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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF DR NOELLEEN KIPRILLIS

I, Noelleen Kiprillis, of [redacted] Melbourne in the State of Victoria, sa

1. I am a member of the Australian Nursing and Midwifery Federation (ANMF) and I make this statement based on my experience as an Enrolled Nurse (**EN**) and as a Registered Nurse (**RN**) in the nursing profession, as well as an employee of the ANMF.

Work history and qualifications

2. I am a registered nurse and the Lead – Strategic Programs and Engagement of the ANMF Federal Office. I have held this position since May 2025.

3. Prior to my current role at the ANMF, my work history is as follows:

    a. Eastern Health, Associate Director – Learning and Teaching, Permanent part-time, July 2022 to April 2025
    b. Eastern Health, Acting Director of Nursing, Box Hill Hospital, Permanent full-time, May 2023 to November 2023
    c. Monash Health, COVID Monitoring, Casual, around October 2021 to January 2022 (4 months)
    d. Monash Health, COVID Immuniser, Casual, around March 2021 to October 2021 (8 months)
    e Alfred Health, Team Leader in COVID Hotels, Casual, around October 2020 to February 2021
    f. St John of God, Theatre Registered Nurse Berwick Hospital, Casual, 2012 to 2015
    g Monash University, Lecturer in Nursing and Midwifery, Permanent, part-time, February 2010 to July 2022
    h La Trobe University, Lecturer in Nursing and Midwifery, Permanent, part-time, January 2009 to January 2010
    i. Monash Health (formerly known as Southern Health), Clinical Nurse Specialist, Permanent, part-time, November 2006 to around January 2009

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j. Monash Health (formerly known as Southern Health), ICU RN, Permanent, full-time January 2000 to November 2006
k. Monash Health (formerly known as Southern Health), Graduate Registered Nurse, Permanent, full-time, January 1999 to January 2000
l. Kingston Centre (a residential aged care and rehabilitation facility), Enrolled Nurse, Permanent, full-time, February 1992 to June 1993

4 I became a hospital trained enrolled nurse (EN) in or around February 1992 and subsequently became a registered nurse in 1999. I have attained the following qualifications:

a. Bachelor of Health Science (Nursing) – Victoria Institute of Technology
b. Graduate Certificate of Critical Care (ICU) – Monash University
c. Certificate IV in Training and Assessment (ANF)
d. Bachelor of Nursing (Honours) - Monash University
e. Graduate Certificate of Health Professional Education - Monash University
f. Clinical Governance stackable – Eastern Health
g. Master of Nursing – Monash University
h. PhD – La Trobe University – a multi-modal study that investigated horizontal violence for newly qualified nurses in their first year of practice

5 I also have certifications in Clinical Governance from Eastern Health and Deakin University and have completed the Executive Ready Program from Women in Leadership Australia. I am a longstanding member of both the ANMF and the Australian College of Nursing (ACN).

6 After my clinical practice experience, I spent 12 years working in academia at Monash University, including a brief period teaching overseas at Brighton University in the United Kingdom. Beyond my own research and teaching experience, I was also engaged in several leadership roles:

a. Deputy Director of Education, School of Nursing and Midwifery
b. Clinical Coordinator, Masters of Nursing Practice
c. Clinical Governance Lead, School of Nursing and Midwifery
d. Course Coordinator, Bachelor of Nursing at Clayton and Berwick campuses
e. Year Level Coordinator, Bachelor of Nursing at Clayton campus
f. Further curriculum and career development work, including chairing academic misconduct committees and clinical placement misconduc committees

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7. In my current role at the ANMF as Lead – Strategic Programs and Engagement, I am responsible for leading a team of specialist officers across several priority areas including aged care, education and professional standards in nursing and midwifer I provide advice to our Federal Executive and lead strategies to achieve change and deliver political, policy and campaign wins for ANMF members. I also lead external engagement with government and other nursing and midwifery bodies to build alliances to improve the ANMF's influence on decision-making and public policy development.

Enrolled Nurses (ENs)

My early career experience as an EN

8. I started my working life as an EN in the early 1990s. When I left school I didn't want to go straight to university and I wasn't sure what I wanted to do. I decided to become an EN. I was one of the last cohort to qualify as a hospital trained EN. Hospital based training as a stand alone pathway to registration finished in 1992.

9. At this time, becoming registered as State Enrolled Nurse (**SEN**) – Division 2 involved hospital- based training. I attended 6 weeks preliminary training at a nursing school in South Yarra. The training was Monday to Friday and involved practical training. I learned caring skills, including how to wash people, make beds, feed people and basic clinical education.

10. After completing the 6 weeks preliminary training, I went straight to full time work at the Kingston Centre, which was part of Monash Health as a paid student. We were employees and included on the regular roster. I was rostered in three different wards. We had a study day every 6-8 weeks and educators supported us as we worked. It was very hands on training, done under the supervision of an RN and other enrolled nurses.

11. The SEN role at that time was patient care, it was very similar to personal care work now. The work involved feeding and washing patients. I learned how to use a lifting machine, how to do simple wound dressing, catheter care and to take vital signs. I learned how to document the patient care provided. It was very task focussed, but the education we were provided did focus on disease states and nursing care.

12. We were not authorised to administer medication, except for using suppositories.

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13. After 12 months as a student SEN, I sat the exam to become a registered SEN. This was Victorian state based, all SENs did the same exam. I passed the exam, which tested my knowledge of how to provide nursing care to patients. Many of the questions focussed on how to do a skill safely, with basic anatomy and physiology tested. The exam was a combination of multiple choice and short answer responses. After successfully passing the exam I was able to register with the Victorian Nurses Board as an SEN Division 2.

14. After becoming registered, I worked at Kingston Aged Care for about a year. My work involved providing nursing care and rehabilitation for elderly patients. I reported to and was supervised by an RN.

15. After about a year, I travelled overseas for a few years. When I returned I enrolled in a Bachelor of Nursing in order to become an RN. I continued to work as an EN in aged care while I studied. At that time, aged care was mostly delivered by ENs and RNs as the role of PCWs wasn't prevalent as it is now.

16. Back then, the role of the EN was very care based. These days, ENs can do almost everything an RN can do, except lead clinical care. ENs are trained in how to recognise deterioration, escalate concerns and provide the required care, subject to the direction and supervision of an RN. This represents a real shift from what the role was like in the 1990s when I was an EN. I say this having regard to my later experience, detailed below, overseeing ENs in acute and aged care settings.

17. I qualified and became registered as an RN in 1999.

18. I completed my PhD in Nursing in 2022. My PhD investigated the prevalence and experience of horizontal violence of nurses in their first year of practice.

My experiences working with ENs

19. I started working as an academic in 2010 at Monash University. Part of my role was to support ENs who were enrolled in a Bachelor of Nursing in order to become an RN. Many of these ENs had completed the Diploma of Nursing, so when they enrolled in the Bachelor's degree they got recognition of prior learning (RPL), which meant that they did not have to do the first year of the degree. They enrolled directly into second year.

20. In this role at the university, my colleagues and I observed that some ENs found the transition from vocational training to academic training difficult. They were very skilled in practical clinical care, but lacked academic study skills needed to

complete a degree. The University developed a transition program for ENs to transition to university life. One of my roles was to teach in this program. The course was voluntary and focussed on academic writing and library skills. This course created a pathway for those ENs who needed additional support to upskill in key areas and succeed in obtaining a degree qualification. The course was particularly helpful to those students who were migrants or who had not completed secondary education.

2 . I was involved in the EN to RN transition program for many years. My observation over that time was that ENs entered the course with increasing levels of practical skills. They were very good at showing students who had not worked as ENs how to do practical care delivery. They also had good skills dealing with families and patients. Their learning was focused on implementing the fundamentals of patient care they had practised for some time in the broader scope of practice of an RN. ENs transitioning to RNs significantly expanded their knowledge base and learnt new skills in prioritising and directing clinical care.

22. In 2022 I left working at the University and started work at Eastern Health in the role of Associate Director Learning and Teaching, Acute, Complex Medicine, Residentia Aged Care Services (RACS) and Care at Home.

23. My team supported ENs who were on placement in the health service, while doing their Diploma and also graduate ENs transitioning into the workforce. My role involved overseeing these programs and responding to any discipline or performance issues that came up for ENs whilst on placement or as graduate ENs. also managed another employee of Eastern Health who was the educator for ENs working in aged care.

EN training

24. I can provide the following summary of EN training over the years by reference to my own career as an EN, the roles I have held at academic institutions and my current role at the ANMF Federal Office.

25. By the mid 1990s ENs could study a 12 month program at TAFE. The course focused predominantly on patient care in an aged care setting, though there was an opportunity to work in an acute setting.

26. In the 2000s the course to become an EN moved to being a Diploma course. By 2008, a Diploma in nursing was a requirement to become registered with the national registration body, the Nursing and Midwifery Board of Australia (NMBA).

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27. In the 2000s, ENs could do an additional subject which allowed them to be endorsed to administer oral medications and later intravenous medication as well. They were referred to as Endorsed ENs (EENs) and this was a separate category of registration. By 2008, all programs included medication administration in their courses. This meant that the registration category of EEN was grandfathered, and all new registrations were as an EN.

28. The Diploma course is now a minimum of 18 months, and can be a two year course. In Victoria, it is a two year VET approved program, with 400 hours of clinical placement. There are strict guidelines on the breakdown of what must be done over the course of the 400 hours.

29. The Diploma is delivered in the VET sector. Education and training is provided by a registered training organisation (RTO). The RTO that delivers the program is regulated by the Australian Skills Quality Authority (ASQA). Teachers within the program must hold a Certificate IV in Training and Assessment, which is a vocational qualification. Many members of my team at Eastern Health held this qualification.

30. There are strict requirements in competency to be completed, in line with the EN standards of practice, that must be completed throughout the two year Diploma. These competencies are formulated by reference to the Diploma of Nursing training package. The program must be accredited by the Australian Nursing & Midwifery Accreditation Council (ANMAC) and is subject to oversight from the NMBA.

31. Annexed and marked **NK1**, **NK2**, **NK3** and **NK4** respectively are copies of the HLT54121 Diploma of Nursing qualification, the ANMAC Enrolled Nurse Accreditation Standards, the NMBA Enrolled Nurse Standards for Practice and an NMBA 'Scope of practice and capabilities of nurses' fact sheet.

EN registration

32. Once an EN has obtained their Diploma, they can apply for registration with the NMBA under the auspices of AHPRA. An applicant for registration must provide evidence that they have met the requirements of the Diploma, including having completed 400 hours of placement experience.

33. To maintain registration, ENs have a responsibility for their own Continuing Professional Development (CPD). Like RNs, they must complete 20 hours of CPD each year. On request, an EN must provide evidence of the CPD undertaken and that

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it is relevant to their scope of practice. Annexed and marked **NK5** is a copy of the NMBA's Registration Standard: Continuing Professional Development.

EN graduates transitioning to work as an EN

34. In my role as the Associate Director of Teaching and Learning at Eastern Health, I spent a lot of time working with my team in managing new EN graduates. This team also managed ENs on clinical placement. It was my job to ensure ENs received the support needed.

35. In that role I observed that newly graduated ENs benefitted greatly from additional support to safely transition to practice. While the Nursing Diploma equipped them with the knowledge and skills needed to work as an EN, new ENs needed support to successfully move into the workforce as part of the nursing care team.

36. Starting out in the EN role on the floor necessitated a steep learning curve. Over time in the first year, with an emphasis on the first 12 weeks in the role, ENs developed critical on the job skills. Skills like how to conduct written communication effectively, how to communicate effectively with other nurses on handover and critical skills in bedding down medication knowledge and safety. While the Diploma equipped ENs with the necessary medication competency, there is a difference between applying this knowledge in theory and applying this knowledge in practice in a busy acute or sub-acute setting. Working for the first time in a large public health service, working alongside other nurses and a multidisciplinary team, has its own pressures.

37. At Eastern Health, we did this by ensuring scaffolding within the team. Graduate or placement ENs worked alongside more experienced ENs and RNs. This ensured an appropriate level of skilled and experienced team members were available for each person to learn and consolidate skills. EN graduates were also allocated supernumerary days prior to commencing in a team with other nurses.

ENs in aged care

38. A different trajectory exists for ENs entering aged care. ENs will have more immediate responsibility in aged care than in acute care, because the care focus in aged care is different. The focus is the ongoing care of older people, as distinct from than the variety and high turnover of patients in acute care.

39. Eastern Health had both acute care and aged care settings. In my work as the Associate Director of Teaching and Learning overseeing EN graduates transition to

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work in both settings, I observed that ENs working in aged care had more immediate responsibility in leading and supporting care within their scope of practice.

40. I worked closely with my team who were educators within the aged care settings at Eastern Health. I was heavily involved in designing a transition program for EN graduates as they entered the aged care workforce. This was a structured orientation program delivered by Clinical Nurse Educators that focused on aged care standards including but not limited to skills in identifying and managing behavioural disturbance.

Career progression for ENs

41. In my role as Associate Director of Teaching and Learning, I oversaw the EN progression in practice at Eastern Health. I managed Clinical Nurse Educators who managed all learners within their dedicated wards/areas. I observed definite improvement in skill over the first 6 months. Formative assessments were done at 3 6 and 12 months to ensure certain milestones were met. This would happen through good support from Eastern Health and, where needed, would include intensive 1:1 additional support, which my team provided. If an EN was not progressing they could be placed on a learning plan to support their transition to the workforce.

42. As ENs develop in their practice, I have observed that they learn how to manage increasingly complex patients. They learn, for example, how to prioritise time and patients' needs according to their level of sickness. The EN over time will also provide more complex care and gain skills in being part of and working with the broader medical team. At Eastern Health, the Clinical Nurse Educators in my team continued to provide ongoing support to ENs to help them increase their level of clinical skills over the years.

Distinguishing ENs from RNs

43. Sometimes graduate RNs would be paired with more experienced ENs in order to learn. While the RN is technically in the supervisory role, and suceeds the EN in the hierarchy of nurses, ENs and RNs work together collaboratively to support the skill development of the entire nursing team.

44. Over the course of my career, I have consistently observed that an experienced EN working in any setting can teach a graduate RN many concepts and skills, while understanding that their scope of practice is different. The pairing of an experienced EN with a consolidating graduate RN can work really well to provide safe quality care. An experienced EN will have a stronger understanding of workflow and patient needs. They can role model certain skills and processes to the graduate. For

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example, when to escalate care, what to report to the nurse in charge and how to contact members of other teams.

45. In an acute setting, it can be hard to distinguish between an experienced EN and an early career RN. I observed, in my Teaching and Learning role at Eastern Health, tha experienced ENs were often paired with graduate RNs in nursing teams. Within that team, the experienced EN would take the lead role. At that stage of an RN's skill progression, the experienced EN typically had the superior clinical skills. The experienced EN may not have the same understanding of the framework that underpins why they do what they do, but they know how to do the job. They have a confidence and a certain skill set that puts them well ahead of the early career RN who at that stage is still finding their feet. It was common to observe the EN in that team lead role prompt the RN; "we should assist these patients in toileting now", "now's the time to call the doctor". Experienced ENs were also significantly ahead in terms of the soft skills of nursing. For example, they were considerably more at ease communicating with patients and families. Early career RNs learnt a great deal from experienced ENs.

Why progression in the EN classification is important

46. Part of my role as the Acting Director of Nursing at Eastern Health, was to assess experienced ENs in their applications to be recognised as Level 3 ENs. This process involved a number of interviews with Nurse Unit Managers and Assistant Nurse Unit Managers in which the EN would speak to their skills and responsibility.

47. Being a part of that process, I observed that progression for individual ENs through classification levels in both aged care and acute care is important in order to:

    a. recognise the experience and expertise of ENs as they progress in their careers;
    b. support retention of ENs and staffing of this important role;
    c. facilitate workforce stability, by enabling experienced ENs to be readily identified and allocated to higher acuity patients; and
    d. promote cohesion in the workplace/workforce as between nurses.

48. Eastern Health was constantly looking at ways to support, upskill and retain current staff. During 2022 and 2023, I was involved in the creation and delivery of an EN upskilling program focusing on ENs working in the acute care sector. These were the post COVID-19 years, and we needed to retain and motivate staff to work in new areas. Staff who completed the program, and either updated or progressed their acute skills, were observed to be generally happier, and stay in their current role and/or increase their EFT hours as a result. At Eastern Health, facilitating this kind of

career progression and upskilling was considered an important part of ensuring job satisfaction in the EN cohort and, by extension, retention of the workforce.

49. EN classification pay points play an important role in enabling progression. Pay points provide a structured pathway, that stands alongside the RN pathway. The role of the EN is a valuable and viable alternative career to that of an RN and has a place in providing nursing care across a range of settings. A career pathway that recognises the increase in competence, skill and knowledge gained over time through working is an important way of supporting the role of the EN.

50. Over the course of my career, I have consistently observed that skilled and experienced ENs are well regarded and respected in their role. They are a valuable part of the nursing team. Their skills increase with time in their role, as does their value.

ENs who elect to become RNs

51. Some ENs will go on to become RNs, however, this is not what all ENs will do. Some will not want to become an RN, or may not be able to afford the time and cost of doing a degree and the further unpaid clinical placements.

52. At Eastern Health, there was a planned pathway to support ENs to complete their RN qualification; a combination of scholarships, time off to support clinical placement, and reduced EFT to allow tertiary study requirements. Nonetheless, many ENs never elected to follow this pathway. I ran a Peer Support Group at Eastern Health for nurses undertaking tertiary study. Many ENs I spoke with told me the cost of further study was prohibitive on account of family commitments and/or personal finances.

53. When I worked at Monash University, I observed that the cost of university study was difficult for many students, as was managing part time work and study commitments. The cohort is primarily young women. Taking time out of paid work to achieve their goal of becoming a registered nurse is difficult for many.

54. Experienced ENs have many transitional skills, and a wealth of experience in nursing, that they can call on when studying and starting out as an RN. For example, ENs bring excellent soft skills in talking to patients and families. Likewise, they have a strong understanding of medication competency and safe administration – they know, for example, about three points of ID and the six Rs of medication administration. What they lack, is the framework by which to understand why they

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do what they do. This additional knowledge and critical thinking, alongside skills in delegation and prioritisation, is what distinguishes the EN from the RN.

55. At Eastern Health, and in my role at Monash University, I observed that ENs who had consolidated their practice for a few years generally needed less support in transitioning to being an RN than those who completed the Bachelor degree immediately after finishing their EN Diploma.

56. Clinical experience in the EN role helps a great deal, as does having observed other RNs in the workplace previously. These students, while they occasionally struggle to adjust to the academic rigour of the Bachelor's degree, are much better equipped once on the job, on the nursing floor interacting with patients and doctors, to do the work of the RN.

ENs working in different settings

57. As the Associate Director of Teaching and Learning at Eastern Health, overseeing both acute hospital and residential aged care services, I had a good vantage point from which to observe and distinguish the role and skills of ENs in each setting.

ENs in aged care

58. ENs in aged care perform their work with a greater level of independence than the EN in an acute setting.

59. As discussed earlier, in aged care the EN is the nurse on the floor and often the team leader. The RN will often not provide frequent direct resident care and will instead play more of a managerial administration role. There are also far fewer RNs available, compared to in a hospital setting, so while ENs in aged care are supervised by the RN, there is far less access to the supervising RN. The EN on the floor is responsible for leading patient care, overseeing observations of residents and escalating care.

60. The EN role in aged care is particularly important for this reason. They need to have the skills in recognising clinical deterioration to know when to escalate care to an RN. ENs in aged care are particularly good at this, because they work with their patients over an extended period and they get to know them well.

61. Additionally, as discussed previously, the EN in aged care will often move directly into a lead role supervising other care workers. In that environment, the EN is the regulated worker registered with AHPRA and governed by professional standards (as distinct from other care workers).

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ENs that transition from aged care to acute care

62. As the Associate Director of Teaching and Learning, I oversaw programs at Eastern Health that assisted ENs transitioning from work in an aged care setting to work in an acute or sub-acute hospital setting. These ENs had a number of transferable skills that enabled them to make that transition.

63. That said, like all nurses starting on any new ward and unit, they needed support in updating certain clinical skills. They may not have seen, for example, insertion of a nasal gastric tube. They had a base level understanding of all that was required of them, attained through their EN Diploma, but they had either yet to be exposed to certain clinical tasks in practice or had not seen them performed for some time.

64. Eastern Health played a significant role in running upskilling programs to successfully transition these ENs from aged care to an acute setting. Likewise, all ENs had their competency at certain tasks assessed at regular intervals.

65. With support, ENs with experience in the role in an earlier setting were well placed transition their skills to an acute setting. Their skill development was always well ahead on new ENs commencing their careers in an acute setting.

Nurse Practitioners

My experience working with NP candidates

66. In my role as Deputy Director of Education at the School of Nursing and Midwifery at Monash University, I was involved in providing education assistance to the course co-ordinator for the Masters of Nurse Practitioner.

67. An NP candidate is a registered nurse, who must complete 5000 hours of advanced clinical experience in a designated area of practice while enrolled in a Masters of Nurse Practitioner.

68. I had to assess NP candidates at certain milestones in their course, for example doing a patient presentation, to assess whether the candidate met the requirements of the course and was progressing at the level necessary to be endorsed as an NP by the NMBA, on completion of the Masters program. This assessment was in conjunction with the course co-ordinator, and I was present due to my education and curriculum expertise.

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69. As an independent assessor of candidates, I gained a strong understanding of the standard of work and depth of knowledge required to be successfully endorsed as an NP.

70. At Eastern Health, I worked with a lot of NPs based in the emergency department at Box Hill Hospital. I was seconded to the role of Director of Nursing at Box Hill Hospital in 2023-24. At this time, the Victorian Government announced it intended to make the Masters of NP free to candidates. This policy attracted a lot of RNs who wanted to become NPs. Becoming an NP within a public health service is very challenging due to funding that needs to be found within a very tight health service budget.

71. Part of my role was to find ways to generate funding for NP positions within the health service, so that there was a job for the NP once endorsed. It was also important to give NP candidates within the health service work that was at a sufficient level of complexity within their designated scope of practice to ensure they would meet the necessary requirements for endorsement. My role included structuring candidate work to maximise the scope of the work.

72. When a health service offers a candidacy program, it is a significant investment, both for the health service and the candidate. The health service has to fund the 5000 hours of work for the candidate, as well as funding for a position for the NP a the end of the program. My role was to facilitate finding and funding suitable roles, which involved working closely with the NP program.

73. I also mentored NPs in a professional capacity as they worked through their candidacy and endorsement process.

When and why were NPs introduced in Australia

74. My experience in the sector and my work at the ANMF informs my understanding o the following history in respect of when and why NPs were introduced in Australia

75. The role of NP was first introduced in New South Wales via pilot programs conducted in the mid-1990's. Nurses in NSW were the trailblazers for the role in Australia. The trials were based on models that were used in the United States, Canada and the United Kingdom.

76. The trials found that the NPs were 'feasible, safe and effective in their roles and provide quality health services.'[1] Two NPs were authorised to practice in December

[1] NSW Department of Health (1995) Nurse Practitioner Project Stage 3 Report

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2000. They were endorsed to practice in emergency health and rural and remote health, respectively.

77. At this time, NPs, like all nurses, were in the jurisdiction of state and territory based legislation nursing boards.

78. The introduction of NPs in 1999-2000 arose from identifying gaps in the health system, particularly in rural and remote areas, where there was a shortage of doctors capable of delivering specialised care. This is still an area where NPs play an important role.

79. Early NPs really paved the way for others and the role was celebrated, but initially only in certain areas, particularly rural and remote health care. By the mid 2000's the role started to expand into emergency departments. It was not easy to establish the role as there was resistance from doctors who were concerned the role encroached on their field of work and expertise. Funding for the role of NP was difficult to secure as well, as it was new and needed to be supported by a health service.

80. It took a long time for NPs to be endorsed in a range of settings.

Training and qualifications required to become an NP, and planning ahead for NP endorsement

81. In the early days of the NP role, when it was state based, a generic Masters of Nursing was sufficient to qualify for the role. Applicants had to demonstrate advanced clinical practice, with intensive medical mentorship. It was not until 2010, when the national system was in place, that the NMBA ensured consistency of programs.

82. From approximately 2010 in order to be endorsed as an NP, the requirement became to complete a Masters of Nurse Practitioner or a Masters degree that is clinically relevant to the context of advanced practice nursing for which the nurse is seeking endorsement as an NP. These programs include units in advanced health assessment, pharmacology and therapeutics, diagnostics and research. They are quite different from the Masters of Nursing that leads to registration as an RN. Annexed and marked **NK6** is a copy of ANMAC's Nurse Practitioner Accreditation Standards.

83. The Masters of Nurse Practitioner, has specific entry requirements. Prospective students must have the equivalent of 5000 hours at an advanced nursing level and current registration as an RN.

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84. To be endorsed as a NP by the NMBA at the conclusion of the qualification, a candidate NP must complete an NMBA approved Masters course and then apply fo endorsement. Their endorsement will provide for a scope of practice in an area of clinical specialty in which they have demonstrated advanced practice.

85. There are two pathways to endorsement:

86. The first is where an employer advertises an NP candidacy role, which means being employed and working while studying.

87. The second is the nurse completes a Masters and then obtains a candidacy role. Candidacy roles can be either employer or employee driven, but the RN needs to consider these options when considering their capability to become an NP. Completion of the Masters does not guarantee becoming an NP.

The NP endorsement process

88. To be endorsed by the Nursing and Midwifery Board of Australia (NMBA) as an NP, a person must:
    a. hold general registration without restrictions as an RN (Division 1);
    b. be able to demonstrate clinical experience equivalent to three years (5000 hours) at an advanced practice level;
    c. hold a Masters – Nurse Practitioner degree or an equivalent qualification and
    d. comply with the standards of practice for an NP.

89. When an NP applies for endorsement, they need to provide certain documents that provide evidence of their advanced practice in an area of speciality and supporting documents from supervisors and medical mentors. These documents will include the NP's curriculum vitae, evidence of professional activities, letters of support and a copy of the transcript showing a completed Masters.

90. If the NMBA is not satisfied that the applicant has demonstrated sufficient evidence to support their level of clinical expertise, endorsement will be refused. This does happen, usually as a result of poor planning or documentation and/or poor preparation of the NP. It is not uncommon for letters to be provided by a nursing executive to the NMBA to support the NP's application.

91. NPs need to be closely supported and mentored by a medical colleague with input from an executive nursing role and/or another NP throughout their candidature.

There needs to be very strong links with the NP candidate and their mentor and employer throughout the process. Supporting NP candidates is a big commitment.

92. Some employers also employ NP candidates in candidacy programs, developed by the employer to assist staff in demonstrating advanced clinical practice and seeking endorsement. Candidacy programs provide a framework to support the RN to become an NP candidate while they undertake their Masters through to endorsement.

93. Once endorsed as a NP, the NP must maintain 'recency of practice' hours of experience at an advanced practice level. Recency of practice is demonstrated by having 450 hours of clinical contact over the last five years and completing ongoing continuing professional development.

Scope of practice

94. An NP's scope of practice is linked to their specialised area or practice. NPs need to identify their speciality when first commencing in the role as a candidate. Their recency of practice and their scope should be consistent with the conditions they are qualified to manage. For example, if an NPs scope of practice is renal care, they can diagnose, prescribe and refer within the speciality of renal care.

95. It's an important part of the NP's role to understand their scope within a specialised area. Just because an NP is endorsed in one area, does not mean the NP can then practice in all areas. The NP is endorsed to practice safely within their scope. The NP must ensure, consistent with their professional obligations, that their practice and employment sits within their scope of practice.

Distinguishing the NP from other health professionals

96. In my role as the Acting Director of Nursing (DON) at Eastern Health, I had occasion to mentor a NP candidate in the process of seeking endorsement. In performing this work, I liaised with qualified NPs and Consultant Doctors on our staff so as to better understand the level of skill and responsibility expected of the NP and the relative position of the NP's advanced clinical practice.

97. I make the following observations so as to distinguish the NP from other nurses and medical professionals, having regard to those discussions and the knowledge I gained in that role.

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Distinguishing the NP from other nurses

98. NP endorsement and advanced practice differs significantly from that of an RN. RN may have an area of speciality, but they hold general registration and there is no applicable endorsement process in respect of their practice.

99. NPs perform work quite distinct from that conducted by an RN. RNs follow clinical protocols and work under the direction of a more senior RN, NP or medical doctor. NPs work independently.

100. NPs are autonomous clinicians, they are authorised to provide care similar to a medical doctor within their speciality. They provide advanced clinical assessment, diagnose and undertake investigations. They provide care co-ordination and refer patients to other medical specialists. They have legal authority to diagnose and trea patients within their scope, in the same way that a doctor is authorised to do.

101. An RN or Nurse Unit Manager (**NUM**) cannot prescribe, diagnose or refer patients. The difference is an NUM will have operational management expertise which is quite different to an NP who has advanced clinical practice. An NP might report to an NUM in a professional line, but the scope of practice is very different.

102. An NP and an RN are poles apart in terms of experience and scope of practice. An NP will create education, undertake research, provide clinical support, mentor and supervise RNs and NP candidates. They are clinical and professional leaders, often being part of the senior leadership group.

103. Even a senior RN, who may have a Masters of Nursing, will have a different skill set and mindset in terms of understanding specialisation.

104. An NP is much more skilled than an RN. An NP will understand, in absolute clinical terms, why they are doing something. Their knowledge base is exponentially larger, by virtue of their Masters qualification. They alone, amongst their colleagues in nursing, will be able to determine why a person is unwell, what can be done to treat the person and exactly how that treatment should be enacted. They are in a position to truly advocate for the patient. The care that they deliver is unique and specialised.

Distinguishing the NP from other medical professionals

105. An NP is equivalent to a senior registrar in the medical hierarchy. That is, a senior registrar in a public hospital who is eight to nine years out of medical school. Both provide autonomous clinical care within a defined scope of practice. An NP's level of

skill and knowledge and scope of practice within their speciality sits above an intern doctor, resident doctor and medical officer. A consultant doctor sits above an NP. In primary health, an NP primary care specialist sits at the same level as a GP.

106. In addition to this elevated level of skill and responsibility, NPs provide a high level of nursing care in a way that is holistic and differs from the type of care provided by medical practitioners. NPs provide care that is grounded in nursing principles.

The value of NPs to Australia's health care system

107. I say the following, having regard to my work at the ANMF Federal Office in the following capacities:

a. as a member of the Nurse Practitioner Workforce Plan Implementation Advisory Group;
b. consulting with government in respect of the role NPs do and could play in publicly funded Urgent Care Clinics; and
c. working with my ANMF colleagues in the Queensland branch (QNMU) in relation to the QNMU Statewide Nurse Practitioner Branch.

108. NPs now work everywhere across the health and aged care systems. They are in emergency departments, primary care, mental health, acute pain services, public hospitals, private practice and community health.

109. NPs are important providers of care. They play an essential role in reducing barriers and bottlenecks to accessing health care.

110. Resistance from the medical profession has been a barrier to the use of the role. Where there is a good understanding of the role and the value NPs bring as part of a multi-disciplinary team, they bring great value to the health and aged care system.

111. Evidence shows when NPs are able to lead care, patients are happier due to the nurse patient relationship that is developed and established. Patient outcomes are comparable to physician-led care in many settings such as primary care and areas of emergency care and chronic disease management. Annexed and marked **NK7** is a copy of Maung Htay and Dean Whitehead, 'The effectiveness of the role of advanced nurse practitioners compared to physician-led or usual care: A systematic review' (2021) 3 *International Journal of Nursing Studies Advances* 100034.

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112. Government data from 2021 indicated that about a quarter of endorsed NPs were not employed in an NP role, due to the limited number of roles funded and the demands of maintaining endorsement[2].

113. I know from my previous role as the Acting Director of Nursing at Easter Health, that funding for NP roles and candidacies is a barrier to greater utilisation of NPs.

114. At the end of 2024, the requirement for an NP to have a collaborative agreement with a medical practitioner was removed. This means an NP no longer needs to have a formal agreement or relationship with a medical practitioner to enable patients to access the Commonwealth Medical Benefits Scheme (MBS) rates or Pharmaceutical Benefits Scheme (PBS) subsidies.

115. This was a great change for NPs. The legislative change recognises NP's skill and autonomy within their scope of practice and removes barriers to NP practice, resulting in improved access to care for patients.



NOELLEEN KIPRILLIS

[2] Department of Health and Aged Care, *Nurse Practitioner Workforce Plan* (15 May 2023

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK

Date: 17 March 2026

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Australian Government

HLT54121 Diploma of Nursing

Release: 6

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

HLT54121 Diploma of Nursing

Modification History

Release	Comments
6	Minor change to replace superseded units of competency in the elective bank.
5	Supersedes and is equivalent to HLT54121 Diploma of Nursing release 4 Minor change to update Infection Control units of competency.
4	Supersedes and is equivalent to HLT54121 Diploma of Nursing release 3 Minor change to update Infection Control units of competency.
3	Minor corrections to mapping details. Equivalent outcomes.
2	Minor corrections to formatting to improve readability. Equivalent outcomes.
1	This qualification was first released in HLT Health Release 6.0.

Qualification Description

This qualification reflects the role of an enrolled nurse working under the direct or indirect supervision of a registered nurse.

Enrolled nurses provide nursing care for people across the health care continuum and at all stages of life.

To be eligible to apply for registration as an enrolled nurse and to practice in Australia, individuals must complete a Diploma of Nursing program accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved as ‘an approved program of study’ by the Nursing and Midwifery Board of Australia (NMBA) in accordance with the Enrolled Nurse Accreditation Standards. To confirm the education provider holds th necessary accreditation check the Australian Health Practitioner Regulation Agency (AHPRA) at www.ahpra.gov.au.

The scope of practice for enrolled nurses is determined by legislative requirements and the policies and procedures of the employing organisation.

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Licensing/Regulatory Information

This qualification may contribute to the Nursing and Midwifery Board of Australia's (NMBA) registration requirements to practice as an enrolled nurse.

Entry Requirements

There are no entry requirements for this qualification.

Packaging Rules

25 units must be completed:

- 20 core units
- 5 elective units, consisting of:
    - 3 units from the list below
    - 2 units from the list below, elsewhere in the HLT Health Training Package, o any other current Training Package or accredited course.

The selection of electives must be guided by the job outcome sought, local industry requirements and the complexity of skills appropriate to the AQF level of this qualification.

Core units	
CHCDIV001	Work with diverse people
CHCDIV002	Promote Aboriginal and/or Torres Strait Islander cultural safety
CHCPRP003	Reflect on and improve own professional practice
HLTAAP002	Confirm physical health status
HLTAAP003	Analyse and respond to client health information
HLTENN035	Practise nursing within the Australian health care system
HLTENN036	Apply communication skills in nursing practice
HLTENN037	Perform clinical assessment and contribute to planning nursing care

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HLTENN038	Implement, monitor and evaluate nursing care
HLTENN039	Apply principles of wound management
HLTENN040	Administer and monitor medicines and intravenous therapy
HLTENN041	Apply legal and ethical parameters to nursing practice
HLTENN042	Implement and monitor care for a person with mental health conditions
HLTENN043	Implement and monitor care for a person with acute health condition
HLTENN044	Implement and monitor care for a person with chronic health conditions
HLTENN045	Implement and monitor care of the older person
HLTENN047	Apply nursing practice in the primary health care setting
HLTENN068	Provide end of life care and a palliative approach in nursing practi
HLTINF006	Apply basic principles and practices of infection prevention and control
HLTWHS002	Follow safe work practices for direct client care
Elective Units	
BSBLDR414	Lead team effectiveness
BSBPEF402	Develop personal work priorities
CHCCCS037	Visit client residence
CHCCOM005	Communicate and work in health or community servic

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CHCLLN001	Respond to client language, literacy and numeracy needs
CHCPOL003	Research and apply evidence to practice
HLTAHA043	*Support the provision of basic nutritional advice and educati*
HLTAID011	Provide First Aid
HLTAID014	Provide Advanced First Aid
HLTENN046	Contribute to maternal and infant health care
HLTENN057	Contribute to the nursing care of a person with diabetes
HLTENN060	Apply nursing practice in the paediatric care setting
HLTINF007	Implement and monitor infection prevention and control standard policies and procedures
HLTOHC007	Recognise and respond to oral health issues
HLTOHC008	Inform and support patients and groups about oral health
HLTOHC009	Apply and use basic oral health products
HLTWHS003	Maintain work health and safety
HLTWHS006	Manage personal stressors in the work environment
TAEDEL412	Facilitate workplace-based learning

Units listed in italics include a mandatory workplace requirement

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Pre-requisite Requirements

There are no prerequisites requirements for this qualification.

Qualification Mapping Information

Current Code and Title	Previous Code and Title	Comments	Equivalence
HLT54121 Diploma of Nursing	HLT54115 Diploma of Nursing	This version was released in HLT Health Training Package Release 6.0 and meets the requirements of the 2015 Standards for Training Packages. Updated to reflect current industry practices and terminology.	Not-Equivalen

Links

Companion volumes, including implementation guides, are found on the national training register - https://vetnet.gov.au/Pages/TrainingDocs.aspx?q=ced1390f-48d9-4ab0-bd50-b015e5485705.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK-2

Date: 17 March 2026

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

Australian
Nursing & Midwifery
Accreditation Council

Enrolled Nurse

Accreditation Standards 2017

enrolled nurse

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Australian
Nursing & Midwifery
Accreditation Council

Enrolled Nurse
Accreditation Standards 2017

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

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Published by the Australian Nursing and Midwifery Accreditation Council (ANMAC), Canberra, January 2017.

ISBN: 978-0-646-97293-0

This document is online at www.anmac.org.au/publications

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Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

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Acknowledgements

The Board of the Australian Nursing and Midwifery Accreditation Council (ANMAC) gratefully acknowledges the expertise, time and commitment contributed by each member of the Expert Advisory Group (EAG) to review and update these Enrolled Nurse Accreditation Standards. EAG membership comprised:

- Ms Gabrielle Koutoukidis, Educationalist, Expert Advisory Group, Chair
- Associate Professor Alison McMillan, Australian and New Zealand Council of Chief Nurse and Midwifery Officers (member from February 2015 to May 2016)
- Ms Ann Maree Keenan, Australian and New Zealand Council of Chief Nurse and Midwifery Officers (member from September 2016)
- Ms Julianne Bryce, Australian Nursing and Midwifery Federation
- Ms June Cox, Australian College of Nursing
- Ms Janine Mohamed, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Mrs Noela Baglot, Consumers Health Forum of Australia
- Professor Penelope Paliadelis, Council of Deans of Nursing and Midwifery
- Miss Myra Book, Department of Health, Western Australia
- Professor Melanie Birks, Educationalist
- Ms Louise Dearman, Enrolled Nurse, Practice Nurse
- Dr Siobhan Bidgood, National Enrolled Nurse Association of Australia
- Ms Petrina Halloran, Nursing and Midwifery Board of Australia
- Ms Jodie Hughson, Quality and Risk Manager, Health Care Australia
- Ms Debbie Blow, TAFE Directors Australia
- Professor Robert Meyenn, ANMAC, Standards Accreditation and Assessment Committee (Disbanded), Chair
- Ms Elizabeth Grant, ANMAC, Associate Director (member from February 2015 to December 2016)
- Ms Julie Watts, ANMAC, Associate Director
- Adjunct Clinical Professor Fiona Stoker, ANMAC, Chief Executive Officer
- Ms Donna Mowbray, ANMAC, Executive Director of Accreditation Services (member from February 2015 to November 2016)
- Dr Margaret Gatling, ANMAC, Director of Accreditation Services (member from December 2016)
- Ms Jackie Doolan, ANMAC, Associate Director, Project Lead.

ANMAC would like to acknowledge the expert advice provided by Professor Lesleyanne Hawthorne, Centre for Health Policy, University of Melbourne, when revising content relating to English language skills assessment.

ANMAC also acknowledges the individuals and representatives of organisations who participated in the consultation forums, provided a submission or responded to the electronic surveys during the consultation period.

The intellectual input, collective wisdom and critical thinking provided exemplified the goodwill and professionalism of those committed to advancing the nursing profession in Australia.

ANMAC commends these accreditation standards to the Nursing and Midwifery Board of Australia and acknowledges the NMBA's support in their review and revision.

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1 Preamble

1.1 Enrolled nurse education in Australia

Enrolled nurse programs of study support students to achieve the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice. This ensures graduates are able to practice safely and competently with the required attitude, knowledge and skills.

Enrolled nurse education occurs in the Vocational Education and Training (VET) sector and requires students to complete an NMBA approved Diploma of Nursing program through a private or public Registered Training Organisation (RTO) registered with the Australian Skills Quality Authority (ASQA) or other state regulator[1]. The program's structure, design and content is derived from a National Health Training Package, which ensures consistency with Australian Qualification Framework (AQF) requirements and national practice standards.(1) The National Health Training Package is also sequenced to prepare students for workplace experience. Graduates of an NMBA approved program of study can apply to register with the NMBA to practice as an enrolled nurse.

1.2 Health practitioner regulation

The *Health Practitioner Regulation National Law Act 2009* (the National Law), enacted in July 2010, is the national law by which the National Registration and Accreditation Scheme for health practitioners is instituted.

The scheme has six objectives, one of which is:

> **...to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.(2)**

According to the National Law, graduates must have successfully completed an ANMAC accredited and NMBA approved enrolled nurse program of study to be eligible to apply for NMBA registration.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for monitoring education providers and programs of study that provide a qualification for the purposes of registration in nursing and midwifery. In addition, through a process of cyclical review, ANMAC maintains the integrity and effectiveness of accreditation standards that underpin the accreditation of programs of study under its mandate.

Professional education accreditation is concerned with the quality of the profession and its work, from the perspective of the public interest and community safety. It is part of a broader process of assuring the community that, having completed an approved program of study, beginning practitioners have achieved agreed professional outcomes and are able to practise in a safe and competent manner because they are equipped with the necessary foundation knowledge, professional attitudes and essential skills. This process, however, relies on two fundamental principles:

1. That the education providers themselves are authorised to issue the relevant qualification and are evaluated to assure continued quality learning outcomes for their graduates.
2. That there is a set of agreed and contemporary practice standards for the profession, against which the capability of graduates of programs is assessed.

1 Other state regulators include Training and Accreditation Council, Western Australia and the Victorian Registration and Qualification Authority

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The first principle is discussed in Section 1.3. The second relates to the NMBA Enrolled nurse standards for practice, that came into effect on 1 January 2016. These standards articulate the core practice standards that provide a framework for assessing those wanting to obtain and retain registration as an enrolled nurse in Australia. Education providers use the standards when developing enrolled nurse programs of study and assessing student performance. Employers use them when evaluating registrant performance.

The accreditation process administered by ANMAC is an efficient and effective proxy for externally assessing graduates against standards for practice. Professional program accreditation must balance ensuring professional standards are protected without inhibiting diversity and innovation or constraining continuous quality improvement. As with the national standards for practice, the national accreditation standards are regularly reviewed to ensure relevance in the light of changes in health and education legislation, policy, delivery and ethos.

1.3 Vocational Education and Training sector regulation

ASQA is the regulatory body for the VET sector across all states and territories, with the exception of Victoria and Western Australia, which have retained state regulatory bodies.(3)

ASQA maintains the quality of the VET sector through effective regulation of:

- VET providers
- accredited VET courses
- Commonwealth Register of Institutions and Courses for Overseas Students providers including those delivering English Language Intensive Courses to Overseas Students.(4)

ASQA's regulatory functions are supported by a framework of legislation and standards which is referred to as the 'VET Quality Framework'.(5) This framework includes the Standards for Registered Training Organisations 2015, the purpose of which is to:

- set out the requirements that an organisation must meet to be an RTO
- ensure that training products delivered by RTOs meet the requirements of training packages or VET accredited courses, and have integrity for employment and further study
- ensure RTOs operate ethically with due consideration of needs of learners and enterprises.(6)

The Australian Qualification Framework (AQF) is another component of the VET Quality Framework. The AQF is the national policy for regulated qualifications in Australian education and training. (7) It stipulates the learning outcomes expected within each AQF level and qualification type. It expresses these as dimensions of knowledge, skills and their application. This ensures the integrity of qualifications and standardises them across education providers, settings and delivery modes.

ASQA cyclically reviews courses and training providers to ensure their continued compliance with the VET Quality Framework.

Training packages

ASQA assesses and monitors an RTO's ability to deliver training and assessment in accordance with training package requirements. RTOs that have been authorised by ASQA to deliver training package qualifications or units of competency (training products), have these added to their scope of registration. ASQA can take regulatory action against a RTO if it is found not to comply with training package requirements.(8)

ASQA's quality assurance role in the delivery of training products does not extend to their development, endorsement or maintenance.

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As stated on the ASQA website, Skills Service Organisations (SSOs) (formerly Industry Skills Councils) create training packages in response to a nationally recognised training need. SSOs develop and validate training packages by way of a policy-driven process that includes extensive research and consultation with industry stakeholders.

A training package will specify for the RTO the skills and knowledge required to perform effectively in the workplace. It does not advise RTOs on how learners should be trained. A training package comprises

- units of competency—specifies the required skills and knowledge for effective performance in a workplace context
- a qualifications framework—groups of units of competency ranging from Certificate I to Graduate Diploma level
- assessment guidelines—identifies assessment processes and industry's preferred approach to assessment.(8)

SSOs also supply a Companion Volume Implementation Guide to support RTOs in the implementation of the training package.

Training packages that are Government endorsed and approved for use throughout Australia, are uploaded to the national register: training.gov.au Once published, RTOs are required to transition to delivering the new product within a specified time frame.

When a training package is updated and deemed equivalent to the superseded product, ASQA will automatically add the training product to relevant RTOs scope of registration.

The current qualification for the Diploma of Nursing (HLT54115), derived from the National Health Training Package, was deemed by the SSO to be 'non-equivalent' to the superseded product (HLT51612 As a consequence, RTOs were required to apply to ASQA to have this Diploma of Nursing qualification added to their scope of registration.

A RTO's scope of registration can be viewed on the national register: training.gov.au

1.4 Review of the Enrolled Nurse Accreditation Standards

In February 2009, the Australian Nursing and Midwifery Council published the 'Enrolled Nurses Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia – with Evidence Guide'. These were subsequently approved by the then, newly established NMBA.(9)

As part of the cyclical review of all accreditation standards, the ANMAC Board authorised the review of these accreditation standards to start in July 2015 with stakeholder engagement to be implemented in accordance with Section 46(2) of the National Law, which states:

> **In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.(10)**

The ANMAC Board convened an EAG (members are listed in Acknowledgements) to oversee the review. The EAG guided project planning, document development, stakeholder engagement and feedback synthesis. ANMAC sent a letter of invitation to a wide range of stakeholders outlining opportunities for participation. Feedback options included completing an online survey, sending a written submission and/or attending any of the four consultation forums.

The review was an iterative process that included two stages of consultation. Each stage had a separate consultation paper that was made accessible to stakeholders via the ANMAC website, for a period of 6 weeks.

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Stage 1–first consultation paper

The first consultation paper and first version of the revised standards was researched and drafted by ANMAC staff, edited by the EAG and approved by ANMAC's Standards Accreditation and Assessment Committee (now disbanded). The paper was circulated to stakeholders in October 2015, with an invitation to attend any of three consultation forums held in Sydney, Melbourne and Adelaide.

The consultation paper encompassed the background, context, purpose and process of the review. It also outlined practice, professional and policy matters shaping Australian health care and the enrolled nurse practice landscape and, as a consequence, enrolled nurse education. The paper also noted an absence of international equivalency with the Australian enrolled nurse role and education programs. Further, it acknowledged the lack of high-level evidence or useful international benchmarks to guide the design and delivery of enrolled nurse programs.

With this background information, stakeholders were asked to consider and provide their perspectives on key content areas in the first version of the revised accreditation standards, including:

- Program development and structure—whether a minimum of 400 hours of workplace experience, not inclusive of simulation activities, should continue to be stipulated in the revised standards.

  Feedback indicated majority support for the continuation of this stipulation.

- Program content—whether content in the National Health Training Package and content in the current accreditation standards relating to chronic disease and mental health were adequately encompassed by proposed revisions to relevant criteria.

  Feedback indicated majority support for proposed program content revisions.

  Student assessment—whether there were facilitators or barriers in the current system to the assessment of students' English language skills (ELS) before undertaking workplace experience. Also whether, as part of this ELS assessment, a required minimum level for students' ELS should be stipulated in the revised standards.

  Feedback indicated that current pre-enrolment ELS testing and specific types of learning and teaching approaches facilitated the assessment of students' English language proficiency before undertaking workplace experience. Reported barriers to undertaking this assessment were the lack of resources, valid and reliable assessment tools, and standardised processes. Feedback also indicated majority support for stipulating a minimum ELS requirement in the revised standard.

- Stakeholders were also asked to review the standards as a whole and to consider their effectiveness and relevance in providing guidance to providers of enrolled nurse education.

  Feedback indicated overall support for the first version of the revised standards, however, there were numerous suggestions for improvement in criteria wording and glossary terms.

The EAG reviewed and synthesised all stakeholder feedback. Outcomes from this process lead to a period of further research and expert consultation, which informed content changes in the next version of the revised standards.

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Stage 2–second consultation paper

The second consultation paper, released in January 2017, provided stakeholders with an overview of Stage 1 outcomes. The paper went on to examine available evidence relating to minimum levels of ELS and language, literacy and numeracy (LLN) skills required by students studying in Australian VET and tertiary sectors. Stakeholders were asked to consider this evidence and proposed criteria aimed at establishing enrolled nurse program entry requirements.

Further in Stage 2, stakeholders were invited to attend a summative forum, held in Brisbane. Facilitated discussion at the forum focused on proposed revisions to the standards and content areas of interest to stakeholders.

After reviewing all stakeholder feedback from Stage 2, the EAG met to finalise standards or criteria that stakeholders had commented on. The EAG paid particular attention to criteria stipulating minimum level requirements for students' ELS and LLN skills on program entry.

1.5 Regulatory impact assessment

During the review of the Enrolled Nurse Accreditation Standards, ANMAC undertook a preliminary assessment of the potential regulatory impact of proposed revisions to the standards. This assessment is required by the Australian Government's Office of Best Practice Regulation to ensure that national standard setting agencies, such as ANMAC, have explored the impact of regulation, standards and othe quasi-regulation before implementation.

Development of the preliminary assessment was guided by Government resource documents (11, 12) and considered such matters as the benefits and burdens of introducing the revised accreditation standards and the potential impact on stakeholders.

ANMAC's preliminary assessment was submitted to the Office of Best Practice Regulation, which considered the proposed revisions to the NMBA-approved national accreditation standards to be minor and requiring no further regulatory impact assessment.

1.6 Ratification and approval

While ANMAC is responsible for developing the accreditation standards, the NMBA—under section 47(2) of the National Law—decides whether to approve them or ask the accreditation authority to review them.

The EAG and ANMAC's Chief Executive Officer reviewed the final draft of the Enrolled Nurse Accreditation Standards before presenting them to the ANMAC Board to ratify. After ratification, the Enrolled Nurse Accreditation Standards were submitted to the NMBA for consideration of their approval.

These standards were approved by the NMBA on 24 May 2017.

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2 Introduction

2.1 Purpose of the ANMAC accreditation process

Professional program accreditation is concerned with the quality of the nursing profession and its work, on behalf of public interest and public safety. In contrast, accreditation (or similar assessment) by national education regulators, such as TEQSA or ASQA, is concerned with quality assurance and risk management. Accreditation by these types of regulators complements professional program accreditation. It is therefore a requirement for ANMAC to assess nursing and midwifery programs of study for accreditation.

ANMAC accreditation evaluates whether education providers, on the evidence they provide, can ensure program graduates have the common and transferable skills, knowledge, behaviours and attitudes as articulated in the relevant national competency standards or standards for practice.

ANMAC's process of accreditation involves comprehensively examining a higher education provider's:

- governance system and quality management framework
- student enrolment processes
- conceptual framework
- structure and content
- learning and teaching approaches
- student support, assessment and workplace experience.

Periodic accreditation of nursing and midwifery programs stimulates education providers to review and assess their own programs. It enables providers to validate the strengths of existing programs, identify areas for improvement and introduce new learning and teaching initiatives.

ANMAC accreditation, therefore, contributes to ensuring public safety and supports, where possible, diversity, innovation and evolution in nursing and midwifery education.

2.2 Enrolled Nurse Accreditation Standards

The Enrolled Nurse Accreditation Standards detail the minimum requirements that RTOs must meet if they want their program of study to be accredited by ANMAC. Graduates cannot apply to register with the NMBA unless their program of study is accredited by ANMAC and approved by the NMBA.

A summary of the nine Enrolled Nurse Accreditation Standards is tabled in Section 3.

2.3 Using the Enrolled Nurse Accreditation Standards

The Enrolled Nurse Accreditation Standards are designed principally for use by education providers seeking to accredit a Diploma of Nursing program of study. ANMAC's Associate Directors, the Enrolled Nurse Accreditation Committee and members of ANMAC assessment teams evaluate programs against these standards and make recommendations to the ANMAC Board for decision making.

While the standards are principally for use by education providers, they are also useful for anyone interested and involved in the education of enrolled nurses.

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RTOs seeking accreditation are required to complete an application pack that incorporates the Enrolled Nurse Accreditation Standards 2017 and guidance on addressing them. ANMAC regularly reviews and updates this guidance to help education providers prepare their submissions.

Other materials to assist education providers include the:

- National Accreditation Guidelines: Nursing and Midwifery Education Programs—describes the structures, personnel and processes for accrediting nursing and midwifery education providers and programs of study
- ANMAC Assessor Handbook—provides an overview of the accreditation process.

All ANMAC materials to assist education providers, including the application pack, are available at www.anmac.org.au

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3 Enrolled Nurse Accreditation Standards

This is a summary table of each standard in the Enrolled Nurse Accreditation Standards.

STANDARD 1: GOVERNANCE
The education provider has established governance arrangements for the enrolled nurse program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.
STANDARD 2: CONCEPTUAL FRAMEWORK
The program provider makes explicit, and uses a contemporary conceptual framework for the enrolled nurse program of study that incorporates an educational philosophy and a philosophical approach to enrolled nurse practice.
STANDARD 3: PROGRAM DEVELOPMENT AND STRUCTURE
The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in education and professional nursing; complying in length and structure with the Australian Qualifications Framework (AQF) for the qualification offered and enabling graduates to meet the NMBA Enrolled nurse standards for practice. Workplace experience is sufficient to enable safe and competent enrolled nursing practice by program completion.
STANDARD 4: PROGRAM CONTENT
The program content delivered by the program provider comprehensively addresses the NMBA Enrolled nurse standards for practice and incorporates Australian best practice perspectives on enrolled nursing as well as existing and emerging international, national and regional health priorities.
STANDARD 5: STUDENT ASSESSMENT
The program incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the NMBA Enrolled nurse standards for practice.
STANDARD 6: STUDENTS
The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.
STANDARD 7: RESOURCES
The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number to enable students to attain the NMBA Enrolled nurse standards for practice.
STANDARD 8: MANAGEMENT OF WORKPLACE EXPERIENCE
The program provider ensures that every student is given a variety of supervised workplace experiences conducted in environments providing suitable opportunities and conditions for students to attain the NMBA Enrolled nurse standards for practice.
STANDARD 9: QUALITY IMPROVEMENT AND RISK MANAGEMENT
The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the learning and teaching experience for students and the competence of graduates.

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Standard 1: Governance

The education provider[2] has established governance arrangements for the enrolled nurse program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the NMBA Enrolled nurse standards for practice. (13)

Criteria

The education provider must provide evidence of:

1.1 Current registration by the Australian Skills Quality Authority (ASQA) or other state regulator[3], as an Australian Registered Training Organisation (RTO).

1.2 Current accreditation of the enrolled nurse program of study by ASQA, or other state regulator, detailing the expiry date and recommendations, conditions and progress reports related to the education provider.

1.3 Listing on the national register for training in Australia of an approved scope that incorporates the qualification of Diploma of Nursing, derived from the current National Health Training Package, at Australian Qualification Framework (AQF) Level 5.

1.4 Current documented academic governance structure for the RTO conducting the program which ensures academic oversight of the program and promotes high-quality learning and teaching scholarship and ongoing evaluation across all learning settings.

1.5 Terms of reference for relevant education provider committees and advisory and/or consultative groups, including consumer representation and partnerships with Aboriginal and Torres Strait Islander health professionals and communities.

1.6 Staff delegations, reporting relationships, and the role of persons or committees in decision making related to the program.

1.7 Governance arrangements of the RTO that are responsive to requirements for ongoing compliance with the Enrolled Nurse Accreditation Standards.

1.8 Policies relating to credit transfer or the recognition of prior learning that are consistent with AQF national principles and the graduate's ability to meet the NMBA Enrolled nurse standards for practice.

1.9 Governance arrangements between the education provider and health service providers to monitor students' learning and teaching when undertaking workplace experience including, but not limited to, clinical teaching, supervision and assessment.

2 Refer to glossary for an operational definition of education provider.

3 Includes registration by Training and Accreditation Council, Western Australia and the Victorian Registration and Qualification Authority

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Standard 2: Conceptual framework

The program provider makes explicit, and uses a contemporary conceptual framework for the enrolled nurse program of study that incorporates an educational philosophy and a philosophical approach to enrolled nurse practice

Criteria

The program provider demonstrates:

2.1 A clearly documented and explained conceptual framework for the program, including underpinning educational and professional nursing philosophies.

2.2 The incorporation of contemporary Australian and international best practice teaching, learning and assessment methodologies and technologies to enhance the delivery of program content, accommodate differences in student learning styles and stimulate student engagement and learning.

2.3 A program of study that is congruent with contemporary and evidence-based approaches to enrolled nurse practice and education and underpinned by principles of safety and quality in health care[4].

2.4 Learning and teaching approaches that:

a. enable achievement of stated learning outcomes

b. facilitate the integration of theory and practice

c. scaffold learning appropriately throughout the program

d. encourage the development and application of reflective and analytical practice

e. engender deep rather than surface learning

f. encourage students to become self-directed learners

g. embed recognition that graduates take professional responsibility for continuing professional development and life-long learning

h. instil in students the desire and capacity to continue to use and learn from research and implement as evidenced-based care throughout their careers

i. promote emotional intelligence, communication, collaboration and teamwork, cultural safety and ethical practice expected of an enrolled nurse

j. incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.

4 Including the current *Australian Safety and Quality Framework for Health Care* released by the Australian Commission on Safety and Quality in Health Care. Viewed at: www.safetyandquality.gov.au/wp-content/uploads/2012/01/32296-Australian-SandQ-Framework1.pdf on 5 February 2015.

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Standard 3: Program development and structure

The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in education and professional nursing; complying in length and structure with the Australian Qualifications Framework for the qualification offered and enabling graduates to meet the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice. Workplace experience is sufficient to enable safe and competent enrolled nursing practice by program completion.

Criteria

The program provider demonstrates:

3.1 Consultative and collaborative approaches to program design and program organisation between teaching staff, those working in health disciplines, students, consumers and other key stakeholders, including Aboriginal and Torres Strait Islander health professionals and communities.

3.2 Contemporary enrolled nursing and education practice in the development and design of the program.

3.3 A map of units against the NMBA Enrolled nurse standards for practice which clearly identifies the links between learning outcomes, assessments and required graduate outcomes.

3.4 Descriptions of program content and the rationale for its extent, depth and sequencing in relation to the knowledge, skills and behaviours expected of students.

3.5 Opportunities for student interaction with other health professions to support understanding of the multi-professional health care environment and facilitate intraprofessional and interprofessional learning for collaborative practice.

3.6 A minimum of 400 hours of successfully completed workplace experience as an enrolled nursing student, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health care settings that support achievement of the NMBA Enrolled nurse standards for practice.

3.7 Content and sequencing of the program of study, as well as the incorporation of simulated learning opportunities, prepare students for workplace experience.

3.8 Workplace experience included as soon as is practically possible in the first year of study to facilitate early engagement with the professional context of nursing.

3.9 Workplace experience placements toward the end of the program, undertaken in Australia, to consolidate the acquisition of competence and facilitate transition to practice. A summative assessment is made at this time against the NMBA Enrolled nurse standards for practice in the clinical setting.

3.10 Equivalence of unit outcomes for programs taught in Australia in all delivery modes in which the program is offered (units delivered on-campus or in mixed-mode, by distance or by e-learning methods).

3.11 Where the structure of the program allows for multiple entry pathways for which students receive credit or advanced standing (other than on an individual basis), evidence that each pathway meets ANMAC's Enrolled Nurse Accreditation Standards.

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Standard 4: Program content

The program content delivered by the program provider comprehensively addresses the Nursing and Midwifery Board of Australia's (NMBA) Enrolled nurse standards for practice and incorporates Australian best practice perspectives on enrolled nursing as well as existing and emerging international, national and regional health priorities.

Criteria

The program provider demonstrates:

4.1 A comprehensive program content document structured around the conceptual framework tha includes:

a. program structure and delivery modes

b. unit outlines that detail content, objectives, learning outcomes and associated assessment

c. links between unit learning outcomes and their assessment and the NMBA Enrolled nurse standards for practice

d. learning and teaching strategies

e. a workplace experience plan demonstrating opportunities to meet the NMBA Enrolled nurse standards for practice.

4.2 The central focus of the program is enrolled nursing practice, comprising core health professiona and specific enrolled nurse knowledge and skills and incorporating national and regional health priorities, health research, health policy and reform.

4.3 Research and evidence-based inquiry underpins all elements of program content and delivery.

4.4 Program content supports the development and application of knowledge and skills in:

a. person-centred care

b. evidence-based care

c. analytical and reflective practice

d. legal, regulatory[5] and ethical requirements for contemporary practice

e. quality and safety principles

f. health informatics and health technology[6]

g. cultural safety.

4.5 Inclusion of subject matter that gives students an appreciation of the diversity of Australian culture, develops their knowledge of cultural respect and safety, and engenders the appropriate skills and attitudes to enable culturally safe practice.

5 As detailed in NMBA policies, standards, guidelines and codes—available at www.nursingmidwiferyboard.gov.au/

6 Refer to ANMAC Health informatics and health technology: an explanatory note—available at www.anmac.org.au/sites/default/files/documents/20150130_Health_Informatics_Technology_Explanatory_Note.pdf

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4.6 Inclusion of a discrete unit specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness, culture and culturally safe practice. Health conditions prevalent among Aboriginal and Torres Strait Islander peoples, including the impacts of racism on health, are also appropriately embedded into other units within the program.

4.7 The Diploma of Nursing qualification, as derived from the National Health Training Package, is delivered within Australia, including workplace experience.[7] Other learning experiences gained outside Australia are not included in the program's unit objectives, learning outcomes or assessment.

4.8 Elective units[8] in the program are relevant to the community's health priorities as determined through consultation with key stakeholders, including industry representatives.

7 Due to there being no international equivalency in enrolled nurse practice or education, off shore components of enrolled nurse programs are not supported.

8 Elective units here mean any approved unit that is not part of the core units.

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Standard 5: Student assessment

The program incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.

Criteria

The program provider demonstrates:

5.1 Ultimate accountability for the assessment of students in relation to their workplace experience

5.2 A consistent approach to student assessment across teaching sites and modalities that is periodically reviewed and updated.

5.3 Clear statements about assessment and program progression requirements are provided to students on program commencement and at the start of each unit.

5.4 The level, number and context of assessments are consistent with determining the achievement of the stated learning outcomes.

