Ms Kerri Kellett
Senior Advisor to Prof Mark Cormack
Department of Health and Aged Care
GPO Box 9848 ACT 2601

Email: scopeofpracticereview@health.gov.au

Dear Ms Kellett,

Re: Unleashing the Potential of our Health Workforce Review

The Australian College of Nursing (ACN) would like to thank the Department of Health and Aged Care for the opportunity to provide input into the Unleashing the Potential of our Health Workforce Review.

ACN has distributed the consultation document to all members of ACN. Members represent the country's rural, remote and metropolitan regions and work in many care settings, providing a rich and complex range of responses. The responses have been collated and are available on the following pages.

This timely review tackles the much-discussed topic of working to scope of practice. We trust you have received informative views and valuable suggestions for a way forward. ACN looks forward to being involved in the following stages of this review.

If you have further enquiries about this matter, please do not hesitate to contact Dr Carolyn Stapleton, Director of Policy and Advocacy, contact for this consultation at carolyn.stapleton@acn.edu.au.

Yours sincerely,

Karen Grace MACN
National Director - Professional Practice
Australian College of Nursing
23 October 2023

ACN response to the Cormack Review survey

1. About us

The Australian College of Nursing (ACN) is a peak body representing nurses across Australia.

ACN's postcode is 2600.

2. Who can benefit from health professionals working to full scope of practice?

☑ Consumers
☑ Funders
☑ Health Professionals
☑ Employers
☑ Government/s
☑ Other

3. Other groups – who else benefits from health professionals working to full scope of practice?

The whole of the Australian healthcare system and all stakeholders involved in the delivery or receipt of healthcare in all settings, including:

- All health professionals
- All health service providers/administrators
- Families and Carers
- Future generations
- Education providers and students
- Researchers
- Communities across Australia – from Rural and Remote to Metropolitan areas
- Underserved, vulnerable groups who may have difficulty accessing appropriate care, including those with disabilities, First Nations people, those from culturally and linguistically diverse (CALD) backgrounds, people experiencing homelessness, older people, migrants and refugees, etc.
- Taxpayers

4. How can the groups identified benefit (refs and links to literature encouraged)

Defining the scope of practice: As outlined by the Nurses and Midwifery Board (2022), Scope of Practice for Nurses is a term that describes the range of activities and responsibilities that nurses are educated, competent, and authorised to perform. Scope of practice is determined by the legislation, regulations, standards, codes, and guidelines that govern the nursing profession in different jurisdictions. Scope of practice also depends on the context of practice, the health needs of the people, the level of competence and confidence of the nurse, and the policy requirements of the service provider.

Scope of practice for nurses can vary depending on the type and level of nursing. For example, registered nurses (RNs) have a broader scope of practice than enrolled nurses (ENs), and nurse practitioners (NPs) have an expanded scope of practice that includes prescribing medications and ordering diagnostic tests. Midwives have a distinct scope of practice that focuses on providing care for women during pregnancy, labour, birth, and postnatal period.

Scope of practice for nurses is not static but dynamic and evolving. Nurses can expand their scope of practice by acquiring new knowledge and skills through education, training, and experience. Nurses can also adapt their scope of practice to meet the changing needs and expectations of the people they care for and the health care system they work in.

Greater awareness of the meaning of scope of practice for nurses will enhance the acceptance of new and innovative nursing roles by the healthcare sector and the general public.

Positive impact on workforce and community: ACN members believe the whole healthcare workforce will be positively impacted, creating a much-improved environment. The ability to work to full SOP will lead to more effective and efficient services, improved health outcomes, shorter wait times for consumers and greater job satisfaction for health practitioners, leading to better staff retention.

When unnecessary restrictions are placed on nurses performing their duties, they cannot perform their role to its full potential. The inconsistency in the interpretation of the nursing scope of practice across healthcare sites can cause a delay in required treatment. This can result in the deterioration of the patient's condition, leading to an extended stay in the hospital. This is a negative outcome for the patient and increased cost to the hospital (health fund if privately funded) and ultimately the government healthcare budget.

Benefits to consumers: Nurses working to SOP provide consumers with more care options. Primary health care nurses support many diverse groups within the community. This includes people in aged care, people from CALD backgrounds, First Nations peoples, those with disabilities, etc. Allowing primary health care nurses to work to their full scope of practice would provide greater access,

particularly for people who do not access treatment due to fear, lack of money, homelessness, etc. Nurses working in mobile and nurse-led clinics need the ability to work to their full SOP to improve health outcomes for people in marginalised groups.

It must be acknowledged that there is a shortage of doctors, impacting many communities' health. It must also be acknowledged that many elements of traditional general practice fall within a nurse's scope of practice. Supporting nurses to work in areas with limited access to medical practitioners will provide better care for many people in collaborative multidisciplinary models of care that recognise the valuable contributions of all disciplines.

Nurses' scope of practice allows them to conduct a range of assessments and to provide therapeutic interventions. Nurses are already demonstrating their independence in managing and working in nurse-led clinics, a role valued by consumers. The shortage of doctors should be viewed as a chance to re-design and rethink how nurses work to benefit consumers and to create positive, productive and interdisciplinary care with doctors and other health professionals all playing complementary and mutually supportive roles.

Cost and cost-effectiveness: Nurses working to full SOP means services are more available and affordable for everyone. Delays in treatment caused by restricted access to primary care can lead to more hospital admissions, longer stay lengths and higher complication rates. All these increase the cost of care.

