



Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

describing your scope of practice:

a resource for rural nurses

This resource is intended to assist rural nurses applying for nurse practitioner status, but will be useful to all nurses who need to define their scope of practice.

Shelley Jones and Jean Ross
Centre for Rural Health

2003

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PUBLISHER

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New Zealand

ABOUT THE CENTRE

The Centre for Rural Health was established late 1994. It was funded (initially by the Southern Regional Health Authority, then the Health Funding Authority and finally by the Ministry of Health) for a series of projects to support rural health services and community involvement. The Centre was under the directorship of Martin London and Jean Ross from, respectively, rural general practitioner and rural nurse backgrounds. It was also known as the National Centre for Rural Health. The Centre closed in late 2002, with final publications being completed in 2003. The resources and reports created under the auspices of the Centre were uploaded mid 2003 to be available indefinitely.

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CITATION DETAILS

Please cite this work as follows:

JONES Shelley, ROSS Jean (2003) **Describing Your Scope of Practice: A Resource for Rural Nurses** Centre for Rural Health : Christchurch, New Zealand

Accessible from www.moh.govt.nz/crh

ISBN 0-9582475-6-0 (Internet)

In the new health system, nurses with *advanced* expertise can, in principle, negotiate their own scope of practice. How each of us articulates it reveals our professional participation in contemporary society, and our ethical foundation in honouring a social contract. How it is defined and addressed within national structures has profound implications for the extent to which nursing as a profession can survive and, further, for how nurses might make an innovative contribution to the quality and cost containment of health care in the future. ***Thus scope of practice embraces all that nursing is and can be*** (Litchfield 1998:13-14, our emphasis).

SOME PROVISOS BEFORE YOU READ THIS DOCUMENT

1 This resource has been funded and designed for a specific purpose, i.e. rural nurses applying to Nursing Council for endorsement as a Nurse Practitioner. Our discussion of perspectives pertaining to rural nursing is, of course, essential to our primary audience.

However, we believe that this resource will be useful to any nurse who needs to define or describe her/his scope of practice. This thought was endorsed by those who gave feedback on the final draft.

Therefore, we welcome all readers to this rural nursing resource, produced as one of the last projects from the Centre for Rural Health.

2 This resource was uploaded to the Centre's website (to be available indefinitely), and will **not** be updated. Information was current and correct at the time of writing, but future readers should check whether there are more recent documents than those we have cited, particularly in the case of those published by Nursing Council.

3 As this resource was being finalised, it was becoming evident that the term 'scope' was going to be defined in the Health Practitioners Competency Assurance Act differently than how it had been used to date in Nursing Council's material on nurse practitioner endorsement. Although Nursing Council had yet to consult within the profession on the meaning of 'scope of practice' after the Act had been passed, it seems likely that it will be replaced with a term such as 'specialty practice'¹. Readers are advised to consult Nursing Council documents as events unfold.

Without a clear indication of a replacement term, we have decided to continue to use the term 'scope' as it is still current at the time of writing. And as we are talking about describing 'what your nursing work involves and what it means', we believe that any new term that replaces 'scope' can easily accommodate this meaning.

4 It's about what is right for you... In showing how to go about defining and describing your scope of practice, especially in relation to nurse practitioner endorsement, we are not saying that you must plan your career towards a nurse practitioner role. It is likely that you are entertaining it as a possibility if you are reading these lines – but we believe it's important that nurses make their own decisions appropriate for their current life commitments, and on the basis of good information and practical advice. We hope that you will find this information and advice useful.

¹ As advised by Pamela Lee, Registration Adviser, Nursing Council New Zealand.

ACKNOWLEDGEMENTS

For their helpful review of the final draft:

Angela Bradley
Education Adviser
Nursing Council New Zealand

Jenny Carryer
Executive Director
and
Stephen Neville
Chair of the Board
College of Nurses Aotearoa

Merian Litchfield
Litchfield and Associates

Robin Steed
Chief Executive
Institute of Rural Health

Susanne Trim
Chair
Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ)

*For their willingness to share a description of their practice,
and hard work in writing a statement of their scope:*

Sue Grimwood
Akaroa Community Hospital
Akaroa

Leonie Howie
Aotea Health
Great Barrier Island

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HOW TO USE THIS RESOURCE

This resource offers a process that gets you ready to define your scope of practice, and a template for a statement of scope

We have designed this resource as a process that leads to a written statement of your scope of practice. Such a statement – which describes your practice – is required as part of the portfolio application for nurse practitioner endorsement:

This should include identification of the range and parameters of your practice and your area of specialty/subspecialty if applicable. The scope should reflect the dynamic nature of health care and nursing and advanced practice competencies. It should reflect collaboration with nursing and other colleagues working in the same scope. You should also identify strategies that you have in place to maintain and develop your competence within your scope of practice (NCNZ Sep 2002a:10).

The process we offer here (*see page 2*) is structured in three stages – understanding, analysing and synthesising – which involve:

- ▶ **READINGS** which help you ‘get your head around’ what is involved in nurse practitioner endorsement and advanced practice
- ▶ **EXERCISES** which provide you with the material you need to formulate a description of your practice
- ▶ a **TEMPLATE** to help you organise your material into a coherent and concise statement.

We recommend that you work through the resource as a structured process, doing the **EXERCISES** and **READING** as you go – although you may find it useful to quickly review the whole resource first. If you are tempted to go straight to the **TEMPLATE**, please remember that it has been designed to help you express the result of an analysis and synthesis of your practice.

We have assumed your familiarity with key documents...

The resource is based on the assumption that you are thoroughly familiar with Nursing Council’s definition of the nurse practitioner role and its competencies. If you are not, accessing the most up-to-date material from Nursing Council becomes the first thing to do. This resource does not replace or override the information and guidelines available at www.nursingcouncil.org.nz.

Rural nurses should be thoroughly familiar with other Centre for Rural Health resources – especially the career and competency frameworks (Jones and Ross 2003) available from www.moh.govt.nz/crh.

...and that you will avail yourself of other sources of help

As part of learning how to describe your scope, we strongly advise that you discuss what your practice entails and what it means with others involved in that practice. Ask for constructive feedback on your application portfolio from colleagues who you respect and who are familiar with your practice, or applying for recognition, or professional portfolios.

The Nurse Practitioner Advisory Group (NPAC-NZ) has representatives from the New Zealand Nurses’ Organisation, College of Nursing Aotearoa, Council of Maori Nurses, New Zealand Branch of the Australia and New Zealand College of Mental Health Nurses (*see also* Neville 2002). NPAC-NZ has prepared a brochure of answers to frequently asked questions and trained a group of mentors to assist applicants for nurse practitioner endorsement. These mentors may be accessed through the professional groups represented in NPAC-NZ. At the time of writing, this group was being coordinated by Susanne Trim, Professional Nurse Advisor, New Zealand Nurses’ Organisation (check the link on www.nzno.org.nz for details).

FIGURE 1: HOW THE EXERCISES AND MODELS RELATE TO THE TEMPLATE

	<i>UNDERSTANDING advanced practice</i>		<i>ANALYSING your practice</i>		<i>SYNTHESISING your analysis into a statement of scope</i>
	<i>increasing refinement of your thinking ►</i>				
		<i>page</i>		<i>page</i>	<i>page</i>
useful to all nurses	<i>Exercise 1: Background Reading</i>	6			
	<i>Exercise 2: Nursing Knowledge in Advanced Practice</i>	9			
	<i>Exercise 3: Readings on Clinical Scholarship</i>	10	<i>Exercise 6: Characteristics of My Own Scope</i>	15	
	<i>Figure 1: Advanced Practice: Maxi Nurse vs Mini Doctor</i>	11	<i>Exercise 7: Elements of My Own Scope</i>	17	
	<i>Exercise 4: Reading: Competencies for Entry to Practice</i>	12	<i>Exercise 8: Diary Record</i>	18	Template for Statement of Scope of Practice
<i>Exercise 5: Reading (Litchfield 1998)</i>	14				
useful to rural nurses	'Distinctively Rural' Competencies	<i>App 1</i>	<i>Exercise 9: Primary Health Care?</i>	18	
	A Model of Variation in Rural Nurse Practice	<i>App 5</i>			

WHY DESCRIBE YOUR 'SCOPE OF PRACTICE'?

Would you be able to describe your scope of practice as a nurse?

Being able to explain 'what your nursing work involves and what it means' is how we will think of describing your scope of practice in this document. Describing what you do as a nurse *should* be as easy as actually doing it. But nurses often find that it isn't!

When asked to describe your practice you may not know where to start, or you may feel that words cannot possibly express the complexity or importance of what you do. You may feel that you might be open to question or critique on the basis of the account you give of your work. Obviously, while there may be understandable reasons why nurses might respond in these ways, these responses are not the mark of a confident professional who has an in-depth and considered understanding of the import of her/his practice and who is able to articulate what it involves and what it means.

We will outline some background thinking on 'scope of practice' and suggest where you might start. It is part of your own professional growth to develop an understanding of what it is that you are doing when you are nursing, to learn the skills required for expressing yourself clearly, and to become confident in communicating and explaining your practice.

Because we have seen how much study enables this kind of development, we recommend postgraduate education as a powerful way to advance in your practice. One of the most useful things about formal study is the opportunity to reflect on your practice and to develop some ways of questioning and expressing your ideas.

Further formal study offers opportunities to

- stand back from your busy job and reflect on your practice
- compare your personal understandings of practice against theoretical models and research findings
- question or validate the why/how/what you do, and think through new approaches
- learn and practise skills for expressing your ideas (e.g. group discussion, writing and presentation) in a supportive environment where you will get high quality feedback.

Other professional development activities may also offer these opportunities, for example, reading relevant professional/clinical literature, clinical supervision, learning groups, journal writing.

Changes in the regulation of nursing present some new reasons for being able to describe your scope

Firstly, the Nursing Council of New Zealand has implemented a process for endorsing nurse practitioners. The Centre for Rural Health's primary reason for developing this resource was to support rural nurses applying for nurse practitioner endorsement. The first competency outlined by Nursing Council for recognition as an advanced practitioner is 'Articulates scope of nursing practice and its advancement' (NCNZ Sep 2002:16-17), and a core area of documentation in the portfolio application is a '...statement of your scope of practice' (NCNZ Sep 2002:10).

A second reason for being able to give a description of your practice relates to Competence-Based Practising Certificates (CBPCs) as proposed by Nursing Council (NCNZ November 2001). While only some nurses will apply for nurse practitioner status, **all** nurses will need to meet the requirements for CBPCs. At the time of writing, passage of the Health Practitioners Competence Assurance Bill (which will enable implementation of CBPCs) is at the select committee stage.

The requirements for CBPCs include keeping a personal professional profile which includes a

...description of your practice as a registered nurse which could include a brief description of the area/scope of practice in which you work and an outline of your position description (NCNZ Nov 2001:9).

Rural nurses who do not have a job description will find this resource useful in describing their scope of practice.

But although these changes in the regulatory environment drive the need for nurses to describe their scope of practice, we believe there are more fundamental reasons for nurses to be able to explain what it is that they do. One reason is related to your contribution to the professional community, and reason is to do with the public's understanding of the contribution to health care made by nurses.

Adding your voice to the professional dialogue

As a nurse you are part of the profession of nursing. We can think of a profession as a 'community of practice', according to learning theorists Lave and Wenger (1991). Such a community looks inwards and outwards at the same time,

...as an activity system about which participants share understandings concerning what they are doing and what that means in their lives and for their community....Thus, they are united in both action and the meaning that the action has, both for themselves and the larger collective (1991:98).

Liedtka, discussing Lave and Wenger's work, notes that they

argue that such communities are fundamentally and simultaneously concerned with producing both practical outcomes for customers and learning for members. [Therefore] the nature of learning requires participation in the doing, the sharing of perspectives about the doing itself, and the mutual development of both the individual and the collective's capabilities in the process. Thus it is in the social interaction of the community, not in the individual heads and hands of its producing members, that the community's practice exists and evolves (Liedtka 1999:7).

You could think about describing your scope of practice – 'the sharing of perspectives about the doing itself' – as an interaction that enhances both yourself and the professional group, and enables both to better serve the public.

Litchfield (1998) suggests that as nurses in New Zealand move to define nursing's scope,

...dialogue at all levels is essential to address the need for practitioner responsiveness, professional accountability, safety and legitimacy of practice. Without this dialogue we will remain invisible and reactive to the whims of others shaping health care (1998:23).

This resource is designed to help you think through and express coherently and concisely '**what my nursing work involves and what it means**' so that you can contribute to the professional dialogue.

