



**Report to the Australian Nursing and Midwifery Council**

**Project to produce a National Framework for the Development of  
Decision-making Tools for Nursing and Midwifery Practice (*National  
DMF*)**

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**April 2007**

Project to produce a *National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice (National DMF)*. This project was previously titled *Project to Develop a National Framework for Decisions about Scopes of Practice by Nurses and Midwives*.

Report to the Australian Nursing and Midwifery Council

Published by ANMC xxx 2007

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ISBN xxxxxxxx

## Foreword

The regulatory environment in which the project to produce *A National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice* was completed was, and continues to be, dynamic. For example, during the project:

- the Council of Australian Governments (COAG) announced that there would be national registration and educational accreditation for health professionals by mid 2008
- consultation on a national training package for ENs was conducted
- the National Nursing and Nurse Education Taskforce (N<sup>3</sup>ET) completed its term of appointment
- the health workforce continued to be recognised as one experiencing critical shortages
- there was a continuing drive for deregulation of the health workforce, in the context of recognising the public benefit of professional regulation

There were also developments in Australian States and Territories which had implications for the project. Among these developments were:

- implementation of the revised (2005) *Scope of practice framework for nurses and midwives* in Queensland
- the publication of a revised *Scope of Practice Decision Making Tool* in South Australia in 2006
- publication of the *Final Report on implementation of a scope of practice decision making framework* and enactment of a By-law in Tasmania in 2006
- consultation on the *Discussion Document - Guidelines determining the scope of nursing and midwifery practice* in Victoria in 2005 – 06.

Nursing and midwifery regulation at this time is a State and Territory responsibility, although this is projected to change with implementation of the COAG decision noted above. Any national regulatory standards and tools are therefore implemented by, and through, the nursing and midwifery regulatory authorities (NMRAs). The product of this project will be no exception. It was therefore essential that the tool produced from this project could be adapted and used in jurisdictions which did not yet have a decision-making framework or tool, but could also be used by those with their own documents, for review and evaluation.

To achieve the project outcomes, the ANMC worked with the NMRAs and in close partnership with key stakeholders to address the needs of the broader community for safe practice and for a responsive, flexible and dynamic health workforce. These stakeholders included professional organisations such as the Royal College of Nursing Australia, the Australian Nursing Federation, the Australian College of Midwives, and the National Enrolled Nurses Association; the National Nursing and Nurse Education Taskforce (until 30 June 2006); the Australian and New Zealand Council of Chief Nurses; the Council of Deans of Nursing and Midwifery, and nurses, midwives and consumers in each Australian jurisdiction.

The project would not have achieved its goals without the commitment of these stakeholders, and I thank them for this on behalf of the ANMC.

**Karen Cook, CEO of ANMC**

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## Acknowledgements

The success of this project was dependent on the work of many people, and on their generous contribution of time and support. In particular, the following should be acknowledged:

- The members of the Project Management Committee who provided guidance, comment and feedback throughout the project. Refer to **Appendix 1** for the names and affiliations of members.
- Ms Christine Ashley-Coe, Research and Policy Adviser with the ANMC who worked closely with the project consultant throughout the project.
- Stakeholders who participated in the Consultation Forums in each State and Territory. Refer to **Appendix 6** for affiliations.
- Nurses, midwives, consumers and organisations who made written submissions. Refer to **Appendix 9** for affiliations.
- The members of the Reference Group who provided feedback on the second consultation draft of the *National DMF*. Refer to **Appendix 1** for the affiliations of members.
- Staff from the Nursing and Midwifery Regulatory Authorities who participated in a workshop held on 14 August 2006
- The convenors and other NMRA staff who organised the Consultation Forums in each State and Territory.
- Ms Jenny Prentice, from the Nurses Board of Western Australia for her review of, and feedback on, the draft decision-making tools produced following the consultation forums.
- The clinicians who participated in the Focus Groups in Canberra and Adelaide in March 2007, reviewing the third consultation draft *National DMF* Template Tools.

## Abbreviations

ACDNM	Australian Council of Deans of Nursing and Midwifery
ACNM	American College of Nurse-Midwives
ACT NMB	Australian Capital Territory Nursing and Midwifery Board
ANF	Australian Nursing Federation
ANMC	Australian Nursing and Midwifery Council
ACMI	Australian College of Midwives Inc
ANZCCN	Australian and New Zealand Council of Chief Nurses
COAG	Council of Australian Governments
CNMO	Chief Nursing and Midwifery Officer
DMF	Decision Making Framework
ICM	International Confederation of Midwives
ICN	International Council of Nursing
<b>nbsa</b>	Nurses Board of South Australia
NBT	Nursing Board of Tasmania
NBV	Nurses Board of Victoria
NBWA	Nursing Board of Western Australia
NCSBN	National Council of State Boards of Nursing
NENA	National Enrolled Nurses Association
NMRA	Nursing and Midwifery Regulatory Authority
N <sup>3</sup> ET	National Nursing and Nurse Education Taskforce
NP	Nurse Practitioner
PMC	Project Management Committee
PNA	Principal Nurse Advisor
QNC	Queensland Nursing Council
RAP	Research and Policy
RCNA	Royal College of Nursing Australia
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors (now known as the Nursing and Midwifery Council)
USA	United States of America

## Executive summary

Beginning in August 2005, the Australian Nursing and Midwifery Council (ANMC) project that culminated in the production of a *National framework for the development of decision-making tools for nursing and midwifery practice (National DMF)* (**Attachment 1**) involved Australia-wide consultation and extensive review by stakeholders and clinicians.

The need for a *National DMF* was identified in the ANMC's strategic goals for 2004 – 2007, and in the recommendations of the report of the National Review of Nursing and Nurse Education: *Our Duty of Care* (2002).

The process for development of the final *National DMF* commenced with the appointment of the project consultant and a Project Management Committee (PMC) in the latter half of 2005. A draft consultation document was developed based on a literature review and developments in Australia and internationally. The Draft National DMF and background paper / literature review were then used as the basis of consultation, both via written submission from key stakeholders and at consultation forums held in all Australian States and Territories in February and March 2006. Twenty-seven written submissions were received and 530 people attended the nine consultation forums<sup>1</sup>.

A second consultation draft incorporating the feedback from the written submissions and consultation forums, and input from representatives of the NMRAs which had frameworks / tools in their jurisdictions, was then circulated to members of the Reference Group in October – November 2006. A third consultation draft, prepared on the basis of the Reference Group's comments, was reviewed by clinicians at two focus groups held in Canberra and Adelaide in March 2007.

The final *National DMF* includes *Principles* for the development of decision-making tools, two *Template Tools* for nursing and midwifery practice decisions (incorporating a Guide for Practice, a Flowchart, a Flowchart Narrative and a Summary Guide Diagram for each profession) and Explanations of Terms used in those *Template Tools*.

This project has been conducted in accordance with the ANMC's commitment to:

- regularly review, in partnership with the Australian NMRAs, the various elements of the regulatory frameworks and ensure that they reflect best contemporary evidence and changes in the practice of nurses and midwives
- open, transparent and collaborative processes with stakeholders in seeking national consistency in the regulation and practice of nurses and midwives.

A number of values underpinned the development of the *National DMF* throughout the project. Foremost among these was that NMRAs have an obligation to provide for competent nursing and midwifery practice for the public benefit and decision-making tools are one part of the suite of standards and guidelines that help meet this obligation. Professional judgement resting on collaboration with the consumer was therefore a central tenet of the final product. Other values influencing the *National DMF's* development included that:

1. consultation in association with expert input would ensure the best outcomes

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<sup>1</sup> two forums were held in New South Wales.

2. nurses best know what nursing is and midwives best know what midwifery is, and therefore registered nurses and midwives are the accountable decision makers about what aspects of their professional practice must be performed by a person with a nursing or midwifery qualification / licence
3. health care delivered by a team of people with different skills, knowledge sets, levels of competence and spheres of practice contribute to good health outcomes
4. changes to professional practice that are planned and grounded in the professional judgement of the individual nurse or midwife, in collaboration with the consumer, are safer and more sustainable than those that are -
  - a. ad hoc, not regulated by the relevant profession / professional
  - b. achieved through mechanical addition of tasks via certification, where anything beyond what is included in the initial educational preparation for practice requires official sanction
  - c. employer-driven to reduce costs
  - d. driven only by consumer demand
5. humans do not naturally use rational decision-making strategies, but can learn to do so using decision-making tools that are an integral part of professional self regulation of risky practice
6. the most effective decision-making tools are those that support the application of informed professional discretion guided by principles
7. the best decision-making tools reflect a permissive rather than restrictive approach, and although they give certainty about the processes of change, they are less useful in detailing the scope of any specific individual's practice or of the profession's practice (that is, they are not, nor should they be, a list)
8. flexibility and access to care by the right person in the right place at the right time is as significant a feature of safe care as is competent practice by qualified health professionals
9. principle-based decision-making tools neither promote nor condone substitution of nurses or midwives for other health professionals, rather they enable nurses and midwives to enhance consumer health outcomes and fill niches in health service delivery
10. similarly, delegation of aspects of care to others by nurses and midwives does not promote or condone substitution of unlicensed workers for nurses and midwives when the competence of a licensed nurse or midwife is required.

## Recommendations

The recommendations arising from the project are that the ANMC:

1. adopt the *National DMF (Attachment A)*
2. publish the *National DMF* on the ANMC website, and on CD ROM, following professional graphic design input to the document and diagrams
3. publish the Report of the project on the ANMC website at the same time
4. implement the *National DMF* through the NMRAs, implementation strategies to include those listed in Table 8 (pages 68 – 70) of this report and to address the

concerns listed in Table 7 (pages 64 – 68) of this report

5. evaluate the implementation both nationally (by ANMC) and in jurisdictions (by the respective NMRA) not less than 1 year from publication using the strategies listed on pages 73 - 74 of this report
6. review all State and Territory DMFs to establish whether they adhere to the National Principles for the development and evaluation of decision-making tools in 3 years from publication
7. evaluate the usefulness of State and Territory DMFs and satisfaction with those DMFs in 3 – 5 years from publication, using the strategies listed on pages 73 - 74 of this report
8. review the *National DMF* for continued relevance, value and need for revisions including the continuing need for separate nursing and midwifery tools in 5 years from publication
9. include guidance on interpretation, based on the list on page 72 of this report, as part of implementation and education of users
10. ensure all components of the tools – Guide for Practice, Flowchart, Flowchart Narrative, Practice Decision Summary Guide Diagram and Explanation of Terms Used in the Tool - are published together to maximise comprehension
11. withdraw the existing ANMC *Guidelines on Delegation and Supervision* from circulation.

## Project background

A project to develop a national decision-making framework for decisions about scopes of practice for nurses and midwives was approved by the Australian Nursing and Midwifery Council (ANMC) in August 2005. As the peak organisation established to bring a national perspective to the regulatory framework for nursing and midwifery, the ANMC leads, and is responsible for supporting and establishing, credible research initiatives to inform that agenda. Working in partnership with the State and Territory nursing and midwifery regulatory authorities (NMRAs) to attain the goal of national consistency in regulation, the ANMC is committed to the regular review of the foundation elements that comprise the respective regulatory frameworks for the professions, to ensure they reflect best research evidence and changes in contemporary practice.

This project addressed one of the ANMC's Strategic Goals for the 2004 – 2007 triennium, as well as one of the recommendations of the Report of the National Review of Nursing Education 2002 – Our Duty of Care that was referred by the Australian Health Ministers to the National Nursing and Nurse Education Taskforce (N<sup>3</sup>ET). The National Review of Nursing Education Report recommended a national framework for professional practice and promoted consideration of the model developed by the Queensland Nursing Council in its work to produce a framework for decision making about scopes of practice. That model has since been adopted by four other States – Western Australia, Tasmania, South Australia and Victoria. Growing interest in, and endorsement of, the Queensland model was evident from the commencement of the ANMC project.

The ANMC worked in close partnership with a consortium of key stakeholders including professional organisations such as the Royal College of Nursing Australia (RCNA), the Australian Nursing Federation (ANF), the Australian College of Midwives (ACMI) and the National Enrolled Nurses Association (NENA); the National Nursing and Nurse Education Taskforce (N<sup>3</sup>ET) [until 30 June 2006]; the Australian and New Zealand Council of Chief Nurses (ANZCCN); and the Council of Deans of Nursing and Midwifery (CDNM). There was broad agreement among these stakeholders that consideration of the elements that inform the professional scopes of practice for nursing and midwifery was warranted.

A range of complex, dynamic, diverse and inter-related elements are involved in articulating scopes of professional practice, including:

- education
- legislation
- professional standards for ethical conduct and practice
- regulatory policies
- the contemporary health care environment
- workplace relations, culture and capacity to support safe practice.

The development of a national decision-making framework was therefore seen by ANMC as an important part of a broader strategy to bring national consistency to the regulation of nursing and midwifery practice for the benefit of consumers. The outcomes of this project are expected to contribute to national consistency for the regulation of nursing and midwifery practice in Australia through the articulation of a nationally-agreed professional standard for decision making on scopes of practice.

## Purposes of the project

The purposes of the project were to:

1. produce a *National Framework for Decisions about Scopes of Practice by Nurses and Midwives*, now titled a *National Framework for the Development of Decision-making Tools for Nursing and Midwifery Practice (National DMF)*
2. achieve endorsement of the *National DMF* by the eight Australian NMRAs
3. develop guidelines to support interpretation and implementation of the *National DMF*
4. make recommendations on evaluation and a communication strategy.

ANMC anticipates that the *National DMF* will be a robust tool providing a standard approach for individuals, employers and professional groups to use in making informed decisions about nursing and midwifery scopes of practice..

## Significance of the project

Professional regulation provides the framework for safe practice, while also promoting an adaptable and responsive approach to practice. The ANMC holds the view that decision-making tools for nurses and midwives will assist in developing a health workforce that is educated and prepared to meet health consumer needs into the future. Nurses and midwives using these tools will contribute to risk management and to ensuring a flexible workforce.

## The scope of the project

The project involved extensive national consultation to articulate and endorse the core elements of decision-making tools for nursing and midwifery scopes of practice for implementation by the Australian NMRAs.

The project also identified guidelines for successful implementation and principles to support consistent interpretation, and made recommendations on an evaluation strategy to monitor the efficacy and effectiveness of, and satisfaction with, the resulting decision-making tools in a range of contexts across Australia.

## Expected project outcomes

At the outset of the project, the outcomes were expected to be:

1. production of a *National DMF*, endorsed by the NMRAs for implementation, that was informed by
  - a. existing models
  - b. a review of contemporary literature and evidence
  - c. the outcomes of consultation
2. recommendations on communication and implementation strategies that would effectively and efficiently address the information, professional and regulatory needs of the professions and of the Australian community
3. recommendations on an evaluation strategy to monitor the effectiveness and efficacy of, and satisfaction with, the *National DMF* by stakeholders and the professions of nursing and midwifery

4. recommendations on principles to guide interpretation of the *National DMF* by the NMRAs when they use it as a regulatory standard.

## Limitations of the project

The project was not intended to define the scope of nursing or midwifery practice. Nor was it intended to revisit research that had already been conducted by a number of NMRAs. The aim of the project was to consult with stakeholders on a *National DMF* based on work begun in Queensland in 1998 and further developed in Western Australia, Tasmania, South Australia and Victoria. These jurisdictional projects had demonstrated the value of decision-making tools for nurses and midwives who needed to exercise their professional judgement about practice decisions on a daily basis.

## Potential risks in the project

Potential risks in the project were identified as:

1. a perceived or real failure to consult openly or widely enough, leading to poor acceptance of the *National DMF*
2. budget constraints leading to inability to complete the project deliverables on time
3. the possibility of evoking political sensitivities among the multiplicity of stakeholders with vested interests in the outcomes
4. a lack of consensus, leading to inability to meet projected timelines
5. the potential that all jurisdictions may not adopt the *National DMF*.

Steps taken before and during the project to minimise the effects of these risks included:

1. wide invitations to stakeholders to participate in forums held in every State and Territory, and / or to make written submissions on the initial consultation document
2. monitoring changing needs in the project and seeking budget and timeline adjustments from ANMC as required
3. ensuring that all jurisdictions were involved in the development and review of the *National DMF*, including holding a workshop of NMRA representatives to review the draft developed for the second round of consultation with the Reference Group
4. ensuring that representation on the Reference Group was as wide as possible and working with key stakeholders to ensure that their views were accurately represented
5. seeking a final review of the *National DMF* by two groups of clinicians, one in a State where a decision-making tool had already been developed by the NMRA and one in a Territory which did not have such a tool
6. taking time to review and revise the document to reach consensus where possible, recognising that timelines needed to be more flexible to achieve this goal.

## Literature review

The focus of this review is to clarify the origins and purposes of tools for decision making by nurses and midwives about their scopes of practice. It is not a comprehensive review of literature about the wider issues associated with nursing and midwifery's scopes of practice. Those wider issues associated with defining nationally-consistent scopes of practice for nurses and midwives are well canvassed in the Nursing and Nurse Education Taskforce (N<sup>3</sup>ET) *Scopes of Practice Commentary Paper* (2005). This review also does not go over ground covered in earlier reviews leading to the production of the Queensland Nursing Council's *Scope of Nursing Practice Decision Making Framework* in 1998.

It should be noted that, in jurisdictions where midwifery has been a postgraduate qualification / specialisation for registered nurses, many publications prior to the last few years have used "nursing" as a generic term that included midwifery. It is only in recent years that midwifery in these places has been specifically, separately identified. Given this recent recognition as a separate profession, midwifery is "invisible", although present, in much of the literature from those places.

## Background

Professional regulation is undertaken in the public interest, to ensure that the community is provided with the highest standard of health care, delivered by well qualified and competent people. Decision-making tools can assist professionals, their employers, their clients and policy makers understand and consider the complex and interdependent factors influencing the scope of practice of individuals practising within a specific profession.

There is broad (although not unanimous) agreement that it is inappropriate to limit nursing or midwifery practice by listing activities that:

- may be performed by nurses and midwives (with individuals being "credentialled" to perform them) or
- may only be performed by a nurse or midwife (a restricted practice model).

The World Health Organisation and the International Council of Nurses (ICN) have examined issues relating to the scope of nursing practice since the mid 1980s. This work was undertaken in recognition of the changing role and functions of nursing. In order to provide leadership for the nursing profession globally, the ICN developed a Scope of Nursing Practice Position Statement. This position statement highlighted the importance of providing a scope of practice definition as it "communicates to others the competencies and professional accountability of the nurse" while also accommodating change (ICN, 1998).

Since the early 1990s, decision-making frameworks or tools have been developed and implemented in a number of Australian and international jurisdictions. They have enabled adjustments to an individual nurse or midwife's scope of practice and to the scopes of practice of their professions. These decision-making tools reflected a move away from both the credentialing and restricted practice models towards recognising the individual nurse or midwife's professional accountability to determine their own scope of practice.

Decision-making frameworks represent what are described as "permissive approaches" to determining scopes of practice. They shift the responsibility for determining the limits of professional practice away from regulatory authorities to individuals (N<sup>3</sup>ET, 2005:54). With this approach, as N<sup>3</sup>ET (2005:54) noted, scopes of practice become highly individual and context-specific, and therefore more able to accommodate the health system's needs for flexibility,

responsiveness and diversity. Although they may result in less clarity in the detail of practice, they give greater certainty to the process for making sound decisions to extend practice or delegate tasks to others (N<sup>3</sup>ET, 2005:54).

