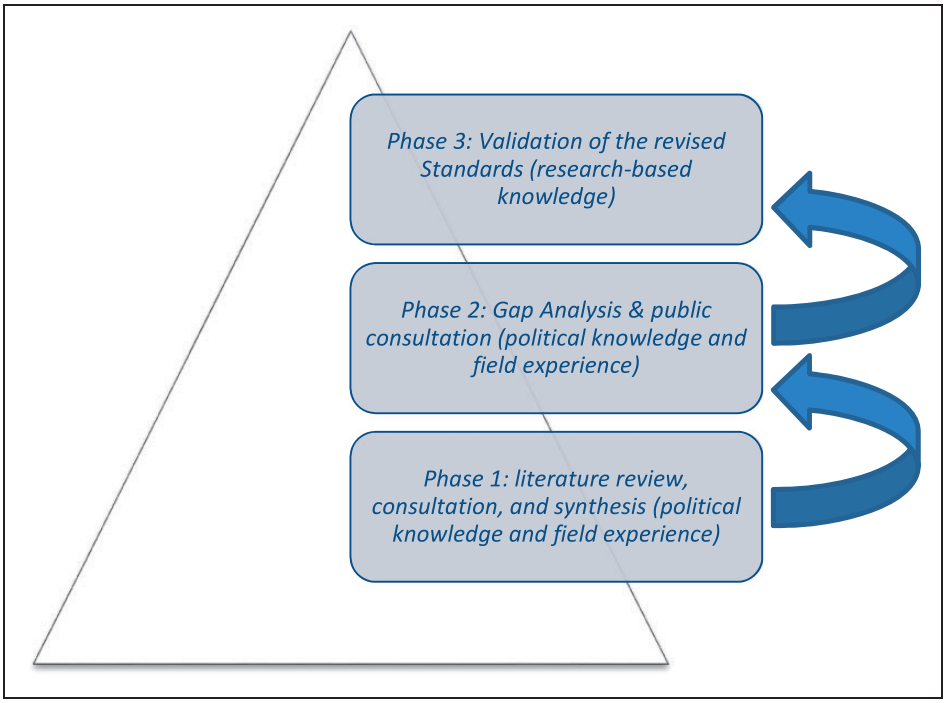

Figure 1. Phases of the development of the Nurse Practitioner Standards of Practice Australia project.

reference to countries with an identifiable NP role. Topics surveyed included NP role, scope of practice, competency and standards, and legal requirements. The terms *advanced practice nursing*, *advanced nursing practice*, *scope of practice*, and *extended practice* were searched separately in CINAHL, Medline, and PubMed online databases. The pearl-growing strategy was utilized, where lists of references were searched to locate additional articles not picked up in the original search (Harter, 1986). The research team also reviewed variations in practice among jurisdictions (e.g., national and state) or sectors (e.g., public health system and primary care), the impact of employment arrangements on role and scope of practice, and relevant legislation and regulations. The results of the review were published separately (Stasa et al., 2014). The major finding was the great variability in the use of basic terms related to advanced practice in nursing internationally and at times within countries. This imprecise use of language has promoted confusion within the profession and the public at large.

The second part of Phase 1 consisted of 17 1-hr telephone interviews with six chief nurses, five professional officers in state and territory health departments, and six AHPRA staff from South Australia, Western Australia, Queensland, Victoria, and New South Wales. The sample consisted of those who responded to a formal invitation to all state and territory departments to participate. The interviews sought information on how the existing NP standards were used, particular challenges with any item or wording, components of the existing standards that should be retained, and changes to improve the standards' *usability*. All interviews were audiotaped and transcribed for subsequent analysis.

Another data source during this first phase was a working group discussion among 48 NPs who responded to an invitation to participate at the annual Australian College of Nurse Practitioners conference in 2012. A research team member facilitated smaller groups, undertaking a detailed examination of each standard, its wording, and identification of content potentially requiring revision. The subgroups reported their feedback to the whole group for broad discussion concerning the recommended changes.

Phase 1 Findings

Findings from interviews and focus groups with relevant stakeholders revealed five key themes: (a) use of language, (b) level of behaviors, (c) expression of attributes in guiding NP behaviors, (d) use of the standards, and (e) scope of NP practice. Each of these findings is discussed in more detail, below.