'What nurses know and must communicate to the public'

Bernice Buresh and Susanne Gordon, journalists who question why nursing work and nursing itself is 'invisible' within the health service, believe that nurses themselves can be the best publicists for nursing as a profession distinct from medicine:

In conversations with patients and others, you can educate people about the scope of nursing by being more specific about the kind of nursing you do. Instead of saying only that you're a nurse, you might say a bit more, such as, 'I'm an oncology nurse, I work with children with cancer,' or 'I'm a psychiatric nurse, I work with patients with...'

Nurses are too seldom given credit for relying on their own knowledge and judgement. Many people believe that everyone in health care – including the nurse – follows the doctor's orders. They believe that a sort of invisible line runs from the doctor's brain to yours, and that you are acting on his knowledge, not your own....

To convey the content of nursing, nurses must describe the complexity of care *they* give and the clinical judgments *they* use. They must take care in discussions with patients and families, with the broader public, and with media and political representatives not to depict themselves as extensions of the doctor's agency (Buresh & Gordon 2000:70-71).

When speaking about nursing with patients and families and the broader public, Buresh and Gordon remind us to '...mobilize the words to do the job' (2000:82) – to use language that explains in lay terms what practical difference your nursing knowledge and expertise means for the people and community in your care. Nurses who take responsibility for making nursing more visible in this way are not grandstanding at the expense of other health care team members' contributions or credibility, but educating the public about the critical role of nursing in the provision of health care¹.

¹ We strongly recommend Chapter 4 'Tell the World What You Do' pp 69-91 in Buresh and Gordon to readers interested in exploring a personal professional responsibility for promoting nursing.

ESSENTIAL BACKGROUND CONCEPTS

Familiarise yourself with key documents for a clear understanding of advanced nursing practice and rural nursing

Focussing again on the primary reason for this resource – to support *rural* nurses applying for nurse practitioner endorsement – it is absolutely critical that those applying understand what is meant by advanced practice, and how Nursing Council has defined the competencies and process for endorsement. It is also critical to be familiar with research-based thinking about rural nursing practice in New Zealand.

EXERCISE 1 BACKGROUND READING

We advise intending applicants to be completely familiar with at least the following documents related to nurse practitioner:

From Nursing Council www.nursingcouncil.org.nz

The Nurse Practitioner™. Responding to Health Needs in New Zealand September 2002
or latest version available

Nurse Practitioner™ Endorsement. Guidelines for Applicants September 2002
or latest version available

From Ministry of Health www.moh.govt.nz

Nurse Practitioners in New Zealand by Frances Hughes and Jenny Carryer (2002)

We also advise you as a rural nurse to be thoroughly familiar with the following two resources:

From Centre for Rural Health www.moh.govt.nz/crh

Competency Framework for Rural Nurses by Shelley Jones and Jean Ross (2003a)

Career Development Framework for Rural Nurses by Shelley Jones and Jean Ross (2003b)

Understanding your practice as a rural nurse in terms of generalisation, specialisation, expansion and advancement

Being clear about the meanings and possibilities of generalist, specialist, expanded, and advanced practice in relation to rural nursing and the nurse practitioner role is key to our discussion of scope. Being clear about these terms also helps us to see them as patterns or directions for development. We believe it possible that a rural nurse might describe her/his practice with all these terms.

We might think of the dimensions of GENERALIST practice as broad and shallow

Many rural nurses could describe their practice as encompassing what might otherwise be thought of as specific scopes¹. They may care for individuals (of all ages), families or communities, in matters ranging from health promotion and education, from acute/emergency care to disease management to palliative and terminal care, and may therefore be inclined to describe themselves as **generalists**.

¹ To date, documents on Nurse Practitioners had proposed a grid of clinical foci and populations for scope of practice (e.g. NZNC Sep 2002:15). However, discussion at the Forum to Progress the Nurse Practitioner Role (hosted by New Zealand College of Nurses in Palmerston North, 27-28 February 2002) suggested that 'this matrix should now be reviewed and replaced with a broad statement encouraging individuals to define their own scope of practice' and an 'action point for the profession' recommends that Nursing Council to review the matrix (Carryer 2003:11).

We might think of the dimensions of SPECIALIST practice as narrow and deep

We might think of the dimensions of generalist practice as broad and shallow – having sufficient knowledge and competence in many things, but the in-depth expertise of a specialist in none or only a few.

On the other hand, we think of specialists as having expertise in a relatively confined area and therefore the dimensions of specialist practice as narrow and deep:

Specialization is concentrating or delimiting one's focus to part of the whole field of nursing (ANA cited in Cronenwett 1995:115).

Nursing Council has defined specialty nursing practice as

...any area or scope of practice with a specific focus, body of knowledge and practice.... Specialties may be designated with a nursing focus, for example, community nursing; a medical focus such as renal nursing; a lifespan focus like care of the older person; a cultural focus such as Maori mental health; or a location focus as in rural nursing. Under this definition it is difficult to identify any area or scope of practice that cannot be described as specialty nursing practice (NCNZ May 2001:12).

Rural nurses are clear that rural nursing is a 'specialty' in that there is a 'specific focus, body of knowledge and practice'. Rural nurses commonly find that 'rurality' – being in a rural area, working with rural people, and all that this means – is the factor that most characterizes and unifies their practice. Rural nurses in New Zealand have identified a set of 'distinctively rural' competencies common to all rural nursing roles and practice (Jones and Ross 2003a), see *Appendix 1*. Without the competence required by the distinctive rural setting, the otherwise clinically skilled nurse's effectiveness in the rural context and community may not be fully realised.

However, the paradox is that the **nurse who specialises in rural nursing is likely to have to be a generalist**, in that she/he must maintain competence in a broad range of skills, even if she/he also has particular clinical or population expertise.

We must acknowledge that rural nurses have found it difficult to fit their 'generalist/specialist' practice against the grid of clinical and population foci as first proposed by Nursing Council (e.g. NZNC Sep 2002:15), as they may care for a community (all age ranges), whose health needs require responses ranging from health promotion to emergency/acute/chronic/terminal care.

We might think of the dimensions of EXPANDED practice as overlapping the boundaries of other health professionals...

Where medical or other health professional cover has been intermittent or insufficient, rural nurses have **extended or expanded** their practice to fill the gaps and meet needs that would otherwise go unmet.

Expansion refers to the acquisition of new practice knowledge and skills including the knowledge and skills that legitimise role autonomy within areas of practice that overlap the traditional boundaries of medical practice (ANA cited in Cronenwett 1995:115).

A rural nurse's expanded practice may include only a few specific skills, such as local anaesthesia and suturing – taught on the job by a medical colleague. Or her/his expanded practice could have a more comprehensive skill base, such as capability for assessment and response in emergencies – learned in a course such as Primary Response In Medical Emergencies (PRIME).

... and prescribing is a case in point

Prescribing is an area of expanded practice that has attracted fairly intense debate since 1998 when the then Minister of Health, Bill English, announced provisions for nurses to prescribe for specific age groups (elderly, and child and family health). However, Nursing Council's development of a process for endorsing nurse practitioners has seen a shift from 'nurse prescribing' to 'nurse practitioner prescribing'.

Prescribing is the sixth nurse practitioner competency – ‘Prescribes interventions, appliances, treatments and authorised medicines with the scope of practice’ (NCNZ Sep 2002:19). While it is recognised that not all nurse practitioners will seek to prescribe, the right to prescribe is therefore restricted to nurses endorsed by Nursing Council by nurse practitioners.

The Nurse Practitioner™ seeking prescribing rights will be required to complete an approved pharmacology course relevant to their defined scope of practice as part of [satisfactory completion of a Nursing Council-approved clinically focused Masters degree...] (NCNZ Sep 2002b: 15).

Therefore, in New Zealand, ‘nurse prescribing’ sits **within** advanced nursing practice, and the required preparation for prescribing is at postgraduate level.

We might think of the dimensions of ADVANCED practice as broadening and deepening nursing knowledge and practice...

In a nutshell, advanced nursing practice is about ‘**maxi-nurse**’, which is a very different thing than the idea of ‘**mini-doctor**’ or ‘physician extender’ often associated with expanded/extended practice. We cannot stress strongly enough that there is a critical difference between expanded/extended and advanced practice, as it is a source of great confusion for the medical and nursing¹ professions, and therefore, unsurprisingly, politicians and the public.

The following definitions and descriptions of advanced nursing practice have in common (1) postgraduate² education as an integral foundation for (2) the development of a broad range of theoretical, research-based knowledge, which in turn (3) must be integrated with the in-depth practical knowledge that comes only with extensive experience:

Advancement involves both specialization and expansion and is characterised by the integration of a broad range of theoretical, research-based, and practical knowledge that occurs as a part of graduate education in nursing (ANA cited in Cronenwett 1995:115).

Advanced nursing practice has a clinical or therapeutic focus. It is the integration of *research-based theory and expert nursing in a clinical practice area, and combines the roles of practitioner, teacher, consultant and researcher* to advance the professional practice of nursing (Canadian Nurses Association, 1997, cited in NCNZ May 2001:28).

Advanced nursing practice reflects a range of highly developed clinical skills and judgements acquired through a combination of nursing experience and education. Essentially, advanced nursing practice requires the application of advanced nursing knowledge, with practitioners drawing not only on their clinical experience, but also on the experience of the profession as a whole (NCNZ May 2001:28).

...for the nurse as an individual and the profession as a whole

Note also that the definitions and descriptions above reference the nurse’s development to nursing knowledge, **and** identify advanced practice as something that necessarily contributes to the development of nursing knowledge and practice. This point – building on and contributing to the body of nursing knowledge (whether formal codified knowledge or informal practice-based knowledge) – is written into the competencies defined by Nursing Council for nurse practitioner endorsement.

¹ For instance, Hegney (1997), writing about the lack of support services in smaller communities or isolated areas as a major determinant of rural nurses’ scope of practice, argues for the extended/expanded practice of rural nurses ‘...which, in a larger centre, would be considered to be the domain of medicine or allied health’ to be supported, recognised and **renamed** as advanced practice.

² Health professionals and health science programmes frequently use the terms ‘graduate’ and ‘post-graduate’ differently than do other academic disciplines. For instance, in general university usage: ‘undergraduate’ study leads to a Bachelor’s degree or Baccalaureate; ‘graduate’ study is at Master’s level or a Masterate (this is how the term is used in the quotation from Cronenwett above); ‘postgraduate’ study is at Doctoral level, for a Doctorate or PhD; and therefore ‘postdoctoral’ fellowships enable a person with a PhD to undertake further research. However, university programmes and courses offered to health professionals use the term ‘postgraduate’ to denote study after the professional entry qualification – which may or may not have been a Bachelor’s degree.

EXERCISE 2
NURSING KNOWLEDGE IN ADVANCED PRACTICE

We recommend that you make a spare copy of the Nurse Practitioner competencies, and highlight all those which refer to building on and contributing to the body of nursing knowledge – whether formal codified knowledge or informal practice-based knowledge. This exercise will help you identify how Nursing Council has put nursing knowledge as the basis and outcome of advanced nursing practice.

Clinical scholarship is required of the nurse practitioner as part of advanced practice

‘Scholarship is the creative intellectual activity that advances knowledge in the discipline’ according to Roberts (1995:211) who distinguishes between

[t]heoretical scholarship [which] mainly focuses on the theoretical aspects of the topic, clinical scholarship [which] concerns applications to practice and research scholarship [which] reports research projects (1995:213).

Acknowledging overlaps between the three types of scholarship, Roberts points out that those involved in theoretical and research scholarship are likely to be in an academic environment, whereas those involved in clinical scholarship are likely to be in a practice environment or may hold a joint appointment between academic and clinical environments.

Clinical scholarship ‘...is the study of the nature and effect of nursing. It depends on the people who do that, who are engaged in the clinical work. It helps us know what nursing is and does’ (Diers 1988:2). Thus your exploration of ‘**what my nursing work involves and what it means**’ continues the tradition of practical clinical scholarship begun by Florence Nightingale when she explored in ‘Notes on Nursing: What it Is and What it Is Not’ (1859/1952).

Referring to Diers (1988), Roberts says that:

Clinical scholarship must be based on a body of nursing and relevant scientific knowledge. Clinical events are observed by the experienced clinician, and analysed to make new connections between things or ideas, thus producing a synthesized whole. As does any scholar, the clinical scholar seeks truths, explanations, and ever more increasing information about the phenomena of the discipline. The scholarliness of the clinical work is produced by the constant analysis of the work and the interpretation of the events to others. Clinical scholarship has its bases in the application of theory and research to practice. Nurses who are true clinical scholars are able to enhance the well being of their clients through improvement of nursing practice (Roberts 1995:215).

