GUEST EDITORIAL - Julie Henderson, RN, Aged Care Cert, Grad Cert Adult Education, Master of Advanced Practice (Nurse Practitioner), Warabrook Aged Care Facility, New South Wales, Australia. Bryan McMinn, RN, BSc, MNurs(NP), FANZCMHN, Clinical Nurse Consultant, Mental Health of Older People, Hunter Mental Health Service, New South Wales, Australia

EXTENSIVE NEED, EXTENDED PRACTICE

In recent editions of *AJAN*, guest editorials have been provided by people who are experienced academics and managers in health care. In keeping with our commitment to highlighting developments in nursing, this editorial is the outcome of interviews conducted with experienced RNs who have recently completed studies to enable application for authorisation as Nurse Practitioners (NPs) in New South Wales.

We invited Julie Henderson and Bryan McMinn to share their thoughts about developments in nursing, particularly in aged care and mental health, and to reflect on their own professional development paths. In doing so, we wish to recognise and honour the expertise and experience of the many other nurses who achieve excellence in their clinical roles.

One of the key strategic goals of policy makers attempting to influence the extent to which workforce is responsive to service delivery needs is a focus on greater flexibility and an enhanced and extended scope of practice within professions. For many in the nursing profession, the achievement of NP as an award-recognised level of nurse has been a long time coming, but the rewards of professional action are beginning to be evidenced.

In Australia, the various registration boards/councils are at different stages of implementation of the formal processes of authorisation of NPs. Nevertheless, the movement is gaining momentum and sustainability. For example, in New South Wales, which has been focused on this initiative for over a decade, there are now 35 authorised NPs and over 30 more in transitional NP positions. These clinicians practice at an advanced level of nursing as well as undertaking activity that was historically governed by medical practitioners. This activity includes (through the use of a range of clinical guidelines) initiating and prescribing a range of medications, ordering diagnostic tests and making referrals to other providers.

Many NPs are now prepared through an increasing number of masters level programs, although some nurses approach the nursing registration boards directly to be authorised through processes involving showcasing of a portfolio, viva and case study presentation. The specifics and nature of their practice is dependent on the context of practice and the guidelines for positions. The two RNs we have spoken to share with you some insights into their personal journeys resulting in an extension of their nursing roles and responsibilities.

Q: What are the changes in your practice environment that lead to identification of extensive needs and expanded practice roles in nursing?

Julie: My practice environment encompasses the private aged care sector which interfaces with the community and the acute care sector. It is 'high demand' aged care. I recognise a number of changes in society which suggest there is a real need for NPs. Our facility is currently in negotiations with the health department to become part of a pilot for the introduction of NPs in aged care.

While only a relatively small number of people are in residential aged care (RAC) at present, there is an expectation the numbers will increase. I know that about two thirds of people in acute health care facilities are over 65 years of age and that they generally stay longer than other patients. The people RAC facility staff are dealing with are frail, often requiring palliation, experience symptoms related to multiple pathology, and cover a vast age range. Many are extremely debilitated and there are increasing numbers experiencing dementia. There are greater numbers in dementia specific units now. Often the people who come into care have been given quality care by family members for a long period of time before they enter a RAC facility. It is often an acute care event with which families cannot cope that brings the person to the RAC placement. Families are very good at dealing with one individual at home, even though they are often stressed. I find it really challenging to deal with this individual, as well as their families, who find it hard to come to terms with the fact that their family member is now one of 30 other people all of whom have challenging behaviours that need to be managed.

Bryan: In my role as consultant-liaison nurse I have seen an increase in the extent to which nurses are integral to the effective functioning of a multidisciplinary health care team. I have also noticed that some of the issues in clinical practice are causing a shift in the roles within the nursing team itself. I think there is expansion in the role of nurses within all levels of nursing, not just the RN.

For example, when I undertake consultations in aged care settings, I noticed that the experienced RN has well honed skills in undertaking an activity such as meeting accreditation standards and securing funding.

Experienced RNs continue to engage with clients, but the purpose of the engagement has changed from being a direct caregiver to a facilitator of the processes that enables care delivery. Therefore, for the type of information about an individual client I require in my role as consultant-liaison nurse, I frequently have to ask assistants in nursing for information about patient behaviours, needs and responses to interventions. This has led to my awareness of the need for education programs for assistants in nursing to include things such as communication about patients with other members of the health care team, and a greater consciousness in myself of the need to modify my communication style.

I have also noted an increase in the intensity of nursing work in the acute care setting. I am challenged by the need to encourage nursing staff to participate in labour intensive therapeutic interventions with clients when the context in which they practice provides limited opportunities for this type of intervention. I think nurses often resort to more restrictive options for interventions with the clientele I work with as a result of the context of the work unit, not because they are unwilling to engage in less restrictive therapeutic interventions.

