

Background

1.1 History of clinical career paths in New South Wales

Despite the fact that nursing and midwifery have always been considered to be practice disciplines, the introduction of clear clinical career paths for nurses and midwives working at expert or senior clinical levels¹ is a relatively recent phenomenon, both in Australia and throughout the developed world². In the earlier part of the 20th century, careers for senior nurses and midwives were either in education or management and “career pathways in the past have not facilitated keeping nursing expertise and leadership at the clinical interface.”³ Given the increasing complexity of patient care and the rapid changes in health care therapeutics and technology, the need for expert nurses and midwives who are both clinically based and current is essential.

The need for an improved clinical career structure for nurses and the recognition of expert clinical nursing capability in nursing was agreed as relatively recently as the 1986 Ministerial Reference Case⁴. Two new classifications were inserted into the Public Health System Nurses’ (State) Award as a result of that decision. These were the Clinical Nurse Specialist (CNS) and the Clinical Nurse Consultant (CNC). The CNS category was designed “to cater for nurses who function as resource personnel and sources of expert nursing knowledge within their unit and specialty” whereas the CNC category was intended to “cater for specialist nurses who fulfil a cross-hospital or cross-area or regional role and who are principally involved in clinical consultancy, review, assessment and research.”⁵

The CNC category was further classified into three grades in 2000 as a result of *Circular 2000/1 Public*

Hospital Nurses’ (State) Award Clinical Nurse Consultant – Higher Grades. Five domains were identified, each of which contained a list of functions. These domains are: clinical service and consultancy, clinical leadership, research, education and clinical services planning and management. Different levels of function in each domain are then described for each grade. However, the Circular points out that “the domains/functions have been selected to differentiate between the grades of Clinical Nurse Consultant and are not intended to describe the whole range of functions undertaken by Clinical Nurse Consultants.”⁶

In recent years, as midwifery has come to be recognised as a distinct professional category in Australia, the term Clinical Midwifery Specialist (CMS) and Clinical Midwife Consultant (CMC) have also been adopted.

Another group of nurses and midwives who have gradually gained formal recognition in Australia are those who not only function at an advanced level of practice, but also accept accountability and authority for a range of tasks that were formerly the legislative or policy domain of medical practitioners. These tasks include prescribing medications, ordering and interpreting of diagnostic investigations in pathology and radiology and making referrals to other practitioners. In Australia, as in other countries in the world, nurses who are accountable and have authority for these roles are known as nurse practitioners (NPs). In the past two years there has also been the recognition of midwife practitioners (MPs) with the introduction of the Nurses Amendment Act 2003 (NSW), a piece of legislation which, inter alia, integrated midwives in a more generic way into the regulatory framework for nurses and midwives in NSW.

Nurse or Midwife Practitioners (N/MPs) are described as registered nurses (RN) or registered midwives (RM) who have “satisfied the requirements of the Nurses and Midwives Board of NSW (NMB) to be authorised.” Authorisation allows the NP or MP to initiate diagnostic investigations, to prescribe medications and to make lim-

1 Note that the term expert or senior clinical nursing/midwifery role has been used, rather than the traditional term “advanced practice”, unless making reference directly to the use of the term within the literature. The reason for this is that the term “advanced practice” has now become itself an Award classification in some countries and is used in NSW as a non-Award classification position title. Whilst it is probably the best description of the work senior clinical nurses do, it has not been used in this document unless in reference to the literature because of the potential for confusion with Award and non-Award nomenclature.

2 Senate Community Affairs References Committee, *The Patient Profession: Time for Action Report on the Inquiry into Nursing* Commonwealth of Australia 2002

3 J Daly, S Speedy and D Jackson, *Nursing Leadership Elsevier*, Sydney, 2004, p.174

4 Heard by the Public Hospital Nurses (State) Conciliation Committee and chaired by Senior Conciliation Commissioner Wells.

5 M Dickenson, *An Unsentimental Union*, Hale and Iremonger, Sydney, 1993, pp 257-258

6 NSW Health Department Circular 2000/1 *Public Hospital Nurses’ (State) Award Clinical Nurse Consultants – Higher Grades*, 2000, p.2

ited referrals provided they are working under approved clinical guidelines. They may also use the protected title of “Nurse Practitioner” or “Midwife Practitioner”. N/MPs work at an advanced practice level that demands: expert clinical knowledge, advanced specialised education and complex decision making skills⁷. Following a series of Steering Committees, Pilot Projects and reports during the 1990s⁸, legislation was passed in 1998 to enable the title of NP to be protected by law in NSW and to provide for a legal and policy framework in which they were able to practise (Nurses Amendment (Nurse Practitioners) Act 1998 (NSW)). A policy framework for the implementation of NP roles and a Steering Committee to oversee their implementation and evaluation were established under the NSW Health Department policy document Nurse Practitioners in NSW⁹. A number of those nurses and midwives who have applied for N/MNP status were formerly practising as CN/MCs, but in roles akin to those of N/MNPs. Following the introduction of N/MNPs into NSW, most other states and territories in Australia have passed legislation to introduce N/MNPs into the health workforce.¹⁰ There is now a strong global body of research evidence to support the safety and efficacy of advanced practice nursing and midwifery roles.¹¹ This review does not set out to replicate those findings. Rather, the purpose of the review is to determine how best to develop the senior clinical nursing/midwifery practice roles in the future to ensure: optimal utilisation of these highly qualified personnel in the delivery of evidence supported, expert patient care; maximum gain from their inclusion in the clinical health workforce; maximum job satisfaction for these well educated clinicians; and the provision of strong clinical career paths and thus optimal retention

of expert clinical nursing and midwifery personnel in the health workforce.