Use of language for NP standards. Informants reported that the standards required modernization and rewording, so that consumers and others, such as clinicians and health administrators, could clearly understand them. Feedback

from one NP, who expressed the sentiments of many others, indicated that the language was "too wordy, vague and unclear in places and a number of the competencies are repeated." Interviewees who utilized the standards to determine suitability to practice reported that the existing standards *lacked clarity* as some wording was *difficult to understand*. Some participants reported that use of the word autonomous in the standards was problematic, particularly for professionals in other disciplines who think that nursing should be part of a collaborative arrangement of patient care.

The notion of collaboration was important to many NPs who considered they made decisions within a team. However, these views were not unanimous, and other participants expressed that there should be a focus on the independent and autonomous role of the NP. Some NPs considered that language used obscured other health professionals' understanding of the NP role, which potentially made certain NP practices (like prescribing and referrals) unnecessarily challenging. The references to a nursing model in the previous standards were reported as not clearly understood as what this meant was not clearly articulated.

Interpretation of the level of behaviors in the standards. Interviewees responsible for evaluating applications for NP endorsement asserted that applicants generally provided insufficient evidence of advanced practice behavior, particularly in the attributes of leadership, education, and research. Interviewees also reported that applicants demonstrated knowledge gaps in what constituted advanced practice evidence. They suggested that the standards needed to clearly distinguish the difference between NP and registered nurse (RN) practice, which in turn will guide NP candidates. Participants suggested that standards needed to accommodate the reality that an NP might be an expert in one area but not others. Most members of the NP focus group suggested that the standards needed to articulate the knowledge requirements for working as an NP. It was suggested that NPs may have skills in the same areas as RNs (e.g., clinical, research, ethics), but the level of knowledge of the NP must be more comprehensive, far-reaching, detailed, and sophisticated.

Expression of attributes to guide NP behaviors. Several interviewees responsible for policy formation and implementation commented that some components of the NP role were not clearly expressed in the previous standards. Leadership was considered to be challenging for NPs to demonstrate, even within their own organization. NP participants also expressed that clinical leadership was a key aspect of the role. Other interviewees asserted that some NPs have difficulty articulating their role to other health professionals and that they lack political astuteness and a working understanding of legal requirements. The evolved standards were seen as necessary to create an organizing framework for representing current NP *clinical* practice.

Nurse leaders recommended that research requirements be elucidated more clearly. They suggested that the interpretation of research in the revised standards includes clinical audit and highlighted the importance of NPs assuming responsibility for self-auditing their practice. The leaders relayed the need for NPs to understand the healthcare system's funding and financial structures.

Focus group participants also discussed the importance of NPs as educators. Most clarified that this meant serving as role models and mentors to other nurses and health professionals, as opposed to referring only to didactic classroom-based academic education.

Use of the standards by NPs. Study participants agreed that standards and competencies are useful guidelines for determining minimum expectations for novice NPs and that with experience in the new NP scope, their practice will develop beyond the minimum standards. Participants stated that consistency in practice was important to give consumers confidence in NP practice capabilities.

Many NP focus group participants said that the standards are *important* as a framework for their scope of practice, but as one NP said they did not use them, *on a day-to-day basis*. Some of the NPs suggested that a move from the abstract organizing pillars of the previous standards to more clinically focussed standards was desirable.

Scope of practice. There was general consensus that NP applicants need a set of agreed core attributes for use by all NPs, whatever their specialty. Some participants advised that these *generalist NP standards* should build on the NMBA RN standards with the addition of NP-specific competencies. One NP commented that, "NPs should have a generalist capacity within their specialty" and that "if standards are too fixed they will quickly become outdated given the shortage of health workforce staff that is predicted for the future." A strong theme emerged from the interviews that NPs were, in fact, not necessarily more specialized in their practice than RNs but indeed were specialists who had built up a broad generalist base.

Another key theme identified from interviewees was the difficulties NPs had in providing evidence of advanced practice and that to facilitate the process definitional clarity was needed between *ANP* and *APN*, terms sometimes used interchangeably and other times with discrete difference (Stasa et al., 2014). Following completion of Phase 1, the authors, based on findings

from the literature review, the telephone interviews, and the NP working group, developed the revised draft standards.

