Chapter 1
Introduction

Advanced nursing practice: a growing presence

Halfan Mahler during his term as Director General of the World Health Organization (WHO) declared to the WHO Executive Board:

> *If the millions of nurses in a thousand places articulate the same ideas and convictions about primary heath care, and come together as one force, then they could act as a powerhouse for change (WHO, 1985).*

These words continue to resonate today for nurses around the globe as they harness their experience, energy, knowledge and commitment to improve the quality of care through adapting and expanding practice. For instance, we learn that in many of the island countries in the Western Pacific:

> *nurses diagnose, and treat patients on a regular basis; dispense medication; provide all maternal and child health care including deliveries; provide some dental care, perform minor surgical procedures, keep statistics (in Fiji nurses even do the census); and provide community outreach services (Abou Youssef* et al., *1997, p. 9).*

During the 1990s, the International Council of Nurses (ICN) monitored the growing presence of advanced nursing practice roles as countries reformed health systems, and sought innovative health care options in efforts to keep up with demands, trends and economic constraints. There appeared to be a better acceptance of new nursing roles and practice models, which included initiatives such as nurse prescribing of medications and treatments; diagnosis and ordering of laboratory tests; and referral and admitting rights.

Schober (2002) identified a number of other factors contributing to a greater demand for an expanded scope for nurses. These included overcoming access barriers to primary health care (PHC); rising demands for specialised nursing services; the growth in home health care nursing where more clients needed complex care; the desire for professional advancement; and escalating disease rates worldwide.

The New Zealand Ministry of Health (NZMOH), recognising the existence of increasing numbers of highly educated nurses with advanced clinical and leadership competencies, believed this untapped potential could be released for greater use in health care if nurses are facilitated to:

- Use their knowledge and skills more effectively
- Pioneer innovative services provision
- Enhance the access to, and quality of, primary health care
- Contribute positively to health gain (NZMOH, 2002, p. 4).

As more evidence emerges suggesting that optimising the nursing contribution to health care through expanding their role is an effective strategy for improving health services (WHO-EMRO, 2001; WHO, 2002; NZMOH, 2002; Buchan & Calman, 2004), authorities are more prepared to seek solutions that include this option. Mounting costs, limited fiscal resources, increasing health challenges, and rising public expectations for health care have encouraged governments to accept that adequate coverage and access to the health services are more important than who provides them. In 2002 WHO commented:

> *Shortages in many countries of health care professionals mean that new approaches to organizing teams of staff are required; traditional role boundaries may be a hindrance. Skills that have been the province of physicians may become common practice for nurses, while some nursing roles may be taken over by health care assistants (WHO, 2002).*

Also, as Schober & McKay (2004) point out, recent models of practice tend to be more collaborative when there is 'mutual recognition of discrete and shared competencies and respect for the interests and roles and responsibilities of all participants' (p. 8). The trend to partnership and collaboration in practice is compatible with the scopes of practice in the new roles nurses are beginning to carve out.

Advanced nursing practice: patterns of development

This section gives an overview of what the authors have uncovered about the existence of advanced nursing practice or similar type roles around the world. The authors, aware that there are developments going on this area that are not documented or not accessible for various reasons, have drawn heavily on the information provided by the key informants who have been generous and patient with explaining how advanced nursing is evolving in their situation.

In a fluid international context deciding what constitutes advanced practice is not easy, especially as international understanding of the role differs and consensus on title does not exist. Therefore, for the purposes of charting the presence of advanced nursing practice in this chapter, the authors have included what is reported and considered by the key informants to fall under the broad category of advanced practice as they understand it.

The expanded role of the nurse is not a modern phenomenon. Keeling and Bigbee (2005) trace the roots of advanced nursing practice in the USA to the 19th century. The term specialist began to be employed in the early years of the twentieth century as more postgraduate courses in specific areas of practice became available. Nurse anaesthetists, nurse midwives and psychiatric clinical nurse specialists (CNS) led the way, but the growth of hospitals in the 1940s and the development of medical specialties and technologies stimulated the evolution of CNS. These nurses were judged to practise at a higher level of specialisation than that already present in nursing (Schober, 2005), and are the precursors of the modern CNS. In the 1960s, nurse practitioners (NP) were created in the USA to provide primary health care services to populations with unmet needs, and promote community-based continuity of care. As this group began to push the boundaries of nursing practice even further, they faced greater challenges from other groups, especially physicians who considered NPs to be encroaching on their domain of practice.

