FROM THE EDITOR – Dr Jackie Jones RN PhD

‘SOUL FOOD’ IN AND OF NURSING – WHAT IS IT?

Having just enjoyed the debates at the International Academy of Nursing Editors (INANE) meeting where many of the delegates were from North America, I find myself writing this Editorial amidst fears of a major terrorist plot to blow up aircraft leaving Heathrow, London for the United States of America. Such terrorists are said to be selling their soul for their ‘spiritual’ cause. Nurses on the other hand make it their cause to help people in times of spiritual distress. As one of our papers in this edition suggests (Day) interventions by health professionals, such as cardiac rehabilitation, are said to promote spiritual recovery, but what constitutes recovery of the spirit and how does one therefore feed the soul? Not all individuals relate spirituality to religion nor do they consider themselves very spiritual. However, spiritual ‘awakening’ is said to occur particularly in the face of adversity, illness, disease and mental illness. Many nurses may, on reading this, question what this has to do with ‘real’ practice. Others will nod because they have been ‘awakened’ spiritually through their practice as nurses and encounters with patients. Yet others will consider themselves very spiritual in general or through formalised religious beliefs.

Even the most cursory glance at the literature reveals spirituality as a growth area of nursing research. Key issues arising from this body of work include a lack of clarity in terminology, language and definitions and a clash with the personal values and comfort level of nurses themselves. This clash of values and comfort level of nurses around spirituality can be problematic.

For example, in a recent research paper Wilding et al (2006) describe some of the perceived boundaries between mental illness and spirituality and the consequences of negative stereotypes and prejudice by health professionals as experienced by mental health patients. Hearing voices could be consistent with a psychotic episode or consistent with acknowledging one’s own spiritual guidance. Is this spiritual element of being human still taboo and hidden in a similar manner to that of being named a healer (nurse) in one century or a witch in another dependent on the politics and prevailing discourses of the time? Participants in the Wilding study described a uniquely experienced journey of spiritual beliefs where ‘profound changes can occur particularly following profound experiences’ (Wilding et al 2006, p.151). This journey was considered to be life-sustaining and therefore vital to the participants’ ongoing wellbeing.

Returning again to the notion of relevance to practice it is important to highlight that the Australian Nursing and Midwifery Council states that a registered nurse ‘facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security’ (ANMC 2006). Wilding et al advocate health professionals ‘take a wide and inclusive view of what spirituality can be (2006, p.150)’; reminding us that these views do not remain static and therefore the ‘food for the soul’ that is needed at a particular time also varies. Being self reflective of ones own spiritual beliefs and the relationships between spirituality and client care is increasingly important. Whether nurses have yet realised its importance against a backdrop of relentless technological growth and change, our prevailing discourses, remain to be seen.

Listening carefully to clients and moving away from a ‘one size fits all’ approach to care dimensions will be needed if nurses are to hear what a person values about their life and the care they believe they need in their encounters with the system. Nurses need also to recognise that some aspects of a patient’s value system may mean patients are afraid to share their values with those caring for them. Nurses are constantly being challenged by the needs and beliefs of those around them; they also challenge and are being challenged by their own beliefs and values.

Contemporary health care and existing dominant discourses of the body and soul are being challenged by the rigors of science such as described by quantum physics, vibrational medicine (O’Brien 2002, p.164), energetic healing and various bodywork modalities. There is a timeliness therefore about the need to consider flexibility in service provision, recognise and attend to some current rigidity of practice and thinking with, in and between culturally diverse boundaries and parameters as offered by the likes of Wilding et al. In this edition of AJAN, papers explore a variety of boundaries, systems and beliefs related to the practice and service delivery of nurses.

In our first paper Gardner et al outline research conducted to inform the development of standards for nurse practitioner education in Australia and New Zealand. Findings from this research include support for master’s level education as preparation for the nurse practitioner and for programs with a strong clinical learning component, in-depth education for the sciences of specialty practice and centrality of student directed and flexible learning models. Next, Cioffi using a qualitative descriptive study provides a snapshot of the experiences of culturally diverse family members who make the decision to stay with their relatives in acute medical and surgical wards. Three main roles identified were: carrying out in-hospital roles; adhering to ward rules; and facing concerns. Findings indicate nurses and family members could benefit from negotiating active partnerships, and that family friendly ward environments need to be fostered supported by appropriate policies.

Day and Batten having identified that cardiac rehabilitation programs have been based on research with almost exclusively male participants investigate women's perceptions of the contribution of cardiac rehabilitation to their recovery from a myocardial infarction. Using Glaserian grounded theory the core theme that emerged from their data was 'regaining everydayness'. These authors found programs did not meet the needs of all participants and it was apparent that one size does not fit all. The final research paper from Brumley et al aimed to improve access to clinical information for nurses and doctors providing after hours community palliative care in a regional Australian setting. They describe an action research project designed to improve collation and distribution of succinct, pertinent and timely information about unstable palliative care patients, to nurses and general practitioners (GPs) involved in after hours care.

Dewar reviews the nursing research literature on chronic pain in the older person living in the community. She argues that to provide care, the many parameters of chronic pain, which include physical as well as the psycho-social impact and the effect of pain on patients and their families, must be carefully assessed. Further, that the beliefs of the older person about pain and pain management are also important and not necessarily sought. Our final scholarly paper by Clark et al draws on experiences from a national clinical research study to highlight the registration issues for nurses who wish to practice nationally, particularly those practicing within the telehealth sector. The authors found that the state and territory structure of the regulation of nursing in Australia is a barrier to the changing and evolving role of nurses in the 21st century and consider this a significant factor when considering workforce planning.

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GUEST EDITORIAL – Dr Kathryn Zeitz, RN, PhD, Chief Nursing Officer, St John Ambulance Australia. zeitz@onaustralia.com

WORKING TOGETHER FOR BETTER OUTCOMES

Increasing internationalisation of nursing highlights the need for an increasingly flexible nursing workforce (Buchan and Sochalski 2004). The International Council of Nurses advocates 'viable and appropriate systems of professional regulation, both nationally and internationally' in response to the increased mobility of nurses' (ICN 2005). A good place to start is more flexible processes for cross border recognition of nursing practice. Today there are increasing opportunities for cross border nursing practice including telenursing, supporting rural and remote communities, agency nursing, emergency response, for example retrieval services, transplantation coordinators and emergency disaster response.

We are seeing more 'nursing sans frontiers' especially in response to significant world events including the South East Asian tsunami and Hurricane Katrina in the United States. As Jill Iliffe states 'Disasters bring home to us the real importance of community and collective responses. When people work together, they achieve better outcomes' (Iliffe 2005). St John Ambulance operates in 44 countries providing opportunities for nurses who are members to assist not only as a component of disaster response but also planned events such as the Commonwealth Games. Locally first responder organisations, including St John, may deploy members, including nurses, to emergencies to assist neighboring states and territories in times of need.

The increasing application of information technology to nursing practice will open more opportunities for national nursing practice. This is happening now and is not some '2020' problem. Electronic data-bases, computerised care plans, tele-nursing[4], online nursing education and video-conferencing were once futuristic concepts of health care and are now very much 'normal' practice.

There is no more evident need for a singular process of nursing registration to enable cross border practice than within the states and territories of Australia. There is currently no such thing as an Australian nurse or doctor or allied health worker. There is of course a state based nurse – a Queensland RN, or a Victorian RN. The current situation in Australia is there are eight different regulatory authorities for nursing (Bryant 2001). Each state or territory holds state legislation to guide and regulate nursing practice. All states or territories require registration with the local nurse regulatory authority in the jurisdiction in which they are practicing. This supports eight systems of variable levels of difficulty to gain registration.

The Commonwealth of Australia does provide a Mutual Recognition Act 1992 for goods and occupations whereby registered nurses and midwives may apply for mutual recognition of their nursing registration. This process is of little value to St John nurses volunteering to a cross border incident such as a bushfire and may cost, for multiple nursing registration fees, up to a maximum of $900 per year.

In this edition of the *Australian Journal of Advanced Nursing* the editor has published a timely case study by Clark et al, of a clinical nursing research team implementing a national program. Clark et al have made a call for the nationalisation of nursing regulation in this country (ANMC 2005). They have presented their case after an extraordinary three years experience in dealing with state based bureaucratic regulatory inconsistencies.

An Australian Nursing and Midwifery Council was established to facilitate a national approach to nursing and midwifery regulation. Core activities include: identifying impacting factors on nursing and midwifery regulation; facilitating relevant projects; and fostering cooperation on nursing and midwifery regulatory matters. The ANMC is now represented on the ICN Observatory on Licensure and Regulation exploring global regulatory practices, calling for more flexible regulation (ANMC 2006). The ANMC released a position statement on cross border nursing practice (Duffield et al 2002). Their statement on mutual recognition provides a means for fee waiver but still supports eight different systems in relation to registration in the different states. The current system can only respond to requests that are planned and is only available during business hours!

The ICN's current focus on disaster nursing will challenge national nursing regulation systems. As suggested by Clark, multiple state registrations is rarely practicable. St John has experienced similar difficulties and have found it impossible to develop a national Australian position on cross border deployment in emergency situations for their nursing volunteers. Nurses face a system that is complex, time consuming, very expensive and not responsive to urgent requests.

There are international conversations occurring regarding nursing workforce mobility (Clark et al 2006). The International Council of Nurses describes a need for viable, responsive and appropriate regulatory systems. There is a need to ascertain clarity on a national level before embarking on global complexities. The highly flexible nursing workforce required to meet current demands requires mutual recognition across Australia.

Mutual recognition for cross border practice needs to be more than a token waiver of fees. A consistent and automatic process for recognising registered nurses practicing across borders needs to be either incorporated into all local registration systems or a singular national Act needs to be developed. 'When people work together, they achieve better outcomes' (Iliffe 2005).

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COMPETENCY AND CAPABILITY: IMPERATIVE FOR NURSE PRACTITIONER EDUCATION

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Key words: nurse practitioner education, competencies, capability, advanced practice nurse education

ABSTRACT

Objective:

The objective of this study was to conduct research to inform the development of standards for nurse practitioner education in Australia and New Zealand and to contribute to the international debate on nurse practitioner practice.

Setting:

The research was conducted in all states of Australia where the nurse practitioner is authorised and in New Zealand.

Subjects:

The research was informed by multiple data sources including nurse practitioner program curricula documents from all relevant universities in Australia and New Zealand, interviews with academic convenors of these programs and interviews with nurse practitioners.

Primary argument:

Findings from this research include support for master's level of education as preparation for the nurse practitioner. These programs need to have a strong clinical learning component and in-depth education for the sciences of specialty practice. Additionally an important aspect of education for the nurse practitioner is the centrality of student directed and flexible learning models. This approach is well supported by the literature on capability.

Conclusions:

There is agreement in the literature about the lack of consistent standards in nurse practitioner practice, education and nomenclature. The findings from this research contribute to the international debate in this area and bring research informed standards to nurse practitioner education in Australia and New Zealand.

Acknowledgements:

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INTRODUCTION

The nurse practitioner is a new and unique level of health care provider in Australia and New Zealand. The title, nurse practitioner, is now legally protected in New Zealand and in most Australian states and there is mutual recognition of registration between the two countries.

While the mutual recognition of registration has been in effect for several decades there has been no standardisation of education, practice competencies and authorisation process relating to the nurse practitioner within the different jurisdictions in Australia or between Australia and New Zealand. To address this anomaly the Australian Nursing and Midwifery Council (ANMC) and Nursing Council New Zealand formally committed to collaborative development of the nurse practitioner role under a Memorandum of Cooperation and jointly commissioned a study to develop research based standards for nurse practitioner practice competencies and education. The research reported here, is the findings from this study related to educational standards for the nurse practitioner.

BACKGROUND

Health care reform is on the agenda of most developed countries including the USA (Lancaster et al 2000), UK (Charlton and Andras 2005), Australia (Duckett 2002) and New Zealand (Ministry of Health 2001). Also in these countries, nurse practitioners are playing a vital role in reforming health care through improved access (O'Keefe and Gardner 2003); cost effective care (Burl et al 1998); and quality of care and improved patient satisfaction (Gardner and Gardner 2005). Additionally, studies have demonstrated that the nurse practitioner enhances team approaches to health care delivery (Litaker et al 2003).

The nurse practitioner role first originated in North America in the 1960s, and in the UK in the 1980s. The impetus for implementation was related to the prevailing inequitable distribution of health care often attributed to a shortage of doctors and in response to the need to reduce junior doctors' hours; cost containment in health service provision; and the need to provide improved access to health care services (Horrocks et al 2002; Harris and Redshaw 1998).

The burgeoning of the nurse practitioner role in North America and the UK in response to community needs has been echoed in Australia and New Zealand over the past decade. Nurse practitioners have been formally practicing in some jurisdictions in Australia since 1999 and in New Zealand since 2001.

Despite, and possibly related to, the rapid adoption and ongoing development of the nurse practitioner role internationally, there is little research related to educational standards for the nurse practitioner. This paper reports on the educational aspect of the findings from the ANMC Nurse Practitioner Standards Project (Gardner et al 2004a).

METHOD

The overall aim of the study was to investigate nurse practitioner education and practice in Australia and New Zealand and to draw upon this information in combination with relevant literature to develop core practice competencies and educational standards that could be applied in both countries.

The research design incorporated a multi-methods approach with a range of data collection tools and data sources including current policy documents, nurse practitioner program curricula, and interviews with academics and clinicians. Data were collected from relevant sources in Australia and New Zealand.

Participant sample and recruitment processes

A population sample of authorised and practising nurse practitioners, and the academic convenors from all nurse practitioner programs being offered in Australia and New Zealand during 2004 was used.

Nurse practitioners in New Zealand and relevant states in Australia were invited to participate in the study. Through the nursing regulatory authority in each jurisdiction, nurse practitioners were contacted and invited to respond to one of the investigators if they were interested in participating in an interview.

Academic convenors of all nurse practitioner education programs were identified through expert networks in Australia and New Zealand and searching university school of nursing websites. Programs under development were excluded. The academics were contacted by one of the investigators, supplied with an information document and consent form and invited to participate. Their participation involved submission of their nurse practitioner curriculum document and participation in a follow-up structured telephone interview.

Data collection

Nurse practitioner education

The curricula documents on all nurse practitioner education programs in Australia and New Zealand were collected by one of the investigators who was not involved in nurse practitioner education at the time of the research. A data abstraction tool to standardise the information from these documents was developed and tested (table 1). In addition, semi-structured interviews with academic program convenors were conducted by this investigator.

Nurse practitioners

Telephone interviews were conducted with consenting nurse practitioners in New Zealand and relevant jurisdictions in Australia. The in-depth interviews collected text data on the experiential dimensions of nurse practitioner work and their perceptions of requisite preparation for the role.

Data analysis

Nurse practitioner curricula

The data from all program curricula documents were collated and analysed for patterns in relation to program characteristics, teaching and learning process and program content. Data from nurse academic interviews were matched to these fields to strengthen and confirm or qualify the abstracted curricula data.