1.2 Rationale for review of expert clinical nursing roles

It is now 21 years since the initial introduction into NSW of CNSs and CNCs and 10 years since the establishment of the original NP policy framework. The Joint Strategic Reference Group for Nursing and Midwifery, a group of senior nurses and midwives established to advise the Chief Nursing Officer (CNO) in 2003, identified the need for a review of clinical career paths as one of four key priorities. As previously stated, a review of the implementation of N/MNP positions was foreshadowed as part of the 1998 framework for N/MNP implementation. Despite the relatively recent public support for N/MNPs in NSW by key leaders within the medical profession,¹² there is significant anecdotal evidence to suggest that N/MNPs continue to experience difficulties in implementing their roles. In addition, there were also anecdotal reports that CN/MCs in particular, whose roles are more geographically diverse, were experiencing a lack of role clarity. The then CNO, Adjunct Professor Kathy Baker, undertook to evaluate the professional and clinical aspects of CN/MC and N/MNP roles, with an understanding that an industrial review of the clinical career structure would be discussed secondary to the completed report of the evaluation. In 2005, the New South Wales Nurses Association (NSWNA) also petitioned for a Work Value Case to review the roles of CNS, Clinical Nurse Educator (CNE) and Nurse Educator (NE). This work is progressing simultaneously and with cognisance of the work of this N/MNP/CN/MC review.

1.3 Review Method

It was agreed that this review was to provide a broad understanding of the effectiveness of the types of roles CN/MCs and N/MNPs undertook and of the environments in which they practised, but was not to be an analysis of the effectiveness or safety of individual clinicians. Individual evaluation is the domain of line management and local performance review. However, there was a need to identify supports for and barriers to the successful implementation of the roles, and also to establish a clearer picture of how the roles functioned, and what overlap there was between these and other senior nursing and midwifery roles. It was agreed to use an exist-

7 Nursing and Midwifery Office (NaMO) 2005 The term “midwife practitioner” is not uniformly supported by midwives in Australia. The Australian College of Midwives Inc. (ACMI) has a position statement on the use of the term midwife practitioner which argues that all midwives should have access to prescribing rights and the ability to order investigations in order to fulfil their midwifery role completely. (ACMI website visited 5.2.06)

8 For an account of the process leading to N/MNP authorisation see A Adrian and J O’Connell, ‘The NSW Nurse Practitioner Project’ in D Picone and J Lumby *Clinical Challenges*. Allen and Unwin, Sydney (2000)

9 NSW Health, 1998

10 Gardner, G, Carryer, J, Dunn, SV & Gardner A. (2004). *Report to Australian Nursing Council. Nurse Practitioner Standards Project*. Canberra: Australian Nursing Council, 10 May 2004, Driscoll A W-CL, O’Reilly J & Stewart S. (2005). A historical review of the nurse practitioner role in Australia. *Clinical Excellence for Nurse Practitioners* 9(3): 141-152.

11 Chang E, Daly J, Hawkins A, McGirr J, Fielding K, Hemmings L, O’Donoghue A & Dennis M. (1999) An evaluation of the Nurse practitioner role in a major emergency department. *Journal of Advanced Nursing* 30 (1) 260-298; Mick DJ & Ackerman MH. (2002) Deconstructing the myth of the advanced practice blended role: support for role divergence. *Heart and Lung*; 31(6): 393-398; Fahey-Walsh J, (2004) *Literature Review Report: practice component. Advanced nursing practice and the primary health care nurse practitioner. Title, scope and role*. Canadian Nurse Practitioner Initiative: Ottawa; Hoffman LA, Happ MB, Scharfenberg C, Di Virgilio-Thomas D & Tasota FJ. (2004) Perceptions of physicians, nurses and respiratory therapists about the role of acute care Nurse Practitioners. *American Journal of Critical Care* 13 (6): 480-488; Jones L & Way D. *Literature review report: delivering primary health care to Canadians: nurse practitioners and physicians in collaboration: practice component*. Ottawa: Canadian Nurses Association, 2004; Perry C, Thurston M, Killey M & Miller J. (2005) The Nurse Practitioner in primary care: alleviating problems of access. *British Journal of Nursing* 14 (5): 255-259; Vazirani S, Hays RD, Shapiro MF & Cowan M. (2005) Effect of a multidisciplinary intervention on communication and collaboration among physicians and nurses. *American Journal of Critical Care*. 14 (1): 71-77.

12 NSW Health Department Media Release, *NSW AMA Out of Step with Leading Doctors* 5th September 2002.

ing validated questionnaire, as this would provide an opportunity both for replication and benchmarking. The Irish National Council for the Professional Development of Nursing and Midwifery (NCPDMM) had published a Review of the Effectiveness of the Role of the Clinical Nurse/Midwife Specialist in 2004¹³. This role, although differently named, is similar in status to the CN/MC role. Nomenclature for expert clinical nursing/midwifery roles is not consistent either within Australia¹⁴ or in the USA¹⁵, in England¹⁶ or in Canada¹⁷.

The NCPDMM questionnaire canvasses the demographics of the cohort, both personal and role related; their reporting structures, both clinical and professional, the bridges and barriers to the establishment of their roles; and the resources available to them in order to function in their roles. However, because the NSW study also wanted to review the relatively recently introduced N/MC roles, a number of additional questions were included relating to patterns of prescribing and ordering of investigations, geographical coverage of the role, and the impact of the new roles on access to services for patients. In addition, an open question (Q47) was added for any extra issues that respondents felt had not been covered within the questionnaire. Any data of significance that are common to both the NCPDMM and NSW will be compared within this report.

The quantitative data from this study were entered into Excel spreadsheets for numerical analysis. The qualitative data emerging from the open-ended Q47 were analysed and themed individually. These data are described within this report. These themes were then cross-checked for consistency¹⁸. A number of recurrent themes emerged from the qualitative data that complemented and further informed the quantitative data.