Advanced practice nurse (APN), an umbrella term coined in the USA to cover the types of nurses working in diverse advanced roles, is defined by the American Nurses Association as 'a registered nurse (RN) who has met advanced educational and clinical practice requirements beyond the 2–4 years of basic nursing education required of all RNs' (ANA, 1993). By 1993, the ANA estimated there were about 140 000 APNs, which in the USA context included clinical nurse specialists (CNS), nurse practitioners (NP), nurse anaesthetists (NA) and nurse midwives (NM).

Nurse midwives and nurse anaesthetists began to appear in Korea in the 1950s. By the 1980s they were joined by community health nurse practitioners (CHNP) carrying a wide range of responsibilities (Kim, 2003; Schober & Affara, 2001). This latter category, created to serve isolated rural areas and fishing villages, was recognised through legislation after sustained political action by nurses. Nurses were able to support their proposals with data documenting that nurses, in contrast to other health professions, were more successful in providing efficient services to these populations (Cho & Kashka, 2004). Later, home care nursing was added to the advanced practice categories, and in 2000 the title was legally changed from *special field nurse* to *advanced practice nurse*. Now ten types of APNs are recognised through certification (Kim, 2003).

In Japan the first master of nursing programme aimed to prepare nurse researchers, but as medicine diversified and specialised it became clear that nursing had to develop practice to fit this development. The first CNS graduate programme was in psychiatric and mental health nursing and graduated its first students in 1986 (key informant, personal communication). Certification came later when the Japanese Nurses' Association (JNA), in partnership with the Japanese Association for Nursing Programmes in University (JANPU), initiated a postgraduate course in 1994 for certified nurse specialists. In addition to completing a masters degree in nursing-related studies and earning a specified number of credits in an area of specialisation as defined by the JANPU, to become a CNS a nurse must be certified by JNA (ICN Credentialing Forum, 2004a). By

2005, Japan had 139 practising CNS. Initially certification was available in psychiatric and mental health and oncology, but it now can be obtained in community, critical care, geriatric, paediatric, maternal and chronic adult nursing. The functions of the CNS lie in practice, consultation, coordination, ethical coordination, education and research (key informant, personal communication).

Another JNA initiative was to create the certified expert nurse (CEN) in 1966, a non-university-based qualification obtained after taking a JNA accredited programme. (ICN Credentialing Forum, 2002; JNA News 2002). There were over 1 741 CENs by 2005, practising in 17 areas such as emergency nursing, wound /ostomy/continence care, critical care, hospice, cancer and chemotherapy, diabetes, infection control, and infertility nursing.

Since 2003 the JNA certification scheme has been evaluated, and has demonstrated that the posting of CNS in emergency and oncology settings is valued, and has a positive influence on health care costs. However, there has been a reluctance to recognise the special contribution of CNS through giving appropriate reimbursement, and there was a tendency to compensate them through promotion to a head nurse position. In a breakthrough in 2005, a special allowance is now being paid to all CNS and CENs working in national hospitals (ICN Credentialing Forum, 2005b).

Taiwan employed the first CNS in cardiac surgery in 1994. While CNS quickly spread to other areas, legislation recognising the role in the health system was to come later in 2000 (Chen, 2005). However, standards of education, scope of practice, and credentialing processes remained undefined until 2004 when agreement on scope of practice, regulations for education, and credentialing processes was reached. In addition, the Department of Health has established an NP advisory committee to oversee national development of this role (Chao, 2005).

The Hospital Authority of Hong Kong introduced the nurse specialist post in 1994 hoping that it would motivate nurses to remain in clinical practice. The implementation of the role without regulatory oversights resulted in an uneven development of the clinical, education and research components, with research being the aspect given the lowest priority (Chang & Wong, 2001). The development of the APN in Hong Kong is related to the move of basic nursing education to the tertiary education setting, and efforts by the Hong Kong Hospital Authority to introduce a new grading structure designed to improve the clinical focus of nurses (key informant, personal communication). The role is slowly evolving as Hong Kong begins to integrate its first graduates from masters programmes (Loke & Wong, 2005).