Nurse practitioner interviews

The data from nurse practitioner interviews were analysed according to the standard for qualitative data. An inductive process was used to order the data according to identified themes within each interview. These themes were then collated according to identified conceptual categories. A final read cross-checked all interviews for the identified categories.

Table 1: Data Abstraction Tool – Nurse Practitioner Curricula

1. Program Characteristics	
1.1	Name of University
1.2	Title of program
1.3	Entry requirements
1.4	Level of award
1.5	Entry and exit points (if multiple)
1.6	Duration of Program F/T semesters
1.7	Generalist or specialist NP program: Yes/No If yes, list specialities offered:
2. Program Management	
2.1	Nurse Reg Authority accredited: Yes/No
2.2	Membership categories for curriculum committee
2.3	Membership categories for program advisory committee Standards included? Yes/No
3. Conceptual Curriculum	
3.1	Explicit assumptions informing content
3.2	Explicit assumptions informing process
3.3	Graduate profile
4. Program delivery	
4.1	Study mode offered
4.2	Credentials of program convenor
4.3	Description of people involved in delivery
4.4	Teaching learning process
5. Program evaluation	
List processes to be adopted for ongoing monitoring of the course	
6. Program content	
6.1	Aims and objectives
6.2	Employment requirements for entry to course
6.3	Clinical / field learning Requirements
6.4	List course titles with brief description. Link to competencies if explicit.
7. Student assessment	
7.1	List clinical assessment strategies (link to course/s)
7.2	List non field based assessment strategies (link to course/s)
7.3	Is assessment explicitly linked to competencies? If yes list competencies

Note: *Program:* Refers to the total education experience leading to the qualification, also called a 'course' in some universities. *Course* is an individual unit of study. Several courses make up a program, also called a 'subject', 'unit' or 'paper' in some universities.

Ethical approval for the study was secured from relevant university Human Research Ethics Committees. Informed consent was obtained from all participants. Specific assurances were given to universities, and observed by the research team, regarding commercial-in-confidence issues.

FINDINGS

This data collection was conducted in 2004 and the findings reported here reflect the state of nurse practitioner education in Australia and New Zealand at that time.

Fourteen program curricula comprising five from New Zealand and nine from Australian universities were included in the study. This represents 100 per cent of nurse practitioner programs offered throughout the two countries in 2004. Interviews were conducted with 12 academic convenors. While all universities sent their curricula documents for inclusion in the study, convenors from two of these universities did not follow up requests to participate in interview.

Data have been aggregated and reporting is in the form of trends and patterns. The findings from analysis of nurse practitioner interviews are integrated in each of the areas.

Program Characteristics

Level and duration of award

Thirteen of the fourteen programs leading to the award of a nurse practitioner qualification were master's degrees. Of the master's degree programs, six programs were four semesters in length and seven were three semesters (equivalent full time). Academic convenors all agreed that the master's degree was an appropriate standard for nurse practitioner education.

In interviews with nurse practitioners, participants were asked their view on the level of education necessary for nurse practitioner training. Most suggested master's degree and their reasoning related to:

- public perception of the level and stature of a master's degree as an important aspect of ensuring public confidence in nurse practitioner service;
- a belief that the master's degree offers scholarship that is comparable with the nature of the skills, knowledge and attributes required; and
- personal experience of the value of that level of education.

In some instances nurse practitioners provided support for this view based on their own experiences as pioneers while others offered a perspective influenced by having come to the nurse practitioner role through a different route. Nurse practitioners who did not have a master's degree tended to take a more qualified stance and were overwhelmingly committed to the primacy of clinical experience as preparation for the nurse practitioner role.

Entry requirements

Entry requirements across the 14 programs were highly consistent, with the main variation being in requirements for experience in the specialty. This varied from none to five years. Nine of the programs required postgraduate training/qualifications in the specialty field and most of these were integrated into the master's degree.

In terms of miscellaneous requirements, two required a completed portfolio for entry to the program and two required membership of professional / specialty association. Ten of the 14 programs had flexible entry and exit features.

Scope of the programs

Three of the programs were focused on one specific specialty and six offered a range of structured specialty studies. Five universities offered programs with generic subjects and a framework or assessment mechanisms to obtain advanced/extended education in the candidates' own specialty. In interviews with academics this latter model was described as a necessary approach to nurse practitioner education to facilitate the development of skills and knowledge in new fields of extended nursing practice.

Approaches to teaching and learning

In forming the basis for the education process certain assumptions were common across all curricula. These related to the importance of:

- adult learning principles;
- learning as collaborative;
- use of the clinical field with clinical mentor/preceptor;
- use of experiential/situated learning; and
- promoting self-directed/lifelong learning skills.

Additionally, all academics interviewed were committed to the clinical environment as a context for nurse practitioner education.

Data from the nurse practitioner interviews also strongly supported the centrality of clinical learning as preparation for the nurse practitioner role. For some, there was a dichotomy. Clinical experience was viewed as different from and better than, the (perceived) alternative academic orientation of a master's degree.

Others were wary of the quality of the clinical content in master's degree programs. Participants in both countries who were very recent graduates of an approved master's degree expressed concern at the adequacy of the clinical content. They were especially concerned for students who would come to the degree without the level of clinical experience which had informed their own student experience. Consequently, these nurse practitioners were adamant that the clinical rigour of the master's degree must be developed and maintained while not losing the special qualities of master's degree education.

Curricula content

Findings from this study indicate that the prevailing professional and regulatory environment in Australia, in which nurse practitioner programs of education were designed, was diverse, with scant attention to national priorities and cross-border collaboration. The situation in New Zealand is more cohesive due largely to the centralised nature of nursing regulation. The trans-Tasman context therefore is also diverse. Hence the content imperatives for nurse practitioner education have been determined locally and in response to local regulatory requirements and the attitudes and opinions of each health service or clinical environment.

Accordingly, one of the questions in the interviews with academics related to the factors that influenced the program content. The responses were varied. In one program the content was designed from empirical curriculum research conducted during the nurse practitioner trial in their jurisdiction. For the remainder, content was determined through consultation with clinical specialists, specialty competencies when available, advisory committees, medical practitioners and the academics' own vision for the nurse practitioner role. Additionally many were influenced by publications from North America and the United Kingdom.

In many of the programs the nurse practitioner stream was embedded in a general nursing master's degree. Hence it was at times difficult to determine the content/courses that were specifically designed for nurse practitioner education.

Twelve of the programs required or preferred the candidates to be currently employed in their specialty field. The same pattern applied to the requirements for clinical subjects and internships where practice learning was supported by a clinical team, clinical preceptor or mentor. For many of these courses the clinical learning support was provided by medical practitioners and other health-care professionals.

Across all programs there was a pattern relating to the specific nurse practitioner content. These data have been categorised into three areas namely universal content, frequent content and specialty content.

Universal content

Three study areas were contained in all 14 programs. These were:

- *Pharmacology:* In many programs the study of pharmacology and pharmacotherapeutics was iterative in that this content was spread in several courses across the curriculum.
- *Research with or without a focus on evidence-based practice:* Research training, while present in all programs, varied in terms of scope. Some required candidates to conduct a small research project or practice audit while other programs contained research and/or evidence-based practice courses without empirical study requirements.
- *Assessment and diagnosis, including imaging and laboratory diagnostics:* This area of study was a major feature in all programs. While course titles varied there was a consistent commitment to content related to advanced and extended assessment and diagnostic skills.

Frequent content

Other study areas that were common across many of the programs included:

- Clinical sciences (anatomy and physiology, pathophysiology);
- Nursing professional and scope of practice studies;
- Clinical leadership;
- Society, law and ethics; and
- Studies in cultural awareness and cultural aspects of nurse practitioner practice.

Content such as symptom management and therapeutics was listed in some programs, however these areas of study tended to be linked to specialty streams.

Specialty content

Specialty content was apparent in two forms: those programs that had designated specialty focus or streams (n=9) and those programs with a generalist core component and framework for specialty study (n=5). The pattern of specialty education varied. In some, content in the specialty streams focused on specialist assessment and therapeutics that, in some cases, were guided by the competencies for that specialty. Other programs located specialty education in the clinical practicum component. The remainder required the candidate to enter with a graduate diploma in a specialty field. Those programs with frameworks for specialty study worked from learning contracts and/or clinical practicum with dedicated preceptors/mentors or a clinical team for specialty learning.

Interviews with nurse practitioners included questions related to content areas for nurse practitioner education. Advanced assessment and pharmacology received top rating which was consistent with the curricula data. Content related to pathophysiology and health systems, with policy and political issues also receiving frequent mention. Legal issues, and research skills and utilisation were noted as important.

Analysis of nurse practitioner narratives – other issues

The participants spoke strongly of what is described as lifelong learning, captured in the comment of one participant: *'as you go along you learn what you need to know'*. Several spoke of the difficulty in valuing one particular style of learning over another, describing all education as valuable and some noting that their appreciation for education expanded as their sense of the role developed. All participants in different ways spoke of the necessary complexity of educational preparation. They emphasised the requirement for specific clinical knowledge and skills and also the requirement for learning how to learn and developing confidence in their ability to practice in an unpredictable and dynamic clinical, professional and political context. Consistently the data spoke to the need for a nursing model as the core tenet in preparation for nurse practitioner practice. The political vulnerability of these nurses in many settings validates their need for a range of skills to ensure their professional safety.

DISCUSSION

Preparation for practice

Analysis of the nurse practitioner interview data supports master's degree level of education as preparation for the role. This was justified on two levels. First the findings supported the need for strong educational preparation in order to meet the demands of the role. The second level was related to credibility with the community and other health disciplines as to the preparedness of these clinicians, best achieved by a master's degree for entry to practice. These findings are supported by the international literature where there is a strong trend to recommending master's degree programs for advanced practice and, therefore, nurse practitioner education (Fowkes et al 1994; American Academy of Nurse Practitioners 1995; Davidson 1996; de Leon-Demare at al 1999; Aktkins and Ersser 2000; van Soeren et al 2000).

Specialisation is an important issue in nurse practitioner education and analysis of the curricula data identified two approaches used to deliver specialty studies. These approaches included a) structured specialty streams or programs, and b) generic frameworks that could accommodate a student's chosen specialty field of study. While some of the specialty streams and programs were informed by specialty competencies (eg. Council of Remote Area Nurses of Australia Inc. 2001), others relied on generic advanced practice competencies.

The findings also support the need for a significant clinical learning component in nurse practitioner education. Nurse practitioner participants universally endorsed the centrality of the clinical environment to nurse practitioner education. There was also universal support from the academics interviewed for clinical learning to be a major component of the programs. A related issue on nurse practitioner education that was strongly supported by both clinicians and academics was the importance of student-directed learning. These findings are supported by research (Gardner et al 2004b) which reported the critical role played by the clinical environment in nurse practitioner training and the preference of nurse practitioner candidate participants for student-determined learning content and process.

In looking to educational theory that met the joint imperatives of student directed learning and contextual learning, the literature on capability (Hase and Davis 1999; Stephenson and Weil 1992) provided an important theoretical framework to inform curriculum development for nurse practitioner education. A capability approach to the learning process incorporates the flexibility to respond to the specific, self-identified learning needs of students (Phelps at al 2001).

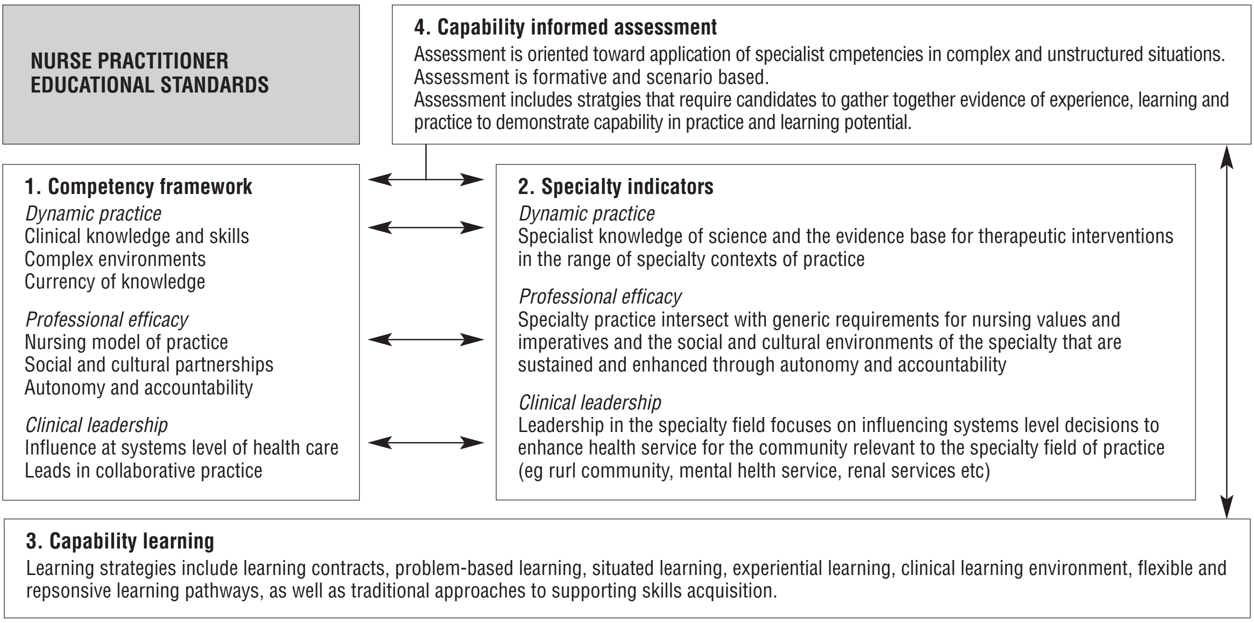

Figure 1: Model for NP education

NURSE PRACTITIONER EDUCATIONAL STANDARDS

4. Capability informed assessment

Assessment is oriented toward application of specialist cmpetencies in complex and unstructured situations.
Assessment is formative and scenario based.
Assessment includes stratgies that require candidates to gather together evidence of experience, learning and practice to demonstrate capability in practice and learning potential.

1. Competency framework

Dynamic practice
Clinical knowledge and skills
Complex environments
Currency of knowledge

Professional efficacy
Nursing model of practice
Social and cultural partnerships
Autonomy and accountability

Clinical leadership
Influence at systems level of health care
Leads in collaborative practice

2. Specialty indicators

Dynamic practice
Specialist knowledge of science and the evidence base for therapeutic interventions in the range of specialty contexts of practice

Professional efficacy
Specialty practice intersect with generic requirements for nursing values and imperatives and the social and cultural environments of the specialty that are sustained and enhanced through autonomy and accountability

Clinical leadership
Leadership in the specialty field focuses on influencing systems level decisions to enhance health service for the community relevant to the specialty field of practice (eg rurl community, mental helth service, renal services etc)

3. Capability learning

Learning strategies include learning contracts, problem-based learning, situated learning, experiential learning, clinical learning environment, flexible and repsonsive learning pathways, as well as traditional approaches to supporting skills acquisition.