Phase 2: Gap Analysis and Public Consultation

Phase 2 focused on the revised draft of the standards undertaken through interviews and focus groups. The same stakeholders as in Phase 1 were included, augmented by academics (Australian Council of Deans of Nursing and Midwifery), a sample of 32 healthcare consumers and a 10-week public consultation.

Consumer and Carer Focus Groups

Six health consumer focus groups were conducted in urban and rural locations across Australia, including Western Australia, New South Wales, Queensland, Canberra, and South Australia. Thirty-two consumers participated for approximately 1 hr in group discussions facilitated by a project team member.

Several weeks before each focus group was scheduled, participants were sent a copy of the revised standards. This approach was taken to provide participants sufficient time to review the provisional standards and identify words or concepts that were problematic prior to the group session. Participants' responses to prompt questions were audiotaped for three focus groups and recorded by hand-written notes for the other three groups. These six focus groups explored participants' knowledge of the role of the NP based on what was written in the standards. This included their understanding of the language used, identification of whether they would use the services of an NP, and reasons for their decision. Using an inductive process, the data were thematically analyzed by the research team (Hsieh & Shannon, 2005). Team members individually analyzed the notes and electronic data from the six groups. The team then collated shared findings. Some themes were merged and others collapsed as they became redundant. The team then reanalyzed the information to look for data that affirmed or disrupted the thematic analysis. The process of analysis continued until consensus was reached.

Key Findings From Consumer Focus Groups

When consumers were asked if they knew what an NP was, the majority were unsure. A few did know about the NP role because they had used *walk-in* clinics managed by NPs in Australia. However, most did not understand the difference between different titles of nurses (specifically NPs, practice nurses, registered or enrolled nurses; see Table 4), even though some participants said they knew which tasks nurses working in general practitioner's clinics undertook. Generally, participants could not explain the difference between the practice nurse and the NP. Additionally, participants did not know whether the practice nurse was a registered or enrolled nurse.

Consumer focus group participants thought that the NP role as described in the standards would be most useful in rural and remote locations or in after-hour settings, in which physician access was poor. However, when consumers were questioned further about the NP role, some did not know that an NP could order diagnostic tests and interpret the results. One participant said, "NPs are like the nurses in the United States of America who can diagnose and treat people." Some participants were unaware that an NP service operated in their locale. Most participants did not know that NPs could prescribe medication within their scope of practice and refer patients to other services. Some said they would have used the NP services if they had known.

Consumer group participants stated that if consumers are to use the standards, then the language needs to be easily understood. Another point that consumers made was that NPs need to detail and promote their work to the public and clarify what NPs do that differentiates them from RNs.

Along with the need for plain and unambiguous language, focus group participants expressed how standards needed to move from the abstract organizational frame of leadership, research, education, and practice, to a more concrete clinically applicable format that represented NP interactions with patients.

Consultation and Feedback

Two types of consultation were conducted by the authors to receive feedback on the next draft of the standards: a month-long preliminary consultation with employees and key NMBA stakeholders; followed by a 10-week public consultation using a structured response survey. A limited amount of feedback (responses $n = 10$) was received from the internal the AHPRA consultation.

The key feedback points were:

- Strengthen areas such as professional development, education/teaching, leadership, and research. One respondent commented that within the professional, education, and teaching realm, NPs should meet the registration requirement for their own continuing professional development. Another respondent suggested, "a nurse at this level should be teaching others, speaking at professional forums, conferences and contributing to the teaching of undergraduates, newly graduated nurses, and nurses developing specialty skills."
- Within the leadership domain, it was suggested that NPs be active in professional associations and forums

and contribute to the development of policy, procedure, and practice guidelines for the profession. Another recommendation was that NPs contribute to maintenance of standards by participation in professional and registration/regulation bodies through provision of advice, taking on a membership role in standards committees, tribunals, and panels. It was also suggested that NPs participate in community forums and awareness relating to health issues.