In the same region, Singapore signalled its intent to embark on the advanced practice route by launching a masters degree in nursing in 2003. The advanced practice role has been legitimised by amending the Nurses and Midwives Bill in 2005, and removing the *nurse specialist* as a category recognised in the Bill, and introducing the *advanced practice nurse.* The Bill also provides for an expanded role and defines required educational qualifications. Annual renewal of the APN practice certificate and continuing education will be conditions for practice (Singapore Ministry of Health, 2005).

While nurse anaesthetists were recognised in 1988, it took a further ten years to have the advanced practice role accepted more generally within the Thai health system. As academic nursing is well established, Thailand is well placed to provide a masters education for this role. The Thai Nursing Council conducted the first certification examination for advanced practice nurses in 2004 (key informant, personal communication).

Advanced nursing practice roles are beginning to emerge in certain countries in Europe, shaped as in other parts of the world by the contexts in which they operate. In the United Kingdom nurses described as demonstrating a *higher-level practice* (United Kingdom Central Council [UKCC], 1999) have moved into settings ranging from general practice and ambulatory care to the chronic and acute care specialties (Royal College of Nursing, [RCN], 2002 revised 2005). White (2001) writes that the emergence of the NP is an acknowledgment of the inadequacy of past medically dominated approaches to health care, and a reaction to the physician shortage in primary care. The United Kingdom has not found it easy to agree on a concept of advanced practice resulting in confusion over scope, titles and education for the role (Woods, 2000; Castledine, 2003).

In 1995, the UK's regulatory body established a standard for what it calls *specialist practice.* However after a recent consultation, the Nursing and Midwifery Council (NMC) recognised that with role expansion and the growing number of NPs and consultant nurses

> *a significant amount of health care is provided by nurses practising independently, managing case loads of patients and clients in a variety of hospital and community settings . . . There has been common agreement that the standards for the level of specialist practice are no longer robust enough to prepare practitioners for these new roles (NMC, 2005, p. 7).*

The consultation indicated there is widespread support for advanced practice regulation with preference for the title *advanced nurse practitioner*. The NMC proposes legal recognition of nurses practising beyond specialist practice (NMC, 2005).

Lorensen *et al.* (1998) describe the emergence in Nordic countries of a role similar to the CNS in the USA as hospitals employed nurses with graduate education to promote research and develop expert clinical roles. Most CNS have developed in fields associated with medical problems such as diabetes, hypertension and psychiatric disorders. Iceland traces the development of CNS to the return of nurses from the USA with masters qualifications. At first Icelandic hospitals were not ready to accept APNs, but universities welcomed them as faculty. Once the government agreed to license nurse specialists in 2003, hospitals became more willing to employ nurses in specialist posts (key informant, personal communication).

The NP type role has been slower to emerge in Nordic countries probably because the supply of physicians was adequate (Lorensen *et al.*, 1998). However, Sweden is now exploring the use of NPs as a strategy to improve access to primary health care (key informant, personal communication), and in providing

care to the elderly in the community (Danielson, 2003). Educational programmes have been established for these two areas. The primary health care authorities in Skaraborg worked with the University of Skovde to develop a model and educational programme that met the requirements of the National Board of Health and Welfare and community primary health care needs as well as preparation as an APN. The first students were enrolled in 2003. The challenge has been to introduce a new role and function that fits the Swedish health system and is acceptable to all stake holders (key informant, personal communication). In doing so they have been able to negotiate the following definition:

> *An Advanced Nurse Practitioner in Primary Health Care is a registered Nurse with special education as a district nurse with the right to prescribe certain drugs, and with a post graduate education that enables [the advanced nurse practitioner] an increased and deepened competence to be independently responsible for medical decisions, diagnosing, prescribing of drugs and treatment of health problems within a certain area of health care (key informant, 2005).*

Currently the Danish Nurses Organisation (DNO) is seeking national approval for a definition for specialty and advanced nursing practice. However, educational programmes that have the potential to prepare nurses for advanced practice are in place. Aarhus University offers masters courses in nursing science and clinical nursing and access to PhD degrees in nursing. Post-registration specialty education is offered by Danish centres of higher education. These programmes are regulated by the National Board of Health and developed in collaboration with the Board of Nurses' specialty and higher education (ICN Credentialing Forum, 2005a).