Thus, when you have a ‘...depth of clinical expertise ... as well as tertiary education which emphasises theoretical knowledge and the skills of scholarship’, you have the prerequisites for clinical scholarship (Roberts 1995:216). This is exactly the kind of practice-based knowledge development that Benner refers to when she encourages us to the kind of dialogue prompted by clinical exemplars, as she believes that

...a wealth of untapped knowledge is embedded in the practice and the ‘know-how’ of expert nurse clinicians, but this knowledge will not expand or fully develop unless nurses systematically record what they learn from their own experience (Benner 1984:11).

EXERCISE 3 READINGS ON CLINICAL SCHOLARSHIP

Review one of these position statements on nursing scholarship from the American Association of Colleges of Nursing and Canadian Association of Schools of Nursing respectively (see below) and identify what you have done that can be described as discovery, teaching, application or integration.

www.aacn.nche.edu/Publications/positions/scholar.htm

www.causn.org/Accreditation/definition_of_scholarship.htm

The nurse practitioner role is therefore seen as requiring preparation at Master's level 'or its equivalent'

The educational preparation for the nurse practitioner required is a clinically focused Master's degree as approved by Nursing Council. Such a programme is intended to extend

...theoretical knowledge in addition to providing clinical, technical and ethical learning experiences for the delivery of care and the ongoing development of practice. It includes theory, research and practice hours that are sufficient to enable the student to meet Nursing Council of New Zealand competencies for advanced nursing practice within a defined scope.

A clinically focused Masters degree prepares nurses with the knowledge and clinical competency required to practise as nurse practitioners in their chosen scope of practice (NCNZ Sep 2002b:15-16).

So as not to exclude nurses with significant clinical experience who have not completed a clinically focused Master's degree, Nursing Council is intending (at the time of writing) to hold an educational equivalence policy until 2010, after which applicants will be required to hold a clinically focused Master's degree (NCNZ Sep 2002b:16).

It follows that alternatives equivalent to a clinically focused Master's degree will have enabled those applying for endorsement under the equivalence policy to develop the required competencies. Such alternatives may include 'other pathways... other programmes ... other ways' (NCNZ Sep 2002a:12) that enable them to demonstrate evidence of their

... ability to integrate theory, research and practice, ...the application of nursing frameworks to her/his practice and the application of critical thinking and evidence as the basis of clinical decision making (NCNZ Sep 2002b:16).

Of course, those prepared via a clinically focussed Master's programme must also demonstrate these abilities. The key question in relation to equivalence to a clinically focussed Master's degree is this: 'Is the outcome a practitioner who is practising at an advanced level?' (NCNZ Sep 2002a:13).

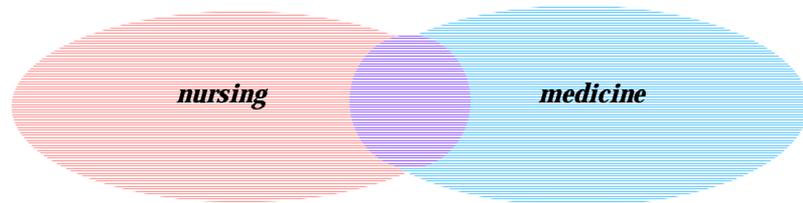
We advise you to be very clear about the difference between expanded/extended practice, and advanced practice before considering nurse practitioner endorsement

In relation to nurse practitioner status, we advise nurses working in rural areas to be entirely clear about what is appropriate for them personally and for their roles. We do not see that the more independent and isolated rural nurse positions are ***necessarily and inevitably*** nurse practitioner positions, although some may well be. While we disagree with Hegney's (1997) naming of expanded/extended roles as advanced roles (*see Footnote 4*), we agree that nurses in them must be adequately prepared for and supported in that expanded/extended practice – especially as it may be the only reasonable way to sustain a health service in a smaller community.

We cannot stress strongly enough the differences identified between expanded or extended practice and advanced nursing practice. Expanded/extended practice is not excluded from the criteria for Nursing Council endorsement as a nurse practitioner, but it is not sufficient. It is critical to understand that the advanced practice role of nurse practitioner as defined by Nursing Council, is about **advanced nursing practice**. Figure 2 below offers a representation of the difference.

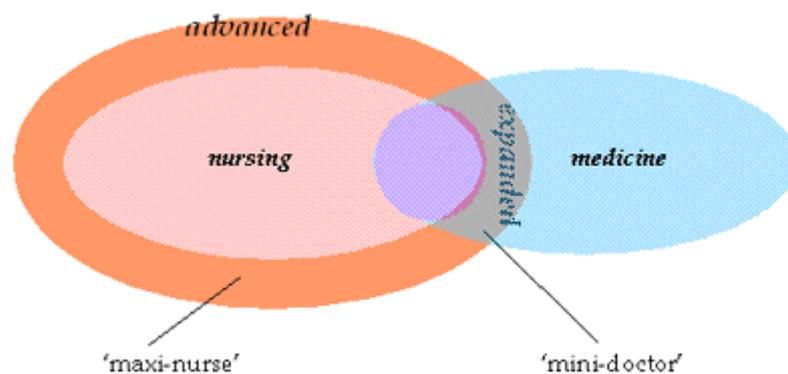
FIGURE 2: ADVANCED PRACTICE: MAXI NURSE VS MINI DOCTOR

In the first diagram, if we acknowledge that nursing and medicine have some overlap in terms of knowledge and skills, we can recognise that there are areas where either the nurse or doctor might attend to the patient/client. It will depend on which is available at the time, or which has the greater rapport with the client, or stronger skills or interest in relation to the particular need. Patient education is a good example of an area where nurses and doctors might act relatively interchangeably.



In the second diagram, we might consider that the nursing role has undergone considerable development. The area of overlap into medicine, on the basis of further development and upskilling, is what we have referred to as expanded or extended practice.

Without a proper understanding of nursing, some might see expanded practice as akin to a 'mini-doctor' role, as it takes over some areas usually thought of as within the scope of medicine. Expanded practice is therefore sometimes **misunderstood** as advanced practice. However, the area labelled 'advanced' shows a deepening and broadening of nursing knowledge and skill. It may incorporate expanded practice, but goes far beyond it – and we could think of it as 'maxi-nurse'.



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WHAT DO WE MEAN BY 'SCOPE OF PRACTICE'?

Dictionary definitions

The New Shorter Oxford English Dictionary offers a number of meanings of the word 'scope', the closest to our consideration having personal and professional aspects:

The range of a person's mental activity or perception; extent of view, sweep of outlook. Freq. in *beyond, within (one's) scope....* The sphere or range over which any activity operates; range of application; the field covered by a branch of knowledge, an inquiry, etc. Freq. in *beyond, within the scope of* (Brown 1993:2721).

But we need not think of scope as only **limiting** or **restricting** practice, another meaning is much more expansive – as a registered nurse, you have the opportunity **to do**:

Unhindered range, free play, opportunity or liberty *for* or *to do* something. Freq. to *give scope to, have scope* (Brown 1993:2721).

As defined in legislation and professional regulations

Clause 5 in the Health Practitioners Competence Assurance Bill defines scope of practice as a term which

- ▶ means any health service that forms part of a health profession and that has been gazetted by the responsible authority [e.g. The Nursing Council of New Zealand]; and
- ▶ when used about a health practitioner of that profession [e.g. a nurse registered with Nursing Council], means any of those health services that the practitioner is permitted to perform, subject to any conditions imposed by the responsible authority (Government Bill 2002: 4).

In tune with the Government's objective that the HPCA legislation will '...be flexible enough to meet changing skill sets, roles, diagnostic regimes, and treatments' (Government Bill 2002: 2), Nursing Council as the authority responsible for nursing, has defined the scope of practice for nursing very broadly, as follows:

Registered nurses utilise nursing knowledge, reflective practice and professional judgement to provide competent care for people and advice in health promotion, maintenance and restoration of health, preventative care, rehabilitation and care of the terminally ill. This occurs in a range of settings with individuals or groups. It focuses on nursing practice. (NCNZ 2001:7).

EXERCISE 4

READING: COMPETENCIES FOR ENTRY TO PRACTICE

*What Nursing Council defines as nursing practice is further explained in **Competencies for Entry to the Register of Comprehensive Nurses** (February 2002). Since one of the requirements for CBPCs is that nurses evaluate themselves against these Competencies (and other recognised standards of practice) (NCNZ 2001:9), we suggest that you familiarise yourself with them and the generic performance criteria, as to do so will also help you as you explore your scope of practice. This document is available at www.nursingcouncil.org.nz*

Ways of thinking about scope in professional discourse

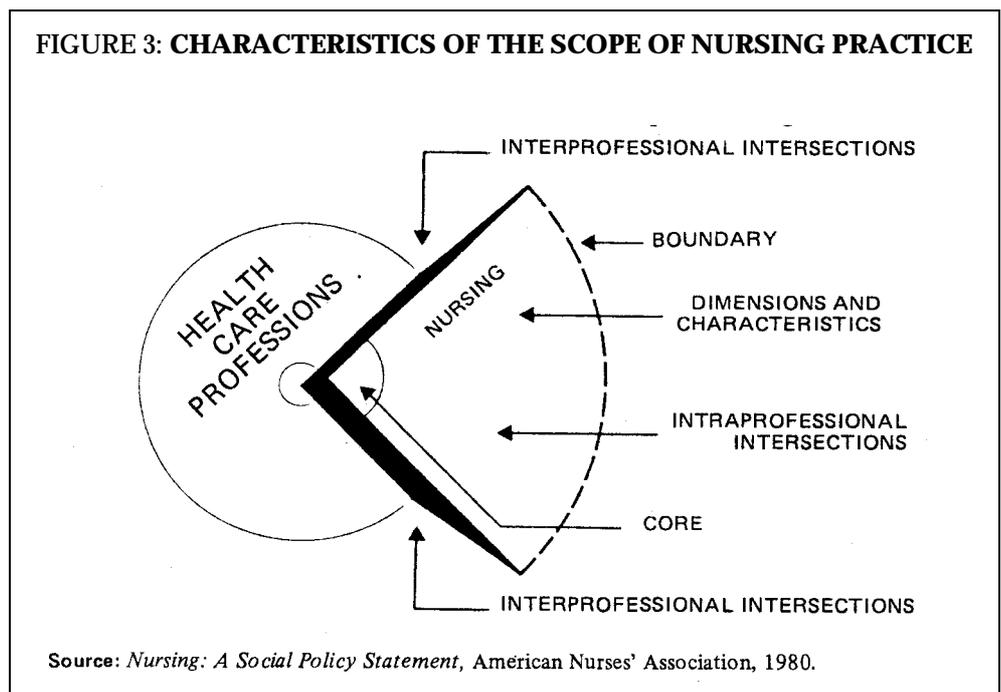
Recognising that different people will find different models useful, we have presented two models below, with related EXERCISES to help you use them as frameworks for your own thinking. Both models are concerned with what makes nursing 'nursing'; what distinguishes it from other disciplines; and what is its particular and distinctive focus.

Bea Salmon's discussion of an American Nurses' Association framework...

In the early 1980s, Salmon, a New Zealand nurse scholar, discussed the scope of nursing practice with reference to contemporary work by the American Nurses' Association. She wrote:

...I have described nursing's scope of practice in terms of a boundary expanding in response to changing social needs and demands; intersections with the practice of other health professionals; a core that distinguishes nursing from other health professions by virtue of its phenomena of concern; and dimensions that characterise nursing in terms of its practitioners, its practice setting, and its accountability (1982:122).

These four characteristics of a scope of practice are characteristics you need to be clear about when describing your own scope of practice, and particularly as you prepare a statement of your scope of practice. We have based the **TEMPLATE FOR A SCOPE OF PRACTICE STATEMENT** on these characteristics, which are discussed with reference to the American Nurses' Association model, following Salmon. The model appears in Figure 3 below.



(Permission to reproduce this diagram sought from ANA)

... identifies a number of characteristics that a scope of practice must encompass

In this model, we focus on the segment of health care that is nursing. It has an external **boundary** (represented as a dotted line to indicate the potential for movement) which

...expands outwards in response to changing needs, demands and capacities of society. As is true of all professions, nursing is dynamic rather than static. As new needs and demands impinge upon nursing, and as a consequence of nursing research, the other three defining characteristics of scope [intersections, dimensions and core] begin to change, resulting in expansion of the boundary (ANA 1980:13,16).

The nursing segment is also bounded by **intersections** (represented as thicker shaded bands which allow for overlapping with other segments).

These are interprofessional interfacing and meeting points at which nursing extends its practice into the domains of other professions. These are not hard and fast lines separating nursing from another profession; [for instance,] the relations between nursing and medicine at these interfacing are especially fluid and pose few problems in the all too rare situations in which collegial, collaborative joint practice obtains. All of the health professionals interact, share the same overall mission, have access to the same published scientific knowledge and in some degree overlap in their activities (ANA 1980:16).