5.5 Both formative and summative assessment types and tasks exist across the program to enhance individual and collective learning as well as inform student progression.

5.6 A variety of assessment approaches across a range of contexts to evaluate competence in the essential knowledge, skills and behaviours required for enrolled nurse practice.

5.7 Validated instruments are used in workplace experience assessment to evaluate student knowledge, skills, behaviours and achievement of the NMBA Enrolled nurse standards for practice.

5.8 Assessments include the appraisal of competence in pharmacokinetics, pharmacodynamics and the quality use of medicines relevant to the enrolled nurse legislated scope of practice.

5.9 Evidence of procedural controls, fairness, reliability, validity and transparency in assessing students.

5.10 Processes to ensure the integrity of assessment across all modes.

5.11 Collaboration between students, health service providers and teaching staff in selecting and implementing assessment methods.

5.12 Summative assessment of student achievement of the NMBA Enrolled nurse standards for practice conducted by a registered nurse[9] in an Australian clinical context close to program completion.

9 Holds current Australian general registration as a registered nurse

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Standard 6: Students

The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.

Criteria

The program provider demonstrates:

6.1 Applicants are informed of the following before accepting an offer of enrolment:

a. students that would be required by the Nursing and Midwifery Board of Australia (NMBA) to provide a formal English language skills test when applying for registration[10], must provide a formal English language test result demonstrating they have achieved the NMBA specified level of English language skills, prior to commencing the program

b. students are required to provide evidence[11] of having sufficient language, literacy and numeracy skills to successfully undertake the program's academic and workplace experience requirements, prior to commencing the program

c. education providers will, under the National Law, register students with the NMBA and notify the Australian Health Practitioner Regulation Agency if a student undertaking clinical training has an impairment[12] that may place the public at substantial risk of harm

d. specific requirements for right of entry to health services for workplace experience

e. the NMBA requirements for registration as an enrolled nurse including, but not limited to, the registration standard on English language skills.

6.2 Students are selected for the program based on clear, justifiable and published admission criteria.

6.3 Students are informed about, and have access to, appropriate support services, including counselling, health care and academic advisory services.

6.4 Processes to enable early identification of and support for students who are not achieving academic learning outcomes or with conduct issues.

6.5 All students have equal opportunity to meet the NMBA Enrolled nurse standards for practice. The mode or location of program delivery should not influence this opportunity.

6.6 Processes for student representation and feedback in matters relating to governance and program management, content, delivery and evaluation.

10 Refer to NMBA English language skills registration standard at www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

11 Evidence refers to a language, literacy and numeracy (LLN) test result from an Australian Government approved provider (for example, Australian Council for Education Research or Basic key skills builder) at exit level 3 in the Australian Core Skills Framework in both reading and numeracy. Australian students who have successfully completed an Australian Grade 12 certificate with an English subject and students who have undertaken a formal English language skills test (for example, the International Language Testing System) that meets program entry criteria referred to in criterion 6.1a, need only undertake the numeracy component of the LLN test.

12 Impairment is defined in the *Health Practitioner Regulation National Law Act 2009*, as in force in each state and territory. Section 5. Viewed at: www.ahpra.gov.au/Legislation-and-publications/Legislation.aspx on 8 March 2016.

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6.7 Affirmative action strategies are adopted to support the enrolment of Aboriginal and Torres Strait Islander students and a range of supports are provided to students as needed.

6.8 Policies are adopted to support the enrolment of students from culturally, socially and linguistically diverse backgrounds, and a range of supports are offered to these students.

6.9 Affirmative action strategies are adopted to support people with diverse academic, work and life experiences to enrol in the program.

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Standard 7: Resources

The program provider has adequate facilities, equipment and teaching resources as well as staff who are qualified, capable and sufficient in number, to enable students to meet the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.

Criteria

The program provider demonstrates:

7.1 Staff, facilities, online tools, equipment and other teaching resources are sufficient in quality and quantity for the anticipated student population and any planned increase.

7.2 Students have sufficient and timely access to program and clinical teaching staff to support their learning.

7.3 A balance of teaching, clinical, technical and administrative staff appropriate to meeting research or scholarship, governance and teaching commitments.

7.4 Staff recruitment strategies:

a. are culturally inclusive and reflect population diversity

b. take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.

7.5 Documented position descriptions for teaching staff, clearly articulating roles, reporting relationships, responsibilities and accountabilities.

7.6 The Head of Discipline is registered with the NMBA as a registered nurse with no conditions relating to conduct or performance, and holds a post graduate tertiary qualification relevant to their discipline.

7.7 Staff teaching enrolled nurse practice related units are registered with the NMBA as an enrolled nurse or registered nurse, with relevant clinical and academic preparation and experience.

7.8 Teaching staff are qualified in the relevant discipline for their level of teaching, to at least one qualification standard higher than the program of study being taught or with equivalent professional experience.

7.9 In cases where a teaching staff's tertiary qualifications do not include nursing, that their qualifications and experience are relevant to the unit(s) they are teaching.

7.10 Processes to ensure teaching staff demonstrate a sound understanding of contemporary nursing research, scholarship[13] and practice in the unit(s) they teach.

7.11 Learning and teaching, are underpinned by research and staff are engaged in scholarship. Areas of interest, publications, grants and conference papers are documented.

7.12 Policies and processes to verify and monitor the academic and professional credentials, including registration, of current and incoming staff and evaluate their performance and development needs.

13 See glossary for an operational definition of scholarship.

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Standard 8: Management of workplace experience

The program provider ensures that every student is given a variety of supervised workplace experiences conducted in environments providing suitable opportunities and conditions for students to attain the Nursing and Midwifery Board of Australia (NMBA) Enrolled nurse standards for practice.

Criteria

The program provider demonstrates:

8.1 Constructive relationships and clear contractual arrangements with all health providers through which students gain their workplace experience, and processes to ensure these are regularly evaluated and updated.

8.2 Risk management strategies in all environments where students are placed to gain their workplace experience and processes to ensure these are regularly reviewed and updated.

8.3 Workplace experiences provide timely opportunities for experiential learning of program content that is progressively linked to attaining the NMBA Enrolled nurse standards for practice

8.4 Each student is provided with a variety of workplace experiences reflecting the major health priorities and broad landscape of enrolled nurse practice. Opportunities are provided for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.

8.5 Clearly articulated models of supervision, support, facilitation and assessment are in place for all workplace settings so students can achieve the required learning outcomes and the NMBA Enrolled nurse standards for practice.

8.6 Teaching staff, nurse clinicians and other health professionals engaged in supervising and supporting students during workplace experiences are prepared for this role and seek to incorporate contemporary and evidence-based Australian and international perspectives on nursing practice.

8.7 Assessment of student practice against the NMBA Enrolled nurse standards for practice, within the context of the workplace experience, is undertaken by an appropriately qualified registered nurse.

8.8 Appropriate resources are provided, monitored and regularly evaluated to support students while on workplace experience.

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Standard 9: Quality improvement and risk management

The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the learning and teaching experience for students and the competence of graduates.

Criteria

The program provider demonstrates:

9.1 The ability to assess and address risks to the program, its outcomes and students, with a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

9.2 Regular evaluation of teaching staff and clinical supervisor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance.

9.3 Professional and academic development of staff to advance knowledge and competence in teaching effectiveness and assessment.

9.4 Feedback gained from the quality cycle is incorporated into the program of study to improve the experience of theory and practice learning for students.

9.5 Regular evaluation and revision of program content to include contemporary and emerging issues surrounding enrolled nursing practice, health care research and health policy and reform.

9.6 Students and staff are adequately indemnified for relevant activities undertaken as part of program requirements.

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Glossary

Australian Council for Educational Research (ACER)—organisation that undertakes development and provision of assessment and reporting tools and services for schools, universities, technical and further education institutes and registered training organisations, health professionals, employers and governments in Australia and internationally. ACER offers online assessment tools that are matched to the Australian Core Skills Framework and identify and measure an individual's foundation skills levels in English language literacy and numeracy skills.(14)

Advanced standing—the recognition of prior learning through experience and/or studies.

Australian Core Skills Framework (ACSF)—a tool which assists both specialist and non-specialist English language, literacy and numeracy practitioners to describe an individual's performance in the five core skills of learning, reading, writing, oral communication and numeracy.(15)

Australian Health Practitioner Regulation Agency (AHPRA)—organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA supports National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme. AHPRA manages the registration and renewal processes for health practitioners and students around Australia.

Australian Nursing and Midwifery Accreditation Council (ANMAC)—the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme. In this role ANMAC is responsible for developing the content of accreditation standards and determining whether programs of study for nurses and midwives seeking to practice in Australia meet the required education standards. This contributes to protecting the health and safety of the community.

Australian Nursing and Midwifery Council (ANMC)—evolved into ANMAC following approval as the accrediting authority for nursing and midwifery. ANMC authored the original set of accreditation standards as well as the national competency standards for nursing and midwifery.

Australian Qualifications Framework (AQF)—the national policy for regulated qualifications in Australian education and training. AQF incorporates the qualifications from each education and training sector into a single comprehensive national qualifications framework.

Australian Skills Quality Authority (ASQA)—the national regulator for Australia's vocational education and training sector that regulates courses and training providers to ensure nationally approved quality standards are met.

AQF qualification—the result of an accredited complete program of learning leading to formal certification that a graduate has achieved learning outcomes as described in the Australian Qualification Framework.

Basic key skills builder® (bksb)—an organisation that provides online literacy, numeracy and foundation skills assessment tools. The bksb assessment tool has been mapped to the Australian Core Skills Framework and provides an overview of an individual's learning strengths and determines their English and Maths level.(16)

Collaborative practice—where health professionals work as an effective team, optimising individual skills and talents and sharing case management to reach the highest of patient care standards.

Competence/competent —Competence is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability. (17)

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Conceptual framework—promotes coherence in the program of study by identifying how underpinning educational and nursing philosophies is used to guide learning and teaching approaches and support program learning outcomes.

Continuing professional development—the means by which members of the professions maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.(18)

Criteria—rules or tests on which a judgement or decision in relation to compliance with the accreditation standards can be used.

Cultural safety—a term that originated in the nursing profession in New Zealand and specifically focuses on the health care experiences and outcomes of First Nations Peoples.(19) It has been adapted to the Australian context for Aboriginal and Torres Strait Islander Australians over the last 15 years, and is often used in conjunction with cultural respect. Cultural safety occurs when Aboriginal and Torres Strait Islander peoples experience health care practices and policies from both individual practitioners and organisational health services that are culturally respectful and free from individual racism.(20-22) The presence or absence of cultural safety can only be determined by Aboriginal and Torres Strait Islander peoples and requires continuous review and change at both individual and systemic levels.(19-22) In terms of his or her individual practice, an enrolled nurse:

> ...delivering a nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.(23)

Education provider—refers, for the purpose of these standards, to the organisational entity responsible for the design, delivery and quality assurance of a program of study in enrolled nursing from which graduates are eligible to apply for registration with the Nursing and Midwifery Board of Australia.

Emotional intelligence—the ability to understand, identify in oneself and others, and manage emotions. Includes the domains of self-monitoring, self-regulation, self-motivation, empathy and social skills.(24)

Enrolled nurse—a person who provides nursing care under the direct or indirect supervision of a registered nurse. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse for the delegated care.(25)

Enrolled nurse standards for practice—are the core practice standards that provide the framework for assessing enrolled nurse practice.(13)

Equivalent professional experience—the successful completion of a qualification equivalent to that being taught and sufficient post-graduate professional experience in the discipline being taught, to demonstrate competence in applying the discipline's principles and theory.

Governance—framework, systems and processes supporting and guiding an organisation towards achieving its goals and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements.

Graduate outcomes—knowledge, skills, behaviours and attitudes possessed by graduating students in accordance with the Nursing and Midwifery Board of Australia Enrolled nurse standards for practice and those specified by the education provider.

Head of discipline—lead nursing academic responsible for the design and delivery of the program of study on behalf of the education provider.

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Health informatics—the appropriate and innovative application of the concepts and technologies of the information age to improve health care and health.(26)

Health Practitioner Regulation National Law Act 2009 **(the National Law)**—legislation contained in the schedule to the Act, which provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010. It covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner.

Health service providers—health facilities or other appropriate service providers, where students undertake supervised workplace experience as part of a nursing or midwifery program of study.

International English Language Testing System (IELTS)—used to test English language proficiency. The IELTS test is designed to assess the language ability of non-native speakers of English who intend to study or work where English is the language of communication.(27)

Interprofessional learning—when two or more professions learn with, from and about each other to improve collaboration and the quality of care.(28)

Intraprofessional learning—when learners from the one or similar profession learn about, from and with each other to enable effective collaboration and improved outcomes.(29)

Life-long learning—includes learning firmly based in clinical practice situations, formal education, continuing professional development and informal learning experiences within the workplace. Also involves the learner taking responsibility for their own learning, and investing time, money and effort in training or education on a continuous basis.

Nursing and Midwifery Board of Australia (NMBA)—the national regulator for the nursing and midwifery professions in Australia. The NMBA was established under the Health Practitioner Regulation National Law, as in force in each state and territory. Its primary role is to protect the public and set standards and policies that all nurses and midwives registered within Australia must meet.

Pharmacodynamics—study of the biochemical and physiological effects of drugs and the mechanisms of their action in the body.

Pharmacokinetics—study of the bodily absorption, distribution, metabolism, and excretion of drugs.

Practice—any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession.(30)

Program or program of study—full program of study and experiences that are required to be undertaken before a qualification, such as a statement of completion or attainment, can be awarded.

Program provider—the Registered Training Organisation authorised by the Australian Skills and Quality Authority to deliver the qualification of Diploma of Nursing, as derived from the current National Health Training Package.

Quality use of medicines—part of the National Medicines Policy to ensure the judicious, appropriate, safe and effective use of medicines.(31)

Recognition of prior learning—refers to an assessment process for the students formal and informal learning to determine the extent they achieved required learning outcomes, competency outcomes or standards for entry to and/or partial or total completion of a qualification.

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Registered Training Organisation (RTO)—training providers registered by the Australian Skills Quality Authority (or, in some cases a state regulator such as the Training Accreditation Council Western Australia or the Victorian Registration and Qualification Authority) to deliver vocational education and training services.(32)

Registered nurse—is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia.(25)

Preliminary regulatory impact assessment—a tool used by the Office of Best Practice Regulation to assess the potential effects of a regulatory proposal and whether there is a need for further analysis and consultation by way of a Regulation Impact Statement.

Scholarship—application of a systematic approach to acquiring knowledge through intellectual inquiry Includes disseminating this knowledge through various means such as publications, presentations (verbal and audio-visual) and professional practice. Also includes applying this new knowledge to the enrichment of the life of society.(28)

Simulation—any educational method or experience evoking or replicating aspects of the real world in an interactive manner.

Standard—level of quality or attainment.

State regulators—includes the Training and Accreditation Council, Western Australia and the Victorian Registration and Qualification Authority. All other states and territories are regulated by the Australian Skills Quality Authority.

Student—any person enrolled in a program from which graduates are eligible to apply for registration to practice as an enrolled nurse.

Student assessment—process to determine a student's achievement of expected learning outcomes. May include written and oral methods and practice or demonstration.

Supervision or supervise—can be direct or indirect:

- *Direct supervision* is when the supervisor is present and personally observes, works with, guides and directs the person being supervised.
- *Indirect supervision* is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the person receiving care and the needs of the person who is being supervised.(13)

Surface versus deep learning—surface learning is when students accept information at face value and focus on merely memorising it as a set of unlinked facts. This leads to superficial, short-term retention of material, such as for examination purposes. In contrast, deep learning involves the critical analysis of new ideas, linking them to already known concepts and principles. This leads to understanding and long-term retention of concepts so they can be used to solve problems in unfamiliar contexts. Deep learning promotes understanding and application for life.(33)

Teaching staff—education provider staff who teach into the program of study, meet the requirements established in Standard 7 of ANMAC's Enrolled Nurse Accreditation Standards, and are engaged in teaching, supervising, supporting and/or assessing students for acquiring required skills, knowledge, attitudes and graduate competency outcomes.

Unit—a unit of study taught within an enrolled nurse program of study. Referred to as 'subject' in other ANMAC accreditation standards. 'Unit' is used here to promote consistency with nomenclature commonly used in the National Health Training Package.

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Vocational Education Training (VET)—one of the three major sectors of education and training in Australia, the other two being the school and higher education sectors. VET is provided by industry, adult education, community based and private training providers. VET is supported by the Commonwealth and State governments in Australia primarily through technical and further education (TAFE) Institutes and TAFE divisions in dual sector universities.(34)(31)

Workplace Experience—a component of nursing education, not inclusive of simulation activities, that enrolled nurse students are required to successfully complete, so as to foster sound clinical judgement when applying theoretical knowledge in a practice setting and demonstrate achievement of the Nursing and Midwifery Board of Australia Enrolled nurse standards for practice.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK-3

Date: 17 March 2026

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Nursing and Midwifery Board of Australia

Nursing and Midwifery Board of Australia

ENROLLED NURSE STANDARDS FOR PRACTICE

January 20

NMP00006

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ENROLLED NURSES STANDARDS FOR PRACTICE

Introduction

The *Enrolled nurse standards for practice* are the core practice standards that provide the framework for assessing enrolled nurse (EN) practice. They communicate to the general public the standards that can be expected from ENs and can be used in a number of ways including:

- development of nursing curricula by education providers
- assessment of students and new graduates,
- to assess nurses educated overseas seeking to work in Australia, and
- to assess ENs returning to work after breaks in service

In addition, they may also be used by the Nursing and Midwifery Board of Australia (NMBA) and relevant tribunals or courts to assess professional conduct or matters relating to notifications.

The *Enrolled nurse standards for practice* replace the *National competency standards for the enrolled nurse* (2002).

These contemporary standards reflect the role of the EN within the health environment. The standards for practice remain broad and principle-based so that they are sufficiently dynamic for practising nurses to use as a benchmark to assess competence to practise in a range of settings.

The EN works with the registered nurse (RN) as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice generally requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to patient safety.

Although the scope of practice for each EN will vary according to context and education, the EN has a responsibility for ongoing self and professional development to maintain their knowledge base through life-long learning, and continue to demonstrate the types of core nursing activities that an EN would be expected to undertake on entry to practice. Therefore the core standards in this document are the *minimum* standards that are applicable across diverse practice settings and health care populations for both beginning and experienced ENs. They are based on the Diploma of Nursing being the education standard.

ENs engage in analytical thinking; use information and/or evidence; and skilfully and empathetically communicate with all involved in the provision of care, including the person receiving care and their family and community, and health professional colleagues.

The EN standards are clinically focused and they reflect the EN's capability to:

- provide direct and indirect care;
- engage in reflective and analytical practice; and
- demonstrate professional and collaborative practice ENs, where appropriate, educate and support other (unregulated) health care workers (however titled) related to the provision of care.

ENs collaborate and consult with health care recipients their families and community as well as RNs and other health professionals, to plan, implement and evaluate integrated care that optimises outcomes for recipients and the systems of care. They are responsible for the delegated care they provide and self-monitor their work.

How to use these standards

The EN standards for practice are intended to be easily accessible to a variety of groups, including ENs, governments, regulatory agencies, educators, health care professionals and the community. It should be noted that the 'indicators' (refer to glossary) written below the statements are indicative of EN behaviours, they are not intended to be exhaustive. Rather, they are examples of activities that demonstrate the specific standard.

The standards should be read in conjunction with the following relevant documentation, including, but not limited to:

- Decision-Making Framework (NMBA 2013),
- Nursing practice decisions summary guide (NMBA 2010

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- Nursing practice decision flowchart (NMBA 2013), and
- Code of conduct for nurses (NMBA 2017).

They should also be read in conjunction with the attached glossary, which describes the way in which key terms are used in the standards.

There are three domains, namely:

- professional and collaborative practice,
- provision of care, and
- reflective and analytical practice.

The indicators are expressed through knowledge (capabilities)[1], skills[2], and attitudes[3] inherent within these clinically focused domains. All are variable according to the context of practice.

Domains

Professional and collaborative practice

The professional and collaborative practice domain relates to the legal, ethical and professional foundations from which all competent ENs respond to their environment. The domain reflects the responsibilities of the EN to maintain currency and to demonstrate best practice. The standards are:

- functions in accordance with the law, policies and procedures affecting EN practice,
- practises nursing in a way that ensures the rights, confidentiality, dignity and respect of people are upheld, and
- accepts accountability and responsibility for own actions

Provision of care

The provision of care domain relates to the intrinsic care o individuals or groups entrusted to the EN. It encompasses all aspects of care from assessment to engaging in care, and includes health education and evaluation of outcomes. The standards are:

- interprets information from a range of sources in order to contribute to planning appropriate care,
- collaborates with the RN, the person receiving care and the healthcare team when developing plans of care,
- provides skilled and timely care to people receiving care and others whilst promoting their independence and involvement in care decision–making, and
- communicates and uses documentation to inform and report care.

Reflective and analytical practice

The reflective and analytical practice domain relates to the ability of the EN to reflect on evidence-based practice and ensure currency of essential knowledge and skills, to care for the personal, physical and psychological needs of themselves and others. The standards are:

- provides nursing care that is informed by research evidence,
- practises within safety and quality improvement guidelines and standards, and
- engages in ongoing development of self as a professional.

1 *Knowledge (capabilities)* refers to information and the understanding of that information to guide practice.
2 *Skills* refers to technical procedures and competencies
3 *Attitudes* refers to ways for thinking and behaving

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ENROLLED NURSES STANDARDS FOR PRACTICE

Professional and collaborative practice

Standard 1: Functions in accordance with the law, policies and procedures affecting EN practice

Indicators:

1.1 Demonstrates knowledge and understanding of commonwealth, state and /or territory legislation and common law pertinent to nursing practice.

1.2 Fulfils the duty of care in the undertaking of EN practice.

1.3 Demonstrates knowledge of and implications for the NMBA standards, codes and guidelines, workplace policies and procedural guidelines applicable to enrolled nursing practice.

1.4 Provides nursing care according to the agreed plan of care, professional standards, workplace policies and procedural guidelines.

1.5 Identifies and clarifies EN responsibilities for aspects of delegated care working in collaboration with the RN and multidisciplinary health care team.

1.6 Recognises own limitations in practice and competence and seeks guidance from the RN and help as necessary.

1.7 Refrains from undertaking activities where competence has not been demonstrated and appropriate education, training and experience has not been undertaken.

1.8 Acts to ensure safe outcomes for others by recognising the need to protect people and reporting the risk of potential for harm.

1.9 When incidents of unsafe practice occur, reports immediately to the RN and other persons in authority and, where appropriate, explores ways to prevent recurrence.

1.10 Liaises and negotiates with the RN and other appropriate personnel to ensure that needs and rights of people in receipt of care are addressed and upheld.

Standard 2: Practises nursing in a way that ensures the rights, confidentiality, dignity and respect of people are upheld.

Indicators:

2.1 Places the people receiving care at the centre of care and supports them to make informed choices.

2.2 Practises in accordance with the NMBA standards codes and guidelines.

2.3 Demonstrates respect for others to whom care is provided regardless of ethnicity, culture, religion, age, gender, sexual preference, physical or mental state, differing values and beliefs.

2.4 Practises culturally safe care for (i) Aboriginal and Torres Strait Islander peoples; and (ii) people from all other cultures.

2.5 Forms therapeutic relationships with people receiving care and others recognising professional boundaries.

2.6 Maintains equitable care when addressing people's differing values and beliefs.

2.7 Ensures privacy, dignity and confidentiality when providing care.

2.8 Clarifies with the RN and relevant members of the multi-disciplinary healthcare team when interventions or treatments appear unclear or inappropriate.

2.9 Reports incidents of unethical behaviour immediately to the person in authority and, where appropriate, explores ways to prevent recurrence.

2.10 Acknowledges and accommodates, wherever possible, preferences of people receiving nursing care.

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Standard 3: Accepts accountability and responsibility for own actions.

Indicators:

3.1 Practises within the EN scope of practice relevant to the context of practice, legislation, own educational preparation and experience.

3.2 Demonstrates responsibility and accountability for nursing care provided,

3.3 Recognises the RN[4] as the person responsible to assis EN decision-making and provision of nursing care.

3.4 Collaborates with the RN to ensure delegated responsibilities are commensurate with own scope of practice.

3.5 Clarifies own role and responsibilities with supervising RN in the context of the healthcare setting within which they practice.

3.6 Consults with the RN and other members of the multidisciplinary healthcare team to facilitate the provision of accurate information, and enable informed decisions by others.

3.7 Provides care within scope of practice as part of multidisciplinary healthcare team, and with supervision of a RN.

3.8 Provides support and supervision to assistants in nursing (however titled) and to others providing care, such as EN students, to ensure care is provided as outlined within the plan of care and according to institutional policies, protocols and guidelines.

3.9 Promotes the safety of self and others in all aspec of nursing practice.

4 Where an enrolled nurse is working in maternity services setting it is expected that they will be supervised by a midwife.

Provision of care

Standard 4: Interprets information from a range of sources in order to contribute to planning appropriate care

Indicators:

4.1 Uses a range of skills and data gathering techniques including observation, interview, physical examination and measurement.

4.2 Accurately collects, interprets, utilises, monitors and reports information regarding the health and functional status of people receiving care to achieve identified health and care outcomes.

4.3 Develops, monitors and maintains a plan of care in collaboration with the RN, multidisciplinary team and others.

4.4 Uses health care technology appropriately according to workplace guidelines.

Standard 5: Collaborates with the RN, the person receiving care and the healthcare team when developing plans of care

Indicators:

5.1 Develops and promotes positive professional working relationships with members of the multi-disciplinary team.

5.2 Collaborates with members of the multi-disciplinary healthcare team in the provision of nursing care.

5.3 Contributes to the development of care plans in conjunction with the multidisciplinary healthcare team the person receiving care and appropriate others[5].

5.4 Manages and prioritises workload in accordance with people's care plans.

5.5 Clarifies orders for nursing care with the RN when unclear.

5.6 Contributes to and collaborates in decision-making through participation in multidisciplinary healthcare team meetings and case conferences.

5 Appropriate others include those in direct association with the person receiving care (with his/her consent) such as family, unpaid and paid carers, volunteers and clergy.

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Standard 6: Provides skilled and timely care to people whilst promoting their independence and involvement in care decision–making

Indicators:

6.1 Provides care to people who are unable to meet their own physical and/or mental health needs.

6.2 Participates with the RN in evaluation of the person's progress toward expected outcomes and the reformulation of plans of care.

6.3 Promotes active engagement and the independence of people receiving care within the health care setting by involving them as active participants in care, where appropriate.

6.4 Demonstrates currency and competency in the safe use of healthcare technology.

6.5 Exercises time management and workload prioritisation.

6.6 Recognises when the physical or mental health of a person receiving care is deteriorating, reports, documents and seeks appropriate assistance.

Standard 7: Communicates and uses documentation to inform and report care

Indicators:

7.1 Collects data, reviews and documents the health and functional status of the person receiving care accurately and clearly.

7.2 Interprets and reports the health and functional status of people receiving care to the RN and appropriate members of the multidisciplinary healthcare team as soon as practicable.

7.3 Uses a variety of communication methods to engage appropriately with others and documents accordingly

7.4 Prepares and delivers written and verbal care reports such as clinical handover, as a part of the multidisciplinary healthcare team.

7.5 Provides accurate and appropriate information to enable informed decision making by others.

Reflective and analytical practice

Standard 8: Provides nursing care that is informed by research evidence

Indicators:

8.1 Refers to the RN to guide decision-making.

8.2 Seeks additional knowledge/information when presented with unfamiliar situations.

8.3 Incorporates evidence for best practice as guided by the RN or other appropriate health professionals.

8.4 Uses problem-solving incorporating logic, analysis and a sound argument when planning and providing care.

8.5 Demonstrates analytical skills through accessing and evaluating healthcare information and quality improvement activities.

8.6 Consults with the RN and other relevant health professionals and resources to improve current practice.

Standard 9: Practises within safety and quality improvement guidelines and standards

Indicators:

9.1 Participates in quality improvement programs and accreditation standards activities as relevant to the context of practice.

9.2 Within the multi-disciplinary team, contributes and consults in analysing risk and implementing strategies to minimise risk.

9.3 Reports and documents safety breaches and hazards according to legislative requirements and institutional policies and procedures.

9.4 Practises safely within legislative requirements, safety policies, protocols and guidelines.

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Standard 10: Engages in ongoing development of self as a professional

Indicators:

10.1 Uses EN standards for practice to assess own performance,

10.2 Recognises the need for, and participates in, continuing professional and skills development in accordance with the NMBA's Continuing professional development registration standard.

10.3 Identifies learning needs through critical reflection and consideration of evidence-based practice in consultation with the RNs and the multidisciplinary healthcare team.

10.4 Contributes to and supports the professional development of others.

10.5 Uses professional supports and resources such as clinical supervision that facilitate professional development and personal wellbeing.

10.6 Promotes a positive professional image.

Glossary

Accountability/accountable: Nurses and midwives must be prepared to answer to others, such as people in receipt of healthcare, their nursing and midwifery regulatory authority, employers and the public for their decisions, actions, behaviours and the responsibilities that are inherent in their roles. Accountability cannot be delegated. The RN or midwife who delegates an activity to another person is accountable, not only for their delegation decision, but also for monitoring the standard of performance of the activity by the other person, and for evaluating the outcomes of the delegation. However, they are not accountable for the performance of the delegated activity.

Best practice: A technique, method, process, activity or incentive which has been proven by evidence to be most effective in providing a certain outcome.

Core practice: The day-to-day or regular activities or policies of a health service provider that fundamentally guide the service as a whole.

Decision-making framework: The NMBA expects all nurses and midwives to practise within the relevant standards for practice and decision-making frameworks.

Delegation/delegate: A delegation relationship exists when one member of the health care team delegates aspects of care, which they are competent to perform and which they would normally perform themselves, to another member of the health care team from a different discipline, or to a less experienced member of the same discipline. Delegations are made to meet people's needs and to ensure access to health care services — that is, the right person is available at the right time to provide the right service to a person. The delegator retains accountability for the decision to delegate and for monitoring outcomes.

Duty of care/standard of care: A responsibility or relationship recognised in law. For example, it may exist between health professionals and their clients. Associated with this duty is an expectation that the health professional will behave or act in a particular way. This is called the standard of care, which requires that a person act toward others and the public with watchfulness, attention, caution and the prudence that would be made by a reasonable person in those circumstances. If a person's actions do not meet this standard of care, whereby they fall below the acceptable standards, any damages resulting may be pursued in a lawsuit for negligence.

Enrolled nurse (EN; Division 2): A person with appropriate educational preparation and competence for practice, who is registered under the Health Practitioner Regulation National Law.

Evidence-based practice: Assessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings and the individuality of situations and personal preferences as the basis for practice decisions.

Indicators: Key generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist the assessor when using their professional judgement in assessing nursing practice. They further assist curriculum development.

Midwife/midwifery practice: A midwife is a person with appropriate educational preparation and competence for practice who is registered by the NMBA. This term includes endorsed midwives for the purposes of this document.

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ENROLLED NURSES STANDARDS FOR PRACTICE

The NMBA has endorsed the ICM definition of a midwife (that includes the statement below on scope of practice) and applied it to the Australian context.

The International Confederation of Midwives (ICM) defines a midwife as follows:

> *A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the ICM essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.*
>
> Scope of practice[6]
>
> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.*
>
> *A midwife may practise in any setting including the home, community, hospitals, clinics or health units* (ICM international definition of the midwife 2012). www.internationalmidwives.org

Nursing and Midwifery Board of Australia (NMBA): The national body responsible for the regulation of nurses and midwives in Australia.

Person/people: Refers to those individuals who have entered into a relationship with an enrolled nurse.

Person/people encompass patients, clients, consumers and families that fall within the EN scope and context of practice

Person-centred practice: A collaborative and respectful partnership built on mutual trust and understanding. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Plan of care: Outlines the care to be provided to an individual family/ community and includes the nursing component. It is a set of actions the nurse will implement to resolve/ support nursing diagnoses identified by nursing assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care.

Professional boundaries: Refers to the clear separation that should exist between professional conduct aimed at meeting the health needs of people, and behaviour which serves a nurse's own personal views, feelings and relationships that are not relevant to the professional relationship.

Quality: Refers to characteristics and grades with respect to excellence.

Refer/referral: Referral is the transfer of primary health care responsibility to another qualified health service provider/health professional. However, the nurse or midwife referring the person for care by another professional or service may need to continue to provide their professional services collaboratively in this period.

Registered nurse (RN; Division 1): A person who has completed the prescribed educational preparation, demonstrated competence to practise, and is registered under the Health Practitioner Regulation National Law a a registered nurse in Australia. For the purposes of this document the term also includes nurse practitioners.

6 Scope of practice forms a part of the ICM definition of a midwife.

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Risk assessment/risk management: An effective risk management system is one incorporating strategies to:

- identify risks/hazards,
- assess the likelihood of the risks occurring and the severity of the consequences if the risks do occur, and
- prevent the occurrence of the risks, or minimise their impact.

Scope of practice: Is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice of individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider

Standards for practice: Set the expectations of enrolled nurse practice. They inform the education standards for enrolled nurses; the regulation of nurses and determination of nurses' fitness for practice; and guide consumers, employers and other stakeholders on what to reasonably expect from an enrolled nurse regardless of the area of nursing practice or years of nursing experience. They replace the previous *National competency standards for the enrolled nurse.*

Supervision/supervise: Supervision can be either direct or indirect:

- **Direct supervision** is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised.
- **Indirect supervision** is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the person receiving care and the needs o the person who is being supervised.

For the purpose of this document, supervision is defined as access, in all contexts of care, at all times, either directly or indirectly to professional supervision to a named and accessible RN for support and guidance of the practice of an EN.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK-4

Date: 17 March 2026

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

Fact sheet

Scope of practice and capabilities of nurses

Updated May 2024

Nursing and Midwifery Board Ahpra

Introduction

The Nursing and Midwifery Board of Australia (NMBA) regulates the practice of nursing and midwifery in Australia and one of its key roles is to protect the public. The NMBA does this by developing standards, codes and guidelines which together establish the requirements for the professional and safe practice of nurses and midwives in Australia. The NMBA undertakes its functions as set by the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory.

Under the National Law, nursing and midwifery are recognised as two separate professions and there are two divisions of nursing, registered nurse and enrolled nurse. In addition to registered nurses, enrolled nurses and midwives, there are also nurse practitioners. Each of these titles are protected under the National Law with each having different education, knowledge, skills and standards for practice and different responsibilities and activities.

This guidance on the scope of practice and capabilities of nurses provides a high-level collective synopsis of the NMBA's registration standards, standards for practice, codes and guidelines. It has been developed as guidance for stakeholders such as employers, private and public health services, and other health practitioners, on the varying roles and scope of practice of registered nurses, enrolled nurses and nurse practitioners. Employers can use the information as a starting point, when determining which practitioner best suits the needs and requirements of their health service. It can also provide clarity and guidance to the public when receiving care and treatment from a nurse.

The information in the following tables clarifies the educational outcomes, provides examples of core activities and fundamental differences between each NMBA health practitioner category. While the tables provide examples of some core activities that nurses carry out in practice, throughout their careers nurses continue to develop their knowledge and skills and expand their scope of practice.

For information about the education pathways and core activities of midwives and endorsed midwives, please refer to the NMBA's Fact sheet: Scope of practice and capabilities of midwives.

For information on Australian Qualifications Framework (AQF) please refer to the AQF website.



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Nursing education pathways and outcomes

Qualifications

Under the National Law there are specific titles which are referred to as 'protected titles'. Registered nurse (RN), nurse practitioner (NP) and enrolled nurse (EN) are a protected titles. This means that only those registered or endorsed with the NMBA can use these titles in Australia.

The following qualifications and outcomes are necessary for registration/endorsement with the NMBA

	Enrolled nurse (EN)	Registered nurse (RN)	Nurse practitioner (NP)
Qualification/ program of study (NMBA approved)	**Diploma of nursing (AQF 5)**[1] *Study duration:* Minimum 18 months within the vocational education training (VET) sector, delivered by Registered Training Organisations (RTO).	**Bachelor of nursing (AQF 7)**[1] *Study duration:* Three years full time (or equivalent), tertiary education (university) **or** **Master's degree (AQF 9)**[1] *Study duration:* Two years or equivalent. Graduates commonly complete a supported transition to practice program, though this is not mandatory.	Holds registration as an RN and has 5,000 hours of advanced practice (as defined by the NMBA). **Plus,** completion of a **Master of Nurse Practitioner (AQF 9)**[1] *Study duration:* minimum 18 months, tertiary education.
Clinical placement hours/setting	Students complete a minimum of 400 hours of clinical placement in a variety of settings.	Students complete a minimum of 800 hours of clinical placement in a variety of settings.	Students complete a minimum of 300 hours of supernumerary clinical practice.
Educational outcomes	ENs graduate from a competency-based education framework with essential knowledge to manage and complete nursing care under the supervision of an RN, NP or midwife. The supervision can be direct or indirect.[2] ENs are educated with the essential knowledge required to effectively provide nursing care that is person-centred, informed by evidence, complete delegated care, manage tasks and manage contingencies in the context of the role. ENs recognise normal and changing health conditions of people in their care.	RNs graduate as generalists with a person- centred approach to practice and an integrated theoretical and practice-based knowledge of care across the lifespan and across all body systems. RN practice is person-centred and evidence-based During their education RNs develop critical thinking skills that are transferable across the many contexts where RNs work. RNs have an in-depth scientific knowledge that includes the administration, supply and quality use of medicine. RNs have foundational skills in communication, relationships and management.	NPs graduate with advanced health assessment skills and diagnostics skills, with a person-centred approach underpinned by clinical research and practice improvement methods. NPs are educated and authorised to diagnose, prescribe scheduled medicines and order diagnostic investigations. NPs have advanced skills in communication research, leadership and clinical practice.

[1] Australian Qualifications Framework (AQF) is the national policy for regulated qualifications in Australian education and training.

[2] www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Enrolled-nurse-standards-for-practice

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Scope of practice

While the foundational education of RNs, ENs and NPs in Australia captures the full breadth of the scope of the profession at the graduate entry level, the scope of practice of individual practitioners is influenced by the settings in which they practise. This includes the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider. As the nurse gains new skills and knowledge, their individual scope of practice changes.

Sometimes a registered practitioner has a type of registration or conditions that limit what they can do. The NMBA publishes a list of nurses who are registered to practise in Australia. The list is called the 'Register of practitioners[1]'. When a nurse's name appears on the list, you know that they are registered and whether they have any restrictions or conditions associated with their registration.

[1] https://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx

	Enrolled nurse (EN)	Registered nurse (RN)	Nurse practitioner (NP)
What do nurses do?	ENs provide nursing care as part of a team, contribute to the development of plans of care while working under the supervision of an RN or NP. ENs have the knowledge and skills to gather and interpret data using observation, interview, physical examination and measurement. ENs are accountable in providing care that has been delegated to them by an RN or NP, according to the health needs of the person, and that is within their competence. ENs work as part of a multi-disciplinary team and collaborate with other healthcare workers. **Examples of core EN activities include:** • providing personal care and hygiene needs such as showering, dressing and assisting with meals. • recording and interpreting clinical observations including • temperature, pulse and blood pressure • urinalysis • blood glucose and other tests used in specific areas of practice • recognising and communicating changes in the person's condition to the RN and, with the RN, formulate the next steps of care	RNs are accountable for the management of people in their care. They conduct comprehensive assessments, develop care plans and coordinate other health workers and resources to provide nursing care. RNs apply critical thinking and analyse nursing practice, providing safe, appropriate and responsive quality nursing practice. RNs provide information and education to enable people to make decisions and take action in relation to their health and well-being. RNs supervise, and when appropriate, delegate care to ENs, student nurses and other healthcare workers **Examples of core RN activities include:** • responsibility for the assessment, planning and delivery of care to people who have acute and/or chronic physical and mental health issues • developing, reviewing and maintaining nursing care plans and other health records • the ongoing monitoring and evaluation of the nursing care provided and identification where care may need to be escalated or altered due to the changing health of the person • performing treatments, commencing administering and monitoring medication and IV therapy • interpreting diagnostic test results and reports	NP practice is primarily a clinical role. NPs integrate theoretical and advanced practice knowledge to apply to diagnostic reasoning to formulate diagnoses. NPs have authority to practise independently and collaboratively in multi-disciplinary teams, at an advanced practice level. NPs supervise ENs, nursing and NP students and other healthcare workers. Depending on the individual scope of practice, the NP may have the ability and authority to work at an extended or specialist level. This includes providing or assisting with medical or surgical procedures, or advanced care in range o specialist and/or generalist clinical areas. **Examples of core NP activities include many registered nursing activities, and in addition:** • advanced health assessment that includes ordering and interpreting diagnostic tests (pathology and medical imaging) • diagnosing and treating acute and/or chronic physical and mental health conditions • independent prescribing of scheduled pharmacological and non- pharmacological interventions • independent referral to general practitioners, medical specialists and allied health practitioners

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	Enrolled nurse (EN)	Registered nurse (RN)	Nurse practitioner (NP)
What do nurses do?	• providing basic care for those with acute and chronic physical and mental health needs • providing basic wound care in line with an agreed plan of care • administering and monitoring medicines and intravenous therapy • supporting basic nutrition advice and education responding to people's health and care needs.	• educating people about treatment plans, their follow up care, and any referrals to specialist services that have been made • providing emotional and psychological support to people and their families • supervising nursing students • participating in medical or surgical procedures as part of a multi-disciplinary team (for example in surgical wards and operating theatres) • working with a nursing focus with other healthcare providers.	• independent referral to general practitioners, medical specialists and allied health practitioners • establishing healthcare delivery • a strategic role to improve, manage or prevent health issues • support meeting the need of community health using contemporary research to provide evidence-based care • policy development initiation and quality improvement activities.

Document history

Approved by: Nursing and Midwifery Board of Australia

Date commenced: September 2022

Next review due: February 2027

Policy history: Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y**
If so which version? **V2.0**
Does this policy replace another policy with a different title? **Fact sheet: *Scope of practice and capabilities of nurses and midwives***

Approval date	Version	Reason for change
September 2022	v1.0	Published
November 2023	v2.0	Separated the nursing and midwifery professions into two documents.
May 2024	v2.1	Remove of word 'clinical' in description of nurse practitioner qualification to align with NMBA definition of 'advanced practice'.

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK-5

Date: 17 March 2026

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

Nursing and Midwifery Board of Australia

Nursing and Midwifery Board of Australia

REGISTRATION STANDARD: CONTINUING PROFESSIONAL DEVELOPMENT

1 June 2016

NMBAXXXXXX

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

REGISTRATION STANDARD: CONTINUING PROFESSIONA DEVELOPMENT

Nursing and Midwifery Board of Australia

Summary

This registration standard sets out the Nursing and Midwifery Board of Australia's (NMBA) minimum requirements for continuing professional development (CPD) for enrolled nurses, registered nurses and midwives.

Does this standard apply to me?

This registration standard applies to all enrolled nurses, registered nurses and midwives.

The standard applies equally to enrolled nurses, registered nurses and midwives who work either full time or part-time in paid or unpaid practice. The standard applies to enrolled nurses, registered nurses and midwives who are on leave from work, e.g. maternity leave.

This standard does not apply to those with non-practising registration or students of nursing or midwifery.

What must I do?

To meet this registration standard, you must complete a minimum of 20 hours of CPD per registration period.

If you have held registration for less than 12 months, pro rata CPD hours apply. See *Pro rata CPD requirements* on page 3.

Specific requirements for nurses who hold an endorsement

If you are a registered nurse who has an endorsement as a nurse practitioner or holds an endorsement for scheduled medicines, you must complete additional CPD requirements. These are described in the table below.

Nurses	CPD requirements	Total additional CPD hours	Total CPD hours
Nurse practitioner	Registered nurse – 20 hours Nurse practitioner endorsement – 10 additional hours relating to prescribing and administration of medicines, diagnostic investigations, consultation and referral	10 hours	30 hours
Registered nurse with scheduled medicines endorsement	Registered nurse – 20 hours Scheduled medicines endorsement – 10 additional hours relating to obtaining, supplying and administration of scheduled medicines	10 hours	30 hours

Specific requirements for midwives who have a notation or hold an endorsement

If you have a notation as an eligible midwife or hold an endorsement as a midwife who holds an endorsement for scheduled medicines, you must complete additional CPD requirements. These are described in the table below.

Midwives	CPD requirements	Total additional CPD hours	Total CPD hours
Midwife with a notation and/or scheduled medicines endorsement	Midwife – 20 hours Endorsement and/or notation – 10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostic investigations, consultation and referral	10 hours	30 hours

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Nursing and Midwifery Board of Australia

Specific requirements for people registered as both a nurse and a midwife

If you are registered as either an enrolled nurse or a registered nurse and a midwife, you must complete the required amount of CPD for both nursing and midwifery

If your CPD activities are relevant to both the nursing profession and the midwifery profession, you may count those activities as evidence for both nursing and midwifery CPD hours.

Pro rata CPD requirements

If you have been registered for a period of less than 12 months prior to the renewal of registration, the following pro rata CPD requirements apply.

Months registration has been held	Pro rata CPD hours that must be completed
0 – 3 months	⩾ 5 hours
>3 – 6 months	⩾ 10 hours
>6 – 9 months	⩾ 15 hours
> 9 –12 months	⩾ 20 hours

If you have an endorsement and/or notation for a period of less than 12 months prior to the renewal of registration, the following additional pro rata CPD requirements apply.

Months endorsement/ notation has been held	Additional pro rata CPD hours that must be completed
0 – 3 months	⩾ 2.5 hours
> 3 – 6 months	⩾ 5 hours
> 6 – 9 months	⩾ 7.5 hours
> 9 – 12 months	⩾ 10 hours

Are there exemptions to this standard?

The NMBA may grant an exemption to this standard in exceptional circumstances. The NMBA CPD guidelines and relevant policies, published under *Codes, guidelines and statements* on the NMBA website, provide further guidance.

What does this mean for me?

When you apply for registration

You don't need to meet this standard when you apply for registration in Australia as a nurse and/or midwife.

At renewal of registration

When you apply to renew your registration/endorsement you are required to declare that you have complied with this standard.

During the registration period

Your compliance with this registration standard may be audited from time to time. It may also be checked if the NMBA receives a notification about you.

Evidence

You should maintain records of your CPD activity for five years in case you are audited. If you are required to provide the NMBA with evidence of your CPD activities, your personal portfolio will help demonstrate that you have met the CPD requirements.

What happens if I don't meet this standard?

The National Law establishes possible consequences if you don't meet this standard, including:

- the NMBA can impose a condition or conditions on your registration/endorsement or refuse an application for registration/endorsement or renewal of registration, if you do not meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)

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- a failure to undertake the CPD required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the NMBA (section 128 of the National Law), and
- registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for registered nurses and/or midwives (section 41 of the National Law).

Continuing professional development guidelines for nurses and midwives

The *Guidelines for continuing professional development* provide more information about how to meet this standard. You are expected to understand and apply these guidelines together with this registration standard

Authority

This registration standard was approved by the Australian Health Workforce Ministerial Council on 27 August 2015.

Registration standards are developed under section 38 of the National Law and are subject to wide-ranging consultation.

Definitions

National Law means the Health Practitioner Regulation National Law, as in force in each state and territory.

Continuing professional development is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

Nurse includes enrolled nurses, registered nurses, nurse practitioners, registered nurses with a scheduled medicines endorsement and enrolled nurses and registered nurses with a notation.

Midwife includes midwives with a notation and midwive with a scheduled medicines endorsement and midwife practitioners.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession.

Review

This registration standard will be reviewed from time to time as required. This will generally be at least every five years.

Last reviewed: 1 June 2016

This standard replaces the previous registration standard from 1 July 2010.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK-6

Date: 17 March 2026

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

Australian
Nursing & Midwifery
Accreditation Council

nurse practitioner

Nurse Practitioner

Accreditation Standards 2015

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Australian
Nursing & Midwifery
Accreditation Council

Nurse Practitioner
Accreditation Standards 2015

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

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ISBN: 978-0-9943856-0-4

Published by the Australian Nursing and Midwifery Accreditation Council, Canberra, subject to Nursing and Midwifery Board of Australia approval, July 2015

This document is online at www.anmac.org.au/search/publication

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Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

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Acknowledgements

The Board of the Australian Nursing and Midwifery Accreditation Council (ANMAC) gratefully acknowledge the expertise, time and commitment contributed by each member of the Expert Advisory Group (EAG) to review and update these Nurse Practitioner Accreditation Standards. Membership comprised:

- Professor Anne Gardner—Expert Advisory Group, Chair and Director of Research for the School of Nursing, Midwifery and Paramedicine, Australian Catholic University, Australian Capital Territory
- Dr Rosemary Bryant—Former Commonwealth Chief Nurse and Midwifery Officer, Department of Health, and ANMAC Board Director
- Ms Julianne Bryce—Australian Nursing and Midwifery Federation
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- Ms Amanda Davies—Nurse Practitioner, Assistant Director of Nursing (Advanced Practice), Department of Health, Queensland
- Professor Phil Della—Council of Deans of Nursing and Midwifery Australia and New Zealand, and Head of School–School of Nursing, Midwifery and Paramedicine, Curtin University, Western Australia
- Professor Maxine Duke—Educationalist, Head of School, Nursing and Midwifery, Deakin University, Victoria
- Professor Glenn Gardner—Chair, Nurse Practitioner Accreditation Committee and Professor of Nursing–Institute of Health and Biomedical Innovation, Queensland University of Technology, Queensland
- Ms Helen Gosby—President, Australian College of Nurse Practitioners
- Mr Christopher Helms—Nurse Practitioner, Australian Capital Territory
- Ms Helen Mikolaj—Health Consumer Forum of Australia
- Professor Lisa Nissen—Pharmacist, and Head of School, Faculty of Health, School–Clinical Sciences Queensland University of Technology, Queensland
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- Ms Veronica Croome— Chief Nurse, Australian and New Zealand Council of Chief Nurses and Midwives
- Mrs Lesley Salem—Nurse Practitioner, Private Practice, Wonnarua woman and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Professor Bob Meyenn—Chair, Standards, Accreditation and Assessment Committee and ANMAC Board Director
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- Clinical Professor Fiona Stoker—Chief Executive Officer (membership commenced October 2014)
- Ms Amanda Adrian—Former Chief Executive Officer (member from February to August 2014)
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- Ms Louise Carter—Executive Director of Strategy Implementation and Communications
- Ms Jackie Doolan—Standards Development and Review Co-ordinator and Project Lead

ANMAC also acknowledges the individuals and representatives of organisations who participated in the consultation forums, provided a submission or responded to the electronic surveys during the consultation period.

The intellectual input, collective wisdom and critical thinking provided exemplified the goodwill and professionalism of those committed to advancing the nursing profession in Australia. It was vital to the end result.

ANMAC also acknowledges Quorus consultancy for contributing to the development of the first consultation paper used in this review.

ANMAC commends these accreditation standards to the Nursing and Midwifery Board of Australia (NMBA) and acknowledges the support of the NMBA in their review and revision.

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1 Preamble

1.1 Nurse practitioner education in Australia

To apply to become a nurse practitioner in Australia, individuals must first have completed a program of study accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the Nursing and Midwifery Board of Australia (NMBA). Programs of study eligible for accreditation are delivered by a government-accredited university or other higher education provider. These programs lead to the award of a Master of Nurse Practitioner.

The Australian regulatory environment in which nurse practitioners are endorsed and programs of study accredited and delivered, has undergone significant change over the last five years. Higher education regulation and quality assurance has also undergone major transformation during this time. Implementation of national reforms in health policy, governance and funding, particularly in relation to eligibility for the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), has also influenced nurse practitioner education. This context underpinned the review of these Nurse Practitioner Accreditation Standards.

1.2 Health practitioner regulation

The *Health Practitioner Regulation National Law Act 2009* (the National Law), enacted in July 2010, is the national law by which the National Registration and Accreditation Scheme for health practitioners is instituted.

The scheme has six objectives, with the first of primary importance:

> **... to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.**[1]

Under Section 49(1) of the National Law, graduates of nurse practitioner programs of study are not eligible to register unless the program is accredited by ANMAC and approved by the NMBA as meeting the educational requirements for endorsement as a nurse practitioner.

After the National Law was introduced, the Australian Nursing and Midwifery Council (ANMC) was appointed under the National Registration and Accreditation Scheme as the independent accreditation authority for all nursing and midwifery education providers and programs of study leading to registration and endorsement in Australia. The name ANMC was changed to ANMAC in November 2010 to reflect its principal role as an accrediting authority.

ANMAC is responsible for monitoring education providers and programs of study leading to qualification for registration in nursing and midwifery. In addition, through a process of cyclical review, ANMAC maintains the integrity and effectiveness of accreditation standards that underpin the accreditation of programs of study under its mandate.

Professional education accreditation is concerned with the quality of the profession and its work, from the perspective of the public interest and community safety. It is part of a broader process of assuring the community that, having completed an accredited program of study, beginning professional practitioners have achieved agreed professional outcomes and are able to practise in a safe and competent manner because they are equipped with the necessary foundation knowledge, professional attitudes and essential skills. This process, however, relies on two fundamental principles:

1 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

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1. That the education providers themselves are authorised to issue the relevant qualification and are evaluated to assure continued quality learning outcomes for their graduates.
2. That there is a set of agreed and contemporary competency or practice standards for the profession against which the capability of graduates of programs is assessed.

The first principle is discussed in Section 1.3. The second relates to the Nurse Practitioner Standards for Practice[2] developed by the NMBA in 2014. These standards articulate the core competencies used to assess the performance of those wanting to obtain and retain a licence to practise as a nurse practitioner in Australia. Higher education providers use them when developing nurse practitioner curricula and assessing student performance. Employers use them when evaluating new graduate performance.

The accreditation process administered by ANMAC is an efficient and effective proxy for externally assessing graduates against standards for practice. Professional program accreditation must ensure that professional standards are protected without inhibiting diversity and innovation or constraining continuous quality improvement. As with the national standards for practice, the national accreditation standards are regularly reviewed to ensure relevance in the light of changes in health and education legislation, policy, delivery and ethos.

1.3 Higher education regulation

The Tertiary Education Quality and Standards Agency (TEQSA) was established in July 2011 as an independent national body to regulate and assure the quality of all types of higher education and fulfil the Government's commitment to:

> **... accredit providers, evaluate the performance of institutions and programs, encourage best practice simplify current regulatory arrangements and provide greater national consistency.**[3]

Recent Australian Government directions are intended to assure quality while reducing the higher education regulatory burden.[4] Consequently, there is now emphasis on improving the focus, timeliness and efficiency of TEQSA's regulatory activities.[5]

A part of TEQSA's regulatory responsibility is to evaluate the performance of universities and other higher education providers within a period that does not exceed seven years or when there is evidence that standards are not being met. The Higher Education Standards Framework sets a legislated standard by which TEQSA accredits higher education providers.[6] These standards apply to all higher education providers offering Level 5 (diploma) to Level 10 (doctoral) qualifications as described in the Australian Qualifications Framework (AQF).[7] Consequently, all higher education institutions offering degree programs in nursing are regulated and accredited by TEQSA.

The AQF is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into one comprehensive framework comprising 10 levels of qualification, with a Masters Degree sitting at Level 9.

2 NMBA (2014). *Nurse Practitioner Standards for Practice*. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

3 Australian Government (2009). *Transforming Australia's Higher Education System*, p. 31.

4 Australian Government (2013). *Review of Higher Education Regulation Report*. Viewed at: https://docs.education.gov.au/documents/expert-panel-s-review-higher-education-regulation-report on 10 March 2015.

5 Australian Government (2011). *Tertiary Education Quality and Standards Agency Act—Ministerial Direction No. 2 of 2013 Explanatory Statement*. Viewed at: www.comlaw.gov.au/Details/F2013L01824/Explanatory%20Statement/Text on 10 March 2015.

6 Australian Government (2011). *Higher Education Standards Framework (Threshold Standards)*. Viewed at: www.comlaw.gov.au/Series/F2012L00003 on 10 March 2015.

7 Australian Qualifications Framework (AQF) Council (2013). *Australian Qualifications Framework*, Second edition. Viewed at: www.aqf.edu.au/wp-content/uploads/2013/05/AQF-2nd-Edition-January-2013.pdf on 9 April 2015.

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The AQF stipulates the learning outcomes expected within each AQF level and qualification type. It expresses these as dimensions of knowledge, skills and their application. This ensures the integrity of qualifications and standardises them across education providers, settings and delivery modes. All institutions offering nursing programs are required to comply with AQF criteria for learning outcomes

1.4 Health reforms

Major reforms in the governance, funding and provision of health services[8] over recent years have aimed to increase national integration and local control of the health care system. The reform is intended to improve patient access and the performance, transparency and accountability of health services, while ensuring funding sustainability.

As part of the Australian Government's health reform, nurse practitioners have been supported in having a greater role in the delivery of patient care.[9] The reform proposes that nurse practitioners, working within the hospital setting, would support and contribute to such national initiatives as:

- four-hour national access target for emergency departments
- increased number of sub-acute care beds
- reduced waiting times for elective surgery.[10]

In 2010, funding was provided to allow eligible nurse practitioners access to the MBS and the PBS with the purpose of improving access to primary health care services and promoting multidisciplinary team based approaches to health care.[11] MBS access enables eligible nurse practitioners to:

- treat patients with a broad range of medical conditions in a variety of settings, including aged care facilities
- access a number of telehealth clinical support items
- perform certain pathology tests and request a range of pathology and diagnostic services
- refer patients to specialists and consultant physicians within their scope of practice.[12]

Access to MBS and PBS would also provide nurse practitioners with an opportunity to have a greater role in non-acute settings, including in the areas of primary care, aged care and in rural and remote Australia[13], although a recent study suggests that more MBS access is necessary for viability of the nurse practitioner primary health care role.[14]

These health reforms are influencing both nurse practitioner practice and education.

8 Australian Government (2010). *A National Health and Hospitals Network for Australia's Future* and *A National Health and Hospitals Network: Further Investments in Australia's Health*. Viewed at: www.budget.gov.au/2010-11/content/glossy/health download/health_overview.pdf on 9 April 2015.

9 Australian Government (2012). Health Workforce, Nurse Practitioners. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/work-nurse-prac on 8 April 2015.

10 ibid.

11 ibid.

12 Australian Government (2013). Medicare: Primary Care (GP, nursing, allied health), Midwives and Nurses. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-practitioners on 8 April 2015.

13 Australian Government (2012). Health Workforce, Nurse Practitioners. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/work-nurse-prac on 8 April 2015.

14 Helms C, Crookes J & Bailey D (2015). Financial viability, benefits and challenges of employing a nurse practitioner in general practice. *Australian Health Review,* 39(2), 205–2010, http://dx.doi.org/10.1071/AH13231.

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1.5 Background

The original Nurse Practitioner Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia—with Evidence Guide were developed in February 2009 by the ANMC with key industry stakeholders, including regulators, professional bodies, consumers and academics. The standards were approved by the newly established NMBA in 2010.[15]

As the external accreditation authority for nursing and midwifery programs, ANMAC has, since 1 July 2010, used the current standards to undertake accreditation assessments of programs of study leading to nurse practitioner endorsement. During this time, education providers have submitted valuable feedback on the accreditation standards, as have independent assessment team members and ANMAC Associate Directors for Professional Programs.

As part of the cyclical review of all accreditation standards, the ANMAC Board authorised the review of the Nurse Practitioner Accreditation Standards to start in January 2014 with stakeholder engagement to be implemented in accordance with National Law, which states:

> **In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content of the standard.**[16]

1.6 Review of the Nurse Practitioner Accreditation Standards

The ANMAC Board convened an EAG (see Acknowledgements) to oversee the review of the Nurse Practitioner Accreditation Standards. The EAG provided input into a project timeline and identified a wide-ranging list of stakeholders to consult. A letter of invitation was sent to stakeholders outlining the process and options for providing comment and feedback throughout the review. Feedback optio included completing an online survey, sending a written submission and/or attending one of three consultation forums.

The review was an iterative process including two stages of consultation, each focused on a separate consultation paper.

Stage 1—first consultation paper

The first consultation paper and first version of the revised standards was prepared with a consultancy firm, edited by the EAG, approved by the ANMAC Board and sent to stakeholders to consider in May 2014

This paper covered the background, context, purpose and process of the review. It also addressed key areas of change in education and health care policy pertinent to revising the nine Nurse Practitioner Accreditation Standards. Stakeholders were asked to consider specific content areas in the first version of the standards, including:

- defining and implementing the concept of 'capability' as understood by nurse practitioners
- attaining national prescribing competencies
- replacing 'professional experience' terminology
- strengthening viva voce assessment
- specifying program entry criteria
- specifying supernumerary clinical hours

15 ANMC (2009). *Registered Nurse Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia—with Evidence Guide*, February 2009, Canberra.

16 AHPRA (2009). *Health Practitioner Regulation Law Act 2009* as in force in each state and territory. Viewed at: www.ahpra.go au/Legislation-and-publications/Legislation.aspxon on 6 May 2013.

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- specifying program convenors be endorsed nurse practitioners
- developing students' generic and specialty knowledge and skills
- clarifying what is meant by 'a suitably qualified multidisciplinary team member'.

Stakeholders were also asked to consider if the first version of the standards was complete and sufficient to assure the NMBA and Australian community that a graduate of an accredited nurse practitioner program was fit to be endorsed and practise in a safe and competent manner in the context of a contemporary, Australian health care setting.

Feedback indicated overall support for much of the content in the first version of the Nurse Practitione Accreditation Standards, with a few areas of difference emerging:

1. Specifying 500 hours of supernumerary clinical hours: stakeholders focused on the absence of evidence to guide curriculum design and the potential benefits and/or burdens associated with specifying supernumerary practice.
2. Specifying the program convenor be an endorsed nurse practitioner: stakeholders held varying perspectives on whether the incumbent could maintain their nurse practitioner endorsement and meet the academic demands and educational requirements of this role.
3. Specifying student exposure to generic and speciality practice settings: stakeholder feedback indicated lack of agreement as to what constituted 'generic' and 'speciality' knowledge, skills and practice settings and whether multiple settings were pedagogically required.

Stage 2—second consultation paper

The second consultation paper, released in September 2014, included the second version of the draft Nurse Practitioner Accreditation Standards, which was informed by stakeholder feedback.

In this version, the EAG considered there to be, on balance, support for specifying minimum requirements for integrated professional practice. Previous stakeholder feedback indicated that 500 supernumerary hours was excessive and likely to be a significant burden. Consequently, the minimum requirement was reduced to 300 hours.

Questions posed in the second consultation paper sought clarity on the:

- role of endorsed nurse practitioners in providing the nurse practitioner program of study
- management of integrated professional practice so it supports student preparation for nurse practitioner practice in contemporary health care settings.

Stakeholders were again asked to comment on any other issue, wording, error, gap or duplication in the draft accreditation standards.

Written feedback was collated before the summative consultation forum held on 11 November 2013. A review of each standard and final issues were addressed at the forum. After considering emerging literature and stakeholder feedback, the EAG arrived at these outcomes:

Standard 3. Program development and structure

The minimum of 300 supernumerary hours of integrated profession practice was maintained in the standards in light of case study findings from the CLLEVER Study[17] that reported perceived conflict at times where employed role and student role exist together (that is, lack of supernumerary clinical time allocation) resulting in employment requirements taking precedence over learning and teaching opportunities.