These were as follows:

- Descriptive comments regarding both CN/MC and N/MC roles
- Positive comments regarding both CN/MC and N/MC roles
- Competing elements of the CN/MC role
- Role ambiguity and confusion in both CN/MC and N/MC roles
- Presence and absence of support for both CN/MC and N/MC roles
- Funding issues for both CN/MC and N/MC roles
- Inconsistency of grading for CN/MC roles
- Clinical guidelines for N/MC roles
- Pharmaceutical Benefit Schedule (PBS)/Medicare Benefit Schedule (MBS) numbers for N/MC roles
- Suggestions for change and improvement.

The themes will be grouped and discussed as appropriate under relevant headings throughout the report. A review of the most recent literature on advanced practice nursing roles from 2000 onwards was also undertaken. In addition, a number of extensive literature reviews previously undertaken in Australian and overseas were used to inform the study.

13 National Council for the Professional Development of Nursing and Midwifery. (2004) *Review of the Effectiveness of the Role of the Clinical Nurse/Midwife Specialist National Council for the Professional Development of Nursing and Midwifery*. Dublin

14 Jamieson L & Williams LM. (2002). Confusion prevails in defining "advanced practice nursing". *Collegian*; 9(4): 29-33.

15 Mick & Ackerman, *op cit*. pp 393 - 398

16 Carnwell R & Daly WM. (2003) Advanced nursing practitioners in primary care settings: an exploration of the developing roles. *Journal of Clinical Nursing* 12: 630-642.

17 Jones & Way, *op cit*.

18 My thanks to Dr Roslyn Sorenson for this assistance.

Results

2.1 Distribution and sample size

1,279 questionnaires were sent out, covering all CN/MCs, all authorised N/MPs and all nurses working in N/MPT transitional positions¹⁹. Questionnaires were sent to 1,202 CN/MCs and 77 N/MPTs and transitional N/MPTs. The total response rate was 48.2% (n=617) being 49.2% of CN/MCs (n=584) and 42.9% of N/MPTs (n=33).

Table 2.1 Distribution and response rate by peer groupings

Peer Groups	Given out	Return	Response rate
A1a - Principal Referral Group A	431	170	39.4
A1b - Principal Referral Group B	117	59	50.4
A2 - Paediatric Specialist	66	37	56.1
A3 - Ungrouped Acute	36	18	50.0
B1 - Major Metropolitan	101	54	53.5
B2 - Major Non-Metropolitan	94	53	56.4
C1 - Hospital District Group 1	52	28	53.8
C2 - District Hospital Group 2	19	17	89.5
D1 - Community Acute	7	1	14.3
D2 - Community Non-Acute	92	71	77.2
F1 - Psychiatric	38	15	39.5
F2 - Nursing Homes	5	2	40.0
F5 - Hospices	10	3	30.0
F6 - Rehabilitation	21	14	66.7
F7 - Mothercraft	2		0.0
F8 - Ungrouped Non-Acute	21	9	42.9
Justice Health	37	16	43.2
N/MPT & transitional N/MPT group	77	33	42.9
Miscellaneous - Admin	9	2	22.2
Miscellaneous - Lab	8	2	25.0
Public Health	6	2	33.3
Unknown	30	11	36.7
Total	1279	617	48.2

¹⁹ A transitional position is one where a nurse or midwife working in a role akin to that of a N/MPT is nominated as a potential N/MPT whose task it is to develop both the role and the guidelines required to function as a N/MPT. During their time as a transitional N/MPT they are expected to obtain N/MPT authorisation.

Unfortunately, N/MPTs have reported experiencing “evaluation overload” due to the fact that many interested parties want to evaluate their roles and their work through questionnaires, focus groups and individual interviews, which may account for the lower response rate from N/MPTs. This is a good overall representation, as the recruiting cohort was the total group of CN/MCs and N/MPTs in NSW. There was fairly even overall representation across the peer grouped hospitals and health care facilities, as demonstrated in Table 2.1.

2.2 Demographics

2.2.1 Gender

Of the total response cohort who provided gender information, 82.9% (n=503) were female and 17.1% (n=104) were male. The percentage of males was higher in the N/MPT group (27.3%) than in the CN/MC (17.2%) group, but the smaller numbers in the N/MPT group impact the percentage score.

2.2.2 Location and areas of practice

The respondents worked over a wide range of settings, the majority (45.9%, n=283) working in hospitals, but still a significant number (22.7% n=140) working across hospital and community and a further 13.5% (n=83) identifying themselves as being community based. Other settings identified included psychiatry/mental health (5.3%, n=33), outpatients (4.4%, n=27) and hospice (0.3%, n=2). They also covered a wide range of areas of practice, as identified in Table 2.2. The categories of areas of practice were taken directly from the NCPDNM questionnaire and created some difficulty for respondents who felt they were not sufficiently specific to their specialties or work environments. It is indicative of the specific and locally developed nature of the CN/MC roles in NSW that, in the open-ended responses sought within Q47, there were 54 fairly lengthy responses where the CN/MCs provided enthusiastic and detailed descriptions of their roles and the work they undertook, both clinical and non-clinical. For example, from a non-clinical perspective:

My role is Area Nurse Coordinator/CNC3 for my specialty across [the] Area Health Service. It was established to have a strong clinical governance role for the other CNCs and nurses in the specialty, as well as strategic direction and coordinating education, policy and procedure development, clinical supervision. I find that my role provides great opportunity to support and provide leadership to the specialty nurses. It was graded CNC3 because it didn't fit a management definition but really is a mixture of CNC3/manager roles²⁰

and from a clinical perspective:

I work at the Drug Court of NSW. My multidisciplinary team consists of the legal profession and probation and parole. I do not see people in a clinical setting, but in a court setting. I refer and liaise with many rehabilitation services and area health services. My level of clinical expertise is viewed [as such] that I give the Drug Court 'expert advice'. I work with drug dependent offenders²¹