At the centre of the nursing segment is its **core** – the whatever it is that makes nursing ‘nursing’. Salmon says that ‘[t]he core of nursing is made up of the phenomena of concern that lie within the scope of the responsibility of the professional nurse’ (1982:121). Or in other words, the things that nurses concern themselves with and pay attention to when they are looking after the individuals/families/communities in their care.

The final characteristic of scope of practice in this model is the **dimensions** of nursing practice. These are elements that pertain to and further describe the scope of nursing. The ANA said that

[a] comprehensive statement of these characteristics would include but not be limited to

- descriptions of what philosophy and ethics guide nurses
- what responsibilities, functions, roles and skills characterise their work
- what scientific theories they use and by what means they apply them
- when and where they practice
- and with what legal authority nurses function (ANA 1980:17-18).

An exercise

We have designed two **EXERCISES** that are useful preparation for using the **TEMPLATE FOR A SCOPE OF PRACTICE STATEMENT**, and suggest you use the one you’re most comfortable with. The first is based on the ANA model and appears on page 15. Choose between this **EXERCISE** and another on page 17.

Merian Litchfield’s discussion of the need to realise ‘all that nursing can be’ in its scope of practice

Litchfield is not only a New Zealand nurse scholar, but one familiar with the realities and possibilities inherent in rural nursing practice through her work with the Centre for Rural Health (2001).

Litchfield outlines how conceptualisations of the scope of nursing in New Zealand have changed according to the socio-political context. She defines scope of practice as ‘...the expression of the discipline of nursing in the work of the nurse: the characteristics that express the “nursing perspective” or “nursing focus” ‘ (1998:13).

EXERCISE 5 READING: LITCHFIELD 1998

We recommend pp 13-21 of Litchfield’s article as a really good way to background your thinking about scope.

Reference: LITCHFIELD Merian (1998) The Scope of Advanced Nursing Practice **Nursing Praxis in New Zealand** 13(3): 13-24

EXERCISE 6: CHARACTERISTICS OF MY OWN SCOPE (with reference to ANA 1980/Salmon 1982)	
<i>prompt</i>	<i>my response</i>
<p>BOUNDARY</p> <p>In what ways are you growing your professional capability and practice in response to changing needs, demands and capacities of society?</p> <p><i>(Think about study you've completed to increase your formal knowledge; practical skills you've learned; research you've undertaken, or reviewed and applied; changes and improvements you've made in your practice and to the systems in your workplace...).</i></p>	
<p>INTERSECTIONS</p> <p>With whom and in what ways do you collaborate to deliver the care and services your clients and community needs?</p> <p>Are there any areas where you have expanded/extended your practice in an area that might have traditionally been thought of as the scope of another professional group?</p> <p>If so, what was the need or circumstance that prompted that expanded/extension?</p> <p>And what upskilling did you undertake to be able to do it with an adequate knowledge base and understanding of safe practice?</p>	
<p>CORE</p> <p>What are your core beliefs about health and ill-health?</p> <p>About individuals/families/communities in relation to health care?</p> <p>About your role as a nurse in relation to the above? And about what you do as a rural nurse?</p>	
<p>DIMENSIONS</p> <p>What is your philosophy of nursing? <i>(see answers to questions under above heading).</i></p> <p>What ethics guide your practice?</p> <p>What do you do in your rural nurse role? <i>(Where and when do I work? My qualifications as a... enable me to... I am responsible for... The kinds of things I do are... My role is to... The skills I bring to this are...).</i></p> <p>What is your knowledge base? How do you apply this knowledge?</p>	

For Litchfield, scope of practice expresses nursing's obligations to society, and the possibilities for society in nursing's contribution:

Job descriptions express the scope of practice expected of nurses by service providers. In the new health system, nurses with *advanced* expertise can, in principle, negotiate their own scope of practice. How each of us articulates it reveals our professional participation in contemporary society, and our ethical foundation in honouring a social contract. How it is defined and addressed within national structures has profound implications for the extent to which nursing as a profession can survive and, further, for how nurses might make an innovative contribution to the quality and cost containment of health care in the future. Thus scope of practice embraces all that nursing is and can be (Litchfield 1998:13-14).

According to Litchfield, scope includes a number of elements

In defining scope as 'the reach of the nurse: what the nurse attends to and the sphere of nursing activity within the professional partnership [between nurse and client/family/community]' (1998:19-20), Litchfield conceptualises scope being about a specific opportunity, governed by the nature of the nurse's professional role in a given relationship. What is included within (and excluded from) the nurse's 'reach', is determined according to the following interdependent elements:

Work parameters for the nurse: conditions of employment/role, credentials, service setting.

The **client** characteristics of e.g. state/status, unit/institution/community group, geographical locality.

Health care **need**: 'need' that focuses the nurse-client encounter expressed in the criteria for entry to and ending of the partnership (admission/discharge).

The nature of the **process/es** by which the nurse encounters the client (access and care) and health care workers: including but not limited to assessment, planning and intervention.

The meaning of **health**: the perspective the nurse has of 'health' in relation to disease, illness and disability, that focuses action (Litchfield 1998:19-20).

Another exercise

A second EXERCISE on page 17, based on Litchfield's outline of the elements of scope and useful preparation for when you come to use the **TEMPLATE FOR A SCOPE OF PRACTICE STATEMENT**. Use just one of these two EXERCISES (pages 15 and 17).

Describing your scope of practice is like using a kaleidoscope

On completing one of the above EXERCISES, you may feel that what you have written will be all changed in the very next client/community encounter – so how can you ever make an accurate statement of scope?

Imagine, for a minute, a kaleidoscope¹. It has an aperture through which you view the patterns; it has pieces of coloured glass that create patterns as they move; and a couple of mirrors that reflect and multiply just a few pieces of glass into a repeating pattern. The picture you see – the pattern created by the pieces of glass – will change as you move the barrel of the kaleidoscope. But you have not changed the pieces of glass, they are simply in a different arrangement. Neither has the way you are looking at them changed, your perspective is created by the way the kaleidoscope is fashioned. And in the same way there is a degree of constancy in the elements of your practice and the way you look at things as a nurse – your perspective is shaped by your socialisation and development as a nurse.

¹ Shelley Jones would like to acknowledge an earlier conversation with Jocelyn Keith around the changing nature of nursing practice for prompting the metaphor of a kaleidoscope in this discussion.

EXERCISE 7: ELEMENTS OF MY OWN SCOPE (with reference to Litchfield 1998)	
<i>prompt</i>	<i>my brief description</i>
<p>YOUR WORK PARAMETERS</p> <ul style="list-style-type: none"> • conditions of employment/role • credentials • service setting 	
<p>YOUR CLIENT'S CHARACTERISTICS</p> <ul style="list-style-type: none"> • state/status of client • unit/institution/ community group • geographical locality 	
<p>THEIR HEALTH CARE NEED</p> <ul style="list-style-type: none"> • the 'need' that focuses the nurse-client encounter expressed in the criteria for entry to and ending of the partnership (admission/discharge) 	
<p>THE PROCESSES THAT BRING YOU INTO PARTNERSHIP WITH CLIENTS AND OTHERS</p> <ul style="list-style-type: none"> • the nature of the process/es by which the you encounter the client (access and care) and other health care workers • including but not limited to assessment, planning and intervention 	
<p>WHAT HEALTH MEANS</p> <ul style="list-style-type: none"> • your perspective as a nurse of 'health' in relation to disease, illness and disability • and on which you base your actions as a nurse 	

THE SCOPE OF YOUR PRACTICE AS A RURAL NURSE/NURSE PRACTITIONER

Rural nursing does not seem to have a good fit with the parameters identified so far for scopes

As rural nurses may care for a community encompassing all age ranges, whose health needs require responses ranging from health promotion to emergency/acute/chronic/terminal care, they have found it difficult to fit their practice against the grid of clinical and population foci as first proposed by Nursing Council (e.g. NZNC Sep 2002b:15).

And although Nursing Council has suggested that a scope may have '...a location focus as in rural nursing' (NCNZ May 2001:12), we have argued previously that rural practice is less a 'scope' than a **setting** or **context** of practice:

'Rural' is not a scope of practice, it is a context of practice. Rural nursing practice is shaped by its situatedness. Distinctive settings determine nursing roles and responses -- which differ according to the health needs and health service provision in particular rural communities (Jones and Ross, discussion, 2000).

As a corollary, we have suggested that the context requires context-specific competence, and identified a set of competencies distinctive to rural practice and common across all rural nursing roles (Jones and Ross 2003a), *see Appendix 1*. The requirement for 'rural competence' as an overlay to clinical competence is part of what makes rural nursing a specialty, although rural roles frequently require practitioners to be generalists with a broad range of knowledge and skills.

EXERCISE 8 DIARY RECORD

A basic outline for recording and analysing your work day in terms of clinical focus and population group is offered in the DIARY EXERCISE in Appendix 2. This could form the basis of the diary required as part of an application for NP endorsement. This EXERCISE has been designed to particularly help rural nurses identify the parameters of generalist and expanded aspects of their role.

What is the fit between the primary health care scope and your practice?

It has been suggested that rural nurses might view their scope of practice as falling within primary health care, conceived in the broadest possible way, for instance as in the declaration made at Alma-Ata (WHO 1978).

EXERCISE 9 PRIMARY HEALTH CARE?

To ascertain the extent to which your practice as a rural nurse aligns with a broad conception of primary health, why not review the Declaration of Alma Ata which is available at www.who.int/hpr/archive/docs/almaata.html and in Appendix 3.

If you have completed the DIARY EXERCISE, you could see how many of your recorded activities match with the idea that primary health care '... addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services'.

In this line of thinking, a scope defined by primary health care nurses in New Zealand may look promising for rural nurses seeking a ready made scope of practice statement.

The following definition was developed by the Expert Advisory Group on Primary Health Care Nursing:

Primary health care nurses are registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first-point-of-contact care and disease management across the lifespan. The setting and the ethnic and cultural grouping of the people determine models of practice. Partnership with people – individuals, whanau, communities and populations – to achieve the shared goal of health for all, is central to primary health care nursing (2002:9).

If you are applying for nurse practitioner endorsement, and believe that this statement adequately captured your scope of practice, then you could use it in your application, but Nursing Council advises:

If you include an established scope statement developed by a group of nursing colleagues..., you should describe how your own practice relates to this scope (NCNZ 2002a:10).

Moreover, in ‘...the country the differentiation between primary and secondary services is less clear-cut’ according to the Primary Health Care Strategy (MOH 2001:23). You may need to adapt the above scope statement if what you do in a rural nurse role blurs the difference between primary and secondary services (or, more positively, better integrates them).

We believe that rural nurses will best portray what their practice involves and what it means by developing a scope of practice statement particular to their own role and community

We have said that each rural nurse needs to construct a set of competencies on a ‘pick and mix’ basis (Jones and Ross 2003a), and that each rural nurse needs to map her/his own career development in a number of directions – the idea of a climbing frame rather than a ladder (Jones and Ross 2003b), *see Appendix 4*. In this resource, we advise you to develop a scope of practice statement particular to your own role and community.

We will outline our reasons for this advice to rural nurses in the following discussion, but as we have seen, it is confirmed by recent developments in professional dialogue: ‘...this matrix should now be reviewed and replaced with a broad statement encouraging individuals to define their own scope of practice’ (Carryer 2003:11).

Rural nurses’ roles vary...

Rural nurses **need to express generalist, specialist, expanded and advanced aspects of their practice**. As the rural context demands specialisation in ‘rural’, specialty aspects may be more or less common across rural nursing roles, but we expect that just how all these aspects fit together will vary between rural nursing roles, and therefore require different expressions. How generalist or how expanded a role is depends on the availability of other health professionals for the community, and/or the distance from larger centres.

Rural nurses roles **vary on a number of dimensions** (Jones and Ross 2003a), according to the nature of the nurse’s employment, work setting, and the demands and features of a particular community or area. We found that these factors account for four interrelated dimensions of variation in the degree to which

- ▶ service provision is driven by **structure** and routine vs unpredictable **demand**
- ▶ the role requires a greater or lesser **range and depth of skills**
- ▶ the role is located in a **smaller or larger community**
- ▶ **availability of backup**, i.e. the role is a sole practitioner or a member of a team/group practice.

... therefore it makes sense for rural nurse practitioners to develop an individual statement of scope of practice...