Capable practitioners are those who know how to learn, are creative, have a high degree of self efficacy, can apply competencies in novel and familiar situations and work well with others (Hase and Davis 1999). Furthermore, capability emphasises the role of complexity in influencing the learning context whereby dynamic systems provide the environment for non-linear and unpredictable events (Hase 2000; Phelps et al 2001). The clinical environment of health care therefore is a fitting milieu for the basis of nurse practitioner education, and student-identified needs as an appropriate learning process.

Lack of standardisation

Apart from these areas of agreement, the findings relating to nurse practitioner education indicate that a variety of standards, competency frameworks and interpretations of the role of the nurse practitioner have informed curricula development and accreditation approaches. There is also variability in educational levels for nurse practitioner education and a lack of consistency in the conceptual basis of these programs. Content varies across the programs with just three study areas of pharmacology, research, and advanced assessment, being common to all. One of the particularly inconsistent factors in the nurse practitioner education programs across the Australian states and between Australia and New Zealand is the lack of clarity in terms of specific nurse practitioner, as distinct from advanced practice, study requirements. This is consistent with the literature on nurse practitioner education (Woods 1999) where there is confusion and ambiguity related to nomenclature and educational requirements for the nurse practitioner (Gardner et al 2004b).

Recommendations toward national / trans-Tasman standards for NP education

The findings from this research contribute to the international debate and also present an opportunity for Australia and New Zealand to take a global leadership role in adopting a standardised, research-informed approach to nurse practitioner education and nomenclature. The advantages for the Australian interstate and trans-Tasman context are significant.

This research has identified the need for a two-layered structure for nurse practitioner education. This includes i) the ANMC nurse practitioner competency framework that inherently describes the knowledge, attitudes and skills of extended practice (Gardner et al 2005), and ii) the concept of capability, which defines the features of performance of these competencies that are, in combination, uniquely related to the method of nurse practitioner practice.

Nurse practitioner education programs that are structured to meet these generic standards will need to address not only the content requirements of a competency framework but most importantly the learning process and assessment requirements as determined by the imperatives of capability theory (Gardner et al 2004a; Stephenson and Weil 1992). This two layered approach is illustrated in figure 1. As Hase and Davis (1999) suggest, becoming capable requires different learning experiences from becoming competent. This thinking is also relevant for the specialty learning required in the extended practice context. Nurse practitioner candidates, as advanced specialist nurses, are well placed to define and respond to their own specific learning needs. Structured pedagogical approaches to learning will be inadequate for the education of the nurse practitioner.

Capability learning offers an alternative in the form of flexible learning pathways that allow for increasing complexity and curriculum scaffolding through a rich variety of learning resources, and mentored self-directed learning (Phelps et al 2001).

The model in figure 1 illustrates the configuration of all elements related to nurse practitioner education and the interface between the requirements for competency learning and assessment, and, the influences of capability theory on the learning environment for nurse practitioner education. The structure illustrates standards to support tertiary education providers in the development and delivery of nurse practitioner master's degree programs. Additionally the model provides an evidence informed benchmark that can be applied in the accreditation of courses leading to authorisation as a nurse practitioner across all regulatory jurisdictions in Australia and New Zealand.

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CULTURALY DIVERSE FAMILY MEMBERS AND THEIR HOSPITALISED RELATIVES IN ACUTE CARE WARDS: A QUALITATIVE STUDY

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ABSTRACT

Objective:

To describe the experiences of culturally diverse family members who make the decision to stay with their relatives in acute care wards.

Design:

A qualitative descriptive study.

Setting:

Medical and surgical wards in an acute care hospital with a 70% non-English speaking background patient population.

Subjects:

Eight culturally diverse family members who stayed with their hospitalised relatives for at least four shifts or the equivalent hours.

Method:

In-depth interviews of approximately 45 minutes.

Findings:

Three main categories described the experience of family members. These categories were carrying out in-hospital roles, adhering to ward rules, and facing concerns.

Conclusions:

Findings indicate nurses and family members could benefit from negotiating active partnerships; family friendly ward environments need to be fostered, supported by appropriate policies; and further research is needed into culturally diverse family members' partnerships with nurses in acute care settings.

INTRODUCTION

Australia is a multicultural country (Roach 1997) with culturally diverse people encompassing people of Indigenous and migrant backgrounds (Roach 1999). When culturally diverse patients are hospitalised they often have a preference for their family member to stay with them. This preference results in nurses managing family member access during their relative's stay in hospital. However, little is known about the experiences of these culturally diverse family members. This study describes the experiences of family members who have stayed with their relatives during their hospitalisation.

In many cultures, illness is a family affair and family members play an important role in care-giving (Chang and Harden 2002). Family members have a right to support their hospitalised relatives (Johnson 1988). According to Chang and Harden (2002) nurses and other health care providers need to be willing to share the act of caring with family members so hospitalisation does not interfere with, for example, family responsibility and customs. When culturally diverse patients are admitted to acute care settings their families need to feel comfortable with the access to their relative that is available to them.

Family members involved in caring for hospitalised adults have been shown to exhibit vigilance (Carr and Fogarty 1999). Studies found two main forms of care are provided by family members: em otional support (Li et al 2000; Astedt-Kurki et al 1997; Laitinen 1994, 1993, 1992; Halm and Titler 1990); and visiting and helping with activities of daily living or procedures (Li et al 2000; Astedt-Kurki et al 1997; Laitinen 1994, 1993, 1992; Collier and Schirm 1992; Haggmark 1990; Halm and Titler 1990; Sharp 1990). Family involvement has been studied with two main groups of adult patients: the hospitalised elderly (Li et al. 2000; Higgins and Cadd 1999; Greenwood 1998; Collier and Schrim 1992); and the patient in critical care (Soderstrom et al 2003; Walters 1995; Halm and Titler 1990). No studies were found that focused on culturally diverse patients in acute care settings.

Studies have examined the needs and involvement of family members in the care of their hospitalised elderly relatives in acute care settings (Li 2005; Li et al 2000; Higgins and Cadd 1999; Greenwood 1998; Collier and Schrim 1992). In general, the needs of family members have been found to be for information, emotional support, hope, a caring attitude and to be close to their relative (Rutledge et al 2000). Further, aspects of family member dissatisfaction that have been identified include a lack of respect for themselves and their hospitalised relative, a lack of information, and inadequate care (Von Eigum 2000; Athlin et al 1993). However, little attention has been given to the culturally diverse family member who wishes to be involved in the care of their hospitalised relative despite nurses regarding the relationship between patients and their family as core to nursing care (Suhonen et al 2002; Astedt-Kurki et al 2001). This study explored the experiences of culturally diverse family members who made the decision to stay with their relatives in acute care wards during their relatives' hospitalisation.

METHOD

Research approach

This qualitative study describes experiences of culturally diverse family members staying with their hospitalised relatives on medical and surgical wards in an acute care hospital with a 70% non-English speaking background patient population. An interpretive-descriptive design in the qualitative tradition (Thorne et al 1997) has been selected to address the question as it can capture the multiplicity of family member experiences in acute care hospital wards.

Sampling

Eight family members who volunteered to join the study and met the inclusion criteria formed the purposive sample. The criteria for recruitment of a family member to the study were: had stayed with their hospitalised relative for at least four shifts or the equivalent hours; and were culturally diverse. The resultant sample of cultural diverse family members had lived in Australia for more than 10 years with seven having previous experience of hospitals (see table 1). Their hospitalised relatives were public patients in hospital from three to eight days with five being hospitalised for a surgical procedure and three for a medical condition.

Study sampling was based on the estimation of Kuzel (1992) that six to eight family members are required for a sample that is homogeneous with regard to a common experience. This experience was staying with a hospitalised relative on an acute care ward. Ethics approval was obtained from both the area health service and university human research ethics committees. All appropriate ethical aspects of the study were addressed to ensure the rights of participants were protected.

Table 1: Characteristics of family members

Characteristic	f=
Ethnicity	
- Lebanese	4
- Tongan	2
- Turkish	1
- Vietnamese	1
Gender	
- Male	1
- Female	7
Relationship	
- Spouse	4
- Daughter	3
- Son	1
Age Range (in years)	
21-40	2
41-60	4
61-80	2

Table 2: Main categories and subcategories that described family members' experiences

Category	Sub categories
Carrying out in-hospital roles	- being with their relative - helping the nurses - acting as an interpeter - being the family representative
Adhering to the ward rules	- going with the rules - recognising access as a privilege - tension around rules
Facing concerns	- person-centred - relative-centred

Data collection procedure

Each participant interview was scheduled at a time and place convenient to them. Interviews were approximately 45 minutes in duration and were audiotaped. All interviews were carried out by the investigator and commenced with the open-ended question, 'Can you tell me about your experience of staying with your hospitalised relative on the ward?' Participants were encouraged to talk freely about their experiences and feelings and asked to clarify, extend or explain further, if able, particular aspects of relevance to answering the research question. When the participant indicated they had no more to share pertinent to the question the interview was concluded. Each participant was asked if they were willing to be contacted when the findings of the study were available to consider their credibility in light of their experiences. Contact details of three participants were obtained.

Data preparation and analysis

Transcribed tapes were checked for accuracy then all transcriptions were read until a full understanding of their meaning was grasped (Thorne et al 1997).

Data were analysed using Lincoln and Guba (1985) approach with units of meaning being identified, then grouped into categories and subcategories based on similarity. Following this the resultant findings were presented to the three participants who had indicated a desire at the interview to be involved in the verification process. These participants considered their experiences were captured by the categories and subcategories. Bilingual health care workers who liaised with non-English speaking patients, their families and nursing staff on a daily basis were also shown the findings and indicated they reflected their experiences of working with culturally diverse family members.

FINDINGS

The family members described their experience of staying with their hospitalised relative within three main categories. These categories are: carrying out in-hospital roles; adhering to the ward rules; and facing concerns. The categories and subcategories are presented in table 2 followed by each category and its subcategories being described in detail.

Carrying out in-hospital roles

In-hospital roles identified were: being with their relative; helping the nurse; acting as an interpreter; and being the family representative. The role of being with their relative involved staying with their relative for various lengths of time. From family member descriptions this was in the form of a presence and occurred during the day and into the evening most usually. Below are examples of the nature of this presence for family members.

'It's sort of like a duty for us to come and look after her ... it's in the blood of us. Especially when we are sick ... in my heart I have to be here for her ... '

'In our culture when our loved ones come into hospital… we include ourselves in the situation. I'm here for him for everything he wants.'

Another role family members assumed when staying with their relatives was *helping the nurses*. For most family members this involved caring for their relative when at the bedside. A typical description is:

'Sort of helping, giving a hand to the nurses, helping daily living plan, things like that. It's our culture ... work all together ...'

As culturally diverse hospitalised relatives often experienced difficulties with language family members identified they were required to act as an interpreter for their relatives, for example:

'... he likes to have someone here to translate for him. Sometimes he has a question to ask and his English isn't good so he feels that he hasn't fully explained it to the doctor and that the doctor is not picking up on everything that he wants him to know. That's when he gets concerned.'

'My mum wouldn't like the … interpreter. It's easier for her if one of her children is here. ... When we are here she can just tell us everything and we can tell the doctors and nurses.'

All the family members disclosed their families expected them to be the family representative. A typical comment by a family member was:

'The family depends on me, all of them. Whatever I will say they will say yes. I have to tell the family what's going on with our dad.'

Adhering to the ward rules

Family members showed they were extremely aware of the ward rules that arose from hospital policy. They showed they considered them when making decisions to be with their relatives. The need to go by the rules, to recognise access as a privilege and tensions associated with this situation were described by all family members. Typical descriptions of *going by the rules* are as follows:

'The hospital has its own rules ... have to go with them'

'... in my heart I know I want to sleep here with her but I have to go with their rules.'

They recognised access as a privilege that was extended to them most usually by nurses. The description below is an example.

'Usually I come every morning and stay up to eight hours. They allow me in just to look after him. I don't think that I'm in a position to ask for any more than that.'

Some tension around access that created discomfort for family members was described. These tensions were associated with obtaining permission and their actual presence at the bedside. The extracts below show that they were careful not to upset the access privileges they had been given. Examples are:

'When Mum's resting, I try to sneak out for a cup of tea but it's mainly just to get out of the way. I'm just very happy that they allow me to be here with her outside the visiting hours.'

'I never annoy them. I come here and give him his lunch then go downstairs. I come back at two. I didn't want them to see too much of me because some of them might say, "Why is she here?" I never disturb them.'

Facing concerns

Concerns family members had to face when they stayed with their relatives on the ward were both person- and relative-centred. Each family member expressed *person-centred concerns* about their experience of being with their relative that were varied and include: recognising they were not able to manage some aspects of their relative's care; being uncomfortable about situations they witnessed; finding the strength to continue to support their relative; and being worried.

Examples of personal concerns were:

'My Vietnamese isn't as good as my English so I find it hard to translate for my dad some of the stuff.'

'The nurses are short staffed and too busy to take care. ... they are trying their best. If I push them too much some of them are very, very short-tempered. They are not patient.'

'In my heart I just say things to God. He gives me the energy to come to the hospital and still have more energy to help, comfort him and keep him company during the day before I go home and have a rest in time for the next day.'

Family members were strongly aware of relative-centred concerns associated with being hospitalised. Expressed concerns involved their relatives' preferences, beliefs and emotional responses. Concerns focused on preferences included visiting and gender of attendants, for example:

'She finds it really hard as her visitors come in large numbers about ten or more at once. She knows how it is here and that makes her uncomfortable. In her heart she wishes that they come and go quickly.'

'As he is Tongan letting a male nurse wash a male is really a bit hard. He prefers a woman. So he just tells the male person who showers the men my wife will shower me.'

The beliefs that hospitalised relatives held for example about sickness were endorsed by the family members and in some cases influenced the interactions of family members with their relatives in the ward situation as demonstrated in example extracts below.

'He believes this illness is from God and God gives you the illness to clean up many things in a person. He really fears God so he is happy the sickness comes and he doubles his thanks to God with prayer. I help him to go to the end room to pray.'

'In the Tongan way if no one is around him he will feel lost. He'll feel I'm lost they've forgotten me he won't say it to me but I know the feeling because we're born with that feeling. So I need to be here for him.'

The emotional responses of relatives were often of concern to family members. Typical comments from family members were:

'He gets upset that some of the nurses don't try harder to listen and understand him. Their tone of voice, the way they looked down when he can't explain what he wants to say sometimes. He gets a bit upset about that.'

'My mum ... is one of those who is really, really scared when she is sick. That's why it is important we are here for her.'

The ward experience of a family member being with their hospitalised relative as described shows family members assume a series of roles that are supportive, pay attention to the rules of the ward and/or hospital and experience a number of concerns that are generated both from their relationship with their relative and the in-hospital situation.