- In addition to the *level* being sufficient to meet the NP Standard of Practice envisaged by respondents from health departments, other feedback suggested that the definition of APN as a legislated/protected title for NPs was problematic because nurses with advanced nursing could also be leading clinical teams and should not be excluded from the title of APN, even though their position titles are not regulated, and their practice is within the RN scope. Comments reflected a conflation of ANP in the RN scope, demonstrated in RN positions such as Clinical Nurse Consultant and its relationship to the NP. Feedback was inconsistent and sometimes appeared confused in understanding of definitions of advanced practice. The issue of the use of standards in assessing suitability for endorsement and the need for clarity in the standards and accompanying definitions were articulated. Several participants highlighted the lack of clarity regarding ANP and confusion with APN making endorsement process a *nightmare* and *open to subjective interpretation*. The internal consultation identified two key issues: some debate about perception of the standards as setting a minimum rather than maximum level; and the operational definition of advanced practice, which remained contentious and in need of clarification.

Following the Australian Health Practitioners Regulation Agency preliminary consultation, the draft standards were made available for broader stakeholder/public feedback. Although 152 separate responses were received, the number of responses varied for different statements and cues. The average number of responses per Statement was 42. Responses were primarily related to individual wording as opposed to the need for conceptual revision. While some respondents proposed more nuanced language, others requested further simplification of language.

Phase 3: Validation of the Revised Standards

The third and final phase was observation of NPs at work. This phase was conducted through the lens of scientific and technical analysis (Head, 2008). It involved a stratified sample of 35 NPs from diverse locales in Australia. This was the first Australian study to use a representative stratified sample of NPs. NP practice was compared with the fourth draft version of the standards to validate the standards' content. It also informed the fifth and final version of the standards.

The three major criteria for NP selection in this phase were as follows: (a) their location in a state or territory based on proportionate representation of NPs in all states and territories; (b) whether they worked in an urban, regional, or remote location based on the Measuring Remoteness: Accessibility/Remoteness Index of Australia (ARIA; Commonwealth Department of Health and Aged Care, 2001) classification of their postcode; and (c) their practice specialty (b and c determined proportionately; see Tables 1 to 3). Observers were either members of the research team or NPs trained to use the observation instrument. Each NP was observed undertaking a routine day of practice. Observers noted behaviors in a structured observation tool based on the draft standards. Three types of observation evidence were sought for each standard. They were as follows: (a) observations of behavior, (b) the NP speaking openly about a process that was not visible to the observer (modus operandi thinking), and (c) artifacts or documented evidence, including teaching appointments, published journal articles, and research projects.

The following are the key findings from the observations: (a) all standards were visible in 97% of NPs observed; (b) 86% of the standard cues were observed or evidenced in more than 80% of participants; (c) a high variance in levels of NP practice from novice to experienced existed,

Table 1. Representation of Nurse Practitioners by Australian State and Territory for the Sample Observed.

Location	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
All NPs in Australia, *n* (%)	37 (3.9)	250 (26)	9 (1.3)	245 (25.5)	88 (9.2)	25 (2.6)	124 (12.9)	170 (17.7)
Planned, *n*	1.17	7.8	0.39	7.65	2.76	0.78	3.87	5.31
Achieved, *n* (%)	2 (5.7)	12 (34)	1 (2.8)	7 (20)	3 (8.5)	1 (2.8)	4 (11.4)	5 (14.2)

Note. NP = nurse practitioner; Planned = planned number of nurse practitioner observations; Achieved = actual number of nurse practitioners observed; ACT: Australian Capital Territory; NSW: New South Wales; NT: Northern Territory; QLD: Queensland; SA: South Australia; TAS: Tasmania; Vic: Victoria; WA: Western Australia.

Table 2. The Percent of Representation and Actual Numbers of Nurse Practitioners by Accessibility/Remoteness Index of Australia (ARIA) Classification.[a]

ARIA category	Category 1	Category 2	Category 3	Category 4	Category 5
All NPs in Australia, *n* (%)	635 (81)	91 (12)	27 (3)	9 (1)	21 (3)
Planned, *n*	24.3	3.6	0.9	0.3	0.9
Achieved, *n* (%)	28 (80)	4 (11.4)	1 (2.8)	1 (2.8)	1 (2.8)

Note. NP = nurse practitioner; Planned = planned number of nurse practitioner observations; Achieved = actual number of nurse practitioners observed; AHPRA = Australian Health Practitioner Regulation Agency.
[a]AHPRA data sorted as per http://www.health.gov.au/aria/ariasrch.cfm.