A MODEL OF VARIATION IN RURAL NURSE PRACTICE (*see Appendix 5*) sets out how these factors interrelate and impact. Rural nurses have been able to locate their practice on each of the four continua (Jones and Ross 2003a), demonstrating that roles vary by degree of 'rurality':

1. The nurse's work may be more or less structured and predictable according to the parameters of demand in the work and employment setting, being more predictable when work with other team members structures availability of health services e.g. when a health service has regular hours and programmes, and becoming more demand driven when the nurse is the sole provider of health services in a small community.
2. The availability of back-up support and the need to be on call differs according to whether the nurse is working solo as the primary or only health professional in a remote area, or is working in a multidisciplinary teams in which team members are all physically in one location.
3. The range and depth of clinical skills required by rural nurses also varies depending on whether the nurse is working solo or as one of a number of professionals in the local health service.
4. The demands of managing the professional and personal self increase in smaller communities, as the individual is more visible in and identified with the professional role, but at the same time the individual's private life is more likely to be intertwined with community life.

... which includes competence in managing the demands of the rural context

Although Scharff makes several claims as to the uniqueness of rural nursing, we believe her strongest argument for a unique scope of rural practice is based on the nature of the relationship between professional and clients:

In no other setting is a nurse's practice so thoroughly and integrally a constant factor in the nurse's life. In a society where separating one's private life from one's professional life is considered obligatory, rural nurses are singularly challenged, stripped of their own anonymity while simultaneously charged with protecting their patients' privacy (Scharff 1998:37-38).

The nature of the relationship between nurse and community is an important reason that the rural context requires 'rural competence' to make general or specific clinical skills 'work' in the rural situation. The more 'rural' the role, the more **specific rural specialty competencies** are required.

'Distinctively rural' competencies (*see Appendix 1*) relate to managing

- isolation and distance, and the availability of back up
- the professional and personal self in a smaller community
- nurse/patient relationships in a smaller community
- independence, and interdependence with other health professionals (Jones and Ross 2003a).

It is advisable to keep your scope of practice as broad as you can

Remembering that endorsement as a nurse practitioner pertains to practice in the scope you have defined (NCNZ 2002a:16), it is advisable to keep your statement of scope as broad as possible so that you allow yourself sufficient 'room to move' should your role change, or the community's health needs and responses:

Where scope is fixed in time to provide the workforce for existing health services today, and regulated within bureaucratic structures, the dynamic responsive nature of nursing is submerged (Litchfield 1998:17).

Conceptualising your scope in terms of 'the rural community' may be relevant to future roles in rural areas, and possibly also other communities.

We do encourage you to think about the nurse practitioner role and what possibilities it could create for your community and your own career development ...

Rural practice involves factoring in terrain, weather patterns and access implications; the health needs and culture of transitory and permanent populations; which community members can do what; and how on-call, transport and referral systems work, etc. The need for **lateral thinking** in distant, isolated, sparsely populated and potentially underserved rural communities is paramount.

The creativity that finds possibilities rather than impossibilities in rural practice is well suited to the opportunities for improvements and innovations in health services through the nurse practitioner role.

...and to recognise that your study and reflection will stand you in good stead

The same scholarship that informs your practice at an advanced level, will provide you with the skills for analysing the complexity and contextuality of your rural practice and for the concise and coherent expression of it in a statement of the scope of your practice.

USING A TEMPLATE FOR CONSTRUCTING A PERSONAL STATEMENT OF SCOPE

Nursing Council's parameters for a statement of scope of practice

The **Nurse Practitioner™ Endorsement. Guidelines for Applicants** require a statement of your scope of practice:

This should include identification of the range and parameters of your practice and your area of specialty/subspecialty if applicable. The scope should reflect the dynamic nature of health care and nursing and advanced practice competencies. It should reflect collaboration with nursing and other colleagues working in the same scope. You should also identify strategies that you have in place to maintain and develop your competence within your scope of practice (NCNZ Sep 2002a:10).

Such a statement not only demonstrates that you can concisely and coherently articulate your practice (which of course is the first competency), it also helps the assessors orient themselves to who you are and what your practice is about. It therefore sets up their understanding of why you are applying for nurse practitioner endorsement and should go near the beginning of the application portfolio.

We have suggested reading and exercises which will help you use the template provided

We have explored a number of ways of thinking about scope of practice and provided a number of suggestions for reading and some **EXERCISES**. If you have done these **EXERCISES**, you will have 'warmed up' your thinking and prepared yourself for bringing your thoughts together and editing your notes into a coherent and concise statement of 'what your nursing work involves and what it means'. See page 2 for how the **EXERCISES** and **MODELS** help refine your thinking.

The **TEMPLATE** on page 23 suggests a number of sentence stems that should set you off on a paragraph or two covering the material outlined in the middle column (for which you have already notes from the **EXERCISES**). The right hand column identifies further resources that you may find useful to refer to when writing your scope statement.

One of these metaphors for the statement of scope of practice may help you – or make up your own:

- ▶ an abstract or executive summary
- ▶ an overture to an opera
- ▶ a plot summary on the jacket of a novel
- ▶ the trailer for a film.

Clear the desk!

You will need some uninterrupted time to bring the material from the **EXERCISES** and the resources identified in the **TEMPLATE** together. You know how you work best – some will want to cut and paste bits of paper or word-processed documents, others will start with a blank sheet. If you find verbal expression easier, warm up to writing by talking to a tape recorder or empty chair or colleague or your dog or cat.

Plan to reflect on your draft scope statement and to revisit it. You might leave your first draft for a few days before looking at it again. We suggest that once you have got it 'reading well', that you then

TEMPLATE FOR A SCOPE OF PRACTICE STATEMENT

What we are looking for is a description of your practice in terms of the people/community you care for/work with, their health needs, the skills you bring to that and what it is that you do with them – and of course, your collaborative role with other team members. This **TEMPLATE** provides sentence stems to prompt a set of paragraphs, which will cover all the above points. It also links back to the ideas discussed by ANA(1980)/Salmon (1982) and Litchfield (1998), which you will have covered in **EXERCISE 5** or **EXERCISE 6**. Finally, we remind you to use the resources you have in your practice and the other **EXERCISES** you've completed.

<i>Triggers for your paragraphs</i>	<i>Concepts</i>	<i>Resources and notes</i>
<p>The population for which I am responsible in my registered/rural nurse role is...</p> <p>and their health needs are...</p>	<p>'A core that distinguishes nursing from other health professions by virtue of its phenomena of concern' (Salmon 1982:121-122).</p> <p>Or '...the reach of the nurse: what the nurse attends to and the sphere of nursing activity within the professional partnership [between nurse and client/family/community]' (Litchfield 1998:19-20)</p>	<ul style="list-style-type: none"> ▶ Practice profile ▶ Needs analysis (formal) ▶ Service specifications <p>Needs may pertain to health promotion, maintenance and restoration of health, preventative care, rehabilitation and/or palliative care (<i>see Appendix 4: for 'Climbing Frame' from Jones and Ross 2003b</i>).</p>
<p>My independent (nursing) role meets those needs by/through...</p>	<p>'Dimensions that characterise nursing in terms of its practitioners, its practice setting, and its accountability:</p> <ul style="list-style-type: none"> ▶ descriptions of what philosophy and ethics guide nurses ▶ what responsibilities, functions, roles and skills characterise their work ▶ what scientific theories they use and by what means they apply them ▶ when and where they practice ▶ and with what legal authority nurses function etc' (ANA 1980:17-18). <p><i>also</i> Development activities (your own professional and skill development) that push out the boundary of your practice (ANA 1980:13,16)</p> 	<ul style="list-style-type: none"> ▶ Diary (analyse your 'streams/themes' of work and your focus in each ▶ Reflective writing (e.g. journaling) ▶ 'Distinctively Rural Competencies' (Jones and Ross 2003a) ▶ Job description ▶ Your personal skill inventory, career goals, and learning objectives
<p>As a member of a team which consists of ...</p> <p>...my collaborative (team member) role meets those needs by...</p>	<p>Intersections with the practice of other professionals (ANA 1980:16).</p>	<ul style="list-style-type: none"> ▶ Practice/Team Profile (refer also to Ross 2001)

- ❑ check it against your diary record – does the statement cover everything you do?
- ❑ look at it against what Nursing Council have said is required in a statement (Sep 2002a:10)
- ❑ ask a colleague familiar with your practice to look at it constructively (and kindly!) and give you feedback and suggestions on how to improve it.

Check your statement for congruence with and confirmation by the rest of your portfolio material

Be sure to review it after you have completed your portfolio application, as the process of putting the whole thing together will further clarify your thinking. You may find that your statement holds true for all the supporting material in your portfolio, or that you need to refine it. Obviously, the statement of scope of practice must be congruent with all the other ways you articulate your scope of practice in the portfolio, and vice versa.

Some examples are provided in Appendix 6

We are fortunate that two rural nurses – Sue Grimwood and Leonie Howie – who have worked through the process of defining their scope have agreed to share their work in *Appendix 6*.

We wish to thank them for this brave step, and ask you to respect the originality of their work. Obviously, these statements have been developed at a certain point in time, and it is likely that as their understanding of what ‘scope of practice’ means, and their practice itself develops, that they may come to define their scope differently.

APPLICATION FOR NURSE PRACTITIONER STATUS: PROVIDING EVIDENCE OF YOUR ABILITY TO ARTICULATE YOUR NURSING PRACTICE

Application for nurse practitioner status: providing evidence of your ability to articulate your nursing practice

Your ability to articulate the scope of your practice and its advancement needs to be **evidenced on every page** of your portfolio application.

While Nursing Council has not indicated a particular format for the portfolio – which means that you can make your presentation sympathetic to your material – we recommend organising your material according to the five (or six) competencies. You will need to find a way to direct the assessors to relevant material filed under another competency, e.g. through indexing.

Nursing Council (Sep 2002a: 10-11) suggests a range of types of evidence to include in your portfolio, which include:

- application form
- statement of your scope of practice
- strategies to maintain and develop competence
- confidential referees
- written letters of support/references
- performance review
- peer evaluations
- educational qualifications
- curriculum vitae
- case studies
- exemplars
- quality development initiatives
- client case notes
- educational programmes delivered
- diary
- scholarly activities
- publications
- research
- presentations
- membership and involvement
- current practising certificate
- qualifications achieved
- professional credentialing.

A grid/checklist in *Appendix 7* will help you plan what kinds of evidence to use for each criterion. As you finalise your portfolio, you may like to use the grid again to check that you have included relevant and sufficient material.

Note that we have assumed that if you are applying for nurse practitioner endorsement, you already have the skills and scholarship required to produce these kinds of evidence and probably a significant collection of it. If you have been keeping a portfolio in anticipation of CBPC, or for clinical career path recognition, then this process will be one you are familiar with.

Put yourself in the assessor's place: ask yourself why you are including this material, and ask yourself if you have provided evidence

You are the first and perhaps most important assessor of your application. You must think critically about the relevance, adequacy and sufficiency of the material you put in your portfolio.

Ask yourself of each piece of evidence: Why am I putting this in here? Your answer should give you

- ▶ an explanatory note to accompany the material e.g. ‘This exemplar evidences my professional judgement in assessing a client’s health status and also my ability to rapidly anticipate a situation...’
- ▶ an idea of where else it should go
- ▶ an indication that you need to link it to other material or develop new material to frame it
- ▶ or a decision that it has no place in the portfolio as it stands or at all.

Equally, you must be sure that you haven’t simply asserted that you meet the competencies. A good rule of thumb would be to be sure that you have an example for each of the points under a competency. Remember that several points may be covered in one piece of evidence.

You will get an idea of what the assessors will be looking for in an example of their assessment tool, which is in Appendix 4 of the **Nurse Practitioner™ Endorsement. Guidelines for Applicants** (NCNZ Sep 2002a). We recommend that you study this in-depth, especially as it relates to the first competency.

You will also find helpful points in a brief article ‘Applying Yourself’ (Jones 2003:20-21).

Be sure to get advice, support and feedback from amongst your professional networks

Look to your colleagues in practice, management and academic roles for advice and feedback as you go through the process of applying for endorsement. You may want to strike a balance in those you enlist – a couple of people who will walk alongside you on this part of your professional journey, and perhaps a couple of one-off expert opinions. Don’t forget that NPAC-NZ has set up a network of mentors to support people through exactly this process. You will find NPAC-NZ’s brochure ‘**The Nurse Practitioner: Frequently Asked Questions**’ useful.

Your portfolio prepares you for the interview

Remember that when you are preparing your portfolio application, you are also preparing yourself for the conversation you will have with the assessment panel:

The purpose of the assessment interview is to give you an opportunity to present your practice and your achievement of nurse practitioner™ competencies. The interview also allows the panel to explore with you the content of your portfolio and to clarify in more depth your scope of nursing practice (NCNZ 2002a:15).

One of the key areas of focus within the interview is likely to be ‘Defining your scope of practice (independent and collaborative) including boundaries and how you bring the unique perspective of nursing to your practice’ (NCNZ 2002a:15), for which we hope this resource has helped you prepare.

