

What are the Career Structure Issues in Community, Country, Prison Settings; in Mental Health, Midwifery; and in Research, Night Duty, Nurse Practitioner Roles?

This is the fifth in a series of articles to encourage discussion about nursing and midwifery career structures in South Australia. Your responses to the surveys linked to these articles are not only welcome, they are crucial.

In Article three (How are Nursing Roles and Nursing Work Organised?) the main focus was acute metropolitan based nursing service delivery.

This article briefly raises issues for some of the other settings of nursing practice. In addition, some career structure issues related to midwifery practice are considered.

Introduction:

In Article Three several issues were raised including:

- How might nursing accommodate changes in work roles while ensuring that the core of nursing is not compromised, or indeed, is retrieved?
- What new leadership roles will be needed?
- What infrastructure might be needed to support nursing care?
- How might the knowledge work of nursing (decision making, clinical judgement and problem solving) be made as visible as the procedural, technical and physical work activities?

The Article also considered the kinds of work that nurses are expected to “pick up” when other health professionals reduce their services, or “after hours” when there are few other health professionals in the hospital.

There are many interventions that may be undertaken by medical doctors or by registered nurses. The question of which person undertakes which task should be based on competency in the skill and having sufficient knowledge and understanding of the expected and unexpected outcomes. However, at present it is more likely that the time of day or geography will dictate who undertakes some tasks.

Many of the core issues outlined in Article Three are also relevant in the settings discussed in this article. In addition there are other issues which a review of career structures needs to consider.

“As a social system, the nursing profession comprises an amalgamation of dynamic sub-systems and sub-cultures” (Brooks 2000). Some of these have particular structural issues to consider.

Sometimes the impact of the location or setting of practice can influence the nursing roles required. Where nursing is practised in an explicitly multi- or inter-disciplinary delivery model, a nursing career structure may have particular requirements.

In the sometimes interwoven and sometimes separate disciplines of midwifery and nursing, and in primary health care and clinical community nursing, differing philosophical approaches to care delivery may impact on preferred role titles and role relationships.



In the Community:

What does the term “community nursing” cover?

- | |
|---|
| District Nurses
School Nurses
Maternal & Child Health Nurses
GP Practice Nurses
Immunisation Nurses
Home Care Nurses
Community Health Nurses
Community Mental Health Nurses
Remote Area Nurses
Drug and Alcohol Nurses
Occupational Health & Safety Nurses
Indigenous Health Nurses
Hospital in the Home Nurses |
|---|

In Australia, community nursing has encompassed the dual roles of community-based clinical care and primary health care.

Authors in Australia and the United Kingdom (UK) have noted many pressures on the broader focus of community nursing over the past decade, because of increased post-acute care, hospital in the home, early discharge, and the increasing number of chronically and terminally ill patients, resulting in more acute-needs clients being cared for in the community (Kemp 2005).



In more recent years, governments have also increased their focus and expectations in regard to health promotion, prevention, early identification and intervention, particularly in early childhood and chronic disease.

The pressure from acute care and the focus on illness is 'competing' with the primary health care focus on health promotion, prevention and early intervention (Kemp 2005).

Whether intended or not, primary health care and primary care are terms that are increasingly interchanged as if their philosophies and practices were the same.

Primary care is commonly considered to be a client activated first point of entry into the health system. Drawn from the biomedical model, primary care is practised widely in nursing, allied health and general medical practice. It may consist of a single service or intermittent management of a person's condition typically contained to appointments with or without follow-up and monitoring. Primary care practices by definition are not intended to deliver social programs (Keleher 2001).

In contrast, primary health care is a strategy of public health, derived from the social model of health.

Characteristically, primary health care practitioners work to change the social, political, environmental and economic determinants of illness in order to create better health in communities, regions or cities (Keleher 2001).

Research shows that community nurses have much to offer in both models. Large studies have demonstrated that implementing structured and collaborative community based care for chronic conditions using health focused approaches (as opposed to disease focused care) have improved the quality of care. The role of nurses in

GP practices has been shown to have a positive impact on quality of care for diabetes, asthma, and cancer screening as well as for patient education.

Nurses/allied health professionals undertaking home assessment of older people also provide an opportunity for more comprehensive assessment of home safety and medications than do GP office or hospital based assessments. Evidence suggests such models can improve both access to, and quality of care.