Table 3. Planned and Actual Numbers of Nurse Practitioners by Specialty Area.

Specialty area	Planned number	Actual number of NPs observed
Emergency care	9.6	10
Chronic[a]	4.5	5
Acute care[b]	4.2	5
Primary care	3	4
Aged care	1.8	2
Mental health	1.8	3
Pediatrics	1.5	3
Palliative care	1.2	1
Sexual health	1.2	1
Women's health	0.9	0
Other	0.3	1

Note. NP = nurse practitioner. 1 in other = pain management.
[a]Chronic = diabetes management, chronic cardiac, chronic renal, wound management × 2.
[b]Acute = oncology, acute care.

especially in the domains of leadership, education, and research. The validation observations confirmed that NPs work across many different contexts of practice and systems requiring high levels of systems literacy.

The validation of the standards through observations of the NPs at work was both informative and inspirational. Although the validation phase was technically challenging to organize, it enabled the research team to observe the diversity and sophistication of practice and the impact of NP services in a rich variety of contexts across Australia. It provided important evidence that enabled the team to conclude that the revised standards reflected NP practice in Australia and provided a basis for future adaptation to specialty-specific standards.

Following completion of Phase 3, the penultimate version of the standards was submitted to the NMBA for review. The final standards as approved by the NMBA were made public in September 2013 (NMBA, 2013) and came into effect after January 1, 2014.

Discussion and Conclusion

The research and policy development process that we used allowed an iterative building of new draft NP standards for Australia. Once we developed the draft standards far enough, we were able to conduct work--based observations. Stakeholder perspectives, especially the importance of definitional clarification, were two major issues that arose through the iterative process.

Tension between the needs of different stakeholders in terms of the technical detail of the standards also emerged. The needs of consumers and carers differed from those of NPs, themselves, faculty designing university courses, and AHPRA staff assessing applicants for endorsement. Another theme that the initial phases of the project generated was that the standards need to depict NP attributes as clinically focussed, reflecting what an NP can do. The pillars from the Strong Model (Ackerman, Norsen, Martin, Wiedrich, & Kitzman, 1996) of leadership, education, research, and practice are expressed in relation to NP clinical practice (see Figure 2).

Another important finding was that before standards could operate effectively, they needed to include definitional clarity across ANP (as opposed to APN). This is essential to allow recognition of advanced practice within the RN scope for NP candidates applying for endorsement by the NMBA as an NP. Further, it was evident that the term *NP* needed to be clearly defined and separated from the colloquial term of practice nurse. This was addressed in the glossary of the standards (see Table 4).

Definitional clarity allows consumers and policy makers to situate NPs among the other multitude of nursing titles that have proliferated internationally (Pulcini et al., 2010). This is a first step, matching nursing providers with work to be done, or service sought. For policy makers, this is particularly important in Australia with its move to *scenario-based modeling* of the health workforce (McCarty & Fenech, 2012). Scenario-based modeling refers to the process of exploring possible futures in health workforce through modeling based on