The first decision-making tool was a set of scope of professional practice criteria<sup>2</sup> produced in 1992 for nurses and midwives by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), now known as the Nursing and Midwifery Council. A contrasting approach was adopted in Ontario, Canada. In 1993, changes to the regulation of health practitioners in that province identified a list of 13 controlled acts<sup>3</sup> that were authorised in whole, or in part, to one or more of 23 health professions.

In 1995, the Queensland Nursing Council (QNC) produced a Scope of Nursing Practice Discussion Paper as an initial step towards defining the scope of nursing practice<sup>4</sup>. This document included a review of national and international developments in the area and was designed to be the basis for consultation. The results of that consultation were reported in *The Scope of Nursing Practice* report (McMillan, Little, Baker, Bujack & Johnson, 1996). Included in the report was a bibliography and systematic review of the literature.

The outcome of these literature reviews and the consultative project in Queensland was the production of the QNC's *Scope of Nursing Practice Decision Making Framework* in 1998 (*QNC Framework*). Sets of principles for expansion of practice, delegation between nurses and delegating aspects of care to unlicensed health care workers were included in the *QNC Framework*. The *QNC Framework* has since been modified and adopted for implementation in Tasmania (2001, reviewed 2006), Western Australia (2002), and South Australia (2005).

The major components of these Australian frameworks, and of similar documents in Canada, the United States of America and Ireland, are principles to guide decisions about changing nursing and midwifery practice through education, experience and competence assessment and to assist in determining when, or if, it is appropriate to delegate care activities to other, unlicensed health care workers.

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<sup>2</sup> The UKCC Principles were that the registered nurse, midwife or health visitor must:

- Be satisfied that each aspect of practice is directed to meeting the needs and serving the interests of the patient
- Endeavour always to achieve, maintain and develop knowledge, skill and competence to respond to those needs and interests
- Honestly and openly acknowledge any limits or personal knowledge and skill and take steps to remedy any relevant deficits in order effectively and appropriately to meet the needs of patients and clients
- Ensure that any enlargement or adjustment of the scope of personal professional practice must be achieved without compromising or fragmenting aspects of professional practice and care and that the requirements of the council's code of professional conduct are satisfied throughout the whole area of practice
- Recognise and honour the direct or indirect personal accountability borne for all aspects of professional practice
- In serving the interests of patients and clients and the wider interests of society, avoid any inappropriate delegation to others which compromise those interests.

<sup>3</sup> In Ontario, the three controlled acts that were authorised to nurses were (1) performing a prescribed procedure below the dermis or a mucous membrane; (2) administering a substance by injection or inhalation and (3) putting an instrument, hand or finger (i) beyond the external ear canal, (ii) beyond the point in the nasal passages where they normally narrow (iii) beyond the larynx (iv) beyond the opening of the urethra (v) beyond the labia majora (vi) beyond the anal verge and (vii) into an artificial opening of the body.

<sup>4</sup> At this time, midwifery was subsumed in nursing in the Queensland *Nursing Act 1992*, and the term "nursing" in any documents produced by the QNC included midwifery unless specified otherwise.

Two examples of these frameworks or tools may be found in Canada and Ireland. The regulatory authority for registered nurses in Manitoba, the College of Registered Nurses of Manitoba, produced two sets of guidelines in 1999 and 2002. One was for determining the scope of practice of an individual registered nurse and the other was for decision making about delegation. These documents addressed public need, stakeholder consultation, practice support, scope of practice, competence, supervision and evaluation of outcomes, and used a decision-making tree (or algorithm) to guide decisions about delegation. In 2000, An Bord Altranais (the nursing and midwifery regulatory authority in the Republic of Ireland) produced an algorithm for changing nursing or midwifery practice and principles to be followed by Irish nurses and midwives in delegating activities to others.

### ***Tools addressing delegation alone***

A number of jurisdictions have focussed on decision-making tools that address delegation alone. An example is that of the National Council of State Boards of Nursing (NCSBN) in the United States of America which identifies five rights of delegation:

1. right task – supported by policies, assessment of the patient’s condition, assessment of the competence of the unlicensed assistive personnel and determination of the level of supervision that is needed
2. right circumstances – taking account of community needs, staffing needs, consumer needs including resources, equipment and supervision
3. right person – considering legal issues, competency standards, the competence of the person who will accept the delegation and the registered nurse’s skill to assess competence / make the delegation
4. right direction and communication – based on standards and including reporting requirements
5. right supervision and evaluation – including adequate staffing and time to do this (Fisher,1999).

An example from Australian allied health literature is the project to develop supervision standards for multidisciplinary therapy assistants in rural practice that was reported by Lin and Goodale (2006). These standards included reference to:

- the frequency (at least fortnightly) and methods of discussions of client progress / their program;
- observation of the therapy assistant by the allied health professional twice per therapy program, at least one of these being face to face; and
- program demonstration, with new / changed programs.

Lin and Goodale (2006) also noted the importance of training, in supervision, for allied health professionals.

### ***Workforce issues***

Workforce issues have been identified in a number of contexts as integral to considerations of changing professional practice and of delegation to other health care workers. Professional demarcation, exacerbated by traditional education models, and inflexible regulatory requirements (such as radiation safety and drugs and poisons regulations) were among the significant barriers, identified by Queensland Health (2005), to effecting successful and sustainable change in utilising extended practice roles. The medical profession’s concerns about expanded nursing roles and the nursing profession’s concerns about expansion of support personnel roles were also mentioned. But the most significant issue was that

workforce projections suggest that there may be an insufficient workforce pool to take up new roles in any case (Queensland Health, 2005).

Rising demand for health services, cost containment and shortages of nurses, midwives and other health workers were cited as the major catalyst for skill mix changes by ICN (2005d in ICN 2006). ICN (2004 in ICN 2006) noted that the evidence base in the area of skill mix was limited, but growing, with examples of studies that reported cost and quality improvements after introducing care assistants, but others that suggested a decreasing quality of care and increases in cost factors such as on call, sick leave and overtime, higher workloads for nurses and high turnover and absence rates. ICN (2006) quoted Buchan et al (cited in ICN 2005) who reported three key limitations to research on skill mix:

- most originated in the USA, with the potential that different health care systems could have different experiences
- most didn't provide a rationale for the approach to skill mix chosen or sufficient information about the organisational setting
- most didn't provide any evaluation of the quality and cost to enable objective analysis of the skill mix studied.

Others have noted similar problems. Crossan and Ferguson (2005) in a review of the skill mix literature, noted that there was a lack of rigour, small sample sizes and no appropriate evaluation of quality / outcomes and cost in the reports they reviewed. And Spilsbury and Meyers (2003) reported that research in the area of skill mix in the UK was vague and that therefore no firm conclusions could be drawn from reported studies about appropriate skill mix. They added that a plethora of research was being conducted looking at the changing roles of nurses, with these developments appearing to be having a positive impact on patient care and multidisciplinary teamwork. However, they also noted that there was little evidence related to the changing roles of health care assistants.

Needleman, et al (2002) in a study of nurse staffing levels and the quality of care in hospitals, found that when nurses were short-staffed, patients suffered up to 25% more life-threatening complications including infections, bleeding, pneumonia, shock, cardiac arrest, and "failure to rescue<sup>5</sup>," all of which contributed to an increased length of hospital stay. However, Simpson (2005) pointed out that there were significant systemic factors that were also relevant, including support from the clinical environment and absence of power differentials between nurses and the other health professionals who must be convinced to respond to the nurse's assessment. Simpson went on to quote the Joint Commission on Accreditation of Healthcare Organisations in 2004 which reported that of 71 sentinel events involving infant death or disability since 1996, 72% were related to communication issues such as organisational cultures with hierarchy and intimidation that acted as barriers to effective communication and team work, failure to function as a team and failure to follow chain of command procedures.

### ***Decision making literature***

There is a substantial body of literature in the areas of decision making / clinical judgement. Most supports the view that humans have difficulty reducing complex decisions to simple judgements, and decision-making tools / education can be of assistance in this process.

A number of authors have noted that decisions are affected by factors that can lead to poor outcomes (Tversky and Kahneman, 1974; Dawes, 1988; Groner, Groner and

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<sup>5</sup> Failure to rescue is defined as the death or prolonged illness of a patient when early identification of complications by nurses and medical and nursing interventions can influence the risk of death / morbidity.

Bischof, 1983; Nisbett and Ross, 1980; Day, Langevin, Maynes and Spring, 1972). These factors can include:

1. using stereotyping
2. relying more on knowledge that is more easily retrieved from memory than on seeking the best solution
3. being disproportionately influenced by extreme cases and weighting evidence according to its vividness
4. searching for an outcome which *satisfices* rather than the optimal outcome which *maximises*, especially in time-limited contexts
5. over-reliance on personally relevant information or information that fits the decision maker's values / world view
6. being over confident of first impressions

In a review of literature on clinical judgement, Tanner (2006) noted that humans are poor informal statisticians, their memories are limited, and their judgement is affected by context. She added that research has found that:

1. clinical judgements are more influenced by what the decision maker brings to the situation than by any objective data in the situation at hand
2. sound clinical judgement rests to some degree on knowing the patient, and his or her typical pattern of responses, as well as engagement with the patient and their concerns
3. clinical judgements are influenced by the context in which the situation occurs and by the culture of the unit
4. no single pattern of reasoning works for all situations
5. reflection on practice is often triggered by breakdown in clinical judgement and is critical for the development of clinical knowledge and improvement in clinical reasoning

## Major reviews of literature on the topic

In early 2000, two projects were commissioned by the National Review of Nursing Education that related to the concept of scope of practice. Chiarella's review included "nurse regulatory legislation from Australia, New Zealand, United Kingdom, Ireland and Canada" from a number of perspectives, including "Definitions of the Scope of Practice Provided by Regulatory Authorities" (2002:51-62). A key finding from this review was the differences in approach to defining the scope of practice as restrictive activities or overarching statements. Chiarella concluded that the restrictive approach "seems to be fraught with difficulty, as it . . . require[s] constant vigilance to ensure currency" (2002:57).

The second commissioned project, undertaken by McMillan, Conway, Little and Bujack (2002:117-209) examined the implications of scope of practice for contemporary nursing education and practice. This team extended their earlier work undertaken for the QNC and included data collection from key informants across Australia via written reports, as well as opportunistic sampling of the views of nurses. Findings from the review of the literature and content analysis of submissions indicated that:

*There is considerable movement in the roles and functions of the levels of nurses and evidence of changing expectations of usual practice in both registered nurse and enrolled nurse<sup>6</sup> roles and functions. What was previously considered exceptional practice now represents usual practice (2002:155).*

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<sup>6</sup> Enrolled nurses are known as Registered nurses, Division 2 in Victoria

McMillan et al (2002) concluded that these findings provided support for a framework of guiding principles for determining the scope of practice for all registered nurses.

Recommendation 4 of the National Review of Nursing Education: Our Duty of Care (2002) was:

*To promote a professional scope of practice for nurses and greater consistency across Australia:*

- a) *a nationally consistent framework should be developed that allows all nurses to work within a professional scope of practice, including the administration of medications by enrolled nurses*
- b) *to facilitate the development, all Commonwealth, State and Territory legislation and regulations that impact on nursing should be reviewed and reformed as required.*

This recommendation arose from discussion of the origins of an increase in the use of unlicensed care workers, and displacement of enrolled nurses by this group of workers, particularly in aged care (2002:115). The displacement was reported to be based on an overlap of the scope of practice of unlicensed care workers with that of enrolled nurses, and a perception that supervision requirements and restrictions on the administration of medications made the enrolled nurse less flexible than the registered nurse, or the unlicensed health care worker.

## **Other recent literature**

The extensive systematic reviews of the literature by Chiarella (2002) and McMillan et al (2002) were used as a beginning point for the following systematic search of the international literature. A surprisingly limited number of published articles that included reference to nursing or midwifery scopes of practice were located, and even fewer about decision-making tools. The findings from the review of the articles on topics including expansion or change of practice, decision-making frameworks or tools and delegation are presented below. Those with a specific midwifery focus are presented first.

### ***Publications with a specific midwifery focus***

Schuiling and Slager (2000) reviewed developments for certified midwives and certified nurse midwives in the USA, noting that scope of practice had a host of meanings. It was commonly used, they reported, to describe the range of practice for a profession; but it was also used to define what an individual midwife could or could not do. They argued that the scope of a midwife's practice evolved and changed over time due to factors such as community needs; the midwife's philosophy, education and years of experience; state laws; national standards; and the policies and procedures of the local employing institution. Scope of practice therefore identified the range and extent of a midwife's practice within specified regulatory limits and flexible clinical parameters such as the practice setting. They also noted that, as science and technology advanced, many midwives were expanding their skills beyond the basic core competencies in response to client, community or organisational requests, using guidelines produced by the American College of Nurse Midwives to provide the parameters for safe inclusion of new skills.

The United Kingdom Royal College of Midwives published two position papers in the area of scope of practice. The first, "Support workers in maternity services" (Position Paper 5a, 1999) provided for support workers to undertake "limited clinical duties for which midwifery education and registration are not required either by statute or by professional guidelines but *only under the direction and supervision of a midwife*". The second, titled "Refocusing the role of the

midwife” (Position paper 26, 2002) canvassed a number of developments, both external and internal to the profession, that were creating change in midwives’ roles and working practices, including opportunities for midwives to develop obstetric and other medical / allied health skills such as ultrasonography and ventouse deliveries.

Sullivan (2000) noted that the scope of practice of midwives in the United States of America (USA) had been expanding in both depth (care of more complex, high care pregnancies) and breadth (care of women outside the maternity cycle) during the past 50 years. King (2000) noted that midwives in the USA must frequently reassess their clinical practice parameters in response to changes in the professions with which they collaborate, especially nursing and medicine, and conform to state and federal laws and regulatory body standards. Moreover, she added, the imperatives present in individual clinical settings often changed because health status was fundamentally dynamic.

Watson, Turnbull and Mills (2002) reported on an evaluation of the “extended” role of the midwife noting that recognition of that extended role (ordering and interpreting tests and initiating medications) had the potential to deliver high level continuous midwifery care to women, to increase work satisfaction for midwives, and to enhance professional autonomy in the workplace.

McKenna and Hasson (2002) reported on a study of skill mix requirements of a midwifery service based in Ireland. Findings indicated that midwives spent a large proportion of their time undertaking clerical, domestic, portering and stock duties, and would welcome the introduction of midwifery assistants to teams to undertake these activities.

Mann (2004) in her article on the interface between legal and ethical issues in reproductive health discussed, among other topics, laws affecting scope of practice and the ethical obligation to provide access to care. She noted that the nurse-midwife in the USA, seeking to exist within a system which offered employment and an opportunity for practice, may have to offer less than comprehensive quality care to comply with the demands imposed by the health care delivery system. Mann concluded that professional practice statutes, originally promulgated to protect the public from incompetent practitioners and to provide health care services to under-served populations, had not ensured access to health care, and that nurse-midwives continued to face challenges to their practice, including attempts to restrict their ability to order laboratory tests, prescribe drugs and perform and repair episiotomies.

The Canadian Midwifery Regulators Consortium (2005) noted that, as well as entry level competencies expected to be demonstrated by any midwife practising in the full scope of practice and without supervision, there were a set of advanced competencies. These could be performed by midwives in Canada in certain jurisdictions and / or under certain circumstances, when provincial / territorial regulations and standards allowed it. They noted, however, that some of the competencies considered advanced in one jurisdiction were entry level in another and that discussions were taking place nationally to identify how advanced competencies might be recognised. The advanced competencies included, but were not limited to:

1. epidural monitoring
2. application of scalp electrodes
3. pharmacologic augmentation of labour
4. induction of labour for post dates pregnancy
5. performing vacuum extraction
6. first surgical assist at caesarean section
7. suturing third degree tears
8. evacuation of the uterus
9. fitting barrier methods of contraception
10. prescribing contraceptives

11. inserting umbilical catheters in the newborn
12. providing well baby care after 6 weeks postpartum and to healthy newborns in general
13. providing well woman care after 6 weeks postpartum and to healthy women in general.

The American College of Nurse-Midwives (2003) (ACNM) identified colposcopy as an example of an expanded midwifery practice skill; that is, one that was not required of a new practitioner and not included in the core competencies, but that may be acquired by some midwives beyond basic midwifery education. The ACNM proposed that a midwife would follow Standard VIII of the College's *Standards for the Practice of Midwifery* (2003) to incorporate new procedures into their midwifery practice. Standard VIII stated:

*Midwifery practice may be expanded beyond the ACNM core competencies to incorporate new procedures that improve care for women and their families. The midwife:*

- *identifies the need for a new procedure, taking into consideration consumer demands, standards for safe practice, and availability of other qualified personnel*
- *ensures that there are no institutional, state or federal statutes, regulations, by-laws that would constrain the midwife from incorporation of the procedure into their practice*
- *demonstrates knowledge and competency including –*
  - *knowledge of risks, benefits, and client selection criteria*
  - *process for acquisition of required skills*
  - *identification and management of complications*
  - *process to evaluate outcomes and maintain competency*
- *identifies a mechanism for obtaining medical consultation, collaboration and referral related to this procedure*
- *reports the incorporation of this procedure to the ACNM.*

In January 2004, the Australian College of Midwives published National Midwifery Guidelines for Consultation and Referral. Three levels of consultation and referral were identified in this publication as recommended steps to be taken by midwives when an abnormality or complication presented during a woman's care:

- *discuss the issue / condition with another midwife and / or with a medical colleague*
- *consult with a medical practitioner*
- *transfer responsibility for the woman's care to a medical specialist.*

The Australian Nursing and Midwifery Council (2005) report of the project to examine the role and scope of practice of Australian midwives and the development of competency standards for midwifery noted that there was wide support for continuing to endorse the International Confederation of Midwives (ICM) definition of a midwife as the basis of the role and scope of practice for midwives in Australia.

### ***Specialisation and expanding, advancing and extending practice***

The language used to discuss changes to the practice of nursing or midwifery over time is varied. Terms such as advancing, amending, expanding, extending, amplifying, maximising and enhancing are often used interchangeably. Heartfield (2006) in a publication on specialisation and advanced practice written for N<sup>3</sup>ET, discussed the ways in which this varied terminology was used, and concluded that there was a need to act now – either to commit to one set of definitions or to participate in new and amended roles while looking at what the definitions should do.

Daly and Carnwell (2003) noted that, in the United Kingdom, role differentiation between Nurse Practitioners, Clinical Nurse Specialists and Advanced Practice Nurses was difficult. They proposed that one clear difference was the Nurse Practitioner dealing with undiagnosed patients, conducting comprehensive health assessments, making diagnoses, intervening autonomously, and arranging discharge and referral. However, they conceded that clarification was difficult and that the debate would continue.

Arguments to support expanding the scope of nursing practice within specialty areas of practice were the focus of a number of articles. These included the management of surgical emergencies (Radford, Abbassi, Williamson & Johnston, 2003) and nurse-led services (Richardson & Cunliffe, 2003) in the United Kingdom and in a cancer prevention and treatment context in the USA (Hilton et al, 2003). In Australia, a descriptive study by Knight and Corkill (2003) examined the scope of sexual health nursing practice. The results from their survey of 201 nurses indicated that the scope of their practice was extremely varied and was dependent on the context of their practice.

Richardson (2002) and Donnelly (2003) discussed the concept of advanced nursing practice and scope of practice. Richardson (2002), arguing from a historical perspective, suggested that advanced practice in New Zealand was reclaiming elements of earlier nursing roles in contrast to the current perspective of pushing against the boundaries of other professions. Donnelly (2003:170) suggested that there continued to be “considerable confusion about the nature and role of advanced practice nurses” in Canada. The need for clarity of the nature of advanced practice, Donnelly argued, was paramount to ensure these nurses could function to the full extent of their scope of practice.