Teamwork and a team environment in primary care settings are associated with better processes of antenatal care, care for patients with diabetes, and better continuity of care, access to care and patient satisfaction (CHETRE 2004).

Community development models of nursing care involve work with other health professionals and across other industries, such as schools, housing and social welfare organisations.

In research that charted the changes in community nursing practice, the following themes emerged. The first was the consistent devaluing of ethical nursing practice by policies such as compulsory competitive tendering and output-based funding which reward economic management.

Nurses in the study also indicated that current reporting methods do not describe the complexity of their nursing practice.

The second theme was that current structuring of community health programs relies on the provision of health care by generalist community nurses. The nurses in Smith's study (2000) had a wide range of experience and qualifications, together with case loads which could not be assigned to allied health professionals. Nurses, however, were frequently called on to undertake the roles of other workers and deal with

complex problems that required extensive skills and experience. Much of that contribution is unrecognised and undervalued due to the quantitative focus of current information reporting systems (Smith 2000).

Given these kinds of issues, how can career structure principles be applied to community nursing? Is the concept of three grades of nursing ability (eg, beginning, experienced or advanced and expert) just as applicable to nursing care whether it is delivered in a hospital or a community centre, clinic or home?

How can high skill roles in community development (or true Primary Health Care) be made more visible and be recognised in a career structure? How might we better understand the term 'clinical' and encompass groups and community segments as well as individuals as recipients of nursing care and interventions?

How might screening, surveillance, client education and other preventive activities be better recognised?

Will some of the ideas in the Generational Health Review such as more local clinics and small procedure units become a reality? How could nursing roles best be used as these new community based services develop?

Nurses working in a social model of health clearly have very different roles to those working in a biomedical model. But is one of these models more 'advanced' than the other in terms of classification of work?

Also, how can entry level roles be created for nurses 'beginning' in community care settings? And how would nursing clinical leadership best be structured in community? Are clinical leadership and service management only relevant in single teams or locations or could these roles occur across a cluster of teams or location.



In the Country:

Rural nursing is recognised as being different to nursing practiced in non-rural environments (DEST 2001). Specific issues for rural nursing practice include professional isolation, scarce resources, the expectation that skills will be more generalist than specialist in nature, identifying professional boundaries of practice (Bushy 2005), and limited promotional opportunities.

The NHRA 2001 profile of the rural nursing population indicates the high number of older nurses. This can mean both advantages of experience and practice expertise, and disadvantages of ritualisation and routine. A lack of new entrants with new and different ideas and a fresh pair of eyes mean that practice can potentially stagnate (NHRA 2001).

Characteristics of rural nursing include:

- overlap between the social and occupational roles of the nurse in a specific community;
- local demands for nursing care that are not solely related to medical care;
- the need for self reliance in the absence of specialist support; and advanced generalist or cross specialty options;
- the extension of the nursing role into that of many other health professions. (Keyzer 1997); and
- the need for rural nurses, with a "physical health background" to implement health promotion activity to raise awareness about mental illness and to act when a crisis presents (Cleasby 1997).

Rural nurses need and are expected to have a similar knowledge base to those working in urban areas. However the characteristics outlined above have contributed to the different expectations of rural nurses.

In particular, the decision making ability of the nurse comes under increased pressure in the country. Although all RNs are expected to work without supervision, and are legally and ethically accountable for their actions and/or inaction, the reality of this responsibility is more starkly apparent in rural nursing.

On a day to day basis, rural nurses generally cover broader roles than city nurses however the patient care is generally less intensive. What might this mean for nursing roles?

In career structure terms, the advanced role of nursing is more than simply an increase in tasks or the location of the nursing practice. It is about the very character of nursing.

It is therefore important that rural nurses should not be seen as medical substitutes by themselves, their employers, government or rural communities. They are nurses practising in a way unique to the individual conditions created by the rural health environment." (Ross 1997)

How might the career structure best link the uniqueness of rural nursing with the concepts of advanced and expert practice? Could the recent development of a single Country Region assist the development of promotional roles covering a cluster of health service units?

In South Australia rural environments range from regional cities with different characteristics, to smaller regional areas, to very small outback towns – both on and off main roads and tourist destinations. What impact might these different settings have on nursing roles? Are regional hospitals more like metropolitan hospitals or

does their location make them more like small rural units?

Some rural nurses feel that they lag behind their metropolitan colleagues in terms of advances in technology. They equate rural practice with low technology and inferior practice. However, it is recognised that increasingly health services are reliant on communication technology (DEST 2001).

