N3ET Summary of Responses to:

A National Specialisation Framework for Nursing and Midwifery

Defining and identifying specialty areas of practice in Australia

Background

In May 2006, N3ET released *A National Specialisation Framework for Nursing and Midwifery: Defining and identifying specialty areas of practice in Australia*[1]. As part of the work referred by Ministers on specialisation, N3ET commissioned a team from Deakin University to develop the framework. An invitation was extended to all interested parties to respond to the framework and the consultation period was one month. In addition to inviting all registered stakeholders, specific invitations to review the document were extended to all chief nurses, all nursing and midwifery regulatory authorities and the Australian Nursing and Midwifery Council, the Council of Deans of Nursing and Midwifery (ANZ), all members of the National Nursing Organisations, the Australian College of Midwifery, the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and members of the Australian Health Workforce Officials Committee.

Over 25 individuals or organisations provided comments to the Taskforce on a range of issues related to the document and the framework development process. Fifteen were from organisations (three regulatory authorities, two industrial bodies and eight specialty interest/professional groups). This document is a summary of the issues raised by the respondents. It is an attempt to capture the main themes to provide stakeholders with an overview of responses, rather than a detailed analysis.

General comments

The specialisation work, mandated by Ministers has a clear workforce imperative rather than a professional one, which was clearly a point of tension for a number of the respondents. With the exception of medicine in Australia, there are no other specialty frameworks, although some respondents erroneously thought that the specialties were being made to fit within existing data sets or that comprehensive specialty data was kept by the regulatory authorities.

Many of the respondents began with reserved approval for the development of the framework, commending the work done, congratulating the authors and acknowledging the need for the work in this area. A number commented on the methodology – "*valid and comprehensive*" and "*well researched and well presented and the outcomes have been justified".* It was felt by one respondent that the document itself was well set out. One organisation wrote that they '*strongly support the establishment of a specialisation framework for N & M practice…'.*

Some respondents then went on to raise questions about various issues within the report. There was a call for the criteria to be better defined and a request for definitions of included acronyms. One respondent felt that the framework did not fulfil the requirements set out in the report. There was also some confusion regarding the role of the paper in defining specialisation, as opposed to identifying specialties. It was also observed that an agreed definition of specialist nursing (a list of ten criteria), already exists, having been developed and endorsed by the NNOs. It must be noted that this was actually one of six documents used by the authors in developing the framework and referred to in the framework.

The rationale for including clinical and non clinical areas such as health care planning and education and research as legitimate areas of practice had been included in the document however this was questioned by a number of respondents. One respondent asked: '*Is the framework intended to cover the entire range of nursing practice, including non-clinical practice within its* ***practice strands****?'*

There were concerns voiced regarding a perceived lack of consultation without acknowledgement that the respondents were engaging in a formal part of the consultation process by providing comments and responses. Some felt that the timeframe did not allow for wide consultation, with a request that the report be an interim document.

Some respondents felt there was not enough emphasis on chronic diseases or illness and others felt it did not reflect the many highly specialised (and often acute care focussed) subspecialties within either the recognised specialties or the practice strands.

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[1] The Framework is available to download from http://www.nnnet.gov.au/downloads/recsp_framework.pdf

Criteria

Generally the criteria proposed were well received although a couple of respondents suggested some alteration to the wording and some thought some criteria needed further explanation. The actual terms used was of concern to some, such as the use of areas of 'care' instead of 'nursing', 'family' and the meaning of the 'functions' of nursing and midwifery. Whilst concerns were raised about the language, alternatives were only supplied in a few cases.

Specialties

In terms of the specialties themselves, most respondents felt that the identified national specialties were too broad and that some areas of practice that should be recognised specialties had been excluded. It was felt by one respondent that '*to collapse over sixty specialties of nursing into fourteen seems unreasonable'*. There was also some doubt expressed as to whether those fourteen categories were the right groupings, eg. that health care planning and management is not nurse specific. Some doubts were expressed about the inclusion of one area and not another, eg. renal care, but not respiratory care.

Eleven respondents argued for the inclusion of their own area of practice as a specialty. Each of them delivered their argument, very often with detailed evidence they believed was relevant and that demonstrated how they understood they met the criteria for inclusion. These areas included:

- Cardiovascular nursing
- Pain management
- Rehabilitation
- Alcohol and drug use
- General practice
- Diabetes
- Neonatal intensive care

Several other respondents expressed dismay at the exclusion of their own area as either a specialty or a practice strand, without providing a case for inclusion. On the other hand, there were several requests for any reference to midwifery to be removed from the document on the grounds that '*this specialisation framework fails to identify midwifery as a separate profession from nursing*'. Midwives had difficulty with the notion of a framework that could (or should) encompass both nursing and midwifery but offered no solutions to address areas of tension such as where skill sets might be shared across disciplines such as neonatal care.

Although some respondents questioned the first criteria (related to "national in scope"), a number of responses in fact demonstrated how important a national perspective is rather than a State/territory based one when identify specialties. Several respondents from NSW were concerned about the exclusion of disability from the framework. Only one respondent acknowledged that the transfer of disability services from health to social has largely occurred across Australia as a purposeful policy, but argued that this was difficult for the nurses who were still working in the area and so the framework should not encourage that policy or position.

Practice strands

This was the least understood area of the framework and as it is a novel part of the framework, the difficulties a number of respondents had is understandable. The main issue appeared to be that many readers incorrectly interpreted the practice strands as "subspecialties" in the conventional sense that medicine (and by default nursing) uses. Some respondents proposed, "manipulating" the criteria to ensure the inclusion of their preferred specialties, suggesting they did not understand the purposes of identifying (and then applying) criteria to provide a robust and defensible methodology. It was apparent that in some cases, the respondent's view of a particular skill and knowledge set differed from the authors' view, and several mistakenly thought that because a skill set appeared linked to one practice strand, it could not be used across others.

Some respondents felt that the practice strands were too broad and that '*many will cross different skill domains and fit under a variety of specialties*. The location of practice strands relative to specialties, caused some comments and raised questions such as why continence was *confined* to gerontic health (assuming because it is located as a practice strand associated with Gerontic health that it cannot be practiced in other settings).

Others argued that some practice strands were in fact considered to be specialties, citing palliative care as one example. One respondent suggested that infection control would fit into a practice strand, but was

unsure of which grouping, while another felt that there were many areas omitted from the practice strands, citing several examples, including hospital in the home, medication management, pain management, diabetes education and asthma education or medical imaging. It was pointed out by another, that adolescent health appears twice, perhaps not appreciating that child and adolescent 'care' related to mental health and was distinct from adolescent health) while another commented that there were no provisions for areas such as forensic nursing (when it was included).

Questions

Questions were raised regarding whether any process would be put in place to update the list and how that might be managed, who would be given the responsibility to further develop and monitor the list, and whether the list would be linked to pay scales. One respondent asked: '*In practical terms, will it make a difference to be recognised as a national specialty, rather than as a practice strand?*'

Next Steps

At this time, the Deakin Team is currently reviewing in detail all the responses and will shortly be advising N^3ET of any modifications that may be required. The framework will then be updated and made available to stakeholders in late July 2006. The responses received will also be useful for revising how the framework is contextualised and presented to stakeholders.

10th July 2006