17 Educating nurse practitioners: advanced specialty competence, clinical learning and governance. Also known as the CLLEVER study: NP CLinical LEarning & GoVERnance Project, Final Report 2014. Viewed at: https://acnp.org.au/article/cllever-study on 12 January 2015. NB: Publication not released in time for inclusion in Consultation Paper 2.

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Standard 6. Students

The change to the specified amount of advanced level practice experience required on entry to the nurse practitioner program balanced the need for students to demonstrate sufficient depth and length of experience with the need to minimise potential restrictions on advanced practitioners entering a nurse practitioner program. The term 'advanced nursing practice' was introduced into criterion 6.2b so as to align with terminology used in the NMBA's Nurse Practitioner Standards for Practice.

Standard 7. Resources

The academic role of the endorsed nurse practitioner was specified as one that contributes to, rather than is responsible for, the design and development of nurse practitioner curricula, teaching and learning approaches and quality improvement and risk management strategies.

Standard 8. Management of integrated professional practice

Planned health care experiences were needed to support student knowledge and skill development in patient-centred care that are consistent with principles of primary health care and complementary to the student's speciality skills and knowledge.

1.7 Regulatory impact assessment of Accreditation Standards for Nurse Practitioner

During the development of the Nurse Practitioner Accreditation Standards, ANMAC undertook a Regulation Impact Statement Preliminary Assessment. This assessment is required by the Australian Government's Office of Best Practice Regulation so that national standard setting agencies, such as ANMAC, consider the impact of regulation, standards and other quasi-regulation before implementation.

This assessment was undertaken in accordance with the Council of Australian Governments' Best Practice Regulation—A Guide for Ministerial Councils and National Standard Setting Bodies 2007[18] and considered such matters as benefits and burdens of introducing the new accreditation standards and the potential impact on stakeholders.

ANMAC's Regulation Impact Statement Preliminary Assessment was submitted to the Office of Best Practice Regulation which considered proposed changes to the NMBA-approved national accreditation standards to be minor and required no further regulatory impact assessment.

1.8 Ratification and approval

While ANMAC is responsible for developing the accreditation standards, the NMBA is responsible for approving them under the National Law. This same dual regulatory function applies to the accreditation of individual programs of study leading to registration or endorsement as a nurse or midwife.

The EAG and the Standards, Accreditation and Assessment Committee reviewed the final draft of the standards before presenting them to the ANMAC Board to ratify. After ratification, the Nurse Practitioner Accreditation Standards were submitted to the NMBA for review.

The standards were approved by the NMBA on 3 July 2015.

18 Council of Australian Governments (2007). Best Practice Regulation—A guide for Ministerial Councils and national standard setting bodies. Viewed at: www.dpmc.gov.au/sites/default/files/publications/COAG_best_practice_guide_2007.pdf on 5 February 2015.

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2 Introduction

2.1 Purpose of the ANMAC accreditation process

ANMAC's accreditation process aims to ensure the quality of the nursing and midwifery professions and their work, on behalf of public interest and public safety. The public needs to know that those who graduate from higher education provider nurse practitioner programs of study are competent to practise safely and effectively and eligible to be endorsed through the NMBA as a nurse practitioner in Australia.

Education providers ensure that graduates have the common and transferable skills, knowledge, behaviours and attitudes (as articulated in the Nurse Practitioner Standards for Practice) required to practice. Accreditation evaluates if the education provider, on the evidence they provide, will meet this goal.

Professional program accreditation is concerned with the quality of the profession and its work, from the perspective of public interest and public safety. This is in contrast to accreditation (or similar assessment) of higher education providers by TEQSA for quality assurance and risk management. However, having TEQSA accreditation is a prerequisite for ANMAC to assess nursing and midwifery programs for accreditation.

External professional (or occupational) accreditation helps assure the community that professionals who have completed an accredited program of study are safe and competent beginning practitioners. It is an efficient and effective proxy for assessing every graduate against the Nurse Practitioner Standards for Practice. Accreditation therefore involves comprehensively examining the higher education provider's:

- governance system and quality management framework
- student enrolment processes, student support, assessment and workplace experience
- curriculum philosophy, curriculum structure and content
- teaching and learning approaches.

Periodic accreditation of nursing and midwifery programs stimulates education providers to review and assess their own programs. It enables providers to validate the strengths of existing programs, identify areas for improvement and introduce new teaching and learning initiatives.

ANMAC's accreditation process supports diversity, innovation and evolution in approaches to education The standards therefore have minimal prescription of curricula content, core subject inclusion and educational approaches required for program delivery.

2.2 Nurse Practitioner Accreditation Standards

The Nurse Practitioner Accreditation Standards detail the minimum requirements that higher education providers must meet if they want their program of study to be accredited by ANMAC. TEQSA-approved higher education providers must also be accredited. Under Section 49(1) of the National Law, graduates cannot register unless their program of study is accredited by ANMAC and approved by the NMBA.

The nine Nurse Practitioner Accreditation Standards are in Figure 1:

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Figure 1: Nurse Practitioner Accreditation Standards

STANDARD 1: GOVERNANCE
The education provider has established governance arrangements for the nurse practitioner program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the Nurse Practitioner Standards for Practice.
STANDARD 2: CURRICULUM FRAMEWORK
The education provider uses an appropriate and relevant philosophy to make explicit the assumptions about the nature of knowledge that informs the curriculum content and nature of the health service environment that the graduate will enter. In addition, the education provider makes explicit the educational theory that informs the design and delivery of sustainable processes for learning and teaching in the nurse practitioner program.
STANDARD 3: PROGRAM DEVELOPMENT AND STRUCTURE
The program of study, developed in collaboration with key stakeholders, reflects current nurse practitioner practice and learning and teaching approaches; complies with the Australian Qualifications Framework for a Level 9 Masters Degree and has sufficient integrated professional practice to enable graduates to meet the Nurse Practitioner Standards for Practice and to function as a safe, autonomous and collaborative nurse practitioner by program completion.
STANDARD 4: PROGRAM CONTENT
The program content delivered by the program provider comprehensively addresses the Nurse Practitioner Standards for Practice as well as existing and emerging national and regional health priorities across a range of health service delivery contexts.
STANDARD 5: STUDENT ASSESSMENT
The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes. This includes a comprehensive summative assessment of student performance against the current Nurse Practitioner Standards for Practice.
STANDARD 6: STUDENTS
The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.
STANDARD 7: RESOURCES
The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number, to enable students to meet the Nurse Practitioner Standards for Practice.
STANDARD 8: MANAGEMENT OF INTEGRATED PROFESSIONAL PRACTICE
The program provider ensures that every student is given supervised integrated professional practice in environments providing suitable learning and teaching opportunities and conditions for students to meet the Nurse Practitioner Standards for Practice.
STANDARD 9: QUALITY IMPROVEMENT AND RISK MANAGEMENT
The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

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2.3 Using the Nurse Practitioner Accreditation Standards

The Nurse Practitioner Accreditation Standards are designed principally for use by higher education providers seeking accreditation of a nurse practitioner program of study. ANMAC's Associate Directors for Professional Programs, the Nurse Practitioner Accreditation Committee and members of ANMAC assessment teams evaluate programs against these standards and make recommendations to the ANMAC Board for decision making.

While the standards are principally for use by higher education providers, they are also useful for anyone interested and involved in the education of nurse practitioners.

Higher education providers seeking accreditation have to complete an application pack (available at www.anmac.org.au), which includes the Nurse Practitioner Accreditation Standards and guidance on addressing them. This guidance is regularly reviewed and updated to help education providers prepare their submissions.

Other reference material that may assist education providers (available at www.anmac.org.au) include the:

- National Guidelines for the Accreditation of Nursing and Midwifery Programs Leading to Registration and Endorsement in Australia[19], which describes the structures, personnel and processes of accreditation of nursing and midwifery providers and programs of study
- ANMAC Assessor Handbook.[20]

19 ANMAC (2012). *National Guidelines for Accreditation of Nursing and Midwifery Programs of Study Leading to Registration and Endorsement in Australia*. November 2012. Viewed at: www.anmac.org.au/document/national-guidelines-accreditation-nursing-and-midwifery-programs on 5 February 2015.

20 ANMAC (2012). Assessor Handbook. Viewed at: www.anmac.org.au/sites/default/files/documents/Assessors_Handbook.pdf on 5 February 2015.

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3 Nurse Practitioner Accreditation Standard

Standard 1: Governance

The education provider has established governance arrangements for the nurse practitioner program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the Nurse Practitioner Standards for Practice[21].

Criteria

The education provider must provide evidence of:

1.1 Current registration by the Tertiary Education Quality and Standards Agency (TEQSA) as an Australian university or other higher education provider.[22]

1.2 Current accreditation of the nurse practitioner program of study by the University (or TEQSA for non-self-accrediting higher education providers) detailing the expiry date and any recommendations, conditions and progress reports related to the school.

1.3 Listing on the Australian Qualifications Framework (AQF) National Registry for the award of Masters Degree (Level 9)[23] as a minimum, with the title Master of Nurse Practitioner as the named degree.

1.4 Current, documented academic governance structure for the university or other higher education provider and the school conducting the program (program provider) that ensures academic oversight of the program and promotes high-quality teaching and learning scholarship, research and ongoing evaluation across all learning settings.

1.5 Terms of reference for the relevant program advisory committee demonstrating partnership with key stakeholders[24], including partnerships with Aboriginal and Torres Strait Islander health professionals and communities.

1.6 Staff delegations, reporting relationships, and the role of persons or committees in decision making related to the program.

1.7 Governance arrangements between the university or higher education provider and the school that ensure responsiveness to requirements for ongoing compliance with accreditation standards.

21 NMBA (2014). *Nurse Practitioner Standards for Practice*. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

22 For an explanation of provider categories see: TEQSA, (2011). *Higher Education Standards Framework (Threshold Standards)* Viewed at: www.teqsa.gov.au/higher-education-standards-framework on 5 February 2015.

23 This is the 'required level' referred to throughout these standards.

24 Key stakeholders include, but are not limited to, consumers and representatives from relevant professional organisations.

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1.8 Policies relating to credit transfer or the recognition of prior learning that are consistent with AQF national principles and the graduate's ability to meet the Nurse Practitioner Standards for Practice.

1.9 Governance arrangements between the education provider and health service providers to monitor students' practice experience and learning and teaching in the clinical setting including but not limited to, program resourcing and clinical teaching, supervision and assessment.

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Standard 2: Curriculum framework

The education provider uses an appropriate and relevant philosophy to make explicit the assumptions about the nature of knowledge that informs the curriculum content and nature of the health service environment that the graduate will enter. In addition, the education provider makes explicit the educational theory that informs the design and delivery of sustainable processes for learning and teaching in the nurse practitioner program.

Criteria

The program provider demonstrates:

2.1 A clearly documented and explained framework for the program, including a curriculum philosophy that includes knowledge concepts relating to:

a. a nursing model of health care

b. primary health care principles and contexts

c. capability theory.

2.2 A clearly described educational theory that is applied throughout the nurse practitioner program to

a. shape, organise and guide the delivery of curriculum content

b. accommodate differences in student learning style and learning contexts

c. stimulate student engagement, innovation and self-directed learning.

2.3 Application of learning and teaching approaches, derived from the stated educational theory, that are responsive to the goals of the stated curriculum philosophy and:

a. enable achievement of stated learning outcomes

b. scaffold learning appropriately throughout the program

c. engender deep rather than surface learning

d. embed contextualised experiential learning and scenario-based evaluation

e. develop and enhance intellectual skills in inquiry, analysis and synthesis in dealing with complex information

f. build clinical leadership and clinical scholarship

g. enable intraprofessional and interprofessional learning for collaborative practice

h. engender cultural safety in patient management and health care delivery.

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Standard 3: Program development and structure

The program of study, developed in collaboration with key stakeholders, reflects current nurse practitioner practice and learning and teaching approaches, complies with the Australian Qualifications Framework (AQF)[25] for a Level 9 Masters Degree and has sufficient integrated professional practice to enable graduates to meet the Nurse Practitioner Standards for Practice and to function as a safe, autonomous and collaborative nurse practitioner by program completion.

Criteria

The program provider demonstrates:

3.1 Consultative and collaborative approaches to curriculum design and program organisation between academic staff, nurse practitioners, other relevant clinical experts working in clinical service provision, students, consumers and other key stakeholders including Aboriginal and Torres Strait Islander health professionals.

3.2 A map of subjects against the Nurse Practitioner Standards for Practice that clearly identifies the links between learning outcomes, assessments and required graduate standards for practice.

3.3 A map of subjects against the National Prescribing Competencies Framework[26] that clearly identifies the links between learning outcomes, assessments and required graduate competencies.

3.4 Descriptions of curriculum content and the rationale for its extent, depth and sequencing in relation to the application of the knowledge and skills expected of students at this required level.

3.5 A map of student interaction opportunities with other health professions to facilitate interprofessional learning.

3.6 A minimum of 300 hours of supernumerary integrated professional practice incorporated in the program that provides exposure to a range of health care experiences relevant to the students' learning needs and enables students' achievement of the Nurse Practitioner Standards for Practice.

3.7 Content and sequencing of the program of study and, where appropriate, additional simulated learning opportunities that prepare students for integrated professional practice.

3.8 Equivalence of subject outcomes for programs taught in all delivery modes in which the program is offered (subjects delivered on-campus or in mixed-mode, by distance or by e-learning methods).

25 AQF (2013). Second Edition. Viewed at: www.aqf.edu.au/ on 5 February 2015.

26 NPS: Better choices, Better health, (2012). Competencies required to prescribe medicines—putting quality use of medicines into practice. Sydney: National Prescribing Service Limited. Viewed at: www.nps.org.au/__data/assets/pdf_file/0004/149719 Prescribing_Competencies_Framework.pdf on 5 February 2015.

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Standard 4: Program content

The program content delivered by the program provider comprehensively addresses the Nurse Practitioner Standards for Practice as well as existing and emerging national and regional health priorities across a range of health service delivery contexts.

Criteria

The program provider demonstrates:

4.1 A comprehensive curriculum document, based on the framework discussed in Standard 2 that includes:

a. program structure and delivery modes, including online components

b. subject outlines that detail content, objectives, learning outcomes and associated assessment

c. teaching and learning strategies

d. an integrated professional practice plan demonstrating opportunities to meet the Nurse Practitioner Standards for Practice.

4.2 The central focus of the program is application of knowledge and skills at the required level that enable the nurse practitioner to provide a patient-centred health service to consumers:

a. within a range of health care contexts

b. that incorporates national and regional health priorities, research, policy and reform

c. that complies with national and relevant jurisdictional legislative frameworks.

4.3 Program content includes but is not limited to:

a. sciences that underpin all elements of nurse practitioner practice

b. advanced holistic health assessment and diagnostics

c. clinical research and practice improvement methodologies

d. therapeutic practice approaches grounded in a nursing model of care and that incorporate quality use of medicines

e. socio-economic, geographical and political factors that influence nurse practitioner service models, for example health care contexts, funding arrangements and business proficiency.

4.4 Inclusion of content giving students a deep appreciation of the diversity of Australian culture, to further develop and engender their knowledge of cultural respect and safety.

4.5 Inclusion of discrete content specifically addressing Aboriginal and Torres Strait Islander peoples histories, health, wellness and culture. Health conditions prevalent among Aboriginal and Torres Strait Islander peoples and communities are appropriately embedded across the curriculum and linked to subject objectives, learning outcomes and assessment.

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4.6 Inclusion of content specifically addressing the health needs of people with geographically, or culturally, socially and linguistically diverse backgrounds.

4.7 Inclusion of content specifically addressing health informatics and health technology and its role in supporting health care.[27]

4.8 Ensure specialties and/or electives in the program are at the required level and complement nurse practitioner practice.

27 Refer to ANMAC (2014). Health informatics and health technology— explanatory note. Viewed at: www.anmac.org.au/sites default/files/documents/20150130_Health_Informatics_Technology_Explanatory_Note.pdf on 5 February 2015.

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Standard 5: Student assessment

The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a comprehensive summative assessment of student performance against the current Nurse Practitioner Standards for Practice.

Criteria

The program provider demonstrates:

5.1 A consistent approach to student assessment across teaching sites and modalities that is periodically reviewed and updated.

5.2 Clear statements about assessment and progression rules and requirements are provided to students at the start of the program.

5.3 The level, number and context of assessments are consistent with determining the achievemen of the stated learning outcomes.

5.4 Both formative and summative assessment exist across the program to enhance individual and group learning as well as inform student progression.

5.5 The use of a variety of assessment approaches to evaluate competence in the application of knowledge and skills at the required level and as required for professional practice as a nurse practitioner, including:

a. a comprehensive portfolio of learning and integrated professional practice

b. contextualised, scenario-based assessment strategies

c. viva voce clinical assessment

d. observation in integrated professional practice settings.

5.6 A range of instruments, validated where possible, are used in integrated professional practice assessment to evaluate student knowledge, skills, behaviours and capacity to meet the Nurse Practitioner Standards for Practice.

5.7 Ultimate accountability for the assessment of students in relation to integrated professional practice.

5.8 Evidence of procedural controls, fairness, reliability, validity and transparency in assessing students.

5.9 Processes to ensure the integrity of assessment across all modalities.

5.10 Collaboration between the education provider, health service providers and other stakeholde involved in integrated professional practice in selecting, implementing and evaluating assessment methods.

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5.11 Comprehensive summative assessment of the student's achievement of the Nurse Practitioner Standards for Practice on program completion. This includes a comprehensive summative clinica *viva voce* within the student's nominated scope of practice, by suitably qualified members[28] of the multidisciplinary team, to demonstrate the achievement of Australian Qualifications Framework Level 9 graduate descriptors.

28 'Suitably qualified members' refers to health care professionals recognised by education and health service providers and clinical peers as having: sufficient qualifications, knowledge and skills to be considered an expert in a clinical field relevant to the scope of practice of the student; a thorough understanding of the role and scope of nurse practitioner practice; and appropriate preparation and training in undertaking student assessment. Nurse practitioners should be included as part of thi team where possible.

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Standard 6: Students

The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.

Criteria

The program provider demonstrates:

6.1 Applicants are informed of the following before accepting an offer of enrolment:

a. modes for program delivery and location of integrated professional practice placements

b. specific requirements for entry to the program of study, including English language proficiency

c. compliance with the National Law[29] by notifying the Australian Health Practitioner Regulation Agency if a student undertaking integrated professional practice has an impairment that may place the public at risk of harm

d. specific requirements for right of entry to health services for integrated professional practice experience placements (including, fitness for practice, immunisation and criminal history)

e. requirements specified in the Nursing and Midwifery Board of Australia's Endorsement as a Nurse Practitioner Registration Standard.

6.2 Students are selected for the program based on clear, justifiable and published admission criteria that includes:

a. current general registration as a registered nurse

b. a minimum of two years full time equivalent (FTE) as a registered nurse in a specified clinical field and two years FTE of current[30] advanced nursing practice in this same clinical field

c. a postgraduate qualification at Australian Qualifications Framework Level 8 in a clinical field.

6.3 Students have sufficient English language proficiency and communication skills to successfully undertake academic experience and integrated professional practice requirements throughout the program.

6.4 Students are informed about, and have access to, appropriate support services including counselling, health care and academic advisory services.

6.5 Processes to enable early identification and support for students who are not performing well academically, clinically or have professional conduct issues.

6.6 All students have equal opportunity to meet the Nurse Practitioner Standards for Practice. The mode or location of program delivery should not influence this opportunity.

29 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

30 'Current' is within the previous six years.

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6.7 Processes for student representation and feedback in matters relating to governance and program management, content, delivery and evaluation.

6.8 Aboriginal and Torres Strait Islander peoples are encouraged to apply and a range of support is provided to those students as needed.

6.9 Other groups under-represented in the nursing profession, especially those from culturally, socially and linguistically diverse backgrounds, are encouraged to apply and support is provided to those students as needed.

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Standard 7: Resources

The program provider has adequate facilities, equipment and teaching resources as well as staff who are qualified, capable and sufficient in number, to enable students to meet the Nurse Practitioner Standards for Practice.

Criteria

The program provider demonstrates:

7.1 Staff, facilities, online tools, equipment and other teaching resources are sufficient in quality and quantity for the anticipated student population and any planned increase.

7.2 Students have sufficient and timely access to academic and clinical teaching staff, including nurse practitioners to support student learning.

7.3 A balance of academic, clinical, technical and administrative staff appropriate to meeting teaching, research and governance commitments.

7.4 Staff recruitment strategies:

a. are culturally inclusive and reflect population diversity

b. take affirmative action to encourage participation from Aboriginal and Torres Strait Islander peoples.

7.5 Documented position descriptions for teaching staff, clearly articulating roles, reporting relationships, responsibilities and accountabilities.

7.6 The Head of Discipline holds current Australian general registration as a nurse with no conditions relating to conduct or performance[31], holds a relevant post graduate qualification, maintains active involvement in the nursing profession, and has strong engagement with contemporary nursing education and research.

7.7 At least one endorsed nurse practitioner is a member of academic staff that teaches into the nurse practitioner program of study and as part of this role contributes to curriculum design and development, supervision and mentorship models, as well as quality improvement and risk management processes.

7.8 Staff teaching and assessing nursing practitioner specific subjects, including those with pharmacology, advanced health assessment and diagnostics (pathology and medical imaging) content, have relevant clinical and academic qualifications and experience.

7.9 Each student's integrated professional practice clinical and professional support team is qualified for their level of teaching and/or supervision. This includes clinical practice expertise in a relevant clinical area and an academic qualification in education or equivalent learning and teaching experience.

7.10 In cases where an academic staff member's tertiary qualifications do not include nursing, their qualifications and experience are directly relevant to the subjects they are teaching.

31 For definitions related to conduct and performance [refer to Part 1, Section 5] in the *Health Practitioner Regulation National Law Act 2009*, as in force in each state and territory. Viewed at: *www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx* on 22 April 2015.

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7.11 Processes to ensure academic staff demonstrate engagement in research, scholarship and practice in the subjects they teach.

7.12 Teaching and learning takes place in an active research environment where academic staff are engaged in research, scholarship or generating new knowledge. Areas of interest, publications, grants and conference papers are documented.

7.13 Policies and processes to verify and monitor the academic and professional credentials of current and incoming staff, including current general registration as a registered nurse and endorsement as a nurse practitioner, where applicable, and to evaluate their performance and development needs.

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Standard 8: Management of integrated professional practice

The program provider ensures that every student is given supervised integrated professional practice in environments providing suitable learning and teaching opportunities and conditions for students to meet the Nurse Practitioner Standards for Practice.

Criteria

The program provider demonstrates:

8.1 Negotiated and secure integrated professional practice experiences and an associated clinical and professional support team for each student and a process by which these are assessed as satisfactory prior to the commencement and for the duration of the program.

8.2 Constructive relationships and clear contractual arrangements with all health providers where students gain their integrated professional practice and processes to ensure these are regularly evaluated and updated.

8.3 Risk management strategies in all environments where students are placed to gain integrated professional practice and processes to ensure these are regularly reviewed and updated.

8.4 Each student is provided with a range of health care experiences that supports knowledge and skills development in patient centred care that is consistent with the principles of primary health care and complements the student's speciality skills and knowledge.

8.5 Each student is provided with sufficient integrated professional practice to support the meeting of the Nurse Practitioner Standards for Practice.

8.6 Each student is provided with integrated professional practice experiences that reflect the major health priorities specific to the student's area of practice with opportunities for intraprofessional and interprofessional learning and the development of knowledge and skills and their application for collaborative practice.

8.7 Clearly articulated models of supervision, support, facilitation and assessment are in place so students can meet the Nurse Practitioner Standards for Practice.

8.8 Academics, nurse clinicians and other health professionals engaged in supervising and supporting students during integrated professional practice are adequately prepared for the learning and teaching role and apply contemporary and evidence-based Australian and international perspectives on nurse practitioner practice.

8.9 Nominated professionals in the student's clinical and professional support team undertake assessment of the student against the Nurse Practitioner Standards for Practice within the context of integrated professional practice experience.

8.10 Resources are provided, monitored and regularly evaluated to support students and their supervisors while on integrated professional practice to meet the Nurse Practitioner Standard for Practice.

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Standard 9: Quality improvement and risk management

The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

Criteria

The program provider demonstrates:

9.1 Responsibility and control of program development, monitoring, review, evaluation and quality improvement is delegated to the school with oversight by the academic board or equivalent.

9.2 Regular evaluation of academic and clinical and professional support team supervisor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance.

9.3 Professional and academic development of staff to advance knowledge and competence in teaching effectiveness and assessment.

9.4 Feedback gained from the quality cycle is incorporated into the program of study in consultation with stakeholders, including health care consumer advocates[32], to improve the experience of theory and practice learning for students.

9.5 Regular evaluation and revision of program content to include contemporary and emerging issues surrounding nurse practitioner practice, health care research and health policy and reform

9.6 Students, supervisors and staff are adequately indemnified for relevant activities undertaken as part of program requirements.

32 Available through organisations that provide leadership in representing the interests of Australian health care consume (for example, Consumer Health Forum of Australia).

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Glossary and abbreviations

Advanced nursing practice— is a continuum along which nurses develop their professional knowledge, clinical reasoning and judgement, skills and behaviours to higher levels of capability (that is recognisable). Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex health care requirements.

Advanced nursing practice is a level of practice and not a role. It is acknowledged that advanced nursing practice is individually attributed within a regulated nursing scope (enrolled nurse, registered nurse or nurse practitioner).[33]

Australian Health Practitioner Regulation Agency—AHPRA is responsible for the implementation of the National Registration and Accreditation Scheme across Australia. Supports the National Health Practitioner Boards (such as the Nursing and Midwifery Board Australia) in implementing the scheme.

Australian Nursing and Midwifery Accreditation Council—ANMAC is the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme. ANMAC sets standards for accreditation and accredits nursing and midwifery programs leading to registration and endorsement, and for the providers of those programs.

Australian Nursing and Midwifery Council—the ANMC evolved into ANMAC following approval as the accrediting authority for nursing and midwifery. ANMC authored the original set of accreditation standards as well as the national competency standards or standards for practice for nursing and midwifery.

Australian Qualifications Framework—the AQF is the national policy for regulated qualifications in Australian education and training. It incorporates the qualifications from each education and training sector into a single comprehensive national qualifications framework.

Australian Qualifications Framework qualification—the result of an accredited complete program of learning leading to formal certification that a graduate has achieved learning outcomes as described in the AQF.

Australian Qualifications Framework national register—a register of all AQF qualifications and the organisations authorised to issue them.

Australian university—a higher education provider registered with TEQSA in the 'Australian university' provider category.

33 NMBA (2014). *Nurse Practitioner Standards for Practice.* Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

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Capability—moves beyond competency[34] and is the extent to which an individual can adapt to change generate new knowledge and continue to improve practice.[35] Capability and its dimensions include:

- knowing how to learn
- working well with others
- being creative
- having a high degree of self-efficacy
- applying competencies to both novel and familiar situations.[36]

Competence—the combination of skills, knowledge, attitudes, values and abilities underpinning effective and/or superior performance in a profession or occupational area (from the National Competency Standards for the Registered Nurse).[37]

Criteria—rules or tests on which a judgement or decision in relation to compliance with the Accreditation Standards can be based.

Cultural safety—can only be determined by those who are receiving healthcare; they will determine if their cultural identity and meanings are being respected and they are not being subjected to discrimination.[38]

Curriculum—the full outline of a program of study, usually built around a conceptual framework with the educational and professional nursing or midwifery philosophies underpinning the curriculum, including:

- program philosophy
- program structure and delivery modes
- subject outlines
- links between subject objectives, learning outcomes and their assessment as well as national competencies or standards for practice
- teaching and learning strategies
- workplace experience plan.

Education provider—university, or other higher education provider, responsible for a program of study the graduates of which are eligible to apply to the NMBA for nursing or midwifery registration or endorsement.

Equivalent professional experience—successful completion of a qualification equivalent to that being taught and sufficient post-graduate professional experience in the discipline being taught to demonstrate competence in applying the discipline's principles and theory.

34 O'Connell J, Gardner G and Coyer F, (2014). Beyond competencies: using a capability framework in developing practice standards for advanced practice nursing. *Journal of Advanced Nursing*, doi: 10.1111/jan.12475.

35 Fraser S and Greenhalgh T, (2001). Coping with complexity: educating for capability. *British Medical Journal*, 323, pp. 799–803.

36 Gardner G, Dunn S, Carryer J and Gardner A, (2006). Competency and capability: Imperative for nurse practitioner education. *Australian Journal of Advanced Nursing*, 24 (1), pp. 8–14.

37 Nursing and Midwifery Board of Australia, (2006). Registered Nurse Competency Standards. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx on 23 September 2014.

38 National Aboriginal Community Controlled Health Organisation, (2011). Cultural Safety Training Standards: A background pape Viewed at: www.naccho.org.au/promote-health/cultural-safety/ on 9 September 2014.

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Governance—framework, systems and processes supporting and guiding an organisation towards achieving its goals and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements.

Head of school or discipline—lead nursing academic responsible for designing and delivering the program of study on behalf of the education provider.

Health Practitioner Regulation National Law Act 2009 **(the National Law)**—this legislation contained in the schedule to the Act, provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010 and covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner. The National Law is legislated in each state and territory. The *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* outlines the administrative arrangements established under the first stage of the National Registration and Accreditation Scheme for the Health Professions (Act A).

Higher education provider—tertiary education provider who meets the Higher Education Standards Framework (Threshold Standards) as prescribed by the *Tertiary Education Quality and Standards Agency Act 2011* and is registered with TEQSA.

Integrated professional practice—an integrated learning approach that enables nurse practitioner students to develop and demonstrate the Nurse Practitioner Standards for Practice within the clinical practice setting. Supports the use and generation of theory to enhance emerging and developed knowledge, behaviours and clinical and professional judgement. Also provides a supported learning environment for the development of clinical practice skills, including, but not limited to:

- comprehensive assessment, diagnosis and management of complete episodes of care
- prescription of medicines
- ordering and interpreting of diagnostic tests
- initiating and accepting referrals from other health professionals for the purposes of care coordination.

The concept includes 'clinical training' as embodied in the National Law.[39]

Interprofessional learning—occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

Medicare Benefits Schedule—this a listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme managed by the Department of Health.[40]

Nurse practitioner—a protected title that refers to a nurse whose registration has been endorsed by the NMBA as a nurse practitioner under Section 95 of the National Law.[41]

39 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

40 Australian Government, Department of Human Services, Medicare Benefits Schedule. Viewed at: www.medicareaustralia.gov.au/provider/medicare/mbs.jsp on 13 June 2015.

41 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

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Nurse Practitioner Standards for Practice—core standards for practice by which performance and professional conduct is assessed to obtain and retain endorsement as a nurse practitioner.[42]

Nursing and Midwifery Board of Australia—the NMBA is the national regulator for the nursing and midwifery professions in Australia. It is established under the Health Practitioner Regulation National Law (the National Law)[43], as in force in each state and territory. Its primary role is to protect the public and set standards and policies that all nurses and midwives registered within Australian must meet.

Pharmaceutical Benefits Scheme—this is a scheme run by the Australian Government to subsidise prescription medicines for Australians who have a Medicare card. If a medicine is subsidised under the scheme, the patient pays a lower price for the medicine, and the Australian Government pays the rest.[44]

Primary health care—derived from the World Health Organization's Declaration of Alma-Ata and the National Aboriginal Community Controlled Health Organisation definitions which explain primary health care as a holistic approach, incorporating body, mind, spirit, land, environment, culture, custom and socio-economic status to the provision of essential, integrated, quality care based upon practical, scientifically sound and socially acceptable methods and technology. Made accessible to all people, families and communities as close as possible to where they live and through their full participation, in the spirit of self-reliance and self-determination, and at a cost the Australian community can afford.

Primary health care forms an integral part both of Australia's health system and of the overall social and economic development of the community. The policy and provision of primary health care is shaped around the contribution of citizens identifying priorities for the promotion of healthy living, the prevention of disease, injury and disability. In addition, it must meet the health care, treatment, self-management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care throughout their lives.[45] [46]

Program or program of study—the full program of study and experiences that must be completed before a qualification recognised under the AQF, such as a Bachelor or Masters Degree of Nursing, can be awarded.

Program provider—the school or faculty responsible for designing and delivering a program of study in nursing leading to the award of a Bachelor Degree in Nursing as a minimum.

Quality use of medicines—part of the National Medicines Policy[47] to ensure the judicious, appropriate, safe and effective use of medicines.

Recognition of prior learning—assessment process for students' formal and informal learning to determine the extent to which they have achieved required learning outcomes, competency outcomes or standards for entry to and/or partial or total completion of a qualification.

42 NMBA (2014). *Nurse Practitioner Standards for Practice*. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx on 10 March 2015.

43 AHPRA (2009). *Health Practitioner Regulation National Law Act 2009*, as enacted in each state and territory. Viewed at: www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx on 5 March 2015.

44 NPS MedicineWise. Viewed at: www.nps.org.au/glossary/pharmaceutical-benefits-scheme-pbs on 15 June 2015.

45 Australian Nurses Federation, (2009). Primary Health Care in Australia. A nursing and midwifery consensus view. Viewed at: www.anmf.org.au/documents/reports/PHC_Australia.pdf on 31 March 2014.

46 National Aboriginal Community Controlled Health Organisation (NACCHO), (2009). Towards a national primary health care strategy: fulfilling Aboriginal peoples' aspirations to close the gap. Canberra: NACCHO.

47 Commonwealth of Australia, (2000). National Medicines Policy. Viewed at: www.health.gov.au/internet/main/publishing.nsf/Content/national-medicines-policy on 23 September 2014.

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Research—According to the Department of Innovation, Industry, Science and Research specifications fo the Higher Education Research Data Collection, research comprises:

- creative work undertaken on a systematic basis to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications
- any activity classified as research which is characterised by originality; should have investigation as a primary objective and should have the potential to produce results that are sufficiently general for humanity's stock of knowledge (theoretical and/or practical) to be recognisably increased; most higher education research work would qualify as research
- pure basic research, strategic basic research, applied research and experimental development.

Scholarship—application of systematic approaches to acquiring knowledge through intellectual inquiry Includes disseminating this knowledge through various means such as publications, presentations (verbal and audio-visual) and professional practice. Also includes applying this new knowledge to the enrichment of the life of society.[48]

School—organisational entity of an education provider responsible for designing and delivering a program of study in nursing or midwifery. Where the school of nursing is part of a larger faculty, the school is regarded as the program provider for these standards.

Simulated learning or practice—educational methods or clinical experiences that evoke or replicate aspects of the real world in an interactive manner. As an educational method for nurse practitioner students it can provide learning conditions to develop knowledge and skills such as how to prescribe and write prescriptions.

Standard—level of quality or attainment.

Subject—unit of study taught within a program of study.

Student assessment—formative and summative processes used to determine a student's achievement of expected learning outcomes. May include written and oral methods and practice or demonstration.

Supernumerary—where the student undertakes supervised practice outside their employed position o when they are not counted in the staffing roster.

Tertiary Education Quality and Standards Agency—TEQSA was established in July 2011 to regulate and assure the quality of Australia's large, diverse and complex higher education sector. Registers and evaluates the performance of higher education providers against the Higher Education Standards Framework. Also undertakes compliance and quality assessments.

48 Nursing and Midwifery Board of Australia, (2006). Registered Nurse Competency Standards. Viewed at: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx on 23 September 2014.

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***Viva voce* clinical examination**—method of assessing students' ability to use knowledge in a face-to-face examination. This assessment approach has two basic models:

- The 'short case' model is used as a formative assessment. It focuses on specific skills or sub-skills and can take the form of an objective structured clinical examination or a case presentation on a specific clinical activity.
- The 'long case' model is used as a summative assessment. It seeks to examine the student's ability to apply knowledge in an actual clinical situation. The 'long case' exam requires the student to use professional communications skills to collect, analyse, synthesise and evaluate clinical information, to use differential diagnostic procedures and determine a management plan. It assesses learning outcomes related to deep learning, application and synthesis of knowledge and high-level clinical reasoning.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure NK-7

Date: 17 March 2026

Docusign Envelope ID: 961F0A28-9E37-4EF6-A603-7644F52B1E56

International Journal of Nursing Studies Advances 3 (2021) 100034

Contents lists available at ScienceDirect

International Journal of Nursing Studies Advanc

journal homepage: www.sciencedirect.com/journal/international-journal-of-nursing-studies-advances

The effectiveness of the role of advanced nurse practitioners compared to physician-led or usual care: A systematic review

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ARTICLE INFO

Keywords:
Advanced nursing practice
Advanced nurse practitione
Clinical impact
Service improvement
Care quality
Patient care

ABSTRACT

Aim: To evaluate the effectiveness of the role of advanced nurse practitioners compared to physicians-led/ usual care (care managed by medical doctors or non-advanced nurse practitioners)

Background: Advanced nurse practitioners contribute to the improvement of quality patient care and have substantial potential to optimise the health of people globally. Since the formal recognition of advanced nurse practitioners by the International Council of Nurses, among others, the role has been adopted across most departments and clinical specialties, particularly in high-income countries.

Design: Systematic review of primary research evidence

Data Source: MEDLINE, EMBASE, CINAHL, Cochrane registry, Cochrane trials, and Cochrane EPOC (PDQ Evidence) were searched for randomised controlled trials (RCTs) of patient care and health resource utilisation outcomes associated with advanced nurse practitioners.

Review Methods: The review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) statement. The chosen articles were restricted to full-text English language trials published in the last 20 years, incorporating comparators of usual care. Search terms were limited to variations of advanced nurse practitioner role and practice. The eligible studies were bias risk assessed and quality assessed using the Grading of Recommendations, Assessment, Development and Evaluation (GRADE). Clinical and service outcomes were analysed using narrative synthesis as the marked heterogeneity between studies precluded meta-analysis.

Results: Thirteen RCTs were reviewed. All of them were conducted across high-income countries within primary care and hospital settings involving paediatric and adult patients. Five trials were assessed as high quality, and eight were of low to moderate quality. Positive effects were demonstrated for the impact of advanced nurse practitioners on usual care; for indigestion, mean difference [MD] 2.3: 95% CI 1.4, 3.1]), perceptions of health status [(MD –140.6; 95% CI –184.8, –96.5)], satisfaction levels [(MD ranged from –8.79; 95% CI –13.59, –3.98 to 0.61; 95% CI –4.84, 6.05)], physical function (1.58 [SD 0.76] v. 1.81 [SD 0.90]), and blood pressure control (systolic [133 [SD 21] v. 135 [SD 19] mmHg $p = 0.04$] and diastolic [77 [SD 10] v. 80 [SD 11] mmHg $p = 0.007$]) were looked at. Positive effects related to service provision included improved patient satisfaction and reductions in waiting times and costs, which significantly favored advanced nurse practitioners (all $p < 0.05$).

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https://doi.org/10.1016/j.ijnsa.2021.100034
Received 29 May 2021; Accepted 3 June 2021
Available online 17 June 2021
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Conclusion: The evidence of this review supports the positive impact of advanced nurse practitioners on clinical and service-related outcomes: patient satisfaction, waiting times, control of chronic disease, and cost-effectiveness especially when directly compared to medical practitioner-led care and usual care practices - in primary, secondary and specialist care settings involving both adult and pediatric populations.

What this review paper adds?

Introduction

Advanced Nurse Practitioners (advanced nurse practitioners) are now a well-recognized subset of nurses who have acquired expert knowledge and advanced clinical skills. Since the formal acceptance and recognition of advanced nurse practitioners by the International Council of Nurses and other formal regulatory bodies and organizations, the role has been adopted by most departments and clinical specialties; particularly in high-income countries (81 countries classed as high-income countries [World Bank, 2019]) such as the United States, United Kingdom, Australia, New Zealand, and the Netherlands (Scanlon *et al.,* 2020). Advanced nurse practitioners have been perceived to benefit patient care and experiences while. At the same time reducing the workload of medical staff, and subsequently optimizing the cost-effectiveness and efficiency of health care services and improving overall patient satisfaction. Emerging evidence has revealed that advanced nurse practitioners can provide comparable levels of care and achieve similar outcomes as physicians (both junior and senior clinicians / medical doctors) and, in some cases, attain superior outcomes with regards to patient satisfaction, waiting times, control of chronic disease, and cost-effectiveness. Although this position has been supported by the International Council of Nurses, Carney (2014) highlights that defining the distinctive nature of advanced nursing practice, recognizing the key competencies and capabilities of advanced nurse practitioners, and exploring facilitative strategies in maintaining, implementing. and supporting the role of advanced nurse practitioners worldwide, is still incrementally developing and on-going studies are needed to map and monitor ANP progression. Given this context, this review aims to explore the impact of advanced nurse practitioners' role and practice on nurse-led care – especially when aligned with other key health professional groups who have traditionally previously led this care.

Background

An advanced nurse practitioner has been formally defined by the International Council of Nurses as a nurse with professional registration, who has acquired additional expert or specialist knowledge, clinical skills, and complex decision-making capabilities and whose role varies in accordance with the contextual demand (ICN, 2002). In the UK, the Royal College of Nursing (RCN) has outlined the minimum standards for advanced nurse practitioners, which encompass a masters-level education in one of several core clinical or research areas through to the capacity of being able to independently prescribe medication (RCN, 2018) – competencies that are required of most advanced nurse practitioners at an international level. The role development of advanced nurse practitioners is usually congruent with the four defining pillars of advanced practice, which are clinical practice, leadership, education, and research, and reflect the level at which advanced nurse practitioners are able to operate (RCN, 2010).

Over recent years, up to 13 different titles have been used to denote advanced nursing practice: clinical nurse specialists (CNS), advanced practice nurse (APN), Advanced Practice Registered Nurse (APRN), nurse consultant (NC), nurse endoscopist, nurse anaesthetist etc (Cooper et al., 2019). This has led to confusion related to role definition and structure – and exactly where such roles fit within the role of the medical disciplines (King *et al.*, 2017). While CNS, APN, and NCs continue to play fundamental supportive roles in various medical disciplines, it is only in the last two decades that countries have observed an increasing utilisation of these advanced nurse practitioners (Delamaire and Lafortune, 2010).Notably, global health care services are currently experiencing unprecedented pressure, through the growing demands rising of rising population numbers, a rapidly ageing demographic, an increasing prevalence of chronic diseases, shortage of staffing among frontline health professionals, and financial austerity (Ham, 2017). Efforts to address these issues have included considerations around the advanced nurse practitioners' role in adapting to and coping with such adversity and generating new initiatives to maintain and improve patient care practice (Baileff, 2015). Indeed, ANPs are now considered essential in meeting the complex care needs of patients and generating overall improvements in patient care quality and safety (Brook and Rushforth, 2011). Advanced nurse practitioners are also considered crucial in improving the cost effectiveness and efficiency of healthcare delivery and waste reduction, which may help achieve various government's efficiency savings target. For instance, such saving has been valued at £10 billion (NHS England, 2014). However, conducting research that can directly measure the impact (financial and otherwise) of advanced nurse practitioners in the healthcare arena as the variable that independently benefits patient outcomes is a methodological challenge. In a previous systematic review, Carter and Chochinov (2007) evaluated the impact of nurse practitioners (NP) on four key Emergency Department outcomes: cost, quality of care, satisfaction, and waiting times. After reviewing the primary evidence, the authors suggested that nurse practitioners reduced waiting times, promoted high patient satisfaction levels with care, and provided care that was equivalent to that of a senior medical doctor. No positive effect on cost was demonstrated, but this was compounded by insufficient data regarding the hiring of medical practitioners. In a later systematic review, Wilson *et al.*

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(2009) explored the clinical effectiveness of advanced nurse practitioners' management of minor injuries among adults in the Emergency Department and found that there was no statistically significant difference demonstrated in comparison with the management provided by junior doctors. This review seeks to extend these previous review studies through adding further information related to the expansive roles and capacity of ANPs in both primary and secondary care settings between ANP- led care and physician led care and/or usual care.

The efficiency and impact of the greater utilization of the advanced nursing practice is recognized on an international scale, with advanced nurse practitioners being reported to exist in approximately 70% of all health care systems worldwide (Parker and Hill, 2017; Sheer and Wong, 2008). Given the international prevalence of advanced nurse practitioners, it has been observed that such nurses are contributing to current patient care and outcomes, driving improvements in hospital admission and readmission rates, and playing an instrumental role in reducing healthcare costs and improving efficiency within primary and secondary care settings (Parker and Hill, 2017). Table 6 identifies the current international advanced nursing practice context, set criteria, capabilities, and regulations by country of origin.

Research aim

Given the above background and the increases in the number of published studies pertaining to the effectiveness of widely implemented advanced nurse practitioner roles in preliminary literature search, it was deemed appropriate to systematically review the most recent primary research evidence, particularly since this could be used to inform current advanced nursing practice, which does and will continue to play a critical role in meeting increasing population demands and managing rising patient complexity both nationally and internationally (Christensen *et al.*, 2009). The uniqueness of this review is that it adds expansive roles and capacity of ANPs in both primary and secondary care settings between ANP- led care and physician led care and/or usual care. The care settings, in this review, were expanded to include further specialized disciplines/settings, such as intensive care, whereas studies such as the Laurant and colleagues (2018) Cochrane review focused specifically on primary care and was not exclusively ANP-specific. Furthermore, their study focused on nurse-led care outcomes alone (whilst discussing them against physician-led care) – whereas this review focuses on studies that directly compare ANP-led care to physician-led care. Therefore, this review sought to evaluate the effectiveness of advanced nursing practice on patient outcomes in comparison with other relevant healthcare practitioner providers. The main aim, of this review then, was:

- To summarize and critically evaluate the evidence of how advanced nurse practitioners can best be utilized to help meet the growing complexity and demands of service-user populations in high-income nations, to further inform current advanced nursing practice by way of how and in what context the role of advanced nurse practitioners can maximally benefit patient care – related to ANPs in both primary and secondary care settings between ANP-led care and physician led care and/or usual care.

Method

This review of the primary literature pertaining to patient outcomes associated with the effectiveness of advanced nurse practitioners was performed against the Cochrane Collaborations criteria for producing credible reviews (Higgins and Thomas, 2018).

Search methods

A search for relevant primary studies was conducted using a series of bibliographic databases, including MEDLINE, EMBASE, CINAHL, Cochrane registry, Cochrane trials, and Cochrane EPOC (PDQ Evidence) in April 2019. Studies were restricted to publication in the last two decades (2000–2019), which were subjected to peer-review and available in English. However, no restrictions were placed on the age of the research subjects, as this would allow for a broader capturing of the impact of advanced nurse practitioners.

Table 1
PICO/ Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Research Design	RCTs	Observational studies, case-control studies, case reports, theses
Language	English	Non-English
Population	Paediatric and adult patients in primary care settings including care home, rehabilitation centre, specialist clinics. and acute care settings which include chest pain clinic, intensive care units, ambulatory care unit within acute care hospital	Patients from mental health institution Patients from mother and baby units
Intervention	Exposure to advanced nurse practitioner-led / advanced practice nurse-led intervention or service	Exposure to nurse-led interventions or services that lack advanced or specialist training
Comparator	Physician-led care (care provided by medical doctors) or usual care (care provided by medical doctors or non-advanced practice nurse)	Comparators comprising health professionals other than physicians
Outcomes	Resource utilization outcomes, health status, morbidity, mortality, quality of life, satisfaction, knowledge, adherence Preferences, length of stay Re-admission, re-attendance, need for admission, cost, other exploratory outcomes	-

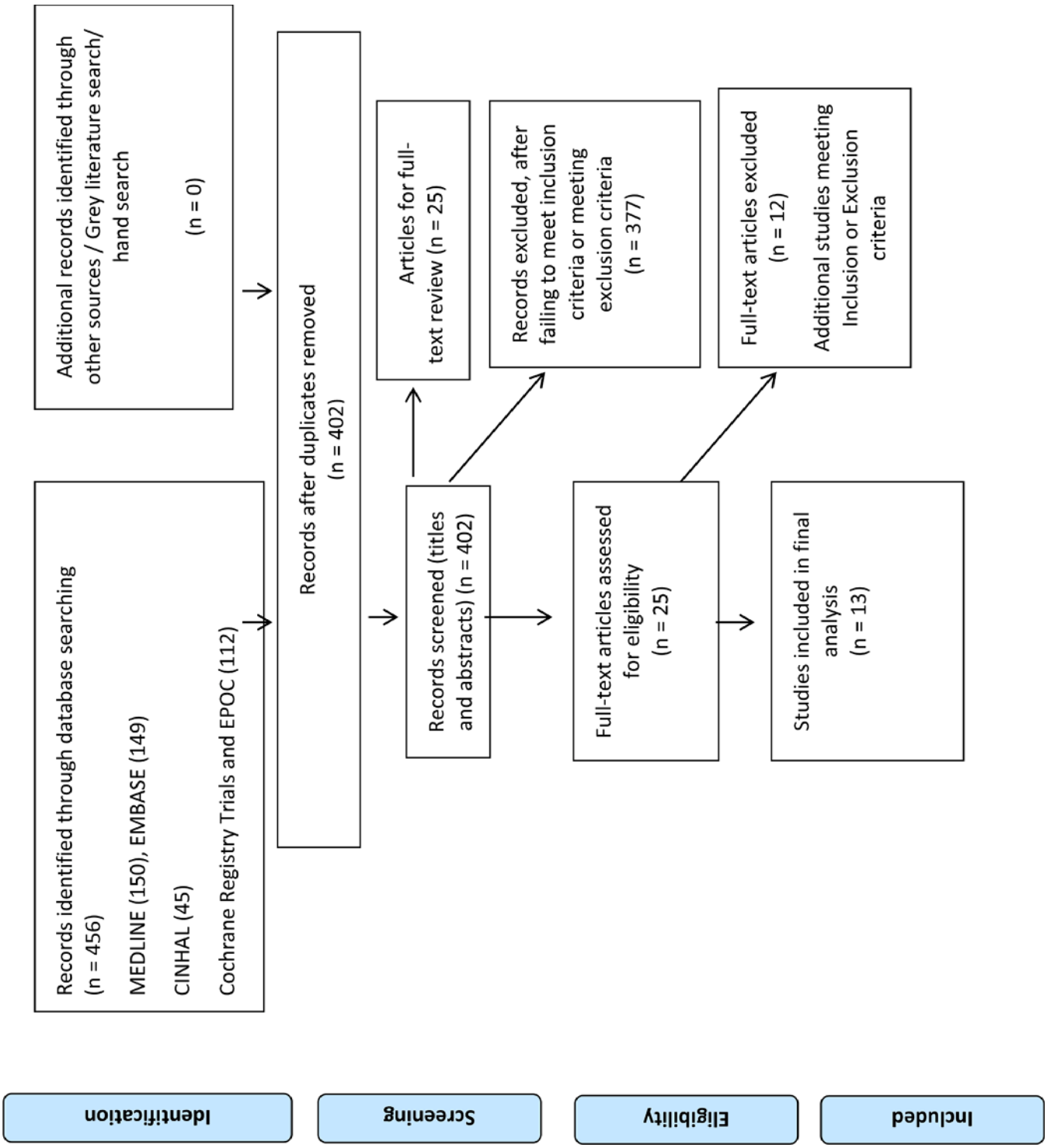


Fig. 1 PRISMA chart showing the process leading to study eligibility

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Table 2
Synthesis of Risk Assessment of Included Studies

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Baseline characteristics	Baseline outcome measurement	Blinding of participants and staff (performance bias)	Blinding of outcome assessment (detection bias)	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Contamination	Bias due to insufficient power
Chan *et al.* (2009)	Low	Low	Low	Low	Unclear	Low	Low	Unclear	Low	Low
Dierick-van Daele *et al.* (2009)	Low	Low	Low	Unclear	Unclear	Unclear	Low	Unclear	Low	Unclear
Kamps *et al* (2003)	Low	Low	Low	Low	Unclear	Unclear	High	Unclear	Low	High
Kinnersley *et al.* (2000)	Low	Low	Low	Low	Unclear	Unclear	Low	Low	Low	Low
Krichbaum (2007)	Low	Low	Low	Unclea	Unclear	Low	High	Unclear	High	High
Kuethe *et al* (2011)	Low	Low	Low	Low	Unclear	Unclear	Low	Low	Low	Low
Mundinger *et al.* (2000)	Unclear	Unclear	Low	Low	Unclear	Unclear	High	Unclear	High	Low
Ndosi *et al.* (2014)	Low	Low	Low	Low	Unclear	Low	Unclear	Low	Low	Low
Ryden *et al.* (2000)	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	High	Low	Low	Unclear
Stables *et al.* (2004)	Low	Low	Unclear	Unclear	Unclear	Unclear	Unclear	Low	Low	Low
van Zuilen *et al.* (2011)	Low	Low	Low	Low	Unclear	Low	Low	Low	Low	Unclear
Venning *et al.* (2000)	Low	Low	Low	Unclear	Unclear	Unclear	High	Unclear	Unclear	Unclear
Williams *et al* (2005)	Low	Low	Low	Low	Unclear	Unclear	Low	Low	Unclear	Low

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Table 3
Included Studies, Study Characteristics, and Main Findings

Study, setting, and number of centres	Participants	Intervention	Comparator	Follow-up duration	Main Outcomes
Chan *et al.* (2009) United Kingdom Multiple (unclear number)	Patients with mild gastro-oesophageal reflux diseaseN = 175	Nurse Practitioner in Gastroenterology with one outpatient appointment	Care by usual General Practitioner	Six months	Significant symptom (dyspepsia) improvement was noted in the use of Glasgow Dyspepsia Severity Score (mean difference [MD] 2.3: 95% CI 1.4, 3.1) in the GNP group. Health status (140.6; 95% CI –184.8, –96.5) and cost of medication (£39.60; 95% CI 24.2, 55.1) were all in favour of the Nurse Practitioner group ($p < 0.001$) compared to the General Practitioner group. Although the baseline ulcers healing drug use was similar in both groups, 6 month-follow up reviews showed that the GNP group consumed less full-dose PPI medications ($p < 0.0001$) and more patients in the group required no treatment ($p < 0.001$). The study finds variable follow-up management of dyspepsia following gastroscopy, but this can be standardised by involving experienced GNP in the view of empowering patients for effective self-care.
Dierick-van Daele *et al.* (2009) Netherlands 15	Patients with minor health problems (upper respiratory, ear and nose, musculoskeletal skin, urinary, gynaecological and geriatric problems) N = 1501	Nurse Practitioner in Primary Care	General Practitioner led care	Two weeks	Patients perceived of the high-quality care provided by both Nurse Practitioners and General Practitioners, but there were no significant between-group differences in relation to health status (MD 0.82 [SD 0.18] v. 0.80 [SD 0.18], medical resource consumption (composite of prescriptions administered, investigations performed, number of referrals, and invitation to return for review) and adherence to guidelines (79.8% v. 76.2%) (all $p > 0.05$). However, patients in the Nurse Practitioner group observed significantly longer and more follow-up consultations than those in the General Practitioner group (12.2 [SD 5.7] v. 9.2 [SD 4.8] min, $p < 0.05$). The study demonstrates the prolonged duration that the nurse practitioners spend on face-to-face consultation (12.2 min on average) in contrast to the GPs (9.20 min (SD 4.8, $p < 0.001$). Although NP consultation is slightly longer in comparison with GP consultation, it was noted that time in consultation mattered to patients. The study concluded that NPs provided positive and comparable quality of care to GP. The study indicates that there is potential for greater continuity of care while proposing a widespread national and international debate about

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Table 3 (*continued*)

Study, setting, and number of centres	Participants	Intervention	Comparator	Follow-up duration	Main Outcomes
					appropriate skill mix in primary care and evaluate the value of NP role.
Kamps *et al.* (2003) Netherland 1	Paediatric patients newly referred from the Primary Care to an outpatient clinic N = 74	Clinical Nurse Specialist in Paediatric Asthma	Usual care delivered by Paediatrician	12 months	No significant differences between groups were observed at 12 months for any of the reported outcomes in terms of percentage of symptom-free days (MD 2.5%; 95% CI –8.8, 13.8), airway hyper-responsiveness (MD 0.06%; 95% CI –0.19, 0.32), functional health status (MD 10.1%; 95% CI –0.3, 19.8), and quality of life (MD 0.08%; 95% CI –0.9, 0.7) (all $p > 0.05$). However, considerable improvements in the outcomes were observed among both groups at 12 months, with 26% of the children requiring a lower daily dose of inhaled corticosteroids compared to baseline ($p = 0.03$). Additionally, all parents in the NP group were satisfied with the asthma care they received. There were no emergency room visits or hospital admission in both groups during the study time. This could suggest improved asthma control. The study clearly signaled that in both primary and secondary care settings, asthma nurses can safely provide safe and comparable long term management of mild to moderate childhood asthma without compromising quality of care or control of disease.
Kinnersley *et a* (2000) United Kingdom Multiple (unclear number)	Patients seeking a same-day consultation in General Practice. N = 1368	advanced nurse practitioner with a nurse practitioner diploma	General Practitione care	Two weeks	Generally, patients in the Nurse Practitioner group were more satisfied with the care received, although not for all included primary care trusts (MD ranged from –8.79; 95% CI –13.59, –3.98 to 0.61; 95% CI –4.84, 6.05). There was no significant difference in the resolution of symptoms between groups (OR 0.32; 95% CI 0.23, 0.43), nor were the number of prescriptions issued OR 1.01; 95% CI 0.80, 1.28), investigations ordered (OR 0.83; 95% CI 0.58, 1.16), need for re-attendance (OR 0.91; 95% CI 0.70, 1.17), and referrals to secondary care (OR 0.96; 95% CI 0.58, 1.57) (all $p > 0.05$). Patients in the NP groups felt that they had received better communication i.e. information about their illnesses and causes. This could reduce chances of recurrence. A higher number of patients would consider future same day consultations with the

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Table 3 (*continued*)

Study, setting, and number of centres	Participants	Intervention	Comparator	Follow-up duration	Main Outcomes
					nurse practitioners. The study findings highlight a wide acceptance of the role of nurse practitioners in the provision of care to patients requesting same day consultations.
Krichbaum (2007) United States 2	Elderly patients discharged from hospital post hip fracture N = 191	Nurse Practitioner in Gerontology	Usual care protocol	12 months	The results at 12 months follow-up showed that the Nurse Practitioner group observed significant improvements in outcomes related to the need for physical assistance (1.58 [SD 0.76] v. 1.81 [SD 0.90]), mobility (1.24 [SD 0.34] v. 1.42 [SD 0.48]), personal care (1.41 [SD 0.53] v. 1.22 [SD 0.32]), and home chores (1.48 [SD 0.51] v. 1.44 [SD 0.19]), than compared to the comparator (all $p < 0.05$), although no differences were found for general health status, depression, or living situation (all $p > 0.05$).
Kuethe *et al.* (2011) Netherland 19	Paediatric patients with stable asthma N = 107	Clinical Nurse Specialist in Paediatric Asthma	General Practitione led care and care delivered by Paediatrician	Two years	The findings showed that there was a significantly lower number of review visits required among subjects assigned to the General Practitioner group (45.7%) than the Pediatrician group (87.9%) and Nurse Practitioner group (94.3%) at the two-year follow-up ($p < 0.0005$). However, the study suggests a low follow-up frequency does not detract from maintenance of good disease control in children with stable asthma. The MD between the Nurse Practitioner and the General Practitioner groups was 49.7% (95% CI 39.2, 92.7) and the MD between the Nurse Practitioner and the Pediatrician group was 6.0% (95% CI 0.1, 74.4). There were no significant differences between any of the groups regarding respiratory outcomes and unplanned patient visits, and it was also reported that Nurse Practitioners were able to provide care without consulting a Pediatrician. The specialized asthma nurse can safely provide comparable and equivalent long-term asthma management in both primary care and hospital care settings. The asthma nurse also improves the confidence of parents caring for asthmatic children leading to reduction in exacerbation, school absences and parental leave. The authors suggested that the findings in this study are applicable in secondary as well as in primary care, given that the same criteria of baseline

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Table 3 (*continued*)

Study, setting, and number of centres	Participants	Intervention	Comparator	Follow-up duration	Main Outcomes
					characteristics are met.
Mundinger *et al.* (2000) United States 5	Patients being followed up in primary care following an Emergency Department or urgent care visit. N = 1316	Nurse Practitioners in Primary Care	General Practitioner led care	12 months	No significant differences between groups were found for patients' health status and indices of diabetes and asthma control ($p > 0.05$). However, patients with hypertension who were assigned to the Nurse Practitioner group observed a significantly lower diastolic blood pressure compared to those assigned to the General Practitioner group ($p = 0.04$). No other significant findings were observed for health resource utilization. There was no statistically significant difference in "overall patient satisfaction" or "patients' mean ratings of satisfaction between the two groups. However, the provider attributes in terms of technical skills, communication skills and time spent with patients, the General Practitioners had significantly higher satisfaction ratings compared to Nurse Practitioners ($p = 0.05$). This finding may be attributable to the fact that the nurse practitioners were transferred to another new site after 2 years before recruitment and data collection were completed whereas the physician practices were not moved during the study period.
Ndosi *et al.* (2014 United Kingdom 10	Patients with rheumatoid arthritis N = 181	Clinical Nurse Specialist in Rheumatology	Rheumatologist-led care	12 months	Overall, the results showed that the mean change in Disease Activity Score 28 (DAS28) was significant for non-inferiority on both per-protocol and intention-to-treat analyses (–0.31; 95% CI –0.63, 0.02 and –0.15; 95% CI –0.45, 0.14 respectively). In addition, significant intention-to treat non-inferiority was also found for pain (MD –1.34; 95% CI –7.13, 4.45, $p = 0.004$), physical functioning (MD 8.91; 95% CI –2.66, 20.5, $p = 0.0113$), satisfaction (MD –0.92; 95% CI –4.96, 3.12, $p = 0.019$), and consultation costs (£128; 95% CI –1263, 1006). The study finds that NLC had lower consultation cost and supports that NLC can provide safe and comparable care to manage RA patients. However, evidence on drawing probability of cost effectiveness was inconclusive due to varying disease specific activity and generic outcomes.
Ryden *et al.* (2000) United States 3	Patients newly admitted to a resident nursing home. N = 319	Nurse Practitioner in Gerontology	Usual care	Six months	Patients assigned to the advanced nurse practitioner group observed significantly greater improvements in outcomes

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Table 3 (*continued*)

Study, setting, and number of centres	Participants	Intervention	Comparator	Follow-up duration	Main Outcomes
					related to incontinence as well as fewer pressure ulcers and episodes of aggressive behavior and higher composite trajectory scores compared to usual care ($p < 0.05$). Moreover, patients with cognitive impairment were also found to observe a more stable effect, which was statistically significant in favor of the Nurse Practitioner group than the control group. The study suggests that the use of APNs in gerontology care incorporating scientifically based protocols into every day practice was encouraging: improvement in level of continence, pressure ulcer care, enhanced progress of mental health wellbeing among the elders.
Stables *et al.* (2004) United Kingdom 1	Patients requiring day-case cardiac catheterisation. N = 339	Nurse Practitioner in Cardiothoracic Surgery	Care by junior medical staff	Unclear, but less than one year	There were no significant differences between the groups with regards to major adverse events and the Cardiologists' acceptance of the patients' preparation was high for both groups (98.3% and 98.8%). However, patients' level of satisfaction was significantly greater among those assigned to the Nurse Practitioner (NP) group ($p = 0.04$) compared to group of Junior Medical Staff (JMS). In addition, the time taken in the clinic visit was lower in the NP group than for JMS group ($p = 0.01$). The overall event rate including minor adverse clinical events was 4/175 (2.3%) in NP group and 1/161 (0.6%) in JMS group. The calculated absolute risk difference = +1.7%, the upper boundary of the one-sided 95% CI = 6.2%. The study reveals NP role recognition and acceptance among junior medical staff who recommend the NP role should be continued. The study concludes that NPs with appropriate training, education, and support can safely prepare patients for elective cardiac catheterisation.
van Zuilen *et al.* (2011) Netherlands 9	Patients with diagnosed chronic kidney disease. N = 788	Nurse Practitioner	Usual care by Physician	Five years (median)	At the two-year follow-up, the Nurse Practitioner group had significantly lower systolic (133 [SD 21] v. 135 [SD 19] mmHg $p = 0.04$) and diastolic blood pressures (77 [SD 10] v. 80 [SD 11] mmHg $p = 0.007$), LDL cholesterol (2.45 [SD 0.81] v. 2.30 [SD 0.75] mmol/L $p = 0.03$), and a higher but non-significant use of ACE inhibitors, statins, aspirin, and vitamin D compared to the controls ($p >$

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Table 3 (*continued*)

Study, setting, and number of centres	Participants	Intervention	Comparator	Follow-up duration	Main Outcomes
					0.05). Subjects assigned to the Nurse Practitioner group also had no significant improvements in smoking cessation, weight, physical activity levels, or sodium excretion ($p > 0.05$).
Venning *et al.* (2000) United Kingdom 20	Patients requesting same-day appointment in Primary Care N = 1316	Nurse Practitioner	General Practitioner	Two weeks	Nurse Practitioner consultation times were significantly longer (MD 4.2 minutes; 95% CI = 2.98, 5.41), the number of tests ordered were significantly higher (MD 8.7% v. 5.6%; 95% CI 1.04, 2.66), patients were asked to return for review more frequently (MD 37.2% v. 24.8%; 95% CI = 1.36, 2.73), and costs were lower (MD £2.33; 95% CI = 1.62, 6.28) compared to General Practitioners (all $p < 0.05$). No significant differences were observed between the groups for health status, prescribing patterns, or health service costs ($p > 0.05$). However, patients were generally more satisfied with Nurse Practitioner consultations, with an adjusted mean difference of 0.18 (95% CI = 0.092, 0.257), but this was not significant ($p > 0.05$).
Williams *et al* (2005) United Kingdom Multiple (unclear number)	Patients with frequent urinary incontinence that affects their quality of life. N = 3748	Nurse Practitioner for Incontinence	Usual General Practitioner-led care and local continence advisory services	Six months	At the three-month follow-up, a significantly higher number of patients in the Nurse Practitioner group found that their incontinence episodes had improved compared to the controls (59% v. 48%, MD 11%; 95% CI 7, 16, $p < 0.001$). Moreover, a significantly higher proportion of subjects in the Nurse Practitioner group reported that their urinary symptoms had completely resolved compared to the controls (25% v. 15%, MD 10%; 95% CI 6,13, $p = 0.001$). The associated quality of life between the two groups (74% v. 68%, MD 6%, 95% CI = 2, 10, $p = 0.003$), patient satisfaction rate with the service provision (52% v. 45%, MD 7%, 95% CI = 3, 12, $p = 0.001$). These effects were maintained at the six-month follow-up. The study finds that the continence nurse practitioner-led service is both feasible and directly applicable for a wider implementation of continence service which is effective in symptoms reduction associated with incontinence, urinary frequency, urinary urgency and nocturia.