The advanced nursing practice role was implemented in hospitals in the Netherlands in 1997 as an answer to a shortage of physicians. Its introduction was opportune as the government was seeking to tackle some of the structural health system difficulties by introducing a readjustment of the scopes of practice of doctors and nurses. Nurse practitioners first appeared in a large hospital where dynamic nursing leadership and supportive management policies allowed for the creation of posts and access to education opportunities (key informants, personal communication).

Advanced nursing practice is a recent development in Switzerland and is being led by the Institute of Nursing Science (INS) at the University of Basel, the first institute in Switzerland affiliated to a university. The INS invested in advanced nursing practice through its masters degree in nursing science, their research programmes, and clinical field development activities (key informant, personal communication). The effort to introduce advanced nursing flies in the face of cost containment measures that favour the introduction of more less-educated nurses into the health workforce in Switzerland. Thus, the impetus to create APN posts is not policy driven, but comes from far-sighted nurse leaders in hospital settings in some cases, and physicians interested in working with nurses with higher level clinical skills in others. Recently there has been more attention on expanded roles for nurses as 'physician assistants'. This seems to be concerned not

with strengthening nursing, but to cope with an anticipated physician shortage in primary care (key informant, personal communication). Examining how to expand the role of nurses and other paramedicals to cope with future physician shortages concords with what was described in the Netherlands and fits with recent developments in France.

The pioneers of advanced nursing in Switzerland have expended a great deal of effort in marketing the APN role to all interested parties, including nurses. There is growing acceptance of APNs but this is being done in the absence of a legal, policy and reimbursement framework.

In France, the first signs of interest in advanced nursing practice are beginning to surface. Although French nurses did acquire more autonomy in 1978, they still cannot be a point of entry into the health system. Private practice nurses (*infirmières libérales*) are unable to act without a medical order in delivering professional nursing care. To be reimbursed by the social security, the nursing assessment is prescribed by a physician, and the written care plan must be approved by the social security expert physician. However recently health authorities, realising that the present configuration of the health care workforce will be inadequate to respond to health care demand especially of an ageing population, has started to consider other alternatives, including the creation of APNs. ANFIIDE, the French nurses association, capitalising on this situation, has conducted a public information campaign on the advanced practice option which targeted nurses, authorities and the public (C. Debout, personal communication).

With the passage of the Royal Decree of Nursing Specialties in 2005 in Spain, the General Council of Nursing, which functions both as a regulatory and professional organisation, is developing a certification process for nurse specialists. This is a natural outcome of the 2003 legal framework for health professionals which gave access to professional advancement through a process of continuing education and the progressive development of more advanced competencies. However, it is yet unclear how far these emerging roles will demonstrate the key characteristics of advanced nursing practice (ICN Credentialing Forum, 2005c).

While in remote regions of Australia registered nurses with extended role functions have operated without legal or formal recognition for several decades, the first legally recognised NPs were registered in 2001. Multiple initiatives have been launched over the past few years to explore the use of NPs in different settings (Turner & Keyzer, 2002; Victoria Government of Department of Human Services, 2000; key informants, personal communication). This development was underpinned by efforts on the part of regulators (Gardner *et al.*, 2004) and professional organisations (National Nursing Organizations of Australia [NNOA], 2003) to reach national consensus on definition, scope, education and regulation and deal with inconsistencies and confusion that have followed the state-by-state approach adopted by their federated system (Jamieson & Williams, 2002).

In New Zealand the shift to population-based and PHC services combined with a realisation by the government that nurses do have unexploited potential to provide a greater range of services, ignited interest in introducing NPs into

the health workforce (New Zealand Nurses Organization [NZNO], 2000; Nursing Council of New Zealand [NCNZ], 2002; 2004; NZMOH, 2002; key informants, personal communication). As a result legislation and regulatory mechanisms are now in place recognising the NP. Additionally, as Australia and New Zealand are bound by the Trans-Tasman Mutual Recognition Agreement, the two countries have proposed a common set of NP standards and competencies (Gardner *et al.*, 2004).