I am particularly enthusiastic and optimistic about the increasing recognition of general practice services as key components of primary health care and see the expanded role of the practice nurse as an exciting innovation in nursing. I think there is greater opportunity for effective care management through general practices and opportunity for practice nurses to operate at nurse practitioner level as they engage in screening, health promotion, gathering of thorough and corroborative information through skilled assessment and structured care planning.

Q: What are the changes in your existing role?

Julie: My practice has changed in a range of ways as a result of preparation for the role of NP. I recognise that I have the ability to deal with multiple demands simultaneously. I can accommodate a range of interactions and I have to deal with a range of problems that just one individual resident presents with. It is sometimes hard to conduct an audit trail on the resident's symptoms, but I know I have advanced assessment skills, they're really more finely tuned now. I have turned what I knew was intuition based on my experience into an ability to assess situations requiring good clinical responses.

Bryan: I don't think my role has changed, but my capacity to meet the domains of practice for a clinical nurse consultant (CNC) has improved enormously. I was particularly attracted to opportunities to develop my skills in diagnostic and therapeutic interventions as these underpin effective practice irrespective of the terms and conditions of employment. Because I work in a multidisciplinary team that is comparatively well resourced in terms of personnel, and am often involved in policy and strategy development, the need for me to do things like write prescriptions, order tests and make referrals is quite limited. Having said that, I see possibilities for CNCs who have a more clinically focused workload to become NPs, particularly in rural, remote or isolated practice settings.

Undertaking masters level study has also refined and consolidated my skill in investigation and analysis, research and education, and increased my awareness of the contribution evidence based practice can make to nursing practice.

Q: What do you see as the outcomes of your professional development?

Julie: I can really make an assessment of my own capabilities and know when to refer to others. You can use all your skill, but sometimes there is a need for back up information to assist with a nursing diagnosis. For example, some additional information might tell me that the muscle wasting is contributing to the resident's recurring falls. Finding a rationale is all part of an assessment process. I find I have to manage a huge amount of information that is available to me. Hence, I take a 'helicopter' view, and then hone in on the information that is relevant to the situation right now. I do this through critical appraisal, being careful about the evidence base from which the information comes, and drilling down when I've hit the right spot.

There are lots of positive personal changes that have been part of my journey. I know we, as nurses, need lots more research in aged care. We need a lot more evidence about our practice. I have also seen this personal initiative as a great opportunity for role modelling to other nurses that we make an impact, that we have an ability to influence. I have let the RNs I work with see the value that can come from these initiatives.

I was also a 'hub educator' in a local transition unit, a new model of managing older people who leave hospital and might have to go to a RAC unit. We look at this as a feeder for admission to our facility and others. We can see that the person who has this transition care comes with the experience of 'enablement', that is the resident has maximum capacity through rehabilitation. In many ways it increases their independence and impacts on the nature of the care they need.

I can see from my preparation for practice as a NP that I have greater self-awareness and I have more confidence in my own ability to practice. The use of learning contracts encourages self-direction. When self-appraising there is a need to be really honest about what you don't know. At first you feel confronted but when you get beyond the self-consciousness you realise you can use critical mentors, both nurses and other health professionals.

Bryan: I have a broader appreciation of the extent to which the service I work in and the skills I have contribute to health care delivery. I am also conscious of

the diversity in nursing work and models of care and see that, although I work in a tertiary care setting with a narrow specialist role, there is considerable value to clients through the establishment of NP roles especially where nurses work autonomously in primary health care and as case managers.

Q: What are your plans for ongoing personal and professional development?

Julie: I will continue to use peers to help me with ongoing professional development. I take the view that if I 'need to know, I need to grow' through finding out. I'm going to keep a 'track sheet', a sort of critical incident record of problems, my rationale for actions, and the resolution of the problem. It's a simple template but I will be able to monitor my progress.

Bryan: One of the most useful strategies that I have participated in and found invaluable has been mentorship. This has enabled me to support others and in doing so develop myself. We need to recognise and not lose sight of the importance of collegial interaction through mentorship as a strategy for learning and acknowledge that it is as valuable and valid as academic activity.

Q: What do you see as potential threats to extended care roles for nurses in your context of practice?

Julie: There are a number of threats to the development of NP roles in aged care. One of those is obviously finance. Under the current aged care funding arrangements it's hard to imagine how the role could be initiated and sustained. There is some sensitivity about the NP role being one of substitution but general practitioners are OK if they're informed and 'in the loop'. They actually see the advanced nurse as a good intermediary and they value knowing there is a constant contact when there is such a range of personnel in staff profiles these days.

Bryan: The incentives to take up the role remain dependent on context and resources and models of service delivery. The diagnostic and therapeutic components of nurses' work and the expansion of nurses' roles because of extended needs should be fostered. I see this as a time of fantastic opportunity to provide effective primary care and enhance continuity of care for clients.

From the above interviews with these experienced clinicians, it is evident that nurses' capacity to engage in professional development is targeted toward meeting the needs of the population in ways that:

- acknowledge the interplay between contexts of practice and nursing roles;
- accommodate changing political and social environments; and,
- establish collegial learning and practice relationships.