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The final search terms were truncated where necessary and combined using Boolean logic. Grey literature was searched using key and unique terms: Advanced nursing practice, advanced nurse practitioner, clinical impact, resource utilisation outcomes, care quality, patient satisfaction, international and adherence in the research question was searched. Moreover, EThoS British Library and GreyNet were visited. The outcomes were based on an exploratory range of patient- and service-related measures of quality of care, in accordance with the fundamental standards of care of the Care Quality Commission (CQC) and the indicators of care quality defined by the National Institute for Clinical Excellence (Care Quality Commission, 2019; NICE, 2019). Restricting the review to just RCT design studies was deemed necessary to facilitate the derivation of causal inferences between exposure to advanced nurse practitioners and reported outcomes, since RCTs represent the agreed standard for evaluating the effect of interventions by being able to control for a range of biases (Spieth *et al.*, 2016; Whitehead, 2020). Exclusion criteria included studies of non-RCT design, studies published in a non-English language, and studies reporting data irrelevant to the 'PICO' framework (see Table 1).

Search outcomes

Following the acquisition of articles through database searching, the eligibility of the studies was determined by the development and application of the inclusion and exclusion criteria (see Table 1) and complemented by the 'PICO' framework (Whitehead, 2020).

A total of 456 studies were identified through electronic database searching and, after the removal of duplicates, 402 were subjected to title and abstract screening. At this stage, the application of the inclusion and exclusion criteria led to the exclusion of a further 377 studies, leaving 25 key sources for full-text review and appraisal. The appraisal process resulted in the identification of 12 more studies for exclusion. The reasons included the reporting of incongruent data, insufficient operational definition of an advanced nurse practitioner ($N = 4$), lack of effective comparison ($N = 1$), and insufficient training of nurses to meet the requirements of advanced nurse practitioners ($N = 7$). Consequently, 13 studies were deemed eligible for the final synthesis of results (see Fig. 1).

Quality appraisal

In order to assess the risk of different biases in the included RCTs, Cochrane Collaboration's *Risk of Assessment Bias Tool for EPOC Reviews* was used (Cochrane Effective Practice and Organization of Care, 2017) (see Table 2). Risk of bias was expressed in terms of internal and external validity. Internal validity included information on the reliability and completeness of the measurement as well as the ability of the study to control for potential confounding factors (Griffiths *et al.*, 2018) (e.g., binding of outcomes assessment, incomplete outcomes data, and selective reporting). External validity was assessed primarily by considering the representative sampling of a center for a large region/country (Griffiths *et al.*, 2018) (e.g., random sample of hospitals/countries) and reported sampling power. The complete quality appraisal checklist used in this literature review is available for access (see Appendix 1).

Data extraction

Data from eligible studies were extracted using proformas developed by the Cochrane Collaboration (2019), which provide a systematic structure for extracting data. The extracted data were then evaluated for amenability to meta-analysis and, if the degree of inter-study heterogeneity permitted, these were presented using standard Forest plots (Campbell, Machin, and Walters, 2007). However, marked heterogeneity was anticipated, and the review, therefore, contingently analyzed data using a descriptive or narrative-type approach, which could provide meaningful and information-rich findings to inform nursing practice (Thomas and Harden, 2008).

Synthesis

The majority of the studies were at a low or unclear risk of selection, confounding, and ascertainment biases, although a number of studies were deemed to be at high risk of attrition (Krichbaum, 2007; Mundinger *et al.*, 2000; Ryden *et al.*, 2000; Venning *et al.*, 2000). This was where the rates of dropouts or loss to follow-up exceeded 15–20%. Two RCTs (Krichbaum, 2007; Mundinger *et al.*, 2000) were also deemed at a high risk of contamination, as the advanced nurse practitioners' intervention group also received input from the comparator of physician care. Finally, a number of studies were of high or unclear risk of bias resulting from insufficient statistical power (Dierick-van Daele *et al.*, 2009; Kamps *et al.*, 2003; Krichbaum, 2007; Ryden *et al.*, 2000; van Zuilen *et al.*, 2011; Venning *et al.*, 2000), in turn, increasing the possibility of type II or false-positive errors (Kim, 2015) (see Table 2 for details).

Results

Included studies

A total of 13 international RCTs were included in this review (see Table 3). The countries of study origin were the United Kingdom (Chan *et al.*, 2009; Kinnersley *et al.*, 2000; Ndosi *et al.*, 2014; Stables *et al.*, 2004; Venning *et al.*, 2000; Williams *et al.*, 2005), the United States (Krichbaum, 2007; Mundinger *et al.*, 2000; Ryden *et al.*, 2000), and the Netherlands (Dierick-van Daele *et al.*, 2009; Kamps *et al.*, 2003; Kuethe *et al.*, 2011; van Zuilen *et al.*, 2011). The NPs as the intervention or exposure of interest were situated in a number of different care settings. These were primary care/general practices (Dierick-van Daele *et al.*, 2009; Kinnersley *et al.*, 2000; Venning *et al.*, 2000), a cardiothoracic day-unit in a hospital setting (Stables *et al.*, 2004), out-patient hospital clinics (Chan *et al.*, 2009; Ndosi *et al.*,

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2014; Kamps *et al.*, 2003; Kuethe *et al.*, 2011; Mundinger *et al.*, 2000; van Zuilen *et al.*, 2011), and community-based care involving home-visits, nursing homes, and rehabilitation centres (Krichbaum, 2007; Ryden *et al.*, 2000; Williams *et al.*, 2005).

Participants and nursing intervention

Two studies included paediatric patients requiring management of asthma (Kamps *et al.*, 2003; Kuethe *et al.*, 2011), whilst the majority included adults aged more than 18 years. Three studies restricted the population to older persons aged 60 years and above, with problems related to urinary incontinence (Williams *et al.*, 2005), management following a hip fracture (Krichbaum, 2007), and multiple comorbidities or complex problems necessitating nursing home admissions (Ryden *et al.*, 2000). In three studies, the NP acted as the first contact of care and managed the ongoing care (Mundinger *et al.*, 2000; Kamps *et al.*, 2003; Ryden *et al.*, 2000). In four studies, the NP was the principal contact for patients seeking same-day or urgent consultations (Dierick-van Daele *et al.*, 2009; Venning *et al.*, 2000; Kinnersley *et al.*, 2000; Stables *et al.*, 2004). Five studies identified that the NP was responsible for the management or follow-up of patients with chronic disease (Chan *et al.*, 2009; Ndosi *et al.*, 2014; Kuethe *et al.*, 2011; van Zuilen *et al.*, 2011; Williams *et al.*, 2005), while one study confirmed that the NP was responsible for co-ordinating and supporting post-acute care (Krichbaum, 2007).

Quality assessment of included studies

Use of GRADE criteria

Following the methodological quality assessment of the included studies, the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) criteria, which is the most widely used and validated transparency framework, was applied for quality assessment of reproducibility, applicability, and generalzability of the included study findings. The GRADE criteria assisted by developing and presenting summaries of evidence in order to determine the methodological quality of the included studies (Guyatt *et al.*, 2011). The rating of quality, using the GRADE criteria, is based on study design and the presence and/or degree of different biases and other factors, where the overall quality is subjectively determined to be very low, low, moderate, or high (Guyatt *et al.*, 2011). In addition to the risk of bias, the downgrading of research quality is informed by other factors such as imprecision in confidence intervals, inconsistency in comparison with other reports and influence of heterogeneity, indirectness in applicability of outcomes to the target population, and publication bias regarding inferences about missing data. Alternatively, the quality of research can be upgraded in the presence of large effects, dose-response effects, and reduction of the effect when accounting for residual confounders (Siemieniuk and Guyatt, 2019).

Based on the GRADE criteria, five studies (Chan *et al.*, 2009; Kinnersley *et al.*, 2000; Kuethe *et al.*, 2011; Stables *et al.*, 2004; Williams *et al.*, 2005) were considered to be of high quality, with minimal risk of bias, imprecision, inconsistency, and indirectness.

Table 4
GRADE Evidence Profile of Included Studies

Study	Number of biases for downgrading	Publication bias	Indirectness of evidence	Imprecision of confidence intervals	Inconsistency with other trials	Reasons for quality upgrading	Overall quality
Chan *et al.* (2009)	One	Undetected	Undetected	Undetected	Undetected	Large Effect Size	High
Dierick-van Daele *et al.* (2009)	Two	Undetected	Undetected	Undetected	Undetected	Undetected	Moderate
Kamps *et al.* (2003)	Three	Undetected	Undetected	Some imprecision	Undetected	Undetected	Low
Kinnersley *et al.* (2000)	One	Undetected	Undetected	Undetected	Undetected	Undetected	High
Krichbaum (2007)	Four	Undetected	Detected	Undetected	Undetected	Undetected	Very Low
Kuethe *et al.* (2011)	One	Undetected	Undetected	Undetected	Undetected	Large Effect Size	High
Mundinger *et al* (2000)	Three	Undetected	Detected	Undetected	Undetected	Undetected	Low
Ndosi *et al.* (2014)	One	Undetected	Undetected	Some imprecision	Undetected	Undetected	Moderate
Ryden *et al.* (2000)	Three	Undetected	Undetected	Undetected	Undetected	Large Effect Size	Moderate
Stables *et al.* (2004)	One	Undetected	Undetected	Undetected	Undetected	Undetected	High
van Zuilen *et al* (2011)	Two	Undetected	Undetected	Undetected	Undetected	Undetected	Moderate
Venning *et al.* (2000)	Three	Undetected	Undetected	Undetected	Undetected	Undetected	Low
Williams *et al.* (2005)	One	Undetected	Undetected	Undetected	Undetected	Large Effect Size	High

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Table 5
Excluded Studies

Study	Reason for Exclusion
Barrett *et al.* (2011)	Insufficient definition of the nurse intervention
Campbell *et al.* (2015)	Insufficient training of nurses to meet definition of advanced nurse practitioner – practice nurses
Houweling *et al.* (2011)	Insufficient training of nurses to meet definition of advanced nurse practitioner – practice nurses
Huber *et al.* (2017)	Insufficient definition of the nurse intervention
Iglesias *et al.* (2013)	Insufficient definition of the nurse intervention
Larsson *et al.* (2014)	Insufficient training of nurses to meet definition of advanced nurse practitioner – nurses with extensive experience in the field of rheumatology
Moher *et al.* (2001)	Insufficient training of nurses to meet definition of advanced nurse practitioner – practice nurses
Ogren *et al.* (2018)	Insufficient definition of the nurse intervention
Sanne *et al.* (2010)	Insufficient training of nurses to meet definition of advanced nurse practitioner – nurses with some extra training
Scherpbier-de Haan *et al.* (2013)	No effective comparison – crossover of shared nurse/physician care
Shum *et al.* (2000)	Insufficient training of nurses to meet definition of advanced nurse practitioner – practice nurses
Voogdt-Pruis *et al.* (2010)	Insufficient training of nurses to meet definition of advanced nurse practitioner – practice nurses

Three of these studies were upgraded due to the reporting of large effect sizes (Chan *et al.*, 2009; Kuethe *et al.*, 2011; Williams *et al.*, 2005). The remaining studies were of moderate quality (Dierick-van Daele *et al.*, 2009; Ndosi *et al.*, 2014; Ryden *et al.*, 2000; van Zuilen *et al.*, 2011) and low quality (Kamps *et al.*, 2003; Mundinger *et al.*, 2000; Venning *et al.*, 2000). One study (Krichbaum, 2007) was deemed to be very low in its methodological quality due to the high number of biases and evidence of indirectness (see Table 4).

Excluded studies

A total of 12 studies were excluded from this review after full-text scrutiny (see Table 5). They did not meet the inclusion criteria for the study selection: either poorly defined the level of training of the nurses and their role or additional education and training carried out by the nurse but to a degree that was inconsistent with formal or operational definition of an advanced nurse practitioner.

Discussion

The studies, included in this review reported a diverse range of outcomes associated with the utilization of advanced nursing practice, with positive benefits observed in relation to the management of dyspepsia (Chan *et al.*, 2009), medication costs and requirements (Chan *et al.*, 2009; Kamps *et al.*, 2003), health status (Chan *et al.*, 2009), patient satisfaction levels (Stables *et al.*, 2004; Venning *et al.*, 2000; Kinnersley *et al.*, 2000), duration of time spent in outpatient clinics (Stables *et al.*, 2004), physical functioning (Krichbaum, 2007), blood pressure levels (van Zuilen *et al.*, 2011; Mundinger *et al.*, 2000), frequency of urinary symptoms (Williams *et al.*, 2005), severity of rheumatoid arthritis symptoms and related costs (Ndosi *et al.*, 2014), frequency of incontinence, pressure ulceration, and aggressive behavior (Ryden *et al.*, 2000).

Advanced nurse practitioners demonstrated greater adherence to recommended targets and practical guidelines. The central themes reported are reflective of the number of diverse ways in which advanced nurse practitioners are currently employed in clinical practice, in settings that vary from long-term nursing home facilities to inpatient clinics. Overall, 13 RCTs were eligible for this review, with almost all trials reporting that care from advanced nurse practitioners led to positive effects on patient care and service outcomes, including symptom severity (Chan *et al.*, 2009; van Zuilen *et al.*, 2011; Mundinger *et al.*, 2000; Williams *et al.*, 2005; Ndosi *et al.*, 2014; Ryden *et al.*, 2000), physical function (Krichbaum, 2007), satisfaction (Stables *et al.*, 2004; Venning *et al.*, 2000; Kinnersley *et al.*, 2000), waiting times (Stables *et al.*, 2004), and costs (Chan *et al.*, 2009; Kamps *et al.*, 2003; Ndosi *et al.*, 2014). No studies were found that explored the impact of advanced nurse practitioner/NP on staff experiences and job satisfaction, although Krichbaum *et al.* (2007) acknowledged that gerontological APRNs have effective links between current scientific knowledge and nursing home staff. A small number of studies support the positive impacts of collaborative care by advanced nurse practitioners and medical doctors. These studies were mostly conducted within critical care settings where the technical skills of advanced nurse practitioners are similar to those of their medical counterparts, i.e., performing blood gas sampling via the arterial line and analysing its result.

Several other studies were also found to have investigated the impact of nurse-led care on similar outcomes, with most being conducted in primary care settings. For example, in a multi-centered randomized controlled trial, Shum *et al.* (2000) assessed the acceptability and safety of a minor ailment service in general practice between trained nurses and physicians. They found that patients were more satisfied with the care received from nurses compared to that provided by doctors ($p < 0.05$). In another primary care-based trial, Moher *et al.* (2001) evaluated the effectiveness of a nurse-led service compared to general practitioner-led service in promoting secondary prevention of cardiovascular disease in a cohort of older adults. The results demonstrated that the assessment of blood pressure, cholesterol, and smoking status was more frequent in patients assigned to the nurse group, although clinical outcomes related to these measures were comparable between groups at the study conclusion. Furthermore, Sanne *et al.* (2010) explored the impact of 'nurse versus doctor-led' management of anti-retroviral therapy care for patients with human immunodeficiency virus. Their results identified that both groups observed comparable outcomes related to treatment failure (48% v. 44%), mortality (10% v. 11%), virological failure (44% v. 39%), adverse effect failure (68% v. 66%), and program losses (70% v. 63%), which were all significantly non-inferior. Notably, these trials were excluded from their review, as the definition of the nurse intervention was not congruent with

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Table 6
Existence of advanced nursing practice, set criteria, capabilities and its regulations by country of origin

Country name	Existence of advanced practice nursing role: Y/N	RegulationY/N	LegislationY/N	Form of legislation/ regulatory bodies	Criteria of Advanced Nurse Practice	Roles and Capabilitie	References
Australia	Y	Y	Y	Health practitioner regulatory agency	Must possess core competencies and assist in indicating the scope of nursing practice	Autonomous practitioner Prescriber	Austrian Nursing and Midwifery Council (ACNM 2009) https://www.anmac.org.au/standards-and-review/nurse-practitioner
Canada	Y			Provincial Responsibility	Pan-Canadian framework- core competencies to autonomously diagnose, order and interpret diagnostic tests, independent proscribing	Autonomous primary care practitioner role Limited prescribing rights	Canadian Nurses Association, Nurses Practitioners Association of Ontario https://www.cna-aiic.ca/en/nursing-practice/the-practice-of-nursing/advanced-nursing-practice
Denmark	N			Bachelor's degree in nursing regulated by Ministry of Education but advanced practice nurse role in development	Nurses specialists	Advanced nursing roles in nursing management nursing education and public health nursing No prescribing rights	Organisation of Economic, Co-operation and Development (OECD, 2012) and Danish Nurses Organisation, 2008) https://internationalapn.org/2014/06/29/denmark/
France				Regulation of first level nurses is approved by the ministry of Health. Minimum qualification to advanced practice nurse has been master's level of education since 2010.	advanced nurse practitioner role expansion is in its early stage of development	Uncertain role development Uncertain prescriptive authority	French nursing organisation was initiated by a group of Advanced practice educated nurses in France in 2010. The French Nursing Council (2009) OECD (2006) (ICN 2008 a, b) https://internationalapn.org/2014/06/29/france/
Finland				Professional nursing regulated by law	Existence of registered nurse specialisation rather than advanced practice nurse role. The First advanced practice nurse graduated in 2006	Autonomous health care practitioner with a potentially wider scope of practice Limited prescribing authority	https://internationalapn.org/category/europe/finland/ (Robinson and Griffiths, 2007) (Delamaire and Lafortune, 2010)
Germany	N			General nurse education regulated by The National Nursing Act and Ordnance of 1985	Nationally defined professional competence and responsibilities of nurses Advanced practice nurse role will not be established in near future	No advanced nurse practitioner role but specialist nursing role existed with no prescribing authority	OECD (2006) https://internationalapn.org/category/europe/germany/ (Sheer and Wong, 2008)
Hongkong	Y			The Nursing Council of Hongkong 1997- recognition of nurse specialist role and advanced practice nurse role	Clinical nurse specialists has been the birth of advanced practice nurse and nurse practitioners in the Hong Long health care system with greater acceptance in in-patient wards within acute hospital as well as outpatient nurse-led clinics but master's level of education has been as minimum requirement.	Varying autonomous practitioner Uncertain prescribing authority	https://internationalapn.org/category/asia/hongkong/ (Vernon and Jinks, 2013)

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Table 6 (*continued*)

Country name	Existence of advanced practice nursing role Y/N	RegulationY/N	LegislationY/N	Form of legislation/ regulatory bodies	Criteria of Advanced Nurse Practice	Roles and Capabilities	References
Ireland	Y	Y	Y	The Nurses and Midwives Act (2011) The Nursing and Midwifery Board of Ireland formerly known as An Bord Altranais	The role is known as Registered Advanced Nurse Practitioner (Radvanced nurse practitioner for those master's degree has been a minimum requirement	Autonomous practitioner Certain treatment and prescribing authority	https://internationalapn.org/category/europe/ireland/ (Delamaire and Lafontaine, 2010; Sheer and Wong, 2008).
Italy	N			Provincial College of Nursing	Role implementation is currently under development and may not be in the near future. No central control/ validation process for degree courses of nursing profession	Role in development stages as well as treatment and prescribing	https://internationalapn.org/category/europe/italy/ (OECD, 2006)
Japan	N			Japanese Nursing Association, JNA, 2006	Two levels of nurse: registered nurse (First) & Licensed Practice Nurse (second level)-the latter is legislated by JNA- Nurse practitioner program is underway	Role existed as practice nurse but no permitted to practise autonomously, nor treatment/ prescribing authority	https://internationalapn.org/category/asia/japan/
Netherlands	Y			Specialist training programmes been recognised by both nursing associations and employers	The role of advanced nurse practitioner/ APN is nurse practitioner in the Netherlands-requires a Master of Advanced Nursing Practice degree. Role introduced in 1997-predominantly incorporated within primary care	Role existed as autonomous practitione with treatment/ prescribing authority	https://internationalapn.org/category/europe/netherlands/ (OECD, 2006) (Storedur and Leonard, 2010)
New Zealand	Y			Nursing Council of New Zealand Health Practitioners Competence Assurance Act	Advanced clinician role was initiated as nurse practitioner role, introduced in 2001-minimum requirement as master's degree for nurse practitioner scope of practice	Autonomous practitioner Certain treatment/ prescribing authority	https://international.aadvanced nurse practitioner.org/Content/docs/New_Zealand.pdf
Norway	Y			Ministry of Education and Research	Master's degree as minimum entry to become nurse practitioner	Autonomous practitioner Varying treatment/ prescribing rights	https://www.oecd.org/els/health-systems/Item-2a-Nurses-advanced-roles-Maier-University-Technology.pdf
Singapore	Y			Singapore Nursing Board which maintains Advanced Practice Nurses Register	Role comprising Clinical Specialist Nurses and Nurse Practitioners	Variable autonomous practitioner Treatment authority permitted Prescribing right allowed under acute care protocols	https://internationalapn.org/category/asia/singapore/ (Sheer and Wong, 2008; Tan Tock Seng Hospital, 2013). Singapore Nursing Board on https://www.healthprofessionals.gov.sg/snb

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Table 6 (*continued*)

Country name	Existence of advanced practice nursing role Y/N	RegulationY/N	LegislationY/N	Form of legislation/ regulatory bodies	Criteria of Advanced Nurse Practice	Roles and Capabilities	References
Spain	Y	Y	Y	General Council of Nursing Ministry of Education and Science	Nurse practitioners Specialist Nurses Minimum requirement of master's degree	Autonomous practitioner with treatment and prescribing authority	https://fhs.mcmaster.ca/globalhealthoffice/documents/AdvancedPracticeNurseinSpain.pdf
Sweden	Y		In development	National Board of Health and Welfare	Role existed as Nurse Specialists and Advanced Clinical Nurse specialists Master's degree	Roles existed as advance clinical nurse specialists but not treatment/ prescribing rights nor autonomous practice	https://internationalapn.org/category/europe/sweden/ (Lindblad, Hallman, Gillsjo, Lindblad, and Fagerstom, 2010).
Switzerland	Y		N	Federal Level for all First level nurses	Role existence in Advanced Practice Nurse and Nurse anaesthetist Master's degree	Role existed but no treatment/ prescribing authority nor autonomous practice	https://internationalapn.org/2013/09/10/switzerland/ (Sprig, Schwendimann, Spichiger, Cignacco, and De Geest, 2009).
United Kingdom	Y		Emerging: Individual Health-care organisations Accredited through professional bodies	Nursing and Midwifery Council Royal College of Nursing	Role existence in Advanced Nurse Practitioner (advanced nurse practitioner) / Advanced Care Practitioners advanced nurse practitioner role greatly focused on Masters level of education	Roles existed as advanced car/ clinical practitioner with prescribing authority – non -medical prescribing right Autonomous practitioner	https://internationalapn.org/category/europe/united-kingdom/ (Morgan, 2010). (RCN, 2012) (Pulcini et al., 2009).
United States	Y		Y	Licensed in all states and District of Columbia	Role existence in Nurse practitioners (NP), Advanced Practice Registered Nurses (APRNs), Clinical Nurse Specialists including nurse anaesthetists Role utilised in all health care settings	Roles existed as APRN, with prescribing and treatment authority	https://international.aadvanced nurse practitioner.org/Content/docs/USA.pdf The American Nurse Association - http://www.nursingworld.org The National Organization of Nurse Practitioner Faculty - https://nonpf.site-ym.com/ The American Association of Nurse Practitioners - https://www.aadvanced nurse practitioner.org/

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that of advanced nurse practitioners. A range of previous studies also assessed the effect of nurse-led care. They found that their input could provide safe care, markedly reduced the workload of general practitioners, and promoted a more rapid access to clinical advice and clinical care (Lattimer *et al.*, 1998; Lewis and Resnik, 1967; Chambers and West, 1978).

The results of this systematic review are also congruent with a relatively recent Cochrane review, where Laurant *et al.* (2018) investigated the impact of nurses as substitutes for primary care physicians on patient outcomes, care processes, and resource utilization. Their study evaluated a total of 18 RCTs, including several studies in this review; however, they also analyzed outcomes from interventions comprising across a range of advanced and non-advanced practice nurses – rather than a focus on just advanced nurse practitioners. The results demonstrated a moderate quality evidence to suggest that nurses positively improved patient satisfaction levels and clinical or health status indicators, such as blood pressure. However other outcomes, such as patient satisfaction and mortality, highlighted a lower degree of certainty and evidence compared to this study. The authors could only conclude that there is some evidence that nurses probably provide equal or even superior care to that of doctors for a range of minor and urgent illnesses and chronic conditions. In a preceding systematic review, Laurant *et al.* (2005) confirmed that trained nurses could safely deliver care and achieve outcomes that were non-inferior to that of doctors, although the review included studies with a range of methodological flaws and a limited duration of patient follow-up. Numerous other reviews have supported and considered advanced nurse practitioners as professionals who can deliver equal and even, at times, superior care than physicians. For example, Swan *et al.* (2015) conducted a systematic review of 10 randomized trials comprising over 10,000 patients, in order to investigate the safety and efficacy of advanced nurse practitioners in the provision of acute care. The follow-up period ranged from one to two years and, notably, advanced nurse practitioners conferred an equal or improved outcome benefit upon a range of physiological measures, service costs, and patient satisfaction levels in contrast to patients receiving physician-only care. In another systematic review of advanced practice nurses, outcomes, among studies published within an 18-year period, Newhouse *et al.* (2011) found that, in acute clinical settings, advanced nurse practitioners were associated with reductions in length of hospital stay and healthcare costs. However, in a systematic review of the effect of nurse-led and physician-led care for patients with chronic diseases, Martinez-Gonzalez *et al.* (2015) discovered that there were no significant or meaningful differences between the intervention groups and only 40% of patients preferred nurse-led care. Indeed, this finding is congruent with this review, where a number of studies (Dierick-van Daele *et al.*, 2009; Kamps *et al.*, 2003; Kinnersley *et al.*, 2000; Mundinger *et al.*, 2000) reported non-significant outcomes related to clinical and service-related measures of care quality.

With regard to specific settings, in a systematic review of 15 studies comprising 23681 participants, Woo *et al.* (2017) evaluated the impact of advanced nurse practitioners on quality of care, clinical outcomes, satisfaction, and cost within emergency and critical care environments. In the Emergency Department setting, the authors found mixed results with regards to the duration of stay, waiting time, patient satisfaction, mortality, cost, and greater adherence of advanced nurse practitioners to the recommended targets of administering analgesia. Two out of the fifteen studies reported a significant reduction in waiting time in the Emergency Departments, but this was confounded by doctors being responsible for patients with greater acuity and complexity of illness, whilst other studies demonstrated no difference between nurses' and physicians' associated length of stay and waiting time for treatment. The positive impact of advanced nurse practitioners on waiting times was less marked, with only the study by Colligan *et al.* (2011) demonstrating that patients with minor injuries endured a 14 min median shorter waiting time compared to the time that would have been taken on being managed by an emergency medical doctor. Meanwhile, other studies demonstrated that waiting times were equal between groups of advanced nurse practitioners and physicians working in the same setting. With regards to the critical care setting, 7 out of the 15 studies used comparative designs, with one evaluating direct management of patient care delivered by advanced nurse practitioners and others analyzing the impact of collaborative advanced nurse practitioner and physician-led care. The length of stay was found to be largely similar between direct care by advanced nurse practitioners and usual/physician-led care. Although one study (Landsperger *et al.*, 2016) showed that patients had significantly lower odds (13%) of a longer stay, this was associated with a higher patient-to-nurse ratio. Nonetheless, it may imply that directed care provided by advanced nurse practitioners may be more efficient than conventional physician-managed care. Interestingly, the time of stroke treatment was found to be significantly lower when on-site care was provided by advanced nurse practitioners and when these nurses were available 24/7 ($p < 0.001$) as compared to the usual service model that was managed by physicians (Moran *et al.*, 2016). However, this merely reflects better availability of stroke intervention measures such as thrombolysis rather than highlighting advanced nurse practitioners as the independent beneficial factor for this service outcome measure (Moran *et al.,* 2016).

The collaboration of advanced nurse practitioners and physicians was also found to have positive effects on mortality in intensive care units, with significantly lower mortality rates compared to physician-only care (6.3% v. 11.6%, $p = 0.01$). However, general in-hospital mortality was comparable between groups ($p = 0.11$) (Skinner *et al.*, 2013; Scherzer *et al.*, 2016). However, the findings of the identified studies, which relied on propensity scoring, are likely to have missed important confounders, thus limiting the reliability of the results. Patient satisfaction levels were comparable between advanced nurse practitioners and physicians, with cost-effective analyses being generally similar between the advanced nurse practitioners–physician collaborative and physician-only models. However, only two studies (Skinner *et al.*, 2013; Hiza *et al.*, 2015) identified results that demonstrated cost saving comparison between NP-physician groups and physician-only groups. Skinner *et al.* (2013) suggested that annual staffing costs of more than £170,000 could be saved if advanced nurse practitioners were employed to manage intensive care unit patients.

While this review and previous studies have reported a variety of beneficial effects from the widespread utilization of advanced nursing practice, the findings are limited by the challenges associated with conducting comparative studies among different health professionals and the inability to account for non-interventional factors and extraneous influences such as physical activity, dietary habits, and the occupational stress of these professionals. This could clearly have confounded the outcome effects (Laurant *et al.*, 2018). Considering the findings, a number of implications and recommendations have been identified for nursing practice and future

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research. These need to be interpreted in light of the study's limitations.

Limitations

Firstly, the limitations of this systematic review mostly involve the inclusion and exclusion criteria that have been used to define study eligibility. In this regard, while efforts were sought to reduce the risk of reporting-type bias (that is, the avoidance of excluding relevant studies for addressing the research question), there is always a risk that important studies may be missed from the database indexing processes. Second, studies had to be restricted to the English language due to limited investigator resources, which may have excluded important and relevant studies conducted in non-English speaking countries as well as some other high-income countries and low-to-middle income countries. Indeed, the exclusion of grey literature and non-English studies could have excluded pertinent articles from collective evaluation, although this was not deemed overall a negatively impactful risk – as this is commonplace with systematic reviews. Thirdly, the credibility of the findings in this review are inherently linked to and limited by the methodological quality of informing RCTs, which was on average moderate at best, with some trials comprising a high number of biases and having detectable inconsistencies and statistical imprecision.

Implications for practice

As the majority of studies have supported advanced nurse practitioners as providers of non-inferior care and outcomes compared to physicians/ doctors-led care and usual care, they pose several implications for practice. These include: the incorporation of advanced nurse practitioners into various clinical settings is both feasible and required to help alleviate the burden placed upon physicians and reduce waiting times for patients; the study findings also extend to implications related to the cost of healthcare and service provisions, as it appears that advanced nurse practitioners may help reduce costs and improve efficiency in the health care system; wider benefit for patient flow, with advantages in terms of higher patient throughput among acute admitting departments and more timely discharge of patients from general medical/surgical wards; and subsequently, inclusion of advanced nurse practitioners can lead to reducing diagnosis and treatment delays and alleviating the risks associated with protracted hospital stays, such as nosocomial infections and venous thromboembolism.

In the interim, since the current literature is predominately of moderate quality, additional RCTs are required to further evaluate the clinical impact of extensive utilization of advanced nurse practitioner role. However, this may prove challenging as a number of biased studies from the past already exist. Future research should not only re-explore the clinical impact of advanced nurse practitioners using RCT design, but also attempt to enhance the methodological quality of the trials by accounting for residual confounders and minimizing the risk of other biases that were identified in this review.

Conclusion

This systematic review has found that advanced nurse practitioners enhance patient care, service cost-effectiveness, efficiency, and general patient satisfaction with the overall quality of care provided. Studies evaluating the impact of advanced nurse practitioners on clinical and service outcomes appear to be generalizable to all health settings, supporting the diverse capability of this professional discipline in addressing current and future health care needs of patients and their families. Despite that the findings are somewhat limited by methodological issues informing trials, it is apparent that advanced nurse practitioners offer a promising solution for addressing the rising complexity and demand of health service users worldwide. Undeniably, the continued delivery of high-quality patient care during times of unprecedented complexity and pressure is fundamental to the present and future safety of patients. Although most of the studies included in this review were conducted in high-income countries, they provide strong evidence that the positive, comparable effectiveness of advanced nurse practitioners, can be explored and exported into low to middle-income countries. Utilizing advanced nurse practitioners to facilitate effective healthcare should be considered an international healthcare imperative at the policy level.

Declaration of Competing Interest

The authors of this review declare no known conflicts of interest.

Acknowledgements

The authors would like to acknowledge Natalie Gabe (NB) as an expert librarian of the Hampshire Hospitals Foundation Trusts in refining the search strategy used for this review.

Funding

This review received no funding.

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Authors' contributions

MH conducted the preliminary literature search and final literature search, completed the study selection, critically appraised the studies, extracted data, analyzed, interpreted data, and drafted the manuscript. DW participated in the data analysis, interpreted data, and drafted the manuscript.

Appendix 1

file:///C:/Users/Maung/Downloads/suggested_risk_of_bias_criteria_for_epoc_reviews.pdf
Key search terms used for ANP outcomes/ effects

Databases	Key search terms	Findings
PubMed/Medline	("Physician Assistant*" OR "Mid Level Pract*" OR "Advance* Nurs* Pract*" OR "Consultant Nurse*" OR "Clinical Nurse	429
Embase	Specialist*" OR "ANP*" OR "Advanc* Pract* Nurs**" OR "Nurse Practitioner*" OR "Nurse Clinician*" OR "Non-Physician*" OR	605
CINHAL	"ENP*" OR "Emergency Nurs* Pract*" OR "Advanc* Clinical Pract*" OR "Nurse Led" OR "Nurse Specialist*").ti,ab	324
Corchrane	("meta analys*" OR "RCT*" OR "literature review*" OR "systematic review*" OR "randomised control trial*" OR "randomized	545
Registry	control trial*" OR "scoping review*" OR "Cochrane Review*").ti,ab	
Cochrane Trials		175
Cochrane		2
EPOC		
Edit		

Cochrane Registry looking into SR database for ANP.text – 545, but looking for ANP and variations .txt- 175 Trials & Cochrane SR database looking at ANP and variations .txt- 1

Among the first search, only a few studies were conducted related to the cost associated with ANP involvement. Therefore, search continued using original key terms combined with (cost* OR economic* OR expenditure*).ti,ab,

Results were;
CINHAL-131
EMBASE 257
Medline 192
Pubmeds 605
Cochrane EPOC Trials- 112
View Results (137,964)
Edit

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF DENISE LYONS

I, Denise Lyons of [redacted] NSW, say:

1. I have been the President of the Australian Primary Health Care Nurses Association ("APNA") since about May 2025. APNA is the national peak body representing nurses working across primary health care in Australia. It supports and advocates for primary health care nurses to work to their full scope of practice, strengthens the workforce through education and professional development, and promotes high-quality, person-centred care that keeps people well. As President, I provide strategic leadership to the Board and the organisation, represent primary health care nursing at a national level, and advocate to ensure the contribution of primary health care nurses is recognised, valued, and embedded in health-system reform. The role focuses on strong governance, policy influence, and advancing a sustainable, future-focused primary health care nursing workforce.

2 I am also a member of the Australian College of Nurse Practitioners ("ACNP") and the Australian Nursing and Midwifery Federation ("ANMF").

3 I am an endorsed Nurse Practitioner and have been working in advanced practice nursing and primary health care roles for more than two decades, including over 13 years as a Nurse Practitioner in Australia after being endorsed in 2012. Annexed and marked **DL1** is a copy of my curriculum vitae.

4 My day-to-day work as a Nurse Practitioner, including in my current employment with [redacted] has involved independently assessing patients, diagnosing health problems, ordering and interpreting pathology and imaging, prescribing medicines, and developing and reviewing treatment plans. I have provided care to people across the lifespan, including children, older people, and those with chronic and complex conditions.

Lodged by:	Telephone:	03 9603 3035
The ANMF		
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5. Most of my Nurse Practitioner experience has been in primary health care, including general practice, after-hours urgent care, telehealth services, pharmacy-based clinics, and large-scale immunisation programs. In these roles, I have worked both autonomously and as part of multidisciplinary teams, taking direct clinical responsibility for patient care and outcomes.

6 I have also worked in after-hours and telehealth services, where Nurse Practitioners play a central role in maintaining access to care, reducing pressure on hospitals, and ensuring timely and safe clinical decision-making.

7 In addition to clinical practice, I have held clinical leadership and workforce development roles. These have included managing clinics, leading training and providing professional development for primary care nurses.

8 I am also currently employed by the [redacted] as a Clinical Editor. I develop evidence-based clinical pathways used by doctors and nurses at the point of care. I collaborate with other health professionals including medical specialists, general practitioners and other Nurse Practitioners in developing those pathways. For example, I recently worked with a Nurse Practitioner in hepatology at a local hospital to develop an appropriate referral pathway to their service. These experiences have given me direct insight into the level of skill, judgement, responsibility, and accountability required of Nurse Practitioners.

9 I have also contributed at a system and policy level, serving on Australian Government advisory groups related to Nurse Practitioner workforce planning, scope of practice, primary care funding, and after-hours services. This work has involved examining how Nurse Practitioner roles are classified, funded, regulated, and valued within the health system and workforce frameworks. The groups with which I am currently involved, including at the Department of Health, Disability and Ageing, are listed in my curriculum vitae.

10 Earlier in my career, I worked as a Registered Nurse in emergency and paediatric settings in the United States, including roles that required advanced assessment, rapid clinical decision-making, and independent professional judgement. This experience provides additional perspective on advanced nursing roles and how they are recognised in different systems.

11 Taken together, my clinical, leadership, and policy experience provides a strong basis to explain:

(a) the work performed by Nurse Practitioners;

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(b) the level of skill, responsibility, and decision-making involved;

(c) how Nurse Practitioner roles differ from, and extend beyond, Registered Nurse roles; and

(d) how these roles contribute to access, safety, and quality of care in the Australian health system.

Introduction of Nurse Practitioners in Australia

12. Nurse Practitioners were introduced in Australia in the late 1990s and early 2000s, with the first Nurse Practitioners authorised to practise in 2000. The role was introduced progressively across states and territories, before becoming nationally regulated. Nurse Practitioners were introduced in response to clear gaps in the health system, particularly:

(a) shortages of medical practitioners, especially in rural, remote and underserved communities;

(b) growing demand for health care due to ageing populations and chronic disease;

(c) long waiting times and avoidable presentations to emergency departments; and

(d) recognition that experienced nurses were already performing advanced clinical work without formal authority or recognition.

13 The intent was to enable highly experienced nurses with advanced education to practise with greater autonomy, including assessing patients, making diagnoses, ordering tests, prescribing medicines, and managing care within their scope of practice. The role was designed to:

(a) improve access to timely care;

(b) make better use of the existing nursing workforce;

(c) support multidisciplinary team-based care; and

(d) maintain patient safety through clear education endorsement and accountability requirements.

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Training and qualifications

14. Nurse Practitioners emerged in Australia through a deliberate regulatory and education pathway, recognising advanced clinical work already being performed by highly experienced nurses.

15. In the late 1990s, Australian governments and nursing regulators formally began exploring the Nurse Practitioner role in response to workforce shortages, rising demand for care, and growing clinical complexity in community and rural settings. At this time, many senior nurses were already practising at an advanced level, but without formal authority or recognition.

16 In 2000, the first Nurse Practitioners were authorised in Australia, following pilot programs and state-based regulatory approval. These early Nurse Practitioners were selected from senior clinicians with extensive experience and demonstrated advanced practice skills.

17 In the early 2000s (2000-2005), Australian states and territories introduced formal endorsement processes for Nurse Practitioners. Entry to the role required:

(a) registration as a Registered Nurse;

(b) significant post-registration clinical experience;

(c) completion of (or enrolment in) a Master's degree relevant to Nurse Practitioner practice; and

(d) demonstration of advanced clinical competence and clinical governance arrangements.

18 In the mid to late 2000s, the Master's degree requirement became standardised, usually a Master of Nursing (Nurse Practitioner). Education focused on advanced assessment, diagnostics, pharmacology, prescribing, clinical decision-making, and evidence-based care. Nurse Practitioner endorsement was clearly separated from Registered Nurse registration, reflecting a higher level of practice and responsibility.

19 In 2010, national registration and accreditation commenced under the Australian Health Practitioner Regulation Agency ("AHPRA"). From this point, Nurse Practitioner endorsement became nationally regulated, with consistent standards across Australia. Endorsed Nurse Practitioners were formally recognised as holding an advanced and distinct scope of practice, with protected title and regulatory obligations.

20 Entry requirements have remained rigorous and consistent including:

(a) Registered Nurse registration;

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(b) Advanced clinical experience;

(c) Completion of an approved Master's degree;

(d) Compliance with endorsement standards; and

(e) Ongoing continuing professional development specific to advanced practice.

21. The role has expanded across primary care, acute care, aged care, mental health, rural and remote services, and telehealth, without lowering entry standards.

Endorsement

22. The requirements to be endorsed as a Nurse Practitioner in Australia today are set out in AHPRA's 'Registration Standard: Endorsement as a Nurse Practitioner' and 'Guidelines for nurses applying for endorsement as a nurse practitioner'. Annexed and marked **DL2** and **DL3** respectively are copies of those documents.

23. To be endorsed as a Nurse Practitioner in Australia today, the process requires:

(a) Registration as a Registered Nurse - A Nurse Practitioner must first be a Registered Nurse and meet all registration standards;

(b) Advanced clinical experience and demonstrated competence at an advanced level - The nurse must demonstrate substantial experience at an advanced level of practice in a defined clinical area, and show that they can practice autonomously, make complex clinical decisions and manage clinical risk;

(c) Completion of an approved Master's degree - This is typically a *Master of Nursing (Nurse Practitioner)* and includes advanced pharmacology, diagnostics, clinical reasoning, prescribing, and evidence-based practice;

(d) Formal endorsement by the national regulator - Endorsement is granted by AHPRA and is separate from RN registration;

(e) Ongoing obligations - Nurse Practitioners must meet additional continuing professional development and recency-of-practice requirements to maintain endorsement, and comply with professional and legal obligations associated with prescribing and independent clinical decision-making.

24 As set out in the Registration Standard and Guidelines, nurses are required to produce evidence of the equivalent of three years' (5,000 hours) full-time experience at an advanced practice level within the prior six years. This requires clear documentation of the nurse's leadership, education activities, research, support of systems,

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autonomous practice, complex decision making and management of (and direct clinical care of people with) complex health conditions.

25 The current definition of 'advanced practice' is set out in AHPRA's 'Nurse practitioner standards for practice'. Annexed and marked **DL4** is a copy of those standards. It is emphasised that advanced practice in nursing is demonstrated by a level of practice – not by a job title or level of remuneration. Since about 2017, many applicants have used the 'Australian Advanced Practice Nursing Self-Appraisal Tool' (published by Gardner et al and the Queensland University of Technology) for the purposes of endorsement. Annexed and marked **DL5** is a copy of that tool.

26 Every year, Nurse Practitioners are required to complete 10 additional hours of continuing professional development relating to prescribing and administration of medicines, diagnostic investigations, consultation and referral. This is in addition to the 20 hours required of other nurses (30 hours in total). Annexed and marked **DL6** is a copy of AHPRA's Registration Standard: Continuing Professional Development.

27 Nurse Practitioners are required to hold their own professional indemnity insurance that specifically covers independent clinical practice. This insurance must cover:

(a) autonomous assessment and diagnosis;

(b) prescribing medicines;

(c) ordering and interpreting pathology and imaging;

(d) development and management of treatment plans; and

(e) legal liability for clinical decisions and patient outcomes.

28 The insurance is a condition of registration and endorsement under AHPRA. Importantly:

(a) Nurse Practitioner insurance is individual and role-specific;

(b) It reflects the higher risk and accountability associated with independent decision-making;

(c) Many Nurse Practitioners cannot rely solely on employer coverage and must ensure personal cover is adequate for their scope of practice.

29 The professional indemnity insurance requirements for Nurse Practitioners reflect a materially greater level of responsibility, risk and accountability.

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Scope of practice

30. A Nurse Practitioner's scope of practice describes the clinical services they are educated, authorised, and competent to provide. In practical terms, the Nurse Practitioner scope of practice includes:

(a) independently assessing patients;

(b) diagnosing health conditions;

(c) prescribing medicines;

(d) ordering and interpreting pathology and imaging;

(e) initiating and managing treatment plans;

(f) referring patients to other health professionals; and

(g) providing ongoing management of acute, chronic, and complex conditions.

31 A Nurse Practitioner's scope of practice is broader and more autonomous than that of a Registered Nurse. It is:

(a) based on the Nurse Practitioner's education, training, and experience;

(b) specific to a defined area of clinical practice; and

(c) exercised with full professional and legal accountability.

32 Nurse Practitioners are required to clearly define their scope of practice because they practise with a high level of autonomy and responsibility. Further key reasons include:

(a) Patient safety and quality of care - Defining scope of practice ensures the Nurse Practitioner only practises in areas where they have the appropriate education, experience, and competence. This protects patients and supports safe clinical decision-making.

(b) Regulatory accountability - Under national regulation, Nurse Practitioners are personally accountable for their clinical decisions. A clearly defined scope allows regulators, employers, and the public to understand what the Nurse Practitioner is authorised to do and where responsibility sits.

(c) Independent decision-making authority – Given that Nurse Practitioners diagnose, prescribe, and manage care independently, their scope to do so must be explicit.

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(d) Legal and professional risk management - A defined scope of practice ensures the Nurse Practitioner's professional indemnity insurance appropriately covers their practice and clarifies liability if an adverse event occurs.

(e) Workforce and service clarity - Clearly defined scope of practice helps employers, funding bodies, and multidisciplinary teams understand how the Nurse Practitioner role contributes to service delivery and where it fits within the broader health workforce.

Definition and expansion

33. An individual Nurse Practitioner's scope of practice is defined by their education, experience, competence, regulatory standards, and practice context. Expansion of scope occurs through deliberate education and competency development.

34. A Nurse Practitioner's scope of practice is not fixed and is not the same for all Nurse Practitioners. It is defined by the intersection of four factors:

(a) Education and qualifications - The Nurse Practitioner's formal education, including their Master's degree and any additional accredited training, sets the foundation for what they are qualified to do.

(b) Clinical experience and demonstrated competence - Scope of practice is shaped by the Nurse Practitioner's actual experience in a defined area of practice. The Nurse Practitioner must be able to demonstrate competence in the specific clinical activities they undertake.

(c) Regulatory standards and professional requirements - The Nurse Practitioner must practise within the standards set by the national regulator, AHPRA, including endorsement standards, codes of conduct, and scope of practice principles.

(d) Clinical governance and practice context - Scope of practice is also influenced by the setting in which the Nurse Practitioner works, including the clinical governance arrangements, access to referral pathways, and risk management systems.

35 Together, these factors mean a Nurse Practitioner's scope of practice is individualised and evidence-based, and provides accountability.

36 A Nurse Practitioner expands their scope of practice through a structured and deliberate process, not informally or by default. This typically involves:

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(a) Additional education or training - The Nurse Practitioner completes further formal education, accredited courses, or supervised learning relevant to the expanded area of practice.

(b) Development of competence - The Nurse Practitioner gains experience in the new area, often with mentoring, peer review, or supervised practice, until competence can be achieved.

(c) Assessment of risk and capability - The Nurse Practitioner evaluates whether the expanded practice can be delivered safely, including consideration of clinical risk, patient complexity, and available supports.

(d) Alignment with governance and indemnity requirements - The expanded scope must be supported by appropriate clinical governance arrangements and covered by the Nurse Practitioner's professional indemnity insurance.

(e) Documentation and accountability - The Nurse Practitioner documents their expanded scope of practice as appropriate and ensures it aligns with regulatory standards and employer or service requirements.

37 Importantly, while expansion of scope is self-regulated, the Nurse Practitioner is accountable for ensuring they are competent and authorised to practise in the expanded area. AHPRA's 'Safety and quality guidelines for nurse practitioners' state that "[t]he scope of practice for an NP may change over time. If an NP decides to expand or change their scope of practice to meet the needs of their client group, then the NP must make sure they have the appropriate skills, knowledge and education to ensure they remain safe and competent to practise at the advanced practice level. This may include further postgraduate education and skill development. NPs planning to change scope are required to use the NMBA's Decision-making framework for nursing and midwifery. This will ensure that NPs are competent in their proposed expanded or new scope of practice. It is the responsibility of the NP, and where employed, an employer, to ensure that, should an NP be required to expand or change their scope of practice to meet the needs of a client group, they are educated, authorised and competent to perform their role." Annexed and marked **DL7** and **DL8** respectively are copies of the safety and quality guidelines for nurse practitioners and the decision-making framework for nursing and midwifery.

Legislative changes that have impacted Nurse Practitioner scope of practice

38. Legislative and regulatory changes since the early 2000s have progressively recognised, expanded, and clarified Nurse Practitioner scope of practice. These

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changes reflect a clear increase in the value of their work, consistent with higher skill, greater responsibility, and independent professional accountability.

39. Nurse Practitioner scope of practice in Australia has been shaped less by a single law and more by a series of legislative and regulatory changes over time. These changes have expanded and clarified Nurse Practitioner practice, rather than restricted it.

Introduction of Nurse Practitioner legislation (late 1990s-early 2000s)

40. States and territories introduced legislation in the late 1990s and early 2000s to formally authorise Nurse Practitioners. This legislation allowed suitably qualified nurses to diagnose conditions, prescribe medicines, order diagnostic tests and practise with greater autonomy.

41. This marked a significant expansion of scope of practice compared to Registered Nurse roles and created a new, legally recognised scope of autonomous advanced nursing practice.

National registration and regulation (2010)

42. In 2010, national registration commenced under AHPRA. Nurse Practitioner endorsement became nationally regulated and consistent across Australia. Scope of practice was no longer defined by state-based rules, but by national standards, education, and competence.

43. This provided clarity, consistency, and stronger legal recognition of Nurse Practitioner scope of practice, and provided for safer and more portable practice.

Changes to medicines and poisons legislation (ongoing)

44. State and territory medicines and poisons legislation has been progressively amended to recognise Nurse Practitioner prescribing authority.

45. These changes have enabled Nurse Practitioners to prescribe a wider range of medicines within their scope and competence.

46. Prescribing rights remain linked to the Nurse Practitioner's endorsement, education and defined scope of practice. But these changes have expanded and clarified the Nurse Practitioner's prescribing authority, and reinforced their autonomy and responsibility.

Medicare legislation and funding rules (from 2010 onwards)

47. Amendments to Commonwealth legislation governing Medicare have allowed Nurse Practitioners to access Medicare Benefits Schedule ("MBS") item numbers and prescribe Pharmaceutical Benefits Scheme ("PBS")-subsidised medicines.

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48. These legislative amendments have enabled Nurse Practitioners to practice in the Medicare system. However, Nurse Practitioners continue to have limited access to MBS item numbers, referrals and diagnostics compared to doctors, which can inhibit a Nurse Practitioner from working to their full scope of practice.

Contemporary reforms and scope-of-practice reviews (2020s)

49. Recent government-led scope-of-practice reforms have reinforced that scope is determined by education, competence, and regulation, and not by professional title alone.

50. These reforms support Nurse Practitioners working to their full scope of practice, particularly in primary care and underserved settings. This policy direction supports expansion and better utilisation of the Nurse Practitioner's scope of practice, even where funding or system barriers remain.

Removal of mandatory collaborative arrangements (2024)

51. Prior to 2024, legislation required Nurse Practitioners to have a formal 'collaborative arrangement' with a medical practitioner in order to access Medicare and the PBS.

52. This requirement was removed in November 2024 through Commonwealth legislative change. Nurse Practitioners are now recognised as independent practitioners for Medicare and PBS purposes. There is no longer a requirement for a doctor to 'sign off' on care provided by a Nurse Practitioner in order for patients or health providers to access Medicare and PBS subsidies. Critically, the legislative change served to recognise Nurse Practitioners as autonomous professionals who deliver high quality care to patients within their scope of practice.

53. The removal of collaborative arrangements has significantly strengthened autonomy and reduced artificial constraints on scope of practice.

Differences between Nurse Practitioners and Registered Nurses

54. Nurse Practitioners are Registered Nurses. But the scope of practice of a Nurse Practitioner is broader, more autonomous, and carries greater responsibility than that of a Registered Nurse. While both are regulated health professionals, the nature of the work, level of decision-making, and accountability are fundamentally different. The table below sets out some of the differences.

Aspect of scope of practice	**Nurse Practitioner**	**Registered Nurse**	**Key difference**

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Level of autonomy	Practises independently within their defined scope. Makes clinical decisions without delegated authority Directly accountable for diagnosis, prescribing, and treatment decisions.	Practises within a professional scope that is commonly delegated, supervised, or protocol-driven. Clinical decisions are usually made within organisational policies or under medical direction	Nurse Practitioners exercise significantly greater autonomy.
Clinical decision making and responsibility	Conducts comprehensive assessments, including diagnosing health conditions. Initiates and manages treatmen plans. Holds full legal and professional responsibility for clinical outcomes.	Assesses and monitors patients and implements care. Escalates findings and contributes to care planning. Does not usually carry sole responsibility for diagnosis or treatment decisions.	Nurse Practitioners carry higher responsibility and accountability.
Prescribing and diagnostics	Prescribes medicines independently within scope.	Administers medicines and treatments prescribed by others.	Nurse Practitioners undertake expanded and higher-risk clinical functions.

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	Orders and interprets pathology and diagnostic imaging. Refers patients directly to other health professionals and services.	May order limited tests under protocols but does not independently diagnose or prescribe.	
Scope definition and accountability	Must individually define and maintain their scope of practice. Personally accountable to the regulator for practising within that scope. Must hold individual professional indemnity insurance reflecting autonomous practice.	Scope is generally defined by role description, employer policies, and delegation. Accountability is shared within organisational structures.	Nurse Practitioners carry greater personal accountability and legal risk.
Education and regulatory status	Requires a Master's degree and separate regulatory endorsement. Subject to additional regulatory standards and ongoing obligations.	Requires an undergraduate qualification. Registered at a generalist level without endorsement fo autonomous practice.	Nurse Practitioners have higher qualification, continuing professional development and regulatory requirements.

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Nature of the work of a Nurse Practitioner

55. The work of a Nurse Practitioner involves advanced, autonomous clinical practice with direct responsibility for patient care and outcomes.

56. Nurse Practitioners provide care that involves independent clinical decision-making, rather than delegated or task-based work. They assess patients, diagnose health conditions, prescribe medicines, order and interpret tests, and develop and manage treatment plans within their defined scope of practice.

57. The work is clinically complex. Nurse Practitioners manage patients with undifferentiated symptoms, acute illness, chronic disease, and multiple co-existing conditions. This requires advanced clinical reasoning, risk assessment, and judgement, often in situations where decisions must be made without immediate access to another clinician.

58. Nurse Practitioners commonly work in settings where access to care is limited or demand is high, such as primary care, urgent and after-hours services, rural and remote communities, aged care, and telehealth. In these environments, Nurse Practitioners often act as the first point of clinical contact and are responsible for determining diagnosis, treatment, referral, or escalation.

59. The work also carries significant legal and professional accountability. Nurse Practitioners are personally responsible for their clinical decisions, must practice within a clearly defined scope, and are required to hold individual professional indemnity insurance. Errors or omissions directly attach to the Nurse Practitioner's professional responsibility.

60. In addition to direct patient care, Nurse Practitioner work frequently includes:

    (a) coordinating care across services and sectors;

    (b) leading clinical decision-making within multidisciplinary teams;

    (c) contributing to service design and quality improvement; and

    (d) educating and supporting other clinicians.

Independence and collaboration

61. Nurse Practitioners practise as independent advanced clinicians who collaborate with but are not supervised by, other health professionals. Their role is fundamentally

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different in nature, responsibility, and work value from Registered Nurses (including senior Registered Nurses and Nurse Unit Managers), and doctors.

62 Nurse Practitioners practise independently within their defined scope of practice. This means they do not require delegated authority from another health professional to provide care. Clinical responsibility sits with the Nurse Practitioner, not with another practitioner or the organisation.

63 Independence does not mean isolation. It means the Nurse Practitioner has the authority, competence, and accountability to make decisions in their own right. Nurse Practitioners work collaboratively as part of multidisciplinary teams, particularly in primary care, urgent care, hospitals, aged care, and community settings. Collaboration typically involves:

(a) consulting with GPs, specialists, allied health professionals, pharmacists, and nurses when clinically appropriate;

(b) referring patients for specialist assessment or ongoing management;

(c) coordinating care across services and sectors; and

(d) contributing advanced clinical input to shared decision-making.

64 Collaboration is professional and clinical, not supervisory. Other health professionals do not direct the Nurse Practitioner's practice, but work alongside them, each practising within their own scope.

65 Even at senior levels, the Registered Nurse role is not authorised for independent diagnosis, prescribing, or autonomous medical decision-making. A Nurse Practitioner has clinical authority, it is not only a senior nursing role.

66. Doctors and Nurse Practitioners both practice independently. They come from different educational and professional frameworks and bring different clinical perspectives. Nurse Practitioners bring a nursing philosophy to their role. Doctors and Nurse Practitioners complement each other rather than being interchangeable.

The value of Nurse Practitioners to the Australian health care system

67. Nurse Practitioners provide high-value, advanced clinical care that improves access, continuity, quality, and efficiency across the Australian health care system. Their value lies not only in what they do, but in how and where they do it.

68. Nurse Practitioners improve and expand access to timely care, particularly in primary health care, rural and remote communities, aged care, urgent and after-hours services, and telehealth and community-based care. They often act as the first point of contact,

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reducing delays and ensuring people receive care earlier, before conditions deteriorate.

69 Nurse Practitioners manage complex conditions including chronic disease, multimorbidity, and complex and undifferentiated presentations. They provide continuity of care, coordinate services, and support long-term management, which reduces avoidable hospital admissions and emergency department presentations.

70 Nurse Practitioners strengthen multidisciplinary team-based care by working collaboratively with GPs and medical specialists, nurses and midwives, allied health professionals and pharmacists. They bring a nursing perspective combined with advanced clinical authority, enhancing team function and ensuring care is coordinated and patient-centred.

71 Nurse Practitioners improve system efficiency and sustainability. By working to their full scope of practice, Nurse Practitioners reduce pressure on doctors and hospitals, enable care to be delivered in the most appropriate setting, and provide cost-effective care without compromising quality. This is particularly important as demand increases due to ageing populations and chronic disease.

72 Nurse Practitioners increase workforce flexibility and resilience by filling service gaps, leading innovative models of care, and stabilising services in hard-to-staff settings. Their ability to work autonomously makes them a critical part of a resilient health workforce.

73 Nurse Practitioners are utilised across the Australian health care system wherever advanced, autonomous clinical care is needed. They work in primary health care and general practice, hospitals and emergency departments, after-hours and urgent care services, rural and remote communities, aged care, mental health and specialist clinics, and increasingly in telehealth and virtual care. In many of these settings, Nurse Practitioners are the first point of clinical contact and are relied on to assess, diagnose, prescribe, and manage care independently, often in high-demand or resource-constrained environments. Their use across such a wide range of settings reflects the high level of skill, responsibility, and trust placed in them.

74 There are approximately 3,100 endorsed Nurse Practitioners registered and working in Australia. This figure reflects the total number of Nurse Practitioners who have attained endorsement and are recognised on the national register and in workforce surveys. The number has been increasing over time as more nurses complete the required qualifications and endorsement process.

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75. For context, Nurse Practitioners are a small proportion of the overall nursing workforce (which totals several hundred thousand Registered Nurses), underscoring that the Nurse Practitioner role is relatively specialised and advanced within the health system.

Recent changes in the work of Nurse Practitioners

76. Over the past 6-10 years, the work of Nurse Practitioners has expanded and intensified.

77. The nature of Nurse Practitioner work has shifted from being supplementary or service-specific to being core, frontline clinical care in many settings. Nurse Practitioners are more frequently the first point of contact for patients. They increasingly manage undifferentiated presentations, not just defined cohorts or protocols. Nurse Practitioner roles have expanded into primary care, aged care, urgent care, telehealth, hospital avoidance, and virtual care models. Nurse Practitioners now commonly provide end-to-end care, from initial assessment through diagnosis, treatment, follow-up, and referral.