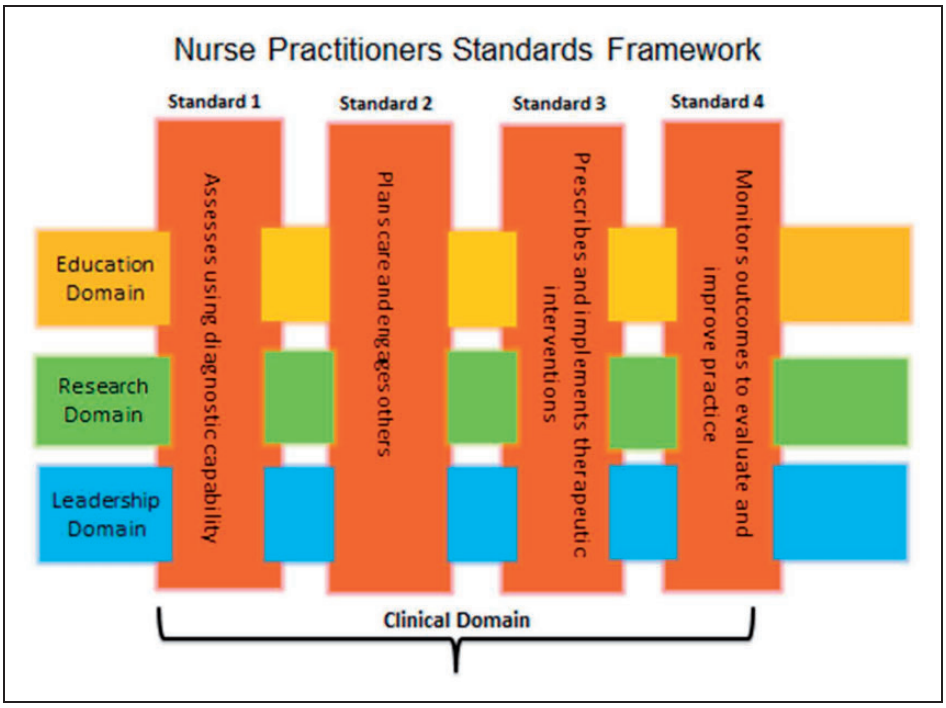

Figure 2. Framework for the Nurse Practitioner Standards of Practice Australia.

Table 4. Glossary Developed for Standards as Published in the Standards.

Advanced nursing practice (ANP): ANP is a continuum along which nurses develop their professional knowledge, clinical reasoning and judgment, skills and behaviors to higher levels of capability (that is recognizable). Nurses practicing at an advanced level incorporate professional leadership, education, and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context, and they are responsible and accountable for managing people who have complex healthcare requirements. ANP is a level of practice and not a role. It is acknowledged that ANP is individually attributed within a regulated nursing scope (enrolled nurse, registered nurse, or nurse practitioner).

Advanced practice nursing (APN): APN in the Australian nursing context identifies the additional legislative functions of an endorsed nurse practitioner that are outside the contemporary registered nurse scope of practice. Advanced practice nursing as a nurse practitioner is a qualitatively different level of ANP from that of the registered nurse due to the additional legislative functions and the regulatory requirements. The requirements include a prescribed educational level, a specified ANP experience, and continuing professional development.

(Advanced practice nursing should not be confused with the term *practice nurse* that is used colloquially to describe nurses working in the general practice setting.)

Attributes: Attributes are characteristics that underpin competent performance. http://www.anmac.org.au/userfiles/file/competency_standards/Competency_standards_RN.pdf

Competence: The combination of skills, knowledge, attitudes, values, and abilities that underpin effective and superior performance in a profession/occupational area.http://www.anmac.org.au/userfiles/file/competency_standards/Competency_standards_RN.pdf

Cues: Key generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist the assessor when using their professional judgment in assessing nursing practice. They further assist curriculum development. http://www.anmac.org.au/userfiles/file/competency_standards/Competency_standards_RN.pdf

Nurse Practitioner: A nurse practitioner is an advanced practice nurse endorsed by the Nursing and Midwifery Board of Australia to practice within their scope under the legislatively protected title "nurse practitioner."

Person/people: In these Standards, person/people is used to refer to those individuals who have entered into a relationship with a nurse practitioner. Person/people encompass patients, clients, consumers, and families that fall within the nurse practitioner scope and context of practice.

Prescribing: Prescribing is defined as the steps of information gathering, clinical decision making, communication, and evaluation which results in the initiation, continuation, or cessation of a medicine.

Scope of practice: The scope of nursing practice is that in which nurses are educated, competent to perform, and permitted by law. The actual scope of practice of individual practitioners is influenced by the settings in which they practice, the health needs of people, the level of competence and confidence of the nurse, and the policy requirements of the service provider.

what types of workers are capable to perform specific roles required in healthcare delivery. For consumers, this is important when deciding whom to consult for a health issue.