References:

Issues brief AHHA (2014) - This paper highlights that training and retaining a health workforce is a significant public expense - the Government and health professionals are obligated to engage in reforms that meet population needs.

Leggat, Sandra G. (2014). Changing health professionals' scope of practice: how do we continue to make progress? Deeble Institute – Issues Brief
https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_nlcg-4_changing_health_professionals_scope_of_practice.pdf

Smith & Bodenheimer (2013) Suggests that the capacity that exists within all health professionals should be better matched to demand - all health professionals should be better matched to demand - there is a demand-capacity mismatch.

Bodenheimer, T. S., & Smith, M. D. (2013). Primary care: proposed solutions to the physician shortage without training more physicians. *Health Affairs*, *32*(11), 1881-1886.

Australian Government Efficiency in Health Productivity Commission research paper (2015) outlines how allowing professionals to work to full scope ensures maximum efficiency of health care.

Productivity Commission 2015, Efficiency in Health, Commission Research Paper, Canberra. JEL codes: I10, I18.
https://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf

Benefits to taxpayers: By enabling nurses to work to their full scope of practice, governments will make the best use of taxpayers' money. This, in turn, will benefit all Australians while helping to address access and equity issues-particularly in rural and remote areas and within vulnerable cohorts.

Reference: Australian College of Nursing (ACN). 2022, 'Value-Based Health Care through Nursing Leadership (abridged) — A White Paper by ACN 2022', ACN, Canberra

Benefits for healthcare organisations: Health services are best delivered in an integrated, multidisciplinary team model that ensures that all clinical professionals are working to their full scope of practice. This enables consumers to receive the right care at the right time and in the right place. This is ultimately effective and efficient as it improves health outcomes, reduces costs and supports a stable workforce through improved career opportunities and increased role satisfaction.

Benefits for the aged care sector: There are significant opportunities for redesigning ways of working in the aged care sector through reimagining nursing roles. Current models tend to rely on traditional medical led models in which nurses are limited in their roles. If nurses are empowered and supported within nurse-led models, there will be less reliance on third-party providers, making care more accessible, timely, effective and safe.

In summary, nurses working to their full scope of practice enables nurses to maintain skills, provides greater access to care and is cost-effective.

5. Risks and challenges. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Examples of own experience encouraged

Risk and level of risk: The risks or challenges of enabling nurses to work to their full scope of practice are low.

There is the risk that nurses have difficulty accessing appropriate training and skill acquisition opportunities due to inadequate access to study leave and financial support for the cost of training. This needs to be addressed as a priority.

Also, the nursing education framework should be reviewed to ensure that the transition to extended roles, including nurse practitioner roles, is supported through education opportunities throughout nurses' career pathways. These pathways need to be clearly understood by the nursing profession to enable all nurses to gain the skills, knowledge and experience required to enable them to practice

at the top of their scope of practice.

There is value in considering more collaborative models of training - scenario-based training. At some time in the past, all the health professionals trained together, showing all health professionals the myriad opportunities for inter and multi-disciplinary training and scenario-based training. A current example would be disaster training, where everyone gets together and learns in practice where their scope fits in the disaster, how they can help those in need, how they can fit into the team, and how their skills are valuable/ essential.

Delays to care – a response from an ACN member within the aged care sector

"*A personal example of risks associated with limiting the scope of practice of a nurse in aged care is an experience I had where an assessment was made of an unwell resident. As a previously experienced ED nurse, I was confident of the symptoms and necessary management and believed the resident needed a Medical Officer Review and probably antibiotics. However, the resident's Advanced Care Directive advised that the resident was not for hospital transfer. As such, a request was made for the community rapid response service (Tasmania), and it was advised that only GPs could refer. The residents' allocated GP provider was contacted, who then triaged the call, and it took 4 hours before speaking with a Nurse Practitioner in Melbourne who was very agreeable to the decision and approved the request. The time I spent as the Registered Nurse (RN) in the facility on the critical nature of the illness was time away from time for the more than 100 other residents.*

By limiting my scope of practice as an RN, there was a substantial delay in care and unnecessary use of resources that could have been avoided had I been allowed to make assessments and referrals such as to the Rapid Response Service."

Support for nurses newly working to the top of scope – a response from an ACN member

"*For nurses working at the top of scope or expanded scope, particularly at the start of working to the top of the scope, it would be beneficial if there is a link or support mechanism to allow the nurse to check up on issues if the nurse is unsure. There were those first times when I was working autonomously in my area of practice at the top of my scope. On one occasion, I felt unsure about what I saw, what it meant, and what was best to do. I needed support to develop confidence. Accessing senior clinicians and medical colleagues for some supervision/mentoring to support my education was valuable for building confidence."*

Challenges to achieving Scope of Practice: Approaches to scope of practice can be restrictive or permissive depending on the employer or person overseeing the nurse's work.

Several ACN members queried, "*What is top of scope, and how do you know you're there?"* There are elements of self-awareness in determining whether a nurse should be working to full SOP. Nurses must be self-aware and know what they can and can't do. There must be acceptance that

some nurses are comfortable working well below top of scope, yet they are efficient and effective at what they do and perform a valuable role. To work to SOP depends on the nurse's competence and confidence, education and training.

One ACN Member wrote, "*Understanding what full SOP means can take time for the workplace to catch up. There needs to be more clarity between registration and receipt for registration. Differences between what you and your employer believe – you might be working at what you think is your full SOP, but that might not necessarily be what the employer thinks*."