78 The work has become broader in scope, more complex, and more central to service delivery.

79 The level of skill and responsibility required of Nurse Practitioners has increased materially. Nurse Practitioners are managing patients with greater complexity, including multimorbidity, polypharmacy, and social vulnerability. Clinical decision-making has become more risk-laden, particularly in primary care, aged care, and remote settings. The removal of mandatory collaborative arrangements in 2024 increased direct clinical accountability, with Nurse Practitioners practising more clearly as independent clinicians. Nurse Practitioners now carry greater responsibility for diagnostic decisions, prescribing and deprescribing, escalation and referral decisions, and clinical risk management.

80 The expectation is no longer that Nurse Practitioners operate with informal medical oversight, but that they hold and manage clinical risk themselves.

81 The conditions under which Nurse Practitioners work have also become more demanding. Nurse Practitioners increasingly work in high-pressure environments, including workforce-short settings, after-hours and urgent care, and aged care and community settings with limited on-site medical support. Telehealth and virtual care have also expanded, requiring independent decision-making without physical examination and management of diagnostic uncertainty. System pressures, including

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hospital avoidance targets and access shortfalls, mean Nurse Practitioners are often required to carry higher caseloads and greater clinical responsibility.

82 These conditions require advanced judgement, resilience, and professional accountability.

83 Over the last 6-10 years, Nurse Practitioner work has become more complex, more autonomous, and more central to health service delivery. Nurse Practitioners now manage more undifferentiated and high-risk clinical presentations, carry greater responsibility for diagnosis and prescribing, and work under more demanding conditions, particularly in primary care, aged care, urgent care, and telehealth.

84 As the number of Nurse Practitioners in Australia continues to grow, the diversity of environments in which they are employed continues to expand. The complexity of the work continues to increase. The population is ageing – which means that more people are living with multiple complex medical conditions which require multiple treatments (e.g. polypharmacy). The recent expansions of the PBS medicines that Nurse Practitioners can prescribe is a welcome development, as it allows Nurse Practitioners to practise to a fuller extent of their scope of practice, but it inevitably increases the complexity of the work as they are now managing a greater range of medicines.

85 Many higher acuity (sicker) patients who would have been treated in hospital in the past may now be treated in the community instead. Nurse Practitioners are leading models of care in many settings, dealing with urgent presentations, filling system gaps, and generally practising with even greater autonomy.



Denise Lyons

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-1

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Curriculum Vitae – Denise Lyons

Personal Information

rse Practitioner), Master of
edentialed Nurse Immunise

[redacted]

University Qualifications Obtained

of Newcastle (Newcastle, Australia)
1996 - Master of Education (Health Promotion and Human Behavior), University of Georgia (Athens, Georgia, USA) –Phi Kappa Phi (honour society)
1985 - Bachelor of Science in Nursing, State University of New York College of Technology (Utica New York, USA) – graduated cum laude (with honours)

Other Relevant Education/Qualifications Obtained

2022 Certificate in Clinical Governance for Patient Safety and Quality Care - Australasian Institute of Clinical Governance
2020 Immunisation Program – Registered Nurse Health (Drugs and Poisons) Regulation 1996 (QLD)
2019 Maternity Emergency Care (MEC) - CRANA
2019 Remote Emergency Care (CRANA) - CRANA
2018 Advanced Life support
2016 Paediatric Resuscitation
2012 Wound Closure Certificate
2012 Certificate in Sexual and Reproductive Health (Family Planning NSW)
2011 TAFE Statement in Traditional and Contemporary Aboriginal Cultures
2011 TAFE Statement in Partnering with Aboriginal Communities
2011 Aboriginal and Torres Strait Islander Cultural Competence Course (Centre for Cultural Competence Australia)
2009 Certificate in Well Woman's Screening (Family Planning NSW)
2008 Certificate IV in Workplace Training and Assessment (HBA Consulting Group)
2008 Course in Ear Irrigation Using Low Pressure Ear Irrigation Devices (Benchmarque Group)
2009 Certificate in Immunisation for Registered Nurses (NSW College of Nursing)
2007 The NIX Program (Nurse Initiated X-ray Program) (Hunter New England Health)
2006 Short Course in Diabetes Education and Management for Nurses (UTS)
2002 Human Resource Management subject (The College of Nursing)

Clinical / Procedural Skills (competent and observed)

Experienced in patient and family support including assessment, counseling, education regarding medications and treatment, care planning, and clinical treatments and procedures
Works at an advanced level of nursing practice to provide holistic care utilizing expert clinical knowledge, based on advanced specialised education and experience. Able to conduct an analysis of the impact of health breakdown and appropriateness of treatments being considered.

- Demonstrates complex decision making skills and expert clinical reasoning and

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diagnostic skills and has the ability to initiate and evaluate therapeutic management plans
- Expert assessment, diagnosis and management skills in relation to minor illnesses and injuries.
- Skilled in information technology and management, and is able to manage heavy daily patient volume including telephone triage, appointment scheduling, and patient referral
- Takes personal responsibility for actions and omissions, and fully recognises personal accountability and appropriately delegates aspects of care to others and accepts responsibility and accountability for such delegation
- Makes sound decisions about ongoing personal and professional development
- Practices within the scope of personal professional competence and extends scope as appropriate
- Works harmoniously and effectively with colleagues, patients and clients and their carers, families and friends
- Conducts self and practices within an ethical framework based upon respect for the well-being and safety of patients and clients
- Demonstrates evaluation skills relating to patient/family care and practice management

Work/Practice History

June 2022 – Present: [redacted] – employed as RN
Providing telehealth support for unwell children and their parents/carers across the Hunter New England LHD region.

Nov 2021 – May 2022: Authorised Nurse Immuniser - [redacted]
Based in [redacted], causal position in COVID mass vaccination hub.

2009 – Present: Nurse Practitioner (since Dec 2012)/Practice Nurse, [redacted]
Part time position (1- 2 days/week) daytime General Practice. The responsibilities of the role include providing care for patients with chronic and acute health problems who range in age from infancy to the elderly. Perform advanced, comprehensive, and holistic health assessments of clients and demonstrate dynamic, evidence-based, extended practice through the incorporation of expert clinical knowledge and skills. Demonstrate utilization of high level evidence to conduct comprehensive health assessments which may involve imaging or pathology tests, and develop and implement patient-centered management plans utilising both pharmacological and non-pharmacological agents. Autonomous practice is evident through nurse initiated imaging and pathology in accordance with evidence based guidelines.

Oct 2016 – Present: Clinical Editor/Nurse Practitioner [redacted]
Part time position (1- 2 days/week) Health Pathways is an online health information portal for GPs and other primary health clinicians, to be used at the point of care. It provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the most timely way. As I Clinical Editor, I am involved in writing evidence based clinical pathways, and liaising with local specialists ensuring they are clinically relevant and evidence based.

2013 – 2024: Nurse Practitioner, Arrotex
Casual, seasonal position providing pharmacy based primary health care, including COVID and influenza immunisations and wellness clinics/health screening. Responsibilities include providing support and education to pharmacists providing immunisations.

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June - Nov 2020 Acting CNC Public Health Torres and Cape HHS, Queensland Health and June – Aug 2021, Immunisation Nurse – COVID vaccine roll out
Based on Thursday Island, full time position. Responsibilities included providing support and education to clinicians providing immunisations during the introduction of a new immunisation schedule. Also involved in follow up and management of all reportable communicable diseases, including contact tracing during pandemic.

January 1999 – Oct 2016: Nurse Practitioner (since Nov 2012)/Practice Nurse, GP Access After Hours
GP Access, 123 King Street, Newcastle NSW 2300, Phone – 02 4952 2259
Part time position (2 – 3 shifts/week – variable hours and shift duration) after hours General Practice. The responsibilities of the role included providing care for patients with acute and urgent health problems who range in age from infancy to the elderly, in collaborative clinical relationships with GPs.

November 2006 – December 2009: Manager Training and Professional Development
GP Access, 123 King Street, Newcastle NSW 2300, Phone – 02 4952 2259
Part time position (2 days per week) GP Access, 123 King Street, Newcastle NSW 2300, Phone – 02 4952 2259
Responsibilities of the role included introducing the concept of quality improvement and clinical governance to General Practice teams. The role also involved undertaking a needs assessment and developing a comprehensive continuing professional development program for nurses working in General practice in the Hunter Region, and supporting nurses to take an active leadership role in the clinical environment, whilst also extending their clinical skills.

October 2002– November 2006: Clinic Manager, GP Access After Hours
GP Access, 123 King Street, Newcastle NSW 2300, Phone – 02 4952 2259
Part time position (2- 3 days per week) GP Access, 123 King Street, Newcastle NSW 2300, Phone – 02 4952 2259
In this role, I was able to advocate for the development of local health service policy that enhances nurse practitioner practice and the health of the community.

October 1998 - May 2002: Community Road Safety Officer
Maitland City Council. PO Box 220, Maitland NSW 2320, phone – 02 4934 9700

January 1998 - October 1998 : Health Promotion Officer
Hunter Centre for Health Advancement, Locked Bag 10, Wallsend NSW , phone – 024924 6000
Responsibilities included evaluating the impact of social factors on the health of individuals and communities and implementing population based health promotion programs. Key performance measures were measured in terms of ability to deliver programs targeting lifestyle behaviours and the influence of these factors on Hunter New England Area Health Service population. Position required a good understanding of financing of the health care system as it affects delivery of care. The Hunter Centre for Health Advancement aims to influence health care policy and practice. This role provided excellent opportunities to witness and practice leadership and active participation in workplace and professional organizations, at state and national government levels.

September 1992 - August 1997: Emergency Room Nurse (USA)
St Mary's Hospital, 1230 Baxter Street, Athens, GA, USA

September 1995 - August 1997 Sexual Assault Nurse Examiner (forensics)
The Cottage, Sexual Assault Center and Children's Advocacy Center (formerly Athens- Clarke County Rape Crisis Centre)
Provided post sexual assault health care as a Sexual Assault Nurse Examiner (SANE) in an interdisciplinary team, which focused on the minimization of trauma for victims by providing

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services in a supportive, caring, and healing environment.
September 1991- September 1992: Emergency Room Nurse (USA)
St Francis Hospital, 35 North Road, Poughkeepsie, NY, USA

1986-1991: Paediatric Nurse (USA)
Worked for various agencies in various hospitals across the USA on temporary contracts (3 – 6 months at a time), in a range of paediatric inpatient units.

1985 – 1991: The Fresh Air Fund (USA) summer camp nurse
Responsible for all health-related care of campers and staff at camp. Duties include: medication, distribution, health education teaching and maintenance, emergency care, referrals to camp doctor, nursing care of campers and staff requiring short-term bed rest, communication of pertinent medical information to The Fresh Air Fund office and parents, and maintaining medical records and logs.

1985-1986: Paediatric Nurse (USA)
Children's Hospital National Medical Centre, Washington, DC, USA

Gaps in Work/Practice History

May 2002 – Oct 2002 – maternity leave
August 1997 – January 1998 – overseas travel and inter-country relocation

Registration History

Current Registration – Registered Nurse, Endorsed Nurse Practitioner NMW0001296690 exp 31/5/26
Previous Registration – in the USA: New York State, District of Columbia, Georgia, Arizona, California, Virginia

Evidence of professional activities demonstrating clinical leadership

- 2017 – 2020 and June 2023 - present : Australian Primary Care Nurses Association – elected Board member, and President from June 2025.
- 2024 – present: Member Primary Care and Workforce Reviews Expert Panel (DoHDA)
- 2024 – present: Member Strengthening Medicare Implementation Oversight Committee (DoHDA)
- 2024 – present: Member Nurse Practitioner Workforce Plan Implementation Advisory Group (IAG) (DoHAC)
- 2023 – 2024: Unleashing the Potential of Our Health Workforce (Scope of Practice Review) Expert Advisory Committee (DoHAC)
- 2023 - 2024: Member Chronic Disease Management Plans Implementation Liaison Group (ILG) as well as the Chronic Disease Management Plans Communications Working Group (CWG) (DoHAC)
- 2023 – 2024: Member Expert Advisory Panel for the Review of General Practice Incentives and the Review of Primary Care After Hours Programs (DoHAC)
- 2018 – 2020: Member National Immunisation Committee (DoHAC)
- 2012 – 2020: member of the National Prescribing Service Nurse Insight Group
- 2011 – 2024: member of Hunter New England Central Coast Primary Health Network Clinician Advisory Committee
- 2010 – Present: Member of Hunter Post Graduate Medical Institute CPD Program committee – involved in planning and organising inter-disciplinary education for health

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care teams working in primary care.

- Membership in professional organizations
  - Australian College of Nurse Practitioners
  - Australian Nursing Federation
  - Australian Primary Care Nurses Association
- Invited speaker at several nursing and primary care conferences and workshops, including:
  - RCNA 4th National General Practice Nurse Conference (13th Oct 2006) “Prioritising Patients in General Practice”
  - RCNA Primary Health Care Conference, Adelaide (9th Nov 2009) “Improving Diabetes Management in General Practice
  - GP New South Wales Nursing in General Practice Conference (10th July 2010) “A Role for Nurse Practitioners in General Practice”
  - Australian Primary Care Nurse Association (May 2015) “Advance Care Planning”
  - Hunter Postgraduate Medical Institute (August 2019) “Fracture Prevention in Primary Care”
  - Australian Primary Care Nurse Association (July 2025) Opening Plenary and panel discussions relating to primary health care reform.
  - Australian Digital Health Agency (Oct 2025) Panel speaker on digitally connected health care

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-2

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Nursing and Midwifery Board of Australia

REGISTRATION STANDARD: ENDORSEMENT AS A NURSE PRACTITIONER

1 June 2016

NMP0004

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

REGISTRATION STANDARD ENDORSEMENT AS A NURSE PRACTITIONER

Nursing and Midwifery Board of Australia

Summary

This registration standard sets out the Nursing and Midwifery Board of Australia's (NMBA) requirements for endorsement as a nurse practitioner under section 95 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

Does this standard apply to me?

This registration standard applies to nurses and nurse practitioners who hold registration as a nurse in Australia, who are applying for, or maintaining, endorsement as a nurse practitioner.

What must I do?

When applying for endorsement as a nurse practitioner, a nurse must be able to demonstrate all of the following

1. Current general registration as a registered nurse in Australia with no conditions or undertakings relating to unsatisfactory professional performance or unprofessional conduct.
2. The equivalent of three years' full-time experience (5,000 hours) at the clinical advanced nursing practice level, within the past six years, from the date when the complete application seeking endorsement as a nurse practitioner is received by the NMBA.
3 Successful completion of:
   - an NMBA-approved program of study leading to endorsement as a nurse practitioner, or
   - a program that is substantially equivalent to an NMBA-approved program of study leading to endorsement as a nurse practitioner as determined by the NMBA.
4. Compliance with the NMBA's *Nurse practitioner standards for practice*.

Ongoing requirements for endorsement

Ongoing endorsement by the NMBA is conditional on the nurse practitioner complying with the current:

1 NMBA-approved *Continuing professional developmen registration standard*, *Recency of practice registration standard*, *Criminal history registration standard*, and *Professional indemnity insurance arrangements registration standard*, and

2. *Safety and quality guidelines for nurse practitioners* and any other applicable codes and guidelines approved by the NMBA.

What does this mean for me?

At renewal of registration

When you apply to renew your registration, you need to declare that you comply with the ongoing eligibility requirements for endorsement as set out in this registration standard.

Nurse practitioners need to demonstrate recency of practice at the advanced practice nursing level to retain the endorsement.

During the registration period

Your compliance with this registration standard may be audited from time to time and may also be checked if th NMBA receives a notification about you.

Evidence

You should retain records as evidence that you meet the requirements of this registration standard in case you are audited.

What happens if I don't meet this standard?

If you don't meet the criteria of this registration standard you will not be eligible for endorsement as a nurse practitioner.

The National Law establishes possible consequences if you do not meet the ongoing requirements of this registration standard, including that:

- the NMBA can impose conditions on your registration/endorsement or refuse renewal of

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registration/endorsement (sections 82 and 112 of the National Law), and

- registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct, for the nursing and midwifery professions (section 41 of the National Law).

Safety and quality guidelines for nurse practitioners

The *Safety and quality guidelines for nurse practitioners* outline the regulatory requirements for nurse practitioners providing clarity and support to practise i their role as a nurse practitioner.

Guidelines for registered nurses applying for endorsement as a nurse practitioner

The *Guidelines: For nurses applying for endorsement as nurse practitioner* provide guidance about how to meet the requirements of the registration standard. You are expected to apply these guidelines together with the registration standard in your application.

Authority

This registration standard was approved by the Australian Health Workforce Ministerial Council on 30 October 2015.

Registration standards are developed under section 38 of the National Law and are subject to wide-ranging consultation.

Definitions

Advanced nursing practice is defined as a continuum along which nurses develop their professional knowledge, clinical reasoning and judgement, skills and behaviours to higher levels of capability (that is recognisable).

Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effectiv and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex health care requirements.

Advanced nursing practice is a level of practice and not a role. It is acknowledged that advanced nursing practice is individually attributed within a regulated nursing scope (enrolled nurse, registered nurse or nurse practitioner). Advanced nursing practice for the purpose of the 5,000 hours required is not related to a job title or remuneration.

Advanced practice nurse is a nurse practising in the advanced practice role.

Advanced practice nursing as a nurse practitioner is a qualitatively different level of advanced nursing practice to that of the registered nurse due to the additional legislative functions and the regulatory requirements. The requirements include a prescribed educational leve a specified advanced nursing practice experience, and continuing professional development.

Advanced practice nursing should not be confused with the term 'practice nurse' that is used commonly to describe nurses working in the general practice setting.

Approved program of study means a postgraduate nursing masters degree approved by the NMBA under section 49 of the National Law and included in the NMBA-approved list of programs of study for endorsement as a nurse practitioner. This includes NMBA-approved masters level units in advanced health assessment, pharmacology for prescribing, therapeutics and diagnostics and research.

General registration as a nurse means a person whose name is entered on the Register of Nurses in the division of registered nurses in the general category.

Nurse practitioner is an advanced practice nurse endorsed by the NMBA who has direct clinical contact

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and practises within their scope under the legislatively protected title 'nurse practitioner' under the National Law

Program that is substantially equivalent means a postgraduate nursing masters degree that is relevant, clinically, to the context of the applicant's advanced nursing practice, for which they are seeking endorsement as a nurse practitioner, and who have completed appropriate supplementary education. Supplementary education includes advanced health assessment, pharmacology for prescribing, therapeutics and diagnostics and research, however titled. Applicants will need to map evidence for assessment against the *Nurse practitioner standards for practice*.

Standards for practice are those standards outlined in the *Nurse practitioner standards for practice* (2014).

Unprofessional conduct of a registered health practitioner means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes:

a. a contravention by the practitioner of the National Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention

b. contravention by the practitioner of: (i) a condition to which the practitioner's registration was subject; or (ii) an undertaking given by the practitioner to the National Board that registers the practitioner

c. the conviction of the practitioner for an offence unde another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession

d. providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being

e. influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care

f. accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider

g. offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner, and

h. referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

Unsatisfactory professional performance of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience.

Note: The NMBA and Australian Health Practitioner Regulation Agency (AHPRA) operate in a co-regulatory model in some jurisdictions and may not be the only entities involved in completing assessment related to a notification.

In co-regulatory definitions these terms may be described differently but have the same intent.

Review

This registration standard will be reviewed from time to time as required. This will generally be a least every five years.

Last reviewed: 1 June 2016

This standard replaces the previously published registration standard dated 4 April 2011.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-3

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Guidelines

Updated December 2022

For nurses applying for endorsement as a nurse practitioner

Introduction

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia and one of its key roles is to protect the public. The NMBA does this by developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements of the professional practice framework for the professional and safe practice of nurses and midwives in Australia.

These guidelines must be used to supplement the Registration standard: Endorsement as a nurse practitioner. The guidelines provide further information about the requirements for registered nurses (RNs) applying for an endorsement as a nurse practitioner (NP).

Who do these guidelines apply to?

These guidelines apply to RNs who hold general registration as a nurse in Australia and who are applying for endorsement as an NP.

Note: The admission to, and completion of, an NMBA-approved program of study does not grant immediate endorsement as an NP. Entry to a program of study is determined by the NP accreditation standards and admission criteria of the education provider. Endorsement as an NP is subject to the applicant meeting the requirements of the NMBA *Registration standard: Endorsement as a nurse practitioner* and associated guidelines.

Requirements for endorsement as an NP

The *Registration standard: Endorsement as a nurse practitioner* (the registration standard) state that a nurse seeking endorsement as an NP must be able to demonstrate the following:

1. Current general registration as an RN in Australia with no conditions or undertakings on their registration relating to unsatisfactory professional performance or unprofessional conduct.

2. The equivalent of three years' (5,000 hours) full-time experience at an advanced practice level, within the past six years, from the date when the application seeking endorsement as an NP is received by the NMBA.

Note: Advanced practice hours that are part of an NMBA-approved program of study **cannot** be included as evidence towards the 5,000 hours of advanced practice.

3. Successful completion of:

   - **Pathway 1**: an NMBA-approved program of study leading to endorsement as an NP

     or

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- **Pathway 2**: a program that is substantially equivalent to an NMBA-approved program of study leading to endorsement as an NP, as determined by the NMBA.

4. Compliance with the NMBA Nurse practitioner standards for practice.

Your application

Applicants are required to complete the AENP-40 Application for endorsement as a nurse practitioner form, which is located on the NMBA website, and attach supporting documentation.

Your complete application must address the requirements of the registration standard as listed above, by providing evidence as described in these guidelines.



Note: It is your responsibility to ensure your application is complete at the time of submission. An application will not be considered unless it is complete, and all supporting documentation has been provided. An incomplete application will delay the progress and assessment of the endorsement application.

Further detail to assist in the submission of a complete application is provided in **Table 1: Evidence model for RNs applying for endorsement as an NP**. The table can also be used as a checklist for the required documents.

Table 1: Evidence model for RNs applying for endorsement as an NP

Requirement	Evidence	Check
1. Current general registration as an RN in Australia with no conditions or undertakings on registration relating to unsatisfactory professional performance or unprofessional conduct.	Your current registration status will be checked by Ahpra staff on receipt of your application. You **do not** need to submit evidence of your registration as a nurse in Australia.	☐
2. The equivalent of three years' (5,000 hours) full-time experience at an advanced practice level, within the past six years, taken from the date when the complete application seeking endorsement as an NP is received by the NMBA.	You are required to provide evidence of practising at the advanced practice level in accordance with the NMBA definition. This means you must clearly document examples of the following in your application: • Leadership • Education activities • Research • Support of systems • Autonomous practice • Complex decision making • Management of, and direct clinical care of people with complex health conditions You can provide this evidence in your CV or through case studies. If you choose to provide case studies these cannot be the same as case studies used for your Master of Nursing (NP) program.	☐

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Requirement	Evidence	Check
	Statement/s of service The Statement of service is provided as part of your application to support your 5,000 hours of advanced practice The Statement of service should clearly reflect the evidence you have provided in your CV and: • be on the employer's letterhead • be dated and signed by the Director of Nursing or equivalent • detail the title of your advanced practice, dates of employment and hours • detail any periods of extended leave (e.g. long service leave, maternity/paternity or extended sick leave). • provide a breakdown/percentage of hours of any position that includes indirect or non-clinical components, such as management or education • be **correctly certified** – refer to Ahpra's guidance on certification of documents **Note**: Self-employed nurses may provide a statutory declaration as their proof of service **Curriculum vitae (CV)** For guidance on CV format refer to the Ahpra guidelines Standard format for curriculum vitae. The CV must clearly mirror the information provided in the Statement of Service from your employer/s or in the letter of support if this is how evidence of hours is provided: The CV will include: • primary qualification/s • post graduate qualification/s • education and/or study relevant to specialist area of practice • a breakdown/percentage of hours that you spend in each role providing both direct clinical care and performing other indirect or non-clinical duties. This will require third-party verification from your employer • detail that demonstrates responsibility and accountability for the management and direct clinical care of people with complex healthcare requirements • detail that shows the evidence of the clinical domain of practice that integrates with the other three NP domains of practice of professional leadership, education and research. (For example- published research and/or application of research into evidence-based practice and/or policy and procedures at local, state or national level)	☐ ☐

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Requirement	Evidence	Check
	Other professional activities • attendance and/or presentations at forums and conferences • active participation in a professional organisation • published articles **Letters of support** Letters of support can be used where the applicant is providing hours of service that cannot be provided by a formal Statement of service. A letter of support must: • be provided on letterheaded paper • be correctly certified • be from a registered health practitioner from the same practice setting/ place of practice/ same area of practice subtype if they are providing support of advanced practice hours and evidence to support advanced practice	☐ ☐
3. Qualification **Pathway 1** Successful completion of a NMBA-approved program o study leading to endorsement as an NP **Pathway 2** a program that is substantially equivalent to an NMBA-approved program of study leading to endorsement as an NP as determined by the NMBA	Evidence to include: • Education details, such as a certified copy of the relevant (original) masters qualification, and transcript with results key • My eQuals You will be contacted by an assessor upon review of your application to provide access details to the My eQuals portal. You may submit your qualification by: • sending a secure My eQuals URL by email, or • downloading a copy of your qualification in PDF forma from My eQuals and sending it by email. This copy must have the blue banner at the top of the document stating, "Certified by (issuing university)". A valid signature is required. Evidence to include: • a postgraduate nursing **masters degree** that is clinically relevant to the applicant's context of advanced practice nursing for which they are seeking endorsement as an NP • evidence of completion of **masters level** units in **advanced health assessment**, **pharmacology** and **therapeutics and diagnostics and research**, however titled. The evidence required is the unit outlines for the units studied and the year studied.	☐ ☐
4. Evidence of meeting the NMBA *Nurse practitioner standards for practice*.	Applicants who have completed an NMBA-approved NP program of study are generally not required to provide evidence of meeting the *Nurse practitioner standards for practice* as this is evidenced through the completion of your program of study. However, on occasion, this may be asked for if further evidence to support your application is required.	☐

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Requirement	Evidence	Check
	An applicant following **Pathway 2** is required to provide information about the masters qualification you have provided including: • Mapping of your units of study to evidence advanced practice as defined by the *Nurse practitioner standards for practice*. This will assist with establishing a qualification that is substantially equivalent • Position description/s • Narratives	☐

For more information

- Registration standard: Endorsement as a nurse practitioner
- Fact sheet: Nurse practitioner standards of practice
- Nurse practitioner standards for practice
- Registration Standard: Recency of practice
- Position Statement: Nurses and cosmetic medical procedures
- Audit information on the NMBA website
- Ahpra's guidance on certification of documents
- Standard format for curriculum vitae
- Visit www.nursingmidwiferyboard.gov.au under *Contact us* to lodge an online enquiry form
- For registration enquiries: 1300 419 495 (within Australia) +61 3 9275 9009 (overseas callers)

Document history

Approved by: Nursing and Midwifery Board of Australia

Date commenced: December 2022

Next review due: December 2027

Policy history: Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y**
If so which version **v2.0**
Does this policy replace another policy with a different title? **N**

Approval date	Version	Reason for change
December 2022	v3.0	Clarification on the evidence required to support the application Inclusion of an evidence checklist
October 2021	v2.0	Amended to include revised definition of advanced practice
June 2016	v1.0	

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-4

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Nursing and Midwifery Board Ahpra

Nursing and Midwifery Board of Australia

Nurse practitioner standard for practice

Effective from: 1 March 2021

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Orientating statements

Nurse practitioners (NPs) provide high levels of clinically focused, autonomous nursing care in a variety of contexts within Australia. NPs care for people and communities with problems of varying complexity.

The NP scope of practice is built on the platform of the registered nurse (RN) scope of practice and must meet the regulatory and professional requirements for Australia including the Nursing and Midwifery Board of Australia (NMBA) Registered nurse standards for practice, Safety and quality guidelines for nurse practitioners, Code of conduct for nurses and International Council of Nurses' Code of ethics for nurses.

The *Nurse practitioner standards for practice* (the standards) build on, and expand upon, those required of an RN. NPs understand the changes in the scope of practice from that of an RN, and the ways that these changes affect responsibilities and accountabilities. NPs are RNs endorsed as an NP by the NMBA and practice at an advanced level. NPs can practice independently and work collaboratively in multi-professional environments.

The standards in this document are the minimum standards that are applicable across diverse practice settings and patient/client populations for both beginning and experienced NPs.

NP attributes are consciously cultivated through formal learning that includes a work-based component. In Australia, the educational requirement for endorsement of NPs is a Master's degree. This formal learning builds on demonstrable advanced practice within the RN scope.

NPs have a high degree of systems literacy and can independently manage care across a variety of health systems to maximise outcomes. NPs engage in support of systems; complex and critical thinking; integrate information and/or evidence; judiciously use clinical investigations; and skilfully and empathetically communicate with all involved in the care episode, including the person receiving care and their family and community, and health professional colleagues.

NP attributes are clinically focused, and NPs are capable in research, education and leadership as applied to clinical care (Refer Figure 1). Research includes leading processes that stimulates improved or new evidence-based care and quality management. NPs educate others related to the focus of, and available options, of care. NPs are leaders and lead care and care teams. NPs engage in reflective practice and support others in this process through clinical supervision or mentoring.

NPs can manage and are accountable for, complete episodes of care including wellness focused care, as the primary provider of care or part of a care team. NPs collaborate and consult with health consumers, their families and community, and other professionals, including health personnel, to plan, implement and evaluate integrated care that optimises outcomes for recipients, their progression through the health system and access to relevant systems of care.

As part of providing care, NPs can independently request and interpret any diagnostic and/or screening investigations within their scope of practice to facilitate diagnosis and/or screening processes. This informs diagnosis and care planning. Care can include nursing interventions that involve initiation, titration or cessation o any medicines in their scope. NPs practice encompasses technical and procedural skills that are applied as part of their responsibility in initiating and managing complex healthcare requirements. NPs take responsibility for following-up on any components of care initiated. They are accountable for care provided and self-monitor their work.

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How to use these standards

The standards have been written so as to be easily accessible to a variety of groups, including NPs, governments, regulatory agencies, education providers, healthcare professionals and the community. It should be noted that the criteria written below the Statements are indicative of NP behaviours, they are not intended to be exhaustive Rather, they are examples of activities that demonstrate the statement for that standard.

These standards should be read in conjunction with other relevant NMBA documentation, and in conjunction with the attached Glossary, which clearly describes the way in which key terms are used in the standards.

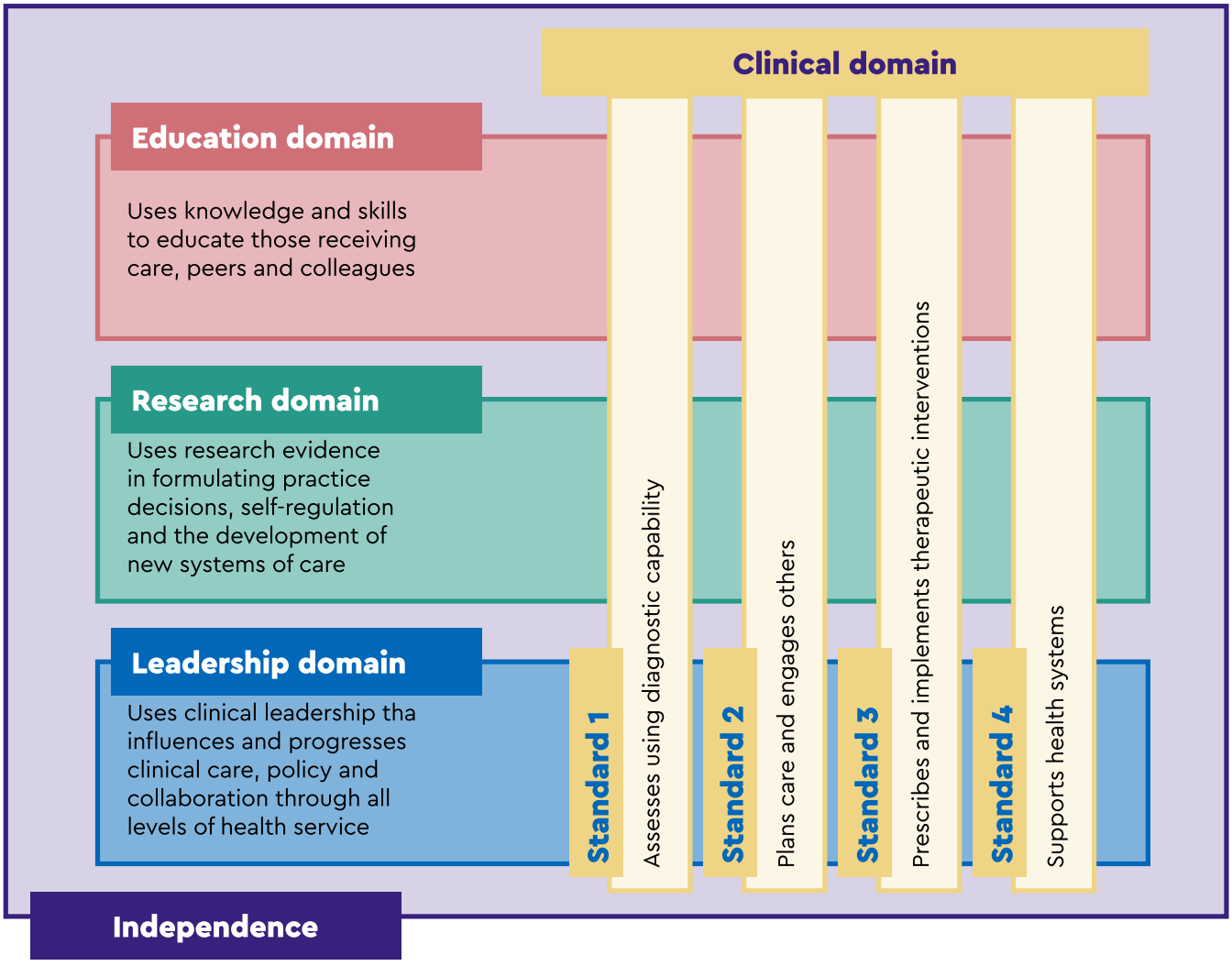
In Figure 1, the Nurse practitioner standards framework is illustrated. The four domains are:

- clinical
- education
- research, and
- leadership.

The expression of the knowledge and skills contained in the education, research and leadership domains is integrated across the four clinically focused standards.

Collectively, these attributes expressed in NPs' knowledge, skills and affect, are applied in the education domain through educating those receiving care, peers and colleagues. The use of knowledge in the research domain is evidenced through the judicious application of research evidence in formulating practice decisions, self-regulation and the improvement to and development of new systems of care. The domain of leadership, initially evident in clinical work, increases in capacity to all levels of health services and includes community and political engagement.

Figure 1: Nurse practitioner standards framework



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Nurse practitioner standards

Standard 1: Assesses using diagnostic capability

Statement 1.1 NPs demonstrate complex and critical thinking to conduct comprehensive, relevant and holistic health assessments

The NP:

1.1.1 demonstrates extensive knowledge of human sciences and health assessment

1.1.2 demonstrates comprehensive and systematic skill in obtaining relevant, appropriate and accurate data that inform differential diagnoses

1.1.3 assesses the complex and/or unstable healthcare needs of the person receiving care through synthesis and prioritisation of historical and available data

1.1.4 assesses the impact of comorbidities, including the effects of co-existing, multiple pathologies and prior treatments in the assessment of the person receiving care

1.1.5 demonstrates comprehensive skill in clinical examination including physical, mental health, social, ethnic and cultural dimensions

1.1.6 consistently and accurately synthesises and interprets assessment information specifically history, including prior treatment outcomes, physical findings and diagnostic data to identify normal, at risk and abnormal states of health, and

1.1.7 critically evaluates the impact of social determinants of health on both the individual person and the population.

Statement 1.2: NPs demonstrate accountability in the timely and considered use of diagnostic investigations to inform clinical decision making

The NP:

1.2.1 makes decisions about the use of person-focused diagnostic investigations that are informed by clinical findings and research evidence

1.2.2 demonstrates accountability in considering access, cost, clinical efficacy and the informed decision of the person receiving care when requesting diagnostic investigations

1.2.3 requests and/or performs selected screening and diagnostic investigations

1.2.4 is responsible and accountable for the interpretation of results and for following-up the appropriate course of action, and

1.2.5 uses effective communication strategies to inform the person receiving care and relevant health professionals of the health assessment findings and diagnoses.

Statement 1.3: NPs integrate theoretical and practical knowledge to apply diagnostic reasoning to formulate diagnoses

The NP:

1.3.1 synthesises knowledge of developmental and life stages, epidemiology, pathophysiology, behavioural sciences, psychopathology, environmental risks, demographics and societal processes when making a diagnosis

1.3.2 considers the person's expectations of assessment, diagnosis and cost of healthcare

1.3.3acts to prevent and/or diagnose urgent, emergent and life-threatening situations, and

1.3.4 determines clinical significance in the formulation of an accurate diagnosis from an informed set of differential diagnoses through the integration of the person's history and best available evidence.

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Standard 2: Plans care and engages others

Statement 2.1: NPs critically and ethically translate and integrate evidence-based knowledge into planning care

The NP:

2.1.1 takes personal responsibility to critically evaluate and integrate relevant research findings into decision making about healthcare management and interventions

2.1.2 ethically explores therapeutic options considering implications for care through the integration of assessment information, the person's informed decision and best available evidence, and

2.1.3 is proactive and analytical in acquiring new knowledge related to NP practice

Statement 2.2: NPs educate and support others to enable their active participation in care

The NP:

2.2.1 respects the rights of the person to make informed decisions throughout their health/illness experience or episode, whilst ensuring access to accurate and appropriately interpreted information

2.2.2 uses appropriate teaching/learning strategies to provide diagnostic information that is relevant, theory-based and evidence-informed

2.2.3 communicates about health assessment findings and/or diagnoses, including outcomes and prognosis, and

2.2.4 works to meet identified needs for educating others regarding clinical and ongoing care.

Statement 2.3: NPs consider quality use of medicines and therapeutic interventions using their comprehensive knowledge when planning care

The NP:

2.3.1 develops an individual plan of care and communicates this to appropriate members of the healthcare team and relevant agencies

2.3.2 exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to NP scope of practice

2.3.3 works in partnership with the person receiving care to determine therapeutic goals and options

2.3.4 verifies the suitability of evidence-based treatment options including medicines, in regard to commencing maintaining/titrating or ceasing interventions, and

2.3.5 demonstrates accountability in considering access, cost and clinical efficacy when planning treatment.

Statement 2.4: NPs collaborate and consult for care decisions to obtain optimal outcomes for the person receiving care

The NP:

2.4.1 collaborates with other health professionals to make and accept referrals as appropriate, and

2.4.2 consults with and/or refers to other health services, disability services, maternity services, aged-care providers and community agencies at any point in the care continuum.

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Standard 3: Prescribes and implements therapeutic interventions

Statement 3.1: NPs use professional knowledge when prescribing indicated non-pharmacological and pharmacological interventions

The NP:

3.1.1 contributes to health literacy by sharing knowledge with the person receiving care to achieve evidence-informed management plans

3.1.2 safely prescribes therapeutic interventions based on accurate knowledge of the characteristics and concurrent therapies of the person receiving care

3.1.3 demonstrates professional integrity and ethical conduct in relation to therapeutic product manufacturers and pharmaceutical organisations

3.1.4 safely and effectively performs evidence-informed invasive/non-invasive interventions for the clinical management and/or prevention of illness, disease, injuries, disorders or conditions, and

3.1.5 interprets and follows-up the findings of screening and diagnostic investigations in an appropriate time frame during the implementation of care.

Statement 3.2: NPs manage episodes of care, establishing and maintaining respectful relationships with people at the centre of care

The NP:

3.2.1 supports, educates, coaches and counsels the person receiving care regarding diagnoses, prognoses and self-management, including their personal responses to illness, injuries, risk factors and therapeutic interventions

3.2.2 advises the person receiving care on therapeutic interventions including benefits, potential side effects, unexpected effects, interactions, importance of compliance and recommended follow-up

3.2.3 shares information with others in consultation with the person receiving care

3.2.4 discloses the facts of adverse events to the person receiving care and other health professionals; mitigates harm, and reports adverse events to appropriate authorities in keeping with relevant legislation and organisational policy

3.2.5 advocates for improved access to healthcare, the healthcare system and policy decisions that affect health and quality of life

3.2.6 practises without the discrimination that may be associated with race, age, disability, sexuality, gender identity, relationship status, power relations and/or social disadvantage

3.2.7 practises in a way that respects that family and community underpin the health of Aboriginal and/or Torres Strait Islander people, and

3.2.8 conducts relationships within a context of collaboration, mutual trust, respect and cultural safety.

Statement 3.3: NPs recognise their duty of care and practise in accordance with federal, state and territory legislation and professional regulation governing NP practice

The NP:

3.3.1 defines duty of care in accordance with relevant legislation and regulation

3.3.2 remains informed of changes to legislation and professional regulations, and implements appropriate alterations to practice in response to such changes, and

3.3.3 contributes to the development of policy and procedures appropriate to context and specialty.

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Standard 4: Supports health systems

Statement 4.1: NPs engage in reflective practice and evaluate the outcomes of their practice

The NP:

4.1.1 monitors, evaluates and documents treatments/interventions in accordance with person- determined goals and healthcare system outcomes

4.1.2 develops plans for appropriately ceasing and/or modifying treatment in consultation with the person receiving care and, when needed, other members of the healthcare team

4.1.3 applies the best available evidence to identify and select appropriate outcomes measures of practice

4.1.4 uses quality indicators to monitor and measure the effectiveness of strategies, services and interventions to promote safe practice

4.1.5 participates in clinical supervision and clinical practice review

4.1.6 implements research-based innovations for improving care, and

4.1.7 contributes to research that addresses identified gaps in the provision of care and/or services.

Statement 4.2: NPs advocate for, participate in, or lead systems that support safe care, partnership and professional growth

The NP:

4.2.1 advocates and provides evidence for expansion to NP service where it is believed that such an expansion will improve access to quality and cost-effective healthcare for populations in all locations and contexts, including those in regional and remote communities

4.2.2 demonstrates clinical leadership in the design and evaluation of services for individuals and communities in health promotion, health protection or the prevention of injury and/or illness

4.2.3 articulates and promotes the NP role in clinical, political and professional contexts

4.2.4 acts as an educator and/or mentor to students, nursing colleagues and others in the healthcare team

4.2.5 critiques healthcare policies for their implications on the NP role and the populations for whom they care, and

4.2.6 influences health, disability and aged-care policy and practice through leadership and active participation in workplace and professional organisations.

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Glossary

Advanced practice is where nurses incorporate professional leadership, education, research and support of systems into their practice. Their practice includes relevant expertise, critical thinking, complex decision-making, autonomous practice and is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex healthcare requirements.

Advanced practice in nursing is demonstrated by a level of practice and not by a job title or level of remuneration

Advanced practice for the purpose of the nurse practitioner endorsement requires 5,000 hours clinically-based advanced practice in the past six years.

Attributes are characteristics that underpin competent performance. Refer to the NMBA Registered nurse standards for practice.

Autonomous practice is having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base (Skar 2010).

Competence is the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/ or superior performance in a profession/occupational area. Refer to the NMBA Registered nurse standards for practice.

Cultural safety was developed in a First Nations' context and is the preferred term for midwifery and nursing. Cultural safety is endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the 'presence or absence of cultural safety is determined by the recipient of care, it is not defined by the caregiver' (CATSINaM, 2014b, p. 9).

Cultural safety is a philosophy of practice that is about how a health professional does something, not [just] what they do. It is about how persons are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health.

Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of persons' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/ midwife's personal culture impacts on care.

In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM, 2017a, p. 11).

In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare.

Cultural safety is also relevant to Aboriginal and/ or Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and/or Torres Strait Islander colleagues (CATSINaM, 2017b).

Independence in these standards is the defining characteristic of NP practice that recognises the educational and advanced practice attributes beyond the Registered nurse standards for practice. This independence is inherent in the NP standards for practice and integrates aspects of the often-complex nursing practice for which the NP initiates and is responsible. NPs work collaboratively as part of a healthcare team and have the authority to diagnose and implement treatments without oversight from another health practitioner.

Nurse practitioner (NP) is a registered nurse endorsed as an NP by the NMBA. The NP practises at a clinical advanced level, meets and complies with the Nurse practitioner standards for practice, is able to practice independently and has direct clinical contact. NPs practice collaboratively in multi-professional environments. The NP practices within their scope under the legislatively protected title 'nurse practitioner' under the National Law.

Person/people in these standards is used to refer to those individuals who have entered into a therapeutic relationship with an NP. Person/people encompass patients, clients, consumers and families that fall within the NP scope and context of practice.

Prescribing is defined as the steps of information gathering, clinical decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine.

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Research includes the creation of new knowledge and/or the use of existing knowledge in a new and creative way so as to generate new concepts, methodologies, inventions and understandings. This could include synthesis and analysis of previous research to the extent that it is new and creative: (Australian Code for the Responsible Conduct of Research, 2018, p.5)

Scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups.

The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population.

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform.

The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full contemporary scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence. Decisions about both the individual's and the profession's practice can be guided using the Decision-making framework (DMF). When making these decisions, nurses and midwives need to consider their individual and their respective profession's scope of practice.

Standards for practice are the expectations of the NPs practice in all contexts. They inform the education accreditation standards for NPs, the regulation of NPs and the determination of NPs capability for practice. These standards guide consumers, employers and other stakeholders on what to reasonably expect from an NP regardless of their area of practice or their years of experience.

Supports health systems is a clinical domain in the NP standards framework and describes the advanced practice activities and functions of NPs as described in 'support of system's (see below).

Support of systems is a practice domain of the Strong Model of Advanced Practice[1] and is a contemporary feature of advanced practice. It is described as activities that promote quality and safe patient care and facilitate the optimal progression of patients through the healthcare system. NPs demonstrate the advanced practice activities in this domain that include:

- actively participate in the assessment, development, implementation, and evaluation of quality improvement programs in collaboration with healthcare teams
- provide clinical leadership in the development, implementation, and evaluation of standards of practice, policies and procedures
- serve as a mentor
- advocate the role of the nurse
- serve as a spokesperson for nursing and the health system when interacting with other professionals, patients families, and the public.

[1] Developed in the USA by a group of advanced practice nurses and academics at Strong Memorial Hospital, University of Rochester Medical Centre

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Document Control

Name of document	Nurse practitioner standards for practice
Version	2
Approval date	26 November 2020
Date of next review	January 2023
Policy owner	Strategy and Policy
Authorised by	Nursing and Midwifery Board of Australia

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

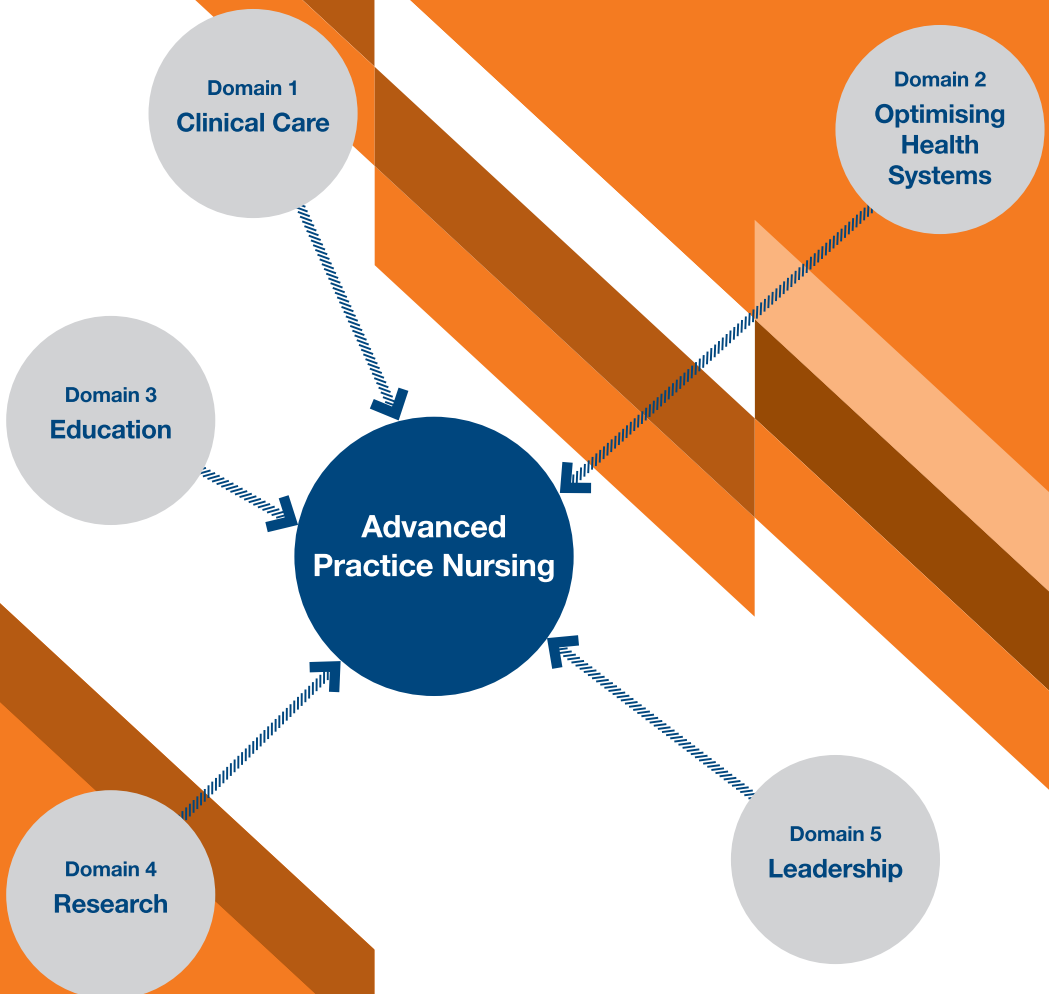
Annexure DL-5

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

The Australian Advanced Practice Nursing Self-Appraisal To

The ADVANCE Tool



Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Overview

Advanced practice in nursing is a level and type of practice rather than a designation of specific titles and roles. Having the tools to identify advanced practice is important and has implications for the nursing profession and the broader healthcare system.

The Australian Advanced Practice Nursing Self-Appraisal (ADVANCE) tool provides a standardised understanding of advanced practice that will support health service planning and cross-discipline team development. Furthermore, the facility to demonstrate achievement of practice at this level is necessary for nurses' individual career planning, succession planning, and can inform postgraduate nursing education curricula.

This tool will be useful **for nurse clinicians to**:

- Supply evidence of advanced practice experience in application for entry to Nurse Practitioner masters courses
- Support an application for any positions that require advanced practice nursing.

The tool will be useful **for service managers in**:

- Designing advanced practice nursing positions
- Determining the most appropriate use of advanced practice nurses in service planning and delivery
- Measuring cost effectiveness of advanced practice nursing
- Budget planning and resource allocation.

The Advanced Practice Nursing Self-Appraisal Tool is grounded in evidence and is one of the deliverables from a ten-year program of research. Other outcomes of this research program include:

- Identifying a model of advanced practice nursing relevant to the Australian context[1].
- Development/amendment and validation of a survey instrument to measure advanced practice[2, 3].
- Delineating the practice profile of advanced practice nursing from other levels of practice[4].
- Identifying advanced practice nursing in Australia[5].
- Standardisation of Australian nursing titles[6].
- Providing an evidence base for international discussion about advanced practice nursing.

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The Tool

The ADVANCE Tool was developed from a survey tool drawn from the Strong Model of Advanced Practice[7, 8]. The Strong Model is an advanced practice nursing framework developed in the USA by a group of advanced practice nurses and academics at Strong Memorial Hospital, University of Rochester Medical Centre[7,8]. With permission from the original authors, the model has been amended and validated to accommodate contemporary nursing practice in Australia and the Australian health service context[2, 3, 9]

The ADVANCE tool includes five domains of nursing practice namely: ***Clinical Care, Optimising Health Systems, Education, Research and Leadership.***

For each domain there is a definition and description of the activities relating to that domain. Our research has shown that nursing practice at an advanced level achieves relatively high scores across all domains. This is practice informed by layers of knowledge underpinned by academic preparation and clinical experience. Nursing activities at this level, whilst seemingly manifest are often structured in complexity.

As a consequence of this complexity some advanced practice nursing activities are clearly observable and others are not. The latter may be practice activities that include higher-order problem solving, advanced planning, critical thinking, ethical decision making and other complex actions. Clinical care activities may be performed in conjunction with related but non-observable activities such as watchful patient response monitoring, reflection on relevant research or planning a potential staff development session. Furthermore, a nurse practising at an advanced level is likely to engage in work-related activities of research, leadership and or education outside of clinical work hours.

Hence, each of the advanced practice domains include observable and non-observable activities which may be practised simultaneously.

How to use this tool

First, take time to carefully read and familiarise yourself with navigating through the tool. Note the five domains and the definition and the activities related to each. The domains are set out consecutively and for each domain there is two parts: Part A – Activity scoring & domain score; Part B – Justification & evidence.

Then complete each domain section as follows:

Part A: Consider each activity. Use the Likert scale (4 to 0) to select the score that indicates the extent to which you engage in that activity. Calculate and enter the average score for that domain *(to obtain the average score add all domain activity scores then divide by the number of activities)*.

Part B: Provide justification of your domain score with descriptions and examples from your current practice. This section is a narrative validation of your own measurement of your level of nursing practice i the domain. Your manager or peer will review and evaluate your domain score justification.

Based on research, the minimum mean scores for all domains to indicate advanced practice are as follows:

DOMAIN 1: CLINICAL CARE	DOMAIN 2: OPTIMISING HEALTH SYSTEMS	DOMAIN 3: EDUCATION	DOMAIN 4: RESEARCH	DOMAIN 5: LEADERSHIP
2	**2**	**2**	**1.7**	**1.7**

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Domain 1 mean score
(Total score ÷ 14)

Domain 1 Clinical Care

Part A: Activity scoring

Definition: Practice in this domain includes activities carried out on behalf of individual patients/clients focusing on specific needs, including procedures, assessments, interpretation of data, provision of physical care and counselling. Clinical Care also includes care coordination, care delivery, and guidance and direction to others relevant to a specific patient population.

Following is a list of activities that are components of Clinical Care. For each of the activities, please indicate the extent of time, in your current position, that you would spend on each one, by recording a number from 4 to 0 against each Activity

Activities

4 = very great extent 3 = great extent 2 = some extent 1 = little extent 0 = not at all

1.1 Conduct and document patient history and physical examination _____

1.2 Assess psychosocial, cultural and religious factors affecting patient needs _____

1.3 Identify and initiate required diagnostic tests and procedures _____

1.4 Gather and interpret assessment data to formulate plan of care _____

1.5 Perform specialty-specific care and procedures _____

1.6 Assess patient/family response to therapy and modify plan of care based on response _____

1.7 Communicate plan of care and response to patient and/or familly _____

1.8 Provide appropriate education (counselling) to patient & familly _____

1.9 Document appropriately on patient record _____

1.10 Serve as a consultant in improving patient care and nursing practice based on expertise in area of specialisation _____

1.11 Facilitate the process of ethical decision making in patient care _____

1.12 Coordinate inter/intra disciplinary plan for care of patients _____

1.13 Collaborate with other services to optimise patient's health status _____

1.14 Facilitate efficient movement of patient through the healthcare system _____

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Domain 1 Clinical Care

Part B: Justification and evidence

(attach additional pages if necessary)

Supporting Statements: Provide a rationale for your overall domain 1 score drawing upon examples and descriptions of your current practice with reference to the activities of the domain and the domain definition. Specific activities, projects, portfolios you are involved in may be emphasised.

Justification for domain score:

Manager/Peer Review Evaluation: **Yes** Agree **No** Disagree

Rationale for evaluation outcome:

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Domain 2 mean score
(Total score ÷ 9)

Domain 2 Optimising Health Systems

Part A: Activity scoring

Definition: This domain includes activities that contribute to effective functioning of health systems and the institutional nursing service including role advocacy, promoting innovative patient care and facilitating equitable, patient-centred health systems.

Following is a list of activities that are components of Optimising Health Systems. For each of the activities, please indicate the extent of time, in your current position, that you would spend on each one, by recording a number from 4 to 0 against each Activity.

Activities

4 = very great extent 3 = great extent 2 = some extent 1 = little extent 0 = not at all

2.1 Consult with others regarding conduct of projects or presentations _____

2.2 Contribute to, consult or collaborate with other health care personnel on recruitment and retention activities ____

2.3 Participant in strategic planning for the service, department or hospital _____

2.4 Provide direction for and participate in unit/service quality improvement programs _____

2.5 Actively Participate in assessment, development, implementation and evaluation of quality-improvement programs in collaboration with nursing leadership _____

2.6 Provide leadership in the development, implementation, and evaluation of standards of practice, policies and procedures ____

2.7 Serve as a mentor ____

2.8 Advocate the role of the nurse ____

2.9 Serve as a spokesperson for nursing and the health facility when interacting with other professionals, patients, families and the public ____

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Domain 2 Optimising Health Systems

Part B: Justification and evidence

(attach additional pages if necessary)

Supporting Statements: Provide a rationale for your overall domain 2 score drawing upon examples and descriptions of your current practice with reference to the activities of the domain and the domain definition. Specific activities, projects, portfolios you are involved in may be emphasised.

Justification for domain score:

Manager/Peer Review Evaluation: **Yes** Agree **No** Disagree

Rationale for evaluation outcome:

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Domain 3 mean score
(Total score ÷ 6)

Domain 3 Education

Part A: Activity scoring

Definition: These are activities that involve enhancement of caregiver, student and public learning related to health and illness. This also includes aiding patients and families to manage illness and to promote wellness, informal staff development and formal presentations to healthcare professionals

Following is a list of activities that are components of Education. For each of the activities, please indicate the extent of time, in your current position, that you would spend on each one, by recording a number from 4 to 0 against each Activity.

Activities

4 = very great extent 3 = great extent 2 = some extent 1 = little extent 0 = not at all

3.1 Evaluate education programs and recommend revision as needed _____

3.2 Serve as educator and clinical preceptor for nursing, medical students, staff, and/or others _____

3.3 Identify learning needs of various populations and contribute to development of education programs/resources ____

3.4 Serve as informal educator to staff while providing direct care activities _____

3.5 Facilitate professional development of nursing staff through education _____

3.6 Provide appropriate patient and family education ____

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Domain 3 Education

Part B: Justification and evidence

(attach additional pages if necessary)

Supporting Statements: Provide a rationale for your overall domain 3 score drawing upon examples and descriptions of your current practice with reference to the activities of the domain and the domain definition. Specific activities, projects, portfolios you are involved in may be emphasised.

Justification for domain score:

Manager/Peer Review Evaluation: **Yes** Agree **No** Disagree

Rationale for evaluation outcome:

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Domain 4 mean score
(Total score ÷ 6)

Domain 4 Research

Part A: Activity scoring

Definition: Activities that support a culture of practice that challenges the norm, that seek better patient care through scientific inquiry and promote innovative problem solving to answer clinical questions. This includes conducting clinical research, identifying funding sources and using evidence to guide practice and policy.

Following is a list of activities that are components of Research. For each of the activities, please indicate the extent of time, in your current position, that you would spend on each one, by recording a number from 4 to 0 against each Activity.

Activities

4 = very great extent 3 = great extent 2 = some extent 1 = little extent 0 = not at all

4.1 Conduct clinical research ____

4.2 Participate in investigations to monitor and improve quality of patient care practices ____

4.3 Identify funding sources for the development and implementation of clinical projects/programs ____

4.4 Uses research and integrates theory into practice and recommends policy changes ____

4.5 Identify clinical data necessary for inclusion in information systems for nursing research and quality assurance projects ____

4.6 Collaborates with Information specialists in the design of data systems for research and quality assurance projects in nursing ____

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Domain 4 Research

Part B: Justification and evidence

(attach additional pages if necessary)

Supporting Statements: Provide a rationale for your overall domain 4 score drawing upon examples and descriptions of your current practice with reference to the activities of the domain and the domain definition. Specific activities, projects, portfolios you are involved in may be emphasised.

Justification for domain score:

Manager/Peer Review Evaluation: **Yes** Agree **No** Disagree

Rationale for evaluation outcome:

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Domain 5 mean score
(Total score ÷ 6)

Domain 5 Leadership

Part A: Activity scoring

Definition: Activities and attributes that allow for sharing and dissemination of knowledge beyond the individual's institutional setting. These activities promote nurses, nursing and healthcare and include disseminating nursing knowledge, serving in professional organisations, and acting as a consultant to individuals and groups. Leadership also includes setting directions and modelling standards towards optimising population and patient care outcomes.

Following is a list of activities that are components of professional Leadership. For each of the activities please indicate the extent of time, in your current position, that you would spend on each one, by recording a number from 4 to 0 against each Activity.

Activities

4 = very great extent 3 = great extent 2 = some extent 1 = little extent 0 = not at all

5.1 Disseminates nursing knowledge through presentation or publication at local, regional, national or international levels ____

5.2 Serve as a resource or committee member in professional organisation _____

5.3 Serve as a consultant to individuals and groups within the professional/lay communities and other hospitals/institutions ____

5.4 Represent nursing in institutional/community forums on the educational needs of populations _____

5.5 Represents a professional nursing image at institutional and community forums _____

5.6 Collaborates with other healthcare professionals to provide leadership in shaping public policy on healthcare ____

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Domain 5 Leadership

Part B: Justification and evidence

(attach additional pages if necessary)

Supporting Statements: Provide a rationale for your overall domain 5 score drawing upon examples and descriptions of your current practice with reference to the activities of the domain and the domain definition. Specific activities, projects, portfolios you are involved in may be emphasised.

Justification for domain score:

Manager/Peer Review Evaluation: **Yes** Agree **No** Disagree

Rationale for evaluation outcome:

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Definition of terms

Understanding the meaning and usage of *advanced* in the nursing profession has been constrained by the multiple descriptions, roles and titles that are used interchangeably and ambiguously in relation to a type of nursing and a level of practice. There is a vast body of literature reporting confusion internationally about definitions and titles related to advanced *nursing* practice and advanced *practice* nursing.

Some writers[10, 11] have clarified this issue by questioning what is being described or qualified by the term advanced. If it is practice that is advanced (as in *advanced practice*), this signifies the performance or the work of nursing. If it is nursing that is advanced (as in *advanced nursing*), this signifies the discipline of nursing.

Drawing on these insights and in order to inform appropriate application of this tool the following evidence-informed definitions are provided for these commonly used terms.

Advanced Practice Nursing

Advanced practice nursing is the experience, education and knowledge to practice at the full capacity o the registered nurse practice scope. It is a level and type of clinical practice that involves cognitive and practical integration of knowledge and skills from the clinical, health systems, education and research domains of the discipline and positions the advanced practice nurse as a leader in nursing and health care. Practice at this level is enabled through master level education.

Advanced Nursing

Advanced nursing is promotion of the nursing discipline through innovation, generation, and expansion of the knowledge, science, education and service models of nursing. Advanced nursing supports interaction between the Discipline and the Profession of nursing.