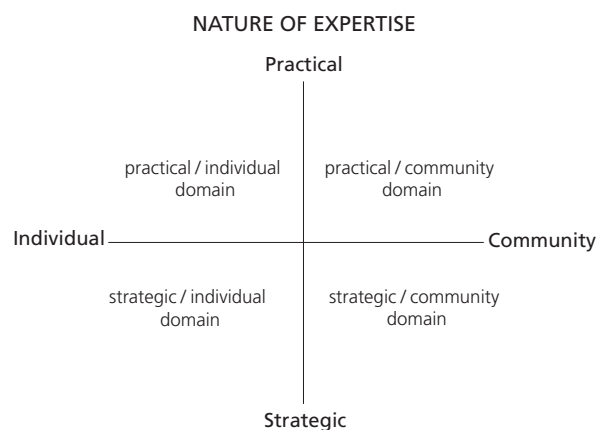
Table 2.2 Broad areas of practice

	Frequency	Percent
Medical	146	23.6
Mental Health	80	13.0
Critical Care-Emergency	74	12.0
Community Health	67	10.7
Mixed med-surgical	59	9.6
Surgical	54	8.8
Aged care	51	8.3
Family child health	37	6.0
Midwifery	25	4.1
Rehab-disability	15	2.4
Peri-operative specialty	7	1.1
Unknown	2	0.3
Total	617	100

Carnwell and Daly²² provide a helpful diagram for conceptualising the themes and domains of expert clinical nursing. Although in their study the domains are derived from primary care setting data, they also provide a means of conceptualising the broad range of roles undertaken by senior clinical nurses and midwives in NSW. They identify the two overarching themes of the advanced practice nursing role as being the nature of the roles and the focus of the roles. The nature of the expertise is set out along a practical to strategic continuum and the focus of the role is set out along an individual to community continuum. The combi-

nations of these continua create four domains of practice – practical/individual, practical/community, strategic/individual and strategic/community, as demonstrated in Figure 2.1. Most of the work of both CN/MCs and NMPs can be grouped under one of these four domains.

Figure 2.1 The nature and focus of advanced practice nurses and corresponding domains



Adapted from:
Camwell & Daly (2003) p640

Examples of the practical/individual domain were:

- a NP who described their work thus: "I work for a consultant psychiatrist who is only here two days a week, and [I] look after his patients on the three days per week when he is not here"²³ and a NP who worked in "community health with first contact in many cases for people who are acutely ill, be it something I can treat or refer to GP"²⁴
- A community example, which seemed closer to the practical than the strategic end of the nature of expertise, was found in the description by an infection control CNC, who said that the role "touches on all areas of nursing and has other jobs in it specially (sic) if it combined with staff health. Also, I cross between two hospitals (and) deal with all needle-stick injuries"²⁵
- An example of the strategic/individual domain was a "focus on improving the skills and knowledge of nurses and allied health professionals in recognising and providing appropriate D&A interventions"²⁶
- A strategic/community example was a CNC Women's health whose "role is to target women who are unable to or do not access preventative health screening services. Work with a larger CALD community"²⁷

23 NP 68

24 NP 66

25 CNC 101

26 CNC 316

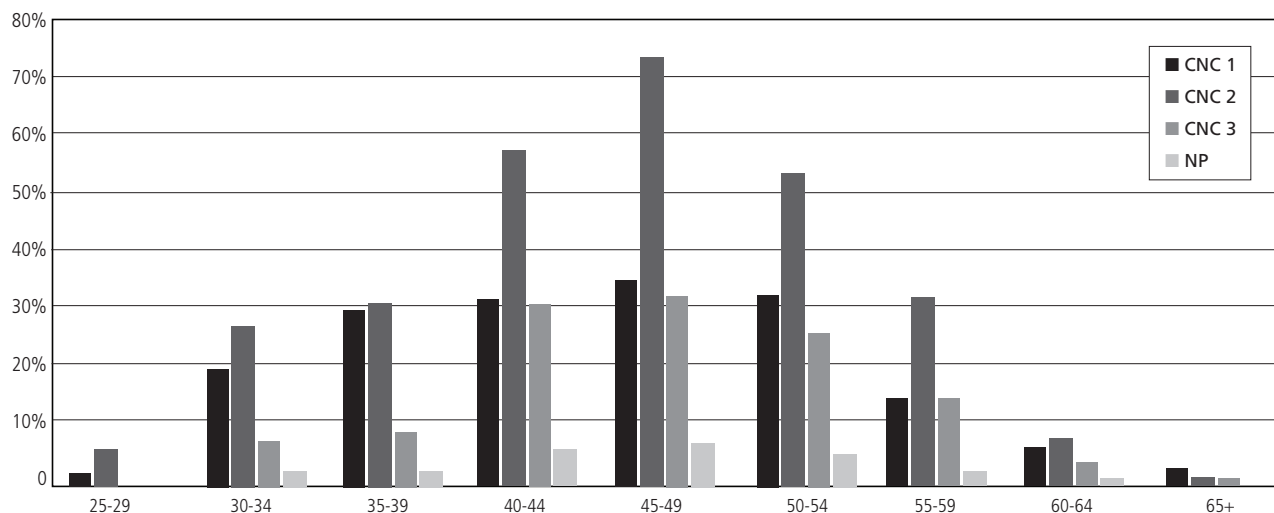
27 CNC 168

20 CNC 271

21 CNC 558

22 Carnwell and Daly, op cit

Figure 2.2 Age Group of Respondents



2.2.3 Age of respondents

In terms of the age groups of the respondents, there was a wide distribution, with seven of the CN/MCs aged between 25 and 29 and four CN/MCs aged over 65. The largest numbers in any one age group in all four categories (CN/MC1-3 and N/MP) were clustered in the 45 - 49 age group, and overall there were more CN/MCs in the younger age groups than N/MPs. It is to be expected that the N/MPs would be older than CN/MCs Grade 1, as to be authorised as a N/MP it is necessary to have 5,000 hours of advanced practice in the particular specialty for which authorisation as a N/MP is sought.²⁸

However, it is likely that many CN/MCs Grade 3 would be a similar age to N/MPs, as a number of them were the people encouraged to become the first N/MPs. The range of age groups for CN/MCs and N/MPs is set out in Figure 2.2. These data demonstrate that expert clinical nurses and midwives are slightly older overall than nurses and midwives in general when compared to the Australian Institute for Health and Welfare (AIHW) reported average age in 2003 of 43.1 years.²⁹

Given the advanced nature of the roles, this is to be expected. However, as more N/MPs are prepared through the Masters program route, the age may decrease slightly, although they will still be required to have 5,000 hours of experience in their specialty area at advanced practice level prior to authorisation.