An ACN member in aged care reported they had attended an education program on swallowing. They wanted to use their knowledge, but her practice was seen as unacceptable due to needing to be formally accredited. This highlights that employers need more information about recognising skills and knowledge attainment and how to translate training into practice.

Risk in a remote setting – an ACN member response

"*As a Nurse working in a remote solo practitioner setting, performing primary health care (PHC), Education, and training through a Registered Training Organisation (RTO) as well as emergency response (using the 'Ambulance' also known as the Emergency Response Vehicle), my current Clinical Governance and scope of practice is not entirely well defined or black and white!*

When needing emergency guidance/approval via the Virtual Emergency MO, the communication (i.e., physical network coverage) can sometimes be patchy and/or non-existent, leaving me and my peers open to 'out of scope' practice and retrospective sign-offs. This leaves us potentially open to being professionally liable."

This example is reportedly typical once Nurses/Paramedics begin working outside capital cities in rural and remote areas.

Opportunity to develop new ways of working – an ACN Member's insights

"*This discussion should lead to opportunities to try new ways of working. ACN should consider taking on holistic models so that several people work together to ensure that the patient receives the best care possible and enable different practitioners to see what their colleagues can do. All team members can appreciate the variety and level of skills available in the team, enabling the team to perform to a much more excellent standard that each individual can achieve in isolation. Trust and understanding of the team's ability will grow."*

Virtual reality and online support: Virtual reality (VR) would be suitable for nurses wanting to gain confidence working to their scope of practice. VR would allow all learners to have sound experience before practising their skills with actual patients. Police, defence forces, and doctors all use VR, so it is only fitting that nurses should have access to this training.

It has been reported that some nurses are anxious when introduced to new practices and procedures. VR provides a chance to experience and try out and become proficient. VR could assist in safely expanding SOP for all nurses.

Embracing VR enables better access for nurses in rural and remote settings. Simulation is essential to build skills and knowledge. VR also allows nurses to experience health issues that nurses would only sometimes come across. It allows nurses to keep up to date with their skill set.

Disjointed capacity to work to SOP across the nursing and related sectors. Jurisdictional differences that impact nurses' ability to work to the same scope across state borders and sometimes from one organisation to another, dependent on policy, need to be addressed. With the advent of the joint RN/Paramedicine qualification, it is necessary to revisit the scope of these practitioners when employed in nursing roles to align their scope to the role more effectively. This will allow these particular nurses to work to their full scope more easily when employed as nurses rather than Paramedics.

Caitlin Fitzgibbon PhD - Doctorate Title: Dual Qualification - what can it mean for the patient, the healthcare system and the paramedic profession? Doctorate Description: This study aims to explore the lived experience of dual-qualified nurse paramedics currently working on the frontline of Australian ambulance services.

Risk of not being allowed to work to full scope of practice – an ACN Member's experience

"*Despite being a highly advanced cannulation nurse, I have been limited in my area by not being 'allowed' to put in a cannula. Because I was not allowed to use my skills, the patient did not receive the best care or the care they needed and consequently had an adverse event that could have been prevented."*

Challenges for all healthcare workers – an ACN Member's experience

"We know there are shortages of GPs in rural and remote locations, but the issue needs more than just a handout of money or a 'put a nurse in that location' solution. The issues for any sole healthcare practitioner in these locations include isolation – they may be the only healthcare professional around; being on call 24/7 – not having time to call their own, always on duty; feeling guilty for taking a holiday – locums can be hard to find; feeling they're not keeping up with their skills or knowledge of new processes or procedures; feeling unsafe, managing community members with drug or alcohol problems alone. A much more considerable effort must be made to come up with solutions for remote and rural communities to provide them with healthcare they can access and to make a job for healthcare workers attractive and not a 'locked in' solitary proposition."

Working with disadvantaged people – an ACN Member's experience

"I work with the homeless and the disadvantaged out of a mobile clinic. Sometimes, we set up in a safe place that offers meals and showers for people, sitting at a table with another health practitioner, and we wait and see those who are comfortable enough to see us. People we see often wouldn't go to a medical practice for a health concern. That might be because they can't physically get there simply because they are ashamed or embarrassed or have had a bad experience and don't want to go there again.

I always take a bundle of underwear, socks, T-shirts, if I can, and flu vaccines with me. Anything that might be acceptable to people.

Trust is a massive component of the relationship we build with clients. They must trust us before allowing themselves to share their medical concern. But you know, today, there were several people I couldn't help. Why? Because I'm not allowed to prescribe some simple drugs that would help people. So now, I hope those people will be happy to come back to see me by next week and that their conditions haven't deteriorated."

6. Evidence that supports your views (refs and links to literature encouraged)

Fragmentation of Care:
Example: Expanding the scope of practice for various healthcare professionals may lead to more cohesive care with adequate coordination and communication among different providers. This can result in a lack of continuity and a potential decrease in the quality of care.
Evidence: The Institute for Healthcare Improvement (IHI) discusses the importance of care coordination and the risks associated with fragmented care in its white paper on the Triple Aim. (Source: https://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx)

Legal and Liability Issues:
Example: Expanding the scope of practice may lead to legal and liability challenges. For instance, if a nurse practitioner's expanded role results in a patient injury, questions of liability and the appropriate standard of care may arise.

Evidence: Research published in the Journal of Healthcare Risk Management explores liability issues related to the expanded scope of practice and emphasises the importance of clear protocols and guidelines to mitigate risks. (Source: https://onlinelibrary.wiley.com/doi/abs/10.1002/jhrm.21271)

Training and Competency Gaps:
Example: When healthcare professionals are granted expanded scopes of practice, there may be

concerns about whether they have received adequate training and have the necessary competency to perform new tasks safely and effectively.