Telehealth is a generic term in use in Australia to denote "healthcare at a distance". Patient assessment by telephone, with a nurse at one end and the patient at the other, has often been done with effective outcomes.

However, the infrastructure required for high-quality information and health service delivery is far from universally available or reliable. It is extremely costly in sparsely populated or distant areas, although ultimately its absence may be more costly (Hovenga 1998).

How might 'virtual' nursing roles, using communication technology, fit into classifications and promotional structures?

Finally, it is clear that continuing education is very important to rural nurses in Australia. Huntley found that 71% of rural nurses surveyed stated that the "lack" of access to continuing education opportunities could contribute to them leaving their rural nursing position (DEST 2001).

The DEST literature review concludes that rural nurses appreciate courses which have face to face content, and have "hands on skill" development. Rural nurses do not like distance education courses or computer based course. These views pose significant challenges for educational providers and funding bodies (DEST 2001).

If career structure progression includes qualifications and/or continuing education requirements, how might relevance, access and equity be assured for rural nurses?



Forensic Nursing:

"Almost every nurse will operate as a forensic nurse at some time. If you work with domestic violence, sexual assault, drug and alcohol addiction, work related injuries, gun shot or stab wounds, child abuse, elder abuse, suicide attempts, medication negligence, motor vehicle or pedestrian accidents or in corrections, you are practicing forensic nursing" (Saunders).

The nurse's first responsibility is to act to preserve life and prevent further injury however this can be done with a forensic approach.

Lynch (1995) has defined forensic nursing as 'the application of nursing science, to public or legal proceedings, the application of the forensic aspects of healthcare in the scientific investigation, and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents'.

Forensic psychiatric nurses help to bridge the gap between the criminal justice system and the mental health system. As the number of mentally disordered offenders increases, the role of the forensic psychiatric nurse expands both in volume and nature. These nurses utilise their psychiatric nursing skills and knowledge in any setting where criminal behaviour and mental health problems co-exist.

Forensic Correctional Nurses work in prisons. Prisoners have health care needs too. Prison Nurses work in a secure environment providing care for individuals who have either been convicted of a crime and are resident in a prison facility or to those who

have been arrested and held in custody until their court hearing.

In this special area of practice there needs to be a balance between the role of the nurse and the prison officer and the tension of care versus custody. As a health care provider, the nurses focus on the health needs of prisoners, while the prison officials focus on security. Both nurses and prison officers must work together, each respecting the other's role and responsibilities in order to maximise health care delivery without compromising security (Saunders).

Prison nurses have to manage chronic disease, mental illness, drug and alcohol abuse, acute medical problems and trauma as well as offering health screening for new prisoners and well-person clinics. Nursing in prisons is comparable to working as a practice nurse in a GP surgery but is arguably more challenging, with a higher concentration of patients needing help for mental health and substance misuse problems.

Prison health care is an environment with a need for self reliance in the absence of specialist support and a wide range of skills.

'Brenda' is a South Australian RN working in prison services in a rural setting. Brenda does all the nursing diagnosis, treatment and medication in the prison. The pace is busy.

On a typical shift, there will be Brenda and one other registered nurse on duty. They will see up to 40 prisoners a day which will often involve conducting assessments, diagnosing, medicating and documenting each visit. In addition, Brenda conducts medication rounds and assists in the doctor's parade, transfers and admissions of prisoners.

No doctor is available most of the time, and so Brenda is the first reference point for any medical emergency or situation within the prison. She will often attend to injuries

sustained from fights, overdoses or self harm attempts. One challenge for her is knowing what emergency equipment to physically take to the prison cell and then the ability to work on the floor of the confined space that she finds herself in (DEST 2001).

For the most part, nurses usually have a more respectful relationship with inmates than do security guards because of the caring nature of their work (Boivin, 2001).

The prison system is a tightly controlled world in which the constant monitoring of small details is crucial to safety.

Prison nursing encompasses elements of primary health delivery, mental health, accident and emergency care and forensic nursing. Balancing the cultures of caring and service with security and custody presents unique ethical tensions (Norman 1999).



Mental Health Nursing:

Mental Health Services are undergoing major changes of direction. Movements from service delivery in institutions to outpatient and community residential settings, and from custodial to 'recovery' approaches are two changes with significant implications for nursing career pathways.