Lyon (2004) contended that care needed to be taken to ensure that regulation of advanced practice did not create insurmountable problems for clinical nurse specialists. In particular, she asserted that there needed to be clarity about the different levels of regulation required for advanced practice which involved authority to prescribe medications, as opposed to advanced practice without such authority.

### ***Publications with a focus on changing practice***

Two papers were published from Jones and Cheek’s National Review of Nursing Education-commissioned study of scope of nursing practice in Australia (2002). This qualitative study used a purposeful sampling technique to gain insight into a day in the life of 38 registered and enrolled nurses across 17 areas of key nursing practice. Findings provided “a snapshot of the challenges and skills needed” by nurses, and further evidence of the dynamic and changing nature and context of nursing practice (2002:228). The first paper (Jones & Cheek, 2003) published from this study provided insight into the complexity of nursing practice, while the second (Cheek & Jones, 2003) discussed the implications of the findings for the education of students of nursing.

The particular focus of a review of the literature relating to the scope of enrolled nurse practice in Australia (Milson-Hawke and Higgins, 2003) was the changing nature of health care environments and the impact of these changes on enrolled nursing practice. Milson-Hawke and Higgins (2003) argued that continued change in the provision of health care required re-evaluation of the scope of enrolled nursing practice to ensure that these nurses had the appropriate education so that they could perform to their maximum potential. They also argued that a consistent scope of practice for enrolled nurses across Australia was required, as well as the implementation of a decision-making framework applicable in a range of health care contexts. In a subsequent study, Milson-Hawke and Higgins (2005) reported that enrolled nurses used a process described as “doing the work without overstepping the mark”. That is, they were making judgments about the nature of work they were being asked to do; doing

routine work; deciding to do non-routine work; and deciding whether to undertake nursing activities beyond their initial preparation.

O'Rourke (2003:95) highlighted the importance of "scope of practice and professional standards" together with accountability to ensure the quality of health care. O'Rourke further argued that an understanding of role authority was essential to understanding role obligations both within the profession and within a multidisciplinary team.

In 2005, the United States National Council of State Boards of Nursing (NCSBN) issued an interpretive document linking scope of practice for the varying levels of nurse (registered nurse, licensed practical nurse and advanced practice nurse) with standards of practice / competency standards (NCSBN, 2005a). Competency standards were acknowledged by N<sup>3</sup>ET (2005:33) as shaping scope of practice on entry to practice but not circumscribing future developments that could be achieved through education and competence.

The NCSBN's White Paper on scope of practice for Practical Nurses (NCSBN, 2005b) provided evidence that differences in scopes of practice in federated political systems are not confined to Australia. The White Paper noted that the scope of practice for Licensed Practical Nurses varied widely with regards to intravenous medication administration, blood transfusions and decision making.

### ***Decision-making frameworks / tools***

A limited number of papers focused primarily on frameworks or tools for decision making about scopes of practice. In 2000, the UKCC published a report of the study of the implementation of their scope of professional practice criteria <sup>7</sup> (Jowett and Wilson-Barnett, 2000). Nurses and midwives who were surveyed for the study reported that the scope criteria could empower practitioners, facilitate personal and professional development and result in constructive levels of accountability. The criteria were also reported to encourage innovation, provide safeguards, and lead to greater respect from other health professionals.

Jowett, Peters, Reynolds and Wilson-Barnett (2001) reported a component of the findings from that larger UKCC-commissioned study. The study used multiple methods of inquiry to examine the application and impact in the field of the UKCC Scope of Professional Practice criteria. There was, overall, a positive response to the criteria suggesting that they had "enormous potential as a development tool to raise the profile of nursing and midwifery" (2001:100). However, the need for further training and for managers to take responsibility for implementation was identified. In the report of the project, Jowett and Wilson-Barnett (2000) noted that there was little concern raised about the Scope document itself, and there was wide endorsement of the Principles, although there were calls for more detail and guidance. It was also widely acknowledged that there needed to be flexibility in how the Principles were incorporated into practice, and that structures to support professional development were essential.

In an earlier article, Scholefield, Viney and Evans (1997) noted that the UKCC Scope of Professional Practice had liberated nurses, midwives and health visitors from previous role constraints, while keeping the focus on the patient. They argued that expansion of the role allowed nurses to make adjustments to their practice that reflected patient need, and led to greater autonomy and satisfaction.

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<sup>7</sup> These criteria were for use by nurses, midwives and health visitors. The Scope in Practice booklet (UKCC, 1997) showcased, among others, a midwifery-led unit and a midwife who had expanded her practice to include ultrasonography.

In Australia, Davies and Fox-Young (2002) reported on the validation of the Scope of Nursing Practice Decision Making Framework undertaken by the Queensland Nursing Council prior to publication of the *Scope of Nursing Practice Decision Making Framework (QNC Framework)*. The consultation and validation had involved nurses, midwives<sup>8</sup>, consumers and other health professionals.

### ***Publications on delegation***

Habgood (2002) addressed issues associated with delegation to unlicensed health care workers in the operating room environment. For Habgood, delegated tasks were those that occurred frequently, were technical by nature, standard and unchanging, with predictable results and minimal potential for risks. Tasks requiring professional judgment or complex multidimensional application of professional knowledge were not, in Habgood's view, appropriate for delegation. The differentiation between delegation and unlicensed practice was also addressed with two criteria being suggested. For Habgood (2002) it was unlicensed / unauthorised nursing practice if the task had not been delegated and supervised by a nurse, or if the careworker was functioning unsupervised.

Curtis and Nicholl (2004) outlined six stages of delegation in the form of a step by step guide for novices and more experienced delegators. They argued that effective delegation gave delegators more time for their own activities, and that it was better to do few tasks well rather than many poorly. They also expressed the view that failure to delegate meant that novices learned more slowly. Curtis and Nicholl's six stages of effective delegation were:

1. deciding what to delegate
2. selecting the delegatee
3. assigning tasks – describing the task in detail, and discussing associated responsibilities such as reporting
4. assessing the delegatee and discussing with them their readiness to accept the delegation
5. choosing the level of supervision and executing the task, with close communication maintained
6. completing the task, evaluating the outcomes and celebrating success

In the USA, the NCSBN (2005c) defined delegation as the act of transferring to a competent professional the authority to perform a selected nursing task in a selected situation and the process of doing the work. This was differentiated from "assignment" which was defined as describing the distribution of work that each staff member is to accomplish in a given time period. Grumet (in NCSBN, 2005c) described delegation as a complex skill requiring sophisticated clinical judgement and final accountability for patient care. Communication was identified by the NCSBN (2005c) as central to good delegation – in particular, communication on the unique client requirements and characteristics, what is to be done, and what information is to be reported to the delegator. Evaluation of the delegation was also an essential component of the process (NCSBN 2005c).

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<sup>8</sup> McMillan et al, in their report of the consultation in 1996, noted that the issue of midwifery being a separate profession as opposed to a specialty of nursing was raised in the consultation, but as the current Queensland legislation covered both, the practice of midwives was included in the scope of nursing practice.

Questions that were recommended by NCSBN (2005c) for this evaluation included:

1. was the task performed correctly?
2. was the desired client outcome achieved?
3. was communication timely?
4. what went well or was challenging?
5. were problems addressed?
6. is there a better way?
7. should the client's plan of care be adjusted?
8. was feedback provided to the person receiving the delegation / performing the task?

A number of caveats were identified by the NCSBN (2005c), including:

1. the functions of assessment, planning, evaluation and judgement were specifically excluded from delegation, that is, they were reserved for registered nurses
2. the activity to be delegated must be within the scope of practice of the delegator;
3. delegation is client-specific and not transferable to other clients or contexts
4. care that is complex and unpredictable increases the need for a nurse
5. activities that have been delegated cannot be redelegated by the person receiving the delegation – there must be consultation with the delegator
6. the person receiving a delegation has responsibilities for advising the delegator of their competence and readiness to accept the delegation.

Identifying when a delegation relationship existed was not widely discussed in the literature. The NCSBN (2005c) proposed that registered nurses consulting or providing episodic care in health maintenance / assisted living settings were “advising” not “delegating” because they did not have power to enforce the delegation or to supervise the work. This view was supported by the American Nurses Association (2005) which stated that their principles for delegation did not apply if the care that was given by others was not directed or supervised by registered nurses.

## **Developments in Australian jurisdictions**

The extensive work undertaken by the QNC to validate the *QNC Framework*, and to develop resources to support its implementation in the practice settings, was acknowledged in the National Review of Nursing Education in their final report, *Our Duty of Care* (2002).

Further confirmation of the applicability of the decision-making framework to other States was provided by the four pilot projects conducted by the Nurses Board of Western Australia (NBWA) since 2000. The pilot projects used an action research approach and were conducted in an acute care facility (Policy and Practice Project), a small nurse-led rural health service (Advanced Practice Project), four nursing home facilities (Aged Care Project) and a major teaching hospital where advanced skilled enrolled nurses had been introduced (Advanced Skills Enrolled Nurse Project). These pilot projects resulted in acceptance in Western Australia of the *QNC Framework* with minor modifications to the models (NBWA, 2002 and 2005).

NBWA reported (2005:1) that the overall impression gained from the pilot projects was that the decision-making framework continued to:

- raise nursing and midwifery staff awareness of role responsibilities and role boundaries between registered nurses and midwives, enrolled nurses and unlicensed caregivers;
- raise professional accountability for clinical decision making; and
- present opportunities for expansion of nursing and midwifery practice.

No adverse effects on consumers or members of the nursing profession<sup>9</sup> were reported following implementation and adoption of the decision-making framework into clinical practice (NBWA, 2005:1). Findings from the NBWA project included:

1. identification of the capacity of the decision-making framework to improve patient care by -
  - a. improving staff competence (p25)
  - b. increasing nurses' tendency to think through decisions (p51)
  - c. preventing nurses from just "doing it" rather than considering whether they were competent to do so (pp29-30)
2. improved critical thinking of staff (p28)
3. improved staffing levels because there was the capacity to get the skill mix right (p29)
4. increased identification of further education needs by staff (p42)
5. empowerment of nurses and unlicensed careworkers to decline delegation if they were not competent, by "giving permission" (p43) (However, the report also noted that some hostility was experienced when this happened)
6. nurses being given a sense of accountability (p43)
7. increased consistency of standards because staff were following the same processes (p52)
8. encouragement of self determination (p64)
9. improved communication and clarification of roles (p81).

NBWA (2005:99) reported strong indications that the decision-making framework had, and would continue to have, the potential to engineer sustainable change in the ways nurses and midwives practised. On the basis of this evaluation, the NBWA accepted the recommendation of the project management committee to continue implementation and use of the framework in Western Australia, with full implementation planned to be achieved by December 2006. Efficacy of the framework in practice would be reviewed in 2007 to allow sufficient time for implementation.

In 2005, a review of the 1998 *QNC Framework* was completed by QNC. This resulted in the production of an updated *Scope of practice framework for nurses and midwives (2005)* that was based on:

- developments in other jurisdictions nationally and internationally
- a trend analysis of the over 1000 calls per year to the QNC from nurses and midwives seeking practice guidance
- consultation with individuals and groups from the professions (QNC, 2005).

Approximately 65 nurses and midwives attended consultative forums in a rural / remote area, in a metropolitan maternity hospital, at a university and with representatives of the Queensland Nurses Union of Employees. Sixty (60) written submissions were received – 40 from individuals and 20 from groups/ organisations.

The only significant changes that were found to be needed in the *QNC Framework* were to:

- increase clarity about when the Principles to advance or expand nursing or midwifery practice and to delegate to unlicensed health care workers should be used
- clarify the role of unlicensed health care workers and what could be delegated to them
- strengthen the regulatory controls to prevent unlicensed midwifery practice (only caring for a woman in childbirth was a protected activity requiring a midwife in the Queensland legislation) – the revised *Framework* increased those limits to clarify that only midwives are authorised by QNC to plan midwifery care, delegate aspects of maternal and newborn care to others from that plan and supervise others undertaking those delegated activities) (QNC, 2005). The QNC and the Australian College of Midwives Inc (Qld) continued to

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<sup>9</sup> Midwifery is included in the nursing profession in Western Australia's nursing legislation.

discuss the position argued by the ACMI (Qld) and midwives during the consultation, and since publication of the revised document, that aspects of maternal and newborn care from a midwifery care plan should not be delegated to anyone other than a midwife.

The Nurses Board of South Australia (**nbsa**) reported in 2004 that they had “commenced the development of a decision-making framework relevant to the South Australian context and consistent with the *QNC Framework*” (**nbsa** Bulletin, 2004:28). To ensure the widest possible consultation, a pilot trial was conducted in ten health units across that State. The study used a pre and post test design, combining qualitative and quantitative methods of data collection to ascertain the applicability of the *QNC Framework* to the South Australian context. In March 2006, the **nbsa** published “A scope of practice decision making tool”, to assist nurses, midwives, employers and policy makers in understanding and considering the complex range of interdependent factors that influence decision making in nursing and midwifery practice. The **nbsa** included in the tool a section on professional inter-relationships between nurses and midwives:

*Registered nurses and midwives will, at specific stages along the childbearing continuum, provide parallel services dependent on the needs of the woman, her family and /or significant support network. It is at these times that the professional collaboration between registered nurses and midwives is paramount in ensuring that the woman receives the most appropriate care relevant to her needs.*

*Nursing and midwifery, though discrete professions, have some shared competencies within their unique scope of practice. The most appropriate health professionals or other health providers to perform the task should take responsibility for the role or function; however, nurses and midwives may at times be required to work across each of the disciplines within their healthcare environment. When this occurs, nurses and midwives must recognise their level and scope of responsibility and accountability in relation to functions to be performed and the level of supervision and delegation required in the performance of the function.*

*The professions of nursing and midwifery work collaboratively within the context of open communication, appropriate exchange of information, seamless transition of care, and respect for the principles and philosophies of practice of the two professions.*

Following a project to examine the roles of unregulated care providers, the **nbsa** produced a separate standard on delegation by a registered nurse or midwife to an unlicensed health care worker (**nbsa**, 2005). In this document, the **nbsa** defined delegation to mean the conferring of authority to perform specific functions or tasks in a specific situation, on a person whose role and functions allows them to perform them, but who does not have the authority to perform them autonomously or without supervision from an appropriately qualified health professional.

The **nbsa** interpreted the meaning of delegation further by noting that delegation involved a registered nurse or midwife individualising any health care task for a specific client so that it could be performed by an unlicensed health care worker. The **nbsa** also noted that it would recognise that a registered nurse or midwife was practising within their professional scope of practice by refusing to delegate in circumstances which involved:

1. a compromise of client safety and wellbeing
2. a client with unstable, unpredictable care needs
3. a breach of professional or regulatory standards
4. the task being outside the nurse or midwife’s scope of practice or competence to delegate
5. breach of legislation
6. an unlicensed health care worker who did not demonstrate competence or breached or worked outside their delegated responsibility.

The Nurses Board of Tasmania (NBT) developed *Guidelines for the Scope of Nursing Practice* (2001). These *Guidelines* covered a range of topics including nursing practice, principles for the implementation of nursing interventions, delegation and accountability, unregulated health workers and a diagrammatic model for the scope of nursing practice. In 2005, the NBT reviewed their *Guidelines*, and sought comment from other regulatory authorities as well as from nurses and midwives in Tasmania. The Final Report of that project was published in February 2006. Tasmania's scope of practice decision-making framework "ensured that practice decisions were based on the individual context and patient rather than defining nursing and midwifery by tasks and procedures" (NBT, 2006). It included principles to guide decisions about the scope of nursing and midwifery practice through education, experience and competence assessment and to determine when it was appropriate to delegate care interventions to other nurses and midwives, students and unlicensed health care workers. Nurses and midwives who gave feedback during the review agreed that the principles behind the tool were not new, that it was very useful to have a structured approach when trying to decide whether to proceed with an intervention or not, and that it helped to clarify who may delegate and who was able to supervise (NBT, 2006:17).

The Nurses Board of Victoria indicated in 2004 that it wished to commence a project to implement the *QNC Framework*, but delayed consultation until the completion of the review of the *QNC Framework* being undertaken by the QNC in 2004 – 05. Consultation commenced in Victoria in December 2005. The consultation document included, for comment, a set of principles for division 2 registered nurses (enrolled nurses) who were expected to delegate and supervise. The final report of the consultation (NBV 2006) noted that 85% of respondents to the questionnaire mostly or completely understood the principles for Division 2 registered nurses (enrolled nurses) to delegate and supervise:

*Principles for registered nurses Div 2 [enrolled nurses] to delegate and supervise*

*There are some registered nurses Div 2 [enrolled nurses] who work in areas where there is no direct or indirect supervision from a registered nurse, although there may be what is called "remote" supervision. They may be working as team leader and expected to assign care responsibilities to unlicensed health care workers. The following criteria have been developed to ensure that there is a safer framework for the unsupervised registered nurses Div 2 [enrolled nurses], to protect the public.*

*Criteria*

*The employment of a registered nurse Div 2 [enrolled nurse] without direct or indirect supervision is not a substitution for the employment of a registered nurse (Div 1, 3, 4 or 5)*

*The registered nurse Div 2 (enrolled nurse) must:*

- hold a current license to practice*
- have a minimum of 2 years full time equivalent experience, and be practising at an advanced level, in the area they are being employed*
- be involved in continuous improvement / quality activities and in professional development and continuing education*
- have education / training / demonstrated competence in management and workplace training and assessment*
- demonstrate problem solving and decision making skills*

- *only delegate activities to others that are within their own and the other's scope of practice / competence, and that are legal for the other care provider to perform*

*The employing organisation must have policies and procedures in place regarding the lines of communication and reporting requirements for clients whose health status becomes unstable or unpredictable*

*There must be a registered nurse or doctor available / contactable to assess clients whose status becomes unstable or unpredictable.*

The Nurses Board of the Australian Capital Territory, as it was then known, developed a document titled "Scope of Nursing Practice" in 2000. This document provided detailed descriptions of nursing practice (including the registered and enrolled nurse, generalist, specialist and advanced practice), competence to practise, accountability and responsibility.

New South Wales and the Northern Territory have not to date initiated projects to develop frameworks for decisions about nursing and midwifery scopes of practice.

## **The consultation document**

NMRAs nationally and internationally continue to use a number of approaches for supporting practice decisions by nurses and midwives. However, with few exceptions, there is growing support for the use of decision-making tools to assist nurses and midwives in making decisions about scopes of practice and delegation. The decision-making framework that was developed initially by the QNC was subsequently implemented, evaluated and reviewed in a number of other Australian States. The initial ANMC consultation document, and subsequent drafts, were based on the findings of those reviews and evaluations, and included the core components of the decision-making tools for nurses and midwives that were used in a wide range of jurisdictions nationally and internationally.

## Project consultation – first round

The project was initiated in August 2005 when the project brief and budget were approved at an ANMC meeting. Dr Stephanie Fox-Young was released from the Queensland Nursing Council for up to 65 days to be the project consultant. The Project Management Committee (**Appendix 1**) was appointed and the first meeting held in October 2005. Draft consultation documents were developed by the project consultant taking account of developments in decision-making frameworks in Australia and internationally over the seven years since the publication of the Queensland *Scope of Nursing Practice Decision Making Framework* in 1998.

Invitations to participate in the consultation forums (**Appendix 2**) were sent to key stakeholders (**Appendix 3**) in each jurisdiction by the relevant NMRA. Stakeholders were informed that the purpose of the consultation was to determine whether the draft document was suitable as a *National DMF*. A pre-reading package was sent to each participant, including:

1. an *Introduction to the Consultation* (**Appendix 4**)
2. the consultation document: *Draft National Framework for Decision Making by Nurses and Midwives about Scopes of Practice* (**Appendix 5**)
3. a Program for the Forum (**Appendix 2**).