Evidence: The British Medical Journal (BMJ) published an article discussing concerns about training and competency when expanding the roles of healthcare professionals, particularly in the context of physician associates. (Source: Drennan VM, Halter M, Wheeler C, et al. What is the contribution of physician associates in hospital care in England? A mixed method, multiple case study BMJ Open 2019;9:e027012. doi: 10.1136/bmjopen-2018-027012)

Resistance from Existing Professions:
Example: Expanding the scope of practice for one group of healthcare professionals may lead to resistance or opposition from existing professionals who feel their traditional roles should be addressed.

Evidence: This issue is discussed in various articles and reports on healthcare workforce policy and regulation. (Source: https://www.rand.org/topics/health-care-workforce.html)

Resource Allocation and Equity:
Example: Expanding scopes of practice may affect the allocation of resources within healthcare systems. It may also raise questions about equity in access to care if certain professionals are given expanded roles in some regions but not others.

Evidence: Equity concerns related to an expanded scope of practice are discussed in various healthcare policy and ethics literature. (Source: https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf)

Wound care:
There are complexities in accessing expertise (with a lack of healthcare professionals working to scope of practice), leading to a lack of evidence-based care. However, studies have demonstrated that readily available access to care, such as wound management expertise, can promote streamlined health services and evidence-based wound care, leading to efficient use of health resources and improved health outcomes (Edwards, 2013).

Edwards, H., Finlayson, K., Courtney, M., Graves, N., Gibb, M., & Parker, C. (2013). Health service pathways for patients with chronic leg ulcers: identifying effective pathways for facilitation of evidence based wound care. BMC Health Services Research, 13, 1-10. https://doi.org/10.1186/1472-6963-13-86

Example: In a 2014 study, two participants had undetected Basal Cell Carcinoma (BCC) diagnosed as chronic leg ulcers and had received several lines of ulcer care treatments for 10½ years. After beginning treatment at a wound clinic with healthcare professionals working to their full scope and expanding the scope of practice for one Nurse Practitioner, both clients were diagnosed with a BCC

within a couple of weeks. They had these cancers removed (Edwards, 2014).

Evidence: *Reference:*

Edwards, H., Finlayson, K., Maresco-Pennisi, D., Gibb, M., Parker, C., & Graves, N. (2014). The long and winding road: health services for clients with chronic leg ulcers in the community. Wound Practice and Research, 22(4), 226-233. http://www.awma.com.au/journal/2204.php

Defining the scope of practice

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Approaches to scope of practice

Nurse practitioner scope of practice review: https://www.rrh.org.au/journal/article/5001

Department of Health: Nursing Care Quality Assurance Commission. (2019). Registered Nurse and Licensed Practical Nurse Scope of Practice. Nursing Care Quality Assurance Commission. Retrieved from https://www.doh.wa.gov/Portals/1/Documents/6000/NCAO13.pdf

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Factors influencing scope of practice

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Scope of practice confusion

Lankshear, S., Rush, J., Weeres, A., & Martin, D. (2016). Enhancing Role Clarity for the Practical Nurse. JONA: The Journal of Nursing Administration, 46(6), 300-307. https://doi.org/10.1097/NNA.0000000000000349

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Journal of Clinical Nursing (John Wiley & Sons, Inc.), 27(5-6), e913-e920. https://doi.org/10.1111/jocn.13987

Jacob, E. R., McKenna, L., & D'Amore, A. (2017). Role expectations of different levels of nurse on graduation: A mixed methods approach. Collegian, 24(2), 135-145. https://doi.org/10.1016/j.colegn.2016.01.006

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Challenges to working within scope of practice

Endacott, R., O'Connor, M., Williams, A., Wood, P., McKenna, L., Griffiths, D., Moss, C., Della, P., & Cross, W. (2018). Roles and functions of enrolled nurses in Australia: Perspectives of enrolled nurses and registered nurses. Journal of Clinical Nursing (John Wiley & Sons, Inc.), 27(5-6), e913-e920. https://doi.org/10.1111/jocn.13987

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7. **Real-life examples. Give examples and evidence (lit references and links) to support examples.**

ACN Members provided the following real-life examples

Patient-Centred Medical Home (PCMH)

This model emphasises team-based care, focusing on care coordination, patient engagement, and a holistic approach to healthcare. Primary care practices that adopt the PCMH model typically include a mix of professionals, such as physicians, nurse practitioners, physician assistants, registered nurses, social workers, pharmacists, and medical assistants.

In PCMHs, healthcare professionals work collaboratively to address patients' physical, mental, and social health needs. For example, pharmacists can help manage medication regimens, social workers assist with social determinants of health, and nurse practitioners provide preventive and acute care.

Palliative care and care homes

Nurse practitioners in palliative care support active participation and support for individuals. In palliative care, often the nurse practitioner has more evidence-based knowledge than the community GP.

Nurse Practitioners and specialised nurse consultants working with a broader scope and working to their full scope when diagnosing conditions and prescribing medications will reduce tertiary presentations.

References:

Australian Primary Health Care Nurses Association. (2018). Career & Education Framework for Nurses in Primary Health Care: Enrolled Nurses. Melbourne, Victoria: Australian Primary Health Care Nurses Association (APNA) Retrieved from https://www.apna.asn.au/files/DAM/8.%20Nursing%20Tools/Career%20and%20Education%20Framework/APNA%20Career%20and%20Education%20Framework%20for%20Nurses%20in%20Primary%20Health%20Care%20-%20Enrolled%20Nurses.pdf

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Manchester, A. (2016). Enrolled nurses take on new roles. Nursing New Zealand (Wellington, N.Z.: 1995), 22(1), 26-27.