For over four decades in remote areas, Canada has used registered nurses with advanced preparation to provide a range of health care services including primary care functions normally limited to general or family physicians (Centre for Nursing Studies, 2001; Nurse Practitioner Association of Ontario [NPOA], 2005; key informants, personal communication). The advanced practice role in acute care similar to the CNS was initially introduced in the 1970s and by the late 1980s Canada was also preparing advanced practice nurses to a masters level for acute care practice under different titles (key informants, personal communication). The CNS role in Canada was developed to:

> *enhance or improve nursing care by bringing expert practice to direct patient care at the bedside, expert indirect care to other nurses through role modelling and consultation, and to provide an avenue for those nurses who wished to advance, but remain at the bedside (Fahey-Walsh, 2004, p. 13).*

To overcome a physician shortage in rural and remote areas, the primary health care NP (PHCNP) was introduced in the early 1970s but by the mid 1980s the NP movement came to a halt. A variety of factors, including a greater availability of doctors, no legislative framework or recognition in the career structure and poor public awareness led to fall off in NP development and a discontinuation of the educational programmes until the 1990s (NPAO, 2005).

To complicate the Canadian scene a category of acute care NP (ACNP) has grown alongside the CNS. They are employed largely in acute care facilities to deal with complex health problems requiring more in-depth knowledge of nursing and of specific diseases. While currently educational preparation of PHCNPs varies from a registered nurse diploma with additional education and experience to graduate preparation, the vast majority of ACNPs are educated at the graduate level (Fahey-Walsh, 2004).

Now there is renewed interest in Canada in NPs as cost-effective health care providers, especially in PHC, but each province and territory has pursued different approaches to education, licensure and scope of practice. Over recent years several initiatives have been undertaken to facilitate the emergence of a national approach to advanced nursing practice. In 2002, the Canadian Nurses Association (CNA) developed a national framework for advanced nursing identifying the key elements in the areas related to assumptions, definition and characteristics, competencies, educational preparation, domains of practice, roles and regulation. This was followed by a national dialogue with key stakeholders due to conclude in late 2005. Currently, the government is funding a multiple stakeholder NP initiative to create a pan-Canada framework for facilitating the

introduction and permanent integration of NPs into the Canadian health system (CNPI, 2005).

The WHO Eastern Mediterranean Regional Office (WHO-EMRO), aware that advanced nursing practice and nurse prescribing were growing issues in the region, consulted all countries in the region on both issues (WHO-EMRO, 2001). A patchy picture emerges where nurses with advanced practice qualifications, usually obtained from abroad, are constrained by lack of legal, professional and institutional recognition. While nurses may be carrying out advanced tasks, the full expression of the advanced practice role is rarely demonstrated or officially permitted. However, in Iran the Ministry of Health has approved an expansion of nurses' functions in different community settings, and plans are in place to regulate advanced practice (WHO-EMRO, 2001). While Jordan has prepared nurses to the master's level since 1986, there is no official recognition of the advanced practice role. However, in the current strategic plan of the Jordanian Nursing Council (2004), the improvement of education and establishment of regulation for the role are included. Finally, in this region advanced nursing practice is beginning to emerge in the health facilities of the Aga Khan University in Pakistan, mostly as a result of the conditions created by the launching of a masters degree in nursing in 2001 by the School of Nursing, though on the whole there is little understanding of the APN role in the country (key informant, personal communication).

Botswana, in the 1970s, created the family nurse practitioner (FNP) to work in the PHC sector, an important health sector as 70% of the population living in rural areas depend on community-based services for care (Seitio, 2000). Functions undertaken by FNPs include taking a full history, conducting physical examinations, diagnosing, prescribing, ordering diagnostic tests, and acting as resources for other nursing personnel. Emphasis is placed on assessment, diagnosis, management of common diseases, disease prevention and health promotion. While Swaziland had an NP programme which produced 102 NPs, the programme was discontinued and the NP role is not recognised within the system (M.D. Mathunjwa, personal communication). Plans are under way to reintroduce the programme as a postgraduate diploma for nurses who have a Bachelor of Science in Nursing (BSN) degree.

Munjanja *et al.* (2005) do report the emergence of clinically focused master's degrees in Botswana, Nigeria, South Africa, Zambia and Zimbabwe, but there is little available documentation that this has translated into developing an acknowledged advanced nursing practice role in the African region. For instance, the ICN Family Nurse Project found nurses in South Africa undertaking elements of the advanced practice role in primary health care (Schober & Affara, 2001) in the South African health system, but Radebe (2000) noted that they are ill prepared to do so. It is possible that current work to articulate a Charter of Practice by the South African Nursing Council (2004) will stimulate interest in providing a distinctive professional and regulatory framework for APNs in South Africa.