Nurse Practitioner

Nurse practitioner is an advanced practice nurse endorsed by the NMBA who has direct clinical contact and practises within their scope under the legislatively protected title ‘nurse practitioner’ under the National Law. (Nursing and Midwifery Board of Australia. 1 June 2016). http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

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Acknowledgements

This Tool was developed from the i) *Answer 4 Nursing* and ii) *Making Nursing Work* studies, respectively funded by

i. The Australian Nursing and Midwifery Federation and
ii. The Australian Research Council Linkage Grant scheme. (PROJECT ID: LP140100320) with financial and in-kind support from Industry Partners: the Australian Nursing and Midwifery Federation and the Australian Nursing and Midwifery Accreditation Council.

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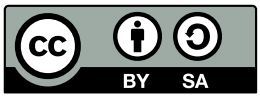
The research team acknowledges the contribution of over 6,000 Australian registered nurses who participated in the *Answer 4 Nursing* E-Survey and, the clinical nurse consultants and the data collectors across Australia who participated in the *Making Nursing Work* study.

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The Australian Advanced Practice Nursing Self-Appraisal Tool
Published by Queensland University of Technology February 2017

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Reference to the Strong Model of Advanced Practice to be attributed to reference # 7 above
Reference to the original advanced practice survey tool to be attributed to reference # 8 above

An appropriate citation for this Self-Appraisal tool is:
Gardner G., Duffield C., Gardner A., Batch M. (2017). The Australian Advanced Practice Nursing Self-Appraisal Tool DOI: 10.6084/m9.figshare.4669432

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-6

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Nursing and Midwifery Board of Australia

REGISTRATION STANDARD: CONTINUING PROFESSIONAL DEVELOPMENT

1 June 2016

NMBAXXXXXX

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

REGISTRATION STANDARD: CONTINUING PROFESSIONA DEVELOPMENT

Nursing and Midwifery Board of Australia

Summary

This registration standard sets out the Nursing and Midwifery Board of Australia's (NMBA) minimum requirements for continuing professional development (CPD) for enrolled nurses, registered nurses and midwives.

Does this standard apply to me?

This registration standard applies to all enrolled nurses, registered nurses and midwives.

The standard applies equally to enrolled nurses, registered nurses and midwives who work either full time or part-time in paid or unpaid practice. The standard applies to enrolled nurses, registered nurses and midwives who are on leave from work, e.g. maternity leave.

This standard does not apply to those with non-practising registration or students of nursing or midwifery.

What must I do?

To meet this registration standard, you must complete a minimum of 20 hours of CPD per registration period.

If you have held registration for less than 12 months, pro rata CPD hours apply. See *Pro rata CPD requirements* on page 3.

Specific requirements for nurses who hold an endorsement

If you are a registered nurse who has an endorsement as a nurse practitioner or holds an endorsement for scheduled medicines, you must complete additional CPD requirements. These are described in the table below.

Nurses	CPD requirements	Total additional CPD hours	Total CPD hours
Nurse practitioner	Registered nurse – 20 hours Nurse practitioner endorsement – 10 additional hours relating to prescribing and administration of medicines, diagnostic investigations, consultation and referral	10 hours	30 hours
Registered nurse with scheduled medicines endorsement	Registered nurse – 20 hours Scheduled medicines endorsement – 10 additional hours relating to obtaining, supplying and administration of scheduled medicines	10 hours	30 hours

Specific requirements for midwives who have a notation or hold an endorsement

If you have a notation as an eligible midwife or hold an endorsement as a midwife who holds an endorsement for scheduled medicines, you must complete additional CPD requirements. These are described in the table below.

Midwives	CPD requirements	Total additional CPD hours	Total CPD hours
Midwife with a notation and/or scheduled medicines endorsement	Midwife – 20 hours Endorsement and/or notation – 10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostic investigations, consultation and referral	10 hours	30 hours

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Nursing and Midwifery Board of Australia

Specific requirements for people registered as both a nurse and a midwife

If you are registered as either an enrolled nurse or a registered nurse and a midwife, you must complete the required amount of CPD for both nursing and midwifery

If your CPD activities are relevant to both the nursing profession and the midwifery profession, you may count those activities as evidence for both nursing and midwifery CPD hours.

Pro rata CPD requirements

If you have been registered for a period of less than 12 months prior to the renewal of registration, the following pro rata CPD requirements apply.

Months registration has been held	Pro rata CPD hours that must be completed
0 – 3 months	⩾ 5 hours
>3 – 6 months	⩾ 10 hours
>6 – 9 months	⩾ 15 hours
> 9 –12 months	⩾ 20 hours

If you have an endorsement and/or notation for a period of less than 12 months prior to the renewal of registration, the following additional pro rata CPD requirements apply.

Months endorsement/ notation has been held	Additional pro rata CPD hours that must be completed
0 – 3 months	⩾ 2.5 hours
> 3 – 6 months	⩾ 5 hours
> 6 – 9 months	⩾ 7.5 hours
> 9 – 12 months	⩾ 10 hours

Are there exemptions to this standard?

The NMBA may grant an exemption to this standard in exceptional circumstances. The NMBA CPD guidelines and relevant policies, published under *Codes, guidelines and statements* on the NMBA website, provide further guidance.

What does this mean for me?

When you apply for registration

You don't need to meet this standard when you apply for registration in Australia as a nurse and/or midwife.

At renewal of registration

When you apply to renew your registration/endorsemen you are required to declare that you have complied with this standard.

During the registration period

Your compliance with this registration standard may be audited from time to time. It may also be checked if the NMBA receives a notification about you.

Evidence

You should maintain records of your CPD activity for five years in case you are audited. If you are required to provide the NMBA with evidence of your CPD activities, your personal portfolio will help demonstrate that you have met the CPD requirements.

What happens if I don't meet this standard?

The National Law establishes possible consequences if you don't meet this standard, including:

- the NMBA can impose a condition or conditions on your registration/endorsement or refuse an application for registration/endorsement or renewal of registration, if you do not meet a requirement in an approved registration standard for the profession (sections 82, 83 and 112 of the National Law)

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- a failure to undertake the CPD required by this standard is not an offence but may be behaviour for which health, conduct or performance action may be taken by the NMBA (section 128 of the National Law), and
- registration standards, codes or guidelines may be used in disciplinary proceedings against you as evidence of what constitutes appropriate practice or conduct for registered nurses and/or midwives (section 41 of the National Law).

Continuing professional development guidelines for nurses and midwives

The *Guidelines for continuing professional development* provide more information about how to meet this standard. You are expected to understand and apply these guidelines together with this registration standard

Authority

This registration standard was approved by the Australian Health Workforce Ministerial Council on 27 August 2015.

Registration standards are developed under section 38 of the National Law and are subject to wide-ranging consultation.

Definitions

National Law means the Health Practitioner Regulation National Law, as in force in each state and territory.

Continuing professional development is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

Nurse includes enrolled nurses, registered nurses, nurse practitioners, registered nurses with a scheduled medicines endorsement and enrolled nurses and registered nurses with a notation.

Midwife includes midwives with a notation and midwive with a scheduled medicines endorsement and midwife practitioners.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession.

Review

This registration standard will be reviewed from time to time as required. This will generally be at least every five years.

Last reviewed: 1 June 2016

This standard replaces the previous registration standard from 1 July 2010.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-7

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Safety and quality guidelines for nurse practitioners

Updated November 2024

Introduction

The Nursing and Midwifery Board of Australia (NMBA) carries out functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public The NMBA does this by developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

About the safety and quality guidelines

The NMBA has developed the *Safety and quality guidelines for nurse practitioners* (the guidelines) to outline the regulatory requirements within which nurse practitioners (NPs) must practise, to ensure ongoing competence and safe practice.

Target audience

The target audience for the guidelines include:

- NPs
- registered nurses (RNs) seeking endorsement as an NP
- education providers offering programs for NPs
- assessors of NP applications, and
- employers of NPs.

Elements of the safety and quality guidelines

The elements of the guidelines are:

1. Scope of practice

The NP scope of practice is built on the foundation of the RN scope of practice and must meet Australian regulatory and professional requirements including the NMBA, Nurse practitioner standards for practice, the Code of conduct for nurses and International Council of Nurses' Code of ethics for nurses.

Changes to scope of practice

The scope of practice for an NP may change over time. If an NP decides to expand or change their scope of practice to meet the needs of their client group, then the NP must make sure they have the appropriate skills, knowledge and education to ensure they remain safe and competent to practise at the advanced practice level. This may include further postgraduate education and skill development.

NPs planning to change scope are required to use the NMBA's Decision-making framework for nursing and midwifery. This will ensure that NPs are competent in their proposed expanded or new scope of practice. It is the responsibility of the NP, and where employed, an employer, to ensure that, should an NP be required to expand or change their scope of practice to meet the needs of a client group, they are educated, authorised and competent to perform their role.

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2. Context of practice

Context of practice refers to the conditions that define an individual's nursing practice. These include the:

- type of practice setting (such as healthcare agency, educational organisation and/or private practice)
- location of the practice setting (such as urban, rural and/or remote)
- characteristics of healthcare consumers (such as health status, age, gender, learning needs and culture)
- focus of nursing activities (such as health promotion, research and/or management)
- degree to which practice is autonomous, and
- resources that are available, including access to other healthcare professionals.

3. Codes of conduct and ethics

The Code of conduct for nurses sets the minimum standards that the NMBA expects all nurses to uphold The International Council of Nurses Code of ethics for nurses provides guidance to all nurses relating to expected ethical conduct.

The NMBA expects NPs to practise in a manner consistent with these codes and other relevant professional standards. These documents provide NPs with a framework for legally and professionally accountable and responsible practice in Australia.

4. Standards for practice

NPs must meet the NMBA Nurse practitioner standards for practice (2021).

The *Nurse practitioner standards for practice* are the core practice standards by which performance is assessed in order to obtain and retain the right to practise as an NP in Australia. They form an integral part of the regulatory framework designed to assist NPs to deliver safe and competent care and are used by the NMBA to:

- communicate to the general public the standards that can be expected of NPs
- determine the eligibility for endorsement of nurses who have completed a program of study leading to endorsement as an NP in Australia
- determine the eligibility for endorsement of nurses who wish to practise as an NP in Australia but have completed courses elsewhere
- assess NPs who wish to return to work after being out of the workforce for a defined period, and
- assess NPs who need to show that they are competent to practise.

5. Annual declaration

Each year as part of the renewal of registration process, NPs are required to make a declaration that they have (or have not) met the registration standards for the profession. The annual declaration is a written statement that NPs submit and declare to be true.

6. NMBA audit process

The NMBA and the Australian Health Practitioner Regulation Agency (Ahpra) have developed a nationally consistent approach to auditing health practitioners' compliance through mandatory registration standards If chosen for audit, an NP will be required to provide further information to support the annual declaration made each year as part of their renewal of registration.

The NMBA and Ahpra operate in a co-regulatory model in some jurisdictions and may not be the only entities involved in undertaking audit activities should they arise.

7. Mandatory reporting

Section 140 of the National Law requires health practitioners, employers and education providers to report **notifiable conduct** to Ahpra to prevent placing the public at risk of harm. For more information refer to the Guidelines for mandatory notifications developed by the NMBA and Ahpra.

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8. Notification and management of performance, conduct or health matters

NPs may come under direct scrutiny when the NMBA receives a report relating to an NP's practice.

Sections 156(1) and 157 of the National Law outline the NMBA's responsibilities with regard to conduct, performance and health matters related to NPs. The NMBA has a range of powers to protect the public, including the power to take immediate action.

The NMBA and Ahpra operate in a co-regulatory model in some jurisdictions and may not be the only entities involved in completing assessment related to a notification.

9. Professional indemnity insurance

NPs must have appropriate professional indemnity insurance (PII) for practice to meet the requirements o section 129(1) of the National Law. This provision states:

> *A registered health practitioner must not practise the health profession in which the practitioner is registered unless appropriate professional indemnity insurance arrangements are in force in relation to the practitioner's practice of the profession.*

The NMBA's Registration standard: Professional indemnity insurance arrangements details the requirements relating to PII arrangements for NPs.

10. Recency of practice

The NMBA's Registration standard: Recency of practice requires that an NP must be able to demonstrate that they have maintained adequate connection with the profession, and recent practice, since qualifying or obtaining registration.

NPs must maintain and demonstrate recency of practice relevant to their specific area and context of NP practice at the advanced practice nursing level to the equivalent of 450 hours over the past five years. This practise must be direct clinical contact.

11. Continuing professional development

Continuing professional development (CPD) is the means by which members of the nursing profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

The CPD cycle involves reviewing practice, identifying learning needs, planning and participating in relevant learning activities and reflecting on the value of those activities.

The NMBA's Registration standard: Continuing professional development (CPD) specifies the annual requirement of CPD for NPs per registration year.

NPs are required to complete an additional 10 hours of specified CPD per year, in addition to the 20 hours of CPD required for general registration. This CPD must be relevant to the NP's context of practice and where appropriate, address:

- prescribing and administration of medicines
- diagnostic investigations, and
- consultation and referral.

12. Medicare Australia and Pharmaceutical Benefits Scheme arrangements

NPs are eligible to apply to the Commonwealth Health Minister as a 'participating NP' under section 16 (a) and 16(b) of the *Health Insurance Act 1973* (Cth), which allows access to the Australian Government Medicare Benefits Schedule (MBS).

NPs are also eligible to apply for access the Pharmaceutical Benefits Scheme (PBS).

These arrangements enable patients of NPs who are authorised for MBS and/or PBS, to access certain MBS rebates and PBS prescriptions respectively.

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Important notes

Endorsement as an NP does not give automatic access to the MBS and PBS. The discretion to authorise access to the MBS and PBS remains with Medicare Australia and is in addition to endorsement by the NMBA to practise as an NP.

An arrangement between the NMBA and Medicare Australia requires either regulatory body to notify the other of any issues. This can relate to conduct, performance or health that may affect the performance of an individual NP, as a prescriber or provider of Medicare services or medicines. For example, if Medicare Australia has cause to investigate a particular provider, they will notify the NMBA of that investigation, and vice versa.

Medicare Australia continues its important monitoring and review role. This is designed to make sure that the services and medicines provided by any health professional with access to the MBS and PBS are effective, efficient, appropriate and within benchmarking limits. If the NMBA receives notification of an issue relating to performance, health or conduct of an NP, as the professional regulatory authority the NMBA will oversee the assessment of that notification and any subsequent investigation or disciplinary action.

13. Prescribing authority and compliance with state or territory legislation

Prescribing authority is conferred under the relevant drugs and poisons legislation of the Australian state or territory in which the NP practises. The conditions under which each authority is granted and the scope of that authority depend on the requirements of the specific legislation in each state or territory. These may range from a blanket authority limited by the NP's scope of practice to a prescribing authority based on a formulary or protocol, or related to a specific context of practice.

NPs must work within the relevant drugs and poisons legislation in their state or territory.

For more information

- Registration standard: Endorsement as a nurse practitioner
- Guidelines: For nurses applying for endorsement as a nurse practitioner
- Nurse practitioner standards for practice
- Audit information on the NMBA website
- Visit www.nursingmidwiferyboard.gov.au under *Contact us* to lodge an online enquiry form
- For registration enquiries: 1300 419 495 (within Australia) +61 3 9275 9009 (overseas callers

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Definitions

Advanced practice is where registered nurses incorporate professional leadership, education, research and support of systems into their practice. Their practice includes relevant expertise, critical thinking, complex decision-making, autonomous practice and is effective and safe. They work within a generalist o specialist context and they are responsible and accountable in managing people who have complex healthcare requirements.

Advanced practice in nursing is demonstrated by a level of practice and not by a job title or level of remuneration.

Advanced practice for the purpose of the nurse practitioner endorsement requires 5,000 hours clinically-based advanced practice in the past six years.

Competence is the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area.

Nurse practitioner (NP) is a registered nurse endorsed as an NP by the NMBA. The NP practises at a clinical advanced level, meets and complies with the *Nurse practitioner standards for practice*, is able to practice independently and has direct clinical contact. NPs practise collaboratively in multi-professional environments. The NP practices within their scope under the legislatively protected title ‘nurse practitioner under the National Law.

Scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups.

The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population.

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform.

The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full contemporary scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence. Decisions about both the individual’s and the profession’s practice can be guided using the Decision-making framework (DMF). When making these decisions, nurses and midwives need to consider their individual and their respective profession’s scope of practice.

Standards for practice are the expectations of the NPs practice in all contexts. They inform the education accreditation standards for NPs, the regulation of NPs and the determination of NPs capability for practice. These standards guide consumers, employers and other stakeholders on what to reasonably expect from an NP regardless of their area of practice or their years of experience.

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Document history

Approved by: Nursing and Midwifery Board of Australia

Date approved: February 2016

Date to commence June 2016

Next review due: November 2027

Policy history: Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y v1.2**
Does this policy replace another policy with a different title? **N**

Approval date	Version	Reason for change
November 2024	v1.3	Removal of 'collaborative arrangements' references as this is no longer a requirement for nurse practitioners to access PBS from November 2024.
March 2021	v1.2	Inclusion of 'Definitions' section
July 2020	v1.1	New document template and updated regulatory document titles
February 2016	v1.0	Initial publication – date of effect 1 June 2016

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Annexure DL-8

Date: 17 March 2026

Docusign Envelope ID: 55E944AB-EC92-46A9-A634-EA4A070DE8E0

Nursing and Midwifery Board Ahpra

Framework

Effective 3 February 2020 (updated August 2022)

Decision-making framework for nursing and midwifery

A guide to practice decisions on scope of practice, delegation and supervision for nurse practitioners, registered nurses, enrolled nurses and midwives.

Introduction

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public The NMBA does this by developing standards, codes and guidelines which constitutes the professional practice framework, and together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

The NMBA *Decision-making framework for nursing and midwifery* (the DMF) is an evidence-based[1] contemporary document that is to be used in conjunction with standards for practice, policies, regulations and legislation related to nursing or midwifery.

Purpose of the decision-making framework

The purpose of the DMF is to guide decision-making relating to scope of practice and delegation and to promote decision-making which is:

- consistent
- safe
- person-centred/woman-centred, and
- evidence-based.

The DMF contributes to flexibility in practice and enables reflection on current practice and practice change.

The decision-making framework

The DMF consists of two parts:

1. **Principles of decision-making**, and

2. Nursing and midwifery **guides to decision-making** that include the:

    a. Guide to nursing practice decisions
    b. Guide to midwifery practice decisions, and
    c. Guide to delegation decisions.

The NMBA also provides the *Decision-making framework summary: nursing* and the *Decision-making framework summary: midwifery* as supporting guidance to be used in conjunction with the DMF.

Background

The DMF provides guidance for registered nurses, enrolled nurses and midwives on:

[1] The DMF is based on research from an academic literature review and stakeholder consultation.

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- individual practice decisions
- expanding scope of practice, and
- when registered nurses or midwives can delegate aspects of care to others, such as other registered nurses or midwives, enrolled nurses, students and health workers.

Scope of practice

Registered nurses, enrolled nurses and midwives are responsible for making professional judgements about when an activity is within their scope of practice and, when it is not, for initiating consultation and collaboration with, or referral to, other members of the healthcare team.

Scope of practice decisions should be made in a collaborative way, through professional consensus, consultation and negotiation with the person or woman, relevant family members and other members of the healthcare team.

Decisions about scope of practice should be based on considerations of:

- the person or woman's health status and any relevant social determinants to their healthcare
- lawfulness (legislation and common law)
- compliance with evidence, professional standards, and regulatory standards, policies and guidelines
- context of practice and the health service provider/employer's policies and protocols, and
- whether there is organisational support, sufficient staffing levels and appropriate skill mix for the practice.

Practitioners with notations on registration that reflect limited foundational education must only practice within the scope of practice relevant to that foundational education. This applies to:

Registered nurses who have a sole qualification in mental health, paediatric or disability nursing do not have a qualification that is substantially equivalent to an NMBA approved qualification leading to registration as a registered nurse. Depending on their qualification, these RNs are registered with a notation stating:

- solely qualified in the area of mental health nursing, or
- solely qualified in the area of paediatric nursing, or
- solely qualified in the area of disability nursing.

Enrolled nurses with a notation stating:

- does not hold a Board approved qualification in administration of medicines, and/or
- may only practice in the area of mothercraft nursing

Responsibilities for employers of nurses and midwives

Organisations in which nurses and midwives work must ensure there are sufficient resources to enable safe and competent care for the people for whom healthcare services are provided. This includes policies and practices that support the development of nursing and midwifery practice within a risk management framework.

The DMF establishes a foundation for decision-making that is based on competence and the provision of safe quality care. **The substitution of health workers for nurses or midwives must not occur when the knowledge and skills of nurses or midwives are needed.** Under the National Law, nurses or midwives must not be directed, pressured or compelled by an employer to engage in any practice that falls short of, or is in breach of, any professional standard, guidelines or code of conduct, ethics or practice for their profession.

Using the DMF

Using the DMF in all practice settings

The DMF provides a consistent approach to decisions about nursing or midwifery practice in all contexts. The DMF is most relevant for the clinical practice setting but may be modified or adapted for decision-making in other areas of nursing or midwifery practice. Nursing and midwifery practice settings extend to working in a non-clinical relationship with people/women, working in management, leadership,

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governance, administration, education, research, advisory, regulatory, policy development roles or othe roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's and midwife's professional skills.

How the DMF can be used

The DMF can be used:

- by registered nurses, enrolled nurses and midwives when considering, determining and self-assessing their individual practice
- for purposeful engagement with employers, managers and policy-makers in interpreting, planning for and changing practice
- to initiate discussion about professional issues and to raise awareness in relation to scope of practice and decision-making
- to embed the principles and concepts underpinning the DMF within educational programs that prepare registered nurses, enrolled nurses or midwives for practice, and
- to identify practice that falls outside the accepted scope of nursing or midwifery practice, or decision-making processes that are not consistent with the statements of principle in the DMF.

The DMF also provides guidance about how registered nurses and midwives delegate aspects of nursing and/or midwifery practice. The DMF does not provide guidance regarding appropriate allocation or assignment of tasks.

The DMF should be read in conjunction with NMBA *Registered nurse standards for practice*, *Enrolled nurse standards for practice* and Midwife *standards for practice.*

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Part one: Principles of decision-making

A set of principles underpin decision-making for nursing and midwifery practice. The principles support the provision of safe, person-centred/woman-centred and evidence-based care and, in partnership with the person/woman, promote shared decision-making and care delivery in a culturally safe and respectful way. Through the principles, and the guides to practice decisions based on them (Part two of the DMF), nurses and midwives are equipped to make decisions in a consistent way.

The principles that underpin decision-making for the nursing and midwifery practice are:

1. Nurses and midwives should make decisions about everyday practice, and changes to practice over time, that prioritise meeting the health needs of the community.

2. Planning, negotiation and implementation of practice change for individuals or groups of nurses and midwives should be focussed on meeting the health needs of the community.

3. Consent is gained from the person or woman receiving care.

4. The promotion and provision of quality, culturally safe health services should be the drivers for change in practice, which should be made in partnership with the person or woman and the broader community.

5. Nurses and midwives should integrate a comprehensive approach to managing risk into their practice to enhance safety and quality.

6 Evidence-based practice applies to all domains and contexts of practice for nursing and midwifery.

7 Changes to the practice of individuals or groups should be guided by:

- the needs of and feedback from those receiving care
- the evolution of new practice areas/capabilities
- negotiation between health workers, and
- evolving health service needs.

8 When making decisions about practice change, nurses and midwives should consider the following determinants of practice and how they may limit or enable practice change:

- legislated authority or restrictions on professional practice
- professional standards of practice
- evidence for practice
- individual scope of practice (education, authorisation and competence for practice)
- arrangements and decision-making in delegation, and
- contextual/organisational support for practice.

9 The DMF forms part of the nursing and midwifery professional practice framework and should be used when making decisions about practice change.

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Part two: Nursing and midwifery guides to practice decisions

Guide to nursing practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables nurses to work to their full and potential scope of practice. The statements and actions set out below provide direction to nurses and others about processes that will help to ensure that safety is not compromised when making decisions about scope of practice, about whether to delegate activities to others and for supervision support.

Statement	Actions
1. The primary motivation for any decision about a care activity is to meet people's health needs or to enhance health outcomes.	Decisions about activities should be made: • in partnership with the person, supporting shared decision-making • based on a comprehensive assessment of the person and their health and cultural needs • only where there is a justifiable, evidence-based reason to perform the activity, and • after identifying the potential risks/hazards associated with the care activity and strategies to avoid them.
2. Nurses are responsible for making professional judgements about when an activity is beyond their scope of practice and for initiating consultation with, or referral to, other members of the healthcare team.	Judgements should be made in a collaborative way, through consultation and negotiation with the person, relevant family members and other members of the healthcare team. Decisions should be based on considerations of: • the person's health status and any relevant social determinants to their healthcare • lawfulness (legislation and common law) • compliance with evidence, professional standards, and regulatory standards, policies and guidelines • which is the most appropriate health professional to provide the education and/or competence-based assessment for the activity • context of practice and the service provider/employer's policies and protocols, and • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice.
3. Expansion to scope of practice occurs when a nurse assumes responsibility for an activity that is currently outside the nurses' scope of practice, or where an employer seeks to initiate a change, because of evaluations of services and a desire to improve access to, or efficiency of, services to groups of people.	Nurses planning to integrate activities that are not currently part of their practice should ensure: • the activity is within the contemporary scope of nursing practice and the relevant standards for practice would support the nurse performing the activity • there is no legislative basis that would prevent a nurse performing the activity • they have any necessary authorisations, qualifications and organisational support to perform the activity • they have the necessary educational preparation, experience, capacity, competence and confidence to safely perform the activity • their competence has been assessed by a qualified, competent health professional or approved provider (who may be a more experienced registered nurse) • that any identified risk has been assessed and if appropriate to proceed, mitigating measures have been adopted • consultation with relevant stakeholders has occurred, if necessary • the person receiving care consents to the activity being performed by a nurse who is undergoing training or expanding their skill set to include that particular activity, and • the organisation in which the activity is to be performed is prepared to support the nurse in performing the activity.

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Statement	Actions
4. Registered nurses (the delegator) are accountable for making decisions about who is the most appropriate health professional or health worker to delegate to (delegatee) to perform an activity that is in the nursing plan of care.	Decisions about nursing practice should be made in partnership with the person whenever possible and to ensure that the right health professional or health worker is available at the right time to provide the care needs for the person. Decisions should be based on whether: • the activity should be performed by a particular category of health professiona or health worker • there is legislative or professional requirement for the activity to be performed by a particular category of health professional or health worker • the registered nurse has completed a comprehensive health assessment of the person's needs and determined that the activity can be delegated • the person has consented to the delegation of the activity, and reconsented to the activity being undertaken by the nominated delegatee • there is an organisational requirement for an authority/certification/credential to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the delegatee has been previously assessed by a registered nurse to ensure the activity will be performed safely • the delegatee is competent and confident of their ability to perform the activity safely, is ready to accept the delegation and understands their level of accountability for performing the activity • the appropriate level of clinically-focused supervision can be provided by a registered nurse for the delegatee performing an activity delegated to them, and • the organisation in which the registered nurse works has an appropriate policy quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the delegatee performing the activity, and to support the decision-maker in providing support and clinically-focused supervision.
5. Nursing practice decisions are best made in a collaborative context of planning, risk management, and evaluation.	Organisational employers/managers, other health workers and nurses share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent, evidence-based practice to the full extent of the scope of nursing practice • processes for providing continuing education, skill development and appropriate clinically-focused supervision, and • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and nursing practice decisions.

The nursing practice decisions summary illustrates the processes that a nurse would follow in making decisions about nursing practice, taking account of the statements set out above.

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Guide to midwifery practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables midwives to work to their full and potential scope of practice. The statements and actions set out below provide direction to midwives and others about the factors to be considered to ensure that safety is not compromised when making decisions about scope of practice, about whether to delegate activities to others, and for supervision.

Statement	Actions
1. The primary motivation for any decision about a care activity is to meet the woman's health needs, or to enhance health outcomes.	Decisions about activities should be made: • in partnership with the woman, supporting shared decision-making • based on a comprehensive assessment of the woman and their health and cultural needs • only where there is a justifiable, evidence-based reason to perform the activity, and • after identifying the potential risks/hazards associated with the care activity and strategies to avoid them.
2. Midwives are responsible for making professional judgements about when an activity is beyond their scope of practice and for initiating consultation with, or referral to, other members of the healthcare team.	Judgements should be made in a collaborative way, through consultation and negotiation with the woman, relevant family members and other members of the healthcare team. Decisions should be based on considerations of: • the woman's health status and any relevant social determinants to their care • lawfulness (legislation and common law) • compliance with evidence, professional midwifery standards, and regulatory standards, policies and guidelines • which is the most appropriate health professional to provide the education and/or competence-based assessment for the activity • context of practice and the service provider/employer's policies and protocols, and • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice.
3. Expansion to scope of practice occurs when a midwife assumes responsibility for an activity that is currently outside the midwife's scope of practice, or where an employer seeks to initiate a change, because of evaluations of services and a desire to improve access to, or efficiency of, services to groups of people.	Midwives planning to integrate activities that are not currently part of their practice should ensure: • the activity is within the contemporary scope of midwifery practice and the standards for practice would support the midwife performing the activity • there is no legislative basis that would prevent a midwife performing the activity • they have any necessary authorisations, qualifications and organisational support to perform the activity • they have the necessary educational preparation, experience, capacity, competence and confidence to safely perform the activity • their competence has been assessed by a qualified, competent health professional or approved provider (who may be a more experienced/ midwife) • that any identified risk has been assessed and if appropriate to proceed, mitigating measures have been adopted • consultation with relevant stakeholders has occurred, if necessary • the woman receiving care consents to the activity being performed by a midwife who is undergoing training or expanding their skill set to include that particular activity, • the organisation in which the activity is to be performed is prepared to support the midwife in performing the activity, and • they are confident of their ability to perform the activity safely.

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Statement	Actions
4. Midwives (the delegator) are accountable for making decisions about who is the most appropriate health professional or health worker to delegate (delegatee) to perform an activity that is in the midwifery plan of care.	Decisions about midwifery practice should be made by midwives in partnership with the woman and ensure that the right midwife or health worker is available a the right time to provide the care needs for the woman. Decisions should be based on, justified and supported by, considerations of whether: • the activity should be performed by a particular category of health professional or health worker • there is a legislative or professional requirement for the activity to be performed by a particular category of health professional or health worker • the midwife has assessed the woman's needs and determined that the activity can be delegated • the woman has consented to the delegation of the activity, and reconsented to the activity being undertaken by the nominated delegate • the activity should be performed by a particular category of health professional or health worker • there is an organisational requirement for an authority/certification/credentia to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the delegate, has been previously assessed by a midwife to ensure the activity will be performed safely • the delegatee is competent and confident of their ability to perform the activity safely, is ready to accept the delegation and understands their level of accountability in performing the activity • the appropriate level of clinically-focused supervision can be provided by a midwife for the delegatee performing an activity delegated to them, and • the organisation in which the midwife works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the delegatee performing the activity, and to support the decision maker in providing support and clinically-focused supervision.
5. Midwifery practice decisions are best made in a collaborative context of planning, risk management, and evaluation	Organisational employers/managers, other health workers and midwives share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent, evidence-based practice to the full extent of the scope of midwifery practice • processes for providing continuing education, skill development and appropriate clinically- focused supervision, and • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and practice decisions.

The midwifery practice decisions summary illustrates the processes that a midwife would follow in making decisions about midwifery practice, taking account of the statements set out above.

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Guide to delegation decisions

Delegations are made to meet people's needs and to ensure timely safe and effective access to healthcare services. Delegation is a consultative, multi-level activity, requiring rational decision-making consent from the various parties involved and a process of risk assessment. Delegation may only take place after education, where required, and an assessment of competence.

The delegation relationship exists when:

- a registered nurse (the delegator) delegates aspects of nursing practice in any practice setting to another person (the delegatee).
- a midwife (the delegator) delegates aspects of midwifery practice in any practice setting to another person (the delegatee).

Delegation is different from allocation or assignment of tasks.

The delegator retains accountability for the decision to delegate, monitoring performance and evaluating outcomes. The delegatee is unable to sub-delegate without referring back to the delegator.
Enrolled nurses work as part of the multidisciplinary team, providing delegated care under the supervision of a registered nurse or midwife. This supervision cannot be replaced or substituted by another health professional.

The decision to delegate an activity to students should align with the educational goals in their program of study and demonstrated level of their individual knowledge and skill.

The delegatee is at all times responsible for their actions and is accountable for providing delegated care.

Registered nurses and midwives (delegators) play a key role in the coordination and delegation of care. Delegation of care should be made following a risk assessment by the registered nurse or midwife identifying the competence of staff.

Registered nurses and midwives are responsible and accountable for the coordination, supervision and delegation of/to enrolled nurses and others who assist them in the provision of care.

The Guide to delegation decisions

Delegation phase	Actions
1. Assessment to determine appropriate delegation	The registered nurse or midwife (delegator) should conduct a risk assessment to determine appropriate delegation for the activity. Factors to be considered in making the decision include whether a nurse or midwife should perform the activity because: • the persons/woman's health status is such that the activity should be performed by a nurse or midwife because specific knowledge or skill is needed • professional standards indicate that the activity should be performed by either a nurse or a midwife • there is evidence that the activity is best performed by a nurse or midwife • any state/territory or Commonwealth legislation specifies that a nurse or midwife should perform the activity • any local or organisational policy, risk matrix, guideline or protocol requires a nurse or midwife to perform the activity, and • the model of care mandates that the activity should be performed by a nurse or midwife.

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Delegation phase	Actions
2. Responsibilities when delegating	To maintain a high standard of care when delegating activities, the registered nurse or midwife's responsibilities include: • a comprehensive, collaborative assessment of the needs of the person/woman receiving care • an assessment of the knowledge, skill, authority and ability of the delegatee accepting the delegation • ensuring that the delegatee understands their accountability and is confident, willing and able to accept the delegation • regular review of the delegation, providing guidance, support and clinically-focussed supervision • identification of potential risks/hazards and adoption of mitigation strategies, and • evaluation of outcomes of the delegation.
3. Responsibilities when accepting a delegation	A key component of delegation is the readiness of the delegatee to accept the delegation. The delegatee has the responsibility to: • be aware of the extent of the delegation and the associated monitoring and reporting requirements • at all times, be responsible for their actions and accountable for providing delegated care • not sub-delegate without referring to the delegator • agree the level of supervision needed • seek support and direct supervision until deemed competent to perform the activity, and • participate in an evaluation of the delegation.
4. Delegation to a health worker or student	If the delegator decides that the activity can be performed by a health worker or student, the delegator will need to consider, within a risk management framework, and through professional consensus, who the most appropriate health worker or student is to perform the activity. In making this decision, the delegator will need to decide if: • performance of the activity by a health worker or student will achieve the desired outcomes, and the person/woman consents, if possible, to the activity being performed by a health worker • there is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a health worker. For students, support from the educational institution for this activity to be delegated to students should also be established • the health worker or student is competent (i.e. has the necessary education experience and skill) to perform the activity safely • the health worker or student is ready (confident) to perform the activity and understands their level of accountability for the activity, and • there is a registered nurse or midwife available to provide the required level of supervision and support, including education.

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Definitions

These definitions relate to the use of the terms in this document and, where possible, align with definitions across other NMBA publications. To note: Person/people is used to refer to those individuals who have entered a therapeutic and/or professional relationship with a nurse or midwife.

Accountability means that nurses and midwives answer to the persons in their care, the NMBA, their employers and the public. Nurses and midwives are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing or midwifery role. Accountability cannot be delegated. The registered nurse or midwife, who delegates activities to be undertaken by another registered nurse, midwife, enrolled nurse, student, another health professional or health worker, remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.

Activity/activities is a service provided to people as part of a nursing or midwifery plan of care. Activities may be clearly defined individual tasks, or more comprehensive care. The term can also refer to interventions, or actions taken by a health worker to produce a beneficial outcome for a person/woman. These actions may include, but are not limited to, direct care, monitoring, teaching, counselling, facilitating and advocating. In some jurisdictions, legislation specifically prohibits the delegation of nursing care to health workers, and mandates that only midwives can care for a woman in childbirth.

Code of conduct refers to the NMBA Code of conduct for nurses and Code of conduct for midwives. There are other codes of conduct that also impact on the practice of nurses, midwives, other health professionals and health workers, including state and territory employer-based codes, profession specific codes and the National code of conduct for health care workers (for those who are not regulated by Ahpra).

Collaboration/collaborate refers to all members of the healthcare team working in partnership with people and each other to provide the highest standard of, and access to, care. Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe care.

Competence/competent is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability.

Competence assessment is the assessment of an individual's competence that may occur through structured educational programs or a peer review process. Evidence of a nurse or midwife's competence may include:

- written transcripts of the skills/knowledge they have obtained in a formal course
- their in-service education session records
- direct observation of their skill
- questioning of their knowledge base
- assessment from the recipient's perspective using agreed criteria, and
- self-assessment through reflection on performance in comparison with professional standards.

Comprehensive (health) assessment is the assessment of a person's/woman's health status for the purposes of planning or evaluating care. Data are collected through multiple sources, including, but not limited to, communication with the person/woman, and where appropriate their significant others, reports from others involved in providing care to the person/woman, healthcare records, direct observation, examination and measurement, and diagnostic tests. The interpretation of the data involves the application of nursing or midwifery knowledge and judgement. Health assessment also involves the continuous monitoring and reviewing of assessment findings to detect changes in the person's/woman's health status.

Consent is a person's voluntary and informed agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved. Consent requires clear and easy to understand information, so that the patient is able to make an informed decision.

Consultation is the seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It is dependent on the existence of collaborative relationships, and open communication, with others in the multidisciplinary healthcare team.

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Context of practice refers to the conditions that define an individual's practice. These include the: type of practice setting (such as healthcare agency educational organisation and/or private practice) location of the practice setting (such as urban, rural and/or remote) characteristics of care recipients (such as health status, age, gender, learning needs and culture) focus of nursing or midwifery activities (such as health promotion, research and/or management) degree to which practice is autonomous, and resources that are available, including access to other health professionals.

Cultural safety concept was developed in a First Nations' context and is the preferred term for nursing and midwifery. Cultural safety is endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the presence or absence of cultural safety is determined by the recipient of care; it is not defined by the caregiver (CATSINaM, 2014, p.9). Cultural safety is a philosophy of practice that is about how a health professional does something, not [just] what they do. It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM, 2017b, p.11). In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues (CATSINaM, 2017a).

Delegator is the person accountable (for this document it means registered nurse or midwife) for making decisions about to who is the most appropriate health professional or health worker to delegate.

Delegatee is a health professional or health worker who is delegated aspects of nursing or midwifery care

Delegation is the relationship that exists when one member of the multidisciplinary healthcare team delegates aspects of care, which they are competent to perform and which they would normally perform themselves, to another health professional or health care worker.

Activities delegated by a registered nurse or midwife (delegator) to another registered nurse, midwife, enrolled nurse, student, another health professional or health worker (delegatee) cannot be delegated by that person, unless they have since obtained the authority to perform the activity. If changes in the context occur that necessitate re-delegation, a person without that authority must consult again with a registered nurse or midwife.

Education includes formal education courses leading to a recognised qualification and informal educational methods include, but are not limited to:

- reading professional publications
- completing self-directed learning packages
- attending in-service education sessions
- attending seminars or conferences
- individual, one-to-one education with a person competent in the subject or skill, and
- reflection on practice alone or with colleagues.

Practical experience and assessment of competence by a qualified person are key components of any educational preparation for the performance of a care activity.

Enrolled nurse is a person who has completed the prescribed educational preparation and competence for practice, who is registered as an enrolled nurse by the NMBA under the National Law. Enrolled nurses must work under the direct or indirect supervision of a registered nurse or midwife. This supervision cannot be replaced/substituted by another health professional. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse or midwife for the delegated care.
Evaluation is the systematic collection of evidence, measurement against standards or goals, and judgement to determine merit, worth or significance. It focuses on the persons response to nursing or

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midwifery care to review the plan of care. It can also be used to determine the appropriateness of continuing to undertake an activity, or to delegate it. Relevant stakeholders who should be involved in evaluation including any party affected by the activity, such as other health workers.

Health professionals are people who have the necessary education to qualify for registration in their respective professions, to provide a health service for which they are individually accountable. Information about health professionals who are nationally regulated is available at www.ahpra.gov.au.

Health workers and others (also known as unlicensed healthcare workers) are any people who are not registered to practise under the National Scheme. Health workers may have a care-worker qualification or no formal education for their role. Health workers are individually accountable for their own actions and accountable to the registered nurse or midwife and their employer for delegated actions. Routine activities requiring a narrow range of skill and knowledge may be delegated to health workers. An activity is routine if the need for the activity, the recipient's response and the outcome of the activity have been established over time and is therefore predictable.

Legislation/legislative refers not only to National Law, but also to a diverse range of state/ territory and Commonwealth acts and regulations that may affect practice. Examples include the national Aged Care Act and Health Insurance Commission Act, and state/territory mental health acts, radiation safety legislation and drugs and poisons regulations.

Midwife is a person with prescribed educational preparation and competence for practice who is registered by the NMBA under the National Law. The NMBA has endorsed the International Confederation of Midwives definition of a midwife and applied it to the Australian context. This term also includes endorsed midwife.

Nurse − See registered nurse and enrolled nurse.

Organisation/organisational support includes employers/organisations who are responsible for providing sufficient resources to enable safe and competent care for people for whom they provide healthcare services. This includes policies and practices that support the development of nursing and midwifery practice to meet the needs and expectations of people, within a risk management framework. In situations where the nurse or midwife is self employed as a sole practitioner, the nurse or midwife assumes the employer's responsibilities for developing and maintaining a policy and risk management framework.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the nurse's scope and context of practice.

Person-centred care is a collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred care recognises the role of family and community with respect to cultural and religious diversity.

Refer/referral involves a nurse or midwife sending a person/woman to obtain an opinion or treatment from another health professional or entity. Referral usually involves the transfer (all or in part) of responsibility for the care of the person/woman, usually for a defined time and for a particular purpose, such as care or treatment that is outside the referring health professional's expertise or scope of practice.

Registered nurse is a person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the NMBA under the National Law as a registered nurse. The term also includes nurse practitioner.

Risk assessment/risk management consists of an effective risk management system, incorporating strategies to identify risks/hazards, assess the likelihood of the risks occurring and the severity of the consequences if the risks do occur, prevent the occurrence of the risks, or minimise their impact.

Scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. Some

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functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population.

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full contemporary scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence. Decisions about both the individual's and the profession's practice can be guided using DMF. When making these decisions, nurses and midwives need to consider their individual and their respective profession's scope of practice.

Student/s refers to those in courses that lead to eligibility to apply for registration as a nurse or registration or as a midwife are an integral part of the healthcare team in many settings. As part of their educational program, they are expected to provide care to people under the supervision of a registered nurse, and to women and babies under the supervision of a midwife. In order to gain the necessary knowledge and skill for professional practice, they may, during their course, undertake under supervision the full range of care activities that are expected of a licensed nurse or midwife. Decisions about what activities a student may perform will be guided by consideration of whether:

- performance of the activity is congruent with the educational goals of the program in which the studen is enrolled, and with the professional role (enrolled nurse, registered nurse, midwife) that the student will undertake once they graduate
- the educational institution supports the performance of the activity by the relevant group of students, and
- the student is competent and confident to perform the specific activity for the person in the current context.

Supervision includes managerial supervision, professional supervision and clinically focused supervision as part of delegation. There are two levels of supervision;

Direct supervision where the supervisor takes direct and principal responsibility for the nursing or midwifery care provided (e.g. assessment and/or treatment of individual patients/clients), and

Indirect supervision where the supervisor and supervisee share the responsibility for individual patients. The supervisor is easily contactable and is available to observe and discuss the nursing or midwifery care the supervisee is delivering.

For the purpose of the supervision of enrolled nurses refer to the Enrolled nurse standards for practice .

Volunteers/family members provide service without expectation of financial reward. In some contexts, they provide services similar to those provided by health workers. While they are unpaid and may be said to participate in care rather than be delegated care activities, the accountabilities of a registered nurse or midwife who involves the volunteer/family member in the provision of care are the same as for delegation.

Woman or women refers to those individuals who have entered into a therapeutic and/or professional relationship with a midwife. The word woman in midwifery is generally understood to be inclusive of the woman's baby, partner and family. Therefore, the words woman or women include all the women, babies, newborn, infants, children, families, carers, groups and/or communities, however named, that are within the midwife's scope and context of practice.

Woman-centred care recognises the woman's baby or babies, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices. Woman-centred care is the focus of midwifery practice in all settings.

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in

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respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the NMBA's Code of conduct for nurses and/or Code of conduct for midwives.

Document control

Approved by	Nursing and Midwifery Board of Australia
Date approved	October 2019
Date commenced	February 2020
Date modified	February 2022 – updated to reflect commencement of *Supervised practice framework* August 2022-updated to include information on RNs and ENs with sole qualifications and notations on their registration.

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF NIKKI JOHNSTON OAM

I, Nikki Johnston of [redacted] say:

Work history and qualifications

1. I have been a Nurse Practitioner (**NP**) for around 15 years. Prior to becoming a NP I practiced as a Registered Nurse (**RN**) for around 15 years. I currently work as a Voluntary Assisted Dying NP at Canberra Hospital.

2. I am a member of the Australian College of Nurse Practitioners (**ACNP**). In 2024, I was awarded a fellowship with the ACNP.

Qualifications, awards and professional roles

3. In 1989, I completed my Diploma of Applied Science: Nursing at the University of Technology, Sydney.

4. In 1991, I completed my Bachelor of Nursing at the University of Technology, Sydney.

5. In 1996, I completed my Certificate in Chemotherapy at the NSW College of Nursing, Sydney.

6 In 1997, I completed my Graduate Certificate in Oncological Nursing at the NSW College of Nursing, Sydney.

7 In 2007, I completed my Graduate Certificate in Palliative Care at Flinders University, Adelaide.

8 In 2009, I completed my Master of NP at Newcastle University. I was endorsed as a NP that same year. At the time, this was a state-based process, whereby I was required to provide evidence of my Masters qualification and at least 5,000 hours of advanced clinical practice in my field.

9. In 2019, I was awarded a Medal of the Order of Australia (**OAM**) for my contribution to nursing in Australia.

Lodged by:	Telephone:	03 9603 3035
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10. In 2019, I was an expert solution focused witness in the Royal Commission into Aged Care Quality and Safety.

11. I have been published 15 times in peer reviewed journals. I have presented to over 30 conferences. I am currently completing a PhD at the University of Canberra on how the experience of trauma affects the way we die. See **Annexure A** for my CV which includes a list of my publications.

Work History

12. In 1989, I started working as a RN at the Royal North Shore Hospital. I worked on the haematology, aged care, trauma orthopaedics, and surgical gastroenterology wards. At this time, I worked full-time on a rotating roster.

13. In 1992, I worked as an RN at Nursing for You in care homes and private homes. This work was in England and I was on a casual contract working for a nursing agency.

14 From 1993 to 1998, I worked as a Haematology RN on the bone marrow transplant unit at St Vincent's Hospital Darlinghurst. In this role, I cared for patients living with HIV/AIDS, patients with haematological malignancies and patients with immunological diagnoses. At this time, I worked full time on a rotating roster.

15 In 1999, I worked as a RN at ACT Hospice. In this role, I was a Palliative Care Nurse caring for people at end of life. I facilitated therapeutic communication and relationships. I worked part time rotating roster 0.2 Full Time Equivalent (**FTE**) returning to work post having a child.

16 From 1999 to 2000, I worked as a Registered Nurse Research Assistant in the Research Centre for Nursing and Midwifery Practice at the Canberra Hospital. As a Research Assistant at the Research Centre for Nursing Practice in 1999, I supported multiple projects aimed at improving evidence-based nursing care and advancing clinical practice standards.

17 From 2000 to 2002, I worked as an Oncology RN at the Canberra Hospital and Health Services. I worked part time 0.2 FTE on a rotating roster.

18 From 2003 to 2007, I worked as a RN in Specialist Palliative Care Services at the Canberra Hospital and Health Services. I worked part time 0.3 FTE on regular shifts from 8:30am – 5:00 pm.

19 From 2007 to 2010, I worked as a RN at the Calvary Public Hospital Bruce, Clare Holland House. In this role, I delivered specialist palliative care in people's homes. I

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worked shift work on any day. The shifts went from 7:00 am – 3:30pm or 1:00pm- 11:00 pm. I worked 0.7 FTE in this role.

20. In 2010, I obtained my first NP position. I was involved in the application for Commonwealth grant funding to create this position. From 2010 to 2014, I worked as a Palliative Care NP at the Canberra Hospital and Health Services. In this role, I developed and ran the first Palliative Care NP service in Canberra. This included inpatient consultation, outpatient clinics, a service in the emergency department, and a nurse-led liver clinic. I provided care for patients with cancer and haematological malignancies, heart failure, lung failure, liver failure, renal failure and degenerative neurological conditions including dementia. I prescribed medications or treatments based on patient nursing assessments, evaluated patient histories and current symptoms, monitored patient condition and progress, ordered appropriate pathology tests, assessed patient needs and communicated diagnosis and treatment plans to patients and families. I worked full time in this role.

21 From 2014 to 2021, I worked as a Palliative Care NP at the Calvary Public Hospital Bruce, Clare Holland House. In this role, I completed several research projects as well as providing specialist palliative care services to residents and their families across twenty-nine residential aged care facilities in Canberra. My research across two studies resulted in costs savings of over $2.6 million in reduced avoidable hospital transfers. The Commonwealth and ACT Governments have now instituted programs as a result of that research. Further, in terms of clinical work, in this role I provided specialist palliative care services to residents and their families who live in 29 residential aged care facilities in Canberra. I worked in this role full time.

22 From 2021 to 2023, I worked as a Lecturer in Nursing at the University of Canberra. I taught RN students from 1st year to 3rd year. I was unit convener for over 300 undergraduate students. I created content that aligned with the curriculum. I lectured, wrote assignments, marked assignments, and supported many students with special needs including refugees, students on visas and students with mental health challenges. While I was working at the University, I organised and ran a day community workshop on "How can we come together to improve the health of those experiencing homelessness". Attendees included policy makers, government officials and service providers. I worked in this role full time.

23 From 2021 to 2023, I have worked as a NP at Next Practice Deakin. In this role, I provided nursing services and care to patients with chronic and acute conditions. I also

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provided end of life care. My job was part time 0.1FTE and I was providing primary care in Residential Aged Care.

24. Since 2021, I have been appointed as a Nurse Practitioner member of the Professional Services Review (PSR) Panel for the Commonwealth of Australia. The PSR Panel is a statutory body established under the *Health Insurance Act 1973* to provide a pool of experienced clinical professionals who may be called upon to form PSR Committees. These Committees investigate whether practitioners have engaged in inappropriate practice in relation to Medicare, PBS or CDBS-funded services. To date I have been employed to work on two committees.

25 In 2023 to 2024, I worked as a Nurse Practitioner within CHS Cancer and Ambulatory Services, providing advanced clinical care across the Cancer Rapid Assessment Unit (**CRAU**) and the Cancer Therapy Day Unit (**CTDU**). In the CRAU, I independently assessed and managed acute cancer-related presentations, including treatment toxicities, febrile neutropenia, pain crises, and other urgent complications. My role involved initiating timely diagnostics and treatments, determining appropriate care pathways, and collaborating closely with oncology teams to support safe same-day management and prevent unnecessary hospital admissions. In the Cancer Therapy Day Unit, I provided clinical oversight for patients receiving outpatient systemic therapies, including chemotherapy, immunotherapy, and targeted treatments. I assessed patients before and during treatment, managed infusion reactions and toxicities, modified supportive medications as needed, and supported nursing staff with complex decision-making. Across both settings, my practice focused on delivering safe, evidence-based, patient-centred oncology care while coordinating multidisciplinary input and contributing to improved ambulatory cancer care pathways. This work was either in the Cancer Rapid Assessment Unit or the Cancer Therapy Day patient Unit. The unit is an acute unit that cares for people having cancer treatment. I worked in this role part-time at 0.3 FTE hours.

26 From 2024 to 2025, I worked as a Palliative Care Nurse Practitioner within CHS Cancer and Ambulatory Services, providing advanced, person-centred care to patients with Specialist Palliative Care Needs. In this role, I conducted comprehensive assessments, managed complex symptoms such as pain, nausea, dyspnoea, and psychosocial distress, and developed holistic care plans aligned with each patient's goals, values, and preferences. My scope included prescribing, ordering diagnostics, and initiating evidence-based interventions to optimise comfort, quality of life, and functional capacity. I worked closely with treating teams and community services. A key part of my role involved supporting patients and families through complex

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decision-making, advance care planning, and transitions in care. I provided education, emotional support, and guidance during periods of uncertainty or clinical decline, ensuring that care remained compassionate and culturally responsive. I also collaborated with multidisciplinary teams—including palliative care physicians, nurses, allied health, psychosocial services, and spiritual care—to coordinate timely interventions and streamline access to supportive services. Through this work, I contributed to strengthening palliative care inpatient consulting service and palliative care pathways within ambulatory cancer services and improving patient experiences during advanced illness. In this role I worked 0.7 FTE hours.

27 Since 2025, I have worked as a Voluntary Assisted Dying (**VAD**) Nurse Practitioner within General Medicine at Canberra Hospital, providing specialised, patient-centred care to individuals considering or accessing voluntary assisted dying under the ACT's legislative framework. In this role, I conduct comprehensive eligibility assessments, provide clear information about end-of-life care options, and support patients to make informed, values-aligned decisions. As part of my authorised scope of practice, I prescribe and administer the VAD substance, ensuring all legal, clinical, and documentation requirements are met with accuracy and integrity. I work closely with patients, families, and multidisciplinary teams to deliver compassionate, ethical, and culturally responsive care throughout the VAD process. I also contribute to service development, staff education, and quality improvement initiatives related to VAD and end-of-life care, with a focus on dignity, autonomy, and safe clinical practice. I currently work 0.6 FTE hours.

Transitioning from a RN to a NP

28. In 2009, I was endorsed as a NP. To become a NP, I needed a Masters' qualification, and I also needed to prove that I had completed at least 5,000 clinical hours of advanced practice nursing. I demonstrated this by reference to my earlier work in palliative care as a RN.

29. I was the first Palliative Care NP in Canberra. Relevant legislation had to be changed, in order for me to practice in accordance with my full scope of practice. I was involved in advocating for the change to the *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT).

30 A RN and NP have very different jobs, reflective of their different qualifications and skill sets. RNs implement a treatment plan that someone else has written whereas NPs handle the whole unit of care. RNs have to work with a NP, GP or other doctor. RNs

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can't change treatment plans and they can't prescribe medication. RNs can't diagnose or order pathology or imaging tests. As an NP, I am an independent practitioner. Comparing the two jobs is like apples and oranges.

The NP's role, work and skill

31. As an NP, I autonomously assess patients, order imaging and pathology, then form a diagnosis and formulate a treatment plan. As part of that treatment plan, I prescribe medications. I refer patients to other health professionals as needed, and write my own referral letters as the treating clinician. I provide ongoing management of complex and/or chronic conditions. In palliative care, my treatment planning includes advance care planning and end-of-life care. I manage complex pain syndromes. I see patients frequently over an extended period of time as both outpatients and inpatients. I'm responsible for documenting their clinical records in respect of everything I do, and accountability for their care lies with me. This is a job with the same level of responsibility as a doctor but with far less pay.

32 An example of this was diagnosing a Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE) in 93-year-old women who didn't want to go to hospital and lived in residential aged care. Clinically this woman presented with a 24 hour history of very severe shortness of breath, a 'rub' breath sound from her lungs and a very swollen and painful left calf. The differential diagnosis were heart failure and pulmonary edema and PE. I collaborated with her General Practitioner, and ordered an urgent D-dimer blood test that came back positive. I prescribed her suitable medication and organised an outpatient CT pulmonary angiogram (CTPA) that happened the next day. The CTPA confirmed PE. This patient was able to stay at home and out of hospital. I use therapeutic guidelines to increase the safety of my prescribing and the Australian Medicines Handbook.

33 The nature of my work and the level of skill and responsibility exercised by me as a NP is best demonstrated by reference to the different settings within which I have practised:

(a) <u>Clare Holland House</u>

While working as a NP in palliative care at Clare Holland House, I was integrating specialist palliative care into residential aged care. in 2019, I assessed and diagnosed metastatic breast cancer in a 76-year-old woman with an enlarged liver who became bed bound. I ordered a CT scan with a result of liver metastasis and L4 spinal

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metastasis and probable spinal cord compression. She was under the care of the Public Guardian and because of a dementia diagnosis and schizoid affective disorder her goals of care were comfort at end of life. She didn't want to take any medication as she said that "they were traying to poison her". I contacted a psychiatrist who knew this patient and said that her psychosis needed to be treated as she becomes very unwell when she is psychotic. I also liaised with a palliative care medical practitioner and between the three of us we agreed on medication types and amounts to be administered subcutaneously through a syringe driver. I commenced a syringe driver with hydromorphone and haloperidol and she died comfortably at home.

I have seen patients as part of the Specialist Palliative Care Outpatient Clinic at Canberra Hospital. In this role, I reviewed a 74-year-old man with metastatic colorectal cancer who presented to my palliative care outpatient clinic with worsening abdominal pain, nausea, early satiety, and several days of minimal bowel output. During my NP assessment, I took a detailed symptom history, reviewed his medications, examined his abdomen, and assessed hydration status, functional decline, and psychosocial concerns. Based on clinical findings—including distension, high-pitched bowel sounds, and ongoing vomiting—I formed a provisional diagnosis of a malignant bowel obstruction. To confirm the severity, I ordered urgent pathology. After interpreting these results, I confirmed the diagnosis and discussed the goals of care with the patient and his family. I was then able to initiate a comprehensive symptom management plan. I then updated the other relevant medical professionals about his diagnosis and next steps. Through this coordinated approach, we achieved improved symptom control, avoided an unplanned hospital admission, and aligned care with the patient's preference to remain at home to die.

(b) <u>CHS Cancer and Ambulatory Service Specialist Palliative Care Team</u>

I have seen patients as part of the Specialist Palliative Care Outpatient Clinic at Canberra Hospital. In this role, I reviewed a 74-year-old man with metastatic colorectal cancer who presented to my palliative care outpatient clinic with worsening abdominal pain, nausea, early satiety, and several days of minimal bowel output. During my NP assessment, I took a detailed symptom history, reviewed his medications, examined his abdomen, and assessed hydration status, functional decline, and psychosocial concerns. Based on clinical findings—including distension, high-pitched bowel sounds, and ongoing vomiting—I formed a provisional diagnosis of a malignant bowel obstruction. To confirm the severity, I ordered urgent pathology. After interpreting these results, I confirmed the diagnosis and discussed the goals of care with the patient and his family. I was then able to initiate a comprehensive symptom management plan.

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I then updated the other relevant medical professionals about his diagnosis and next steps. Through this coordinated approach, we achieved improved symptom control, avoided an unplanned hospital admission, and aligned care with the patient's preference to remain at home to die.

As a NP in the Cancer Rapid Assessment Unit (**RACU**) of CHS Cancer and Ambulatory Service, I treat acutely unwell patients who would otherwise have to go to the Emergency Department. This unit exists to ensure vulnerable patients having cancer treatment can access timely effective care. My work as a NP in the unit involves assessing and treating patients as they present. A patient will attend, I will order some pathology tests, order some imaging, CT scans, X-rays and then interpret the results. I'll formulate a diagnosis, looking at differentials and then form treatment plans. I use my urgent care skills as a NP and my specialist palliative care skills to treat these critically unwell patients.

An example of caring for a patient in the Cancer Rapid Assessment Unit (RACU) is as follows: I reviewed a 63-year-old man who has a history of Squamous Cell Carcinoma (SCC) of the scalp. In 2022 he received curative intent radiotherapy 60 Gy 30 #. The SCC had eroded his cranium at the apex of the parietal bone. Unfortunately, he had local progression post his radiotherapy. He commenced on Cemiplimab (Immunotherapy) June 2023 but due to severe dermatitis it was ceased. He presented in RACU with generalised body itch, peripheral neuropathy and suicidal ideation made worse by newly prescribed pregabalin. He had two plans for suicide, one was taking an overdose of prescription medications, and the other was to use his guns. The generalised body itch and subsequent rash was unbearable, and he said that he just wanted it all over. I contacted Oncological Psychiatry, Palliative medicine, Dermatology registrar who did an urgent telehealth consult and a social worker came to RACU. I also contacted the patients Oncologist. It was a Friday, so the following was put in place: reduced pregabalin with plan to cease, commence diprosone topical all over with wet dressings BD, commence telfast one tablet 3 times a day, commence Phenergan 10mg nocte, commence amitriptyline 10mg nocte. He was sent home with a plan to return on Monday for admission. He returned Monday morning and was admitted under his oncologist. During his admission he was seen by Oncology, Dermatology, Neurology and Psychiatry. He was only in hospital for two nights and he was discharged no longer suicidal, off pregabalin, itch and rash improving as was his neuropathic pain.

(c) <u>Voluntary Assisted Dying at Canberra Hospital</u>

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As a Voluntary Assisted Dying Nurse Practitioner at Canberra Hospital, I supported a patient with advanced metastatic cancer who expressed a clear and sustained wish to pursue VAD. I completed a comprehensive eligibility assessment, including medical history, symptom review and capacity evaluation. I reviewed existing imaging, interpreting these results to confirm clinical eligibility. Based on my assessment and diagnostic reasoning, I confirmed the patient met the legislative criteria and documented the primary diagnosis and rationale for proceeding. I co-ordinated the 10 step VAD process.

As an authorised VAD NP, I prescribed the VAD substance and completed all required statutory documentation. On the day of administration, I verified identity and capacity, prepared the medication, and administered the VAD substance, providing symptom support and ensuring privacy and dignity. Afterward, I completed mandatory reporting and arranged bereavement support for the family.

34. I support my clinical practice as a NP with a wide collegial network. I also use resources such as eviQ www.eviq.org.au, therapeutic guidelines and UpToDate.

Person-centred care

35. NPs practice person-centred care in a holistic manner. This means, as a NP, I take the time to be with people, to listen to them and to tailor care to their needs. My experience in palliative care has shown that patients are often seeing multiple specialists, without sufficient oversight, and on multiple forms of medications, that are often interacting negatively. Their quality of life is necessarily impacted as a result. I talk to patients about what's most important to them that day, rather than having a particular medical agenda.

36. As a NP, I provide the whole unit of care in a different person-centred manner. I adopt a whole person approach in formulating a treatment plan that takes into account how the person fits into the world (have they got money, support etc). This time and consideration is one of the biggest gifts I can give.

The four pillars of NP practice

37. There are four pillars to being an NP. These are clinical, education, research and leadership. In my experience, NPs are generally only paid for the clinical work they do. In Australia, Nurse Practitioner practice is defined by four pillars because the NP role is intentionally designed to extend beyond direct clinical care. The NP endorsement recognises not only advanced clinical practice, but also the responsibility to contribute

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to the development, safety, and quality of the broader health system. The four pillars ensure that the NP role remains holistic, future-focused, and able to influence patient care at multiple levels. By grounding NP practice in clinical care, education, research, and leadership, the profession maintains a strong evidence base, promotes consistent standards, and ensures that NPs help evolve models of care and improve outcomes for patients and the community.