In Mental Health Nursing itself, the implementation of clinical supervision and practice development models is providing opportunities for mental health nurses to demonstrate their skills and their potential influence on improving client outcomes.

Practice development roles can have multiple impacts such as:

- transforming practice and driving improved clinical and organisational outcomes;
- developing collaborative networks between nurses;
- moving nurses 'beyond their comfort zone' to consider new practice processes; and
- assisting mental health nurses to better articulate models of care (Proctor 2005).

Practice development is a continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and health care teams to transform the culture and context of care (Garbett 2002).

Practice development is an approach which seeks to encourage the participation of individual nurses and nursing teams in research activities which focus simultaneously on practice level interventions and broader organizational and policy implications.

In this approach, nurses themselves identify the values and directions by which they can review and change service practices in a consumer centred manner.

Another practice change in mental health nursing is the advent of clinical supervision opportunities beyond student programs.

Clinical supervision is an important component of effective clinical governance. It is a formal process of professional support, skill development and learning that enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance the safety and quality of care in complex clinical situations (Morton-Cooper 2000).

Although the term 'supervision' is used, the processes of clinical supervision are those of professional

colleagues and mentors, not managers and employees.

The importance of clinical supervision is recognised beyond mental health services. In a report examining systems issues impacting on patient care at Royal Melbourne Hospital, the Health Services Commissioner (2002) found that several nursing issues emerged as being particularly affected by management and infrastructure problems, and cuts to middle management nursing positions.

The Commissioner's Report (2002) supported implementation of a recommendation that all registered nurses regardless of full-time or part-time status, receive two hours per month of clinical supervision.

In what ways could the career structure provide roles to support and guide successful implementation of Practice Development and Clinical Supervision?

Another systems change in mental health is the move to a 'recovery' model of mental health services as has occurred in New Zealand.

'Recovery' is defined as 'living well in the presence or absence of one's mental illness'. It recognises the importance of hope and personal and social responsibility. It states that families, communities and people with mental health problems themselves need to be as actively involved in recovery as mental health service providers.

One part of moving to a 'recovery model' rather than long term institutionalisation involves the physical relocation of many clients to community homes (reflecting wellness and normative settings), rather than hospital settings (which emphasise illness and dependence).

Thus in the future many mental health nursing roles will focus on active and supportive recovery services rather than more passive 'custodial' approaches.

What might this mean in terms of career pathways in mental health?



Midwifery:

The midwifery model of care is based on the premise that pregnancy and childbirth are essentially normal life events. The focus of the midwifery model of care is the provision of continuous care for women and their families throughout pregnancy, birth and the early postpartum period.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

In South Australia 'Caseload Midwifery' is a model of care where a client/patient has a named midwife and a backup midwife, who provide full care throughout her pregnancy, labour, birth and postnatal period. "Full care" means all midwifery care.

Working in this model is optional, so across the State there are midwives working in Caseload Midwifery, and midwives working in more traditional models within hospital structures. In the latter, a midwife may work only or mostly in a single area of midwifery practice such as labour ward, or post-natal care.

How might the presence of multiple service delivery models impact on career pathways and classification structures for midwives?

In discussion rejecting the Nurse Practitioner role as being suitable for midwives, the ACMI states that "the role of the midwife is not 'advanced' or 'extended' midwifery practice – it is fundamental to fulfilling the

comprehensive role of a midwife” (ACMI 2005).

When linked to the concept of midwifery being a separate profession from nursing, the concept of a single comprehensive role could lead to a view that there is only one level of practitioner in midwifery.

However there are also many midwives who came to their midwifery roles from a nursing background and do consider themselves specialists, with expected levels of classification.

Some midwives practice in only one area – such as in labour ward, or in postnatal hospital care. Others, following new care delivery models – work with a woman across all phases of her pregnancy to the early weeks after birth.

Do different philosophies automatically mean different work classification structures? Does the principle of a professional moving from an entry performance level to higher levels of performance apply in midwifery?

Are there different levels of work in midwifery? Are there different clinical and service delivery roles in midwifery? Or if there is one role and

one level, what classification level might that be?



Research:

Research is generally more likely to be associated with academic organisations – either universities, or stand alone research centres. – than with practice settings.

Careers in research are usually linked with teaching and/or academic careers (see a summary below). Although research roles have been considered in various nursing career structures, generally research has been squeezed down into job descriptions already listing more work than can be achieved in a single role.