Nurse-led clinics

Nurse-led clinics are a way of providing health care services that are led by nurses, rather than doctors (Howe 2016). They can operate in different settings, such as primary health care, specialist care, or community care. Some of the benefits of nurse-led clinics are:

- They improve patient health outcomes by reducing hospital admissions, improving chronic disease management, and increasing patient satisfaction.
- They provide timely and accessible patient care, especially in areas with restricted access to health services.
- They empower nurses to use their skills and expertise to the full scope of their practice and to work collaboratively with other health professionals.
- They reduce health care costs by providing efficient and effective care.

Nurse-led walk-in clinics provide effective, timely treatment of minor injuries and illnesses, and minimising pressure on hospital emergency departments (Dadswell et al. 2017). They are well-placed to meet increasing demands from the aging population and the resulting increasing burden of chronic disease and health care complexities. Walk-in-centres also provide nurses with a more autonomous role in community health care that can enhance their sense of professional worth and satisfaction (Desborough et al. 2013). Ensuring nurses are supported to be autonomous but with a network of other healthcare professionals to call upon is essential for job satisfaction (Desborough et al. 2013). The role of nurse practitioners in these clinics has been critical to the success of the walk-in centres.

There are many examples of nurse-led clinics that are effective and essential to different communities:

Asthma management in the Mackay, QLD region - Breathe Easy, Breathe Safe Project

Improving the health of prisoners in Trawalla, north of Ballarat, Victoria - Healthy Ageing Clinic in a Prison Service

Providing health checks for Aboriginal and Torres Strait Islander community in Mackay -Aboriginal and Torres Strait Islander Health Clinic.

Improving health outcomes for patients managing chronic heart failure in a community setting and improving access to resources and information for primary care nurses, WA – Chronic Heart Failure Nurse Clinic Project

Preventative health nurse clinics (PHNC) were established as the primary means to facilitate chronic disease risk screening in the practice population using the My Health Check Tool (MHCT). The nurse-led multi-disease risk screening was established in 4 general practices in Western Victoria -

Preventative Health Risk Screening and Nurse Health Coaching.

References:

APNA (n.d) Nurse clinics – A welcome change.

Bonner, A., Havas, K., Tam, V., Stone, C., Abel, J., Barnes, M., Douglas, C. (2019) An integrated chronic disease nurse practitioner clinic: Service model description and patient profile. Collegian, 26(2), pp. 227-234.

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Practice Nurses (PNs) are becoming more involved in caring for people with chronic diseases in their day-to-day work. The PN's role in promoting lifestyle change must be encouraged and supported by practice managers and GPs. The PN can target individuals and practice populations in a prescribed way to enhance health outcomes. The PN could lead in coordinating chronic disease management by using practice data to target those population groups in most need.

Adapted from - Young, J., Eley, D., Patterson, E., Turner, C., (2016) A nurse-led model of chronic disease management in general practice: Patients' perspectives. Australian Family Physician. Vol 45, No 12.

Diabetes nurse practitioners: This specialty area could be expanded and exponentially benefit consumers. For example, shopping malls could have a diabetes clinic where consumers can drop in, test their blood sugar, and connect with an interprofessional team - not a multi-professional team. Identifying people with prediabetes is clearly in everyone's interest and could stop much suffering, save much money and allow people to lead healthier lives.

References:

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review and meta-analysis. Journal of Advanced Nursing, 78(5), 1281-1293.

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Workforce capability, capacity and optimisation – An excerpt from a presentation given by an ACN member. An argument for nurses working to top of scope and being enabled as leaders.

"Maximise the people you have working in a constrained system. This includes the nursing workforce. I perceive the luxury afforded by the affluence of our nation is rapidly drawing to an end as the strategic environment is telling us to optimise and get on with it. Our strategic environment will no longer indulge our historical, traditional biases. We need everyone in health working to the top of their scope. We also require diverse senior leadership, which enhances, embraces, complements and reinforces each other. Having a nurse in the mix would be invaluable. '…this uncertainty requires us to re-sculpt the art of nursing and make us a more significant force capable of providing diverse and persistent nursing capabilities in an uncertain and unpredictable world'."

Clark, S (COL) and Brewer, R (SGM). Building the Army Nursing Campaign Plan. http://www.cs.amedd.army.mil/dasqaDocuments.aspx?type=1

Care Coordination – ACN Member's view

"RNs provide care coordination to lead chronic disease management within a general practice (care plans, care coordination, health promotion). The team of RNs can provide focused care on specific chronic illnesses as per their clinical interest and skill, such as diabetes and obesity, by scheduled appointment. This frees other RNs and ENs to provide more routine and emergency walk-in care. This has led to increased revenue and nursing pay rates, increasing nursing retention rates. It also improves GP engagement as GPs can provide quality care with nursing support."

Recognition of training and education across the country: ACN Members spoke of team members who had completed specific training in another state but were not allowed to use the skills and knowledge in the state where they worked. Tasmania was mentioned, as it has restricted some of the nurse's skills. This has resulted in nurses leaving Tasmania to return to work on the mainland.