38 Although NPs are most often paid only for their clinical work, the remaining pillars are essential because they safeguard the continued advancement and integrity of the role. Education ensures NPs share knowledge, mentor clinicians, and build capability within teams. Research embeds evidence-based practice, contributes to innovation, and ensures that NP-led care remains safe and contemporary. Leadership is critical for service development, advocacy, policy influence, and shaping new models of care that respond to population needs. Together, these pillars allow NPs to have an impact that extends far beyond individual consultations.

39 For me personally, contributing to all four domains is essential to maintaining high-quality NP practice. Clinically, I provide advanced, autonomous patient care that directly improves outcomes. Through education, I support staff development, empower colleagues, and strengthen interdisciplinary teamwork. My involvement in research ensures that my practice remains evidence-informed and that I contribute to the growing body of NP-generated knowledge. Through leadership, I advocate for safe systems, contribute to service improvement, mentor emerging NPs, and help shape policy and organisational culture. Even though these pillars may not all be financially recognised, they are fundamental to the identity and value of the NP role—and they reflect my commitment to advancing both patient care and the profession.

My clinical work

40. My clinical work represents the peak of advanced palliative care nursing, built across diverse roles in inpatient, outpatient, community, cancer and ambulatory services, and Voluntary Assisted Dying (VAD). Over my career, I have developed high-level expertise in comprehensive assessment, diagnostic reasoning, prescribing, ordering and interpreting investigations, and managing complex symptom profiles for people with life-limiting illness. As my roles evolved—from Clare Holland House, to CHS Cancer Services, to my current role in VAD—I have refined my ability to manage highly complex presentations such as malignant bowel obstruction, refractory pain, treatment toxicities, and acute deterioration in the ambulatory setting. My NP practice is defined

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by autonomous clinical decision-making, leading complex care planning, and collaborating across teams to deliver safe, compassionate, patient-centred care.

41. My advanced practice has grown alongside my contribution to nationally recognised palliative care research, particularly my work leading and evaluating Palliative Care Needs Rounds—an evidence-informed model that improves outcomes for residents in aged care by proactively identifying risk, reducing avoidable hospital transfers, and strengthening end-of-life planning. This research has influenced practice both locally and internationally and demonstrates my commitment to integrating research into clinical excellence. I have also contributed to emerging knowledge on re-living trauma near death, helping clinicians understand how past traumatic experiences can resurface in the dying process and how specialised NP-level assessment and intervention can reduce distress and improve dignity at end of life.

42 In my current VAD NP role, my practice includes highly specialised tasks such as determining eligibility, conducting capacity assessments, interpreting investigations, prescribing and administering the VAD substance, and guiding patients and families through complex ethical and emotional decisions. Across all roles, my clinical skills have deepened —reflecting my commitment to advancing palliative care practice, shaping models of care, and improving the experience of people at end of life.

43. I started my PhD study whilst teaching nursing at the University of Canberra. At the same time, I was working every Saturday for a GP doing private NP work in primary care. In order to maintain my NP endorsement, I have to keep up my clinical work.

My leadership and advocacy

44. Leadership and advocacy is an important part of my work as a NP palliative care specialist. I have been involved in the preparation of business cases outlining the fiscal benefits of funding palliative care NPs and other nurses.

45. For example, I gave evidence as an expert witness before the Royal Commission into Aged Care Quality and Safety on the need for proactive, specialist-led palliative care in residential aged care, drawing on my research and clinical leadership in developing and implementing Palliative Care Needs Rounds**.** The Royal Commission relied on my evidence in determining that palliative care must be a core component of aged care, not an optional add-on. Through this contribution, I helped ensure that evidence-based, person-centred end-of-life care was placed at the forefront of aged care reform in Australia

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46. My work on the Professional Services Review Panel for the Commonwealth of Australia is another example of my leadership as a NP in the profession. My work on the Professional Services Review (**PSR**) Panel is an important expression of my leadership as a Nurse Practitioner. As a panel member, I contribute expert clinical judgement to a statutory body that safeguards the integrity of Medicare by determining whether health practitioners have engaged in inappropriate practice. I choose to do this work because I believe NPs have a responsibility to strengthen clinical governance, uphold professional standards, and protect the community. Serving on the PSR Panel allows me to use my advanced expertise to ensure fairness, accountability, and high-quality practice across the health system—reflecting my commitment to leadership beyond direct clinical care.

47 I am leading the practice of end-of-life care within the home in the ACT. Medical practitioners are hesitant to provide end of life care in these settings, but as a NP I can see the profound benefit of it.

48 Further, I was the inaugural recipient of the Australian College of Nursing's Nursing Trailblazer Award. I was recognised for pioneering the nurse-led Palliative Care Needs Rounds model—an approach that transformed palliative care access in residential aged care and influenced national policy, funding, and workforce capability. This award acknowledged not only the innovation itself, but also my role in expanding what Nurse Practitioners can achieve within complex care systems.

49 My leadership also extends to strong advocacy for vulnerable and marginalised populations, including people who use drugs and alcohol. Throughout my NP practice, I have championed harm-reduction principles, non-judgemental care, and equitable access to palliative and end-of-life services. I have worked to ensure that substance use never becomes a barrier to compassionate, evidence-based treatment. By modelling trauma-informed, person-centred approaches, I have supported teams to reduce stigma, improve communication, and create safer care environments. My research and clinical leadership in trauma-informed palliative care, including my PhD work on *re-living trauma near death*, further demonstrate my commitment to improving care for people with complex trauma histories. By identifying trauma cues and translating these insights into practical guidance for clinicians, I have helped services recognise and respond to distress that can emerge near death, improving dignity and comfort for patients and families.

50 Together, these contributions reflect my commitment to using the NP role to drive system-level change, advocate for the underserved, strengthen clinical capability, and

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ensure that all people—regardless of their background, trauma history, or substance use—receive the compassionate, high-quality care they deserve.

My contribution to research

51. My research work has been critical to my ability to lead and effectively advocate for the profession and the palliative care sector. See, for example, my research work at Calvary Public Hospital, my publications at Annexure A, and my present PhD research. Research is a core pillar of Nurse Practitioner practice because it ensures that advanced clinical care is grounded in evidence, innovation, and continual improvement. For me, research is inseparable from my clinical work: the people I care for often have complex needs, multiple comorbidities, trauma histories, and limited access to specialist palliative care. Research allows me to identify these gaps, rigorously test solutions, and translate findings into practice and policy. It strengthens safety, improves outcomes, and elevates the standard of care across services—not only for my own patients, but for the broader community and the profession.

    My research enables me to expand models of care, influence national reforms, and support the development of best practice across aged care, hospital, and community settings. It also reinforces NP leadership by demonstrating that specialist nurses can contribute high-quality, system-shaping research with measurable impact.

My contribution to education

52. I have made a significant contribution to education within the nursing and palliative care professions across multiple settings and career stages. A central component of my impact has been the educational model embedded within Palliative Care Needs Rounds, where I provided structured, case-based teaching to aged-care staff to build their skills in recognising dying, managing complex symptoms, and developing appropriate end-of-life care plans. In addition, I have taught at the University of Canberra, supporting the next generation of nurses and health professionals through formal teaching, supervision, and mentorship. My commitment to education also extends nationally and internationally through more than 30 conference presentations, where I have shared research findings, clinical insights, and innovations in palliative care. Across these roles, I have consistently mentored students, early-career nurses, and interdisciplinary colleagues, strengthening capability, confidence, and the quality of care delivered across the sector.

My scope of practice

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53. My scope of practice as an NP is palliative care, aged care, cancer care and voluntary assisted dying. My scope of practice has changed, as my skills and responsibilities in particular settings have expanded. For example:

(a) Acute Oncology & Cancer Rapid Assessment

Working in the Cancer Rapid Assessment Unit (**RACU**) significantly advanced my ability to assess and manage high-acuity oncology presentations. I developed expertise in: Rapid triage and stabilisation of patients with acute symptoms such as febrile neutropenia, sepsis, treatment toxicities, and pain crises. Ordering and interpreting urgent pathology and imaging to guide safe same-day treatment decisions. Making autonomous decisions about admission, escalation, or outpatient management. These skills expanded my NP practice into acute cancer nursing, allowing me to manage deteriorating patients with confidence and independence.

(b) Cancer Therapy Day Unit – Complex Treatment Management

In the Cancer Therapy Day Unit, I developed advanced clinical skills in: Managing infusion reactions, ordering blood transfusions, immunotherapy toxicity, hypersensitivity responses, and chemotherapy complications. Reviewing treatment plans, assessing readiness for systemic therapies, and adjusting supportive medications in real time. Educating patients and staff about complex treatment regimens and toxicity pathways. This broadened my competency in systemic therapies and advanced symptom management in the ambulatory setting.

(c) Specialist Palliative Care – Complex Symptom Control

In specialist palliative care settings, I expanded my skills in: Managing complex multi-symptom syndromes such as malignant bowel obstruction, refractory pain, delirium, existential distress, and polypharmacy. Prescribing and titrating opioids, adjuvants, antiemetics, steroids, and complex pharmacological combinations tailored to changing clinical trajectories. Conducting comprehensive assessments that integrate physical, psychological, spiritual, and social needs. This work advanced my ability to manage patients with unpredictable illness trajectories and severe symptom distress.

(d) Voluntary Assisted Dying (VAD) – Highly Specialist NP Skills

As a VAD Nurse Practitioner, I further expanded my clinical scope through: Conducting eligibility assessments under legislative frameworks. Completing capacity evaluations and assessing voluntariness. Prescribing and administering the VAD substance, adhering to statutory requirements. This role requires advanced ethical reasoning,

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precision, and clinical judgement, representing one of the highest levels of NP autonomy.

(e) Trauma-Informed Palliative Care

Through my PhD research on re-living trauma near death, I developed specialised expertise in: Identifying trauma cues that signal re-activation of past traumatic experiences. Applying trauma-informed communication, assessment, and environmental modification strategies. Supporting patients, families, and clinicians to navigate trauma resurfacing in the final days and weeks. This expanded my scope into psychological and neurobiological aspects of the dying process, enhancing holistic care.

54 I like to think of my practice as having an overall speciality. An overall specialty that covers a scope of practice that can change and expand if I do the necessary work and training.

55 It frustrates me, as a professional with over 20 years' experience working at an advanced level in the field, that I have to have to define my scope of practice. Medical practitioners are never asked to define or seek approval to expand their scope of practice. We trust oncologists, for example, to practice within their scope. The same is not true, in my experience, for NPs. I had to go through an extensive process in order to expand my scope from specialist palliative care into voluntary assisted dying.

Progression in the NP role

56. Starting out as a junior NP was quite frightening. As a senior RN, I felt like I had a lot of experience and skill. But once I became a NP, and began practising autonomously diagnosing, ordering and interpreting tests, I realised being a NP required a lot more knowledge and skill.

57. With time in the role, I developed more confidence in my abilities, saw more cases, learnt from others and upskilled in particular areas, looking up different medications and conditions. When I first stepped into the NP role, my Master's gave me a strong foundation in advanced assessment, diagnostics, and pharmacology, and my 5,000 hours of advanced practice nursing consolidated these capabilities in real clinical settings. Early on, I practised cautiously and deliberately—using structured assessment tools, checking guidelines, looking up medicines and conditions, and seeking input from senior colleagues to ensure safe decisions. I focused on core NP skills: thorough assessment, clear diagnostic reasoning, careful prescribing, and

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meticulous documentation, while building “soft skills” in shared decision-making, de-escalation, and sensitive, trauma-informed communication with patients and families.

58 By the end of my first few years, increased exposure across inpatient, outpatient, community, aged-care and acute oncology settings translated into greater autonomy and clinical precision. My prescribing became more sophisticated (e.g. opioids and adjuvants, complex polypharmacy, methadone/buprenorphine pathways). I anticipated risk earlier, and I led multidisciplinary discussions with confidence. I also took on higher-stakes responsibilities—initiating anticipatory care plans, coordinating across services, and navigating ethically complex scenarios—while my interpersonal skills matured into calm leadership under pressure. This progression laid the groundwork for my later advanced practice in palliative care integration, trauma-informed care, substance-use advocacy, and Voluntary Assisted Dying.

59 I have continued to expand the scope of my NP practice, with time and experience in different settings, further education and research. I would now consider myself a Senior NP. The nature of my work, and the responsibility and skill I exercise, has changed significantly as I have progressed in my career.

60 I am currently working as a Voluntary Assisted Dying (**VAD**) Nurse Practitioner. In this role, I coordinate consulting assessments, prescribe the medication used for VAD and administer it. I also support the person and their family through the dying process. I am the first NP in the country to administer the Intravenous VAD medication. The legislation in ACT was changed to enable me, and other NPs like me in the future, to practice to their full scope. Outside the ACT, in other states/territories, only medical practitioners are permitted to work as VAD practitioners. I am empowered to practice to my full scope under *Voluntary Assisted Dying 2024 (ACT)*, enacted 3 November 2025.

61 As a NP, I must complete 30 compulsory CPD hours. This is 10 more than RNs have to do. It’s critical my skills are up to date, and that I expand my skills into new areas of need. The EBA governing my employment at Canberra Hospital doesn’t include training time. This means I struggle to get the time I spend furthering my professional development paid for. I also consistently do well above the 30-hour minimum requirement.

Changes in the work of the NP over time

Higher acuity presentations

62. Today, in acute care hospital environments and residential aged care, all patients have complex needs. Day to day, I see a high volume of multimorbidity presentations.

63. In the late 80s and early 90s, patients would present to the hospital two days prior to an operation and would remain admitted for weeks until they had made a full recovery. Now, day surgeries admit patients on the day of their surgeries (often complex ones) and are then discharged into the community to be cared for by community nurses.

64 There used to be a mix of acuity, but now every patient who is in a hospital bed has multiple conditions and complex needs. There is never an empty bed, and admissions and discharges are now much more complex for nurses.

65 People are living longer and not living better. People often living with polypharmacy and all the negative effects of this. We've created a world where cure is valued over supporting people at end of life. Then we have to manage everyone with multiple chronic illnesses.

66 In short, there are higher standards to work to; nothing is 'simple' anymore, everything is complex. As practitioners, our curiosity is always on, our decision-making skills are always on, and we are constantly considering all factors in a patient's case. In my work as a NP, I provide holistic care. Nurses are generally better at considering the entire circumstances of a person's situation, and we are also good at assisting in circumstances where other medical professionals don't want to go. Given that acuity and workload has increased, this has made the job harder.

Changes in responsibilities of the role

67. My scope of practice has definitely changed since my endorsement as a NP.

68. In 2008, the *Medicines, Poisons and Therapeutic Goods Act 2008* (ACT) provided that only medical practitioners could prescribe opioids. So, our chapter of the College of Nurse Practitioners, led by me, successfully lobbied to have the legislation changed to read 'health practitioner.' The ACT is in the process of changing all remaining legislation that is a barrier to NPs working to their full scope of practice.

69 Practice guidelines and legislation changes have broadened what NPs can do. When I first started, I was only allowed to access Medicare if was in a collaborative arrangement with a doctor. Now, clinical practice guidelines have gone, and we can prescribe drugs on the PBS.

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Person centred care

70. When I registered as a RN in 1999, person-centred care was not discussed, nor practiced. Shared decision-making was not a concept, nor was the consumer's voice.

71. Person-centred care was not considered, really, until the last few years. We used to follow the Rogerson model, doing a set of small tasks, rather than looking at a whole person and working on the development of their care.

72 Hospitals are about episodic care. They have an enormous list, medical professionals in a hospital setting don't have time to go the extra mile.

73 The risk of an ever-growing list of possible treatment options is that, as the biomedical model is cure-centric, the person being treated may become sidelined. Nurses often notice sooner than doctors that treatment is futile, and the lack of ability that medical teams have in diagnosing dying leads to futile treatments being given in the last weeks and days of life. Nurses practising person-centred care are well placed to support patients (particularly those with chronic illnesses, including mental illnesses, and those in palliative care) who experience a high number of medical interventions.

74. As a NP, I allow myself the time to actually be with people, listen to them and be creative in my nursing practice to allow me to actually deliver the care that they need. Patients are much happier in the care from a NP. Nursing is built for patients.

Population changes

75. Unfortunately, in Australia, there are many trauma survivors whose health and well-being are overlooked within the biomedical model. Trauma survivors often live with complex physical and mental health conditions, such as chronic pain and PTSD.

76. Domestic violence and violence against women and children are persistent and overwhelming issues. In addition to the obvious suffering caused to survivors, this issue places strain on the nursing workforce.

77. I firmly believe that all nurses need education in mental health, substance abuse disorders, and complex pain syndromes.

78. In major cities, populations have diversified and aged, and new obstacles to care have arisen, including language barriers, cultural differences, and limited access to health care due to very long travel times.

People's access to information about their health

79. Unlike previous generations in the profession, nurses are now expected to help broaden people's access to information about their care. This includes being asked to

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produce informational documents, such as pamphlets or articles, to advance patient education.

80. Patient education is now largely a responsibility of nurses, rather than doctors. For instance, when patients book in for a colonoscopy, nurses are responsible for explaining the procedure.

81 Naturally, the internet has broadened people's access to information regarding health care. However, whether this information is reputable is a consistent problem. Patients will often 'Google' their illness or procedure and are likely to value and assert the information they have found online, believing themselves to be experts. This can be very challenging for nurses.



Nikki Johnston OAM

17-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application By: **Australian Nursing and Midwifery Federation**

Appendix A

Date: 17 March 2026

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NIKKI JOHNSTON OAM

Canberra, ACT [redacted]

PROFESSIONAL SUMMARY

Palliative Care Nurse Practitioner with 15 years of clinical practice and over 30 years of Nursing practice with extensive experience in palliative care, end-of-life care, mentoring, teaching, leadership and research. Multiple awards won for contribution to nursing practice, nursing research and teamwork. Including an Order of Australian Medal for contribution to nursing in Australia, and the Federal Health Minister's trailblazer award for innovation in nursing research that increased access to specialist palliative care in aged care across Australia.

ACCOMPLISHMENTS AND AWARDS

1. Awarded Fellowship of the Australian Collage of Nurse Practitioners 2024
2. CHARM 2021 Poster: Reliving trauma near death: a systematic review won the following:
3. ACT Health Directorate Office of Professional Leadership and Education Award for the best Nursing and Midwifery Research Poster
4. Australian Association of Gerontology Award for best poster relating to Aging
5. HARC Award for the Most Impactful Paper in 2021
6. 2021 ACT Nurses and Midwives Excellence Awards Winner Excellence in Quality Improvement/Research
7. 2019 Palliative Care Australia National Palliative Care Awards Winners Innovation in Palliative Care: The INSPIRED Clinical Team Calvary Community Specialist Palliative Care team
8. ACT 2019 Winner ACNP NP mentor of the year
9. 2019 FINALIST & WINNER: the National Hesta Awards Team Excellence Category – For research integrating specialist palliative care in residential aged care
10. 2019 FINALIST & WINNER: Australian College of Nursing Inaugural Health Minister's award for nursing trailblazers
11. 2019 Recognised in the 2019 Australia Day Honors as a recipient of a Medal of the Order of Australi (OAM) for my contribution to nursing in Australia
12. 2018 Australian Association of Gerontology Best Poster Canberra Health Annual Research meeting
13. 2017 Overall Winner Quality in Healthcare ACT Awards – The INSPIRED trial 2017
14. Won category Effectiveness Quality in Healthcare ACT Awards –

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- The INSPIRED trial 2016 Finalist in the National Hesta Awards Team Excellence Category – For research integrating specialist palliative care in residential aged care

15. 2010 ACT health Quality awards Finalist and overall winners - team excellence awards for producing new data collection model for specialist palliative care services at Canberra Hospital

EMPLOYMENT HISTORY

1. **Voluntary Assistant Dying Nurse Practitioner** 12/2025 -Current

General Medicine Canberra Hospital

2. **Palliative Care Nurse Practitioner**, 11/2024 – 12/2025

CHS Cancer and Ambulatory Services – Canberra, ACT

- Worked on Clinical Expert Panel VAD to develop the clinical handbook for Voluntary Assisted Dying
- Provided comprehensive palliative care assessments for patients with advanced illnesses.
- Initiated Palliative sedation as an end-of-life care option for patients in considerable distress using phenobarbitone infusions
- Educated patients and families on end-of-life options and symptom management strategies.
- Mentored junior nursing staff in palliative care best practices and patient communication techniques.
- Managed complex pain symptoms through medication adjustments, non-pharmacological interventions
- Complex shared decision making
- Diagnosed dying

3. **Nurse Practitioner,** 12/2023 - Current

CHS Cancer And Ambulatory Services – Canberra, ACT

- Prescribed appropriate pharmacologic and non-pharmacologic treatment modalities to support health and comfort of patients.
- Ordered and interpreted diagnostic tests to develop and implement treatment plans.
- Assessed patients to determine individual needs and develop care plans in coordination with multidisciplinary healthcare professionals

4. **Member of the Professional Services Review Panel,** 08/2021 - Current

Commonwealth Of Australia – Canberra, ACT

Appointed as a member of the Professional Services Review Panel - currently working on a case.

5. **Nurse Practitioner,** 02/2021 - Current

Next Practice Deakin – Deakin ACT

- Prescribed appropriate pharmacologic and non-pharmacologic treatment modalities to support health and comfort of patients.
- Ordered and interpreted diagnostic tests to develop and implement treatment plans.

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- Provided medical services and care to patients with chronic and acute conditions.
- Participated in multidisciplinary team meetings to discuss patient cases and treatment plans.
- Provided end of life care for people living in their own home or residential aged care and people experiencing structural vulnerability

6. **Lecturer in Nursing,** 02/2021 - 11/2023

University Of Canberra – Canberra

- Unit convenor
- Teacher for undergraduate nurse's 1st to third year
- Organised and ran a day workshop on "How can we come together to improve the health of those experiencing homelessness"

7. **Palliative Care Nurse Practitioner**, 01/2014 - 02/2021

Calvary Public Hospital Bruce Clare Holland House – Canberra, ACT

Completed research projects

- Palliative Care Needs Rounds quasi experimental pilot study. I initiated and led this study. Successful completion produced 2 articles published in British Medical Journal PSC and cost savings of over $100,000 through reduced avoidable hospital transfers. These in turn influenced federal government to fund $57.2 Million to improve access to specialist palliative care in residential aged care across Australia This partnership agreement named the Comprehensive Palliative Care in Aged Care Measure, has now been taken up across Australia and I have played a part in its implementation and evaluation
- Clinical lead for ethnography that developed the validated Palliative Care Needs Round checklist published in British Medical Journal PSC
- Collaboration study between ANU and ACU, Delphi research project that produced the first definition of specialist palliative care published in Australian Health Review
- Co-investigator successfully developed ran and completed a stepped wedge randomized control trial; the INSPIRED trial. Integrating specialist palliative care into residential aged care using palliative care needs rounds. Leading to cost saving of $2.5 Million in reduced avoidable hospital admissions, improved living and dying in Residential Aged Care and increased the capacity of staff to care for residents at end of life . As a result, $1.6M was allocated in the ACT health budget to fully fund this model of care across Canberra. Published in Palliative Medicine and the Journal of the American Geriatrics Society. A third paper is currently being finalised for submission

Clinical work

- The Nurse Practitioner team provides specialist palliative care services to residents and their families who live in 29 residential aged care facilities in Canberra

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7. **Palliative Care Nurse Practitioner**, 01/2010 - 01/2014

Canberra Hospital and Health Services

- Developed and ran the first Palliative Care Nurse Practitioner service in Canberra. This included outpatien clinics, a service in the emergency department and a nurse-led liver clinic
- Provided care for patients with cancer and haematological malignancies, heart failure, lung failure, liver failure, renal failure and degenerative neurological conditions like including dementia.
- Prepared and delivered guest lectures at the University of Canberra
- Prescribed medications or treatments based on patient nursing assessments.
- Evaluated patient histories and current symptoms.
- Monitored patient condition and progress, ordering appropriate laboratory tests.
- Assessed patient needs, clearly communicating diagnosis and treatment plans to patients and families.

8. **Registered Nurse**, 02/2007 - 09/2010

Calvary Public Hospital Bruce Clare Holland House

- Home based palliative care Clare Holland House Calvary Heath Care ACT.
- Delivering specialist palliative care in people's homes
- Planned, developed and implemented strategies to convey information with key decision makers.
- Education and mentoring to nursing students and registered nurses through the Planned Experience in a Palliative Approach (PEPA) program

9. **Registered Nurse**, 01/2003 - 01/2007

Canberra Hospital and Health Services - Palliative Care Services

- Registered nurse in the specialist palliative care team at Canberra Hospital

10. **Oncology Registered Nurse**, 01/2000 - 12/2002

Canberra Hospital and Health Services – Canberra, ACT

11. **Research Assistant**, 01/1999 - 12/2000

The Research Centre for Nursing and Midwifery Practice: The Canberra Hospital

- Collaborated with leadership team to identify relevant questions and determine best methods of collection
- Evaluated potential subject participants to assess suitability for planned studies.
- Worked with principal investigators to coordinate qualitative research into model of care of hospital in the home at Canberra Hospital
- Recorded data and maintained source documentation following good documentation practices.
- *A Retrospective study to examine the patterns of medical and Nursing Practice in the Care of Dying Patients & Quality Use of Medicines Project-Hospital in the Home*

12. **Registered Nurse**, 01/1999 - 12/1999 **ACT Hospice**

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- Facilitated therapeutic communication, and care for patients and their families at the end of their live

13. **Haematology Registered Nurse**, 01/1993 - 04/1998

St Vincents Hospital Darlinghurst

- Worked on the bone marrow transplant unit at St Vincent's Hospital
- Cared for patients living with HIV/AIDS
- Cared for Patients with haematological malignancies
- cared for patients with immunological diagnoses

14. **Registered Nurse,** 03/1992 - 11/1992

Nursing for you – Portsmouth UK

I worked in both care homes and in private homes

15. **Registered Nurse,** 01/1989 - 12/1990 **Royal North Shore Hospital**

- Completed a new graduate program
- Worked on the heamotology, aged care, trauma orthopedics and surgical gastroenterology wards

GRANTS

Study Grant

Palliative Care Foundation Grant Recipient 2008-2009 $8000 to complete MNP

Research Grant

Samara, J. Johnston, N. (2011) Practice Development Scholarship (PDS) – Advanced Care Planning in Palliative Care Settings: Implementation of Best Practice -$6,500.

Research Grant

Integrating specialist palliative care into residential care for older people: a stepped wedge trial (INSPIRED trial) (2017) ACT health funded $261,716

Research Grant

Multidisciplinary **b**rain cancer **r**ehabilitation, holistic **a**ssessment, and multimodal **i**nterventions to address survivorship **n**eeds: Brain Trial $288, 959

QUALIFICATIONS

1. **Current PhD study**: Investigating how the experience of trauma affects the way we die , expected in 2027 **University of Canberra** - Canberra, ACT
2. **Master of Nurse Practitioner**: Nurse Practitioner Palliative Care, 2009 Newcastle University, Newcastle
3 **Graduate Certificate: Palliative Care**, 1999 The Flinders University – Adelaide

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4. **Graduate Certificate Oncological Nursing**, 1997 The New South Wales College Of Nursing - Sydney
5. **Graduate Certificate: Chemotherapy** , 12/1996 The NSW College Of Nursing - Sydney
6. **Bachelor of Nursing**: Nursing, 1991 The University of Technology **-** Sydney
7. **Diploma of Applied Science**: **Nursing**, 12/1989 The University of Technology **-** Sydney

AFFILIATIONS AND MEMBERSHIP

- Inaugural Member of Palliative Care Nurses Australia Inc
- Fellow Australian College of Nurse Practitioners. Active at a local chapter level
- Member Australian College of Nursing
- Member Palliative Care ACT
- Affiliate University of Canberra
- Member of Synergy University of Canberra

PEER REVIEW PUBLICATIONS

1**.** Mills, Jason and **Nikki Johnston,** '"Leaning in" – Normalizing Trauma-Informed Palliative and End-of-Life Care' (2024) 32(6) *Progress in palliative care* 385

2**.Johnston, Nikki et al,** 'Re-Living Trauma near Death: An Integrative Review Using Grounded Theory Narrative Analysis' (2024) 18 *Palliative care and social practice* 26323524241277851

3. Paterson, C., Roberts, C., Li, J., Chapman, M., Strickland, K., **Johnston OAM, N**., Law, E., Bacon, R., Turner, M. R., Mohanty, I., Pranavan, G. & Toohey, K., (2023), What are the experiences of supportive care in people affected by brain cancer and their informal caregivers: a qualitative systematic review In: *Journal of Cancer Survivorship*. p. 1-22 22 p.

4. Koerner, J., **Johnston, N**., Samara, J., Liu, W-M., Chapman, M., Forbat, L. (2021) Context and mechanisms that enable implementation of specialist palliative care Needs Rounds in care homes: Results from a qualitative interview study. *BMC Palliative Care*

5. Samara, J., Liu, W-M., Kroon, W., Harvie, B., Hingeley, R., **Johnston, N.** (2021) Telehealth Palliative Care Needs Rounds during a pandemic. *The Journal for Nurse Practitioners.* In Press

6**.** Rainsford, S., Liu, W-M., **Johnston, N**., Glasgow, N. (2020) The impact of introducing palliative care needs rounds into rural residential aged care: a quasi-experimental study. *Australian Journal of Rural Health.* 2020;28(5):480-489. https://doi.org/10.1111/ajr.12654.

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7. Rainsford, S., **Johnston, N**., Liu, W-M., Glasgow, N. & Forbat, L. (2019). Palliative care needs rounds in rural residential aged care: A mixed-methods study exploring experiences and perceptions of staff and general practitioners. *Progress in Palliative care* .2019;28(3):110.https://doi.org/10.1080/09699260.2019.1698177.

8**.**Forbat L, Liu W-M, Koerner J, et al. Reducing time in acute hospitals: A stepped-wedge randomised control trial of a specialist palliative care intervention
in residential care homes. Palliat Med. 2019;34(5):571-579. https://doi.org/10.1177/0269216319891077.

9**.** Liu, WM., Koerner, J., Lam, L., **Johnston, N**., Samara, J., Chapman, M., Forbat, L., (2019) Improving Quality of Death and Dying in Care Homes: A Palliative Care Stepped Wedge Randomised Control trial in Australia, *The Journal of American Geriatrics Society* 00:1-8 2020;68(2):305-312.
https://doi.org/10.1111/jgs.16192.

10**.** Forbat, L., **Johnston, N**., Mitchell, I., (2019) Defining 'specialist palliative care': findings from a Delphi study of clinicians*. Australian Health Review.* 2019;44(2):313-321.
https://doi.org/10.1071/ah18198.https://doi.org/10.1071/AH18198

11**.** Forbat, L., Chapman, M., Lovell, C., Liu, W., **Johnston, N**. (2017) Improving specialist palliative care in residential care for older people: a checklist to guide practice. *British Medical Journal Supportive and Palliative Care*. 2018;8(3):347-353. https://doi.org/10.1136/bmjspcare-2017-001332.

12**. Johnston, N**., Lovell, C., Liu, W., Chapman, M., Forbat, L. (2016) Normalising and planning for death in residential care: Findings from a qualitative focus group study of a specialist palliative care intervention. *British Medical Journal Supportive and Palliative Care.* http://spcare.bmj.com/content/early/2016/08/03/bmjspcare-2016-001127.short?rss=1

13**.** Chapman, M., **Johnston, N**., Lovell, C., Forbat, L., Liu, W. (2016) Avoiding costly hospitalisation at end of life: Findings from a specialist palliative care pilot in residential care for older adults. *British Medical Journal Supportive and Palliative* Care. http://spcare.bmj.com/content/early/2016/08/05/bmjspcare-2015-001071.short?rss=1

14**.** Bourgeois, S., Blanchard, D., Doldissen, R., Maher, L., Stoddart, K., **Johnston, N**., Hungerford, C.(2014). *The Nurse Practitioner Role: A pilot study based on the Interview Schedule from the AUSPRAC Research Toolkit.*Contemporary Nurse (2014) 47(1–2): 61–68.

OTHER PUBLICATIONS

1**.** Forbat, L., Liu, W-M., Lam, L., Koerner, J., Samara, J., Chapman, M., **Johnston, N**. (2019) Integrating Specialist Palliative Care into Residential Care for Older People: A Stepped Wedge Randomised Control Trial (INSPIRED Trial). Stirling: Stirling University; 2019:1-70.
https://www.stir.ac.uk/research/hub/publication/1276939. Accessed October 28, 2020.

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2**. Nikki Johnston** (2019) Leadership trailblazer 2019 Winner A Better life –and death *The Hive* #26 Winte the Australian College of Nursing: Deakin

3**. Nikki Johnston** (2019) Q&A with Nikki Johnston OAM *Health Matters* Catholic Health Care Australia Issue 90/ Winter 2019

4**. Nikki Johnston** (2020) Looking Back: Nursing Trailblazer Nikki Johnston OAM MACN *The Hive* #30 WINTER The Australian College of Nursing: Deakin

Implementation Resources Palliative Care Needs Rounds https://www.calvarycare.org.au/wp-content/uploads/2020/08/Calvary-Palliative-Care-Needs-Rounds-Implementation-Manual.pdf

CONFERENCE PRESENTATIONS

- **Nikki Johnston** & Louise McLean (2025) how and what to prescribe compassionate access Medicinal Cannabis workshop**:** Australian Collage of Nurse Practitioners National conference, Canberra ACT
- **Nikki Johnston** (2025) Oceanic Palliative Care Conference 2025 applying evidence for safe End-of-Life care for trauma survivors who are dying, Brisbane QLD
- **Nikki Johnston** (2025) Influencing better end of life care invited speaker. NSW branch of the ANMF national conference Randwick NSW
- **Nikki Johnston**, Micheal Chapman, Jo Gibson, Kasia Bail (2023) Re-living trauma near death: an integrative review. OCEANIC palliative care conference, Sydney.
- **Nikki Johnston** (2020) The evolution and where we are now: Palliative care needs rounds resulting in better living and dying in residential aged care. Tasmanian Nursing Conference: Hobart
- Forbat, L., **Johnston, N**., Liu, Wai-Man., Koerner, J., Chapman, M., Lam, L., Samara, J.(2019) Better lives and better deaths in aged care through specialist palliative care Needs Rounds: Results from a stepped wedge randomised controlled trial Oceanic Palliative Care Conference Perth WA Findings from the INSPIRED trial
- **Johnston, N**. (2019) Donna Diers Oration Australian College of Nurse Practitioners Dimensions in Care Conference, Melbourne, Australia
- Samara, J., **Johnston, N**., Forbat, L., Chapman, M., Liu, Wai-Man., Koerner, J., Lam, L. (2019) Improving access to Palliative Care in Residential Aged care - INSPIRED Trial ACT End of Life & Palliative Care Research Collaboration Inaugural workshop
- **Johnston, N**., Samara, J., Forbat, L., Koerner, J., Liu, Wai-Man., Chapman, M. (2019) Integrating Specialist Palliative Care into Residential Aged Care for Older People: a stepped-wedge randomised controlled trial (INSPIRED trial) Canberra Health Annual Research Meeting Presentation and panel discussion

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- Samara, J., **Johnston, N**. (2019) The Silicone in Residential Aged Care Australian College of Nurse Practitioners Transforming Healthcare Conference, Perth, Australia
- Mitchell, I., **Johnston, N**., Forbat, L. (2019) Defining Specialist Palliative Care: a delphi study ACT End of Life & Palliative Care Research Collaboration Inaugural workshop
- **Nikki Johnston**, Michael Chapman, Prof Liz Forbat, A/Prof Wai-Man (Raymond) Liu, J. Samara (2018) *Improving End of Life Care for Older Australian's.* Aged and Community Service Australia (ACSA) Summit Sydney entertainment centre 4 September
- **Nikki Johnston**, Michael Chapman, Prof Liz Forbat, A/Prof Wai-Man (Raymond) Liu, J. Samara (2018) *Palliative Care at the Doorstep: How an Improved Palliative Care Model Can Improve EOL Care, Avoid Hospital Re-Admissions and Reduce Length of Stay*. 2nd Annual Palliative, Aged & Dementia Care Forum, 3 - 5 July 2018 at Melbourne Convention & Exhibition Centre.
- **Nikki Johnston**, Michael Chapman, Prof Liz Forbat, A/Prof Wai-Man (Raymond) Liu, J. Samara (2018) *Chronic Care update: Dementia Palliative care needs rounds and advance care planning RACF***.** 29th Annual Nepean Blue Mountains Supportive and Palliative Care Conference Penrith 1 June 2018
- **Nikki Johnston**, Michael Chapman, Prof Liz Forbat, A/Prof Wai-Man (Raymond) Liu, J. Samara (2018) *Integration of specialist palliative care into residential aged care – end of life panel.* National Aged Care Alliance (NACA) meeting Melbourne
- **Nikki Johnston**, Evelyn McDonald, Prof Liz Forbat (2017) *Growing old (dis)gracefully: tales from a collaborative project improving quality in residential aged care.* CHARM Canberra Health Annual research meeting
- Sally Kuffner, **Nikki Johnston** (2018) *Pressure injuries at end of life: Is dying a risk factor? Consequences for specialist palliative care inpatient units accessing activity-based funding.* Palliative Care Nurses Australia Conference: Brisbane
- Cecile Alvarez, **Nikki Johnston**. (2018) *Mentoring to foster capability among palliative care nurses*. Palliative Care Nurses Australia Conference: Brisbane
- **Johnston, N.** McDonald, E. (2017) Growing old (dis)gracefully: tales from a project improving quality in residential ages care CHARM conference: Canberra
- **Johnston, N.** Anderson, K**.** (2017) Supporting the community health team 14th Australian Palliative Care Conference: Adelaide
- **Johnston, N**. Forbat, L. Lovell, C. Chapman, M. Liu, W. (2017) Using a checklist to improve palliative care in residential aged care. 14th Australian Palliative Care Conference: Adelaide

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- Forbat, L. **Johnston, N**. Maher, K. (2016) Building resaerch capacity in a clinical practice setting: A framework and transferable learning from palliative care: 11th Conference of the Australian College of Nurse Practitioners: Alice Springs
- **Johnston, N**. Lovell, C. Chapman, M. Wai-Man, LForbat, L. (2016) *Palliative Care Nurse Practitione improves access to palliative care medicines for older Australian* 11th Conference of the Australian College of Nurse Practitioners: Alice Springs
- **Johnston, N**. Lovell, C. Chapman, M. Wai-Man, LForbat, L. (2015) *Effect of a proactive model of Palliative Care service delivery in Residential Aged Care Facilities on hospitalisation and location of death.* 13th Australian Palliative Care Conference: Melbourne
- Anderson, K. **Johnston, N**. (2015) *Keeping our hearts mellow!* 13th Australian Palliative Care Conference: Melbourne
- **Johnston, N**. Pacl, D, Quayle, S. Bale, S. (2013*) What should health care professionals consider when planning your end-of-life care?* 12th Australian Palliative Care Conference: Canberra
- **Johnston, N**. Pacl, D, Quayle, S. Bale, S. (2013) *Dying to get it right.* 12th Australian Palliative Care Conference: Canberra
- Pacl, D. **Johnston, N**. Naing, T. (2013) *Evaluation of Key Performance Indicators in a Streamlined Care of the Dying Collaborative Pathway.* 12th Australian Palliative Care Conference: Canberra
- **Johnston, N**. Blanchard, D. Bourgeois, S. Hagen, D. Hungerford, C. (2011) *Structured data collection for the nurse practitioner role in palliative care: the question of outcomes.* Australian College of Nurse Practitioners conference: Adelaide
- **Johnston, N**. (2011) *Assessment or Assumption: Who cares for terminally ill patients with mental illness and a history of drug use in the acute care setting? A Palliative Care Nurse Practitioners Intervention.*11th Australian Palliative Care Conference: Cairns
- **Johnston, N**. (2008) *What receiving* scholarship means *to me.* Launch of the Palliative Care Foundation A Matter of Life and Death: Canberra
- **Johnston, N**. (2008) *Palliative Care in Residential Aged Care.* Aged Care Forum Initiatives, Innovations in Aged Care Canberra
- **Johnston, N**. (2006) *Myths of Morphine: Neither hasten death nor prolong life.* Finding life through facing death: A palliative care symposium for the community Merimbula NSW
- Stephenson, D & **Johnston, N** (2006) *Databases, service profiling and the hunt for more resources.* Palliative Care Nurses Australia Inaugural Conference: Melbourne
- **Johnston, N**. (2001) *Dying in Hospital-Signposts and Turning Points* 6th Australian Palliative Care Conference: Hobart September 10-12

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF STEPHEN VOOGT

I, Stephen Voogt of [redacted] say:

Qualifications and work history

1. I have been working as a Nurse Practitioner (**NP**) for approximately 15 years.

2. I am currently a NP at Northeast Nurse Practitioner Services in Beechworth (**NENPS**) where I provide primary health care to patients. I also have extensive experience working as a NP geriatric specialist in residential aged care.

3. I am a member of the Australian Nursing and Midwifery Federation (**ANMF**).

Qualifications

4. From 1986 to 1988, I completed my Registered Nurse (**RN**) training at Mercy Private Hospital in East Melbourne.

5. In around 1995, I completed a Graduate Diploma of Business Management at Monash University.

6 In 2001, I completed a Graduate Certificate in Critical Care Nursing at Latrobe University.

7. In 2003, I completed a Graduate Certificate in Mental Health Nursing.

8. In 2009, I completed a Master of Nursing Practice at Deakin University. I was endorsed as a NP in 2010 by the Nurses Board of Victoria. I was the first aged care NP endorsed in Victoria.

Work history

9. After I finished my in-hospital nursing training in 1988, I was employed as a nurse in various roles across Victoria, Australia and internationally:

Lodged by:	Telephone:	03 9603 3035
The ANMF		
Address for Service:	Fax:	03 9603 3050
Level 5, 500 Bourke St	Email:	nwhite@gordonlegal.com.a
Melbourne VIC 3000		

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(a) From the late 1980s to around 1990, I was employed as an RN at St Vincent's Public Hospital, Tenant Creek Hospital, Warrnambool Base Hospital and the Epworth Hospital.

(b) From 1992 to 1997, I was employed as a RN at the Austin Hospital. By the end of my time there, I was the Nurse Unit Manager (**NUM**) of the surgical ward.

(c) From 1997 to around 2000, I was employed as an NUM at Southern Eastern Private Hospital.

(d) From 2000 to 2001, I was employed as a RN at Knox Private Hospital. During this time, I completed my post graduate certificate in Critical Care.

(e) In 2001, I worked as a nurse in Canada.

10 From 2002 to around 2016, I was employed at Northeast Health Wangaratta as both an RN and an NP.

(a) From 2002 to 2010, before my NP endorsement, I was employed as an RN full-time. In that role I split my time as a RN between the Kerferd Psychiatric Unit and the Geriatric Evaluation and Management Unit in Wangaratta. During this time, I completed my Graduate Certificate in mental health nursing.

(b) Then, from 2012 to around 2016, I was employed as an NP at Northeast Health Wangaratta. I was employed at the following Northeast Health Facilities;

i) From 2010 to around 2012, I was employed as a NP at Illoura public health aged care facility. I worked at Illoura two half days a week; and

ii) From around 2013 to around 2016 I was employed as a NP at Older Persons Mental Health (**OPMH**). This service provided psycho-geriatric services to older people in the community. Much of this work involved assisting in the management of dementia, depression and anxiety symptoms in residential aged care. OPMH also delivered the Dementia Behaviour Management Advisory Service, a service that ran out of St Vincent's Hospital. I worked in this role part-time two days a week.

iii) In about 2016, OPMH was transferred from Northeast Health Wangaratta to Albury Wodonga Health. So, while I continued to be employed there as a NP two days a week, my employer changed to Albury Wodonga Health.

11. From 2014 to now, I have worked in my own business, North East Nurse Practitioner Services (**NENPS**). Over this period of time, I have held a number of roles:

(a) From about 2014 to 2023, I was contracted at St Catherines Aged Care Home in Wangaratta to work as a NP three half days a week.

(b) In 2014, I was contracted to work as a NP at St John's Aged Care Home in Wangaratta. St John's Aged Care is a large 120 bed aged care facility. I was contracted to work one half day a week.

(c) In 2017, I was contracted to work as a NP at Omeo Hospital which is an aged care facility with 15 beds. I was contracted to work one full day a month.

(d) From 2017 to 2018, I was contracted to work as a NP at Bentley Wood, a private aged care provider. I worked a half day a week at their Myrtleford Lodge facility and a half day a week at their Woods Point, Yarrawonga facility.

(e) From around 2017 to 2019, I was contracted to work at St Johns Aged Care again. I was contracted to work two to three half days a week. Prior to my engagement, an Aged Care Quality and Safety Commission (**ACQSC**) report had identified several standards that were not being met by St John's. I assisted St John's in trying to improve the standard of care to meet those standards.

(f) In 2019, I was contracted to work at Tallangatta Health Service as a NP in their aged care facility. I was contracted to work one full day a week.

(g) In 2020, I was contracted to work at Yackandandah Health Service as a NP. Yackandandah Health Service is a community based private aged care service. I was contracted to work two to three half days a week.

(h) In 2020, I was also engaged by Glenlyn Aged Care Facility in Glenroy as an NP to advise the facility throughout the COVID pandemic to manage outbreaks. I was there for eight weeks full-time.

(i) In 2021, I was subcontracted by aged care consultants to advise the Monash Health public aged care facilities. The senior Monash Health team had identified potential issues with compliance with regulatory standards. Initially, I was engaged for a 6-7 week stint to advise on meeting these standards**,** conducting clinical assessments on staff and advising the facilities how to manage difficult patients. However, after the facilities had COVID outbreaks, I started advising them in managing care in that context. I worked there two full days a week for the year.

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(j) In December 2024 to now, I have worked in my own primary healthcare clinic in Beechworth. I work three to four half days a week in this clinic. In this role, I provide primary healthcare to local residents, particularly elderly locals.

(k) From April 2025 to now, I have also been contracted to work at the ALBA Health practice in Myrtleford. Again, I perform primary healthcare there for residents. I am contracted three half days a week.

Enrolled Nurses in aged care

12. Throughout my time working as a NP in aged care, I have had ample opportunity to directly observe the nature of the work of Enrolled Nurses (**ENs**). I have a good sense, having worked alongside ENs at all different levels of seniority, alongside Personal Care Workers / Personal Care Attendants (**PCWs/PCAs**) and Registered Nurses (**RNs**), of the areas in which ENs progress in their skill development and practice at a high level.

13 There is a distinction in EN roles as between public hospital aged care facilities, for example Chestnut Gardens run by Monash Health, and private aged care facilities, like Rangeview Nursing Home in Wangaratta.

14 In the public system, nursing roles tended to be clearly delineated. RNs were in charge of the nursing shift. ENs were responsible for taking care of the residents.

15 In the private system, ENs typically had additional responsibilities. These ENs practised at a higher level and with some aspects of care were just as skilled, based on the teams I observed and worked alongside, as their RN colleagues. Often these ENs ran their own wing in the facility, and independently cared for 30 residents.

16 I can make the following observations in respect of the nature of the work and skills exercised by these ENs in private aged care settings. Where possible, I will also comment on the relative seniority of the ENs demonstrating these skills:

(a) ENs generally have excellent skills in identifying and managing <u>acute deterioration</u>. For example, if a resident became acutely unwell with a fever. In the typical scenario, a PCA would tell the EN that a particular resident appeared unwell. The EN would then go and do an assessment, checking the resident's vital signs and ascertain whether the fever was caused by a UTI or chest infection or some other illness. Responding to these situations efficiently and effectively is a skill ENs acquire with time in the role. Typically, of the ENs I have observed, it is the ENs with over five years' experience who have the confidence to effectively handle these cases. As a result of their assessment,

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they are able to form a provisional diagnosis and put a short-term management plan in place to keep the resident safe, while notifying the on shift RN and/or other medical professionals. By short term management plan, I mean the EN will apply all kinds of non-medical interventions; getting the resident in bed, supplying oxygen and providing the patient with a Panadol for the symptoms of the fever.

(b) ENs with four or five years' experience are very skilled at being able to identify signs of acute deterioration. This is a learned skill through on the job training and experience rather than something they learn as part of their Diploma.

(c) Many ENs are skilled in wound management. I am not an expert in wound management but many ENs are able to tell me whether a wound is infected or not, and the best way to care for wounds on patients. There is oversight by the RN of any complex wound management, but the EN in aged care is the first point of call for examining the wound each and every day, assessing whether the wound is improving or deteriorating or assessing in collaboration with the RN whether the product they are using to treat the wound is appropriate or needs to be changed.

(d ENs are very adept at conducting and interpreting observations. This is an important clinical skill that takes time to develop. Anyone can do observations but being able to connect the dots is the key to the skill. ENs take time to develop that skill. Usually, after three to four years, ENs will start to develop the skills of joining those dots and knowing the cause of why most observations are not normal. ENs I worked alongside were very good at reviewing patient's progress charts, fluids, and treatment given to date, in order to identify those patients in need of triage. It takes skill, and is a significant responsibility, to identify that a patient is stable. The EN in aged care is the nurse conducting regular observations of the resident and identifying those patients who need escalation to the RN, NP or Doctor.

(e ENs are skilled at identifying and managing behavioural issues. Recently, there has been a big push to identify the precipitants of behavioural issues from aged care residents. Common precipitants of behavioural issues are things like pain, dehydration or constipation. Experienced ENs are good at identifying the precipitants of these disturbances to avoid an escalation in behavioural issues. They've seen situations before. For example, they will put two and two together and identify that the resident's behaviour has changed when new medication

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was administered. They will then raise concerns with the RN, NP or doctor about that medication having an adverse effect.

(f) ENs in aged care are also noticeably skilled at managing behavioural disturbance including by keeping the resident and other people safe and calming the resident down. The typical management of a behavioural disturbance would be a PCA alerting an EN that a resident is irritable and getting a bit aggressive. The EN would then make a formal assessment about what is going on. For example, the EN would notice that the patient has a fever, is going to the toilet more often or their urine is offensive. The EN will then deduce and come to a preliminary view that the patient has a UTI and take temporary measures to manage this while conferring with the RN on shift. An EN would also tell me directly that the patient has symptoms and signs of a UTI. I would then order a full test and prescribe them antibiotics. The EN will notice a behavioural disturbance and look at underlying issues. Many behavioural issues can be addressed early on when the underlying causes of the behavioural disturbance are effectively recognised.

(g Since the introduction of the Aged Care Quality Commission aged care standards, ENs at all levels are expected to be able to work through individual resident's behavioural issues. I have observed that ENs with at least five years' experience in the role will be particularly good at this. I have observed that ENs with this level of experience have the confidence to deal with someone who is aggressive and explosive. Experienced ENs have the confidence to engage with a person with behavioural issues and determine what is driving that behaviour from a clinical perspective; is the resident in pain? could the resident have a UTI? ENs continue to get better at this with time, as they build professional relationships with residents and get to know their triggers. At Chestnut Gardens, which is run by Monash Health, there was a psychogeriatric unit which had patients with complex behavioural and cognitive issues. Experienced ENs of more than 5 years' experience were quite skilled at managing aggressive behaviours of very difficult patients within this unit.

(h Another big issue ENs deal with is falls. In an immediate sense, the EN will assess whether there are any signs of fracture, laceration or head injury. The EN will then begin to identify the underlying issues that may have caused or contributed to the fall – things like whether they have major geriatric issues, pain, continence issues, acute deterioration and/or mental distress.

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(i) The EN will determine whether to escalate care of the patient immediately or whether the patient is stable. The EN will assess whether the resident's blood pressure is stable enough that they can be transferred back to bed. Likewise, the EN will assess whether the resident is safe to weight bear. The EN will converse with the resident and try to determine whether a cerebral event has occurred. The EN will report the incident and their findings to the RN on shift. The EN is also the one who alerts the patient's next of kin that they have had a fall and advises on the action adopted by the nursing team in response. The ENs are skilled at identifying whether the event is traumatic and requires urgent escalation or whether it can wait for the NP or doctor's next regular visit. The EN will converse with the resident and determine whether there was a cerebral event. The EN needs to have sufficient confidence in their skills in order to effectively raise these issues with the RN. I observed this typically took around 3-5 years' experience in the EN role.

17 I make the following further comments in respect of observations I have made of ENs in aged care progressing in their roles and nursing careers:

(a) New ENs who have only recently obtained their qualification have baseline skills in managing residents but lack experience in the role. They lack experience if things outside the norm occur. These ENs have much to learn on the job about managing acute issues and the stress of the job. Generally, new recruits lack confidence in completing clinical tasks. New ENs will complete their tasks while working alongside another EN or a supervising RN until they demonstrate competence in the role.

(b ENs in their first year are primarily responsible for attending to resident's personal activities of daily living (hygiene, nutrition, behaviours, social connection and immediate safety) and delivering care in accordance with set care plans. For example, the EN will greet the resident in the morning, assess their mood for the day, and either assist the resident in going to the toilet and having a shower, or allow the resident some further time to orient themselves and improve their mood, before returning later in the morning to complete these tasks.

(c ENs with a couple of years' experience are practising at a much higher level. These ENs are demonstrating the skills I detail above in identifying acute deterioration, wound management, behavioural disturbance and managing falls. I have observed ENs with 5 years' or more experience manage entire

wings of aged care facilities within minimal oversight of the RN. Importantly, these ENs were the primary point of contact for the next of kin of the residents on that wing. These professional communication skills, in and of themselves, are acquired skills and a considerable responsibility. Learning how to effectively communicate is a skill you learn on the job. The more adverse events you witness and how you communicate them, the better you become.

(d) From my discussions with ENs over the years, I can say that many ENs do not become RNs because of their perception of the time and cost involved in completing a degree. These ENs are also often happy with the work they are doing.

My work as a NP in aged care

18. As a NP working in residential aged care facilities, I use my advanced clinical skills to assess the residents, order scans and pathology and formulate an appropriate diagnosis and treatment, including but not limited to prescribing medications. In short, as a NP I am using the same modalities of treatment as a medical practitioner.

19. Take my work at St Catherine's facility as an example. I worked in that facility in collaboration with a group of general practitioners (**GPs**). I attended at the facility alone three times each week. My attendance meant the GPs could attend considerably less frequently.

20 At the time I was subject to a collaborative arrangement, and that affected my autonomy because without entering into a collaborative agreement, I could not access MBS or PBS for that patient. That meant you could not get paid by Medicare. So, overall, collaborative agreements negatively affected my practice because if the GPs weren't prepared to enter into a collaborative agreement, you could not treat a patient, even if the patient wanted to see you.

21 A typical day was as follows:

(a) I would begin by seeing residents in the facility that had been identified as experiencing signs of acute deterioration. These cases were pointed out to me by ENs or RNs who had identified the signs and determined escalation to a NP or GP was required. I'd take the time to speak with the nurse or nurses to understand why the person was identified and the extent of the interventions conducted to date. As a nurse myself, I highly value the work of my nursing colleagues who often know the resident well and are well-placed to provide context. Details like the resident's mood today relative to other days, recent

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interactions with next of kin, food and social preferences etc. I would then conduct a comprehensive assessment of the patient, examining and assessing them via a systems approach. This means I would look at the patient's systems like their cardiovascular, respiratory or gastrointestinal systems. Then, I would order pathology, assess the results and begin to formulate a diagnosis. I'd then prescribe a course of treatment, for example a chest infection I would prescribe a course of antibiotics.

(b Residents who have had falls fit into this category. As a NP, I often did an assessment with a patient after a fall in order to determine whether or not there has been a neurological event. For example, the EN or RN might suspect that someone has postural hypotension, meaning they fell when they stood up because their blood pressure fell. After a fall, an EN or RN would check a patient's vital signs and blood pressure and they can infer that it was a fall based on hypotension. The NP would extend on the assessment and determine the actual cause of the hypotensive event; so, whether it was caused by medication or dehydration or whether the patient had an arrythmia.

(c If a patient had a fall or had some earlier treatment, I would check in on their status a few days later. For example, continuing from the example above where a patient fell, I would review observations conducted by ENs and RNs in the intervening days, assess the person's current state of health and evaluate the effectiveness of previous treatment plans. So, if I thought the fall was due to postural hypotension caused by medication, I would commonly halve the dose of medication. Then, after a few days, I would examine the patient and see whether the hypotension had resolved.

(d Once I had attended to the above critical patients, I would move on to assess residents with chronic health concerns. We typically refer to these as the geriatric syndromes. The geriatric syndromes affect the resident's function and quality of life like cognition, chronic pain, mental health, wounds or continence issues. It's important people in aged care with these conditions are seen regularly by a GP or NP because these conditions are generally the primary reasons that people end up in aged care facilities. So, by providing regular and proper treatment we can optimise their quality of life and alleviate some of their symptoms.

(e Finally, I would spend a considerable amount of my time seeing residents in palliative and end of life care. As a NP, when a patient is being treated for end

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of life care, we are treating the symptoms so that we can ensure the patient has optimal quality of life at their end of their days. This treatment is about minimising pain and agitation. So, if needed you would increase pain relief and increase medication for anxiety.

22 All of these modalities of treatment sit comfortably within my scope of practice as a NP. That is, acute deterioration, chronic disease management, palliative care and the advanced geriatric syndromes. I developed this scope of practice when I was becoming endorsed as an NP. My scope of practice has evolved and become more advanced as I have gained further experience.

23 My practice as a NP in aged care complements the medical care given by a GP. When I was regularly going into aged care facilities, there was significantly less need for GPs to attend residential aged care facilities in person or via telehealth.

24 I have observed that demand for GPs is high, particularly in metropolitan areas. Typically, and prior to NPs performing this work in residential aged care settings, I observed that GPs would attend sporadically over their lunch break or at the end of their working day. I can say, as a NP doing the same work, that is nowhere near enough time to effectively see and treat these residents, most of whom have multiple complex diagnoses. I regularly spent three to four half days in person as the treating NP attending to these patients. These GPs had time to see a small number of residents experiencing acute issues, but they rarely had capacity to get on top of chronic issues. Taking the time to provide this kind of holistic healthcare is at the core of NP practice.

My work as a NP in primary health

25. In recent years, I have moved from aged care into primary health.

26. I was well-equipped, because of my scope of practice as a NP and a geriatrician, to do this. The majority of my patients are over 65 and present, to differing levels of acuity, with the same conditions I was accustomed to treating in aged care. Cognitive impairment is common.

27 I now also practice in general primary health – for example, I have no difficulty treating a 25 year old with Influenza. In commencing in my roles in primary health, I did a fair amount of education to extend my scope of practice. When I first moved into primary health, I did a lot of online education reading relevant literature. For example, I did a lot of education around management of men's health like erectile dysfunction and management of prostate issues. I was also mentored by the GPs in these areas.

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28. Many of the skills I acquired as a NP working in aged care are transferable to a younger cohort of patients. For example, assessing the chest of an 80 year old and a 30 year old and diagnosing viral illness is the same.

29 There are important exceptions to my scope of practice: I do not treat children, and I do not practice in women's health. I have yet to upskill in these areas such that I feel competent to practice in these areas.

30 As a NP, and as a professional, I acknowledge the limitations on my experience. I've learnt a great deal in order to transfer into primary health, but I've only ever expanded my scope of practice to care for these patients where I've judged I am safe and competent to do so. My scope of practice is my area of clinical competence. As an NP I determine what I'm clinically competent at. So, I don't treat children or work in women's health because I don't have experience and I don't feel competent. If someone comes in with these issues, I refer them to the GPs. I talk to the GPs about cases daily. In the primary health setting, there's a lot of ongoing informal mentoring and clinical discussion. This is a two way street; a number of GPs refer their patients to me if they are experiencing chronic pain and cognitive impairment.

31 I turn up to Beechworth clinic before my rostered session, log on to view patient's results and then have a diary of patient consultations in a way that is similar to a GP. I do almost identical work to the GP, though there are certain Medicare subsidies I cannot access. For example, while I can provide a referral for a Computed Tomography Scan (CT Scan), the patient cannot claim the associated Medicare benefit.

32. NP services like mine assist to ensure there is enough primary healthcare in regional areas. I know that in my area, patients cannot get a booking with a GP for two to three months. The system needs NPs like me.

Changes in the work of NPs in aged care

33. Over my years as a NP in aged care, I have observed that the work has changed and what is required of NPs practising in this setting has increased.

Higher acuity and complexity of patient care

34. Over the past 20 years, acuity has become higher and higher, particularly in aged care. Patients are presenting a lot later in life. For example, residents are delaying entry into residential aged care a lot later and choosing to stay at home longer. That means, when they do present, they have more complex health issues to manage. As a NP,

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you can be managing physical diseases like heart failure and emphysema, alongside cognitive impairment like dementia and longstanding chronic pain all in one patient.

35. This makes the job harder because of the potential for different prescribed medications to negatively interact with each other. In most medical specialities, a medical practitioner will look after one thing. For example, a cardiologist will be concerned with the person's heart. As a NP in aged care, you're treating the whole person and all their health concerns. At the same time, you're balancing quality of life or end life. You have to be really conscious that your treatment for one issue does not exacerbate some other issue, and you have to keep the extent of treatment and interventions in perspective, in accordance with the person's wishes.

36 For this reason, I consider the skill level of NPs practising in aged care is really underestimated. The spectrum of practice is very broad; you have to be on top of physical assessment, physical treatment *and* death and dying.

37 Additionally, these days there is a greater expectation that high acuity patients will be cared for in an aged care facility rather than transferred to hospital. There are a limited number of beds in hospital. The demand on residential aged care facilities to provide quality acute and palliative care is high. Now, people with severe infections or behavioural issues are generally treated in the facilities rather than being transferred to hospital. 10 years' ago, if a patient had a severe fever, and it got worse, we would transfer the patient to hospital. Now, we provide intramuscular antibiotics and if they are dehydrated, provide them with subcutaneous fluids. In addition to the above, it's also very important to know what the advanced care plan is for someone nearing the end of their life. Some patients do not want medical treatment and do not want to be transferred to hospital. So, if they have a serious medical issue, like a heart attack, and their advanced care plan says they do not want to be transferred to hospital, we may treat them inside the facility.

Aged care standards

38. To a much greater level, the sector is now governed by aged care standards. These have also become a lot stricter over the last 10 to 15 years. I agree with all of the standards, but the nature of the work has necessarily changed as a result.

39. For example, how we care for patients with dementia, and manage their associated behaviour issues, has changed significantly. NPs now avoid the use of sedation, where once this was relatively commonplace. Instead, NPs, RNs and ENs consider a whole suite of non-pharmacological strategies (things like assessing and managing pain and dehydration) to effectively manage these behaviours. Working out the best approach

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for each person takes time. The nature of the work has changed, as has the skill and responsibility involved in doing the work – for example, in identifying the underlying triggers for behaviour disturbance, as discussed above.

40 There's also a great deal more involved in liaising with families in order to obtain medical consent, where necessary. Previously, if we decided that the patient's behavioural issues were caused by poorly managed pain, we would need to call the family and explain the issue and get their consent to use analgesia. These days, as a result of the changes to the standards, NPs like me don't simply treat the symptoms. Rather, we're required to examine the underlying causes of things.

41 The aged care standards mean that you need to be more skilled and treatment takes more time. The standards put an emphasis on quality of life and function and not using things to mask symptoms. There is now a greater emphasis on using the best evidence based management for residents. The standards ask a lot more of aged care facilities in managing the patients.

42. While I agree with the standards, the nature of the work and the level of skill exercised by the NP has changed as a result.