28 New South Wales Nurses and Midwives Board (2005) *Advanced Practice Proforma*. http://www.nmb.nsw.gov.au/np_practice.pdf

29 Australian Institute for Health and Welfare. (2005) *National Health Labour Force Series No.31: Nursing and Midwifery Labour Force 2003*. AIHW: Canberra

2.2.4 Employment status and work patterns

In terms of employment status, Figure 2.3 demonstrates the majority of CN/MCs and N/MPs worked full-time, with few taking on job share or part-time work. Given the demographic of this group and the changing nature of work consideration of flexible options for employment such as part time and job share arrangements may be necessary in the future.

The range of work patterns set out in Figure 2.4 demonstrates the emerging use of N/MPs as part of the round-the-clock care delivery system. Whilst the majority of CN/MCs and N/MPs still worked Monday to Friday, with a small number in each group taking on-call duties, there were a growing number of N/MPs rostered on to evening and weekend duties. This is in keeping with the expectation that N/MPs predominantly are employed in an advanced direct clinical care delivery role, and as such will need to be available on a more comprehensive basis.

Figure 2.3 Full or part-time

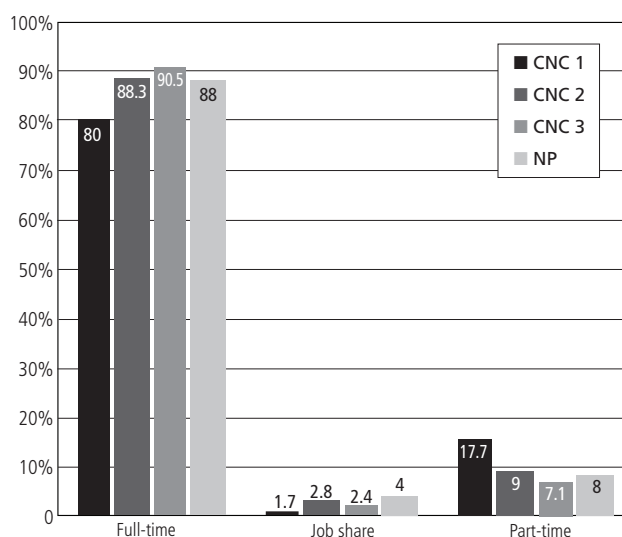
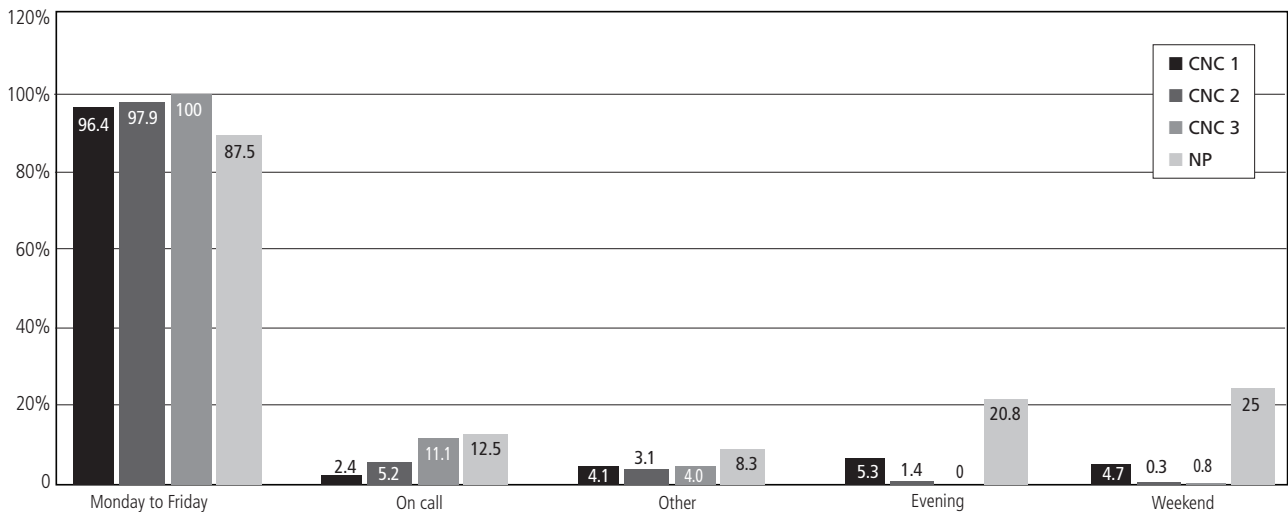


Figure 2.4 Work patterns



2.2.5 Post-graduate qualifications

This survey differentiates between post-graduate qualifications in the respondents' area of specialty practice and other post-graduate qualifications. This is necessary because there is significant variation in the types of qualifications nurses and midwives obtain at post-graduate level to further their careers. In particular higher academic clinical post-graduate qualifications (graduate diploma and above) have only recently become more readily available, with traditional academic post-graduate qualifications being in management or education.³⁰ In the past, graduate certificates and graduate diplomas were the most commonly available clinical specialist programs, with Masters programs being more common in management or education. This is changing, as can be seen in Figure 2.5, the introduction of the N/MP categories has seen that the majority of N/MPs have a Masters degree in their area of specialisation, with a small number of N/MPs and CN/MCs being prepared to doctoral level in their area of specialisation.