DISCUSSION

The main findings that describe family members' experiences in-hospital provide insight into their bedside experiences including their involvement with their hospitalised relatives. In many instances this involvement epitomised vigilance as identified by Carr and Fogarty (1999, p.433) who described it to be a 'close protective involvement with a hospitalised relative'. Previous studies have shown positive outcomes for hospitalised relatives can be affected with such involvement (Hendrickson 1987; Simpson and Shaver 1990; Suhonen et al 2002). Further, the individualisation of patient care can be fostered (Suhonen et al 2002). This strongly indicates that family members at the bedside are very beneficial and nurses need to include family members when planning and implementing care for patients. With culturally diverse families this may well be more critical considering possible language and cultural difference.

Nurses are mainly responsible for managing the access of visitors to patients in wards where family members are with their relatives. This places nurses in a position where they are able to grant exceptions to the hospital visiting policy for family members. Whitis (1994) reported a similar authority existed in a study of visiting policies. Family members were very aware that access was a privilege granted to them by nurses. Violation of this privilege was an issue for them and they took care 'to go with the rules' and not aggravate or draw attention to their presence by the strategies they adopted. This indicates that culturally diverse family members were not comfortable with their access conditions.

There is an opportunity for nurses to negotiate an approach to access that respects cultural ways associated with illness and family care giving as recognised by Chang and Harden (2002). Further, a patient's right to the supportive presence of their family as identified by Johnson (1988) and Suhonen et al (2002) suggests this ethical imperative needs to be uppermost in the decision-making process.

The family member role of helping the nurse by giving care to their relatives confirms findings from other studies with intensive care patients (Halm and Titler 1990) and elderly patients in acute care settings (Collier and Schirm 1992; Laitinen and Isola 1996; Laitinen 1994, 1993, 1992). Family members in this study were carrying out caring activities on a voluntary basis and recognised there were elements of care giving they were unable to give or unfamiliar with and required nurses to provide. This aspect was not found in any previous study reviewed. Family members did not indicate they had negotiated their helping role with nurses. As well as the previously identified need to negotiate clearly defined access conditions nurses need to also determine with each family member how they wish to be involved in their relative's care. For example the aspects of care family members feel comfortable to provide and those they would like nurses to provide.

These details need to be documented to ensure all staff are familiar with the agreed plan of family member involvement in care.

The finding of the family member acting as an interpreter in the hospital setting was a role not previously identified in other studies and can be attributed to the culturally and linguistically diverse nature of the family members and their relatives. The informal use of family members as interpreters is a concern and needs careful consideration particularly in light of the family member who identified he had difficult with translation. When family members are acting as interpreters for patients, nurses and other health professionals need to acquaint themselves with relevant policies and provide a formal means of using qualified interpreters by booking regular sessions during each patient's episode of care.

Some family members actually identified that nurses were short staffed, very busy and at times short-tempered. According to McQueen (2000) when nurses have heavy workloads, as is often the case today with higher patient acuity and short lengths of stay, they are prone to conveying their stress to others. Family members described nurses reacting in ways that suggest nurses were at times overwhelmed by work conditions as indicated by their responses in wards where their hospitalised relatives were. Interactions between family members and nurses have been found to be complicated by ward conditions (Astedt-Kurki et al 2001). Nurses need support to manage their work conditions appropriately and to build caring partnerships with a family focus.

Within family members' descriptions of their experiences there was little reference to the personal support they had received from nurses whilst at the bedside. This supports Greenwood's (1998) assertion that family members do not receive the attention and time they need on general wards. A finding by Hardicre (2003) provides insight into this situation as nurses indicated they felt inadequately prepared to address this aspect. Not only do nurses need to provide care for their patients they also need to pay attention to the emotional and other needs of family members particularly when providing support to their hospitalised relatives.

This study is small and only involves family members from a limited number of ethnic backgrounds. The focus on family members of adult patients in acute care settings requires more in-depth understanding than has been captured in this study. Difficulties with recruiting and interviewing family members who were at the bedside resulted from their in-hospital commitments to their relatives. Interviewing family members after their relative's discharge may result in improved recruitment and increased duration of each interview.

IMPLICATIONS AND RECOMMENDATIONS

Accommodating family members demands nurses immediately meet the challenge to engage with them in active partnerships sharing common goals and understandings. These partnerships need to be fostered in a family friendly environment where co-operation and equality are hallmarks of caring relationships. To support this, hospital policies need to be reviewed to increase their family friendly focus including flexible visiting times that facilitate family involvement. Further, nurses need to be prepared through continuing education programs to develop and sustain collaborative partnerships with family members with documentation of family involvement in clinical pathways, care plans and daily reports. Research into family members' involvement in the care of adult culturally diverse patients is required to explore, for example, access conditions and joint partnerships between nurses, family members and their relatives including family members from other ethnic backgrounds

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CARDIAC REHABILITATION FOR WOMEN:ONE SIZE DOES NOT FIT ALL.

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ABSTRACT

Aim:

To investigate women's perceptions of the contribution of cardiac rehabilitation to their recovery from a myocardial infarction.

Background and Purpose:

Cardiac rehabilitation programs have been based on research with almost exclusively male participants. It was unclear if cardiac rehabilitation programs meet the needs of women.

Method:

Ten women who had experienced one or more myocardial infarctions were interviewed. Data from these interviews were analysed using Glaserian grounded theory.

Findings:

The core category that emerged from the data was 'regaining everydayness'. Participants worked to regain their 'everydayness' through a basic social process of 'reframing'. Reframing involved coming to terms with what they had experienced and fitting it into their lives. Other categories related to symptom recognition and recovery.

Conclusion:

Cardiac rehabilitation programs contributed to overall recovery from a myocardial infarction in different ways for each participant. Although programs provided information for participants, they failed to provide the type of support needed to effectively aid reframing and recovery. Programs did not meet the needs of all participants and it was apparent that one size does not fit all.

INTRODUCTION

According to the New Zealand Ministry of Health (MOH) coronary heart disease (CHD) is the leading cause of death for New Zealanders. In 1999 CHD accounted for 25.4 % of male and 21.1 % of female deaths (New Zealand Health Information Service 2003). Not only is mortality from CHD a problem in New Zealand and internationally, the burden of disease resulting from CHD is also high. In 1996 New Zealand women lost 25,526 years to premature mortality and 4,296 years to disability as a result of CHD (Tobias 2001). Cardiac rehabilitation (CR) programs were developed to lessen the burden of disease both for society and for the individual sufferer. However these programs have been based on research using mostly male participants.

CR is a dynamic multidisciplinary intervention that assists individuals who have survived a myocardial infarction (MI) or other cardiac event to achieve the best level of functioning possible (Higginson 2003; Mitchell et al 1999). The aims of CR are: to help individuals to adjust to their illness; limit or reverse the disease; modify risk factors for future cardiac illness; improve return to occupational and social functioning; and reduce the risk of re-infarction or sudden death (Dinnes 1998; Higginson 2003; Mitchell et al 1999; Petrie and Weinman 1997; Wenger et al 1995).

Internationally CR has three recognised phases: phase one - the inpatient phase; phase two - the outpatient phase (up to 12 weeks post event); and phase three - the maintenance phase (AHA 1998; NZGG 2002; Parks et al 2000). CR generally provides participants with education on topics including: basic heart anatomy and physiology; the effects of heart disease; the healing process; risk factor modification; the resumption of physical and sexual activities; psychosocial issues; the management of symptoms; investigations; individual assessment; and referral to other health professionals if required (NHFA 2004; NHFNZ 2000). In New Zealand CR is based on the World Health Organisation (WHO 1993) guidelines.

Phase one CR is generally an automatic part of in-patient hospital care for all MI patients, integrated within the acute treatment plan. In New Zealand phase two CR programs are of four to ten weeks duration, for one or two afternoons per week depending on the health service providing the program (NHFNZ 2000). Programs may be based in hospital grounds or at community based sites. CR nurses are largely responsible for the initiation of phase one CR during hospitalisation and most patients are also visited at home by the CR nurse after discharge and encouraged to attend phase two.

LITERATURE REVIEW

CR has been shown to benefit patients with a wide range of cardiac conditions including following an MI. Research findings demonstrate an increase in functional capacity (Adams et al 1999; Cannistra et al 1992; Lavie and Milani 1995; Lavie and Milani 2000) and a decrease in mortality (Naughton et al 2000) for both men and women after CR. CR has been linked to: decreased levels of anxiety and depression; improvement in general health and self-esteem (Conn et al 1992); shorter hospital stays; better emotional and spiritual recovery; and greater compliance with lifestyle recommendations aimed at reducing cardiac risk factors (Guzetta and Dossey 1992).

There is some debate about women's rates of referral and attendance at cardiac rehabilitation programs. Studies by Cochrane (1992), Ades et al (1992), Everson et al (1998), and Allen et al (2004) found that women may not be referred for CR as readily as men despite both groups having similar clinical profiles. However other research by Burns et al (1998) did not identify gender as a predictor of referral.

Halm et al (1999), Everson et al (1998) and Wallwork (1996) suggest that women's attendance at phase two CR is generally lower than that of men. Parks et al (2000) performed an audit of the phase two CR program at Auckland Hospital and found that women were less likely to attend than men, with 36% of eligible women attending in comparison to 49% of men.

Halm and Penque (1999) identified that women experience different cardiac symptoms and present in a different manner than men when having an acute cardiac event. It was therefore considered possible that women also cope with symptoms and illness in different ways. Women and men are known to have different roles and responsibilities within society, so women's needs in relation to CR may be different to those identified from research with male populations. The aim of this study was to gain understanding of women's perceptions of the contribution of CR to their recovery from an MI.

METHOD

Grounded theory, as informed by Glaser (1978), was used as the methodology. Prior to commencing this study ethical approval was obtained from the relevant regional health and university ethics committees.

Sample

Eligible participants were women admitted to two New Zealand north island hospitals with a diagnosis of MI who had subsequently been referred for phase two CR. Participants were obtained through purposive and theoretical sampling. Ten women participated, ranging in age from 50 to 89 years old. Three participants had experienced more than one MI.

Data collection

Semi-structured in-depth interviews were used to obtain data. Written informed consent was obtained prior to the first interview and with permission the interviews were audio-taped. All interviews were undertaken by the lead author. Field notes were recorded after each interview providing key phrases, descriptions of the situations, body language and events that occurred during the interview. Field notes were then used as data (Glaser and Strauss 1967, Glaser 1978, Schrieber and Stern 2001). Data were also obtained through the use of theoretical memos during data analysis. Interviews took place between September 2001 and April 2002. Literature related to the emerging categories was included in the data analysis.

Data analysis

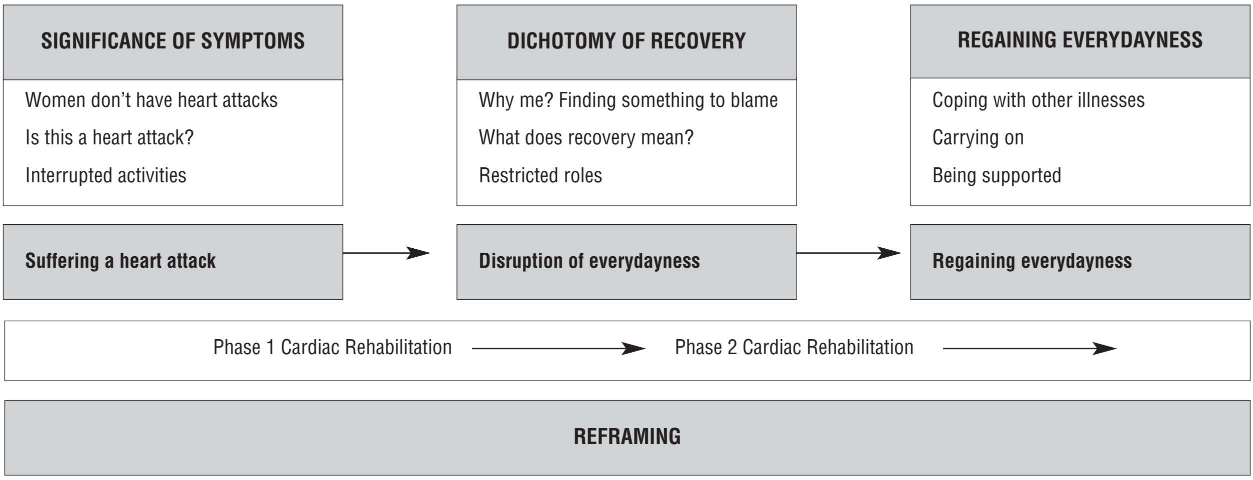
Data were analysed using constant-comparative analysis which involves the joint collection and analysis of data using 'explicit coding and analytic procedures' (Glaser and Strauss 1967, p. 102). Where possible, each interview was analysed prior to the next interview. All forms of data were coded and compared for instances of the substantive categories. Although complete data saturation was not reached due to the small number of participants and time constraints, the core category and basic social process (BSP) were presented to the participants and also discussed with other women who had attended CR.

The women described complementarity and fit between their experiences and the theoretical analysis. An audit trail of theoretical memos and field notes was maintained so that the process of analysis could be retraced. Although a substantive theory did not emerge from this research, valuable insight into women's recovery was gained.

FINDINGS

This study was based on an assumption, derived from literature and clinical experience, that CR would have some positive impact on women's recovery from an MI. This assumption was challenged in terms of the ways in which women framed their experiences of their MI, especially in relation to their pre-understandings of what an MI would be like, their understandings of their treatment, in terms of hospital admission, and the effects that those experiences had on their recovery. These factors all then impacted on what the women thought CR would entail and how it would meet their needs.

Figure 1: Reframing: A continuum of recovery



The way that CR contributed to overall recovery varied for each participant and therefore was not a reliable factor in recovery. Considering the way phase one CR is included in the acute hospital treatment, it was not surprising that most participants were unaware that this had been part of their care.

Eight of the ten participants attended some or all of phase two CR, although some participant's attendance was prevented by physical access issues, work pressures, and co-morbidities which affected, for example, their mobility. These barriers are important considerations as they reflect how the complexity of women's lives was unable to be accommodated in the programs. Women in paid employment also struggled to attend during work hours when they had recently returned to work. Margaret provides an example of this,

'The fact that I work up here isn't a great deal of help but I am going to try, work permitting, to take Wednesdays off, and that's…that's the day they had the meetings here, and certainly go to the next one at least and then I'll see, I'll see how I feel about it, you know, whether I think it is worthwhile to go again or whether it's not' (Margaret).

The phase two CR focused on information and advice about making lifestyle changes, such as increasing exercise, smoking cessation, and dietary changes, and information about risk factors and those that may have contributed to the cardiac event. Participants identified how this advice did not include information about how these changes could actually be implemented. For example, women were informed of the dietary changes they should make but at home they were responsible for preparing food for others who did not want to make those changes, making it harder to modify their lifestyle.