Evidence also highlighted the need to formally recognize that newly endorsed NPs may practice as novices and that it is necessary to set standards of required minimum attributes that build upon the foundational RN standards. Importantly, findings from this study confirmed that instead of NPs becoming increasingly specialized—more than other advanced and specialist practice roles within the RN scope—they actually become more generalist, building a broader base of practice as required to safely exercise the extended privileges embedded within the NP scope. This finding is important as *advanced* within nursing has been applied as a directional metaphor. Directional metaphors are one of the foundational metaphors in Western thought (Lakoff & Johnson, 1980). The Western view of progress is conditioned by advancement, as the steady movement forward in the same direction in the name of progress (Donovan, 1997). Yet, interestingly, our study shows that NP development and APN might require a reversal of direction. NP development moves toward optimizing the specialist practice, formed in ANP with the RN scope. This process involves building a broader generalist base on which to situate the specialist practice. So in effect rather than moving further in the same direction of specialization, the NP becomes more generalist. This finding highlights the pragmatic element of distinguishing between *ANP* and *APN*. The project team developed clear definitions of each term, and they were endorsed as part of the standard by the NMBA (see Table 4).

The project team also expected that there would be some duplication between standards for APN and RNs because NPs are fundamentally nurses who have the ability to fully utilize the RN scope and practice as NPs. Our findings suggested that although this might be obvious to some nurses, the new standards needed to clearly state that NP practice is *nursing practice*. This was principally motivated by the political concern of making sure NPs remained philosophically immersed within nursing and did not drift to the ideological position of medicine, becoming *mini-doctors*.

The context and process used to formulate the policy tool of the Australian *NP* Standards for Practice, launched in September 2013 (NMBA, 2013), provides direction for future evaluation of NP utilization. The policy represents an internationally novel, clinical interpretation of the pillar-based approach (Ackerman et al., 1996) to standards and provides definitional clarity to stakeholders. Evidence of policy success or failure is rarely clear-cut. Rigorous analysis more commonly shows that policy performs in the gray area in between absolute success and failure, with relative success in some of the bundle of outcomes (McConnell, 2010). Hence, it remains to be seen how future analyses of these policy changes will deem its success in achieving objectives across the multiple uses of the standards.

Project Limitations

Limitations to this project are as follows: Stakeholder diversity, single-day observations of a complex and variable role, and the need to balance subjective opinion from a diverse range of stakeholders all of which posed challenges in the analysis. However, viewed in the context of policy formation, all three lenses of political knowledge, scientific research-based knowledge, and field experience have been consciously included (Head, 2008). As the distinction between policy and politics is not clear-cut, and in some languages not distinguished at all, this research limitation can be viewed as policy strength (Buse, Mays, & Walt, 2005). Consultative processes including focus groups are limited by the fact that participants are often unable to move outside their own personal or professional sphere of thinking (Yen et al., 2011). This limitation can bias findings toward support of the status quo. In focus groups, this effect can be compounded, as there can be a drive to normative discourses biased by more dominant members, even when the groups are carefully moderated (Smithson, 2000).

Conclusion

In clarifying constructs throughout the study, we strived to keep clear audit trails to demonstrate validity and rigor and hold to a clear process. Thus, we can defend the mixed-methods design and the plural, cultural, and practical nature of the knowledge claims. The Australian *NP* Standards for Practice, while shaped by the Australian-specific context and actors, provide novel application of the pillar approach to standards. We hope that NPs in other countries might find this article useful in revising their NP standards and offer suggestions as to how the research and policy process might be improved. We also provide insight and advancement the definitional conundrum around advanced practice that concerns nursing and NPs, globally.

Acknowledgment

Special thanks to Colleen Cook and Theane Theophilos for editorial assistance with manuscript revisions.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was funded the Australian Health Practitioners Regulation Agency on behalf of the Nursing and Midwifery Board of Australia.

References

Ackerman, M. H., Norsen, L., Martin, B., Wiedrich, J., & Kitzman, H. J. (1996). Development of a model of advanced practice. *American Journal of Critical Care*, *5*(1), 68–73.

Australian Nursing and Midwifery Council. (2009). *Nurse practitioners: Standards and criteria for the accreditation of nursing and midwifery courses leading to registration, enrollment, endorsement and authorisation in Australia – with evidence guide*. Retrieved from http://www.anmac.org.au/sites/default/files/documents/ANMC%20Accreditation%20standards%20-%20Nurse%20Practitioner.pdf.

Bernier, N., & Clavier, C. (2011). Public health policy research: Making the case for a political science approach. *Health Promotion International*, *26*(1), 109–116.

Buse, K., Mays, N., & Walt, G. (2005). *Making health policy*. London: Open University Press.