Stakeholders were also advised that a Background Paper / Literature Review (**Appendix 6**) was available on the ANMC website [www.anmc.org.au](http://www.anmc.org.au). For those unable to attend, an invitation was issued to make a written submission. Stakeholders were informed that a written submission guide was also available on the ANMC website or by contacting the ANMC office.

Nine (9) forums were held across Australia, one in each state and territory, and two in New South Wales between 22 February and 29 March 2006. In addition to conducting the forums, the project consultant and ANMC Research and Policy (RAP) Adviser, Ms Christine Ashley-Coe, met with the project management team for the Tasmanian review of that State's *Scope of Practice Decision Making Framework* and spoke by teleconference with a senior nurse manager from Alice Springs.

### Participation in consultation forums

A total of 530 stakeholders attended the nine forums. **Table 1** below lists the dates, venues and attendance numbers in each jurisdiction.

**Table 1: Consultation forum attendance**

Jurisdiction	Date	Venue	Numbers expected	Numbers attended
SA	22 Feb 06	The Nurses Board, Adelaide	50	41
WA	24 Feb 06	The Boulevard Centre, Floreat	60	50
NT	3 Mar 06	Palms City Resort, Darwin	12	21
TAS	7 Mar 06	Mercure Hotel, Hobart	48	42
VIC	10 Mar 06	Nurses Board of Victoria, Melbourne	110	92
QLD	14 Mar 06	Royal Brisbane and Women's Hospital Education Centre, Brisbane	82	67
ACT	15 Mar 06	Johnston Auditorium, Pilgrim House, Canberra	50	47
NSW	28 Mar 06 29 Mar 06	Star Room Function Centre, IMAX Theatre, Darling Harbour, Sydney	100 100	82 88
<b>Total</b>			<b>612</b>	<b>530</b>

There was a wide representation of stakeholder categories, although some groups were present at only some of the forums. As can be seen from the lists of stakeholder attendance in **Appendix (3)**, there was sufficient coverage of significant categories, including registered nurses and midwives in clinical practice - from various specialties, rural and remote areas, public and private sectors, and the aged care sector; mental health nurses; enrolled nurses<sup>10</sup>; educators; employers; administrators; consumers; representatives of professional and industrial organisations, and regulatory authorities.

The consultation forums began with overviews of the background to the project and of the draft consultation document. Participants were then divided into small self-selected groups and asked to respond to specific questions about the draft document, as well as discuss any issues that the group themselves believed were relevant. Each small group then gave verbal feedback to the whole forum, and forum participants were invited to ask questions or make comments on that feedback. The verbal feedback session was taped, and notes were also taken by the project consultant and RAP Adviser. Each group also submitted their written feedback on butchers' / note paper to the forum conveners.

The feedback from all three sources (tapes, project staff notes and butchers' / note paper) was transcribed and thematic analysis completed.

## Consultation forums - themes

Discussions and feedback at the forums focused on specific sections of the consultation document. The key themes for each section are presented below. Responses for midwifery are presented separately after those for nursing, to ensure that the different issues for the two professions that were raised in all forums are properly represented. Verbatim transcriptions of the tapes and notes of the discussions and of the notes from all small groups can be found in **Appendix (7)**.

<sup>10</sup> In Victoria, enrolled nurses are known as registered nurse, Division 2.

## **Health care team roles and relationships**

Forum participants were asked whether there were any other health care team role relationships (personnel, delegation and collaboration) that could or should be included in the consultation document. Two specific questions were also asked about whether the descriptions / definitions for “other health professionals” and “unlicensed health care workers” were accurate and clear.

Responses indicated that:

1. there was broad agreement on personnel, although there were some suggestions for changes / additions -
  - a. *unlicensed health care worker (UHCW)*
    - i. *the definition of the UHCW is not clear enough/ too broad - especially as the gamut of workers in this category is increasing.*
    - ii. *it should be the employers’ responsibility to define UHCW role rather than the individual nurse / midwife*
    - iii. *the UHCW description is task oriented when the rest of the document is about scope of practice. Perhaps the group should be defined by reference to stability / predictability rather than tasks.*
    - iv. *the definition should clearly indicate inclusion of eg disability workers who may not see themselves as “health” workers*
    - v. *should the title be “support care workers”?*
  - b. *the description of Aboriginal and Torres Strait Islander Health Worker needs further work given their different status and roles in different jurisdictions – it is more a collaborative role with another professional in some contexts.*
  - c. *where do mothercraft nurses / child care workers fit?*
  - d. *volunteers need to be addressed in more detail*
  - e. *other health professionals who are not licensed eg audiologists, need to be considered - the section is rather brief and could be expanded to discuss the interaction between nursing and midwifery and other health professionals as well as more detail about health professionals*
  - f. *the “student” definition is not complete – could be post graduate, undergraduate, return to nursing etc.*
2. delegation needs to be more clearly described and the descriptions in the glossary were too late in the document to be helpful -
  - a. *relationships in multidisciplinary teams were an issue here, eg social workers leading teams and deciding / directing what can be done by non-nurses without a registered nurse assessment*
  - b. *delegation of “nursing” or of “aspects of care” is an important distinction*
  - c. *the differences between delegation and collaboration need to be clearer*
  - d. *the distinctions between delegation and task allocation are important.*
3. referral needs to be added to the existing relationships (collaboration and delegation) and defined -
  - a. *“referral” is not mentioned*
  - b. *both midwives and nurses refer as well as delegate.*

## **Continuum – beginning to advanced / expanded practice for nursing**

A number of issues associated with the continuum of practice were considered by participants, including whether the concept of a continuum (beginning, advanced and

expanded / extended practice) matched the current practice environment for nurses. Additionally, participants were asked to consider whether advanced practice was different from expanded practice and whether the examples of advanced and expanded practice in the consultation document were appropriate for nurses.

There was broad agreement that the continuum was an appropriate concept for nursing. However, there was a strong view expressed in a number of jurisdictions that it may not be necessary to include a continuum, or reference to specialist practice, in a decision-making framework. One comment illustrating this was:

*regardless of where you are on the continuum, the decision principles are the same, so the continuum may not be needed / could be confusing.*

Another commonly expressed view was that a continuum was too linear a model and something more cyclical may be better.

Advanced and expanded practice were reported to be too similar, with no clear difference evident clinically, or otherwise. An example of this overlap was provided:

*“advanced” indicates higher level decision making with “expanded” inferring a broader range of, but maybe not more difficult, decisions (ie learning / using new technology might be expanded practice, but the user may not be making more advanced / higher level decisions, so this would not be advanced practice).*

Participants also noted that expansion:

- *may be difficult to predict*
- *should be for the benefit of clients, not just the convenience of another health professional group.*

### **Specialisation and nursing**

A number of specific questions about specialty practice were considered by participants:

1. Are the descriptions of specialist practice appropriate for nursing?
2. Is specialist practice an appropriate term to use in nursing?
3. Are the examples of specialist practice in the document reasonable / appropriate for nursing?
4. Is there such a thing as “generalist practice”?
5. Is there such a thing as a “specialist generalist”?

There was general agreement that specialty practice existed and the examples for nursing in the document were, in the main, appropriate. However, for many, the issue was whether reference to specialisation was needed in the framework at all. It was suggested in a number of jurisdictions that the continuum alone may be enough.

The question about a “specialist generalist” generated much discussion. Some saw it as a contradiction in terms, but nevertheless accepted that there may be nurses who fit the description. Rural and remote practice nurses were identified as examples of specialist generalists, as were community and aged care nurses. The usefulness of the concept in the framework was, however, questioned.

## ***Nursing practice descriptions***

Responses to the question on the appropriateness of the descriptions of registered nurse, enrolled nurse, nurse practitioner and student, and their professional practices, produced much controversy. Differences in terminology, based on legislation in each State and Territory, meant that consensus on titles, let alone definitions, was difficult to achieve.

Differences between the terms licensing, authorisation and registration, as well as differences in titles, added to the confusion. For example, in some places, mental health nursing remains a separate “register” and midwives are registered or authorised, or their licences are endorsed, depending on the State or Territory in which they practise.

Some participants wanted to add to, or change, international definitions, but others argued that they should not be altered, even though they may have identified omissions.

A number of comments were made on the definition of nurse practitioner (NP):

- *NP practice shouldn't be defined by tasks; the practice of NPs should be able to expand also*
- *There is too much description in the definition of NP – this makes it task oriented and could lead to it being dated in time*
- *There are limits to the framework related to expanded, eg what is incorporated in NP practice may not become standard practice for registered nurses, although for Div 2s, additional education and experience will enable them to care for tracheostomies and this will become part of usual Div 2 practice. But, for example, will prescribing for NPs become the norm / part of Div 1 standard practice?*
- *NP descriptions are limiting. NPs have to follow very rigid guidelines and find it difficult to move outside those guidelines – the description needs to be more client focused (empowering them) and nursing oriented / evidence based practice, rather than focusing on medicalising the practice of nurses eg prescribing medicines, ordering tests.*

## ***Exclusions for nursing***

Forum participants were asked whether the Exclusions – what could not be delegated - were sufficient for nursing. These exclusions were based on legislative restrictions on practice, competency standards giving certain responsibilities exclusively to registered nurses, and the different levels of educational preparation for registered and enrolled nurses.

Many participants argued that the legislatively restricted exclusions were self evident and didn't need to be stated. Others maintained that the activities that are not able to be delegated should be determined by the framework, not by a list. This argument was based on consideration of individual capacity: if the activity was legal and the person was competent and confident, they should be able to do it.

There was variation across the jurisdictions in terms of the emergency exclusion – *nothing in this document can be construed as preventing a nurse or other person from taking appropriate action in an emergency. In such circumstances, nurses may be required to perform activities outside the accepted, contemporary scope of nursing practice.* Some felt it was appropriate; others were concerned about the legal ramifications of acting outside the scope of practice, which was appropriate for the context in which the individual was practising, although not beyond the individual's level of competence. It was also suggested that the law relating to negligence is clear, and reference should be made to the legal consequences of this.

## **Enrolled nurse role**

Other discussions about what should be excluded from delegation focused on delegation to enrolled nurses. A number of questions were asked in this, and other sections of the forum guidelines, to try to clarify the situation regarding the scope of practice of enrolled nurses. Specifically, forum participants were asked to respond to the following questions:

1. Is the enrolled nurse role description accurate?
2. Should enrolled nurses be able to self assess their own competence for advancing their practice?
3. Should enrolled nurses be accountable for approving care plans?
4. Should enrolled nurses be able to delegate?
5. Should enrolled nurses be able to expand their practice beyond the usual scope of nursing practice?
6. What, if anything, should be reserved for registered nurses? That is, what differentiates an enrolled nurse from a registered nurse?

Comments included:

- Calls for the recognition of reality (with some concern expressed by many that reality was not necessarily reflective of safe / best practice) -
  - *Enrolled nurses are delegating, the document needs to allow for this*
  - *Enrolled nurses are not always supervised by someone “in their organisation” – the definition of supervision may need to be adjusted to take account of this – perhaps it should refer to the same professional area of practice but not the same organisation*
  - *Enrolled nurses delegating to unlicensed health care workers is OK as long as they only delegate what is within their own scope of practice (although there was recognition that “delegation” itself is not currently within enrolled nurse scope of practice/ competency standards)*
  - *If a registered nurse delegates to an enrolled nurse – there is a supervisory loop, and if the enrolled nurse then redelegates, that supervision is lost, but the registered nurse is still accountable for the action – this is concerning.*
- Identification of wider ramifications of any change to the enrolled nurse role in this project -
  - *it may be that we need to consider change to the education / competency standards for enrolled nurses to allow them to do more*
  - *the issue of supervision for enrolled nurses will need to be addressed soon as well*
  - *will also need to consider the changes arising from the National Training Package.*
- Calls for more clarity about what can be done by enrolled nurses, especially in light of differences caused by organisational policy as well as State legislation -
  - *a list of activities that enrolled nurses can or can't do may be useful*
  - *enrolled nurses working for a national organisation can do things that are not familiar to registered nurses working in a State-based organisation*
  - *role description should include record and report abnormal findings.*
- Suggestions for dealing with the issues associated with delegation by and to enrolled nurses through clarification of terminology used in the document -
  - *there needs to be more clarity about when it is delegation and when it is not. Eg if there is one registered nurse in aged care with a team of enrolled nurses and assistants in nursing who work from a plan, sharing the tasks - is this necessarily delegation, or working as a team and sharing the workload?*

- *It should be clearer that enrolled nurses are able to practise within their own scope of practice without delegation.*
- Requests for enrolled nurses to be able to expand their practice using the appropriate set of principles -
  - *Just as a registered nurse's role and scope of practice is 'fluid', it is important that the scope of practice for an enrolled nurse also needs to be fluid*
  - *there is a difference between performing a new skill (perhaps in a different role / position) and incorporating / integrating it into nursing.*
  - *accountability to Boards is an important issue – ie you can do anything if you are competent, but accountability for actions remains by virtue of having enrolment / registration.*

The question on what differentiated a registered nurse from an enrolled nurse, asked to assist in clarifying what should be reserved for registered nurses, produced the following list:

- *breadth of knowledge, knowledge base, research knowledge*
- *critical thinking, critical analysis of complex situations*
- *clinical judgement, clinical reasoning at a higher level*
- *academic preparation, education, qualifications*
- *“thinking” rather than “doing”*
- *knowing why as well as knowing how*
- *core competencies*
- *registered nurses rescue and enrolled nurses report what needs to be rescued – early recognition*
- *legislation, scope of practice*
- *level of accountability and autonomous practice*
- *career structure*
- *ability to effectively collaborate, assess, supervise and delegate*
- *care planning.*

From this, and other comments, it can be seen that there was a fair degree of consensus that enrolled nurses should not be able to plan care, or approve or review care plans. However, there was not as clear a sense of agreement on whether enrolled nurses should be able to delegate to unlicensed health care workers.

The role description for enrolled nurses was thought by some groups to contain derogatory terminology, for example, “second level nurse” and “associate”. “Colleague” was identified as the preferred term for the latter.

There was general agreement that self assessment of competence was not usual for any group, and that peers and employers had responsibilities in this area as well. However, it was acknowledged that all nurses should engage in reflective practice.

### ***The four sets of principles***

As there were many overlaps and similarities between the four sets of principles, participants were asked their view about the potential to amalgamate some or all of the sets. They were also asked to consider whether other sets might be required (for example a set for students as was proposed in the Tasmanian document, or a set to enable enrolled nurses to delegate to, and supervise, unlicensed health care workers as was proposed in the Victorian draft framework).

There was broad (but not unanimous) agreement that reduction of the number of sets, in particular amalgamation of sets 2 and 3 dealing with advancing and expanding practice, would enhance the usefulness and reader-friendliness of the document. It was also generally agreed that delegation principles should be applicable to anyone.

The location of students was vigorously debated. Some groups supported a separate set for students. But a consensus view was reached that they should be part of the unlicensed health care worker group, although recognising that the activities that can be delegated to them are much wider than for the rest of that category. It was also noted that there should be acknowledgement that there was an additional requirement for students - any delegation to students needed to be congruent with the educational aims of their study program.

Specific suggestions on the sets of principles included:

- *Set 1 principles should refer to “meeting health needs” rather than “improving health outcomes” as this may not always be possible*
- *Set 1 principles and Diagram 4 should be better linked*
- *the titles of the sets of principles should be self explanatory*
- *Relationships with families need to be clearer – but not sure delegation is the right term for this group*
- *Set 2 reads as if it is only possible to advance via delegation*
- *Set 2 gives a checklist for those contemplating change*
- *Titles of 2<sup>nd</sup> and 3<sup>rd</sup> Set may not be a clear enough distinction*
- *4<sup>th</sup> Set good – may need to be clearer about unpaid carers*
- *Culture - readiness for change – whether organisation open to accept it is an important concept in Set 3*
- *Set 4’s title should just be “principles for delegation” to anyone.*

An additional set of principles - for negotiating delegation, whether to accept delegation or not - was recommended in two jurisdictions.

### ***The diagrams and nursing***

Participants were asked for suggestions to improve the five diagrams in the consultation document, and for suggestions about others that could increase the clarity of the document.

Diagram 4, the Clinical Decision Making Algorithm, received the most favourable comment, for example:

- *it is the key diagram that may be able to be amended to apply across all practice environments including clinical, management and education*
- *Diagram 4 almost said it all – it could almost cover the whole document – all you need.*

Suggested improvements for Diagram 4 included:

- *use the term “activity” rather than “intervention”*
- *“context” from Diagram 1 should be moved to underpin Diagram 4*
- *should include a question (similar to one in the SA document) that asks “Are the individual and employer prepared to accept accountability for the activity?”*
- *may need to replace “clinical” reason with “rational basis for decision / action”*
- *should include reference to evidence for practice*
- *the term “agency” should be “employer” to avoid confusion with agency nurses*
- *“professional fit” may not be the best title*

- *discussion around the issue of documentation / evidence and where it fits into diagram.*

Diagram 3, the Continuum of Practice, was the least supported. It was also suggested that it was not necessary, as the content was covered in the text.

Opinion was mixed on Diagram 2, the Map of Role Relationships. Many of the criticisms related to the graphics, for example “too many arrows”. However, others reported that it was an important diagram to keep, but that it needed improvements such as:

- *enrolled nurses delegating to UHCW is not reflected*
- *should locate client centrally rather than peripherally*
- *it should clarify whether other health professionals can delegate to registered nurses*
- *family, carers should be included in the UHCW / volunteer box*
- *students should be in the diagram*
- *should include background of legislation / context (as in Diagram 1)*
- *question whether differentiation between novice and expert / advanced is needed.*

A number of groups produced alternative diagrams, and a strong recommendation for just one diagram was made in more than one forum.

### **The Glossary**

Forum participants were asked whether there were any terms that should be added to, deleted from or changed in the Glossary. Participants were also asked specifically whether there were better terms for “nursing care plan” and “midwifery care plan” to describe the activities that are planned by registered nurses and midwives, and which may be delegated by them. Participants were asked to ensure that the substitute term differentiated these nurse and midwife-planned activities from the overall “client / resident / patient plan”, which could include non-nursing / non-midwifery activities that were planned, and legitimately carried out, by others.

Broad suggestions for improvement to the Glossary included:

1. being clear about whether the Glossary used nationally agreed definitions or was developed to produce a shared understanding of terms used in the document (with an explanation to be included in the text of the document on how to use the glossary effectively)
2. keeping definitions simple
3. using terminology that was consistent with other national standards (although it was recognised that terms such as advanced / expanded / extended / enhanced all were used sometimes interchangeably in many documents).

A number of recommendations were made about clarifying the meaning of delegation, including:

- *The differences between delegation and collaboration need to be clarified – especially whether other health professionals can delegate to nurses*
- *Combining the definition of delegation and the principles for delegation rather than having them separate may be useful*
- *Include definitions of allocation of tasks as well as delegation and referral*
- *Delegation is delegation of a task, not of the thinking / assessment / interpretation that goes with it*

- *Should make clear that you cannot delegate what is outside your own scope of practice.*

Alternatives for nursing care plan included:

- *contract of care*
- *client plan*
- *multidisciplinary care plan*
- *nursing plan of care*
- *clinical pathway*
- *team plan.*

## **Midwifery**

In all jurisdictions, groups of midwives chose to consider the whole document from a midwifery perspective. Additionally, there were a number of questions specifically directed at the “fit” of the consultation document with the profession of midwifery. These questions were:

1. Does the concept of a continuum (beginning, advanced and expanded / extended practice) match the current practice environment for midwives?
2. Is midwifery properly represented in the diagrams?
3. Are the Exclusions sufficient? What, if anything, should be reserved for midwives?
4. Should there be a midwife practitioner as well as a nurse practitioner role description?
5. Are the descriptions of the professional practice of midwives appropriate?
6. Is specialist practice an appropriate term to use in midwifery?
7. Are the descriptions and examples of specialist practice appropriate for midwifery?
8. Are the examples of advanced and expanded practice for midwives appropriate?