In the Caribbean region, Jamaica is in the process of enacting legislation to register NPs. Delays to the passage of the Act are related to difficulties in

deciding what type of structure to set up for administering advanced practice credentialing within the Nursing Council (ICN Credentialing Forum, 2004b). While the Pan-American Health Organization (1999) reports that well-established nursing specialisation programmes exist in certain Latin American countries (Colombia, Chile, Ecuador, Mexico, Panama and Venezuela), at present there is little information to judge if developments in these specialties are driving the emergence of a distinct advanced practice role. Ketefian *et al.* (2001), referring specifically to Brazil, believe that factors such as the need to expand nursing to meet basic health needs, the shortage of nurses and the high ratio of physicians to nurses have contributed to inhibiting progress in the advancement of nursing.

Nurse anaesthetists have been organised internationally since 1989 when 11 national associations formed the International Federation of Nurse Anaesthetists (IFNA). Currently associations from 32 countries are members, representing 40 000 nurse anaesthetists from Africa, Asia, the Caribbean, Europe and North America. IFNA has established international standards for education and practice and a code of ethics, and is an affiliated member of ICN (IFNA, 2004).

After this tour around the globe in search of advanced nursing practice in all its different manifestations and stages of development, the next section discusses the findings of an ICN survey, and subsequent actions of the ICN to create a mechanism where all the disparate strands of advanced nursing practice come together to discuss, share and develop an international consensus around the core area of the APN role.

Advanced nursing practice: a global picture

In 2000, ICN conducted a preliminary survey of nurse practitioner/advanced practice roles. At that time, ICN while being aware that the advanced practice role was well established in the United States, and increasingly in Australia, Canada, New Zealand and the UK, knew little about developments in the rest of the world. ICN surveyed its membership of 120 national nurses' associations (NNA) and invited those attending the advanced practice session at the ICN International Conference in London in 1999 and the International Nurse Practitioner Conference in the following year to respond (ICN, 2001). Survey results were ready for the launching of the ICN International Nurse Practitioner/Advanced Practice Nursing Network (INP/APNN) at the 8th International Conference of Nurse Practitioners in San Diego in 2000. The network was set up as an international forum where nurse practitioners and advanced practice nurses could share educational, practice, research and regulatory developments.

Questions covered the nature of the presence of an advanced practice role in their country, characteristics, educational preparation, practice rights and the country's regulatory oversight processes. One hundred and nine surveys were returned from 40 countries.

The picture gleaned from the responses was one of a heightened interest in the advanced nursing practice role, but with a lot of uncertainties, ambiguities

and gaps. Thirty-three (83%) of the 40 countries reported that, while there is a nursing role requiring education beyond that of a licensed or registered nurse in the country, the level of education for these roles was varied. In 30 (69%) countries formal educational programmes preparing individuals for advanced nursing roles existed, but in only 26 (65%) did the education lead to a recognised qualification such as a degree, diploma or certificate. While 31 (78%) of the countries have some kind of accreditation or approval process in place for the educational programme, accrediting or approval agencies were very different in nature ranging from national nursing boards or councils, departments or ministries of health or education to federations of nursing schools, universities, private accrediting bodies and local government. Thirteen (33%) countries had legislation or some other type of regulatory mechanism for nurse practitioners/advanced practice.

The situation was less certain when it came to the titles in use. Fifteen (36%) of the countries reported having a specific title for advanced roles, some countries had more than one title in use. While nurse practitioner, clinical nurse specialist and nurse specialist were mentioned, a variety of other names were given to this role. Chapter two explores this point further.

Variability was more pronounced when it came to role characteristics. A relatively high number identified that nurses working in the advanced role were involved in planning, implementing and evaluating programmes (73%), provided consultant services to health providers (70%), had research functions (68%), were recognised as one of the first point contacts for clients (68%), and had the authority to refer clients to other professionals (60%). However, claimed role characteristics fell significantly when it involved areas likely to conflict with the traditional role of other health care providers such as having autonomy and independence in practice (55%), the authority to prescribe treatments (38%), the right to diagnose (35%), and the authority to prescribe medicines (25%).