Jurisdictional barriers – an ACN Member's current work experience

"I am an RN living on the border of NSW and Queensland. I work in NSW three days a week and in Queensland the other two days. My scope of practice is the same no matter where I am in Australia, yet there are things I can do in Queensland that I am not allowed to do in New South Wales because that jurisdiction allows me less scope than Queensland. I always have to think about where I am before I perform relatively routine tasks. But the complications don't end with the border. I work in two different facilities in Queensland. At one, the medical staff are comfortable with my performing specific tasks that will help them work with patients. On the other, the staff want me to 'be a nurse' and not do work that I am skilled to do. I'm glad I have more than one workplace experience, or I would feel highly underutilised!"

International experiences

Dual qualified nurses - an example about New Zealand from an ACN Member

"A paramedic, for example, who is also an RN can replace a urinary catheter (not currently within a paramedic scope, but is within RN Scope)

A registered health practitioner may choose to provide a treatment that is not within their delegated scope of practice as defined within these Clinical Practice Guidelines; under these circumstances, all of the following criteria must be met:

a) The treatment must be within their scope of practice as defined by their registering authority and

b) Treatment must be consistent with the principles contained in these CPGs

If registered RM/RNs can use their scope concurrently, so should dual registered Paramedic/ RNs. This practice is currently in other places (NZ paramedics with dual qual RN can use their nursing scope when working as a paramedic as above); the reverse should also be permitted, where an RN who is a Paramedic can utilise their scope in full regardless of where they are working."

Reference:

Hato Hare St John NZ - Clinical Practice Guidelines 1.3

Canada

Canada is currently in the process of further expanding scopes to allow pharmacists (as of 2023) and possibly training RNs (in Ontario, currently reviews are being done) to prescribe common medications - making simple treatments more accessible for everyone.

8. Facilitating best practice: What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?

Key issues, examples and enablers identified by ACN Members

Funding barriers

- Must address the ongoing debate between federally funded and state-based services. This division creates gaps that can lead to services going unfunded. Healthcare workers and clients are impacted.
- Consider block funding. In some settings or communities, the fund holders were GPs for a defined population, and the GPs distributed the money to all healthcare workers at the GP's discretion. This is seen as a barrier to many nurses working on SOP. We acknowledge that Medicare reforms may make a positive difference in funding.

Support best practice

- National credentialling framework for advanced practice incorporating all requirements for extended scope, including competency based assessments and training. This will help address the current interjurisdictional challenges.
- Improve collaboration between the various/ all health professions. Ensure a better understanding of the various health professionals and advanced practitioners' scope within each health discipline. Provide interdisciplinary training opportunities.

Education and training opportunities

- Within nursing education programs – move from task-based learning to critical thinking—problem-based learning with scenarios and case studies. Incorporate interdisciplinary training opportunities through the use of complex scenarios. Education frameworks need to clearly define and build on scope over time to support the transition to advanced roles (i.e. Nurse Practitioner).
- Access to and cost of education is a barrier for many nurses who have poor provisions in existing EBAs when compared to their medical counterparts. Valuing and supporting nurses to continue their education and training throughout their careers is essential in progressing SOP.

Institutional barriers: The relationship and power of nursing staff within the residential aged care setting is a barrier to working to SOP. The operational functions of a RACF are designed to support GPs and Pharmacists. Systems are not designed to incorporate best practices or effective care. Instead, they are based on existing culture. Nurses need to be at the front line of designing and implementing systems for care across the aged care service experience.

Deeble Issues Brief of 2014 has a good list:

Leggat, Sandra G. 2014. Changing health professionals' scope of practice: how do we continue to make progress? Deeble Institute – Issues Brief
https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_nlcg-4_changing_health_professionals_scope_of_practice.pdf

McCullough, K., Bayes, S., Whitehead, L., Williams, A., & Cope, V. (2022). Nursing in a different world: Remote area nursing as a specialist–generalist practice area. *Australian Journal of Rural Health*, *30*(5), 570-581. https://onlinelibrary.wiley.com/doi/full/10.1111/ajr.12899

Nurturing best practices: The pandemic reduced the ability of primary healthcare nurses to manage preventive healthcare in the community (Halcomb, 2022). As the pandemic progressed, nurses and other healthcare workers adapted to change and altered how screening and care were managed. Primary health nurses successfully built health literacy skills in the community and taught consumers new ways to care for themselves (Halcomb, 2022). This example of empowering nurses to make decisions and implement change processes proves to be a powerful motivator, allowing nurses to use their skills and judgment. Leaders in the health community who can nurture this are valuable contributors to workplace satisfaction.

Halcomb, E., Fernandez, R., Ashley, C., McInnes, S., Stephen, C., Calma, K., ... & James, S. (2022). The impact of COVID-19 on primary health care delivery in Australia. *Journal of Advanced Nursing*, *78*(5), 1327-1336.

Aged Care Nursing: The nurse's role is changing across Australia. In aged care, the nurse's role is transforming into a significantly more administrative and operational focus while care duties are allocated to carers. There needs to be more clinical knowledge and critical thinking within the nursing cohort, and as a result, the burden is passed onto the acute sector. Increasing the scope of practice and supporting networks to include higher clinical decision-making and critical thinking in aged care will significantly take the burden off the aged care sector. Tasks include primary surveys, simple antibiotic prescriptions, ECGs, booking pathology and imaging, bladder scanning and telehealth emergency management (similar to rural and remote). Nurses already do many of these tasks. However, the infrastructure and systemic support must be improved across the sector. The existing culture is somewhat 'acute care' averse and resistant to accepting accountability for higher clinical needs that are well within the scope of the RN.