'My daughter rang up said 'mum I need to lose weight but I can't do it and it wouldn't hurt you either' and I said 'no' so we are going to Weight Watchers, which is…yeah a lot better. But when you have got somebody (husband) in the house that likes their sausages, eggs and chips and things like that, it makes it very difficult' (Beth).

Although the content of different CR programs was similar, the information covered varied greatly. Participants reported that they did not ask questions during group sessions because they did not feel comfortable and some believed they only had their questions answered because others in the group, most often men, asked for the same sort of information.

Most participants felt that the CR nurses had more time to spend with them than general ward nurses, and this made them appear more approachable. However there was a noticeable difference in the amount and type of support offered by CR nurses to different participants and this support did not appear to be related to individual's perceptions of their need. For example, four participants were visited at home by the CR nurse at least once, one participant was visited three times, and six were not visited at all.

Participants also expressed a need for peer support that was not met by attending phase two CR. Feelings of isolation were expressed by several participants, who felt they had nothing in common with the other people in their CR group.

'I just thought it would be nice talking to someone in the same boat as I was but there wasn't, you know, as I said they have all had bypasses and angiograms and pacemakers, nobody was in my boat' (Beth).

No participants mentioned attending or being referred to a phase three CR program.

The BSP which emerged from the data was that of 'reframing' which was central to the recovery process and allowed most of the participants to fit their MI into their lives. The disruption to everydayness caused by suffering an MI affected roles and responsibilities in ways that were unique to each individual.

It is clear from findings that recovery was not a stationary or rapidly occurring process for these women, rather it seemed to exist on a continuum (figure 1), beginning before MI symptoms were recognised and extending through to 'regaining everydayness'. The participants in this study identified with different stages on this continuum.

For some the process of 'regaining everydayness' involved returning to the life they had before their MI. For others it involved adapting to a new 'everydayness'. There was no specific timeframe for this process, however it was clear from the data that some participants who had experienced their MI two or three years before being interviewed, were still working toward this goal. Because of the limited time frame of CR it is clear that phase one and two CR did not support this continuing recovery. No participants were involved in phase three CR therefore any benefits this may give have not been investigated.

Regaining everydayness was more difficult for participants when they did not attribute their symptoms to an MI. Attending CR did not necessarily change perceptions of symptoms and causes because rehabilitation information tended to focus on the classic symptoms and most participants in this study did not experience these symptoms. Instead some participants felt they were unusual or atypical and one reported having difficulty accepting that she really had suffered an MI. Other illnesses often seemed to cause more disruption than the MI symptoms they experienced, which created confusion.

Participants also wanted to know why they had suffered an MI and what it would mean to their lives. CR programs assisted this by providing information about possible causes, which participants were able to use to identify a possible cause for their own MI. Participants blamed factors such as smoking, stress, inherited tendencies and medications.

'As I say, I attributed it to stress because I have got a very sick husband (…), I have got to do all the thinking for him and see to everything so I have a fair old burden on my shoulders and I think that contributed, you know, together with my daughter, to my heart attack' (Elizabeth).

The participants went through a process of reframing that involved recognising the significance of their symptoms, working out what recovery meant for them, and attempting to 'regain everydayness'. CR contributed to this process in varying degrees by providing information about their illness and education on ways they could reduce their risk of further heart problems. It is apparent however that with or without CR all of the women in this study 'recovered' to varying degrees.

DISCUSSION AND IMPLICATIONS FOR CARDIAC REHABILITATION

The findings of this study provide useful insights into the role that CR plays in women's recovery from an MI. In order to 'regain everydayness' the women in this study had to 'reframe' their lives to incorporate their MI experience. To do this it was necessary to recognise the significance of their symptoms and establish what had caused their MI. CR provided them with some information related to possible causative factors and helped to explain what had happened to them.

However this focus on the risk factors associated with an MI and modification of these factors also implies that the individual's behaviour can be blamed. This blaming may occur whether or not the individual health care professional actually blames the patient, because the language used contributes to the presumption that responsibility for the illness lies with the patient (Gunderman 2000). Health professionals need to be aware of the potential for blaming and actively work against this.

Some of the participants in this study were not advised to attend phase two CR. Women who wish to attend organised programs should be supported to do so. Literature identifies reasons for not attending CR including transport issues, work and family commitments, and feelings of having nothing in common with the group (Filip et al 1999; Mcsweeney and Crane 2001; Scott 2003) and these were also issues for participants in this study. It is clear that CR needs to be flexible to meet the needs of individual clients.

The desire of women to return to 'everydayness' must also be taken into account. Supporting women to regain their everyday roles and responsibilities may make them feel more positive. Burell and Granlund (2002) suggest that single gender groups may enhance the therapeutic efficacy of CR and improve women's participation.

Although participants in this study generally felt positive about the phase two CR it is clear it did not meet all their needs. Of particular concern was that lack of emotional support for recovery. Moore (1996) found that women wanted more emotional support from health professionals. Research examining the lifestyle changes of women post MI identified social support as an inhibitor and facilitator for making changes in health behaviour (Crane and McSweeney 2003; McSweeney and Coon 2004). Health professionals need to have a greater awareness of the individual needs of women who have experienced an MI, including acknowledging that although health professionals have expert knowledge and skills, which can be applied to the rehabilitation of women who have experienced an MI; the women themselves are also experts (Kamwendo et al 1998). Participants tended to attend phase two CR soon after hospital discharge at a time when they were trying to return to their normal roles, and possibly as a result, CR seemed to slow their return to normal life rather than assisting it.

CR has been developed from research based predominantly on male populations (Brezenka and Kittle 1996; Wenger and Hellerstein 1992) and therefore fails to meet the specific needs of many women. For participants, suffering an MI caused feelings of surprise and shock. Most did not attribute their symptoms to an MI and the symptoms experienced were significantly different to those that are publicised as the 'classic symptoms'. Despite much research recognising that women may experience symptoms that are different or less severe than they expect (Dempsey et al 1995; Dracup et al 1997; Johnson and King 1995; LaCharity 1999; Murray et al 2000), public health literature still presents information about 'classic' symptoms (NHFA 2004; NHFNZ 2004; Revington 2004). There is a need to provide both women and health care professionals with more education related to the signs and symptoms of heart disease in women so that they are able to recognise the significance of such symptoms (O'Farrell et al 2000). There also needs to be an educational focus on women sufferers of CHD in the media rather than the current focus on men.

CONCLUSION

CHD is currently a major health issue for women and will continue to be so in the foreseeable future due to demographic changes and lifestyle factors. In this study, the impact of CR on women's recovery from an MI was variable especially in helping women reframe and regain everydayness. Programs did not meet women's needs for education or support and CR needs to be flexible enough to meet individual and group needs.

Further research into how health professionals assess the education and support needs of women is necessary. Research investigating factors which help or hinder women's recovery as well as the effect of roles and responsibilities on women's recovery from an MI would also be of value. As currently structured CR does not meet the needs of women because it appears to be based on an assumption that everybody needs the same information and support. This study clearly shows that one size does not fit all.

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IMPROVING ACCESS TO CLINICAL INFORMATION IN AFTER HOURS COMMUNITY PALLIATIVE CARE

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ABSTRACT

Objective:

To improve access to clinical information for nurses and doctors providing after hours community palliative care in a regional Australian setting.

Design:

This was an action research project designed to improve collation and distribution of succinct, pertinent and timely information about unstable palliative care patients to nurses and general practitioners (GPs) involved in after hours care. Each week day, each patient's purpose-designed single-page information sheet was updated on the community palliative care service computers. This sheet was designed to give key abstracted information on each patient's history, current condition, treatment and plans for future care. Patients considered to be unstable had their sheets faxed to the GPs on call.

Setting and Subjects:

This procedure was followed for all adult patients admitted to Ballarat Hospice Care Inc, Victoria, Australia between June and August 2004. The nurses and Executive Officer at Ballarat Hospice Care Inc and thirteen GPs from the Ballarat and District Division of General Practitioners were involved in the study.

Main outcome measures:

Surveys and feedback from palliative care nurses and GPs.

Results:

A one-page information sheet provided essential clinical information to nurses and doctors. The nurses' confidence markedly increased with ready access to the information sheets on a hand held Palm Pilot™. The nurses also reported improved outcomes for patients using this approach and there was favourable feedback from GPs.

Conclusions:

This project led to the development of a simple, effective and low cost means of improving communication between professionals caring for palliative care patients after hours.

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INTRODUCTION

The literature reveals that problems exist in the provision of palliative care interventions after hours, and that some of these problems may relate to lack of up-to-date clinical information. This suggests that a study designed to improve access to information about clinical issues may enhance patient, nurse and general practitioner (GP) satisfaction with the process of care.

This project aimed to develop an efficient, affordable model for provision of after hours clinical information for the after hours care of palliative care patients in the service region of Ballarat Hospice Care Inc, Victoria, Australia, which might be generalisable to other areas' services who do not have such a system.

Domiciliary Palliative Care

'Palliative care is care provided for people of all ages who have a progressive life limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life' (Palliative Care Australia 2004, p.4). Patients admitted to domiciliary palliative care services spend most of their last year of life at home. Domiciliary nurses and GPs provide most of the palliative care to these patients, and high quality well co-ordinated care is essential for the best outcomes (Mitchell 2002).

The provision of nursing, medical and other supports to palliative care patients at night and after normal working hours is frequently problematical. In a review of out-of-hours palliative care in the United Kingdom (UK), Thomas (2000) reported four main areas of concern:

- communication
- reduced access to support services
- reduced access to medical advice
- reduced access to drugs and equipment

In developing a framework for the improvement of home care for the dying in the UK - the 'Gold Standards Framework' – Dr Keri Thomas observed that a major limitation to effective care at home is the fallibility of organisational systems (2003).

Information Required

The extent of the information required for optimum home and after hours care of the palliative care patient appears to be boundless, yet there is a practical limit to the amount of information that can be effectively documented and shared. In a discussion of the needs in domiciliary palliative care teamwork in Perth, Smith and Yuen (1994) agreed that the following information from the treating GP was essential to the team:

- history,
- current clinical condition,
- current medications,
- patient's understanding of the disease process,
- patient's understanding of prognosis, and
- patient's expectations of care.

To this we would add that effective palliative care also requires anticipation, by experienced practitioners, of events or crisis situations that can reasonably be foreseen in a given clinical situation (King et al 2003).

It is essential to have accurate, reliable and well presented medical information, with an up-to-date drug history. Access to hospital discharge summaries and letters is also vital. Palliative care philosophy requires that care should include respect for the decisions which have been made about preference for site of care and approach to end-of-life. Thus the documentation should ideally include information regarding these issues, appropriate contact information and the existence of any advance directive or Medical Power of Attorney. It should be standard practice to provide emergency medications for home use, and information about the availability of these when necessary.

Information Transfer

The transfer of up-to-date information about patients between doctors and nurses is a generally acknowledged problem (Burt et al 2004). Although Australian literature on the subject is limited, GPs in Victoria report problems with on-call and after hours support when they have to make decisions without medical records being readily available. Patient-held records solve some aspects of the problem, but they do not solve the immediate access to clinical or social information, for the GP or specialist, when contacted by a nurse at home after hours (Shipman et al 2000).

The method of information transfer must be adapted to individual need and involve minimum effort for the practitioner. A totally web-based solution is unlikely to be effective (King et al 2003), for even if such access is available, it will not provide immediate information to the doctor or nurse at night. Neither nurse nor doctor is likely to want to access the web for the information when woken for advice, especially in the early hours of the morning.

Grampians Health Region and Ballarat Hospice Care Inc (BHC)

The Grampians Health Region is one of five rural regions in Victoria, covering an area of 48,000 km2. Ballarat is the largest city and the tertiary referral centre for the region, which had a population of 215,536 in 2001. There were 425 referrals to the four domiciliary palliative care services in the region in 2003, with 413 admissions accepted, and approximately 140 registered clients at any one time (personal communication: Executive Officer, BHC November 2004). Ballarat Hospice Care Inc provides after hours emergency nursing service to patients in the city of Ballarat and immediate surroundings. This service cares for about half of all the palliative care patients in the Grampians Health Region.

Concerns over communication within Ballarat Hospice Care catchment

Ballarat Hospice Care nurses commence a shift with a verbal handover of unstable patients and they have access to a clinical nursing summary and list of drugs. They do not always have ready access to a medical summary produced by the palliative care physician and/or letters from other consultants. Palliative care nurse specialists report consistent difficulty in accessing clinical information about the patients for whom they care.

International and Australian literature indicates that GPs generally find it satisfying to be involved in palliative care, but they nearly all agree that communication is a major issue (Munday et al 1999; Yuen et al 2003).

The transfer of information about individual patients and problems usually relies on informal telephone calls between doctors and nurses. Discussions with Divisions of GPs within the region indicate that they see improved transfer of information as an area of need, which is addressed in this project.

This project aimed to improve communication between existing service providers, with minimal extra effort and cost. It planned to provide a summary sheet for each patient based on a slight modification of the existing medical records used by the palliative care nurses. This project planned to coordinate the information transfer using the services of a medical receptionist to contact relevant GPs' offices, taking one to two hours per day, to keep local GPs closely connected with the care of their patients.

METHOD

Objective

To improve access to clinical information for nurses and doctors providing after hours community palliative care in a regional Australian setting.

Design

Action research allows nurses to participate in research in the local setting, providing ample opportunity for re-evaluation and feedback (McGarvey 1993, p.372). A variety of approaches, definitions and uses of action research have emerged since it was created by Kurt Lewin (Holter and Schwartz-Barcott 1993 p.298). This project employed a *five-step* action research process outlined by McGarvey (1993, p.375) which,

i.) *identified a problem* in distributing timely and appropriate information about unstable palliative care patients to nurses and general practitioners involved in after hours care, and

ii.) *considered the problem* through a literature search, which led to:

iii.) the *proposed plan of action,* which was to survey nurses and GPs to develop a single page of essential medical data relating to the history and current condition of any unstable patients.

iv.) This plan was *put into practice* by transferring the information sheet, by fax or secure computer linkage each week day, between nurses and GPs responsible for the patients' after hours care.

v.) The *reflective stage* of the project *considered feedback* from the nurses and GPs to assess the value of the process and make recommendations for future action.

Setting and subjects

All adult patients admitted to Ballarat Hospice Care Inc, a domiciliary palliative care service in Victoria, were invited to participate in this project, between June and August 2004, so their medical information might be shared between professionals caring for them, especially after hours. The nurses and Executive Officer at BHC, and GPs from the Ballarat and District Division of General Practitioners, were the professionals invited to participate in this study. Ethics approvals were obtained from Ballarat Health Services and BHC for this project.

Main outcome measures

The following outcome measures were planned to be used in this study:

- palliative care nurses' and general practitioners' surveys and focus group feedback;
- the number of accurate predictions of unstable palliative care patients that resulted in call-outs after hours; and
- patient satisfaction survey following after hours service (from McKinley et al 1997).