Currently in NSW there are two pathways for RNs and RMs to become authorised as a N/MP. Pathway 1 is for RNs or RMs who have completed a Nurses and Midwives Board approved Master's program leading to authorisation to practise as a N/MP. In order to qualify for authorisation via this pathway the applicant must:

- Identify the approved broad area and specialty area of practice in which they would like to be assessed

- Show evidence of current registration as a Nurse or Midwife
- Show evidence of 5,000 hours of advanced nursing or midwifery practice during the last six years appropriate to the specialty area
- Show evidence of successful completion of a Nurse Practitioner Master's degree approved by the NMB leading to authorisation as a Nurse Practitioner
- Complete the approved application form and application fee as determined by the NMB.

Pathway 2 is for RNs or RMs working at expert clinical nursing/midwifery levels that have NOT completed a specific NP Master's degree approved by the NMB. In order to qualify for authorisation under this pathway the applicant must:

- Show evidence of current registration as a Nurse or Midwife in NSW and 5,000 hours of advanced practice in the relevant specialty area within the last six years
- Prepare and submit a 'package of evidence' that includes a detailed curriculum vitae and case study that demonstrates the applicant has the knowledge and skills to practice nursing or midwifery at an advanced level within the nominated specialty area
- Complete the approved application form and an application fee, as determined by the NMB
- Attend a peer review interview to demonstrate advanced knowledge and skills in an identified specialty area of practice.³¹

³⁰ Australian Government Department of Education, Science and Training. (2002) *National Review of Nurse Education* AGPS: Canberra.

³¹ NSW Health NaMO, 2005 This information was obtained from the NaMO website (<http://www.health.nsw.gov.au/nursing/npract.html>) as the Nurses and Midwives Board information on NPs was under review at the time of writing this report

Figure 2.5 Proportions of respondents who have a relevant post-graduate qualification in their specialist area of practice

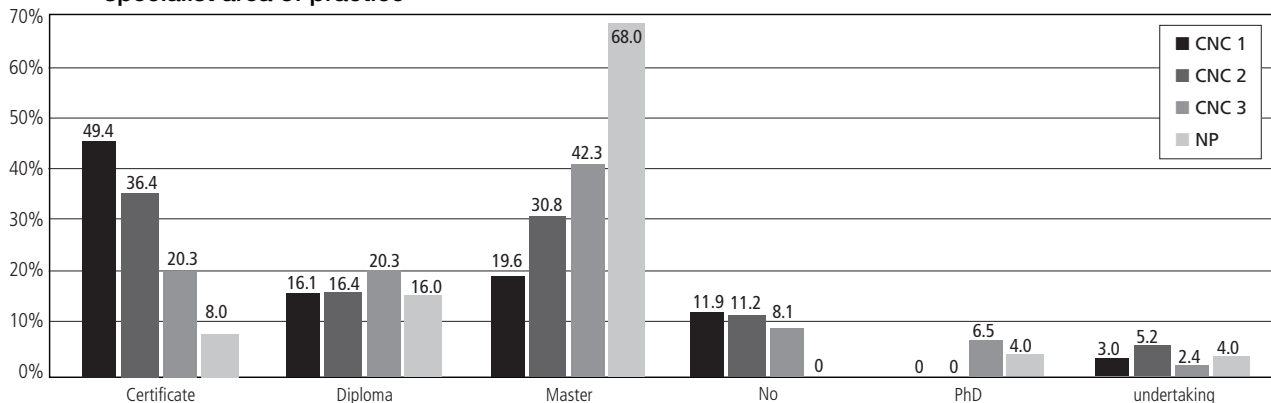
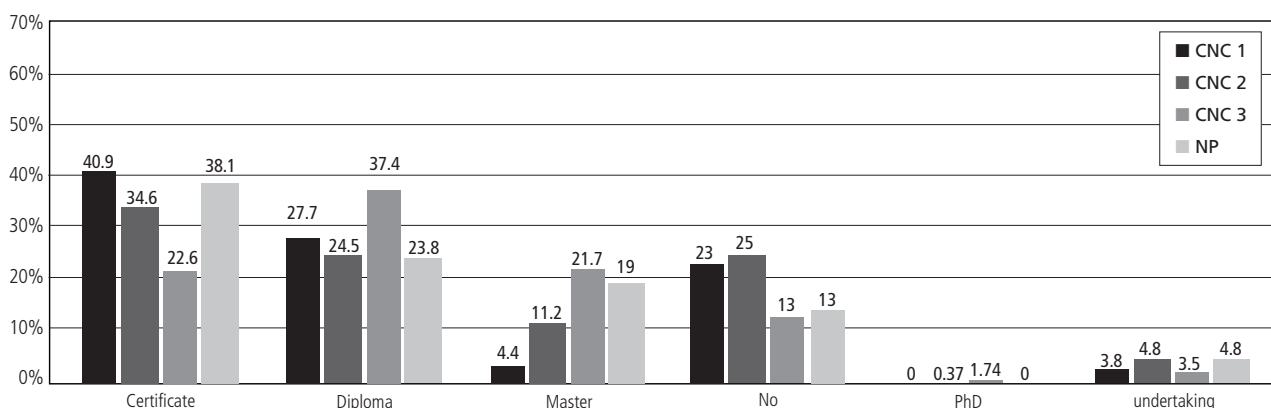


Figure 2.6 Proportions of respondents who have other post-graduate qualifications



Note also that, although a small number of CN/MCs in each category report having no formal qualifications in their area of specialty, this is not the case for N/MPs. Note also in Figure 2.6 the numbers of CN/MCs and N/MPs who have specialist qualifications that are not in their specialist area of practice.

This latter phenomenon is to some degree age-related as prior to undergraduate university education for nurses, many registered nurses traditionally undertook further study in midwifery although they may not have intended to work in that area. When the data for age and qualifications are cross-tabulated in Figures 2.7 and 2.8, it can be seen that the numbers of nurses aged between 30 to 49 who hold qualifications relevant to their clinical specialty is both higher in number and higher in the level of qualification than those than who do not have qualifications relating to their clinical specialty.