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APPENDIX 1

'DISTINCTIVELY RURAL' COMPETENCIES

(revised 2003)

Related to isolation and distance, availability of back up

- ▶ assessment and triage as **first-response** to trauma and other life-threatening or serious emergency
- ▶ **mobilizing and coordinating** local and distant resources in emergencies and non-emergencies
- ▶ **planning care** (self, family, nursing and other) that is appropriate to the patient's situation and resources (care anticipates, supplements, involves those resources)
- ▶ **telephone consultation** including advising, counselling and triage
- ▶ **accessing internet based resources** for clinical management, service and community development; and own professional development and networks as a rural nurse.

Related to managing the professional and personal self in a smaller community

- ▶ gaining entrée and **trust**, and establishing **credibility** in a community
- ▶ establishing both **boundaries** for self and with others as a professional and community member; negotiating a changing role; dealing with breaches and breakdowns
- ▶ establishing and utilizing appropriate/safe/discreet sources of **personal and professional support**
- ▶ selecting **community involvements** and roles to align/amplify professional responsibilities

Related to nurse/patient relationships

- ▶ moving into and out of (establishing/negotiating/disengaging from) **effective nurse/patient relationships** with fellow community members/persons known to oneself
- ▶ establishing an effective relationship with the visitor/tourist/ stranger/foreigner
- ▶ engaging with or entering parts of the community where one is not of the dominant **culture** in ways that are safe, appropriate and effective

Related to independence and interdependence with other health professionals and anticipating the development of Standing Orders:

- ▶ practising within current legal provisions and/or **managing cover or accountability** for breaches and difficulties
- ▶ building respectful and productive **collegial relationships** with doctors, other health personnel and other 'officers of the community'
- ▶ managing **timely and appropriate responses and treatment orders** from other health professionals

from Competency Framework for Rural Nurses, Jones and Ross (2003a)

APPENDIX 2

DIARY EXERCISE

Why

Nursing Council's assessment process for nurse practitioner competencies requires that a week long diary is included in the application portfolio. Also, this will help you in your work on scope – particularly to see how well what you do fits in with 'primary health care (rural)', which is the 'scope' that Nursing Council has suggested for rural nurses.

Regarding primary health care, please refer also the 'Declaration of Alma Ata' 1978 (*Appendix 3* and at www.who.int/hpr/archive/docs/almaata.html).

How

Hopefully the outline on the next page is fairly self-explanatory (print as many as you need so you can handwrite your notes or do it on the computer). It will help you capture the events of the day, and you'll be able to expand on this 'bare bones' outline when you record your discussion and reflection later.

What to record

- ▶ **date/time** for each 'event' in your working and on-call day
- ▶ 'events' may include tasks and procedure, and interactions and nursing care, or not involve a patient etc – note a very brief description – **basically everything you do** – which you will write up into a fuller narrative later
- ▶ at the time or later, decide which '**clinical focus**' was most appropriate (and especially if what you were doing could fit under primary health care as per the Alma Ata declaration)
- ▶ note the population **group** best describing the person with whom you interacted
- ▶ also note whether you used Standing Orders (SO) or consulted with a doctor about medications – and if you were able to prescribe, what **medications** you would have prescribed.

'CLINICAL FOCUS'

Mental health
Disease management
Perioperative
Palliative care
Emergency and trauma
Primary health care
High dependency

GROUP

Infant
Child
Adolescent
Adult
Aged
Maori
Pacific peoples
Immigrant communities (tourists???)

adapted from Diary Exercise, Shelley Jones for Centre for Rural Health 2002

APPENDIX 3

DECLARATION OF ALMA-ATA

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

The International Conference on Primary Health Care, meeting in Alma-Ata this twelfth day of September in the year Nineteen hundred and seventy-eight, expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world, hereby makes the following Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III

Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX

All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitutes a solid basis for the further development and operation of primary health care throughout the world.

X

An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

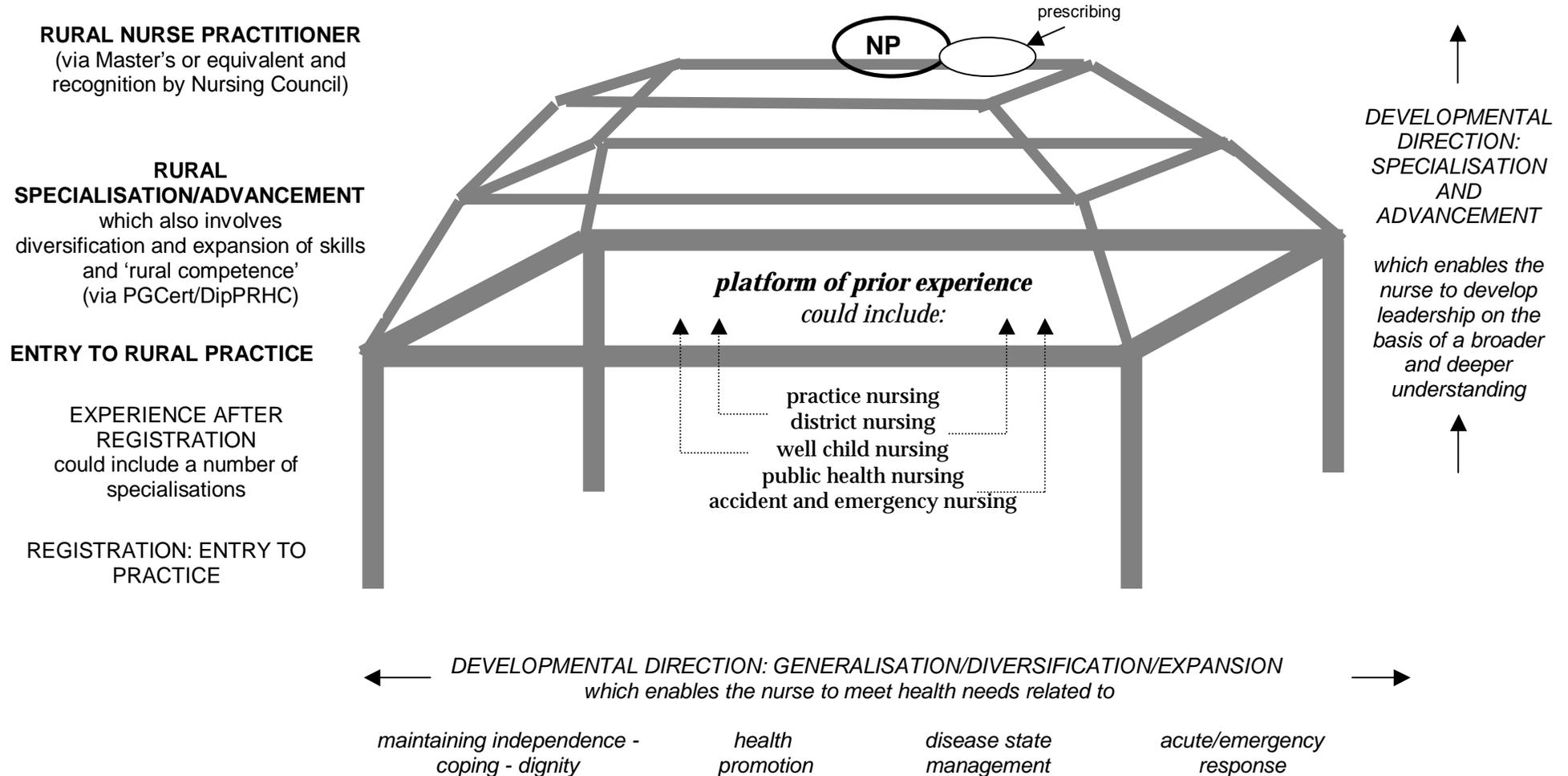
The International Conference on Primary Health Care calls for urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with a New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, non-governmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.

[© WHO/OMS, 1999](#)

<http://www.who.int/hpr/archive/docs/almaata.html>

APPENDIX 4 A SUGGESTED FRAMEWORK FOR RURAL NURSES' CAREER DEVELOPMENT

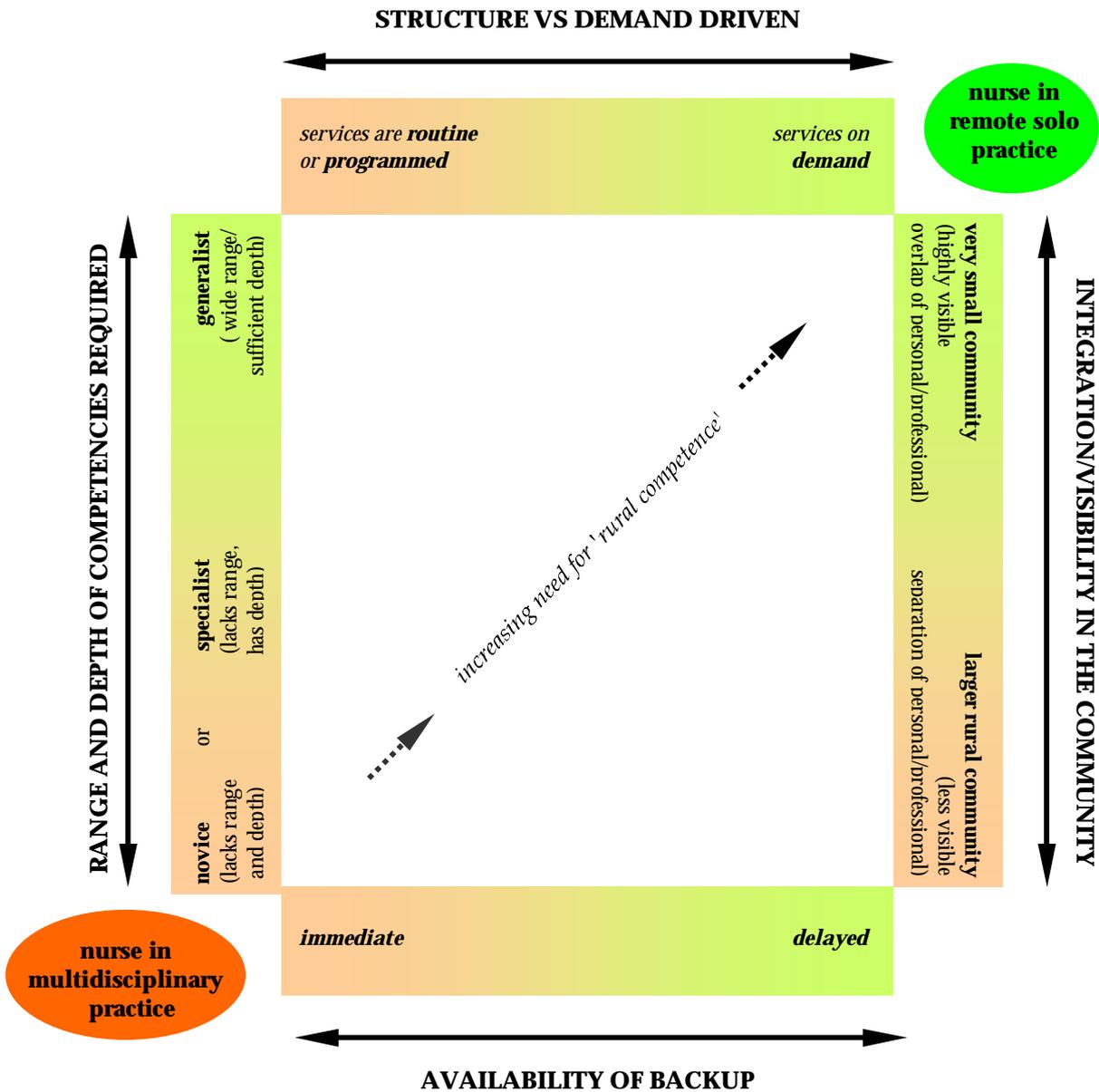
(think of a climbing frame where you can move 'along' and 'up')



from: JONES Shelley & ROSS Jean (2003b) **Career Development Framework for Rural Nurses** Centre for Rural Health : Christchurch

APPENDIX 5

A MODEL OF VARIATION IN RURAL NURSE PRACTICE
(revised 2003)



Note: The bottom and left aspects of the four continua may be thought of as 'less rural' (red tonings) and the top and right aspects as 'more rural' (green tonings).

APPENDIX 6

two examples
OF STATEMENTS OF SCOPE OF PRACTICE

SOME NOTES ON THE PROCESS OF WRITING THESE DESCRIPTIONS OF PRACTICE

by Shelley Jones

These statements of scope are personal and specific to a particular time and purpose

We wish to thank Sue Grimwood and Leonie Howie, two rural nurses who have been willing to trial the process suggested in this resource, specifically to contribute an example for study by their colleagues. These descriptions of their practice, are of course, personal, and specific to their respective context and roles. The statements reflect the writers' practice at the time of writing, and we remind readers that both one's practice and one's understanding of it can change. They have referenced other earlier work (such as assignments and applications) as well as following the process this resource suggests.