Joint appointments between a university and a health service organisation have been used as a mechanism to try to bridge the gap between academic and health service settings.

Although valuable work has come from some of these arrangements, sustainable nursing research roles have not developed in health settings.

But rather than joint appointments what about appointed roles in the health system that would allow people to collaborate with colleagues in the academic setting?

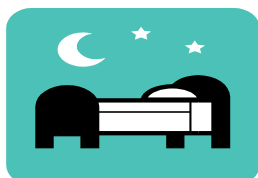
In the health service setting, research is linked to a different set of goals than in a university. In the service area, research is focused on outcomes of interventions, evaluation of service delivery decisions or innovations, and benchmarking quality and efficiency indicators.

How might nursing and midwifery expand service quality and evaluation roles to build the organisation’s capacity for well structured evaluation through research?

If evaluative activities can be given time in roles at various levels of the career structure, would this gradually support a practice based research framework?

Nursing Research Careers: Academic Pathway (Kenkre 2001)

	Research Associate	Research Fellow	Senior Fellow	Professor
Typical role	<ul style="list-style-type: none"> - data collection - coding/entering data - providing input to analysis - assisting with report writing 	<ul style="list-style-type: none"> - assistance developing research protocols - preparing reports - may lead a project 	<ul style="list-style-type: none"> - development of projects - publishing papers - applying for funding grants 	<ul style="list-style-type: none"> - leads the development of the organisation’s research strategy - leads publishing activity
Skills	<ul style="list-style-type: none"> - literature review and IT skills - able to work independently and in a team - time management 	<ul style="list-style-type: none"> - project management skills - protocol development - data analysis skills - writing for publication skills 	<ul style="list-style-type: none"> - team and project supervision skills - expertise in particular research or clinical areas 	<ul style="list-style-type: none"> - able to develop research capacity and infrastructure - ensures that research is accessible to user groups



Night Duty:

Hospital reforms in the UK have paid considerable attention to the clinical work that occurs in the evening and overnight.

Driven mainly by the need to reduce the working hours of medical interns, a Hospital at Night model has been developed.

In contrast to the traditional model of junior doctors working in relative isolation and in specialty-based silos, the new UK model uses a team approach including both doctors and nurses.

Hospital at Night advocates:

- Combined medical nursing handover in the evenings;
- Nurses taking on some of the work traditionally done by junior doctors;
- Moving a significant proportion of non-urgent work from the night to the evening or daytime; and
- Reducing unnecessary duplication of work by better coordination and reducing multiple admission assessments and reviews.

A key role for the nurse co-ordinators at night is effective pager filtering. This minimises the inappropriate paging of medical staff and helps to redistribute work effectively.

Also, nurse prescribing is an element of Hospital at Night, supported by use of protocols and phone orders.

The night co-ordinator roles in larger hospitals are purely clinical and all management responsibilities are fulfilled by a separate nursing role.

The co-ordinator actively supports night nurses with complex patients.

More co-ordinated and efficient responses to patient needs at night have been outcomes of this model.

In career structure terms, what roles might be useful in achieving better patient outcomes, and increased role options for expert clinicians?



Nurse Practitioners and Other Advanced or Extended Practice Roles:

Nursing is first and foremost a practice profession. Some view advanced nursing practice as a combination of advanced nursing skills and functions traditionally considered medical (sometimes called extensions to nursing).

“Taking a person’s temperature and blood pressure were formerly medical procedures. No doubt some of the medical functions of today, such as diagnostic tests and prescribing medications and referring to specialists, will be part of general nursing practice in the future.”

A nurse can incorporate shared functions into practice, whether in basic practice or in advanced nursing practice. It is not the addition of functions from another profession, but the application of advanced nursing knowledge itself that makes nursing practice advanced” (CNA 1997).

In the new NHS (UK) role grading system there is a grade for an

individual practising at Consultant level in various professions.

In Hampshire this role is required to spend a minimum of 50% of time (balanced across the year) in expert practice as these roles are in the clinical career path.

Individuals in these roles are not managers. As such, their input into service delivery and business planning is strictly related to their own area of practice, bearing in mind the broader picture. However it is for the nurse managers to make decisions and take responsibility for broader service planning and delivery.

The NHS suggests these roles should be fully integrated within the practice team and need their share of: secretarial and administrative support; IT and appropriate networks (Kitsell 2004).