MBS rebates: MBS rebates and rules around claiming for general practice nursing items must be reviewed to allow bulk billing or co-payment, as the most at-risk patients cannot pay for these items, and there is minimal incentive for nursing staff to provide such services.

Regulatory reform and interprofessional collaboration: Health practitioners face various barriers to working to their full scope of practice, including restrictive scope of practice rules, certification

requirements, limited educational opportunities to gain qualifications, inadequate reimbursement structures, and limited acceptance of healthcare professionals' capabilities. To facilitate best practice, governments, employers, regulators, and healthcare professionals can address these barriers through regulatory reform, interprofessional collaboration, competency-based assessment, continuing education, stakeholder engagement, pay reform, and sound data collection and monitoring to measure the benefits of nurses working to full scope of practice.

References:

McKenna, L., et al. (2015). An investigation of barriers and enablers to advanced nursing roles in Australian general practice [Primary care]. Collegian, 22(2), 183-189.

McInnes, S., et al. (2017). The influence of funding models on collaboration in Australian general practice [Primary care]. Australian Journal of Primary Health, 23(1), 31-36.

McInnes, S., et al. (2015). An integrative review of facilitators and barriers influencing collaboration and teamwork between general practitioners and nurses in general practice [Primary care]. Journal of Advanced Nursing, 71(9), 1973-1985.

Halcomb, E. J., et al. (2008). Nurses in Australian general practice: Implications for chronic disease management [Primary care]. Journal of Clinical Nursing, 17(5A), 6-15.

Halcomb, E. J., et al. (2008). Cardiovascular disease management: Time to advance the practice nurse role? [Primary care]. Australian Health Review, 32(1), 44-55.

James, S., et al. (2021). Barriers and facilitators to lifestyle risk communication by Australian general practice nurses [Primary care]. Australian Journal of Primary Health, 27(1), 30-35.

Rural settings – An ACN Member's experience at a small rural clinic

"I was working in a small nurse-led clinic in rural NSW. I had ENEC (Enrolled Nurse Emergency Course) and FLECC training assessment (First Line Emergency Care (FLECC) Courses initially developed for rural and remote Registered Nurses in NSW in 1990. It was coordinated by the NSW Rural Emergency/Critical Care Clinical Nurse Consultants) before Telehealth was introduced. Telehealth was invaluable for people unable to get to the clinic, but the locums didn't know how to use it, so that they wouldn't use it. Full-time doctors would adapt to the system we used, but the locums were more reluctant.

We treated, triaged, and transferred all who came in. However, despite the evidence and the work we were asked to do, the health authority didn't feel nurses needed emergency training. It felt as if there was active deskilling of the staff. Was that intentional? Then, the hours for the clinic were cut. There was supposed to be a 12-hour opening period shift, but the centre closed with no patients. But it's a catch-22 situation; the patient numbers are down, but the facility is closed, so patients can't access it. In town, residents constantly ask me why the facility isn't open when they need it, yet the service seems happy to close the facility, and the community will have to travel hours to get to a health centre. Does that make any sense at all?"

9. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?

Health practitioners can work to their full scope of practice by implementing various enablers and supportive measures. These enablers aim to remove barriers, enhance opportunities, and create a conducive environment for healthcare professionals to practice to the fullest extent of their education and training. Key enablers include scope of practice reform, competency-based assessment and certification, education and training opportunities, stakeholder engagement, funding reform, regulatory flexibility, public education and awareness, data and outcome measurement, and interprofessional collaboration.

Scope of practice reform involves updating and reforming regulations to align with healthcare professionals' education, training, and competency. Competency-based assessment and certification involve implementing processes that evaluate healthcare professionals' competence and skills rather than relying solely on educational credentials. Education and training opportunities provide accessible and affordable opportunities for healthcare professionals to acquire new skills. Stakeholder engagement involves collaborating with professional associations, healthcare organisations, and other stakeholders to identify opportunities for scope expansion and to address concerns. Funding reform aligns reimbursement with the value and quality of care healthcare professionals provide, and alternative payment models, such as capitation or bundled payments, incentivise collaborative care and outcomes.

Regulatory flexibility allows for flexible and adaptable practice, and public education and awareness promote the qualifications and capabilities of healthcare professionals in expanded roles. Data and outcome measurement collect and analyse data on the impact of expanded practice on patient outcomes and healthcare system efficiency. Interprofessional collaboration fosters a culture of collaboration and teamwork among healthcare professionals.

Examples of enablers identified by ACN Members

Enablers for nurses to work to their full scope of practice are factors that support and facilitate the optimal use of nursing skills and knowledge. Key enablers include:

1. **Role clarity:** Nurses need to clearly understand their role and scope of practice and the roles and scopes of other health professionals. Role clarity can prevent role confusion, duplication, or overlap and enhance collaboration and communication.
2. **Education:** Nurses need access to relevant and quality education that prepares them for their diverse and complex roles. Education can also enhance their confidence, competence, and professional identity.
3. **Competency:** Nurses need to have clear and consistent standards of practice that define their scope and responsibilities. Competency frameworks can help nurses assess their skills

and identify improvement areas.

4. **Professional identity:** Nurses need to have a strong sense of their professional identity and value within the multidisciplinary team. Professional identity can be fostered by recognition, respect, and support from peers, managers, and other health professionals.
5. **Legislation and regulatory policies:** Nurses need to have legislation and regulatory policies that enable them to work to their full scope of practice. Legislation and regulatory policies can affect the autonomy, authority, and accountability of nurses in primary health care.
6. **Organisational structures:** Nurses need to have organisational structures that support their scope of practice and professional development. Organisational structures include leadership, culture, governance, resources, incentives, and feedback mechanisms.
7. **Financial factors:** Nurses need to have financial factors that align with their scope of practice and value. Financial factors can include remuneration, funding models, billing systems, and reimbursement schemes
8. **Professional and personal factors:** Nurses need to have professional and personal factors that enable them to work to their full scope of practice. Professional and personal factors can include motivation, satisfaction, resilience, well-being, work-life balance, and career opportunities.