There was general consensus that the consultation document was not appropriate for midwifery, a profession distinct from nursing. There was also agreement that, if a midwifery decision-making framework was needed at all, there should be a separate document or, at the very least, a separate section of the document for midwifery. A separate glossary was also recommended to ensure appropriate midwifery-oriented language, *eg activity, authorisation, allocation of accountability and delegation (and direct entry) are not reflective of midwifery language.* A partnership with ACMI, and consumers, was recommended to formulate such a document, which should also be evidence based.

In all jurisdictions, the view was expressed that the international definition of a midwife and the competency standards for midwifery clearly defined the scope of midwifery practice. It was also noted that the scope of midwifery practice is much more defined and stable than the scope of nursing practice. Additionally, midwives argued that their competency standards (Element 2.4) already provided a standard for safe decision making and defined delegation well. The view was expressed that there may not therefore need to be anything more.

The terms “specialist”, “advanced” and “expanded” were rejected by participants in all jurisdictions as not relevant for midwifery, although there was a recognition that some midwives may see their practice as “specialised”. Examples of this specialisation included focusing on care for newborns experiencing foetal alcohol syndrome, or women with high risk pregnancies. Some midwives also felt that there may be a use for principles for expanding practice in midwifery (eg to include the use of ultrasound in their antenatal practice or being able to perform external cephalic version).

A significant issue for midwives was that, in many places, they were not yet able to practice to the full extent of the current scope of midwifery practice. The performance of technical skills

such as ventouse extraction, ultrasound and external cephalic version were seen to be skills for which midwives might, if they desired, seek credentialing, but that this did not equate to an expansion of the scope of midwifery practice. The ability to refer, order diagnostic tests and prescribe were not “expanded” practice. However, it was noted that they may require legislative change to implement in some Australian contexts. There was disagreement about the need for a “midwife practitioner” title (acknowledging that one already existed in NSW). The ACMI view was that it was an issue that had not yet been debated in the profession and until that debate occurred, no further action should be taken. Other midwives reported that they felt it would be beneficial to have such a category in midwifery.

While it was acknowledged that further education and experience may lead to the development of expertise, this was not seen by midwives to be “advancing practice”. It was asserted that all midwives were expected to be able to provide the full spectrum of midwifery care based on their core educational preparation, from their initial registration / authorisation.

There was unanimous agreement that midwives should not delegate midwifery care to others, as this would be inconsistent with a midwifery model of care, would fragment care and have the potential to reduce the quality and safety of the care provided to women. It was, however, acknowledged that midwives did delegate some health care activities, or aspects of care, to others such as enrolled nurses.

Some midwives argued that the framework needed to reflect reality and not leave people without care. It was acknowledged that midwives may delegate activities such as technical tasks that occur frequently, are standard and unchanging, with predictable results and minimal potential for risk. An example of this provided in one forum was a midwife delegating observations to an EN, who did the observations and reported them to the midwife. Midwives were clear that it is the interpretation of those observations, the professional judgement / application of knowledge in a midwifery context / framework that is important (and cannot be delegated), not the actual doing of the observations. A number of midwives also suggested that, in case management contexts in rural settings, maternity clients may be present in the hospital with no midwife on site, although the midwife would remain responsible / accountable for the woman’s care.

The term “referral” was identified as a preferred descriptor for the relationships that midwives had with other health care workers in accordance with the *ACMI’s National Guidelines for Consultation and Referral*. The *Guidelines* suggest that referral may involve the “transfer of primary care responsibility” to another health professional. This is in contrast to consultation, where ongoing clinical responsibilities are jointly discussed between the woman, midwife and other professional; and with delegation where the delegator confers authority to perform an activity on another person, but the delegator retains primary care responsibility.

### ***Other issues raised in the forums***

A number of other issues were raised, including the uses (or misuses) to which the document may be put, difficulties associated with competence assessment, and suggested improvements to the document as a whole.

### ***Potential use and misuse of the document***

The use of the framework as a regulatory standard was raised in a number of the forums. The common view was that, in order to establish trust, regulatory authorities needed to be quite clear about what they will use the document for. There was an expressed preference for the principles to be “guidelines” rather than “standards”. An associated issue was the “interaction” of the national framework with those already existing or being developed.

In two jurisdictions, the question was asked whether the decision-making framework was an example of over-regulation. However, in others, the value of the document for new graduates, enrolled nurses, and registered nurses working with unlicensed health care workers, agency nurses, employers and midwives was recognised:

- *scope of practice is an excellent tool to allow nurses to expand their practice into whatever they need to do that is legislatively permitted – in fact don't really need NPs*
- *essential to have it so that you can show that you have followed guidelines*
- *helps with regulatory body's advice to nurses and midwives*
- *takes the "cowboy" element out of it – ie have they spoken with management and checked that they are supportive before proceeding*
- *this gives power to professionals – and this is something that should not be lost / given away*
- *if it empowers the nurse to say no, not delegate and / or not accept delegation, it has considerable merit*
- *has worked very well in a large, complex organisation – very valuable tool*
- *used document in development of practice nurse role – used these questions to help discuss how to use nurses most effectively to meet client needs*
- *new grads feel disempowered about delegation – this could give them confidence eg when refusing delegation*
- *we need to consider the principle of the right level of care at the time the person needs it – this is not about nursing or midwifery per se, but about what does this person need at this time, and how that can be achieved*
- *scope of practice would give me the opportunity to negotiate to work into my full scope of midwifery practice rather than working only in the antenatal area – if we get the document right, it would suit midwives and enable midwives to meet client needs.*

In almost all jurisdictions, concern was expressed that the framework would be used to impose workforce change by sanctioning delegation. It was a widely held view that the ANMC shouldn't produce a document that condoned "substitution" of qualified nurses and midwives by less qualified personnel.

Concerns about the consequences of a dispute between the registered nurse or midwife and the employer on whether an activity was able to be delegated to another person were also raised. Associated concerns were expressed about situations in which there was only one registered nurse with an otherwise unlicensed staffing complement.

Power differentials (between the professional decision makers and employers as well as between registered nurses and enrolled nurses, and senior staff and new graduates) were therefore identified as a significant issue to be addressed in the implementation of the framework.

### ***Competence assessment***

The issue of registered nurses' and midwives' ability to assess the competence of others was raised in almost all jurisdictions:

- *individuals shouldn't be responsible for assessing the competence of another individual - it should be an organisational or regulatory authority responsibility*
- *it is different teaching (and assessing) at a professional level from teaching (and assessing) clients*
- *registered nurses' capacity to determine competence of students is an issue.*

- *there should be standard approaches to the education and assessment of competence for anyone taking on a new skill*
- *the difference between assessment of competence in a task and assessment of competence to meet professional standards, is not well understood.*

These concerns will also need to be addressed in the implementation phase.

### ***Suggested improvements to the document as a whole***

There was general agreement that the final document needed to be usable in the real environment, so that it should be simple and short. However, it was also recommended that it should be future-oriented, not focused on what was currently being done. A number of participants identified that leadership was not as visible in the document as it should be.

It was also a commonly held view that the current version was too acute-care focused. In one jurisdiction, the possibility of three versions was raised – one for acute nursing, one for primary care nursing contexts such as community, aged care and mental health nursing, and a third for midwifery.

### ***Issues outside the scope of the project***

Three matters were raised during the consultation that were identified to be outside the scope of the project. Nevertheless, they are recorded here to ensure comprehensive coverage of the issues.

These matters were:

- calls for the regulation of unlicensed health care workers and students
- whether competency standards really fit with nursing – *nurses are professionals and competencies are trying to make it a trade.*
- the need to have a wider discussion about the differences between nursing and midwifery to address misconceptions on both sides (a question illustrating this need was about what the relationship between Bachelor of Midwifery graduates and enrolled nurses should be, if midwifery is a separate profession).

## Evaluation of consultation forums

Evaluation sheets were distributed to all who attended the workshops. Three hundred and forty three (343) responses were received from 530 participants – a 64.7% response rate. A copy of the evaluation form and a verbatim summary of the evaluations can be found at **Appendix (8)**. Broadly speaking, the participants reported that the consultation forums were of sufficient duration to enable adequate discussion of issues.

**Table 2: Participant evaluation of the consultation process**

A = attended R = responded	Length of forum just right %	Pace / timing of sessions just right %	Content of presentations just right %	Quality of presentations good to very good %	Group work productive to very productive %
South Australia A = 41 R = 21	76	86	76	76	86
Western Australia A = 50 R = 45	76	87	84	89	89
Northern Territory A = 21 R = 12	92	92	75	58	92
Tasmania A = 42 R = 26	58	65	81	84	77
Victoria A = 92 R = 55	42	45	51	82	60
Queensland A = 67 R = 57	51	61	60	84	83
ACT A = 47 R = 29	55	62	52	62	55
NSW A = 170 R = 98	86	91	83	86	90
<b>Total A = 530 R = 343</b>	<b>66.5</b>	<b>73.5</b>	<b>70.6</b>	<b>81.6</b>	<b>79.6</b>

Almost two thirds of those who completed the evaluations felt that the forum length was just right, and the rest were spread between it being too long (13.7%) or too short (16.6%). Almost three quarters (73.5%) reported that the pace / timing of the forum was just right, with 9.9% finding it too quick and 12.75% too slow. The content was just right for 70.6% of respondents, but too much for 13.3% and too little for 8.7%. Over 80% felt that the quality of the presentations was good or very good, 14.5% felt that the quality was fair, and only three respondents reported that the quality was poor or very poor. Almost 80% felt that the group work was productive or very productive, and 18.6% thought it was somewhat productive. Two participants felt it was not at all productive and two that it was counterproductive.

The respondents were also asked whether they believed their views were heard and valued. Although not everyone commented on this, many said that they did, although a fair proportion indicated that they would wait to see the final version of the document before they would know if their contributions were valued. Verbatim comments included:

- *plenty of opportunity to be heard*
- *everyone was encouraged to contribute*
- *structured enough to enable everyone to have a say*
- *safe environment to voice opinions*
- *the project team was very open to suggestions*
- *well run program, inclusive of all*
- *facilitators able to "handle" diverse, often strong opinions in room - maintained good "mood" in room.*

A number of participants in most jurisdictions commented that the midwifery issues appeared to dominate. Examples of these comments are:

- *Extremely disappointed in 'us' and 'them' attitude of midwives. Not conducive to constructive discussion. Divisive and unprofessional. (Victoria)*
- *The differences between nursing and midwifery detracted from the intended discussion for each of the presentations (Victoria)*
- *I didn't realise how different "midwives" were and their anti-nurse stance. (Victoria)*
- *Hijacked by midwives (SA)*
- *Shocked by midwives' attitudes to nurses (WA)*
- *Midwives very negative to nursing profession (WA)*
- *Unfortunate that the midwives managed to turn the discussion into midwifery models of care instead of discussion about the principles of delegation (Qld)*
- *Midwives got us extremely bogged down in their issues (Qld)*
- *The debate around midwifery/nursing was not closed early enough (ACT)*
- *I feel today was dominated by an old age argument of "nurses" vs midwives (NSW).*

On the other hand, one respondent reported that it was “*extremely useful to have an opportunity to work with a midwifery group - issues are distinctly different which often makes it very difficult to present a unified response. Many thanks*” (WA)

## Written submissions

The invitations to the consultation forums informed stakeholders of the potential to make a written submission through the ANMC website.

Twenty-five (25) written submissions were received by the closing date, which was extended to 3 April 2006 to allow submissions from NSW forum participants. Sixteen (16) were from individuals and 9 from organisations. Two further submissions from national organisations were received after the closing date. A breakdown of the categories of respondents and the verbatim transcription of their submissions, as well as a copy of the submission guidelines can be found in **appendix (9)**. Submissions were able to be made in writing or via email.

The respondents were asked to comment on eight specific questions as well as being asked for general comments.

### ***Ease of understanding***

Responses to the question “How easy was the draft *National DMF* to understand?” ranged from “very difficult” to “easy”. Of the 19 respondents who answered this question, only 21% found it easy / clear.

**Table 3: Clarity and ease of understanding of draft *National DMF***

	Number	%	% of those responding
Very difficult / very unclear	6	22.2	31.6
Difficult / Unclear	3	11.1	15.8
Neither easy nor difficult	6	22.2	31.6
Easy / clear	4	14.8	21.0
Very easy / very clear	0	0	
No response	8	29.6	
<b>Total</b>	<b>27</b>	<b>99.9</b>	<b>100</b>

Comments relating to this question included:

- *The document is fairly straight forward and easy to read. Sound document. Well set out.*
- *The document as it is was quite repetitive in its use of terminology, therefore not keeping the reader interested.*
- *Easy to access when broken down to midwives/registered nurses/enrolled nurses but decisions/guidelines still not clear in relation to enrolled nurses’ scope in regard to IV therapy and medication as it varies from state to state.*
- *Very difficult. The DMF has clearly been written with nursing in mind and midwifery added in. Whilst it may be appropriate for the nursing profession it does not automatically transpose to midwifery. A separate framework is required for midwifery. In its current form there is no clear justification for a DMF for midwifery.*
- *The word ‘delegation’ is not clearly defined and not used appropriately. Scope of midwifery practice not well understood re what we do and the boundaries of practice. Advanced/extended practice for midwives - use of words alarming. Can lead to fractioning of care. Midwifery is in partnership with woman. Continuity of care important.*
- *Very unclear. I found it quite confusing to really get an understanding about what it was all about, ie decision-making or delegation?*

### **Other health care team roles**

Respondents were asked what other health care team roles or relationships should be included in the section of the document and in Diagram 2, the Map of Role Relationships. Comments included:

- *Midwifery is distinct from nursing and should not be included in the diagram on p6. In some areas remote/rural HCW and registered nurses do work together but the registered nurse should be a registered midwife – registered nurses should not provide midwifery care.*
- *Midwives do not delegate midwifery care to enrolled nurses or other non-midwives, or any other health professional, not even students. With students, the midwife supervises and works with the student and with other health professionals; midwives refer women in their care to them. The midwife, therefore, continues to provide the care alongside other practitioners. A separate diagram for midwifery is required to accurately reflect this.*
- *Redraft to show midwives separately – midwives do not delegate care to non-midwives, midwives refer to other health professionals, eg wound care nurse, diabetes nurse practitioner. Provide care alongside complementary workers – don't delegate to unlicensed healthcare workers.*
- *The diagram does not depict referral between midwives and nurses where their roles are complementary and work towards achieving optimal outcomes for women.*
- *Need 'Referral' in there.*
- *Relationship of Advanced Practice Theatre Nurse performing assisting role and delegated interventions such as catheterisations, suturing, positioning patients.*
- *Dental nurses, general practice staff – these are unlicensed but practice within nursing areas.*

### **Nursing practice and midwifery practice sections**

Respondents were asked to comment on what changes were needed to make the sections on Nursing Practice and Midwifery Practice appropriate for contemporary practice. Comments for midwifery included:

- *The notion of advanced practice does not fit this framework for midwives. Advanced practice for midwives is not about 'increasing complexity' as midwives care for women in collaboration with other health professionals in all circumstances. Beginning practice midwives are expected to undertake this 'complex' care as much as experienced midwives are.*
- *The continuum of practice is a very different concept for midwives as a midwife, according to the ICM recognised definition, works in all areas of midwifery care. They, therefore, do not as a rule go more 'towards the beginning of the continuum than was the case in their previous position'. The same issue applies to 'specialist practice', as a midwife cares for women across all areas.*
- *The examples of breastfeeding and antenatal education described as specialist midwifery practice are incorrect. These are part of the "usual" full scope of midwifery practice.*
- *The ACMI do not support the concept of advanced practice in midwifery. All midwives, from beginning to experienced practitioners, are expected to exercise autonomous professional judgement, as depicted in the Competencies for Midwives recently adopted by the ANMC.*
- *Specialist practice, as defined in the document, is against continuity of care and the Scope of Practice for a midwife contained in the definition that is recognised internationally and by the ANMC.*

- Some midwives may carry out activities not contained in the Scope of Practice, eg Ventouse extraction, however this is done after a credentialing process arranged by individual employing agencies. This is not advanced midwifery practice.

Comments specific to nursing included:

- The concept of a continuum does match the current practice environment of enrolled nurses and registered nurses; however, when expressed as principles for advancing the scope of practice of registered nurses, enrolled nurses and midwives, it loses its clarity.
- It could be of value to have separate categories for the two levels of nurse, in order to minimise any possibility of confusion, eg when referring to practice including “coordinating care and supervising others” or “teaching, education ...” (p10). It could also be of value to expand on what is included in the practice of the second level nurse and to refer readers to p29 and the explanation of the three types of supervision.
- Detail could be reduced. Diagram is good and clear. Do we need to keep separating nursing and midwifery, as there are common grounds?
- Point 5 – Specialist Nursing Roles – could be fleshed out to include all nursing roles considered as specialist roles.

### **Exclusions**

Respondents were asked to rate the exclusions (that is the activities that should not be delegated) listed in the consultation document on a scale of too open, just right or too limiting.

**Table 4: Exclusions – openness versus limiting**

	<b>Number</b>
Too open	2
Just right	6
Too limiting	3
Both too open and too limiting	1
Not relevant	2
No response	13
<b>Total</b>	<b>27</b>

More than half the respondents (15) either did not give a rating on the question or believed it was not relevant. However, comments from other respondents included:

- Well covered.
- Too open and too limiting – many second level nurses currently work with very indirect supervision in some settings such as low dependency aged care facilities. Inclusion of the conditions under which second level nurses can work without direct supervision may be appropriate here.
- Too open – there are many midwifery activities that should not be delegated to a non-midwife.
- The assumption that midwifery care can be delegated to non-midwives is unsupported and inappropriate.
- Irrelevant – I do not support the assumption that some midwifery activities can be delegated to non-midwives.
- The ACM (Victoria) does not support non-midwives providing maternity care.
- There are no specific midwifery exclusions listed which means that there is no midwifery activity that cannot be delegated other than those specifically stated in legislation (which varies around the country).

- *Labour is not the only aspect of care in midwifery. Delegation of antenatal / postnatal care are important and life threatening events in the hands of non-midwives. The maternal mortality figures will support that a major proportion of deaths occur in the antenatal and postnatal period.*

### **The four sets of principles**

Respondents were asked to comment on whether the four sets of principles should be amalgamated or expanded. As can be seen from **Table 5** below, no clear preference was identified.

**Table 5: Amalgamation or expansion of the 4 sets of principles**

	<b>Number</b>
Amalgamate	2
No change	5
Expand	3
Not relevant	2
No response	15
<b>Total</b>	<b>27</b>

Of the 10 respondents who gave a rating in this question, half expressed the view that there should be no change.