Notwithstanding these differences, this survey highlights the academic level of preparation of these senior clinical nurses and midwives, as over 50% of the respondents are Masters prepared and over 30% are Masters prepared in their clinical specialty. This is signif-

icantly greater than in the Irish study (<10%) and may reflect the fact that entry to registration in Australia is at baccalaureate level.

These results are indicative of a significant commitment to lifelong learning, a commitment that was identified as essential for the nursing and midwifery professions in the National Review of Nurse Education.³² However, they also confirm the ongoing need for tertiary institutions to provide strong academic clinical programs to ensure appropriate preparation for these senior clinical career paths.

There is much evidence in the literature that nurses who work in advanced practice roles derive significant satisfaction from their work, in particular from the impact they are able to have on quality care delivery.³³ Nurses have described nursing work in general, in particular

32 Australian Government Department of Education, Science and Training. 2002 *op cit*

33 Collins K, Jones, ML, McDonnell A, Read S, Jones R & Cameron A. (2000) Do new roles contribute to job satisfaction and retention of staff in nursing and professions allied to medicine? *Journal of Nursing Management*. 8: 3-12; Brown MA & Draye MA. (2003). Experience of pioneer nurse practitioners in establishing advance practice roles. *Journal of Nursing Scholarship*; 35(4):391-397; Jones & Way, 2004 *op cit*; Lloyd Jones M. (2005) Role development and effective practice in specialist and advance practice roles in acute hospital settings: systematic review and meta-analysis. *Journal of Advanced Nursing*. 49(2): 191-209.

Figure 2.7 Number of CNCs & NPs (of 600) who have relevant post-graduate qualifications

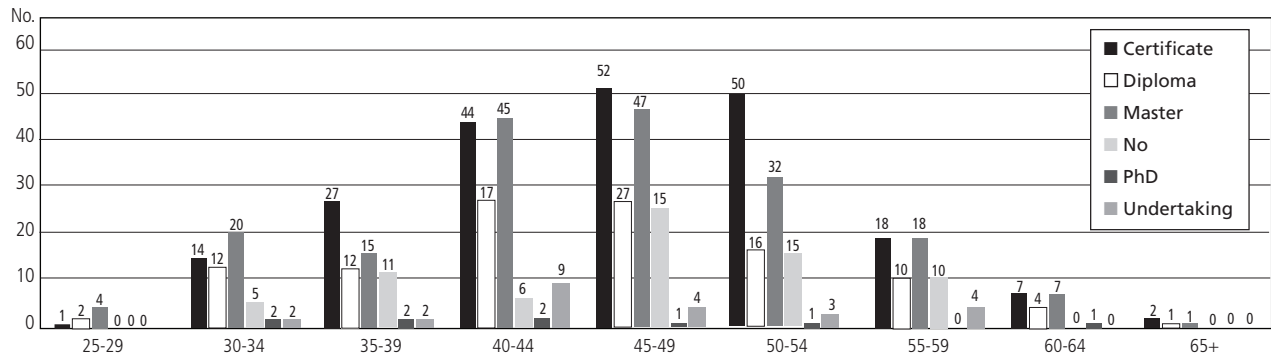
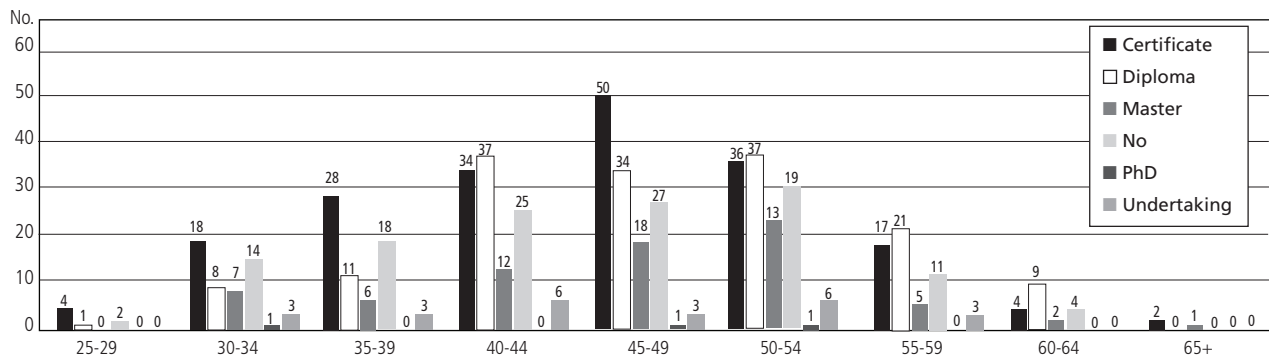


Figure 2.8 Number of CNCs & NPs (of 562) who have other post-graduate qualifications



their interactions with patients and their colleagues, as highly satisfying and rewarding, albeit often physically demanding.³⁴

Furthermore, whilst less experienced nurses focussed significantly on the mastery of increasingly technical clinical skills in their practice, and found these highly rewarding,³⁵ experienced and technically competent clinical nurses who had achieved mastery in these skills still continued to derive significant satisfaction from the caring, interpersonal aspects of their work.³⁶

34 Manion, J. (2003). Joy at work! creating a positive workplace. *Journal of Nursing Administration* 33(12):652-659.

35 Gustafsson, C., & Fagerberg, I., (2004). Reflection: the way to professional development? *Journal of Clinical Nursing* 13(3):271-280.

36 Dempsey, J. (2004). Falls prevention revisited: a call for a new approach. *Journal of Clinical Nursing* 13(4):479-485.