These enablers can help nurses work at full capacity within their scope of practice, improving patient outcomes, enhancing productivity, and providing value for money for health services.

References:

Australian Primary Nurses Association (APNA) Enabling primary health care nurses to work at full capacity and within scope (apna.asn.au)

Registered Nurses Association of Ontario (RNO) 10_steps_to_success_Online.pdf (rnao.ca)

Funding reform: Block funding for general practice nurses, untied to services, could be used by practices to employ nurses or increase nursing pay rates, allowing the individual practice to utilise the RN as best suits the needs of patients and communities. For example, mental health could be a priority in one practice, whilst it could be women's health in another.

Medicare Activity Based Funding reimbursement should be commensurate with interventions. Ensure that stakeholder consultation includes all clinicians involved - not just doctors making decisions about nursing and allied health: that the whole team needs to help develop the best outcomes for patients.

Expand telehealth and remote assessments: For example, neurological assessments can be performed by a nurse. This requires investment in the technology to enable this to happen in the patient's location. The patient can go home earlier or not travel for a review. This requires funding, though it allows the community member better access to care, which means there is a lower cost for the hospital and a more even distribution of patient to health care worker time.

More affordable access to training: There needs to be provision of training and free or reduced post-graduate education, additional education leave entitlements, additional clinical educators, additional funding for research, additional support for cross-departmental experiences

Endorsement: AHPRA and respective nursing bodies need to support nurses to broaden the scope of practice. Once nurses learn a new skill (such as becoming an immuniser), they should have this recognised as a permanent endorsement on their registration. This would allow better transferability and recognition of skills across the profession.

10. Anything else? Broad a range as possible

Flexible and adaptable regulations: The scope of practice in healthcare should be expanded to include interprofessional collaboration, telehealth and telemedicine, standardisation of training, regular review and evaluation, consumer feedback and involvement, health equity, research and evidence-based practice, continuing professional development, transparency and accountability, public awareness campaigns, global best practices, monitoring and reporting, patient-centred care models, emergency preparedness, regulatory agility, health information exchange, mental health and behavioural health integration, and community engagement. These suggestions aim to enhance the quality and safety of patient care, reduce healthcare disparities, and improve access to care for underserved populations.

Developing regulatory frameworks that are agile and adaptable to evolving healthcare needs is crucial. Health information exchange systems should be developed to facilitate coordinated care and reduce duplication of services. Integrating mental health and behavioural health services into primary care settings can enhance access to these critical services. Engaging communities and local stakeholders in discussions about the scope of practice expansion can help tailor policies to meet specific community needs. By considering these additional comments and suggestions, policymakers and regulators can make informed decisions about scope of practice that prioritises patient safety, access to care, and the evolving landscape of healthcare delivery.

ACN Members' perspectives:

"Holistic care is the gold standard in healthcare. The interdisciplinary model, a team function, is a much more suitable model to follow and one that will benefit from everyone working to their SOP."

"Patients are not getting thorough, comprehensive, preventative health care. This is evident in our communities' chronic disease and multi-morbidities. I recommend reviewing literature from Canadian sources for further research on varied ideas and concepts. Note that each province has different regulatory groups and slightly different scopes of practice. Ontario tends to lead the country with concepts."

"To help shape this review, ensure researchers/ developers/ writers take time to embed themselves in the community, spending time amongst the health staff, rural remote and metropolitan, private, aged, public, GP clinics and other services, and training institutions. Reading the results of these extensive investigative reports and commissions that only reflect part of the healthcare professional industry is always disappointing. Even in my 10+ years of Nursing across many different areas, rural and remote, metro public and private, I have yet to encounter anyone involved in the gathering or providing evidence or views."

"I am a fully qualified RN with ten years of experience in various settings. I have completed several postgraduate qualifications, which, on paper, mean that I can do all sorts of things that make the workplace a more effective and efficient environment for all healthcare workers and provide a better, faster response for patients. However, my workplace will not allow me to work on my SOP, which is frustrating. My skills are no longer current in several areas – I can't practice and keep up to date. I ask myself why I bothered to pay for more education.

My friend from uni, also an RN, was similarly frustrated. She has left nursing in disgust and is currently completing 4th year of Medicine at Sydney Uni. We have a bachelor's degree, so entry isn't so hard. My friend is enjoying the work and is excited to be able to do what she was trained to do and so much more. I'm not sure I want to do medicine, but becoming a physio is appealing and much more satisfying. And I would no longer be 'just a nurse.'"

Collaboration issues/culture change challenges

Further references:

An integrative review of facilitators and barriers influencing collaboration and teamwork between general practitioners and nurses working in general practice https://onlinelibrary.wiley.com/doi/10.1111/jan.12647

The influence of funding models on collaboration in Australian general practice https://www.publish.csiro.au/py/PY16017

Understanding collaboration in general practice: a qualitative study
https://academic.oup.com/fampra/article/34/5/621/3063968

A narrative review and synthesis to inform health workforce preparation for the Health Care Homes model in primary healthcare in Australia https://www.publish.csiro.au/py/PY18045