So at the highest levels of advanced and/or extended nursing practice there may be a variety of roles and titles. Some of these roles are based on client groups and some on technical skill areas.

In Australia many of these roles have a protected title, that of Nurse Practitioner. Thus in South Australia a nurse cannot use this title without authorisation by the Nurses Board.

As with all nurses, midwives, doctors and allied health professionals, Nurse Practitioners are always accountable for the care they provide.

Nurse Practitioners are qualified to do things such as examine patients and order necessary tests to determine what may be wrong. They can then use their knowledge of diseases to decide the best treatment or therapy, including prescribing medications if needed.

Nurse Practitioners can also admit and discharge clients and refer to specialists in other disciplines when necessary. Like all registered nurses, nurse practitioners do not need to be

supervised by others when they are providing care or services that they are competent, educated and authorised to do (NNNET 2006).

Recently roles called Practice Nurses have developed but these roles are not Nurse Practitioners – they are nursing roles of various levels located in medical general practitioner practices.

Advanced level and expert levels of nursing practices are not necessarily specialist areas – either nursing or medical specialties, although many develop in this way. The issue of the most advanced or expert practice is about the nature of the practice rather than the traditional boundaries of the practice undertaken by the nurse.

As practice becomes more advanced nurses demonstrate more effective integration of theory, practice and experience along with increasing degrees of autonomy in judgements and interventions. Advanced practice occurs with continued competency development, further education, and experience (QNC 1998).

As summarised in the table below, Kitsell (2004) outlines the need to have knowledge and to be able to both 'know how' and 'show how' in a consultant role.

The expert registered nurse is an authority in their chosen field of

practice. In addition to the standards describing advanced nursing practice, the expert registered nurse would also demonstrate features such as lateral thinking, challenging the status quo, having a research or evaluative focus, extensive knowledge, being able to work as a consultant and leader, and viewing situations globally (QNC 1998).

New and emerging roles create some ambiguity until the roles have become well established in the health system.

Nurses who move into Nurse Practitioner and other expert and extended roles are likely to experience "social psychological discounting" as they establish new roles and relationships both within nursing and with other health professionals.

Social psychological discounting refers to discounting behaviours such as being undermined, ignored, excluded, blamed, verbally abused, stigmatized, made invisible and misidentified.

In the USA, nurse practitioners have described instances of discounting behaviours directed towards them by nurses, including nursing administrators due to their being considered "different" and by medical practitioners apparently threatened by their roles (Martin 1999).

According to Hall (1994) those at the centre of a community (physicians) are in power and the visibility of those at the periphery and not in power (Nurse Practitioners) present a challenge. The invisibility of non-physician providers reflects the continued pervasive dominance of the medical model.

In this Career Structure Review consideration needs to be given to the nature and variety of advanced, expert and extended nursing roles needed in South Australia in 2006. Such roles, at high levels of clinical practice, need to be classified at and beyond the traditional 'Level 3' to ensure a clinical career path for nurses.

What types of roles might this include? What might differentiate more than one salary classification level for such roles?

How do high level clinical roles equate to management roles? How can high level clinical roles be made more sustainable to ensure that they do not become entirely reliant on a single practitioner?

How can we, as the nursing profession, avoid stigmatising these roles and improve our acceptance, visibility and recognition of expert nursing practice?

'Knows' and 'Knows how' i.e. knowledge and understanding	'Shows how' i.e. skills
Knowledge across the full spectrum of practice in the area, with particular emphasis on nursing's contribution, underpinned by theoretical knowledge and experience.	Practice delivery and outcomes are recognised as being at expert level by peers, bearing in mind caseload and circumstances.
Understands the importance and effect of leading by example.	Acts with integrity and works effectively under pressure.
Understands the importance of both independent and team working, as appropriate. Has excellent understanding of different models of leadership and management and their appropriate application. Has accurate insight into own style and its strengths and weaknesses.	Effectively leads clinical practice delivery with confidence and thoughtfulness. Enables an open team environment; utilising a variety of leadership and management styles as appropriate. Empowers team members by being supportive and through effective prioritisation and delegation.
Demonstrates effective understanding of process of leading and implementing change in service delivery	Service delivery accords with best available evidence.
Understands current service/practice indicators and benchmarks within own field of practice	Measures own service/practice delivery against national and international benchmark standards and uses this information to improve practice/service.

(Kitsell, 2004)

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