Job satisfaction

3.1 Enjoyment of the senior clinical nursing and midwifery roles

As with any significant change it was anticipated that the restructure of the health services in NSW would bring with it some level of anxiety and concern amongst those affected by the change and this concern was certainly mentioned in the Q47 responses, as was the concern about overlap of roles which will be discussed in detail in Section Four. It was also anticipated that the responses in the Q47 open comments would provide information about suggestions for improvement and comments on issues not addressed in other aspects of the questionnaire.

What was particularly positive was the significant number of open responses (n=32) that were statements relating to the pleasure expert clinical nurses and midwives derived from their role. There were a number of plain but positive comments such as “I love my CNC role,”³⁷ “the CNC is a fantastic role.”³⁸ Others spoke both about the variety of the role “I love my role as a CNC as I believe I get the best of all worlds – clinical, education, research,³⁹ their ability to combine all their expertise into the senior clinical role and the way in which it was an amalgam of their clinical experience “I feel that I can now bring together everything I have learned from hospital, nursing homes and the community over the past years – in relation to wound care.”⁴⁰

Several mentioned the support they received: from patients⁴¹; from the multidisciplinary team within which they worked⁴²; from their CNC networks⁴³ and from management, both nursing and non-nursing.⁴⁴

Still others described the positive impact they were able to have on their speciality areas such as aged care,⁴⁵

mental health in ED,⁴⁶ rural critical care,⁴⁷ infection control⁴⁸ and women’s health.⁴⁹

There was also pleasure in the recognition of the important role they played as part of the multidisciplinary health care team - “I feel I’m a valued member of the multidisciplinary team and am empowered in my role”⁵⁰ and their good fortune in having such enjoyable roles “I feel very privileged to have a wonderful job that I enjoy doing every day. I would like more nurses to be able to experience the level of job satisfaction I have.”⁵¹

One in particular summed up the sense of achievement that was evident from so many of the comments:

*Perhaps I am just in a fortunate position, but my experience in my role over the past 14 years has been very positive. I have been well supported by nursing colleagues at all levels and have been able to develop sound professional links with medical and allied health staff. I have taken opportunities to develop myself professionally & have been encouraged & supported by my DON. I feel it is important to maintain patient care as the centre of my role, after all that’s why we are here.*⁵²

In part due to the relative novelty of the N/MP roles, there were more caveats on the satisfaction levels of N/MPs, which were mainly due to operational frustrations such as MBS/PBS issues and clinical guidelines. These will be discussed later in Section 8 of the report. However, there were also positive comments about these new positions. Several related to the potential to improve patient care created by the new role. For example:

*I have attained the authority to practise as a nurse practitioner within NSW in high dependency nursing and I am presently using my knowledge and experience to promote improved care and service delivery to the heart failure population.*⁵³

37 CNC 40

38 CNC 167

39 CNC 491

40 CNC 514

41 CNCs 448,334,49

42 e.g. CNCs 543, 514, 44, 352, 249, 280, 79, 346

43 CNCs 256, 79, 6

44 CNCs 514, 44, 148, 79, 485, 590

45 CNC 44

46 CNC 53

47 CNC 256

48 CNC 349

49 CNC 456

50 CNC 44

51 CNC 361

52 CNC 79

53 NP 116

Other positive comments related to the recognition of the value of the role as colleagues came to understand and accept it more.

As my role is evolving I am finding more & more acceptance from other nurses as well as other health disciplines. I am pleased that my medical colleagues are looking at introducing the NP role into more areas.⁵⁴

The level of enthusiasm for these senior clinical nursing and midwifery roles provides further support for the research findings on nurse retention and job satisfaction, which indicate that nurses and midwives derive significant satisfaction from expert clinical nursing and midwifery work.

Furthermore, the literature demonstrates that strong, advanced clinical career paths and the ability for nurses and midwives to continue to deliver patient care in more senior roles assists with the retention of expert nurses and midwives in the health system through improved job satisfaction.⁵⁵

Senior clinical career paths have clearly been highly successful in NSW, with two respondents mentioning that they had held their posts for 14 years⁵⁶ and many others expressing enthusiasm for and commitment to clinical nursing and midwifery career pathways. The recognition of the contribution these roles have, in particular to the retention of nursing and midwifery staff, is immeasurable.

3.2 Sense of achievement through improved services

In order to obtain information on whether or not the services provided by senior clinical nurses and midwives impacted positively on their client groups, a number of Likert scale questions were added to the NCPDMM questionnaire. These questions (Q35-46) made a number of positive and negative statements predominantly around timely access to services and patient education. Whilst the responses are based on the respondents' perceptions only, they provide some insight into whether and how the senior clinical nurses and midwives considered that their roles impacted on patient care delivery. The respondents identified positive views on their impact on access to services and patient information and education, some of which are set out below in Table 3.1.

Table 3.1 Perceptions of improved services through the introduction of the advanced practice role

Question stem: Since my role has been established, patients...				
Question	CN/MC1	CN/MC2	CN/MC3	N/MP
35) ...have improved access to health care	75.7% agree/ strongly agree	80.1% agree/ strongly agree	70.2% agree/ strongly agree	91.7% agree/ strongly agree
36) ...have further to travel	69.7% disagree/ strongly disagree	87.6% disagree/ strongly disagree	83.6% disagree/ strongly disagree	95.6% disagree/ strongly disagree
40) ...receive more primary health prevention education and advice	75.7% agree/ strongly agree	80.1% agree/ strongly agree	78.8% agree/ strongly agree	82.6% agree/ strongly agree
42) ...are better informed about their condition	81.5% agree/ strongly agree	82.65% agree/ strongly agree	79.5% agree/ strongly agree	69.5% agree/ strongly agree

⁵⁴ NP 96

⁵⁵ Easom, AK. (2000) Nephrology APNs: who are we and what do we do? Survey results October 1999. *Nephrology Nursing Journal* 27(2): 187; Kleinpell, RM. (2005) Acute Care Nurse Practitioner practice: results of a 5-year longitudinal study. *American Journal of Critical Care* 14 (3): 211-221

⁵⁶ CNCs 464, 79