The following results and discussion section will show that the first outcome measure was very successful, but there was difficulty with the second, and reasons are given as to why the third was not used.

RESULTS AND DISCUSSION

Developing and using the After Hours Palliative Care Patient Information Sheet:

The seven palliative care staff from BHC and thirteen of the general practitioners from the Ballarat and District Division of General Practice completed a survey which led to the selection of information considered essential for handover of palliative care patients. This was recorded on a single A4 sheet, called the After Hours Palliative Care Patient Information Sheet (see Appendix A for details).

It took approximately one hour to set up each new patient's file on the BHC computer. As these files were based on MS Word, rather than a database, they were very easy to process. This procedure was very simple, efficient, effective and cheap.

King et al (2003, p.279) found that: 'the main problem reported was keeping the [hand over] forms up to date, given the rapidity with which conditions can change in palliative care.' Although at least one nurse in King et al's study said, 'It would be a nightmare to attempt to do it … daily' (2003, p.279), the nurses in our study found it needed to be done daily to be most relevant. At the end of each week day, following their visits to the palliative care patients, the PC nurses updated their nursing notes using MS Word with desktop computers. This information was then downloaded onto the BHC central computer.

After updating their notes, the hospice nurses discussed the patients to predict which were unstable enough to possibly lead to call-outs after hours. Information sheets for these patients were faxed to the GP known to be 'on call' for each patient that evening. The current single-page information sheet, together with the Palliative Care Nurse Consultant's initial assessment notes, any letters to GPs and/or referrer, specialist appointments, hospital discharges, etc were scanned into the files for all patients and transferred to a Palm Pilot for the Hospice nurse 'on call' after hours.

LIMITATIONS

Difficulty predicting call-outs for unstable patients

Where the palliative care nurses considered a patient's condition or care situation to be unstable, and hence likely to result in an after hours call-out and/or hospital admission, the information sheet was sent to the general practitioner concerned. Over eight weeks from 7 June to 10 August 2004, 29 of the patients registered with BHC were sufficiently unstable which could have resulted in call-outs on 99 occasions. Seventeen actual call-outs resulted from these 99 predictions. In the same eight-week period, there were another 36 after hours' call-outs, which were not predicted. This difficulty with accuracy of prediction of call-outs reinforces the need to have accurate, up-to-date information readily available after hours.

Patients' satisfaction survey

The planned survey of palliative care patients' satisfaction, which referred mainly to after hours' service provided by doctors, was not undertaken as there were only four GPs who were called to attend palliative care patients after hours during this study.

Limited GP involvement

Only two of the four GPs, who were called to attend palliative care patients during the two months of this study, had been sent a copy of their patients' information sheet. This provided insufficient data to draw conclusions. However, incidental feedback from several other GPs, who had received the one-page information sheets, indicated that the information would have been useful had they been contacted about their patients after hours.

Benefits for nurses

Although only four GPs were involved in after hours' call-outs for palliative care patients during this study, the palliative care nurses certainly gained benefit from it. Below are summaries of comments from a feedback questionnaire and a round-table discussion with the six palliative care nurses and the EO who participated in this project at BHC.

After some initial concerns, the nurses found the information sheets and computers easy to use and very beneficial to their practice. A simple MS Word-based program was used, which only demanded elementary word processing skills, rather than a more complex database. Updating the information sheets daily made the nurses more thorough in their reporting, especially the section on Expectations of Care, where very specific comments were noted.

Nurses' confidence markedly increased, because they had immediate access to each patient's:

i. full medical history,
ii. treatments,
iii. current status,
iv. up-to-date medications list,
v. progress notes,
vi. risks and problems,
vii. symptom control,
viii. contact information,
ix. doctors' letters, and
x. expectations of care.

Nurses also saved time because they did not have to go to the office to collect patients' notes before either phoning back or visiting the patients after hours. With the nurses on call having all relevant information on hand, it meant they could respond to the pager rapidly and give accurate information for all patients, even those they had not previously seen. This reduced nurses' concerns or worry about not knowing patients and the patients did not have to repeat their medical history to each new nurse who visited them.

Nurses felt more confident with assessments, which led to patients' outcomes being improved due to nurses' increased knowledge. For example, reduced chances of error when administering drugs, in keeping with results from Bates and Gawande (2003), who found that improved communication and readily accessible knowledge prevented errors and adverse events. Although nurses still needed to contact GPs for drug orders, there was a feeling that there was 'less need to call for help [as nurses were] better equipped [and could] pick up problems more accurately.'

Nurses could give more thorough information to GPs and Accident and Emergency staff when necessary, to help provide more sound medical treatment for their patients. The nurses reflected this also helped them present as being more professional in their practice with other medical colleagues. Nurses could confidently tell the doctors to 'call back if more information is needed,' knowing they would be able to provide current information as it was readily available (on a Palm Pilot in this study).

Problems and future development

With a considerable amount of new information coming in each day to be updated on computers, it was difficult to restrict it to one page (see Appendix A), which was done in order to facilitate faxing to GPs. In future:

i. without the need to fax a single sheet to GPs, the notes can be extended to more than one page;

ii. the bottom of the information sheet will be used for medications and long history;

iii. the ‘symptoms: severity 1-10’ will not be used unless there is a drastic change, so this list will be used as a check list for ‘current problems’, with the addition of ‘fatigue’ (see Appendix A).

The minor duplication of nursing notes, which occurred in this study, will be reduced when each nurse has a desktop computer and Palm Pilot, which BHC has decided to implement, due to the success of this project. When they each have a Palm Pilot, the nurses will be able to enter notes directly during home visits. This will facilitate the processing of information to update each person’s records on a daily basis, when the nurses return to Hospice.

This study provided a single sheet of salient information on a Word-based program. This would work on a laptop or a personal computer accessible by mobile phone, as well as on the Palm Pilot. The message, not the medium, is the key finding in this project.

CONCLUSION

The palliative care nurses in this study reported improved outcomes for patients due to the nurses’ more confident approach, based on better knowledge about the patients’ history, current condition and treatments, and plans for future care.

Informal feedback from GPs who received the faxes on their patients found the information to be valuable, even though it was not needed for after hours call-outs by many GPs in this study.

Although there was some initial uncertainty among the palliative care nurses about filling in the information sheet and implementing a computer-based recording system for palliative care patients, once they quickly became used to the simple MS Word-based program storing the data from the comprehensive information sheet, they found it to be remarkably convenient, very effective, efficient and empowering.

Having ready access to each patient’s:

i. full medical history,
ii. treatments,
iii.current status,
iv. up-to-date medications list,
v. progress notes,
vi. risks and problems,
vii. symptom control,
viii. contact information,
ix. doctors’ letters, and
x. expectations of care,

markedly increased the palliative care nurses’ confidence in working with the patients, their peers and other medical personnel.

These benefits to practice were delivered at a low cost. The system developed in this study is simple, readily accessible and available free of charge from the authors. It should be emphasised that the abstracted information sheet used in this study does not remove the need to record fuller clinical data from initial patient assessment and progress monitoring, nor does it generate data. Many systems now integrate clinical information and data gathering functions in the one information technology database system. This increases staff work load and cost considerably, and may or may not meet the out-of-hours needs of a service, which was the aim here.

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Appendix A: After hours palliative care patient information sheet

BALLARAT HOSPICE CARE INC AFTER HOURS INFO SHEET

Name:

Address:

Phone:

UR No.: **DOB:**

Carer Name: Relationship: Phone:

GP Name: Phone: Fax:

NOK: Phone:

Specialist:

Brief History:

Primary Diagnosis:

Secondary Diagnosis:

Current Clinical Condition:

Stable ☐ Unstable ☐ Deteriorating ☐ Terminal ☐

Current treatment:

Symptoms: Severity 1 -10

Pain 1		Anxiety	
Pain 2		Depression	
Nausea / Vomiting		Appetite	
Drowsiness		Constipation	
Dyspnoea		Restlessness/Agitation	
Mobility		[fatigue]	

Current medications: **Allergies:**

Drug Name	Dosage / Route	Recent changes / Problems

Expectations of Care:

	Preferred place of care	Preferred place of dying	Treatment options
Patient			
Carer			

Last updated:

ASSESSMENT AND MANAGEMENT OF CHRONIC PAIN IN THE OLDER PERSON LIVING IN THE COMMUNITY

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Key words: Chronic pain, older people, domiciliary/home/community care nurses, pain assessment, pain instruments

ABSTRACT

Aim:

This paper reviews the nursing research literature on chronic pain in the older person living in the community and suggests areas for future research.

Background:

Chronic pain is a pervasive and complex problem that is difficult to treat appropriately. Nurses managing chronic pain in older people in domiciliary/home/community nursing settings face many challenges. To provide care, the many parameters of chronic pain which include the physical as well as the psycho-social impact and the effect of pain on patients and their families, must be carefully assessed. Beliefs of the older person about pain and pain management are also important.

Method:

Relevant nursing studies were searched using CINAHL, Cochrane Database of Systematic Reviews, EMBASE and PUBMED databases using key words about pain and the older person that were appropriate to each database.

Results:

Tools to assess pain intensity in the older person have been studied but there has been less research on the other parameters of pain assessment or how the older person manages pain. An effective nurse-patient relationship is an important component of this process and one that needs more study. Few research studies have focused on how nurses can be assisted, or on the challenges, nurses' face, when managing this vulnerable population.

Conclusion:

A broad approach at the organisational level will assist nurses to manage this health care issue.

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INTRODUCTION

Chronic pain is a significant health problem for older people living in the community. The prevalence rate is difficult to determine but researchers in Australia and overseas have found between 27% (Blyth et al 2001) and 51% (Helme and Gibson 1997) of those over 65 years report chronic pain. In those 85 years and older, the prevalence rates are higher as researchers report that as many as 70% of older persons who live in community settings report pain (Brochet et al 1998; Roy and Thomas 1987; Scudds and Robertson 2000). This high prevalence is a concern as chronic pain, particularly in the older person, is not well-treated (Ferrell et al 1990; Pitkala et al 2002).

Chronic pain affects all aspects of an individual's life and has a major impact on health services. A Canadian study reported over 75.7% of older people receiving home nursing had been troubled by pain in the past two weeks (Ross and Crook1998). Managing chronic pain in the older person is an important nursing responsibility; however, most research that guides nursing practice has been conducted in acute care or nursing home settings. Nursing research about managing chronic non-malignant pain in non-institutionalised older persons is limited.

The purpose of this paper is to review the nursing literature on assessment and management of chronic pain in older persons in a community setting and to suggest areas for further research.

Relevant nursing studies, in English, were searched in electronic databases up to July 2005. Neoplasms and palliative care studies were excluded and a limit of age 65 and older imposed. Databases included: CINAHL (1982-) using keywords: aged, chronic pain, community health nursing; Cochrane Database of Systematic Review combined aged, chronic pain, community care with complementary and alternative medicine; EMBASE (1996 –) using keywords aged, chronic pain and home services: PUBMED (1967-) using MeSH terms: aged, pain, pain assessment, home care services.

LITERATURE REVIEW

Assessment of chronic pain

Pain assessment in the older person is particularly complex because of other underlying health issues, polypharmacy, and increased sensitivity to pain-relieving medications. A range of other factors such as the patient's beliefs and attitudes toward pain and analgesic medications, health professionals' lack of knowledge and lack of understanding about the complexity of chronic pain, and even organisational barriers, add to the problem and complicate the nurse's role. Chronic pain affects all dimensions of an individual's life: physical; psychological; social; and spiritual, and data should be gathered on all these aspects as well as the meaning of pain for the individual.

Chronic pain can interfere with the older person's abilities to perform activities of daily living (ADLs). In domiciliary/home/community care settings, researchers have found that older people with chronic pain require more assistance with ADLs from domiciliary/home/community care nurses than those who are pain free (Ross and Crook 1998). Chronic pain can also affect appetite (Bosley et al 2004) and sleep (Ferrell et al 1990; Ross and Crook 1998).

Researchers in other fields have noted that pain intensity has the most impact on the older person's physical functioning, but other pain characteristics which include location, onset, duration, frequency, and pattern (continuous or intermittent) also have an effect. For example, pain that is continuous but of moderate intensity can be just as disabling as severe pain that is intermittent (Lichtenstein et al 1998). (Disability is defined as difficulty performing three or more activities of daily living). Level of disability also increases if more than one body site is affected (Lichtenstein et al 1998). Falls in the older person have also been linked to chronic pain (see Varela-Burstein and Miller 2003 for a review), and although all the particulars of the association are not clearly understood, it is postulated that pain may cause individuals to modify their ADLs. These modifications can lead to problems of balance and loss of physical conditioning which can predispose to falls. Pharmacotherapy used for sleep and for pain relief may contribute to falls also.

In the older population, nursing investigators have focused on which tools measure pain intensity accurately. In community settings, assessment tools have been studied to determine if some instruments are too abstract, particularly when cognition is a problem. The following tools have been researched using older persons in community settings as the population: verbal descriptor scales (VDS) (Benesh et al 1997; Herr et al 2004; Taylor and Herr 2003); the vertical visual analogue scale VAS [v-VAS] (Benesh et al 1997; Herr et al 2004); temperature scales (PT) (Benesh et al 1997; Taylor and Herr 2003); numerical rating scales (NRS) (Benesh et al 1997; Taylor and Herr 2003; Herr et al 2004); verbal numerical rating scale (VNS) (Herr et al 2004); and faces pain scales (FPS) (Herr et al 1998; Herr et al 2004; Taylor and Herr 2003). Several researchers have concluded that these commonly used tools are valid and reliable for older persons, and many are suitable for those with mild to moderate cognitive impairment (Ferrell et al 1995; Taylor and Herr 2003) if special provisions such as enlarged print and careful explanations are made (Taylor and Herr 2003).

There is less research on assessing the impact of chronic pain on the psychosocial well-being of the older person living in the community. Chronic pain can interfere with the older person's ability to shop, maintain their home and with family and social relationships (Ross and Crook 1998; Mobily et al 1994). The risk of depression increases with chronic pain (Carrington Reid et al 2003; Lin and Taylor 1999; Ross and Crook 1998). Because some of the symptoms of depression and chronic pain are similar, nurses may need to use a mental status questionnaire such as the Mini-Mental Status Questionnaire (Folstein et al 1975) in conjunction with pain assessment measures to ensure that the patient receives appropriate care (Herr and Mobily 1991). Cognition can be influenced by both pain and analgesics (McCaffery and Pasero 1999).

One of the difficulties associated with pain assessment is that the older person may be reluctant to report pain. Clinicians have suggested that stoic attitudes, fears of aging, fears about medications, fears that pain means they may not recover, are commonly held beliefs about pain and pain management (Ferrell et al 1990; Herr and Mobily 1991; Muonio 2004). Investigators in long-term care settings suggest that the older person may not want to bother nurses and believe that complaining may alienate health professionals and drive away their limited social support (Ferrell et al 1990; Yates et al 1995). Conversely, some clinicians suggest that older persons may report pain instead of other symptoms as pain is more acceptable to report than physical losses, loneliness and boredom (Herr and Mobily 1991).