Comments indicated that Set One of the principles was slightly more appropriate than the other three. Midwives noted that the language in the principles was not appropriate for their practice, and that advanced and expanded practice and delegation were not appropriate for midwifery:

- *Midwives have demonstrated a wish to practice according to the scope of practice outlined in the definition of a midwife. The issue of advanced practice is primarily an institutional decision, although individual midwives may wish to undertake credentialing to perform activities outside that scope of practice.*

The principles for advancing scopes of practice raised some issues, including

- *a distinction is made between new and established delegations where a new delegation is an activity or task which is not normally part of their role and is therefore seen as an advancement of practice. In this definition, it is not clear if “not normally part of their role” means not normally part of their individual role or not part of the role of their nursing designation. This needs clarification to aid in understanding how to apply these principles.*

### **The diagrams**

Respondents were asked to comment on whether the diagrams supported or clarified the document, and how they could be improved. Comments fell into two main categories. The first category related to the proposition that midwifery, if it was to be involved at all, should have a separate set of diagrams. Examples of these comments included:

- *the scope of midwifery practice is clearly articulated by the ICM [definition] & ANMC Competence Standards*
- *not appropriate for midwives*
- *separate out nurses and midwives*

- *these are NOT relevant for midwifery. We do not support the notion of expanding the scope of practice – there is an internationally defined scope of practice for the midwife*
- *diagrams 1 and 2 do not apply to midwives, since midwives do not delegate care to non-midwives, nor do midwives accept the concept of expanded practice*
- *the diagrams are confusing and have attempted to place nursing and midwifery in the same position, despite clear differences in educational preparation*
- *diagram 3 does not mention midwives at all except for direct entry midwives.*

The issue of referring to Direct Entry Midwives separately from other midwives in Diagram 3, the Continuum of Practice, was raised. If it was necessary to distinguish between midwives on the basis of educational preparation, the preference was for the term Bachelor of Midwifery to be used.

The second category related to the clarity of the diagrams and suggestions for improvement. Some found the diagrams “good / clear” and “very helpful” while others found them too “busy” and “really confusing”.

One respondent noted that students did not appear in Diagram 2 (the Map of Role Relationships) and another suggested that Diagram 1 could include specialist Nurse Practitioners.

Diagram 4 (Clinical Decision Making Algorithm) was reported by one respondent as “very good, clear and concise” and as “very helpful” and “clear” by two others. Another added that the source of advice referred to in this diagram should not be specifically stated at the bottom of the algorithm, as the nurse may need to seek advice from other sources.

One respondent suggested that the delegation algorithm (Diagram 5) “seemed to sit outside of the actual DMF” and might more appropriately be included in the main body of the document; although it was also noted that the algorithm needs to be expanded to include daily delegation decisions where advancement of practice is not an issue.

### ***Suggestions for improvement***

Respondents were also asked what would improve the *National DMF* – including content, structure and presentation. Comments were again in two broad categories, one relating to the relevance of a DMF for midwifery, the other to suggestions for improvement.

In the first category, the general view was that midwifery had simply been “added on as an afterthought”. Others also expressed the view that it was a framework for delegation, not decision making.

Suggestions for improvement included:

- *clarify more who will regulate the unlicensed health care worker*
- *‘advanced’ and ‘expanded’ roles need further breakdown / explanation*
- *clearly identify how many unlicensed staff may be delegated to (eg supervision)*
- *moving the tasks that cannot be delegated to a more prominent position*
- *the title – National Framework for Decision Making by Nurses and Midwives about Scopes of Practice (National DMF) – far too long and complicated*

Some of the comments in the “other comments” section of the submission guidelines were of relevance in this section. These were:

- *Who will carry out the ‘competencies’ for the unlicensed workers?*

- *Terminology is not nationally consistent – eg Victoria does not credential, license or authorise nurses for practice. Victoria registers and recognises additional qualifications.*
- *Registered Nurses in Divisions 3, 4 and 5 in Victoria should be included, not just Divisions 1 and 2.*
- *The distinctions between advanced and expanded practice are not clear, especially for enrolled nurses where advancing practice may be an expansion for that level of nurse.*
- *Examples of expanded practice such as prescribing may only be relevant to the Nurse Practitioner role, not to other categories of expanded practice.*
- *The definition of unlicensed health care worker should be expanded to include the technician role and receptionists.*
- *The definition of “education” in the glossary needs to make clear that there needs to be both theoretical and practical components of any education.*
- *The language in the document should reflect the language of other standards of practice eg “care of the newborn”, not “child” care.*
- *Clarification of student nurses’ roles and education is needed.*
- *It would be useful to have the definitions of new and established delegation on the same page as the principles rather than in the glossary.*
- *there are no principles for nurses to use when considering usual delegation on a day to day basis to individual nurses, for example when an activity or task is within the role of that nurse but a particular registered nurse has not delegated to that particular enrolled nurse before, or the enrolled nurse is new to the hospital and has not performed that activity within the hospital. Neither of these situations are an advancement of practice but the registered nurse still needs to make a decision about the scope of practice of the enrolled nurse and whether it is suitable to delegate the activity or not. This situation does not seem to be covered in the definitions or in the delegation algorithm which is given in the glossary.*

### **What should be retained**

The question on what were the best aspects and should be kept in the final document elicited the following comments:

- *identification of the need to all work together*
- *diagrams*
- *I think it is all necessary*
- *explanation of the role of members of the health care team, and tasks that cannot be delegated to persons who are not registered nurses*
- *diagram 4*
- *the parts that are identical to the WA framework*
- *clinical decision making algorithm*
- *the best aspect is that there is recognition that nurses and midwives operate at advanced practice roles and perform multiple delegations. This is supported by the current health system and it is good to see it being formalised and appropriately recognised*

### **General comments**

Three organisations included extensive comments with their submissions. One from Sir Charles Gairdner Hospital noted that the development of a nationally consistent framework was supported and offered some suggestions for improvement, including:

- *the need to avoid confusion in differentiating between advancing and expanding practice, potentially resolved by separating the concepts of addressing changes in everyday practice and the process of delegation.*
- *the potential for the concept of “new delegation” to be interpreted as individual nurses having authority to introduce new functions to particular roles. In our view, changes to the roles of registered nurses, enrolled nurses or midwives should be a conscious decision made at an organisational level, or a conscious decision of the profession rather than to have other professional groups making decisions / delegating new functions to nurses.*

The second listed concerns about the decision-making framework for midwives in NSW, including:

- *The document appeared to be for nursing, with the language being nursing focused and the literature on which it was based being overwhelmingly nursing focused.*
- *There is little understanding of direct entry midwifery, with the implication that registered nurses would delegate to direct entry midwives in general ward areas – areas of practice in which direct entry midwives have not been educated.*
- *The continuum of practice of trainee, enrolled, student, registered clinical specialist, nurse practitioner is not readily transferable to midwifery, where all midwives, on registration, are able to work in the full scope of practice for midwives.*
- *The concept of competence development from beginning to advanced / extended practice while familiar in nursing is not easily recognised in midwifery, as all midwives, from those at initial registration to those with many years experience will be able to demonstrate the same level of competency.*
- *Placing nurses and midwives in the same framework is inherently flawed as their scope of practice is different and the decision-making framework is not congruent with midwifery; it is not a suitable, relevant or safe framework for midwives or for women and babies.*
- *Midwives do not need a decision-making framework to instruct them on delegation when this activity is clearly addressed in our national competency standards.*

The third organisation also addressed their comments to the issues considered to be of importance to midwives and the women, babies and families for whom they provided care:

- *Midwifery, which was not included in the terms of reference of the National Review of Nursing, has been subsumed into the national decision-making framework and this is not appropriate.*
- *International maternity care reform, which is in response to available evidence, includes the defining of midwifery as a distinct profession, separate from, and linked to both nursing and obstetrics. Midwifery and nursing are separate professions, a fact that is duly recognised by the International Council of Nurses, World Health Organisation, the European Union, the International Confederation of Midwives and a number of Registration Authorities world wide including the United Kingdom, New Zealand, and by the name of the ANMC, but in the document the words midwifery/midwives appear to be sporadically added to nursing.*
- *The language used in many places in the document is inconsistent with that which is used in midwifery practice. Midwives work with women, and others as determined by the women, not clients. In this country, midwives work with infants not children.*
- *Midwives do not delegate their responsibilities to non-midwives. At times women may require care from another clinician eg Psychiatric Nurse, Diabetic Educator, GP, Obstetrician. The Australian College of Midwives has developed Consultation and Referral Guidelines to be used by all midwives when referral is necessary. Although it may be necessary to refer a woman for additional care, the midwife continues to*

*provide midwifery in care in consultation with the other clinician. Delegation would only apply to another midwife.*

Other comments that related to the relevance of the document for midwifery included:

- *Midwives have a clearly defined scope of practice within the ICM (2005) definition of a Midwife and national competency standards (ANMC 2005) that support this definition. Midwives are aware of their scope of practice and, as part of their competency standards, are already able to delegate activities whilst ensuring safe midwifery care to women and babies (element 2.4).*
- *Some is appropriate for rural and remote, but need to address the problem and not just allow blurring of professional boundaries.*
- *The reasons for a decision-making framework for midwifery and any potential benefits which will ultimately support safe quality midwifery care are not evident in this document.*
- *We have national competencies for the midwife, we will have national codes of ethics and practice, we have national guidelines for consultation and referral. The use of a decision-making framework has not been justified.*

The perception that the document was one designed to address workforce issues produced the following comments:

- *The framework is not a framework for decision making, it is for delegation.*
- *The decision-making framework is primarily about delegation of activities; in our view, decision making, as in clinical decision making, does not appear to be the core of this framework.*
- *Would a decision-making framework enable a change in midwifery workforce skill mix? If the decision-making framework is accepted in its current form, then it is possible that many midwifery activities would be delegated to others for reasons of cost savings and workforce substitution.*
- *The development of this document would seem to be a workforce solution rather than one that gives midwives clear direction about their scope of practice.*
- *Significant education structure would be necessary to avoid these changes resulting in a less skilled workforce. In addition to extensive education about the framework for delegation, there would be a particular need for education in areas in which a large number of unlicensed health care workers were employed.*
- *I have concerns that it will be used to justify workforce shortages.*
- *ACMI is concerned that the ANMC are attempting to solve workforce issues through delegation rather than having recruitment and retention policies developed to ensure midwives and nurses stay in their respective professions.*
- *It appears that the proposed document is promoting delegation of responsibility to address supposed workforce issues.*
- *It has been noted that there is a shortage of midwives particularly in rural areas. When maternity services are offered in different, women-friendly and midwife-friendly ways, there are sufficient midwives to provide the service.*

Two other professional issues were raised, one dealing with whether enrolled nurses should be able to delegate to, and supervise, unlicensed health care workers; the second expressing the view that there should be regulation for unlicensed health care workers:

- *While believing that it was appropriate that enrolled nurses should not be able to redelegate to others an activity that had been delegated to the enrolled nurse by a registered nurse, one respondent noted that in practice, enrolled nurses are commonly the team leader in aged care facilities where the registered nurse is on another unit or 10 – 20 Km away on call by phone. This could, the respondent noted, hamper the*

ability of staff to function, and thus client care could be compromised by the inability of the enrolled nurse to provide direction to other workers.

- Another respondent made the recommendation that a set of principles for the enrolled nurse/ Division 2 to delegate and supervise should be included.
- A third respondent suggested that if enrolled nurses could supervise and delegate to unlicensed health care workers, then the concept of students being considered in the same category as unlicensed health care workers needed to be reconsidered, as this could mean that enrolled nurses were able to delegate to students of nursing and students of midwifery.
- One respondent, reflecting on the uncertainty about the extent to which the supervising registered nurse may be held accountable for the actions of the unlicensed health care worker, noted that registered nurses could become more reluctant to work in areas in which a large number of unlicensed workers were employed, such that the registered nurse was incapable of providing either appropriate care or appropriate supervision. The proposed solution for this was for the unlicensed worker to be brought under the jurisdiction of regulatory bodies with a minimum mandated level of education.

Issues relating to implementation of the national decision-making framework included:

- *What assurances can be provided that once consultation has been completed, each Board will adopt and use the national decision-making framework?*
- *The busy clinician user will not wade through the content to get the 'quick-fix' answers they are usually seeking. I would suggest a dot point list of critical aspects for clinician users with reference to the background rationales.*

# Discussion and conclusions from the first round of consultation

## Adequacy of consultation

On the basis of the range of backgrounds of the 530 participants in the forums and the 27 respondents to the call for written submissions, the PMC determined that there was no need to seek input from any particular group beyond those proposed to take part in the Reference Group phase of consultation.

## Key concepts identified during consultation

Several key concepts for the *National DMF* were identified during the consultation. These were that:

1. the consumer should be the central focus of decision making
2. access to care by the right /competent person at the right time in the right place for the consumer is a core value
3. educational preparation and competence should be the basis for all decisions about practice, and delegation decisions should be guided by competency standards, legislation, education, and competence
4. decisions should always be in accordance with state and federal legislation and be acceptable to the profession
5. nurses and midwives are accountable for practising within legal and professional standards
6. there is a shared, mutual obligation / accountability between the decision maker, the person receiving / accepting a delegation, and the employer
7. risk assessment and management, and evaluation of outcomes, should underpin the *National DMF*
8. the *National DMF* should enable flexibility and openness to change
9. evidence-based practice should be a core component of the *National DMF*
10. nursing and midwifery are practised in a primary health care context, continuity of care is a central tenet and the consumer is an active participant in, rather than a passive recipient of, care
11. nursing and midwifery are practised in a multidisciplinary, collaborative environment based on mutual respect and understanding of each other's (and other health care workers') roles and responsibilities
12. the concepts of a continuum from beginning to advanced practice and of specialty practice may not be relevant to a decision-making framework
13. nursing and midwifery are distinct professions and therefore should have separate decision-making frameworks
14. an organisational policy framework that supports professional decision making is a necessary feature of successful use of the *National DMF*.

These were taken into account in the development of two decision-making tools – one for nursing and one for midwifery.

Although there was strong support for recognising the role of enrolled nurses in delegation to, and supervision of, unlicensed health care workers, this was not incorporated into the two tools.

The tools were simplified, incorporating only one set of principles, one diagram for each profession and eliminating reference to continuums, specialty practice, exclusions, and advancing and expanding practice.

The reasons for each of these actions are set out below.

## **Separate nursing and midwifery decision-making tools**

The decision to develop separate tools was based not only on the consultation, but also on the information that, in some jurisdictions such as the ACT, there would need to be separate documentation / standards for nursing and midwifery in any case.

While it would be possible to produce a document that was relevant for both nursing and midwifery (or even one that was relevant for any health profession) such a document would be less relevant to any particular group, as it would of necessity use generic language that may not be totally acceptable for either group. This would have the potential to limit acceptance by nurses and midwives.

The production of two tools acknowledges the separation of nursing and midwifery as two distinct professions. This separation has been entrenched by the recent development of Bachelor of Midwifery programs in a number of Australian jurisdictions. Consequently, trying to produce a document that combined the two could lead to a document that is not “owned” by either profession.

## **Not including principles for enrolled nurses and delegation / supervision**

Despite strong support for recognising that enrolled nurses delegate to, and supervise the work of, unlicensed health care workers, the draft principles for this developed by Victoria for their consultation process were not incorporated into the national nursing and midwifery tools. There are a number of reasons for this decision:

1. it is possible that what the enrolled nurse is doing is not delegation (ie involving teaching, comprehensive health assessment, competence assessment and evaluation of outcomes). Rather, it may be allocation of activities to a co-worker within whose scope of practice the activities already fall, and managerial supervision / team leadership (instead of clinically-focussed supervision to ensure that a delegated activity, following teaching and competence assessment, is performed to the expected standard and with the expected outcomes).
2. the national competency standards for the enrolled nurse and the educational preparation of the enrolled nurse do not currently contemplate the enrolled nurse undertaking delegation and clinically-focussed supervision
3. the national competency standards for enrolled nurses are not due for review until 2007 and the work on the National Training Package for enrolled nurses is only just complete at the time of writing the report
4. there may need to be regulatory processes, such as a specific authorisation / endorsement of licence, for enrolled nurses to practice, in effect, without the supervision of a registered nurse
5. this issue is one that is larger than the scope of the project, and should be separately addressed.

## **Simplifying the document**

Three major changes were made to the document to simplify it. These were the combination of the four sets of principles into a single set for each profession, the integration of a number

of diagrams into one flowchart for each profession and the consequent deletion of reference to a continuum of practice, expanded practice, and specialty practice.

### ***One set of key principles and a single diagram for each profession***

Feedback from the consultation forums consistently noted that the various sets of principles in the consultation document were very similar, and could potentially be collapsed into a single set. It was also noted that the flowchart used to illustrate everyday practice decision making could be expanded to include all aspects of decision making.

Four key principles to contribute to safe decisions were identified in the following areas:

1. the central focus on consumers and their needs
2. individual accountability of nurses and midwives for professional judgements about their own capacity and scope of practice
3. accountability of registered nurses and midwives for decisions about the most appropriate person to perform an activity planned by the registered nurse or midwife for a consumer
4. the need for a collaborative context incorporating planning, risk management and evaluation.

A single flowchart for each profession was developed. The diagram was reconfigured to make scope of practice a central consideration, on which decisions about integrating a new practice, identifying competence for practice and the appropriateness of delegating to others rested.

### ***Eliminating the continuum, specialty practice and advancing / expanding practice from the National DMF***

One of the major themes emerging from the consultation was the need to simplify the document. As is evidenced by the paper written by Marie Heartfield on specialised and advanced practice and published by the N<sup>3</sup>ET (2006), there is little agreement about the meanings of advancing and expanding practice, with a multiplicity of terms used interchangeably and often without adequate definition. With the simplification of the Principles and the Diagram as noted above, these terms could be deleted, without detriment to the central decision-making focus of the tools.

### ***A new National DMF***

From the above analysis, two decision-making tools, one for nurses and one for midwives, were developed and submitted to the ANMC office on 19 May 2006. These tools were much simpler than the document that was circulated for consultation, but remained consistent with the frameworks currently in operation in a number of States. Each tool was supported by a diagram and a glossary to ensure that there was an agreed understanding of terms used.

### **Recommendations from the project consultant to the PMC in May 2006**

On the basis of the consultation and literature review, the project consultant recommended to the PMC that:

1. there be separate decision-making tools for nursing and for midwifery and
2. the issue of enrolled nurses delegating to, and supervising, unlicensed health care workers be addressed in another project

## Review by PMC and NMRAs

These recommendations, the two draft sixteen page tools (**Appendix 10**) and the report of the consultation (**Appendix 11**) were considered by the PMC on 9 June 2006. The PMC requested that the document for consultation with the Reference Group be restructured so that:

1. overarching national principles, drawn from the introductory material of the two tools, and proposed by the N<sup>3</sup>ET's member of the PMC, were listed separately to guide the development of decision-making tools.
2. template tools, with diagrams, for each of the professions of nursing and midwifery were presented.

The restructured version was submitted to the ANMC office on 21 June 2006 for a PMC meeting to be held by teleconference on 30 June 2006.

On 30 June 2006, at the PMC teleconference meeting, N<sup>3</sup>ET withdrew from the project stating that it was not sufficiently confident that the ANMC project outcomes would find a high level of broad stakeholder acceptance, or be consistent with the N<sup>3</sup>ET endeavour to position nurses and midwives for the future, to reform regulation and to build a flexible and responsive workforce<sup>11</sup>.

All remaining PMC members' comments on the revised document were received by the project consultant on 9 July 2006. On the basis of these comments, the ANMC Executive determined that a meeting should be held of NMRA representatives who were involved with the implementation of their State's tools and frameworks. Those representatives would review the draft *National DMF* for consistency with their jurisdictions' documents prior to its dissemination to the Reference Group. This meeting of NMRA representatives was held in the ANMC offices on 14 August 2006.