What the statement of your scope of practice should do if you are applying for nurse practitioner endorsement

As an application for nurse practitioner endorsement, the statement of your scope of practice should do two things. First, it should provide the panel reviewers with an introduction of yourself as a nurse and give a clear picture of 'what your nursing work involves and what it means'. This introduction orientates the panel in their review of the portfolio – what follows makes sense as the details relate back to the broader outline presented in the scope statement.

Second, it establishes your ability to articulate the scope of your nursing practice, and your personal advancement in it. In other words, how you express and present a description of your practice is evidence of how well you meet the first competency for endorsement as a nurse practitioner (NCNZ Sep 2002:16-17).

We have recommended that you check your statement for congruence with and confirmation by the rest of your portfolio material. Obviously, every point made about the writer's practice needs to be backed up by portfolio evidence. In these examples, material noted in footnotes and references would either be described in more detail, or included in full in a portfolio. The checklist presented in *Appendix 7* is a way to ensure completeness and congruence between the scope statement and portfolio.

Being able to formulate a written description of your practice is evidence of your professional growth and a contribution to professional dialogue

Elements of your advanced practice contribute the 'what' is being described; ability to express that description in a concise and coherent statement is part of the 'how' you are advancing in your practice.

Diers, writing on clinical scholarship, cites Pelikan (an authority on scholarship) to point out that the first quality required is 'the ability to use the mother tongue' (Diers 1995:25). Leonie and Sue have honed their writing skills in the course of advanced study, and it is certainly true that they have put a lot of work into their statements. It is also true that their application and attention has paid off.

I have worked with them in an editorial role, asking questions for clarity and adequacy of explanation (as I am unfamiliar with their practice and its context), and making suggestions on expression and order. I have enjoyed the professional dialogue, and also the trust that has been a feature of our collaboration. Sue and Leonie also asked colleagues familiar with their practice to review their descriptions, and sought critique on a final draft from people who would read it with fresh eyes.

Unsurprisingly, the structure and order of each statement is slightly different, and each has used headings in tune with her own material. The point is that even though writers may go through a similar process in developing a description of their scope of practice, just as the practice is personal, so is the expression of it.

We hope you find these examples instructive and useful.

MY SCOPE OF PRACTICE AS A NURSE IN A RURAL AREA

Sue Grimwood *RGON PGDipPRHC*
Staff Nurse, Akaroa Community Hospital

THE CONTEXT FOR MY PRACTICE

The scope of my practice is significantly determined by the rural nature of Akaroa, where I have been employed for ten years as a Staff Nurse at the Akaroa Community Hospital. My practice as a rural nurse can be described as relatively generalist, but necessarily encompassing more than one specialised scope.

Akaroa is sited on the southwest harbour of Banks Peninsula, serving geographically scattered rural communities in the inner harbour and outer bays. It is a picturesque tourist town, known for its French settler heritage, and its population swells by several thousand over holiday weekends and the summer season. The usual resident population of the Akaroa Ward of the Banks Peninsula district at the March 2001 census was 1668, a decline of 9.5% since the previous census. Demographic factors to note include 17.5% of the population younger than 15, 56% over 65, and 6% identifying as Maori. While there are 198 businesses, there is some seasonal unemployment and a very small number of permanently unemployed. The median income is \$18,500 per annum.

Akaroa Community Hospital is funded by Canterbury District Health Board (CDHB) for five general and two maternity beds. A privately owned two General Practitioner (GP) practice is attached. There is also an 11-bed rest home adjoined to a small retirement village. It is 90 minutes by road to Christchurch for tertiary, outpatient, specialist, laboratory and x-ray services. Much of the highway is hilly and weather-affected in winter.

Emergency and after hours care are provided at the community hospital, attended by the on-call GP. A well-equipped 'first response vehicle' is staffed by St John's trained volunteers. The rescue helicopter service from Christchurch can be scrambled in 12 minutes depending on availability and weather conditions.

Primary health care in Akaroa qualifies for additional funding because of its rurality. Primary health care nursing services available include practice, Plunket, public health and district nursing.

A small rural hospital such as Akaroa's serves the needs of community members and visitors (national and international) to the area. This is the context for my nursing practice. I provide 'cottage hospital' inpatient and outpatient nursing, and accident and emergency triaging and initial treatment within the hospital's accident and emergency room. I am also involved in community well-health promotion and programmes through the local Resource Centre and Safer Community Council; and in research involving community participation in primary healthcare provision.

EXPRESSION OF MY NURSING PRACTICE IN A RURAL COTTAGE HOSPITAL ROLE

Care provided in our hospital includes, but is not restricted to:

- i) Acute and general medical patients with acute asthma, unstable angina, congestive heart failure, pneumonia, varicose/arterial leg ulcers, cellulitis, diabetes, renal colic, sub-acute obstruction (with known history – i.e. with stoma), post-chemotherapy convalescence, blood transfusions and recovery from cerebral-vascular accidents (CVA) and associated cerebral conditions.
- ii) Post surgical convalescent care for patients recovering from cardiac, abdominal, breast, joint replacement and fracture surgery
- iii) Respite care for patients with neurological conditions e.g. Parkinson's disease, multiple sclerosis, motor neurone disease; CVA; chronic obstructive airways disease and heart disease.
- iv) Palliative and terminal care
- v) Postnatal mother and baby care (delivery care is provided by the GP as Lead Maternity Carer and the hospital based midwife).

The Registered Nurse on each shift has sole responsibility for the hospital and its patients. The local GPs provide medical services for hospital in and outpatients. As people may telephone for advice or simply present at the hospital, the RN provides outpatient and after-hours emergency services, including initial treatment and triaging for the on-call GP. Patients are stabilised, and admitted or transferred when necessary.

I am responsible for developing and implementing care plans with patients in my care, where applicable, including whanau/support people. I initiate timely referrals to other health professionals and multidisciplinary team/family group meetings to ensure coordinated care. Ongoing networking means that my relationships with other professionals and providers are collaborative, and as a result of my further study, our interactions more robust and complex.

I work within the regulations of the Nursing Council of New Zealand. I am mindful of the priorities for health service provision set in the New Zealand Health Strategy (2000) and the Primary Health Care Strategy (2001), particularly as they have been translated into the DHB philosophy, goals, policies, procedures and standards, to which I adhere.

My practice is a complementary part of the diverse expertise and skills in our multidisciplinary team. Our teamwork is based on equal, collaborative and mutually respectful relationships. We are committed to health improvement, empowerment and self-reliance for community and individuals, and a responsive health service. Within the hospital environment my professional interactions are with my hospital nursing colleagues, the GPs, practice nurses, physiotherapists, occupational therapist and first response volunteers. Referrals are made to an extended team of specialists based in Christchurch.

I have 30 years of clinical experience, encompassing perioperative, practice and rural hospital. I am committed to continuing professional development and maintaining my clinical competence. Involvement in professional associations, conferences, workshops, inservices and self-directed learning including reading journals and reviewing research has helped me ensure a theory and evidence base for my practice.

My approach to nursing care is to bring together an holistic understanding of the person, advanced clinical assessment, professional judgement and familiarity with best practice guidelines. For me, the best outcome for each patient recognises their uniqueness, increases their health knowledge and facilitates their decision-making and participation in care. Theoretical frameworks I use in my practice are Benner's 'knowing the patient' (1984) and Benner and Wrubel's 'primacy of caring' (1989); Schon's 'reflecting on action' and 'knowing in action' (1983); and Mezirow's 'levels of reflectivity' (1990). Watson's ten factors of human caring encapsulate the holistic care I endeavour to provide (Watson 1985, Houghton 2001).

EXPRESSION OF MY NURSING PRACTICE IN VOLUNTARY COMMUNITY ACTIVITY

I am also involved in community development through two voluntary roles: Coordinator, Community Akaroa Resource Centre and Coordinator, Safer Community Council, Akaroa/Wairewa. While my employed and voluntary roles are separate, the boundaries between primary and secondary care are quite fluid in a smaller community, each informs and lends credibility to the other¹. In these roles I have become involved in health promotion particularly in facilitating partnerships and providing resources and information to allow individual empowerment for self-responsibility and healthy lifestyles.

In-depth knowledge of my community and its culture is the basis of my leadership in the development of two community-based programmes that respond to local needs. In the first, I have been instrumental in working with elderly residents and our local physiotherapist to provide a weekly exercise programme. Evaluation data (Grimwood 2001) show that the programme has improved participants' physical and emotional well-being, social interaction and enabled participants to develop support networks.

The second programme arises out of a relationship with our young people. Together we have ascertained that current primary healthcare services do not provide appropriate or accessible services for some of this age group. Although teens are satisfied with accessing emergency care through the usual venue, for other health needs some are reluctant to use services where they are 'known'. A teen clinic away from the health centre, staffed by a Registrar GP is planned for implementation.

¹ "Selecting **community involvements** and roles to align/amplify professional responsibilities" has been identified as a 'distinctively rural' competency (Jones and Ross 2003a).

Additionally, I co-ordinate meals-on-wheels prepared by a local hotel; and also network with elder persons care co-ordinators, Government agencies and other health providers to facilitate health awareness days and workshops open to all comers.

As an advocate for rural communities and health professional roles within them, each year I prepare and supervise a four day programme – ‘Early Community Contact’ – for ten third year medical students.

I represent both nurses and my local community on a DHB working party for the establishment of a regional rural Primary Health Organisation, and am the Coordinator for the Safer Community Council and member of the local health committee that liaises with the community and DHB. I am also on the management committee of Akaroa preschool. My participation in community activities and committees is not only as a representative of and for the community, but also to ensure the community understands what health professionals’ roles can contribute and what it means for health professionals to practice in the rural community.

EXPRESSION OF AN ‘ADVANCING’ PRACTICE

In 2001 I completed a postgraduate Diploma in Health Sciences, endorsed in rural primary health care, through the University of Otago. The Diploma included advanced assessment for adults and paediatrics, and primary response in medical emergencies (PRIME). This expanded clinical knowledge and skill means that the working relationship with the local GPs is based on confidence and trust in my assessment and initial treatment in accident and emergency presentations at the hospital. Being able to deal with the non-urgent presentations (e.g. diarrhoea and vomiting) has reduced the rigorous on call-demands made on the GPs. I have recently completed additional post-graduate papers, also through the University of Otago, in health promotion and palliative care.

University level study enabled me to become a critical thinker and reflective practitioner, and to generate new approaches to the extension of my knowledge and the delivery of expert care with patients. I believe that my initiatives to monitor and audit the quality of patient care are an expression of clinical scholarship (Canadian Association of Schools of Nursing, undated), and as some of these tools and templates are being used in other rural hospitals within our DHB, they are having an impact beyond my own sphere of responsibility².

Research skills developed through post-graduate education have been useful to me as the primary author of two reports designed to support rural communities’ involvement in the provision of primary health care services (Grimwood & London 2003a, 2003b). These two resources, funded by the Ministry of Health through the Centre for Rural Health, address the sustainability of primary healthcare services in rural areas. The findings indicate that community empowerment, involvement, decision-making and ownership are key. However, as much as what research ‘proves’, it is my long-time membership of the Akaroa community (22 years) that means I am involved in community support and advocacy.

I believe my practice is approximating this definition of advanced practice:

“Advancement involves both specialization and expansion and is characterised by the integration of a broad range of theoretical, research-based, and practical knowledge that occurs as a part of graduate education in nursing” (ANA cited in Cronenwett 1995),

but I am more comfortable with Litchfield’s idea of an ‘advancing’ practice (1998), as I believe that there is always more to be learned from practice, from the people and community I care for, and in my continuing enquiry and education.

ACKNOWLEDGEMENTS

My thanks to Shelley Jones for feedback that helped me refine this statement, and for her editorial advice and input.

² One example is an audit tool I developed for surgical wound infections and breakdowns in patients with low post-surgery haemoglobin levels. Audit results from the local rural hospitals will help determine the incidence of compromised suture-line healing in patients with unreported yet significant blood loss during surgery and indicate the need for early intervention with iron or red blood cell replacement to enhance healing and recovery. Another example is the development of an ‘Accident and Emergency Algorithm’ for nurses to use when patients present at the hospital after-hours. The flowchart format, developed with the involvement and approval of our GPs, provides guidance for the nurse’s first line treatment until the GP arrives. It is also available as a template for modification.