The language used by older persons to describe their pain may differ, as they may not refer to a problem as pain but instead use terms like soreness or annoying (Miaskowski 2000). Obtaining accurate pain reports from those with dementia is a concern.

Mäntyselka et al (2004) found that the older person with dementia living in the community, as assessed by a geriatrician, reported less pain and used less analgesics than those who did not have dementia. This suggests that although persons with dementia do not report as much pain, nurses need to use other means to assess pain and provide pain relief.

Management of chronic pain

Recently there has been more attention to the investigation of the older persons' beliefs about pain and about their preferred methods of managing it (Jakobsson et al 2003; Ruzicka 1998; Tse et al 2005; Walker et al 1990; Yates et al 1995). Ruzicka (1998) found a diversity of beliefs about causes of pain and pain management as some older persons view pain as something that they have some control over and others believe that pain management requires assistance. This researcher also found that older persons believe that being anxious or depressed increases pain (Ruzicka, 1998). Walker et al. (1990) found that comprehensive data should be gathered on the older person's understanding of the cause of pain, methods used for pain control, as well as past life regrets, how busy or occupied they are, and any personal problems experienced, as these factors have a significant impact on the patient's ability to remain in control and cope with chronic pain.

Chronic pain may require a combination of methods to manage it successfully and older people prefer some methods to others. Swedish researchers found that on average, older people used only three different methods and, amongst those living at home, the most frequently used methods were prescribed medication, rest and distraction (Jakobsson et al 2003). However, their preferred strategy varied with their living situation (Jakobsson et al 2003) as those who lived alone preferred exercise above prescribed medications whereas those living with someone preferred to use heat above prescribed medications.

Older persons may rely on, and even prefer, self-care techniques such as home remedies, massage, non-prescription analgesics, and cognitive techniques such as distraction and rest to pain-relieving medications, exercises or physiotherapy (Jakobsson et al 2003; Landsbury 2000; Tse et al 2005). More investigation is needed into the approaches used by older persons and their preferred strategies particularly as older persons are frequently taking multiple prescription medications.

Cognitive strategies used by older people living in the community have not been investigated in depth. Dunn and Horgas (2004) found that behavioral coping strategies which included reporting pain to physicians or nurses were used more frequently than cognitive coping strategies such as self-statements. Religious coping strategies were used by older women and older persons of minority groups (Dunn and Horgas 2004). Ersek et al (2003) found that a self- management chronic pain program can have a significant positive impact on the older person's pain intensity and ability to perform work and daily activities. However, access to these programs may be an issue for the fragile older person.

Research indicates clearly that having a supportive individual to talk to about pain is important to the older person (Dunn and Horgas 2004; Jakobsson et al 2003; Walker et al 1990; Yates et al 1995). Older patients expect and want nurses to provide support, and discuss pain issues (Dunn and Horgas 2004; Walker et al 1990). Emotional support is as important to patients as advice on prescribed treatments (Walker et al 1990).

Nursing issues in assessment and management of chronic pain

Researchers have also suggested that factors in health professionals are associated with poor pain assessment and management. McCaffery's landmark work in the 1960's encouraged health professionals to believe that pain was what the patient's says it is (McCaffery 1968). However, there is evidence that health professionals place their own interpretation on the patient's pain. Research from domiciliary/home/community care (Hall-Lord et al1999) and long term care settings (Katsma and Souza 2000) indicates that health care professionals underestimate pain in the older person. Walker et al (1990) found that the long-term contact with the older patient that occurs in domiciliary/home/community care settings, did not positively influence the nurse's estimates of patient's pain.

Lack of knowledge of pain is often cited as a major reason why nurses do not manage pain adequately in older persons (see Brown 2004 for a review; Brockopp et al 1993; Clarke et al 1996; Closs 1996; Watt-Watson 1987). Most of this research has been done in acute care settings but domicillary/home/community care nurses have identified that they need more knowledge about chronic pain management, management of patients' co-morbid conditions and pharmacology to manage the older person's pain adequately (Glajchen and Bookbinder 2001; Kee and Epps 2001; Laborde and Texidor 1996; Törnkvist et al 1998). Glajchen and Bookbinder (2001) noted that the nurses may not be aware that their pain management knowledge base is inadequate and may overestimate what they know. More systematic exploration of the problems that nurses encounter and the strategies that nurses use to manage these problems is urgently needed.

Research with older persons in the community has tried to determine if various patient characteristics (age, gender, marital status and culture) influence nurses' pain assessments. Hall-Lord et al (1999) found that the patient's marital status has some influence as enrolled nurses (LPN's) overestimated pain in married patients, and underestimated pain in single patients (Hall-Lord et al1999). These researchers suggest that spouses may make the nurses more aware of the patient's pain and thus increase the nurses' ratings of patients' pain. Culture influences the way patients express pain and how nurses assess and manage it (Bell and Reeves 1999; Duggleby 2003; Lasch 2000). There is a lack of research about the cultural aspects of chronic pain in older persons and further investigation is needed as this population may face further disadvantage by having language problems as well.

Researchers have suggested that nurses' attitudes and beliefs as well as lack of knowledge may influence how nurses assess pain and provide analgesia (Clarke et al 1996; Edwards et al 2001; Hamilton and Edgar 1992).

The relationship between knowledge and attitudes in domiciliary/home/community care settings has had only minimal investigation, however Laborde and Texidor (1996) indicated that knowledge had a positive influence on domiciliary/home/community care nurses' attitudes about chronic pain management.

Investigations into nursing interventions used to manage chronic pain in domiciliary/home/community nursing settings are limited. Walker et al (1990) found that nursing interventions that help patients achieve control over their pain are helpful. Therapeutic touch significantly reduced musculoskeletal pain and anxiety in an older population (Lin and Gill Taylor 1999). McCaffrey and Freeman (2003) used a randomized control trial to determine that music therapy reduced pain levels of community-based patients with osteoarthritis. Patient education has a role in pain management.

Research with cancer populations in home nursing settings identified that structured educational interventions helped patients and families cope with cancer pain (Ferrell et al 1998) and reduced home care nursing cancer patients' barriers to reporting pain and using analgesia (Chang et al 2002). Further investigation of the particular educational needs of older persons and their families with non-malignant pain would add to our knowledge in this field.

Patients receiving nursing care at home expect nurses to advocate with physicians for their pain management (Ferrell and Dean 1994; Walker et al 1990). Laborde and Texidor (1996) found that domiciliary/home/community nurses regard the physician as the prime source of knowledge about pain management. Investigators have found that many general practitioners find managing chronic pain a challenge (Blum et al 1990; Weinstein et al 2000), thus nurses need access to expertise in pain management such as pain specialists, clinical nurse specialists and interdisciplinary pain management programs. Often interdisciplinary pain management programs exclude older persons because of an age bias and a goal to rehabilitate those who can return to work. An Australian study established that the geriatric population can benefit from these clinics (Helme et al 1996). One American study found that domiciliary/home/community nurses do not make use of these clinics/centres even as sources of advice to help patients with chronic pain (Laborde and Texidor 1996).

Organisational culture and management structures are crucial to pain management, but research on their contribution is limited. Organisations that manage pain successfully use a multiple pronged approach which includes protocols, policies and assessment practices (Ferrell 1995; Weissman et al 2000) as well as a long-term commitment to education. In the community, when nurse pain-advisors were introduced as resource persons, nurses found that their assessment, evaluation and documentation of pain in patients with leg ulcers improved (Törnkvist et al 2003). This low-cost management strategy also increased the nurses' satisfaction with their care.

SUMMARY AND CONCLUSIONS

There is an urgent need for more research about how nurses care for the older person with pain in community settings. A major research focus has been to determine which tools are appropriate to measure pain intensity. Although pain intensity is an important basis for treatment, other factors also affect pain assessment and management. These factors include the impact of other pain characteristics on the individual's physical and psychosocial functioning. The effect of co-morbid conditions and the influence of patient and nurse characteristics are also important influences on pain assessment and management. The nurse-patient relationship is crucial but this relationship has not received much attention in pain management research. Non-invasive nursing interventions also need more exploration.

The beliefs, concerns, and practices of older persons about pain also have a major impact on pain management. Interventions that assist older persons to develop and retain control of their pain management have improved outcomes but more investigation is required into these areas. As the rate of depression amongst older persons is high and can contribute to other physical symptoms such as decreased mobility and limited social interaction, it is critical that the psychosocial needs of older persons with chronic pain be assessed. These patients are often isolated and the nurse may be one of their few contacts, hence the nurses' abilities to assess for and differentiate between pain and depression and to advocate for care are critical.

Research-based information on the nurses' needs and the challenges they face when managing chronic pain in the home is extremely limited. The lack of evidence-based information is even more significant given that nurses' responsibilities for managing this complex health problem have increased. From the exploration that has been done, nurses need education tailored to address their specific knowledge needs about pain, co-morbid health conditions, pharmacology and appropriate methods of educating older patients and their families. Access to expert advice such as clinical nurse specialists and avenues of referral to specialised pain management programs are also required along with organisational structures such as policies, procedures and resources to address pain. A multifactoral approach at all levels is crucial. Given the high prevalence of chronic pain in this population, and the impact upon patients, families and the health care system this health care problem needs to be addressed.

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NURSING SANS FRONTIERES: A THREE YEAR CASE STUDY OF MULTI-STATE REGISTRATION TO SUPPORT NURSING PRACTICE USING INFORMATION TECHNOLOGY

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ABSTRACT

Objective:

To highlight the registration issues for nurses who wish to practice nationally, particularly those practicing within the telehealth sector.

Design:

As part of a national clinical research study, applications were made to every state and territory for mutual recognition of nursing registration and fee waiver for telenursing cross boarder practice for a period of three years. These processes are described using a case study approach.

Outcome:

The aim of this case study was to achieve registration in every state and territory of Australia without paying multiple fees by using mutual recognition provisions and the cross-border fee waiver policy of the nurse regulatory authorities in order to practice telenursing.

Results:

Mutual recognition and fee waiver for cross-border practice was granted unconditionally in two states: Victoria (Vic) and Tasmania (Tas), and one territory: the Northern Territory (NT). The remainder of the Australian states and territories would only grant temporary registration for the period of the project or not at all, due to policy restrictions or nurse regulatory authority (NRA) Board decisions. As a consequence of gaining fee waiver the annual cost of registration was a maximum of $145 per annum as opposed to the potential $959 for initial registration and $625 for annual renewal.

Conclusions:

Having eight individual nurses Acts and NRAs for a population of 265,000 nurses would clearly indicate a case for over regulation in this country. The structure of regulation of nursing in Australia is a barrier to the changing and evolving role of nurses in the 21st century and a significant factor when considering workforce planning.

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INTRODUCTION

The regulatory structure of nursing in Australia is a barrier to the changing and evolving role of nurses in this new millennium (Bryant 2001; Kjervik 1997; Simpson 1997). In an age where travel and technology have been normalised into practice, we are rapidly moving to a time when not only national but global nursing registration will be required. Nurse regulatory authorities (NRAs) throughout the world need to be able to respond to the 'virtual' location of nurses as the environment and the way in which nurses practice changes (Styles and Arrara 1997).

21st Century nursing

Emerging 21st century nursing roles which require national or multi-state registration include defence nurses, nurses of the Royal Flying Doctor Service, retrieval nurses, transplant coordinators, nurse lecturers with on-line courses, nurses who teleconference, tele-nurses or call centre nurses, nurses who work for an agency which is nationally based and overseas nurses who wish to work and holiday around Australia (Bryant 2001).

The incidence and use of e-health is increasing, however, barriers such as 'turf issues', fee for 'virtual' consultations, and a degree of technophobia amongst regulators, have prevented wide spread adaptation (Mitchell 1998).

As an example, telenursing was defined by the Australian Nursing and Midwifery Council in 2003 as nursing using information technology. Telenursing is an evolving specialty and has the potential to recruit and retain specialist nurses who may not wish to work within the structure of mainstream healthcare (Queensland Health 1999). Due to its nature, telenursing can seamlessly transcend state borders and has the ability to reduce the duplicity that plagues our state based healthcare systems (Preston et al 1992; Whitten 2000; Whitten et al 2000).

Federal and state governments have indicated interest in the implementation of a National Health Service Direct, (NHS Direct) style telephone support service into the Australian health care system (Sheffield Medical Care Research Unit 2000). NHS Direct operates a 24-hour nurse advice and health information service, providing confidential information on: what to do if you or your family are feeling ill; particular health conditions; local health care services, such as doctors, dentists or late night opening pharmacies, and self help and support organisations. The telephone service is available in England and Wales and a similar service called NHS24 was introduced in Scotland in 2002.

Many Australian states already have versions of NHS Direct, out-of-hours telephone triage systems or telemonitoring services which are supported by nurses (Fatovich et al 1998; Celler et al 1999; Lattimer et al 1998; Turner et al 2002). Telenursing systems have been easily adapted into the United Kingdom's (UK) health care system as nurses in the UK are registered under one comprehensive national process for England, Scotland and Wales and therefore cross-border or multi-state practice regulations are irrelevant.

Current medical, nursing and legal literature abounds with discussion about the square peg of practice using information technology fitting the round hole of health care regulation (Joel 1999). This is particularly evident in the telehealth, telemedicine and e-health literature. In the USA and Canada health care workers share similar dilemmas with regard to cross-border or multi-state practice because like Australia these countries also have state based or province based health professional regulation (Creal 1996; Gassert 2000). Problems associated with multi-state practice ie. multiple registration fees and variances in licensure to practice are complex. However, these issues need to be addressed if nursing is to take advantage of current and future technologies, as these modes of health care promise to increase accessibility and equitable delivery of quality care, to vulnerable and underserved populations.

The Chronic Heart Failure Assistance by Telephone (CHAT) study

The Chronic Heart Failure Assistance by Telephone (CHAT) study is a National Health and Medical Research Council (NHMRC) funded project, which involves nurse-led telephone support for patients with heart failure living in metropolitan and in particular rural and remote areas. Although this telenursing system is being tested with heart failure patients it has the potential to be adapted for all chronic diseases. This type of telephone support brings specialist nursing care to the frail and elderly in their homes normally outside of the radar of recommended heart failure care, such as home visiting services.

For the past three years the CHAT study has been used as a vehicle to test whether the nurse regulatory authorities (NRAs) regulation of nursing in Australia supports a model of nursing care which requires using mutual recognition provisions and cross-border fee waiver to enable cost effective national telenursing practice.

DEFINITIONS

For the purposes of this study the following definitions have been used.

Mutual Recognition

Nurses and midwives who have current authority to practise as a registered nurse, registered midwife or enrolled nurse in one state or territory of Australia may apply for recognition in another state or territory under the *Mutual Recognition Act 1992*.