A number of changes were made to the document to reflect the comments from the PMC and the NRMA representatives, including the development of Pocket Guide diagrams for nursing and midwifery practice to be used in the implementation of the *National DMF*, and submitted to the ANMC office on 25 August 2006. Further review was then undertaken by the Chair of the PMC and the NBWA representative in September, and the two consolidated diagrams were professionally designed. A revised *National DMF* was submitted to the ANMC office on 8 October 2006 and considered by the PMC at a meeting on 23 October 2006 prior to circulation to the Reference Group.

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<sup>11</sup> N<sup>3</sup>ET Position Statement "A national Professional Practice Framework – an alternative to a National Decision Making Framework" July 2006 downloaded from the N<sup>3</sup>ET website [www.nnnet.gov.au](http://www.nnnet.gov.au) on 20 July 2006.

## Second round (Reference Group) consultation

The second consultation draft of the *National DMF* including four diagrams (**Appendix 12**) was forwarded by the ANMC on 27 October 2006 to the Reference Group members (**Appendix 1**) with a request for comment using the accompanying response guide (**Appendix 13**) by 24 November 2006. The report of the first round of consultation and a literature review were made available to Reference Group members on the ANMC website.

The second consultation draft of the *National DMF* included:

- principles for NMRAs to use in developing, implementing and evaluating decision-making tools
- templates for nursing and midwifery decision-making tools, incorporating principles to guide practice decisions, flowcharts and a narrative on the flowcharts
- explanations of terms used in the document.

Accompanying the draft document were two Pocket Guides for nursing and midwifery practice for use in the implementation phase.

Comments were received from 14 Reference Group members by the extended due date of 6 December 2006. Comments from another member were considered at the PMC meeting on 13 December, as they had been forwarded to, but not received by, the ANMC

A full transcript of the comments (**Appendix 14**) was considered by the PMC at its meeting on 13 December 2006. Overall, there was wide acceptance of the document as it stood. Some comments by individual members of the Reference Group were balanced by the views of other members. For example, one member stated that *decision making with regard to scope of practice for nurses and midwives should not be dictated by employers and references to the use of the framework or templates by employers should be removed*. However, others noted that *in many instances changes may be about client groups and the change may be driven from an organisation perspective*.

The decision was taken to make editorial and structural changes that would aid understanding and strengthen core concepts such as flexibility, a rational approach to decision making and the central concept of competence. The changes made to the document in response to the comments of the Reference Group are summarised in **Table 6** below.

**Table 6: Changes to the National DMF following Reference Group consultation**

A diagrammatic representation of the whole <i>National DMF</i> was inserted on the first page of the document to better illustrate the relationship of the parts, and assist in reducing confusion between differing sets of principles and between the use of the terms “framework” and “tool”.
The explanation of RN 2 and 5 in Victoria etc was brought forward to a footnote on the first page of the <i>National DMF</i> (as well as in the explanation of terms) to clarify the nomenclature for these groups in relation to enrolled nursing.
The order of the national Principles was changed to bring what was number 7 to what is now number 4
What was National Principle 3 was moved to the Introduction as it provided a context for development of the <i>National DM F</i> rather than a principle for development or evaluation (and the title “Introduction” was added to this section).
The quoted (and therefore differing) sections of the three sets of competency standards (registered nurse, enrolled nurse and midwife) were deleted as they were readily accessible elsewhere

An emphasis was placed on flexibility rather than restrictions on practice in the section: Purpose of the Framework.
The Prefaces etc for the two tools were combined to reduce repetition and information readily available elsewhere (eg ICN and ICM definitions) was deleted where it did not materially affect the clarity of the document
The title of <i>Principles to guide practice decisions</i> in the tools was changed to <i>Guide for practice decisions</i> in both tools
Words were added to the introductory paragraph to the <i>Guide for practice decisions</i> in each tool to highlight the considered, rational process and the importance of not compromising safety, to give the unequivocal message that any decisions about scope of practice are made in a timely fashion, and are not ad hoc, or spontaneous.
The <i>Guide for Practice Decisions</i> sections were changed to landscape to be the same orientation as the Flowchart Narratives, and the Flowchart itself.
Changes in the Flowchart Narrative to improve readability and clarity were - <ul style="list-style-type: none"> <li>• “comprehensive assessment by RN / midwife” was added as a precursor to identification of an activity, and a sentence on identification of group / community access to care / efficiencies was also added.</li> <li>• the paragraph beginning “Before new activities can be integrated...” was moved above the statement “If all factors are found to be positive...”</li> <li>• examples of relevant stakeholders were included</li> <li>• the registered nurse / midwife was added as the decision maker for whether the activity could be performed by a non-nurse / non-midwife and a footnote on what this term means was added</li> <li>• a reference to RN/EN courses was added in the footnote relating to students (as well as in the explanation of terms – student).</li> </ul>
A number of terms previously deleted to reduce the length of the document were reinstated in the explanation of terms to improve clarity of meaning – <ul style="list-style-type: none"> <li>• comprehensive health assessment</li> <li>• education</li> <li>• enrolled nurse</li> <li>• evaluation</li> <li>• legislation</li> <li>• midwifery practice</li> <li>• non-nurse / non-midwife</li> <li>• nursing practice</li> <li>• organisation</li> <li>• other health professional</li> <li>• registered nurse</li> <li>• risk assessment</li> <li>• student</li> <li>• volunteer (including the information that volunteers / family members may participate in the care of a particular client, but this is not technically delegation, however also noting that the decision-making processes for determining if they are ready to provide the care, are similar)</li> </ul>
Some changes were made to the definitions / explanations of terms to clarify meaning: The delegation explanation was modified to include “transferring” as well as “conferring” authority and a section on responsibilities for accepting a delegation was added. Additionally, the ideas that teaching may be done by others and that teaching alone is not delegation were clarified.
Changes in the <i>Summary practice decision diagrams</i> were - <ol style="list-style-type: none"> <li>1. the font colour was changed from black to white in the ACTION boxes to improve readability</li> <li>2. “yes to all” and “no to any” was added to all boxes of both diagrams</li> <li>3. an “ACTION” heading was added</li> <li>4. examples were given for seeking advice and planning to enable change / integration – in the action boxes</li> <li>5. these diagrams are to be professionally designed prior to dissemination</li> </ol>
Changes in the Flowcharts were made - <ol style="list-style-type: none"> <li>1. to ensure that in printing, the size of chart would always be A3</li> <li>2. to help distinguish the three pathways (integration, usual practice and delegation) - the “boxes” were reshaped – rounded edges for integration (top of page), rectangular for everyday practice (centre) and parallelogram for delegation (bottom of page).</li> </ol>

3. to better link the Flowchart Narrative and the Flowchart, wording in the boxes was changed – for the Nursing flowchart
  - a. Heading for first box on top line = **Integration**
  - b. Heading for box in the very bottom line under box headed supervision = **Support / Education**
  - c. In central box titled Risk assessment – wording for first dash point to read “Commonwealth and / or State legislation” and in fifth dash point to read “Professional practice standards or evidence”
4. The Midwifery flowchart was changed as for the Nursing flowchart in 3(a), (b) and (c).

Words in the tools that were in the *Explanations for terms used in the Tools* were underlined and word in the Flowchart Narratives that were the headings in the Flowchart boxes were highlighted.

Changes were made to the National DMF accordingly, and the third draft *National DMF (Appendix 15)* was submitted to the ANMC office on 1 January 2007.

## Review by two clinician focus groups

At the 13 December meeting, the PMC decided that it would be prudent to have the document reviewed by clinicians prior to final drafting to ensure that the tools were appropriate for clinical use. Two focus groups were therefore arranged by ANMC to be held in Canberra and Adelaide on 6 and 7 March 2007 respectively. The project consultant and the ANMC RAP Advisor conducted the focus groups.

The focus groups used the third draft of the National DMF template tools (guidelines, flowchart narratives, flowcharts and summary diagrams) to work through practice scenarios collated for the purpose (**Appendix 16**), or to apply the appropriate template tool to a scenario from their own clinical setting.

The 17 clinicians from ACT included a new graduate and an enrolled nurse as well as representatives from aged care, community nursing, mental health, women’s and children’s health, surgical nursing, child and adolescent health, medical nursing, practice nursing and rural nursing. In Adelaide, twelve attendees were from acute care, a cardiac unit, aged care, a rural setting, midwifery in a hospital setting and a community setting, mental health, one enrolled nurse and one new graduate. Evaluations completed by 18 of the 29 participants confirmed that the sessions were just right in length, with one participant suggesting that they were a little too short. Thirteen also believed that the pace was just right, while the other 5 thought it was a little too quick. Content of the sessions was reported to be “just right” by all of the participants completing the evaluation, with the quality being very good for 11 and good for seven. Seventeen found the group work very productive or productive, with one finding it only “somewhat productive”. Comments on the consultative process included:

- *good consultative process, excellent group dynamic*
- *found opinions / views of others valuable*
- *very interesting discussion.*

Participants in both focus groups found the template tools easy to use, and helpful in resolving the issues raised in the scenarios or in their own clinical settings. Some believed that the tools would be more useful in longer term planned change than in immediate clinical decision making. Some fears about misuse of the tool were also expressed.

Comments about the tools included:

- *a fantastic tool for all nurses*
- *I believe the tool is great and works on many levels*

- *We could definitely use the guide*
- *A very practical guide, useful for an RN to let employers know their limits of competence*
- *This empowers nurses to ask for preceptoring, mentoring and education and helps to give a clear idea of what to do if something is outside their scope of practice*
- *This gives nurses something to use to help decide*
- *It is part of both organisational and individual risk management*
- *Guide very helpful*
- *Guide definitely useful*
- *A useful tool*
- *Tool particularly good for interviews, gives you the right language*
- *It gives us power, it is a tool to assist in providing rationales for decisions*
- *If every nurse and midwife had something like this, it would really clarify the big and little picture and cover all bases. Without the National DMF, some questions could be missed.*
- *The tool could be used to reflect on whether a nurse is needed to do a particular task*
- *The tool highlights the strengths of nursing with the nurse as the care co-ordinator*
- *Gives everyone a tool to use, individuals and organisations. It could stop the variability of EN roles, but could also lead to a push for ENs to do more and more*
- *Tool more likely to be useful at the institutional management level*
- *The tool would be useful in aged care, and in rural and remote areas and for the NP role and to reduce fragmentation for the patient. It may also be good for reducing costs*
- *The tool would be a useful component of change and development*
- *The tool helps to remove subjectivity from decisions – ie looking at competence rather than the individual*
- *It provides a common language, the definitions are good for this*
- *Believe that the tool would not be of assistance in an immediate crisis, by the time the nurse had gone through the steps, the woman would be gone*
- *Potentially useful for raising issues in advance with an organisation*
- *It would be useful in conflict resolution with some referral point if the tool is not sufficient to resolve the conflict*
- *It could be a very useful reflective tool for current practice*
- *More familiar with the SA version, but this is not inconsistent.*

Some suggestions for change / improvement of the tools and for the implementation process were also made:

- *Need to emphasise readiness to accept new role/ activity*
- *Should bring consideration of organisational policies etc earlier in the flowchart*
- *Need a loop at the end of the summary diagram to go back to the beginning and try again once evaluated*
- *The importance of reporting back in delegation needs to be clear*
- *The use of the tool in reviewing / reflecting on current practice, not just for changes, should be highlighted*
- *There needs to be guidance about where else to go for advice / help – they could get to a point where they still are not able to decide*
- *There is too much emphasis on “evidence-based” reasons for an activity as there is not always “evidence” ( in the research meaning of the word) to support activities*
- *Prefer the term “registered midwife” rather than just “midwife”*
- *Partnership with the woman in midwifery needs more emphasis*
- *The need to market a change in practice to the community should be recognised*
- *The difference between paid and family carers needs to be discussed somewhere*
- *The importance of documentation should be highlighted more*
- *Need to be clear that delegation is a two way process, and that feedback both ways is necessary*

- *It would be good to include the international definitions of nursing and midwifery*
- *Need to look at the tense of the document so that it is clear that it can be used to review current practice, not just prepare for future action / change.*
- *There should be an early question – do consumers want nurses to be doing this new thing?*

Suggestions for Implementation included

- *Need to get the universities involved early*
- *The competence and confidence of RNs in teaching and assessing needs attention*

The importance of clarifying the difference between delegation and referral / collaboration was highlighted by a question about a midwife “delegating” the action of suturing an episiotomy to a doctor, if the midwife recognised that they were too tired themselves, after the labour and delivery, to perform the activity safely.

The use of the pathway “integrating a new practice” for an AIN, who was being taught to perform blood glucose readings, indicated the need for directions about the appropriate pathway to be inserted either in the document or in the implementation education sessions.

Fears that the tool could be used against individuals and concerns that an employer could use compulsion against an individual need to be addressed in the implementation, with particular reference to the paragraph in the preface which prohibits inappropriate substitution and undue influence by employers.

The following changes were made to the document:

1. Feedback loops were added to the Summary practice diagrams (to be professionally designed prior to publication)
2. In the graphic illustration of the *National DMF*, the box *Explanations of Terms used in the Template Tools* was moved to be nested within the *Template Tools* to ensure that the explanations are always published as an integral part of the tools.
3. confidence to perform the activity was added to the fourth box of the summary diagrams
4. reflection on current practice was added to third paragraph of the Purpose of the framework in the Introduction (note this is already in the preface to the tools in the section titled *Use of the template tools – considering individual practice*)
5. a statement on conflict resolution was added to the Preface
6. the words “in partnership with the woman” were added to the heading of the first box of the summary diagram for midwifery practice decisions (note the phrase was already in the *Explanatory statements of the guide* and in the first box of the Flowchart Narrative
7. the phrase “community expectations” was added to the list of changes that may be needed before integrating a new practice in both the midwifery and nursing Flowchart Narratives
8. the need for documentation was added to both *Summary guide diagrams* and Flowchart Narratives
9. The phrase “two-way” was added to the explanation of the term delegation which already covered responsibilities of both parties.
10. the tense of the document was reviewed to ensure that it was applicable for reviewing current practice as well as for planning future change.

The following changes were not made:

1. the title “midwife” was retained because not all jurisdictions use the title “registered midwife” – some are endorsed, others are authorised.

2. the differences between paid and family carers were already discussed briefly in the explanation of the terms non-nurse and non-midwife and volunteer. This will need to be covered in more detail during implementation.
3. the suggestion to move “organisational policies” earlier in the Flowcharts was not accepted. It is always difficult to have the best order for actions in Flowcharts to suit every circumstance.
4. no changes were made to references to “evidence”, as inclusion of this was strongly advocated in the first round of consultation
5. international definitions of nursing and midwifery had been removed from an earlier version as they were readily accessible elsewhere
6. the question “Do consumers want nurses to be doing this?” was not added as it was covered by the addition of “community expectations” in number 7 above

The final draft of the *National DMF (Attachment A)* was submitted to the ANMC office with this final report of the project on 3 April 2006 for a PMC meeting to be held on 12 April 2006.

## Implementation, interpretation and evaluation of the National DMF

Three subsidiary aims of the project were that the PMC would make recommendations to the ANMC on:

1. communication and implementation strategies that will effectively and efficiently address the information, professional and regulatory needs of the professions and of the Australian community (including the resources that may be needed, who should be involved, and what packages should be developed)
2. principles to guide interpretation of the *National DMF* by the NMRAs when they use it as a regulatory standard
3. an evaluation strategy to monitor the effectiveness and efficacy of, and satisfaction with, the *National DMF* by stakeholders and the professions of nursing and midwifery.

### Communication and implementation strategies

During the project, comments and ideas that had relevance for implementation were collected from a variety of sources, including the literature and members of the PMC. The first column in **Table 7** lists concerns or issues that will need to be addressed in the implementation phase. The second column suggests strategies to address those concerns. **Table 8** lists activities that are recommended for the implementation of the *National DMF*.

**Table 7: Suggested strategies to address concerns / issues identified during the project**

<b>Concerns and Issues identified during the project</b>	<b>Suggested strategies to address those concerns / issues during implementation</b>
<p>1. The document is a response to workforce pressures and will result in a diminution of the quality of care currently provided by registered / licensed nurses and midwives.</p>	<p><i>Acknowledge this concern and present data on the workforce pressures faced in the context of an ageing population and workforce. Discussion of national workforce strategies, and the implications of attempting to maintain the status quo should also take place.</i></p> <p><i>The assumption that there will always be enough nurses and midwives to perform the services currently provided by those professions will also need to be challenged.</i></p>
<p>2. Allowing less qualified people to perform nursing or midwifery activities is not safe for consumers.</p> <p>This concern is associated with the view that decision-making tools are only about delegation.</p>	<p><i>Emphasise that that development and implementation of decision-making tools are part of the NMRAs' actions to meet their obligations of protecting the public and are therefore based on the assumption that the professional is the only person qualified to judge what can safely be performed by another competent person, and in which circumstances this can occur. That is, decision-making tools, when implemented properly, should prevent inappropriate substitution.</i></p> <p><i>The tools are also a barrier / protection against those unscrupulous employers who may attempt to pre-empt the professional's discretion by insisting that the professional must delegate certain activities to other workers, regardless of the context / consumer needs.</i></p>

	<i>Delegation is a significant aspect of practice decisions. Delegation is one of the means by which practice can change. It is therefore an important, but not the only, part of any decision-making tool.</i>
3. Nurses and midwives accepting delegation from other professionals could lead to nurses or midwives losing control of their professions.	<i>Clarify that one of the main purposes of decision-making tools is to ensure that inappropriate acceptance of such delegation does not occur, and that registered nurses and midwives remain the key decision makers about what is within or outside the scope of nursing or midwifery practice respectively. There needs to be a clear distinction between performing an activity for, and on behalf of, another professional and integrating such activities into nursing or midwifery practice. Similar distinction needs to be drawn between a non-nurse or non-midwife performing an aspect of nursing or midwifery care for and on behalf of a nurse or midwife, and integrating an activity into unlicensed health care worker job descriptions.</i>
4. Some nurses and midwives are not yet willing to accept the level of accountability for decisions such as integrating new activities into their own practice or delegating activities to unlicensed health care workers.	<i>Part of the educational preparation in the use of decision-making tools needs to be about professional accountability and the skills needed in using these tools safely and effectively.</i>
5. The effects of power differentials between delegator and delegatee, as well as between employer and delegator, can have an adverse impact on the safety of delegation.	<i>Acknowledge these power differentials and include strategies such as assertiveness and conflict resolution in educational preparation for implementation.</i>
6. Some registered nurses and midwives do not believe that they are competent to assess another person's competence.	<i>Educational preparation for implementation needs to include refreshing skills for competence assessment, and re-consideration of the professional expectation of, and skills used in, self assessment of competence and assessment of competence of consumers being educated for self care, as well as contributing to the education of colleagues and students within the nursing or midwifery profession.</i>
7. Fears that tools will be misused to substitute non-nurses and non-midwives for nurses and midwives etc / to deskill nurses and midwives and return to task allocation.	<i>Educational strategies used in implementation need to explore these fears and acknowledge that part of the decision-making process is reductionist in nature, in that competence for specific tasks is the focus of delegation decisions. Clarification of the difference between the holistic knowledge and skill required for professional practice and the professional judgement to distinguish between what needs that professional knowledge and what can safely be performed by others, is essential.</i>
8. Other professions don't seem to need a tool – why does nursing and midwifery?	<i>Educational resources for implementation need to include consideration of situations involving other professions where decision support tools may have produced different / better outcomes</i>