Since ICN started monitoring the advanced practice field through the ICN network, considerable progress has been made worldwide. A survey taken three years later prior to the INP/APNN's third international conference indicated that over 60 countries are currently developing or implementing advanced practice nursing roles. Mounting issues of concern in implementation of advanced nursing roles were for the most part related to the education for, and the evaluation of, competence (Roodbol, 2004).

Definition of the advanced practice nurse

ICN's position on regulation emphasises that clear definitions are fundamental to identifying and placing a profession within the heath care system (Styles & Affara, 1997). These definitions are important because they identify who the health worker is, and define boundaries for practice. Thus definitions can be thought of as shorthand ways to communicate what services to expect from what health worker, and how it will be offered.

To define and guide the work of ICN's INP/APNN it was agreed that reaching consensus on an international definition for the APN was its first priority. Countries struggling with the early stages of role definition and development were particularly eager to have an international definition available to them.

The initial step taken was to draft a working definition of the APN and identify characteristics of the role. These were drawn from analysis of country-specific papers on progress of advanced nursing practice submitted to the network; a review of literature; and the results of the ICN survey. The draft definition, accompanied by a discussion paper and response sheet, was sent to ICN national nurses' associations (NNA), the network subgroups and all its members. All the documents were posted on the web and responses were invited. Twenty-six responses were received from 11 countries and represented opinion from NNAs, regulatory bodies, WHO and individual nurses. The responses tended to come from countries where there was some familiarity with the role.

A high level of agreement was reached that the proposed definition is representative of present and potential roles in the responding countries. The recommended masters degree for entry stimulated most debate, but the argument seemed to reflect the different stages of advanced practice development and availability of educational programmes rather than a fundamental disagreement of the unsuitability of this level of education. Some respondents were not comfortable with the bias of the draft definition which seemed to imply that advanced practice was reserved to primary health care (Duffy, 2002).

A further difficulty arose with respect to the title as the terms APN and NP are used inconsistently and interchangeably both within nations, and from one country to another. Although NP is the title that is most frequently protected and defined, APN is in substantial use. To decide on one term would run counter to network strategy to be inclusive and open to all the variations of the role at this stage of international development. Thus both titles are included in the first ICN definition.[1] In 2002, ICN's Board of Directors approved a definition, which broadens the role beyond primary health care, and recommends rather than stipulates a masters level education. Finally, it is important to note that the definition is not intended to be prescriptive, but was established to facilitate common international understanding and foster unity around this emerging role.

The ICN position is that the nurse practitioner/advanced practice nurse is:

> *a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A masters degree is recommended for entry level (ICN, 2002).*

[1] For the purpose of clarity, the authors will use the term APN in general discussion of the developments and issues around this role.

The definition is further expanded by the delineation of characteristics in the domains of education, practice and regulation. These will be discussed in greater detail in Chapter 2.

Conclusion

It is inevitable that as advanced nursing practice evolves around the world, roles associated with its practice will be influenced by the profession's identity and values, the nature of the health care context and socio-political imperatives and current priorities. What emerges from the authors' attempt to make some sense of the patterns emerging, as advanced nursing practice is taken up by more countries, is a picture of confusion and different interpretations as to what is advanced nursing practice. The large number of titles in use, a lack of agreement over the routes and standards of education, and no clear consensus over scope of practice make it difficult to define a clear and distinctive identity for APNs. This uncertainty directs our attention to the need for more rigorous exploration and research of these topics.

Nevertheless, since ICN started to monitor the emergence of advanced nursing practice globally, there appears to be increasing consensus over the usefulness of APNs in a country's health system and greater convergence over role definition, education and regulatory requirements. In defining the APN and identifying the characteristic of this role, ICN has taken the first step towards clarifying the nature of APN practice. A scope of practice definition, standards for regulation and education and APN competencies are being developed at the time of writing, and will serve as a foundation for further dialogue on this issue.

Currently nurses in advanced practice roles are to be found in many health care settings. Nurses, the largest group of health providers in most parts of the world, do have within their grasp a host of opportunities to advance their roles and become core frontline providers of quality, cost-effective health care. However, nurses are no longer willing to accept that contributing to health services in this way remains unacknowledged. There is a growing determination to have these roles officially recognised, regulated and appropriately reimbursed. If advanced nursing practice is acknowledged as a valid part of the health system, and is supported by appropriate education, adequate regulation and career pathways, it has the potential to increase nurses' capacities to work in advanced roles independently and collaboratively in multiple settings.

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