Nurses and midwives who have current authority to practise as a registered nurse, registered midwife or enrolled nurse in New Zealand may also apply for recognition in an Australian state or territory under the *Trans Tasman Mutual Recognition Act, 1997*. Under the provisions of the *Mutual Recognition Act 1992*, a person who has a current authority to practise in one state or territory is eligible to be registered and to carry on that equivalent occupation in a second state or territory. This right may be exercised provided that certain conditions, including lodgement of a Statutory Declaration (written notice), are met. Mutual recognition provides an additional and alternative avenue for obtaining registration or enrolment for nurses in Australia. Applicants have the choice of applying for registration or enrolment under the *Mutual Recognition Act 1992* or the individual nurses and midwives Act in the jurisdiction in which they wish to practice.

Cross-border Fee Waiver

In a country as large as Australia, nurses may at times be required to travel across state and territory borders to provide a nursing service. In the interests of reducing the financial burden on those nurses who are required to register in more than one state or territory, all nurse regulatory authorities in Australia now have the ability in certain circumstances, to consider waiving the fees, or exempt an individual, from the requirement to pay a fee. The criteria for waiver of fees for registration or enrolment are:

- holding current registration or enrolment as a nurse/midwife/mental health nurse/nurse practitioner in another Australian state or territory; and
- employment as a nurse/midwife/mental health nurse/nurse practitioner in another Australian state or territory; and
- required as a condition of your employment to cross a state or territory border to practise nursing in this state for short periods at irregular intervals during a period of time which extends over one month.

This principle exempts a nurse from the obligation to pay the registration or enrolment and practice fees (Nurses Board of South Australia 2005).

Telenursing policy

Telenursing occurs when nurses meet the health needs of clients through assessment, triage and provision of information, using information and communication technology and web based systems. Nurses practising telenursing are generally required to be registered nurses. Enrolled nurses involved in telenursing are supervised by a registered nurse. In Victoria a registered nurse is known as registered nurse (Division 1) and an enrolled nurse as registered nurse (Division 2). Nurses practising telenursing are responsible for ensuring that their nursing skills and expertise remain current for their practise. Nurses who are practising telenursing in Australia are expected to practise within the framework of the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for Registered Nurses, the ANMC Code of Professional Conduct for Nurses in Australia, Code of Ethics for Nurses in Australia and other relevant professional standards (ANMC 2003).

METHOD

Over the three years in which this case study took place, the nurses in the CHAT study, documented, recorded and filed all correspondence phone calls and emails related to the aim of achieving national registration. The application process also involved frequent consultation with experts in the field of nursing regulation. The outcomes of those phone calls and meetings were also recorded. The following is a report of these accounts.

Results

Year One:

In the first year of the project, representatives of the CHAT study's nursing team met with the Nurses Board of South Australia (NBSA) to introduce the project and inform the Board of the intention to practice nationally from a call centre located in the South Australian Branch of the National Heart Foundation of Australia. The team also sort advice on how to apply for national registration. the case for national registration as a requirement of the CHAT study was sent to all state and territory boards and the ANMC.

After five months replies were received from all recipients. The NRAs stated unanimously that they supported the newly signed ANMC National Telenursing Policy. Consequently, seven sets of application forms for mutual recognition and cross-border fee waiver were forwarded to each of the NRA's of each of Australia's five state and two territories (excluding South Australia). Without fee waiver the annual cost for national registration for each CHAT registered nurse (RN), would have been *$959 initially (*home state annual practising fee plus registration by mutual recognition in every other state and territory), then $625 for re-registration annually (see table 1).

The initial applications for mutual recognition required verification of identity, current registration and a statutory declaration witnessed by a Justice of the Peace (JP). This verification process took one to two hours and involved 21 separate co-signings with the JP. The application forms were then posted to the states and territories for processing. Table 2 is a summary of the response from each NRA for Year 1, 2003.

Following the initial application, and due to the differences in policies between jurisdictions, additional information was requested from several states.

Table 1: CHAT Study Telenursing National Registration Costs

	State Territory	Mutual Recognition initial application for RN (Div.1) (based upon 2006 fee structure)	Annual renewal RN (Div.1) (based upon 2005 fee structure)
States		**Once only***	**Annual**
1.	NBSA	$175	$105
2.	QNC	$129	$85
3.	VIC	$120	$80 $120 after March 31
4.	NSW	$60	$50
5.	TAS	$200	$120
6.	WA	$120	$90 $245 for 3 years
Territories			
7.	NT	$75	$50
8.	ACT	$80	$45
TOTAL		**$959***	**$625***

*Source: Australian nursing and midwifery regulatory authorities (accessed March 2006).
Nursing Board of Tasmania: www.nursingboardtas.org.au
Nurses Board of the ACT: www.nursesboard.act.gov.au
Nurses and Midwives Board of NSW: www.nmb.nsw.gov.au
Nursing and Midwifery Board of the Northern Territory: www.nt.gov.au
Nurses Board of South Australia: www.nursesboard.sa.gov.au
Nursing Board of Victoria: www.nbv.org.au
Nurses Board of Western Australia: www.nbwa.org.au
Queensland Nursing Council: www.qnc.qld.gov.au

Table 2: CHAT Study Telenursing National Registration Status

	State Territory	Registration status	Recognition of telenursing policy	Cross-border fee waiver granted
States				
1.	NBSA	Full	Yes	N/A
2.	QNC	Full	Yes	QNC Conditions
3.	VIC	Full	Yes	Yes
4.	NSW	Temp	Yes	NSW Conditions
5.	TAS	Full	Yes	Yes
6.	WA	Temporary	Yes	Temporary
Territories				
7.	NT	Full	Yes	Yes
8.	ACT	Full	Yes	No

Nursing Board of Tasmania: www.nursingboardtas.org.au
Nurses Board of the ACT: www.nursesboard.act.gov.au
Nurses and Midwives Board of NSW: www.nmb.nsw.gov.au
Nursing and Midwifery Board of the Northern Territory: www.nt.gov.au
Nurses Board of South Australia: www.nursesboard.sa.gov.au
Nursing Board of Victoria: www.nbv.org.au
Nurses Board of Western Australia: www.nbwa.org.au
Queensland Nursing Council: www.qnc.qld.gov.au

For example in Queensland, in accordance with the provisions of the amendments to the *Nurses Act 1992* (QLD), it was determined that where nurses are employed and registered in another jurisdiction and, as part of their employment position and role, are required to cross the border into Queensland to provide nursing care, the Board would consider applications on an individual basis subject to the following requirements being met.

1. A nurse must be currently registered with the nurse regulatory authority in the jurisdiction in which the nurse is employed by a health facility.
2. The terms of employment require the nurse to cross into Queensland to provide nursing care for a period of time, but the majority of time is undertaken in the jurisdiction in which the employer is located.
3. The nurse must apply to the Queensland Nursing Council for fees to be waived for initial registration, and for annual renewal as appropriate.

As a result of the Queensland *Nursing Act 1992* amendments the following additional documentary evidence was required:

1. Current registration in the jurisdiction in which the nurse is employed.
2. A formal letter from the employer which identifies: the nurse; advises the role of the nurse; the requirements of the position and confirms that as part of the nurse's employment the nurse must provide nursing care in Queensland. This letter needed to include the number of hours each week the nurse was required to cross into Queensland to provide care, and the days of employment spent in the jurisdiction where the employer is located.

For the waiving of fees to be considered, this information was required at the time of initial application and annually thereafter. The CHAT study chief investigator verified in writing that the study required cross-border practice to care for Queensland participants in the CHAT program and that the time to be spent with Queensland heart failure patients, was not longer than that spent practicing in any other state.

By the time the processes and correspondence for national registration were completed for the initial year (2003) it was time to begin renewing each state registration for the second year of the study 2004 (see table 3).

Year Two:

In year two the CHAT nursing team had to address the issues which arose as a consequence of each state having a different date for renewal. Table 3 demonstrates how three of the states and territories required renewal before the annual renewal was due in the home state. Without guidelines, a decision was made to proceed in the second year by simply repeating the process for the first year.

Table 3: Australian State and Territory Annual Nursing Registration renewal due dates (2005)

State	Due date
ACT	March 31st
QLD	June 30th
TAS	August 31st
SA	**August 31st**
NT	September 30th
NSW	November 30th
VIC	December 31st
WA	Last day of month of birth

3 states due before home state renewal

Registrations which needed to be renewed before our home-state renewal date were paid, and a refund for fee waiver sort once our annual practicing certificates were renewed. Additional information was provided to the QNC as before.

Also in the second year, a meeting took place with key members of the Nurses Board of South Australia to report on progress. A significant break through at this meeting was that the CHAT nursing team were advised that there was flexibility within the re-registration process to allow the team to register early each year (in June rather than August 31st). This concession enabled the nurses to be re-registered each year before renewals in the majority of other states became due (see table 3).

Of interest at this point was a request to forward a discussion paper to the ANMC on the experiences of the CHAT team in accessing mutual recognition provisions for registration and re-registration and in seeking cross-border fee waiver. The discussion paper was requested to inform an agenda item for a national meeting of NRAs. The discussion paper addressed the registration issues the team had encountered and made recommendations based on the experiences in the first two years of the study.

The ANMC is the national coordinating body for the NRAs. Its Board is made up of one representative from each state and territory NRA and two public members (an accountant and a lawyer). The ANMC is the forum where regulatory issues are discussed, and policy and position statements developed. One of the purposes of the ANMC is to assist national consistency in nurse regulation. To date, how successful the ANMC has been in achieving these aims is arguable.

Year Three:

By year three (2005-2006) mutual recognition renewal and cross-border fee waiver had evolved to a smoother and slightly less time consuming process. The method of application had been refined to: completion of the standard renewal forms and competency statements for each state and territory, with 'Fee Waiver' written as a reminder over the section where payment details were indicated. The applications were forwarded collectively, along with a covering letter reminding the NRA administrative processors about the CHAT study and giving notification that the conclusion date for the project had been set for September 2006.

Annually as a baseline, the study nurses renewed, paid full registration fees and completed competency statements in their home state (SA).

As a result of the national applications, mutual recognition and fee waiver for cross-border practice was granted unconditionally in two states Victoria (Vic) and Tasmania (Tas) and the Northern Territory (NT) (see table 2). The remainder of Australian states and territories would only grant mutual recognition or temporary registration for the period of the project due to policy restrictions or NRA Board decisions. The Australian Capital Territory (ACT) reported that it did not have legislation permitting fee waiver (Nurses Board of Australian Capital Territory *Nurses Act 1988*). Although we were given mutual recognition in ACT, we were required to pay full registration each year. ACT was the only state where any concession for fee payment did not occur. Queensland granted mutual recognition and conditional fee waiver for cross border practice (Queensland Nursing Council 2003). NSW and WA granted temporary registration and fee waiver for the purpose and duration of the project only. NSW has since implemented policy requirements similar to those in Queensland to allow fee waiver with similar administrative requirements (Nurses and Midwives Board of New South Wales 2005).

The processing time for the registration applications varied between states and territories. The NT accepted and processed the application within three weeks. Conversely in Western Australia, the final acceptance was completed after nine months from initial application.

Cost

Approval of fee waiver reduced the annual cost of registration from $625 (initial cost $959) to a maximum of $145. The $145 comprises the South Australian annual renewal fee ($100) and the annual renewal fee ACT which could not fee waiver (see table 1).

DISCUSSION

All Australian state nursing regulatory authorities have co-signed a telenursing policy agreement through collaboration with the ANMC. The actual implementation of this policy has been inconsistent due to variances in interpretation (Australian Nursing and Midwifery Council 2003). As a consequence, the aim of this case study, which was to achieve national registration with full fee waiver in every state and territory of Australia, was not achieved.

What was achieved was mutual recognition and fee waiver for cross-border practice granted unconditionally in two states and one territory, reflecting only a 37.5% unconditional support rate for the policies which facilitate the practice of national telenursing.

Currently in Australia, there are eight nurses Acts and eight NRAs for a population of 260,075 registered and enrolled nurses (Australian Institute of Health and Welfare 2002). This, according to Bryant (2001) would seem to be a clear case for over-regulation. Furthermore, the differences in NRA policy and legislation implementation in Australia add to this over-regulation resulting in the delays, costs and frustrations experienced by the research team.

The study experience has confirmed firstly, that mutual recognition has addressed national registration issues in part; however there are still significant sections of the various Acts that are inconsistent (Bryant 2001). And secondly, it is no longer logical for nurses, who are a national resource, to be regulated on a state or territory basis subject to the vagaries of state's rights and the individual whims of politicians and nursing leaders at a local level (Bryant 2001).

There is also an unexplained inequity in fee structure within Australia. The cost range of annual initial registration was from $60 (NSW) to $200 (TAS) with a median of $129 (QLD). The highest fee for annual registration renewal was charged in Tasmania and Victoria ($120) and the lowest level in NSW ($50), with a median fee of $90 (WA). The nurses Acts provide the legislative power to charge a fee for registration however the fees and waiving of fees are based on the individual NRA policies.

Although this paper is a report of a national registration experience from the point of view of nursing it must be noted that regulation of medical practitioners and indeed all eligible health professions in this country are state based and it would be reasonable to assume that the experiences found in this case study would be generalisable across all health care professions.

National registration for nurses is the optimal method of achieving national consistency. There are other less radical options which do not involve the conceding of powers by states, territories and the federal government, such as the call for a national template for the regulation of health professionals and the amendment of all relevant legislation and policy within an agreed time frame (Bryant 2001). As a result of this study, the following recommendations are made:

- The process for streamlining and facilitating national registration should become a priority for nursing and midwifery;
- A single date for annual registration should be established nationally with pro-rata costs for registration beyond that date;
- A national on-line registration system and fee structure administered from each state should be established which automatically includes national registration; and
- A single consistent application and annual renewal process should apply with nationally standardised application forms.

Centralised national registration will not only save money for the nurse but valuable government resources. Central national registration or single payment would also support and encourage health services that are nationally based as it would facilitate the increasing movement of nurses across state and territory borders without penalty.

CONCLUSION

The CHAT Study has enrolled over three hundred and fifty chronic heart failure (CHF) patients who are supported by a team of specialist cardiac nurses. The patients are located in metropolitan, rural and remote areas of every state and territory of Australia. This telenursing project represents a potentially cost-effective and accessible model for the Australian health system in caring for CHF patients. Furthermore, a telephone based/telemedicine system enables a limited resource, namely nurses, to monitor and support a larger than usual caseload of patients. The aim of the CHAT intervention was to support general practitioners in their provision of care to CHF patients by providing evidence based telephone support to keep this generally frail and elderly group out of hospital and at home longer.

Without national registration the CHAT national telenursing research study would not have been possible legally and would have been severely limited financially.

The current cost of national registration (without fee waiver), has the potential to limit growth within practice areas that require cross border nursing care and is a significant burden to employees and/or employers.

Telehealth and telenursing practice is developing at a rapid rate. It is time to create an Australian nurse (as opposed to a Victorian or South Australian nurse etc) who practices without boarders (sans frontières) regulated by one authority with one single piece of legislation and one fee structure.

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