<p>9. Such tools are protectionist of the professions rather than aimed at protecting the public</p> <p>The belief that maintaining professional control over decisions about who does what within the professional's practice environment means that nothing will ever change and people may not therefore get appropriate care when they need it (ie when there is no nurse or midwife available) is a corollary to this concern.</p>	<p><i>This criticism is based on a fundamental misunderstanding of regulation. A profession is regulated (ie entry to the profession and rights to use a particular title) because the decisions that a member of the profession makes or the services that the professional provides are recognised as having the potential to harm consumers if done unskillfully or by unqualified people. Therefore, decision-making tools, which give exclusive authority to members of a profession to make decisions about their practice and about what can safely be done by others who are competent in a particular activity, are consistent with the purposes of regulation.</i></p> <p><i>In a deregulatory environment (that is, one where regulation per se is often seen as restrictive) decision-making tools that give power to registered nurses and midwives to determine</i></p> <ul style="list-style-type: none"> <li><i>• the scope of nursing / midwifery practice;</i></li> <li><i>• when a nurse or midwife is needed;</i></li> <li><i>• what is nursing / midwifery and must be done by a nurse / midwife;</i></li> </ul> <p><i>could be seen as protecting nursing / midwifery. Therefore it is important to emphasise the public protection aspects of these tools, and the professions' commitment to ensure, through the tools' judicious use, that the right person provides the right service for consumers at the right time.</i></p>
<p>10. There is a lack of evidence of the need for such tools, and implementing them is therefore premature and could lead to negative consequences for consumers who would thereby receive sub standard care.</p>	<p><i>This concern is based on a number of assumptions, which are not true for all contexts –</i></p> <ul style="list-style-type: none"> <li><i>▪ That only a professional can safely and competently perform every activity identified by that professional as needed by the consumer for whom they are providing a professional service</i></li> <li><i>▪ That dividing a professional service into activities that should be provided by the professional, and others that can safely and competently be provided by others, can cause confusion for consumers who prefer a single provider</i></li> <li><i>▪ That such division into separate activities leads to deskilling of the professional and is a return to task allocation</i></li> <li><i>▪ That a single professional is able to provide all of the services required by all consumers for whom they are contracted to provide care</i></li> <li><i>▪ That delegating an activity to another person is driven by forces outside the control of the professional and not based on proper decision-making principles including the need to assess competence and provide supervision.</i></li> </ul> <p><i>The concern also ignores the evidence that has been collected in a number of jurisdictions already. Such evidence is mostly about prevention of negative consequences - for example, using the tools prevent problems when properly implemented, and ensure safer decisions about integrating new skills into an individual's practice or delegating activities to another competent person.</i></p>
<p>11. The tools allow / encourage delegation of nursing or midwifery activities.</p>	<p><i>The tools differentiate between nursing and midwifery activities (including applying professional knowledge, making judgements and monitoring) and activities that are planned for and with a consumer by a registered nurse or midwife, which</i></p>

	<i>may be performed by a nurse / midwife or by another competent person. This needs to be clearly distinguished in the implementation phase.</i>
12. Nurses and midwives are not educationally or philosophically prepared to delegate / supervise. They fear the accountability of, and / or feel at risk when, delegating.	<p><i>The Competency Standards for Registered Nurses and the Competency Standards for Midwives both identify delegation to others as an expected competency standard. Hertz, Yocom &amp; Gawel (2000 in Anthony et al, 2001) noted that 85% of newly licensed registered nurses in their study reported that they delegated an average of 2.6 times per day, and 33% reported that they evaluate the care provided by others on average 2.5 times per day.</i></p> <p><i>Anthony, Standing and Hertz (2001) noted that the use of a clinically-based, formalised educational program on the use of a delegation decision grid was reported to have increased effectiveness and confidence in delegation.</i></p> <p><i>The educational component of implementation needs to include knowledge and skills for delegation, supervision and competence assessment.</i></p>
13. Case management midwifery / nursing and primary nursing models do not contemplate delegation and therefore a decision-making tool is unnecessary.	<i>This view assumes that there will never be a need to provide 24 hour care to the consumer. Where 24 hour care is required, some means is needed for the attending professional to ensure that the care which they would provide, if they were able, is provided to the same standard by others who may be of equal or lesser skill. That is, the case manager must maintain input into/ oversight of the care which is within their scope of practice. If the required care is outside their scope of practice, then consultation and referral processes are necessary. These processes are also addressed in the tools. Clarification of these issues is needed in educational preparation for implementation.</i>
15. Integrating new skills / activities into nursing / midwifery practice (expanding practice) could be seen as just another name for expanding expectations / time at work.	<i>During implementation, clarification is needed that decision-making tools are designed to ensure that ad hoc acceptance of new activities, without consideration of the resource implications / consequences, are avoided. Risks are increased where decision-making tools that guide professionals to consider these issues do not exist.</i>
14. It would be easier to just produce lists of activities that can safely be (i) integrated into practice and / or (ii) delegated to others.	<p><i>Lists of activities are not feasible for a number of reasons:</i></p> <ul style="list-style-type: none"> <li>▪ <i>Lists quickly become outdated</i></li> <li>▪ <i>It would be impossible to accurately list potential new activities given the dynamic nature of health care</i></li> <li>▪ <i>Lists do not take account of differences in context – this is why the decision must rest with the professional “on the spot” who can adequately assess the individual circumstances of the consumer, the context and the availability and competence of health care workers / professionals</i></li> <li>▪ <i>Lists do not recognise the professional accountabilities of nurses and midwives to be aware of their own scope of practice and competence for practice.</i></li> </ul>
16. In the transition, until a national DMF is endorsed and implemented in all States and	<i>Table 9 identifies the similarities between the National DMF and the existing State decision-making tools. The principles underlying all Australian tools are consistent. If educational</i>

Territories, steps need to be taken to avoid confusion for nurses and midwives.	<i>programs for implementing decision-making tools are principle-based, confusion will be avoided.</i>
17. Midwifery has a clearly defined scope of practice articulated in the ICM definition and there is therefore no need for a decision-making tool to support decisions to integrate new activities into midwifery.	<p><i>This view rests on the assumptions that</i></p> <ul style="list-style-type: none"> <li>▪ <i>midwifery hasn't changed in the past and will not do so in the future</i></li> <li>▪ <i>midwives do not want to integrate new activities into their repertoire of skills.</i></li> </ul> <p><i>These assumptions need to be acknowledged and addressed in the implementation.</i></p>
18. The tools have the potential to be used punitively by regulatory authorities.	<p><i>This view is based on a misconception that the application of standards and measurement against standards is punitive. All professional practice is expected to conform to standards set by the profession. Decision-making tools are one aspect of a suite of standards endorsed by regulatory authorities. They provide guidance on the expected steps that should be taken and the issues that should be considered before making a decision to</i></p> <ul style="list-style-type: none"> <li>• <i>integrate an activity into nursing or midwifery practice</i></li> <li>• <i>undertake an activity in everyday practice</i></li> <li>• <i>delegate an activity to another person.</i></li> </ul> <p><i>A professional who makes a decision on any matter without following a reasonable process could expect that decision to be challenged. Decision-making tools assist busy clinicians to follow accepted processes in making decisions that affect consumer health outcomes.</i></p>

**Table 8: Activities recommended for implementation and ongoing communication**

<p><b>Education for use</b></p> <ol style="list-style-type: none"> <li>1. Education is required for effective use of any decision-making tools. Rational decision making is not an innate human trait, and many of the concepts used in decision-making tools have multiple possible interpretations. Education is therefore needed not only to provide guidance in the use of the tools, but also to contribute to ensuring consistent application of the principles underpinning the tools.</li> <li>2. Education needs to include concepts such as change, conflict, leadership, communication, regulation, competence, competence assessment, and professional accountability.</li> <li>3. Education is also required by everyone affected by the tools. For example, in terms of delegation, those accepting a delegation, as well as those giving it, need to be provided with training. Nurses and midwives also need to be taught about delegation.</li> <li>4. Appropriate resources are needed for dissemination and implementation, including provision of educational resources, training, and follow-up.</li> <li>5. Where the tools will be used as a standard for decision making, users will need to understand the purposes and limits of the tools as well as the consequences of failing to use them or an equally valid process.</li> </ol>
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### **Inclusions needed in educational resources**

1. Educational resources / presentations need to include reference to the information that much of the evidence of beneficial outcomes of implementation of decision-making tools is about absence of error. That is, the benefits are the prevention of inappropriate integration of activities into professional practice or inappropriate delegation to others.
2. The meanings of terms used in the tools need to be published with the tools, so that consistent understanding and application is enhanced.
3. It is important to teach that the tools should not be treated as a tick list. Therefore, the principles need to be the central focus of educational processes.
4. Advantages of the tools need to be emphasised. Examples of these advantages include that decision-making tools:
  - a. make the registered nurse and midwife the decision maker for all nursing and midwifery practice decisions respectively. This ensures that legislative gaps are overcome and that the true meaning of regulation for the protection of the public is clarified. For example, in some jurisdictions, only the title “registered nurse” or “midwife” or specific practices such as “caring for a woman in childbirth” are protected. Decision-making tools clarify that decisions that have the potential to harm others need to be made by properly qualified and authorised professionals.
  - b. clarify what constitutes an offence under legislation that restricts practice. These tools can be used to assist non-nurses and non-midwives understand what knowledge is needed for activities and skills that need to be performed by a qualified nurse or midwife.
  - c. assist nurses and midwives in managing complexity and change
  - d. initiate consideration of wider professional issues and support clinical judgement in other areas
  - e. can be contextualised / customised for local needs
  - f. reduce trial and error solutions
  - g. fill a need when colleague support / collaboration are not readily available.

### **Clear links with other standards / policies needed**

1. The tools need to be clearly linked to other professional standards including the Competency Standards
2. Local (employer) policies need to change for decision-making tools to be implemented effectively.

### **Involving stakeholders**

1. Once the employer sees the need / benefits of decision-making tools, they are often the tools’ best promoter. Effective implementation needs employer support.
2. Effectiveness of implementation is dependent on strong partnerships between organisations, professionals and unions / associations. Opinion leaders in different sectors need to be involved from the early stages of implementation, which should be a collaborative activity. Working with stakeholders including the unions, professional organisations and education providers (universities and TAFEs) is important, and the aim should be to make them valuable allies.

3. Other stakeholders also need to be involved. Relationships with other professions who will be working with the nurses and midwives in implementing the tools should be enhanced before and during implementation, as should relationships with consumers.
4. Leadership, especially at the middle management level, is an integral factor in bringing decision-making tools to life in clinical practice settings.

#### **Supporting publications / documentation**

1. The tools need to be concise, clear and easy to understand. They should reflect the realities of contemporary practice settings where nurses and midwives require accessible decision support tools.
2. Other potential resources include posters for the back of a treatment room doors, pocket guides / flow charts for the back of ID badges.
3. Educational guides are helped by having narratives, exemplars and / or legal precedents to support the tools, highlighting, for example, inappropriate integration or delegation of practice.
4. Self-directed learning guides have also been found useful in a number of jurisdictions.
5. Electronic formats rather than hard copy should be the main focus in publication and dissemination via the ANMC website and CDs with hyperlinks both within the document and to other related standards and guidelines.
6. the report of the project should be published electronically.
7. The NMRA's should be responsible for implementation in their jurisdiction to ensure that local needs / differences are addressed.

## Consistency of the proposed national tools with existing tools and frameworks

Ensuring that the *National DMF* was acceptable to jurisdictions where decision-making tools were already operational, and would also be useful for those jurisdictions which did not as yet have a framework or tool, was an important consideration in the project. As can be seen from **Table 9**, the existing documents in Queensland, Western Australia, South Australia, Tasmania and Victoria are broadly consistent. The proposed Template Tools for nursing and midwifery are also consistent with the underlying principles of the existing frameworks.

**Table 9: Inclusions in the existing State decision-making frameworks / tools**

	Education, competence and authority as basis for changes to scope of practice	Principle based	Delegation to unlicensed health care workers	Definition of supervision	Expanding practice (however defined – expand, extend, maximise, integrate)	Shared Accountability – delegator, delegatee, and employer	Context affecting scope of practice	Other inclusions
QLD	√	√	√	√	√	√	√	Exclusions, what can't be delegated
SA	√	√	Separate document	√	√	√	√	Collaboration between nursing and midwifery
TAS	√	√	√	√	√	√	√	Principles for students
VIC	√	√	√	√	√	√	√	Principles for div2 (enrolled nurses) delegating to and supervising unlicensed HCW
WA	√	√	√	√	√	√	√	General principles for everyday practice
ANMC Template Tools	√	√	√	√	√	√	√	Incorporates consultation and referral

## Principles to guide interpretation

Consistently throughout all phases of the consultation, participants expressed concern that regulatory authorities would use the *National DMF* punitively. While this expression of concern may be based on a misunderstanding of the purposes of professional standards and of regulation, NMRAs need to ensure that any use of decision-making tools is transparent and open. If an NMRA implements the *National DMF* Template Tools, or a variation, and intends to use the tool as a standard for decision making, any decision maker in that jurisdiction must be aware that they may be asked to provide evidence that they have used either the tool, or an equally valid rational decision-making process, to arrive at their practice decisions.

Where NMRAs use the *National DMF* Template Tools or similar, as a standard for decision making in practice, the following information should be available to registrants:

1. Judgements about the adequacy of practice decisions are made using information collated from all available relevant sources
2. Context is always evaluated, including the adequacy of resources (physical and human) provided by the employer
3. The decision maker is the person with the most current knowledge of the context at the time a decision is made
4. The standard for a practice decision is that of the “reasonable person” - that is, the action that another decision maker of similar education, competence and experience would have taken given the same context
5. The expectations of consumers, in terms of the adequacy of a decision affecting their health, will always be considered.
6. The expectations of peers, including those of the team working with the decision maker, will always be considered in terms of the effect of the decision on their practice.
7. The decision maker will need to be able to demonstrate, through documentation or other evidence, that their decision was grounded in the *Principles to guide practice decisions*, or similar rational decision making processes.

Scenarios are a powerful way to assist in achieving consistent interpretation. NMRAs should consider publishing case histories of professional misconduct cases involving scope of practice decisions.

## Evaluation strategies

All evaluative strategies are based on a number of assumptions, including that

- measurement is possible
- measurement does not change “reality”
- what you are measuring is a true indicator of what you want to examine.

There are a number of aspects that can be evaluated for any new product, and the aspects of the product that are evaluated depend on the purposes of the evaluation. It should be noted that the Council of Australian Government’s plans to introduce national registration for health professionals by mid 2008 may affect the national and State / Territory jurisdictions’ respective responsibilities in any of the following evaluation proposals.

The main aspects of evaluation for the *National DMF* should therefore be:

1. Evaluation of the national implementation of the *National DMF* – purpose to gauge the success of communication and dissemination strategies undertaken by the ANMC, by evaluating the uptake of the *National DMF* by NMRAs and the awareness of the two professions (represented by their professional / industrial associations) of its existence. This evaluative process should occur approximately 6 - 12 months after planned implementation strategies have been completed and include the following areas –
  - awareness of the *National DMF*
  - use of the *National DMF*, and the form in which it is used
  - the consistency of the *National DMF* with other national / State or Territory standards.

A review of the tools used in the jurisdictions might also be conducted at this time by an expert panel to determine whether those tools adhere to the *Principles for developing and evaluating decision-making tools*, as set out on page 5 of the *National DMF*.

2. Evaluation of the implementation of the *National DMF*’s tools locally, evaluation to be conducted by the NMRAs to determine the success of dissemination strategies and the level of understanding / use of the tools in that jurisdiction. This evaluative process should occur approximately 2 years after local implementation strategies are completed and include the following -
  - questions that focus on the actual use of the tools by individuals and organisations
  - questions to gauge whether people have been adequately prepared for using them, including their -
    - understanding of the meaning of particular terminology, processes described in the tool
    - capacity to apply the tool in specific situations (using case scenarios or, potentially, observation in practice)
    - rating of their own understanding of the tool.
3. Evaluation of the effectiveness of the *National DMF* – the focus of this evaluation would be on the NMRAs’ use of the *National DMF* to support either the development of their own tools / implementation of a locally applicable version of the Template Tools, or for evaluating the tools they had previously implemented. The stakeholders here would be the NMRAs, and the evaluation would need to occur approximately 3 – 5 years after the *National DMF* was implemented nationally.

4. Evaluation of the effectiveness of the tools that are implemented in individual jurisdictions. The focus of this evaluation would be on the effect of the tools on professional practice and on the provision of safe care for consumers. It should be remembered that the latter is difficult to evaluate, for a number of reasons. Firstly, the benefit of the tools may be in preventing problems which is difficult to quantify. Secondly, the confounding effects of other factors such as workload, staff mix etc may not be able to be adjusted for. It is also important to include questions about the effect of the tools on access to safe care as well as on the actual safer provision of care. This evaluation should occur approximately 3 – 5 years after implementation is complete in the specific jurisdiction and include questions for clinicians and others about -
- the use of the tools –
    - When / in what circumstances have you used it?
    - Was the use beneficial for you / for others?
    - Did it assist in your practice?
    - Are the tools practical / applicable in all settings? If not, what are the exceptions?
    - Are there examples of times when the tool has led to a positive outcome?
    - Are there examples of times when the tool has had a negative outcome?
    - Are there examples of times when, except for the tool, there would have been a negative outcome<sup>12</sup>?
    - What effects has the tool had on practice / professionalism (eg increased understanding of accountability)?
    - Do you feel the tools give you control over your decisions about practice?
    - What works / doesn't work in using the tools?
    - What are the key limitations of the tools?
  - satisfaction with tools -
    - How comfortable are they in using the tool?
    - How confident are they in using the tool?
    - Has their decision making improved through using the tool?
    - Does the tool contribute to dealing with conflict?
  - other, unintended effects, both positive and negative, elicited through open questions and freehand responses.

Consistent with ANMC policy practice, the *National DMF* should be reviewed for its continuing relevance and value to the professions using the above data, and to identify any changes that may be needed in its format or content, including the continuing relevance of having separate nursing and midwifery tools, on a five year cycle.

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<sup>12</sup> Decision-making tools have been implemented in a number of Australian and international jurisdictions, often following extensive pilot studies. A number have been in use for sufficient time to generate feedback. The evaluative data collected in these places have indicated that the tools are preventing risky behaviour by providing a guide for practice. It is therefore important to ensure that any evaluative strategy captures the absence of negative outcomes as well as the presence of positive outcomes.

## Recommendations arising from the project

The recommendations arising from the project are that the ANMC:

1. adopt the *National DMF (Attachment A)*
2. publish the *National DMF* on the ANMC website, and on CD ROM, following professional graphic design input to the document and diagrams
3. publish the Report of the project on the ANMC website at the same time
4. implement the *National DMF* through the NMRAs, implementation strategies to include those listed in Table 8 (pages 68 – 70) of this report and to address the concerns listed in Table 7 (pages 64 – 68) of this report
5. evaluate the implementation both nationally (by ANMC) and in jurisdictions (by the respective NMRA) not less than 1 year from publication using the strategies listed on pages 73 - 74 of this report
6. review all State and Territory DMFs to establish whether they adhere to the National Principles for the development and evaluation of decision-making tools in 3 years from publication
7. evaluate the usefulness of State and Territory DMFs and satisfaction with those DMFs in 3 – 5 years from publication, using the strategies listed on pages 73 - 74 of this report
8. review the *National DMF* for continued relevance, value and need for revisions including the continuing need for separate nursing and midwifery tools in 5 years from publication
9. include guidance on interpretation, based on the list on page 72 of this report, as part of implementation and education of users
10. ensure all components of the tools – Guide for Practice, Flowchart, Flowchart Narrative, Practice Decision Summary Guide Diagram and Explanation of Terms Used in the Tool - are published together to maximise comprehension
11. withdraw the existing ANMC *Guidelines on Delegation and Supervision* from circulation.

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# **ATTACHMENT 1**

## **NATIONAL DMF AND FLOWCHARTS AND SUMMARY DIAGRAMS**