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MY SCOPE OF PRACTICE AS A NURSE IN A RURAL AREA

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THE CONTEXT OF MY PRACTICE

Te Motu o Aotea (Great Barrier Island) lies in the Hauraki Gulf, 90 kms from both Auckland and Whangarei. Ngati Rehua are the tangata whenua. The Island is predominantly rugged bush clad mountainous terrain, which supports a widely scattered community of 1086 permanent residents (Statistics New Zealand, 2001). The population is in decline – it has decreased by 4.9% since 1996, compared to total New Zealand population growth of 3.3%. Demographic spread has changed from a younger to an older population over the last four census periods. In addition to permanent residents there are an estimated 30,000 visitors per annum (Tourism Auckland) attracted by the wilderness, the east coast white sandy beaches and marine activities.

A characteristic of this unique community is its lack of infrastructure. There is no reticulated power, public transport, bank, secondary schools, ambulance service nor hospital. The roads are predominantly unsealed and commercial transport both within and off the island is expensive. The median adult income is only \$11,700 per annum (Statistics New Zealand, 2001) and the unemployment rate high at 17.4% (Work & Income New Zealand, 2002). Low incomes coupled with limited local provision of most social services impacts heavily on health service provision, as does the changed age group composition in that the elderly have a different and greater set of health needs compared to the young.

Responding to health needs within this environment are two key health bodies. The first is the Great Barrier Island Community Health Trust, which owns both the main central and northern satellite health centres, the vehicles and all health related equipment. These facilities are leased to the service provider. The Trust influences health and socio-economic policy on the Island, and its structure and formation may pre-empt the requirement for PHO development.

The second body is Aotea Health Limited, a nurse-led primary health care company contracted to provide comprehensive services. It is owned by a nursing colleague, a clinically focused general practitioner and myself. Together we hold a tripartite directorship. It is considered innovative in its formation and continuing governance. As a director, my key non-clinical responsibilities are policy development, quality management, resource allocation and MOH/DHB contract negotiation. The employed members of the team consist of a second general practitioner, two rural nurses, a community worker and reception staff.

The Aotea Health team is concerned with the total wellbeing of the community. We work in partnership with individuals, whanau/families, and the community as an entity. We have assessed the community's health needs as encompassing culturally appropriate health promotion and education for disease prevention, interventions for trauma and acute and chronic health problems, rehabilitation and palliative care. As there are no other primary health care services or local secondary services, we are involved in meeting health needs spanning the life continuum from conception to death. Responsibility for nursing care of the population is divided according to geography and the specific skills of the nurse. Responsibilities are negotiated between nursing and medical roles on the basis of team members' availability, workload and disciplinary boundaries. Although the health centre has regular hours of opening, the reality of rural practice means that the setting is determined by the circumstances at the time.

MY PRACTICE ROLE AND TEAM RESPONSIBILITIES

My clinical role is based at the central modern well-equipped community health centre, and can be best understood as that of a practice nurse. However, the needs of our small remote rural community mean that my role is significantly different from my city-based counterpart – it has aspects of generalist, specialist and expanded practice. Rural nursing at times complements the practice of other health professionals and at times substitutes for them. As the boundaries between nursing and medical practice can become blurred, I endeavour to refer appropriately, and to practise ethically and within the legal limits of nursing practice using best practice guidelines and standards relevant to primary healthcare.

Although I am not tangata whenua (my tribal affiliations are with the Waikato iwi and Ngati Wairere hapu) I share with the Ngati Rehua a common cultural heritage, which suffuses my nursing care. I base my personal nursing philosophy on holistic caring and a commitment to community growth. Neuman's Health Care Systems (1982) model is a guide in my practice as it embodies a multidimensional total-being approach to wellness. It provides a framework for the coordination and direction of my nursing activities and yet is flexible enough to contend with the complexity of individual, family and community need. In any setting, I seek to develop relationships that are therapeutic, caring and collaborative.

Health promotion and health education

Aspects of my practice role that are considered generalist are those directed towards improving health outcomes. Activities concerning the promotion of wellness divide into three interconnected spheres: that of community, the whanau/family and the individual.

Community activities involve networking, consulting and participating in the local body political arena on issues pertaining to health. I represent the health team on the 'Summer Management Team', which plans and oversees services when the influx of summer visitors can be in excess of 12,000 on any given day.

Health promotion at the family/whanau level often deals with social issues impacting on family wellness such as housing, water supply and finance as there is no social worker on the Island. As a Registered Midwife, I maintain registration as a Lead Maternity Carer in order to collaborate with and support the resident midwife and cover antenatal and postnatal care when she has leave.

Individual wellness is promoted through specific health assessments. These span the life continuum from well-infant to well-adult and include management of cervical and mammography screening. Immunisation involves health promotion and education, the systematic recall of children and adults, the maintenance of the cold chain, and clinical care. The only children not vaccinated are those from families who have made a conscious, informed choice against vaccination.

I am a strong advocate for health education and have been able to view longitudinally its impact on this community in relation to preventing health problems and improving health outcomes. Issues of privacy, important in a rural community, combined with the widely scattered population base mean that education is often on a one-to-one basis. Health and lifestyle issues are the focus, e.g. exercise, Sun Smart, family planning, accident prevention, stress reduction, weight and nutritional management, as well as issues of addiction, recreational drug use, alcohol and tobacco. I have at my disposal an extensive pamphlet, lending video and book library, which I have been instrumental in setting up, and which is now administered by the Aotea Family Support Group and health team. I am also able to coordinate visits to schools and community groups by specialist educators and services, e.g. Cancer Society/Sun Smart, the Regional Children's Dental Service.

Disease management

My generalist nursing practice has both autonomous and collaborative aspects, and is directed to improving health outcomes in acute and chronic illness. This involves holistically assessing and planning care based on current best practice and implementing nursing interventions. Nursing care can involve managing complex situations, case review, advocacy, and debriefing. For palliative care I am involved with the other rural nurses in providing a home-based service, which entails accessing specialist information, symptom control and care delivery.

Within my broader rural practice I have sought an in-depth level of nursing knowledge and skill in three subspecialties: diabetes, and methadone maintenance and asthma.

Many of the people with diabetes have co-morbidities and other complicating factors, and may not be able to manage the difficulties and cost of travel to Auckland for specialist consultation and services. I have therefore developed a special interest and clinical leadership role in this area, through self-directed updating and by drawing on a network of clinical mentors. Diabetes care is audited by a diabetologist and diabetes nurse educator during their annual visit, and appropriate changes are instituted.

Supported by the prescribing general practitioners and the Regional Alcohol and Drug Service, I coordinate the methadone maintenance programme. This involves an intensive long-term relationship with clients to support them as they regain stability in their lifestyle, re-establishing health, employment and family function.

I am also currently establishing a nurse-led asthma clinic, as part of a disease management strategy. I have completed the Unitec/Asthma New Zealand undergraduate paper, 'Asthma Nursing' and undertaken a clinical update. With the guidance of a clinical mentor I have established a framework and the working knowledge necessary to successfully complete my first year clinical audit.

My involvement in Primary Response In Medical Emergencies (PRIME) demonstrates an aspect of expanded practice required in rural nursing. PRIME is a national initiative designed to ensure a high standard of response in medical and trauma emergencies by rural health professionals. There is no ambulance service on the Island, and when helicopter transfer is required to quaternary services at Auckland City Hospital, it takes on average 90 minutes from request to its landing at the airfield beside the health centre. (Ambulant patients are transferred on scheduled flights in fixed wing aircraft). Our team therefore needs to be able to triage, assess, support life and manage evacuation to mainland specialist care, and accordingly I undertook PRIME training as I am on a 1:2 on call roster. The intensive initial PRIME training is followed by ongoing refreshers every two years. Specific skills achieved include intubation, intravenous cannulation, interosseous infusion, and chest drainage.

All the areas discussed above are examples of providing practical clinical leadership within the team (and especially for the nurses) by setting a standard and initiating evidence-based practice. As an employer I am involved in facilitating team building activities and in-service education. Isolation has deepened our commitment to one another and I believe that the resulting teamwork is the vehicle for maximal performance. I enjoy being a role model and a mentor within this framework.

GROWING IN MY PRACTICE

My nursing knowledge has its foundation in my formal preparation for registration. Postgraduate education has supported specialisations in neurosurgical, community health and rural nursing. Despite the constraints that geographical isolation presents I have ensured my growth and development as a practitioner by regularly attending workshops, conferences, and reading nursing journals.

During the last five years I have experienced significant development in the way I practise and this is reflected in my extended job description. My study for the Post Graduate Diploma in Primary Rural Health Care has enabled me to integrate theoretical research-based knowledge with the in-depth practical skills I have gained through experience. It also has honed my critical thinking and problem-solving ability, which has enabled me to be more creative, flexible and intuitive in assessing, planning and managing care. I have enrolled for a clinical master's degree, as I believe it will support my pursuit of clinical scholarship as a life long learner, and I therefore consider myself to be 'advancing' in my practice¹.

Community development and involvement

In the process of meeting coursework requirements in our rural specialisation, my nursing colleague and I used quantitative and qualitative research methods to develop a detailed community profile for Great Barrier Island (Howie and Robertson 2002). The profile has since been utilised by Auckland City Council for policy decisions related to Great Barrier and by government departments when planning local services. It is also the basis of Aotea Health's service planning.

Since its inception eight years ago, Aotea Health has operated in an environment of contract-based purchasing of health services and has needed to advocate strongly on behalf of the community for appropriate levels of funding. We have been required to formulate appropriately audited policies and protocols. Each has challenged my analytic ability and skills involved in research and development, until the definitive policy has been produced. My confidence in this area over time has improved. I also bring these skills to my governance role with the Great Barrier Island Community Health Trust, where I am the Trustee representing practising nurses. As a member of its Management Committee, I am the Secretary, Supervisor of the Community Worker, and carry a policy development portfolio.

¹ By this I mean progressing towards 'advanced nursing practice' as defined by Nursing Council, which "...reflects a range of highly developed clinical skills and judgements acquired through a combination of nursing experience and education. Essentially, advanced nursing practice requires the application of advanced nursing knowledge, with practitioners drawing not only on their clinical experience, but also on the experience of the profession as a whole" (NCNZ May 2001:28).

I am a member of Te Motu O Aotea Maori Women's Welfare League and Te Taurahere O Aotea. Both actively build strong cultural networks within the community.

Professional development and contribution

My professional accountability is expressed in membership of the New Zealand Nurses' Organisation (NZNO), and the New Zealand College of Practice Nurses and Te Runanga O Aotearoa of NZNO. I have been a member of the Rural Nurses National Network since its inception. Membership of other professional bodies includes the Northern Rural General Practice Consortium and the Rural General Practice Network, which are both very supportive of our otherwise isolated team.

Although I practice in a remote location I have nevertheless been able to contribute to national professional development. Examples include: (1) auditing pre-course material for a postgraduate nursing paper I had previously undertaken and (2) contributing this description of my practice for a web-based resource for rural nurses.

In this small and intimate community environment, where I am an established and accepted member, I take care to manage my personal and professional selves in a way that retains the trust of community members. Leading a balanced lifestyle in the face of such a demanding professional life is key to surviving in this environment. My self-care is now based on setting realistic boundaries, having professional supervision fortnightly, infrequent access to a counsellor for personal needs, a vibrant family life and a group of discreet, supportive friends and colleagues.

I have worked as a registered nurse on Great Barrier Island for 17 years. I am committed to this remote rural community, to the collaborative primary health care team of which I am a member, and to my own role in which I need to bring together generalist, specialist and expanded practice. I have discovered that with increasing expertise comes a sense of responsibility and this undergirds the teamwork and community development that our rural health service is achieving.

ACKNOWLEDGEMENTS

I would like to acknowledge the guidance I received from Shelley Jones, which made drafting this description a positive learning experience.

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APPENDIX 7

**CHECKLIST: DESCRIBING YOUR SCOPE OF PRACTICE
IN THE APPLICATION FOR NURSE PRACTITIONER ENDORSEMENT**

<i>types of evidence and documentation</i>	<i>NP competencies</i>				
	Articulates scope of nursing practice and its advancement	Shows expert practice working collaboratively across settings and within interdisciplinary environments	Shows effective nursing leadership and consultancy	Develops and influences health/socio-economic policies and nursing practice at a local and national level	Shows scholarly research inquiry into nursing practice
application form					
statement of your scope of practice					
strategies to maintain and develop competence					
2 confidential referees					
written letters of support/references					
performance review					
peer evaluations					
educational qualifications					
curriculum vitae					
case studies					
exemplars					
quality development initiatives					
client case notes					
educational programmes delivered					
diary					
scholarly activities					
publications					
research					
presentations					
membership and involvement					
current practising certificate					
qualifications achieved					
professional credentialing					

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with reference to **Nurse Practitioner Endorsement: Guidelines for Applicants** (Nursing Council Sept 2002a)