Commonwealth Department of Health and Aged Care. (2001). *Measuring remoteness: Accessibility/Remoteness Index of Australia (ARIA)*. (Revised ed., Occasional Papers: New Series Number 14). Canberra: Australian Government.

Donovan, T. (1997). *The edge of the possible: Intelligence of a new era*. Sydney: Business and Professional Publishing.

Gardner, G., Carryer, J., Dunn, S., & Gardner, A. (2004). *Report to Australian Nursing Council Nurse Practitioner Standards project*. Canberra: Australian Nursing Council.

Greenhalgh, T., & Russell, J. (2006). Reframing evidence synthesis as rhetorical action in the policy making drama. *Healthcare Policy*, *1*(2), 34–42.

Harter, S. (1986). *Online information retrieval: Concepts, principles, and techniques*. Orlando, FL: Academic Press.

Head, B. (2008). Three lenses of evidence-based policy. *The Australian Journal of Public Administration*, *67*(1), 1–11.

Hsieh, H., & Shannon, S. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago, IL: The University of Chicago Press.

McCarty, M., & Fenech, B. (2012). Towards best practice in national health workforce planning. *MJA Open*, *1*(S3), 10–13.

McConnell, A. (2010). Policy success, policy failure and grey areas in-between. *Journal of Public Policy*, *30*(3), 345–362.

Nursing and Midwifery Board of Australia. (2013). *Australian nurse practitoner standards of practice*. Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx.

Nursing and Midwifery Board of Australia. (2014). *Nurse and midwife registrant data: June 2014*. Retrieved from http://www.nursingmidwiferyboard.gov.au/About/Statistics. aspx.

Pulcini, J., Jelic, M., Gul, R., & Loke, A. Y. (2010). An international survey on advanced practice nursing education, practice, and regulation. *Journal of Nursing Scholarship*, *42*(1), 31–39.

Smith-Merry, J., Gillespie, J., & Leeder, S. (2007). A pathway to a stronger research culture in health policy. *Australian and New Zealand Health Policy*, *4*(19), 1–7.

Smithson, J. (2000). Using and analysing focus groups: Limitations and possibilities. *International Journal of Social Research Methodology*, *3*(2), 103–119.

Stasa, H., Cashin, A., Buckley, T., & Donoghue, J. (2014). Advancing advanced practice: Clarifying the conceptual confusion. *Nurse Education Today*, *34*(2), 356–361.

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, *9*(4), 353–370.

Yen, L., Gillespie, J., Jeon, Y., Kijakovic, M., Brien, J., Jan, S., . . . , Usherwood, T. (2011). Health professionals, patients and chronic illness policy: A qualitative study. *Health Expectations*, *14*(1), 10–20.

Author Biographies

Andrew Cashin, RN, MHN, NP, Dip App Sci, BHSC, GCert PTT, GCert Hpol, MN, PhD, FACNP, FACMHN, FCN, is professor of nursing at Southern Cross University and a practicing mental health nurse practitioner.

Thomas Buckley, RN, BSc (Hons), MN, PhD, is senior lecturer of nursing at the University of Sydney and coordinator of the Nurse Practitioner Programme.

Judith Donoghue, PhD, BA (Hons), DNE, CN, CM, is Emeritus professor at the University of Technology Sydney.

Marie Heartfield, PhD, RN, is associate professor at Southern Cross University.

Julianne Bryce, RN, BN Dip App Sci, Grad Dip Adult Education and Training, is senior federal professional officer, Australian Nursing and Midwifery Federation.

Darlene Cox, BA, DipEd, Grad Dip AppECE, Bed, is executive director, Health Care Consumers' Association Inc.

Donna Waters, RN, PhD MPH (Sydney), BA (Macquarie), Paed Cert FCN, is Head of School of Nursing the University of Sydney.

Helen Gosby, RN, NP, BA, Grad Dip Appl Sc, MN, is a pediatric nurse practitioner and is immediate past president of the Australian College of Nurse Practitioners.

John Kelly, AM, RN, BA (Hons), LLB, Grad Dip Leg Prac, FACN, AFAIM, MAPS, MAICD, is adjunct professor at the University of Technology, Sydney and CEO, Aged and Community Services Australia.

Sandra V. Dunn, RN, PhD, FACN, is Professor of health and clinical practice, School of Health, Charles Darwin University.