[redacted]

Stephen Voogt
18-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF ROSE MCCROHAN

I, Rose McCrohan of [redacted] say:

Qualifications and work history

1. I started working as a Nurse Practitioner (**NP**) approximately 15 years ago in 2009.

2. I am currently the Manager and lead Nurse Practitioner of Curran Place, an alcohol and drug residential detox facility run by Uniting Care Victoria and Tasmania.

3. I am a member of the Australian Nursing and Midwifery Federation (**ANMF**), the Australia College of Nurse Practitioners (**ACNP**), Australasian Professional Society on Alcohol and other Drugs, and Drug and Alcohol Nurses of Australasia.

Qualifications

4. In 1992, I obtained a Diploma in Applied Science (Nursing) from the Phillip Institute of Technology Bundoora.

5. In 1993, I obtained a Bachelor of Nursing from RMIT Bundoora.

6. In 1999, I obtained a Graduate Diploma in Addiction Studies from Deakin University Burwood.

7 Throughout 1999 to 2003, I obtained a number of qualifications in management, e-commerce and communication.

8 In 2007, I completed two medication management modules titled 'Pharmacology and Therapeutics II' and 'Application of Clinical Pharmacology II' at the University of Melbourne.

9. In 2008, I obtained my Master of Public Health (Addiction) from the University of Queensland.

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10. In 2009, I was endorsed as a NP in the alcohol and drug category. I qualified for endorsement, consistent with the process applicable at that time, on account of having my Masters Degree in a related field together with the two medication management modules. There was a panel interview and I submitted a portfolio that demonstrated my professional activity and leadership in the field. At the time, I was the first NP to be endorsed in the drug and alcohol category.

11. In 2013, I received further endorsement as a NP in the mental health category. This was on the basis of demonstrated clinical competency, ongoing professional development and self-directed study.

Work history

12. From 1989 to 1992, I worked as a Personal Care Attendant and State Enrolled Nurse in the Judge Book Nursing Home in Eltham.

13. From 1992 to 1994, I worked as a Registered Nurse (**RN**) at Pleasant View Centre in Preston.

14 From 1996 to 1998 I worked as a RN in the Drug Services Unit at Box Hill Hospital. This was a homebased and outpatient withdrawal service.

15 From 1998 to 2003, I worked as a RN and the Nurse Unit Manager (**NUM**) at ACCESS Alcohol & Other Drug Service in Box Hill. This was a community residential withdrawal unit.

16 From 2003 to 2005, I worked as a RN at Youth Substance Abuse Service at their sites in Glen Iris, Box Hill and Fitzroy. This was a homebased and residential withdrawal facility.

17 From 2005 to present, I have held multiple roles – initially as a RN and from 2009 as a NP – at Curran Place, a residential detox facility run. In those days the facility was run by Uniting Care Moreland Hall, presently known as Uniting Victoria and Tasmania.

18 In 2012, I established my own small business, AOD Solutions Pty Ltd, as a NP. I worked part time in this business as a private NP while on maternity leave from my substantive role at Curran Place.

19 From May to August 2013, I provided long-service leave cover to [redacted] Addiction Medicine Physician and Pain Management Specialist. I have continued to provide regular cover to [redacted] during his leave periods. I undertook this role initially in my capacity as a private NP then as an employee of Uniting Care Moreland Hall / Uniting Victoria & Tasmania.

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Curran Place

20. Curran Place is an acute residential detox facility in Ivanhoe, Melbourne. When I began working there as the NUM (RN) in 2005, we were an adult 12 bed inpatient withdrawal facility. In 2016 this increased to 16 beds and we extended care to mother and babies in need of drug and alcohol addiction withdrawal services.

21. Our patients (referred differently as patients, clients, consumers or residents) are all voluntary patients but many are subject to drug treatment orders imposed by the drug courts of the County Court of Victoria and/or the Magistrates Court of Victoria, or are referred via Specialist Maternity Services hospitals as they have infants and children the subject of Interim Accommodation Orders or Family Reunification Orders imposed in the child protection system. Patients typically stay 7 to 8 days in order to effectively detox from drugs and/or alcohol.

22 As the NP and Manager of Curran Place, I oversee a multi-disciplinary team comprising RNs, social workers and drug and alcohol support workers. There are approximately 40 staff in our facility, and half of them are nursing staff.

23. Up until 6 months ago, and since I was endorsed in 2009, I have been the only NP working in the facility. I'm there full-time and when I'm not there I'm available by phone to give telephone directions. We now have two NPs, including myself. Our other NP works within our organisation's Youth Residential Services, not in my team.

Duties and responsibilities of Nurse Practitioners

24. NPs are advanced clinicians and leaders in the nursing profession. NPs are adept at working autonomously, whilst working in collaboration with medical practitioners and other prescribers.

25. I progressed from being the NUM (RN) to obtaining my NP endorsement whilst working at Curran Place.

26 When I worked as the NUM (RN), my scope of practice was necessarily very different and highly limited. There were no NPs at the time. Our small team of RNs provided nursing care, conducted physical observations and administered medications according to charts set by visiting General Practitioners (**GP**). There was no permanent GP on site, we were and continue to be a primarily nurse led facility. The GPs would come and see our patients, assess their symptoms and set the care plan. They would then leave and it would be our job as RNs to administer care in accordance with that plan and to support the patient. If the patient deteriorated, we'd have to call the GP

back in (often not possible) or transfer the patient to the Austin Emergency Department for treatment.

27. Over the years I had some terrible experiences watching patients withdrawing from heroin escalate, in circumstances where I was unable to get on to the GP and I was ill-equipped as a RN to assist them. This motivated me to upskill in pharmacology and become a NP.

28 RN work at Curran Place is substantially the same today, except these days the medication plan is set by either a GP or a NP and there is constant oversight from a NP. NPs work full-time and are available on call after-hours and on weekends. Many of our GPs do not provide after hours contact or on call support.

29 My scope of practice as a NP at Curran Place is significantly greater than an RN, as is the level of skill and responsibility involved in doing the work.

30 As a NP working in Curran Place, there is not much I cannot do. I can give all prescription drugs except those associated with attention deficit hyperactivity disorder (ADHD), i.e., dexamphetamines. Our facility is still supported by visiting GPs, as it was when I was the NUM, but as a NP with prescribing responsibilities I can commence, increase or switch medication as necessary to meet the needs of the detoxing patient. I also operate as a 'clean up' service. That is to say that typically, after the GPs leave, many of our patients will reveal further information about their substance use. I adapt the clinical medication plan as a result of these further disclosures. Additionally, many of our patients begin to deteriorate once the GP has left. As the NP on site, I see them and provide clinically competent treatment planning. It is my role to manage their situation by tailoring their medication, so they don't require transfer to the emergency department and they aren't discharged against medical advice. Our clients are often chaotic and will turn up without their regular prescriptions, i.e., antidepressants, antipsychotics, methadone and Buprenorphine. As a NP, I can provide replacement medications and we can use the patient's stay at the facility as an opportunity to stabilise multiple aspects of their health.

Prescribing

31. Prescribing drugs is a huge part of my practice as a NP, and one of the things that differentiates my work from RN work.

32. A vast amount of knowledge is required to know how to safely prescribe drugs. There's also a great deal of skill required, working in the drug and alcohol space, in managing client's expectations around access to medication. People who are withdrawing from

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illicit substances can be quick to sweet talk you and just as quick to turn on you when you refuse to prescribe them the opiates they are seeking. As the NP, there's always a level of attempted coercion that you're subject to.

33 The decisions I make about what to prescribe are entirely mine. I make these calls autonomously and I carry the weight and associated risk of these decisions. The reality that our patients are highly vulnerable (typically poly substance users at risk of overdose) and that a patient of mine might die and their death be the subject of a coronial inquest is always there.

34. Part of the reason I am constantly on call is that I consider that it is part of your responsibility as the prescriber. Our afterhours nursing staff know they can ring me to report how a patient is progressing on medication and that I will give them phone orders to tailor the medication as necessary.

Education

35. As a NP, I am constantly learning to make sure I know about new drugs to meet our consumer's needs and looking, where appropriate, to incorporate them into my practice. There is a constant need for upskilling. People accessing our service present with an ever-changing list of dependence; we see whatever drug is in vogue at the time. Once it was all heroin, alcohol and cannabis. These days there is far more methamphetamine, and we are facing a GHB crisis (without appropriate available medications to treat withdrawal).

36 The further education and training I do to maintain my NP endorsement far exceeds the mandated 10 hours (in addition to the 20 hours required for my RN registration). I am constantly reading studies, and attending and presenting professional development courses.

37. I run Masterclasses via the ANMF for RNs and NPs within the alcohol and drug (**AOD**) and mental health field, teaching advanced AOD clinical skills. Many participants are Nurse Practitioners who are expanding their skills in alcohol and drug treatment.

Diagnosis

38. As NPs we are always on the lookout for red flags. We assess presenting symptoms in the patient in order to diagnose what's happening and use medication to effectively treat it. It is this transition to diagnosis that distinguishes NP work from RN work. When I have NP candidates on placement with me at Curran Place, I talk to them about the importance of working out what's beneath the tip of the iceberg.

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Collaboration

39. Having a NP on site or on call substantially improves the safety and quality of the work of our RNs. Th[redacted]ch better supported than they used to be in the days before NPs when I was the NUM. I think like a nurse and consider the challenges RNs face after hours when there is limited support. Whenever I write medication orders I am writing them with the treating nurses in mind, ensuring that the patient has flexible PRN (*'pro re nata',* as the thing is needed) medications available after hours. These PRN medications ensure that if withdrawal related conditions such as anxiety, agitation, nausea, pain and/or tremors are experienced by the patient, the RN can administer medications to ease these symptoms. This in turn means they can better support and escalate the concerns of patients, and there is less risk of occupation violence to them as a result.

40 As a NP I work collaboratively with our visiting GPs. They look to me for my specialist alcohol and drug withdrawal clinical experience, and I look to them to provide vital general practice. Clients who attend our facility have multiple complexities: alcohol and drug dependence; mental health diagnosis such as trauma, depression, anxiety, ADHD, borderline personality disorder; cardiac and liver conditions; physical injuries; social complexities with accommodation; and legal troubles. I treat a range of existing health conditions, whilst also treating their alcohol and/or drug dependence. As the resident NP, I see the most complex patients from an alcohol and drug point of view. Typically, these patients are also the most behaviourally challenging patients.

41 A big part my NP practice in the drug and alcohol space is knowing when I can effectively and autonomously provide care to the patient and when it's time to consult with an Addiction Medicine Physician or a GP.

42. As a NP I also work collaboratively with Addiction Medicine Registrar Trainees. Addiction Medicine Registrar Trainees might be experienced medical practitioners, but they are still learning nuanced and complex alcohol and drug treatment regimens. As an NP with significant experience in the drug and alcohol space, there's a lot I can teach them.

Adaptability

43. In May 2013, I began to provide leave cover for [redacted] at his addiction medicine and pain management clinic. This kind of work is a good example of the adaptability and scope of NPs. I replaced [redacted] for 3 months initially, while he was on long service leave, and went on to do this on a regular basis. Under the Drugs, Poison and Controlled Substances legislation, [redacted] can deputise his practice to me as a NP.

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He remains the permit holder, but in circumstances where I am administering care in his practice and with access to his patient notes, he can delegate his authority to me.

44. Working with [redacted] patients was initially a big step up in my practice. His patients aren't acute and withdrawing, like mine are at Curran Place, they have very different presenting concerns. Many of his patients are on high dose complex pain management medications and high dose Methadone in the community. As a NP you're always upskilling anytime you change roles.

45 I am a safe person to provide leave cover in [redacted] practice because I am experienced at saying no to patients. It is common in the drug and alcohol space, for patients to 'try it on' with the replacement practitioner and try and access drugs like Diazepam (Valium). I'm adept at managing these kinds of complex and coercive behaviours.

46. This is a good example of the medical and nursing professions working together collaboratively, and making the most of the skilled NP workforce to fill gaps.

Progression as a NP

47. When I started out as a NP, I would prescribe from a standard set of about 8 different drugs (for example, Diazepam and Metoclopramide). These days I prescribe approximately 30 different drugs (for example, Methadone, Buprenorphine, antidepressants, antipsychotics, antihypertensives and many of the medications used to reduce the mortality of patients with liver disease).

48 After about 6 months in my NP role at Curran Place, I grew in the role and significantly developed my skills. You get better with time in the job at diagnosing patient needs and tailoring medication to target specific concerns. You also get better, once you have some experience, at moderating medication so it doesn't counteract other treatment. I began undertaking transfer from Methadone to Buprenorphine, this requires careful planning. I expanded my scope of practice to include the ability to write prescriptions for antidepressants when this became available. I did this because our consumers have multiple complexities. It was important for me to expand my scope of practice as a NP as new prescribing clinical scenarios occurred. That is, my scope of practice grew with confidence in my role and in response to patient need.

Higher incidents of occupational violence

49. Managing our patients and their complex needs has always been a part of our job, but the incidents of occupational violence we've had to endure as NPs has definitely gone

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up in the last two years. We're exposed to a lot more aggression from patients than we used to be. These days I have to call the police at least once a month to assist us in managing or removing a patient. Two years ago, I would have called the police maybe 4 or 5 times a year at most.

50 With the emergence of drug dependency on GHB, many more patients experience overdose on arrival at our facility. GHB intoxication is marked by progression to rapid states of unconsciousness. At times during GHB overdose, patients oscillate between unconsciousness (heightened risk for the patient) and heightened agitation (risk for staff). Then hours later, remarkable tremors, anxiety and withdrawal syndromes. In the last 2 years I have become more skilled in the management of both GHB intoxication and management of GHB withdrawal. I collaborate with Addiction Medicine Specialists and Toxicologists. But as the NP, I lead the development of NP clinical practice and clinical management of these scenarios. More often than not, medical staff are not on site to witness and manage acute GHB overdose. Nursing and multidisciplinary staff look to me.

[redacted]

Rose McCrohan

18-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF MARY FENECH

I, Mary Fenech of School of Nursing, Queensland University of Technology, Kelvin Grove Campus, Victoria Park Road, Kelvin Grove 4029 say:

Qualifications and work history

1. I started working as a Nurse Practitioner (**NP**) approximately 15 years ago. I am currently a Project Co-ordinator at the Queensland University of Technology (**QUT**), School of Nursing.

2. I am a member of the Australian Nursing and Midwifery Federation (**ANMF**), the Queensland Nurses and Midwives Union (**QNMU**).

Qualifications

3. In 1979, I obtained my qualification as a Registered Nurse (**RN**). This was achieved via hospital based three-year training, which was the only available option for qualifying as a RN at the time. I went on to obtain the university qualification at a later date.

4. In 1983, I completed an Associate Diploma in Social Sciences at the Queensland University of Technology (**QUT**).

5. In 1993, I completed a Graduate Diploma in Curriculum Studies at QUT.

6. In 1996, I completed a Graduate Diploma in Health Studies at the University of Queensland.

7. In 1997, I completed a Bachelor of Nursing with distinction (post registration) at QUT.

8. In 2005, I completed a Master of Nursing Leadership at the Australian Catholic University.

9. In 2007, I completed a Master of Nursing Science (Nurse Practitioner) at QUT.

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10. In 2008, I became an endorsed NP. I had to submit evidence of my qualifications, together with a dossier establishing my advanced practice, to the then Queensland Nursing and Midwifery Board in order to obtain my endorsement as a NP.

11. In 2025, I completed a Doctor of Philosophy at the School of Nursing at QUT.

Prior work history

12. From 2000 to 2010, I worked as a Clinical Nurse Consultant (RN) at a large tertiary and quaternary public hospital in Queensland. In this role I case-managed inpatients and outpatients experiencing a variety of liver related diseases. I also provided leadership and mentorship to clinical nurses and RNs within the Hepatology division. Clinical nurses are advanced practice RNs with specialised training in specific areas of health.

13. From 2010 to 2018, I worked as a NP at the abovementioned hospital. In this role I assessed, diagnosed, treated and managed liver patients predominantly with viral hepatitis and those with cirrhosis and/or end stage liver disease.

14. From 2013 until 2022, I worked as a sessional academic, tutor and guest lecturer to both undergraduate and postgraduate students in the School of Nursing at QUT. I also provided assessment marking and feedback to these students.

15. From 2016 to 2024, I worked 0.8 full time equivalent hours at the Queensland Injectors Health Network (**QuIHN**) as a NP. In this role I conducted a number of outreach clinics to vulnerable populations. These clinics were predominantly concerned with blood borne viruses and sexual health, along with some primary health care. This work involved assessment, requesting of investigations, diagnosis and development of a treatment plan, prescribing and monitoring of treatment. I also provided holistic care in the form of referral and access to other resources based upon the findings of my assessment.

16. From 2021 to 2024 on a part-time basis, I have worked as a Project Co-ordinator in a variety of funded research projects within the School of Nursing at QUT. I remain engaged in this work today.

Queensland Injectors Health Network

17. QuIHN provides primary healthcare to a cohort of people who either use or are affected by substance use, much of it illicit substance use. QuIHN services a marginalised population, many of whom are experiencing dual diagnoses of drug and alcohol dependence and mental health issues alongside the myriad of social issues associated

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with these diagnoses. Throughout the time I was employed at QuIHN, our focus was on people living with Hepatitis C, HIV, and sexually transmitted infections (**STI**s).

18. QuIHN provided direct care to these patients. As a NP, I tested, diagnosed and, where appropriate, treated all manner of patients that visited our clinics.

19. This kind of NP led clinical care was provided in a number of diverse settings. QuIHN ran outreach clinics through regional offices run by QuIHN or the Queensland Health Services. These regional outreach clinics were NP led. There were no doctors. Our team would travel with all our equipment and set up temporary clinics in regional locations, at the invitation of those services, originally throughout South-East Queensland but in recent years also in Mt Isa, Wide Bay and other rural settings.

20. Sometimes the clinics were in a health setting such as a hospital or a doctor's surgery, other times the location would be in community halls or on-country and sometimes in outreach buses to service a community. For a period of twenty months, QuIHN conducted an NP clinic in the Mt Isa watchhouse. The watchhouse held a number of people apprehended by the police before they were bailed or transferred to another correctional facility. Sometimes people waited weeks in the police watchhouse before being transferred. With the agreement of the Queensland Police Service and the local hospital and health service, we set up our service one day each month in the watchhouse. We tested for Hepatitis C, HIV and other sexually transmitted diseases, which we then diagnosed and treated.

21. In addition, QuIHN also had permanent offices in Brisbane, Sunshine Coast, Burleigh Heads and Townsville. One of these offices functioned as bulk-billing primary health practice where a GP was located but otherwise these offices were led by NPs.

22. Lobbying and advocacy, to secure funding, was also an important part of my role as a NP at QuIHN.

23. A lot of work went in to establishing the Mt Isa outreach clinic. As a NP, I initiated a campaign that was supported by public health evidence that demonstrated that Mt Isa and surrounds had a high prevalence of Hepatitis C but some of the lowest levels of testing and treatment nationwide, particularly amongst First Nations people. A lot of work went into lobbying and advocating for secure funding for the approximately 60 service providers, to create and sustain the program after QuIHN departed.

24. Another example of advocacy and responding to the needs of this marginalised community arose, when we began to see many clients, previously successfully on Opioid Substitute Therapy (**OST**), fall through the gaps when a high volume Opiod

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Substitute Treatment prescribing GP lost his licence. As a NP, I approached the Office of the Chief Nurse and Midwife and lobbied for further funding and increased scope for QuIHN's NP staff, emphasising the risk of self-medication and potential overdose of these clients through resumption of illicit substance use in response to the absence of maintenance therapy. As a result, QuIHN NPs such as myself started offering OST to these clients.

25. This kind of community advocacy for marginalised people was a critical component of my role as a NP at QuIHN. As NPs, we go where no one else wants to go and tend to these clients in a holistic way. QuIHN staff and NPs take a harm reduction or harm minimisation approach, we don't push abstinence. We meet clients where they are at. This means our service is more accessible, acceptable and realistic for clients.

Duties and responsibilities of a nurse practitioner

26. My role as a NP was to function autonomously in caring for clients and to complete an episode of care from beginning to finish. This involved, assessment, ordering diagnostic investigations, diagnosis based on the assessment and test results, prescribing a course of care as well as medications if warranted, monitoring the progress of the condition until resolution or if needed, onward referral.

27. NP scope of practice differs from a RN substantially in that while an RN may work autonomously, they can only do so under delegation. RNs are not permitted to order investigations or to prescribe. As a NP you are working autonomously and, as such, you take full responsibility for all actions undertaken as well as the follow up of investigations and treatment.

28. My NP practice was focused on reading the community and seeing where the needs were. In this setting as in many others, it is necessary for the NP to be enterprising, entrepreneurial and to show initiative.

The four domains of NP practice (clinical, leadership, education and research)

29. There are additional documented domains to being a NP beyond the clinical domain, these include leadership, education and a research domain. These last three domains are present and evident in the work of NPs across varied settings. They are, however, often not well articulated and acknowledged and as such are overshadowed by the clinical domain.

30. The clinical role is well acknowledged. It includes the assessment, testing, diagnosis and treatment of patients. NPs, but particularly NPs in salaried roles, are well placed to provide holistic primary health care to patients. NPs such as myself at QuIHN didn't

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operate on a financial model, as distinct from a doctor relying on Medicare rebates. Complex clients require more than the base level of care that can be administered during a Medicare approved time period. As a NP at QuIHN I had to be efficient, but I didn't have to watch the clock. I could spend an hour with a complex client if I needed to. Providing comprehensive healthcare takes time. Particularly when working with vulnerable clients to build rapport and trust, amidst a background of often bad experiences with mainstream healthcare.

31. The leadership domain is also important. As a NP, I was expected to provide leadership and guidance to other members of the team. I worked collaboratively with peer support workers, volunteers, and harm reduction officers from a variety of backgrounds. My perspective as a NP was invaluable to decisions that were made in the clinic and my skills and knowledge were often called on in educating and supporting other non-healthcare workers.

32. An example was a patient we saw at QuIHN who continued to access multiple services (along with our own) for testing and treatment of the same condition. The client was receiving mixed messages from each service, jeopardising their treatment and causing confusion and lack of confidence in the service we were providing. I suggested we cease testing and treating this patient at our clinic. Other staff were concerned that I was proposing we deny care to a vulnerable person and that I might be demonstrating a prejudice to the client. As a NP, I was called on to justify my stance. I had to explain to other non-nursing members of our team the importance of advocating for best clinical care, which in this case I believed was not being provided to the client through multiple caregivers, interpretations and treatment of their condition. The situation was akin to a patient consistently taking a half dose of antibiotics and then presenting for a repeat prescription. At a certain point, as a prescriber, you have to take a stand.

33. This is a good example of the NPs role in multidisciplinary care settings. As a NP working in this space, I straddled two worlds. I used my clinical experience and expertise to educate the peer support workers, volunteers and harm reduction officers around me. As a NP, my view was respected.

34. Finally, the research domain consolidates what we advocate for as NPs. At a certain point in my career as a NP at QuIHN I raised the need for us to not only provide quality direct care but to evaluate outcomes. My colleagues and I then applied for and were awarded research funding, to establish an independent research project to evaluate the appropriateness, accessibility and sustainability of the testing, treatment and,

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management of Hepatitis C throughout Mt Isa and South East Queensland. QuIHN used this research to embed this service in the local service providers' care.

Changes in my NP work

Complexity of patient presentation

35. The greatest change in my work as a NP in the last seven years or so was the increasing complexity of the care needs of the patients presenting at QuIHN. When I left QuIHN, it was common for me as a NP to have established long-term relationships with clients and to have seen them in respect of a number of a complex issues over many years. The vulnerable patients in the clinic rely on the service that we provide.

36. Commonly, patients would present with methamphetamine use, post-traumatic stress disorder (PTSD), mental health issues as well as physical health issues such as hypertension, cardiovascular disease, diabetes, conditions associated with aging, or issues around general wellbeing, such as the cessation of smoking. Take mental health as an example. There were a lot more patients presenting with PTSD in the context of the establishment of child abuse redress schemes in recent years.

37. As NPs, we are picking up and treating more health issues now than we used to. When I worked in the public hospital sector, the focus was on a particular health concern that reflected the speciality of the department I was in. These days as a NP in the community, I am required to address <u>any</u> emergent issue. The scope of practice for community-based NPs like me has expanded significantly. As demonstrated by the complexities of caring for patients with comorbidities in an aging population.

38. Throughout my time at QuIHN, it became increasingly necessary to refer patients to tertiary health facilities as a result of manifestations of progression of their primary liver disease that required further complex investigations and management. It was often quite difficult to convince patients that they needed to be treated at a tertiary facility such as a hospital. A big part of my role as a NP at QuIHN, was leveraging the rapport I had built with clients over a long period of time to convince them to continue seeking healthcare in tertiary facilities. The requirement has increased and I found myself having more and more of these conversations with clients than previously.

Expectations of the service offering

39. Many of QuIHNs patients had difficulty accessing mainstream services because of their ongoing substance use, past traumatic experiences with mainstream healthcare

services, and because less and less clinics are bulk billing. These patients cannot afford a paid service, and they can't wait for an appointment at a bulk billing clinic.

40. These patients expect and are entitled to holistic health care. They looked to us to address all their health needs. However, there were some things we could not do. For example, as an NP I was not able to order certain investigative tests such as an MRI to follow up on a liver lesion detected on ultrasound.

41. The demand to provide wrap around services has always been high, but it's significantly worse now as less services are available and the demand for those services among marginalised groups has grown. QuIHN saw a real increase in demand as the population aged and developed comorbidities. As a result of these changes it was necessary for me to continue my professional development and incorporate new skills and scope into my practice.

Expanded scope

42. The scope of my NP work has changed over time. For example, in the COVID-19 pandemic we undertook mass immunisations. We always immunised patients when requested and where indicated but we substantially increased our reach by going out into marginalised communities and immunising many people against COVID-19. This work has continued since. QuIHN continues to run big immunisation programs, for shingles, flu and other vaccine preventable diseases within marginalised and vulnerable populations.

43. I led these immunisation clinics as a NP. It's within my scope of practice to direct nurses (RNs) to provide these immunisations. Under my direct supervision, these nurses who were not endorsed to provide immunisations could provide these immunisations, even if the nurse had yet to complete an immunisers program.

Demographic changes in people accessing health care

44. There have also been demographic changes, in respect of the people accessing QuIHN services. Two stand out in particular.

    (a) A real increase in the number of homeless patients. The demographics of who is homeless have changed a great deal in the time I have been a NP. Seven years ago, people I saw at the clinic experiencing homelessness were typically single people, people who used substances, people often with legal issues, and people who had been accessing the sector for a longtime. When I left QuIHN, I saw a lot more mums and dads with kids living rough in tents. These families were often employed, but underemployed, and reliant on services to

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meet all their basic needs. There were also many more middle-aged and single women who were unable to compete in the rental market, and although they had worked most of their lives had little or no superannuation.

(b) The ageing population. When I left QuIHN, there were far more retirees and older people accessing the service than there used to be seven or ten years ago.

45. The demographic changes had a significant impact on my work as an NP. The terrain had changed considerably. As mentioned previously, it was necessary for me to continually upskill in a number of areas i.e. management of menopause for middle aged women. I accepted that this kind of continual development was necessary. But this continual expansion of my role speaks to the flexibility of NPs in responding to the needs of the community that we serve. The work is rarely 'the same' and is always dynamic.

Signed by:
[redacted]
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Mary Fenech
18-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF KERRIE DUGGAN

I, Kerrie Duggan of [redacted] say:

Qualifications and work history

1. I have been a Nurse Practitioner (**NP**) for 14 years. I am the co-current owner and managing director of the Cygnet Family Practice, where I work as a NP.

2. I am a member of the Australian College of Nurse Practitioners (**ACNP**), and the Australian Primary Health Care Nurses Association. I was chair of the Tasmanian Chapter of the ACNP from 2019 to 2020

Qualifications

3. In 1981, I obtained my Registered Nursing qualification at Royal Hobart Hospital.

4. In 1983, I completed a Graduate Certificate in Nursing (Intensive Care) at Royal Hobart Hospital.

5. In 1986, I completed a Graduate Certificate in Nursing (Midwifery) at Queen Alexandra Hospital Hobart.

6. In 1993, I completed a Bachelor of Education at the University of Tasmania.

7. In 2009, I completed a Graduate Certificate in Nursing (General Practice) at the University of the Sunshine Coast. That same year, I completed an Authorised Nurse Immuniser qualification at the University of Tasmania.

8. In 2012, I completed a Master of Nursing Science (Nurse Practitioner) from Queensland University of Technology. This study entailed two years part-time study of two subjects per semester. I completed two semesters of pharmacology, one semester studying evidence-based practice and research, one semester as an intern with GP supervision completing clinical assessments, one semester studying clinical investigations, one semester specialising in chronic disease management, one

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semester on role development and one semester studying advanced clinical assessment skills.

9. In 2011, I obtained my Nursing and Midwifery Board of Australia (**NMBA**) NP endorsement. To obtain my NMBA endorsement, I completed the following steps:

10. *First*, I provided proof of my current general registration as a Registered Nurse (**RN**) in Australia with no conditions or undertakings on registration relating to unsatisfactory professional performance or unprofessional conduct.

11. *Second*, I provided proof of the equivalent of three years' (5,000 hours) full-time experience at an advanced practice level, within the past six years, taken from the date when the complete application seeking endorsement as a NP was received by the NMBA.

12. *Third*, I provided evidence of practising at the advanced practice level in accordance with the NMBA definition. I supplied documented examples of my autonomous practice, complex decision making and management of and direct clinical care of people with complex health conditions. I also provided evidence of my research, education activities, support of systems and leadership in the profession, together with a copy of my Curriculum Vitae (**CV**) and Statements of Service in respective roles.

13. The Statements of Service provided as part of my application evidenced my 5,000 hours of advanced practice. The Statement of Service reflected the evidence provided in my CV and was on the employer's letterhead, dated and signed by the Practice Principal GP. It showed details of my advanced practice, dates of employment and hours. It provided a breakdown and percentage of hours of any position that included indirect or non-clinical components, such as management or education, and was correctly certified according to AHPRA's guidance on certification of documents.

14. The CV had to be in a certain format prescribed by AHPRA and include the following:

- primary qualification/s;
- post graduate qualification/s;
- education and/or study relevant to my specialist area of practice;
- a breakdown/percentage of hours spent in each role providing both direct clinical care and performing other indirect or non-clinical duties;
- detail that demonstrated responsibility and accountability for the management and direct clinical care of people with complex healthcare requirements;

- detail that showed the evidence of the clinical domain of practice that integrates with the other three NP domains of practice of professional leadership, education and research;
- attendance and presentations at forums and conferences;
- active participation in a professional organisation; and
- letters of support.

15. To maintain my NP endorsement each year, I am required to complete a minimum of 30 hours Continuing Professional Development (**CPD**) annually to maintain registration, as mandated by the NMBA. This includes 20 hours for general registration, plus 10 additional hours focused on prescribing, diagnostics, and consultation. CPD must be relevant to my scope of practice, covering areas like pharmacology, clinical skills, and professional development.

Work history

16. In 1981, I started working as a RN at the Royal Hobart Hospital. Once qualified as a RN, I spent a post graduate year doing three-month placements in orthopaedics, plastic surgery and ophthalmology, intensive care and a general medical ward. I then studied a post graduate intensive care (**ICU**) course for 12 months at the Royal Hobart Hospital and worked clinically in ICU for a total of two years. I then moved to a urology ward for three months before being accepted to study midwifery at the Queen Alexandra Hospital. This post graduate course was also for 12 months. I worked clinically in midwifery in the labour ward, ante and post-natal wards and in the neonatal intensive care unit (**NNICU**). I then worked for 12 months in the NNICU. I then gained a role as a clinical instructor for student nurses at the Royal Hobart Hospital for 12 months, mentoring first and second year student nurses.

17. I was married then, and started my family, raising four boys, working part-time in the Hobart Private, High Dependency Unit (**HPU**). While raising a family, I also worked part-time as a staff development officer for the Department of Health and Human Services, teaching the St. Johns Ambulance CPR and First Aid courses, running courses on educating health professionals on post-natal depression and grief and loss following stillbirth and miscarriage.

18. In 1999, I became the RN Practice Nurse at Cygnet Medical Centre. In this role the key responsibilities included managing chronic diseases, administering vaccinations, performing wound care, triaging patients, and assisting with clinical procedures, all while operating within a primary health care setting.

19. From 2000 to 2005, I worked at Huon Regional Care (formally known as Eldercare) as a RN. I worked in residential, respite and at home aged care. In this role, I was responsible for delivering complex clinical care, developing individualised care plans, administering medication, and supervising staff in residential or community settings. They ensure compliance with quality standards, manage palliative care, and provide 24/7 on-site clinical leadership to address the health and emotional needs of residents.

20. From 2005 to 2012, I worked at Huon Valley Health Centre. I started as a RN. In this role, my responsibilities included managing chronic diseases, administering vaccinations, performing wound care, triaging patients, and assisting with clinical procedures, all while operating within a primary health care setting.

21. Once endorsed as a NP, I worked as a NP at Huon Valley Health Centre from April 2011 until approximately April 2012. In this role, I practised as a nurse at an advanced level of education and clinical training. As a NP, I was authorised to independently assess, diagnose, treat, and manage people with acute and chronic illnesses. I worked collaboratively within a multidisciplinary team, I prescribed medications, ordered diagnostic tests, and focused on health promotion, illness prevention, and patient education across the lifespan.

22. I started working at Cygnet Family Practice approximately in September 2012 as a primary health care NP. In November 2013, the owner advised the team that they were closing the practice.

Current role at the Cygnet Family Practice

23. Around January 2014, I was approached by a philanthropic investor to take over ownership of the Cygnet Family Practice (**the Practice**). I accepted this offer and have been the co-owner and managing director of the Practice since then, while continuing to work as a NP.

24. Cygnet is a town in the Huon Valley about an hour south of Hobart. Cygnet is classified MMM5 "small rural town" (out of a possible 7) on the Modified Monash Model (MMM). The MMM defines locations as metropolitan, rural, remote or very remote. We receive some rural incentive payments from the Federal Government. The Practice is one of only two medical practices in town.

25. I employ General Practitioners (**GP**), NPs, RNs, Enrolled Nurses (**EN**), Community Paramedics (**Paramedics**) and administrative staff at the Practice.

My work as a Nurse Practitioner in primary health

26. My work as a NP calls for a high degree of autonomy and initiative. I apply critical thinking skills, an advanced level of clinical and diagnostic expertise and an advanced knowledge of pathology. I order investigations, such as blood tests, x-rays ultrasounds and medications.

27. In a rural general practice like Cygnet, access to GPs is limited. I regularly see patients that previously would have seen a GP. There simply aren't enough GPs available to staff the Practice, particularly afterhours. As a NP, I'm filling a critical gap.

28. The NP working on any given day (be that me or one of my NP employees) is the nurse leader and the leader of the non-medical clinical team. As the NP on shift, I supervise a number of health professionals including paramedics, RNs, and more recently, ENs. This means I am the person to escalate to if they need further assistance. On top of this, I have my own patient load.

Distinguishing NP practice from other nursing

29. There is a great difference between NP advanced nursing practice and the practice of other nurses in primary health. As a NP, I have a much greater level of responsibility than an RN. RNs in our Practice are responsible for care planning, health assessments, immunisation and wound care. RNs are guided by a doctor or a NP in the delivery of all care. NPs in our Practice, by contrast, are exercising advanced clinical knowledge and skills, and practising autonomously.

30. I can give the following practical examples to distinguish between the work of a RN and a NP in primary health care:

31. *First,* prescribing antibiotics. RNs typically don't prescribe antibiotics. I know of RNs in some settings who might do so, but if they do they're doing so by applying a specified flow-chart in accordance with patient symptoms. There is hardly any decision-making involved. As a NP, I make decisions about prescriptions by applying my own critical thinking skills. I apply knowledge acquired through my Masters qualification (including 6 months study in pharmacology) and make my own decision as to what antibiotics are appropriate to prescribe.

32. *Second,* as a NP I provide multiple forms of healthcare under the Medicare rebate scheme that RNs cannot. A NP is able to diagnose, order tests and prescribe medications. By way of example:

    (a) In the case of someone presenting with a urinary tract infection, the RN can test the urine with a dipstick but that's all they can do. The NP, by contrast, can

order specific pathology tests to identify the micro-organism responsible for the infection and prescribe the antibiotics to treat it.

(b) An RN can take someone's blood pressure. A NP can order blood tests and prescribe medication if needed. A NP, by virtue of their training and the scope of their practice, performs a much more advanced clinical assessment than a RN.

(c) A NP can provide patients with a repeat script. A RN cannot do this. A NP can check the patients history and repeat the script if clinically indicated.

(d) A NP can refer patients directly to medical specialists. A RN, by contrast, needs to refer their patient to a NP or GP to facilitate this service.

The NP's supervisory role

33. Supervision of others is an important part of my role as a NP. The level of supervision required depends on who has done the initial assessment of the patient. For example, if a paramedic has assessed somebody and they've assessed that the patient has a urinary tract infection, the paramedic will escalate the pathology sampling and antibiotics to me. That's within my scope of practice, and outside that of the paramedic. Paramedics are not educated or authorised to order pathology testing or prescribe medications. On the road, paramedics are authorised to administer medication according to clearly defined protocols but not in a primary health setting.

34. A greater level of review and escalation is required of me in respect of RNs, whose supervision needs are higher. For example, if a patient comes in with a headache, RNs don't necessarily have the skills to identify the red flags (conditions like Trans Ischaemic Attack). They might do a basic neurological assessment, but they're not trained to do a cranial nerve assessment. That's an advanced level of clinical practice. Patients with this kind of condition, are triaged by an RN, with care then escalated to a NP or GP.

35. RNs look to me to review a traumatic wound – for example, a dog bite or laceration caused by a power tool. They will clean the wound but they're not permitted to suture the wound without a NP or GP reviewing the wound first. The NP or GP is also responsible for prescribing a tetanus immunisation and antibiotics where necessary. A RN is not authorised to do this. A big part of my role is checking RN work to ensure nothing has been missed in the diagnosis.

36. This kind of escalation of patient care typically comes to me, because our GPs are busy with other patients. Having a NP on shift increases escalation pathways for RNs,

ENs and Paramedics, and ensures the entire team is able to provide better quality timely care.

Scope of NP practice in primary health

37. Working as a NP in primary health care requires in-depth knowledge across many areas of care. I am constantly trying to increase my knowledge and skills, and the pressure to increase your specialisation across different areas is high. I recently attended a session on advanced suturing at the NP annual conference where I learnt to suture deeper wounds. It was important I learnt how to do this as I am seeing more and more patient's presenting with deeper lacerations. Our patients often attend our practice, rather than travel over 100 km to attend on the emergency department. As another example, in recent times we have had more patients presenting with sexual health issues. I have had to learn more about sexual health in order to effectively assess, diagnose and prescribe in this area.

38. Upskilling and extending my scope of practice into new areas to meet community need is a necessary part of my role. I don't get paid any more to undertake additional training and expand their scope of practice. I do it to best serve my community and improve in my role.

The NP's role in delivering person-centred care

39. A core pillar of NP practice is leadership. I've worked to improve the patient experience at the Practice, drawing on my NP practice and skills. I created a new system where patients see the RN first on their initial visit for baseline observations and to obtain a record of their family history, immunisation history and baseline information to ensure a more complete medical record and ongoing care. GPs typically don't have time to cover this in an initial consult. I developed this system, as a reflection of my own NP practice, and trained RNs to conduct this work.

40. This new system means that when the patient sees a GP, the GP can focus on why the patient came in to visit the Practice and document any medical conditions and medication.

41. This system generates several benefits for patients. It means patients have two points of contact in the practice. A system of reminders are established from the first visit so that regular assessments are completed, and chronic or at-risk conditions are managed proactively. For example, we now diarise yearly health assessments, twice-yearly chronic condition management plans, and assessments for people with intellectual disabilities.

42. My design of this system, utilising my skills and incorporating my practice as a NP, has ensured our patients receive a holistic and higher quality of care. In the past, this kind of continuity of care was overlooked in favour of treating immediate presenting concerns. Looking at the whole person in front of you – effectively assessing, diagnosing, and treating all their care needs – this is nursing and is at the core of NP practice. Demonstrating leadership is one of the 4 pillars of practicing as a nurse practitioner. The other 3 pillars include clinical practice, education and research.

Progression in my role as a NP

43. Starting out as a novice NP, after a career in nursing, was its own steep learning curve. With time in the role, I saw more patient presentations, gained greater experience in different specialisations and greater confidence in my decision-making.

44. As I have progressed as a NP, I have taken on more complex cases and more responsibility. I now work with a high level of autonomy, but this wasn't always the case. For example, when I started out as a NP at Huon Valley Health Centre and a sick child came in, I would do the initial assessment and observations but I would not take primary responsibility or accountability for that child's care. Paediatric patients are more demanding and harder to treat because their symptoms can get worse quickly. I'd call a GP and wait for them to come to the same conclusion I did before progressing to treatment. Since gaining more clinical experience as a NP, I'll comfortably handle the care of these children. I use my skills and experience as a NP to determine whether it's an emergency situation, an urgent situation or whether simple reassurance of the patient and their parent is all that's required.

Changes in NP work that I have observed

The NP as the most senior medical professional delivering care in an increasing number of care settings.

45. Three years ago, our Practice introduced an urgent care service. It runs on Thursdays and Fridays from 10:00 am until 8:30 pm and on Saturdays from 9:00 am until 8:30 pm. We started the urgent care service because our data indicated that there was a four to six week wait to see a GP. We tried to have some appointments open so that people could see a doctor on the same day they called. However, these were consistently booked out. We were turning 15 to 20 patients away each day. We introduced an urgent care service to fill this gap. This service is predominantly led by NPs. GPs are present during the day on Thursday and Friday but only until 5pm. They're also not there at all on Saturday. I lead the urgent care service during these

times and the Paramedics, RNs and ENs report to me. If I am not available, another NP will lead the team that day.

46. We have also started doing home visits as part of the urgent care service. We visit homes of people with mobility issues, and who have urgent care needs, but do not need emergency treatment. This happens after a paramedic has visited them. Rather than the paramedic transporting them to hospital, which will be a long wait for the patient and a two hour round trip, we go and visit them and give them care. We have a memorandum of understanding with Ambulance Tasmania to provide this service. Although this is a small part of our Practice, we are trying new and different things to expand our offering. Because of this NP led service, more patients are able to receive care at home.

47. Over Christmas last year, our NPs at Cygnet will cover GPs on leave in the local residential aged care facility. NPs have the same scope of practice in aged care as GPs do – they assess, diagnose, treat and prescribe just as GPs do. Our NPs are well placed to step in and fill this gap over the holiday season.

Higher acuity presentations

48. I have observed that people presenting at our practice are sicker now than they were a decade ago, often as a result of not accessing health care sooner. This appears to me to be real problem in our community, particularly amongst men in rural areas. For example, we might treat someone who has had a cow headbutt them in the chest, and in the process check their blood pressure and find the person has undiagnosed high blood pressure. As the NP, I then diagnose and treat to minimise their risk of stroke or heart attack. Unfortunately, this has gotten worse because people in our area think they won't get an appointment on the same day, so they leave things for longer, until they get worse. When they do eventually present it's at the urgent care clinic, and they often have multiple higher acuity needs.

49. People with presentations we specifically exclude from the service offered at our urgent care clinic attend anyway i.e. people experiencing chest pain, stroke or acute mental health crisis. Even if we say call an ambulance instead, they still come in. We have had people with sepsis and meningitis symptoms or people who are shocked. Late last year, one of our paramedics and I treated someone who was having a heart attack. This occurred on a Saturday. I was the most senior practitioner available. Because the paramedic is an employee of our Practice he reports to the NP on duty. Without our treatment and the availability of our NP led afterhours urgent care service, the patient would have died.

50. People often come to us in emergency situations. People tell me that they come to our Practice because they believe they will be seen sooner than if they wait for the paramedics to come and take them to hospital or they drive themselves to hospital. Our Practice is local and part of the community. Our patients tell me they'd rather be seen by a doctor or a nurse they know. When they do present with urgent care needs, as the local NP, their care often falls to me.

51. Higher acuity presentations mean there is more work for me as a NP in providing information to patients as they leave our care. Care plans are more detailed. Plans need to be in place to manage escalation of symptoms. As we are a rural service, significant education is needed around what patients should do in the event escalation occurs and no on-site healthcare is available.

The removal of barriers to NP practice

52. There have been a number of legislative changes in the last few years to remove barriers for NPs to practice and in recognition of the NP's skills and responsibilities.

53. I can give the following examples:

54. *First,* it's only in the last 2 or 3 years that NPs have been authorised to prescribe vaccinations that are not on a childhood schedule. NPs can now prescribe more medications under the Pharmaceutical Benefits Scheme (**PBS**) which were once considered outside the NP scope of practice. For example, providing a tetanus injection to someone who presents with a tetanus prone wound.

55. *Second,* NPs are performing new medical procedures, such as the insertion of Implanon birth control

56. *Third,* significant legislative changes in Australia, effective from late 2024 and 2025, have expanded NP scope of practice by removing mandatory collaborative arrangements for Medicare (**MBS**) and Pharmaceutical Benefits (**PBS**) access. Key reforms include increased autonomy, enhanced prescribing rights, and, in the ACT, the authority to issue death certificates.

57. A summary of the key legislative changes is as follows:

    (a) In November 2024, the Federal Government removed the legal requirement for NPs to have formal, written collaborative arrangements with medical practitioners to provide MBS services and prescribe PBS medications, reducing red tape and allowing independent practice.

(b) Legislative changes in various states have allowed NPs to participate in voluntary assisted dying processes and prescribe medical terminations of pregnancy.

(c) In March 2025, the Nursing and Midwifery Board of Australia (**NMBA**) adopted a new definition of cultural safety, and the "Nurse practitioner standards for practice" were updated to include a "Supports health systems" domain.

(d) In November 2025, specific eligibility criteria for MBS telehealth services provided by NPs were introduced.

(e) In the ACT, there is a proposal for an increased scope for NPs. The *Nurse Practitioners Legislation Amendment Bill 2025* (ACT) would enable NPs to issue cause of death certificates and witness non-written health directions, a first in Australia.

58. Overall, the nature of the work undertaken by NPs, through their permitted scope of practice, has significantly expanded and is constantly evolving. This has increased patient access to care, particularly in rural and remote areas, by permitting NPs to work to their level of expertise.

Population changes and increased demand for primary health care

59. Cygnet and the surrounding area are growing rapidly. There have been major subdivisions to create more housing in the area. We had to close our books for two years, meaning we did not take on any new patients. We opened them again recently and after four days we had sixty more new patients registered. Population demand has gone through the roof, and with it the demand for our service. The pressure to provide greater levels of healthcare to more people is ever-increasing. We are now averaging 70 new patients per month for the past four months.

People's access to information about their health

60. These days, patients often look up their symptoms on Google before they visit the Practice. I have had patients come in and say, "I want an MRI on my knee". I have to unpack how they got to that point, go back to a diagnosis and then determine what the patient actually needs.

61. Access to technology, and the assumed knowledge that comes with it, means that people are more demanding. Some patients identify what they want and think they need and then get angry when I disagree with their diagnosis. As a NP, I have to manage that discontent.

62. This can be challenging as some people see my role as a NP as inferior to a medical practitioner. If a patient doesn't get what they want from a NP, they sometimes ask to speak to a doctor instead. As a NP, I often feel like I have to prove myself and my skills. The NP role is still relatively unknown and disrespected. A big part of my role is building trust and respect with the patient to overcome this. I rely on my skills as a nurse, in establishing rapport with the patient, to do this.

[redacted]

Kerrie Duggan

1813126

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF JASON MOLONEY

I, Jason Moloney of [redacted] say:

Qualifications and work history

1. I have been a Nurse Practitioner (**NP**) for around 12 years. I am currently working as a Nurse Practitioner at the Morven Community Clinic.

2. I am a member of the Queensland Nurses & Midwives' Union (**QNMU**) and am on its Branch Council.

Qualifications

3. In 2001, I completed a Bachelor of Nursing at Griffith University.

4. In 2002, I completed a Transition to Intensive Care Certificate.

5. In 2008, I completed a Certificate IV in Frontline Management.

6. In 2009, I completed a Graduate Certificate (Clinical Management).

7 In 2013, I completed a Masters of Nursing (Practitioner Studies) at the University of Queensland. In the same year, I received my NP endorsement.

8 To obtain my endorsement, I had to be evaluated by my peers at the Nurse and Midwifery Board of Australia against the NP endorsement criteria. This process included providing evidence of current general registration as a Registered Nurse (**RN**), completion of an approved program of study, evidence of over 5,000 hours of advanced practice hours within the previous 6 years, and letters of endorsement from training supervisors, managers, and peers. At that time, my initial scope of practice was based on a fast-track model within the emergency department independently treating minor injuries, such as fractures, dislocations, lacerations and foreign bodies, and less complex illnesses. Over many years of practice, I have seen and treated a

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broad range of patients within the acute and primary health settings. This has broadened my scope of practice as a nurse practitioner.

9. In 2014, I completed a Certificate IV in Training and Assessment. In 2020, I refreshed the certificate.

10 I am currently a sessional academic in the Bachelor of Nursing Program at the University of the Sunshine Coast.

11 To maintain my RN registration and NP endorsement, I am required to complete 20 hours of continuing professional development in nursing and an additional 10 hours targeted to the advanced practitioner role each year. I also must maintain professional indemnity insurance, act in a fit and proper manner, and maintain recency of advanced clinical practice. This last requirement makes it incredibly difficult for NPs to maintain endorsement when working in non-clinical facing roles such as academia or management.

Work history

12. From May 2006 to July 2007, I was a Patient Safety Officer at Greater Southern Area Health Service.

13. From July 2007 to September 2008, I was a Nursing Unit Manager at Griffith Base Hospital. This work entailed clinical leadership and mentorship, health service re-design and development, health program implementation, and advanced patient assessments and care planning.

14 From September 2008 to May 2010, I was the Assistant Director and Acting Director of Nursing at Broken Hill Hospital. In this role I was responsible for nursing leadership management, clinical service redesign, education and mentorship, quality improvement activities, clinical service auditing, hospital accreditation, patient episode of care review and planning.

15 From September 2010 to June 2012, I was a Nursing Educator at the Gold Coast Institute of TAFE. This work entailed enrolled nursing education program development and direct nursing education.

16 From June 2010 to October 2010, I was a RN at Emergency and Intensive Care Units around Brisbane. In this role I was an agency nurse delivering direct patient care.

17 From October 2010 to February 2014, I was a RN at Redcliffe Hospital. In this role I worked at an advanced level in a rapid assessment and triage model and delivering

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general patient care. I was the nursing resuscitation team leader, shift coordinator, and triage nurse.

18. From February 2012 to June 2013, I was a NP Candidate at Redcliffe Hospital. During this time, I applied and was accepted into the NP program with support from the hospital. I was supervised by experienced NPs and Medical Officers (**MOs**) in developing the additional skills of diagnosis and pharmacotherapy. The model at Redcliffe focused on minor injuries, such as sprains or strains, fractures, dislocations, lacerations, foreign bodies, animal bites, assaults, and minor illnesses such as upper and lower respiratory infections. I also completed the requirements of the Masters of Nurse Practitioner Studies at University of Queensland.

19 I spent many years working as a NP in emergency departments:

(a) From February 2014 to November 2015, I was a NP in the Emergency Department at Kingaroy Hospital. Here I started to expand my scope away from just the minor injury and illness patients with encouragement and mentorship by the Director of Medical Services.

(b) From November 2015 to May 2019, I was a NP in the Emergency Department at Gympie Hospital. During this time, I developed a broad scope of practice within the emergency department.

(c) From May 2019 to July 2020, I was a NP in the Emergency Department at the Queen Elisabeth II Hospital.

(d) From July 2021 to November 2023, I was a permanent part time NP in the Emergency Department at Rockhampton Hospital.

(e) I now see and treat Australian Triage Scale (ATS) Category 2 to 5 patients that present to the emergency department with a variety of conditions. I do this in both an autonomous and collaborative manner. I perform a range of interventional procedures.

20 From 2020 to 2023, I was an Adjunct Lecturer at Charles Darwin University in the Nurse Practitioner Program. In this role I helped to develop and taught in the Masters of Nurse Practitioner Studies.

21 In 2021, I was a NP at Morayfield Health Hub. I worked in a primary health role seeing patients in an early example of general practice based urgent care models in Australia. My scope of practice at that time was limited due to the types of Medicare item numbers available to NPs. I was and remain unable to provide patients access to rebates or bulk bill for many procedural activities I would normally undertake in the hospital

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setting. This includes suturing, fracture care, certain dressings, and management plans.

22. From 2022 to 2024, I was a private NP at WHY Clinic. I had a client load of almost 400 patients with chronic illness that I independently managed using face-to-face and telehealth.

23. From November 2023 to January 2025, I was a NP in the Minor Injury and Illness Clinic at Kallangur Satellite Hospital. I was a senior NP, independently seeing all types of patient presentations, whilst also mentoring junior NPs, NP students, nursing and medical staff.

24. From January 2025 to January 2026, I was the Director of Nursing and NP at the Camooweal Primary Health Care Clinic. Camooweal is an outback town on the Queensland border with the Northern Territory, with a population of approximately 236 people (2021 census). In this role I worked in the Remote Area Aboriginal Health Service. I was responsible for the management of both chronic and acute health conditions of the local and visiting communities. I operated a health-based ambulance service, as there was no paramedic in town. The ambulance serviced a 200km diameter range from the clinic, attending emergencies and providing prehospital trauma life support. I had a small team of staff that I managed. I also acted as the facilities manager.

25. Since February 2026, I have been a NP at Morven Community Clinic. Morven is a rural town in South West Queensland with a population of approximately 184 people (2021 census). This is another primary health care role. I'm working alongside another NP, who is the Director of Nursing at the Clinic.

Duties and responsibilities of a NP

Defining NP practice

26. NPs have a high degree of autonomy and responsibility. As an NP, I am responsible for the complete episode of care. I assess, diagnose, treat and make a care plan in respect of each patient. I am exercising advanced clinical management of the patient. Every nursing and medical care decision of that patient is made by me, autonomously.

27. This is not to say I don't collaborate with other nursing and medical professionals. I might speak with the Senior Medical Officer (**SMO**) on shift about a patient and obtain their view and advice. But that patient remains in my care, irrespective of whether I discuss their care with another medical practitioner. Legally and practically, I take

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responsibility for care of that patient up to and until I formally handover care (in a documented way) to another medical practitioner.

28. My relationship with the SMO on shift is different to that of medical practitioners. There will be all kinds of junior doctors on shift – Registrars, Junior Medical Officers (**JMOs**) and Principal House Officers (**PHOs**), senior postgraduate doctors with more than 4 years' experience) – who will report to the SMO in respect of a patient's condition. Where that happens, the SMO has responsibility for that episode of care.

29 The same is not true for NPs. My practice responsibility is at a similar level to the SMO. Strictly speaking, if I disagree with the SMO's assessment, I can continue in my own preferred course of treatment. I can also consult with other doctors and specialists, irrespective of the SMO's view.

30 This autonomy in the delivery of medical care distinguishes NP practice from RN practice. The RN is primarily responsible for patient care; monitoring the patient and implementing care plans. The RN is not responsible for diagnosing the patient. They might have a view as to a possible diagnosis, which they can share with me, but I'm the one responsible for diagnosing the patient and overseeing the entire episode of care.

3 The RN delivers nursing care autonomously, but any medical treatment the RN gives is at the direction of a doctor or a NP. There are legislative exceptions to this. For example, RNs are permitted under the *Medicines and Poisons Act 2019* (Qld) and the *Medicines and Poisons (Medicines) Regulation 2021* (Qld) to administer certain kinds of medications through Extended Practice Authorities, or local health service standing orders. Likewise, RNs can complete specialised courses to increase their scope of practice. For example, a RN might complete a training program in assessing x-rays and be permitted to request imaging for single isolated limb injuries as a result.

32 As a NP, you're responsible for patient assessment and examination, ordering and interpreting diagnostic tests, synthesis of data, diagnosis and care planning. I make a clinical decision based on what I have observed of the patient and the information I have gathered. This is a significant step up on the decision-making required of a RN who will decide if it is appropriate to request an x-ray but not interpret the image, diagnose the patient, and commence a treatment plan.

33 As such, NP practice represents the pinnacle of advanced practice as a nurse. It involves utilising nursing skills *as well as* developing further skills of diagnosis and pharmacotherapy. We practice both in the nursing and what is considered traditionally as the medical fields.

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34. As a NP, I'm committed to delivering holistic care to patients. This is a by-product of our training as nurses; we're the ones historically by the bedside providing care to the patient. Throughout my career, I have observed that medical care delivered by doctors differs in this respect. Doctors, no criticism of them, are extremely busy and as a result tend to be condition focused. Nurses often can take the time to be with the patient. Where a doctor would conduct a six-minute appointment, I might spend 40 minutes to an hour with that person. For example, when working in private practice in the bariatric space, I would take the time to assess the patient, and all the mechanisms at play in that person's weight management. Educating the patient about their disease, determining their individual health literacy, family history and background and the triggers to that person's obesity is a critical component of treatment planning.

35 The process and autonomy of my NP practice is similar to a medical practitioner. I assess the patient and the patient's data, order the relevant tests, synthesise the results, form a diagnosis and treat the patient, just like a doctor does.

36 Collaborative arrangements for NPs (where an NP was required to work under an agreed supervision arrangement with a medical practitioner) were removed in 2024. This was an acknowledgement that NP practice can occur safely and effectively autonomously. Any good practitioner understands the scope of their individual practice and will reach out and collaborate with other health professionals to ensure a positive patient outcome. The only real differences between what I do as a NP in primary health in a remote community, and what a GP does are based on statutory restrictions. For example, I can't sign a death certificate, or complete a worker's compensation assessment, or sign off on the removal of someone's driver's licence. Likewise, there is a difference in the Medicare rebate NPs can claim and GPs can claim in respect of the same medical procedures. Otherwise, I'm often performing very similar work to a doctor.

37 As a NP, I assume the same level of risk and liability as a medical practitioner. My professional indemnity (**PI**) insurance reflects this. My insurance is much higher on account of my duties as a NP, than it would be if I was an RN. My cover, and the standard cover for a NP, is $20 million. This is far greater than the cover applicable to RNs. As a result, I maintain PI insurance external to that provided through my employer and the QNMU.

The adaptability of the NP

38. The NP role has evolved to fill gaps in the healthcare system. The nature of the work depends on the kind of work being done in different settings.

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39. Up until very recently, I was working in a remote community in Camooweal. In that setting there was a very high degree of autonomy and responsibility. I had to be adaptable and to upskill where needed, in order to meet the needs of the community.

40 NPs are able to move across different specialities and upskill. Medical practitioners, by contrast, are often restricted to a particular speciality. As a NP, I can undertake appropriate training (a combination of formal courses and self-directed learning) and be assessed as competent to implement those skills into practice.

41 I worked in emergency departments (**ED**) for many years. In some models within the hospital setting, my role was to fast-track treatments such as fractures, lacerations, superficial foreign bodies and minor illnesses. In other models my scope included more complex patients including undifferentiated abdominal pain, chest pain, head injuries, neurological conditions, and others. It meant that those patients did not have to be treated by a doctor. Those episodes of care were entirely within my practice and I would make the necessary referrals.

42 My NP practice is more autonomous in the private sector than it was in the public health system. In private practice I am not defined by a set model of care like I was in the public health system. In my last position at Camooweal Primary Health Care Clinic and my current position at Morven Health Clinic, I am permitted to determine the scope of care that is consistent with my knowledge and experience. This is my call. I can upskill into the areas I choose and expand my scope of practice accordingly.

Supervision and mentoring

43. Leadership and education are two of the core responsibilities of the NP. We speak of these in the context of the four NP practice domains (leadership, education, research and clinical practice). As NPs we need to lead and educate other nurses (and medical practitioners) in order to best serve our community and sustain the health workforce. Nurses like me take this very seriously.

44 My experience and knowledge as a NP is often called on by medical practitioners. Because I have worked as a NP in so many diverse settings, I am able to suggest alternative strategies to doctors I am working with who have yet to treat such scenarios. I can give the following examples:

(a) Once, while working alongside a very senior GP in the minor illness and injury clinic at Kallangur Satellite Hospital, we had a child come in with an obviously fractured ankle and the skin was tenting and at risk of compromise and tissue death. The fracture needed to be reduced urgently. There was no access to

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procedural sedation in that clinic. Because of my NP experience in ED, I was able to talk through and suggest other strategies for how to deal with the injury. Things like Entonox, intranasal fentanyl, diversional therapy headsets, and fun patient interactions to make them laugh and relax. The GP working at Kallangur that day wasn't comfortable with these strategies . As a medical practitioner, and all other practitioners, your scope of practice is gained through experience and whether you've been exposed to a particular presentation before. Any safe practitioner will collaborate with others to ensure the best outcome for their patients. The GP requested that I perform the procedure, which I was able to do with no distress shown by the patient.

(b Another example was a patient at Kallangur who presented with a deep laceration to the hand that limited its functionality. That is not a common injury for a GP to deal with as most will attend the emergency department. The GP recognised their own limitation and sought my advice. I talked through a plan for treatment with the GP and they took my advice in the management of that patient.

45 I am passionate about mentoring other nurses. I am a big advocate for the strength and power of nursing. That's the reason I wanted to join the QNMU Branch Council. In my role at Camooweal, everything was escalated to me. I also had a Clinical Nurse Consultant (an advanced practice RN) and an Aboriginal Health Worker Trainee who I supervised and mentored. Likewise, in my previous role in Rockhampton Hospital, I was a member of a team, and when the junior nurses or medical officers had questions, they would come to me. I have had multiple NP students come work with me whilst completing their studies.

46 Post university, having attained the Masters NP qualification, practising as a NP is its own steep learning curve. Practising as a NP is a significant step up on earlier practice as a RN. Cementing the skills acquired in the Masters program in everyday practice takes time. I talk to my students about the pre-vocational (university qualification) and post-vocational steps involved in establishing competent NP practice. Bedding down your practice takes time. Skills in diagnosis, in particular, take time to develop. New NPs need to learn how, in assessing patients, not to make assumptions and jump to conclusions. You learn how to think outside the box, rather than 'anchoring' a diagnosis. By this I mean you have to remain open to alternative diagnoses, take note of all aspects of the patient's presentation and reported history and weigh up the potential that you might be dealing with the worst-case scenario. Developing this skill as a NP takes vocational training and time in the role.

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47. With time you also evolve in the role and expand the scope of your NP practice. I teach those around me to constantly ask themselves, '*how much do I know?'*, *'what don't I know?', 'what should I do when I don't know?*' and, most importantly, never to guess.

48 As patients present with higher acuity, it's very important that experienced NPs, like myself, are available to new NPs. Being able to guide other NPs, particularly NPs in their first year of practice, through different patient presentations is really important. As an experienced NP, I spend a lot of time handing down my knowledge about how to assess, diagnose and treat in different scenarios. I was the head of the team at Camooweal, so I regularly got calls regarding patients even when I wasn't working. The clinic operated 24-hours a day, so a lot of these questions were after hours.

The value of NPs to the healthcare system

49. NPs have evolved to fill gaps in models of care. There are emergency departments that have developed specific models for at risk groups. These groups include Indigenous Persons, Frequent Presenters, Homeless, and women with bleeding in early pregnancy. As a NP seeing these patients, we took considerable pressure off the emergency department.

50 NPs are a highly valuable workforce, who generate significant revenue to employers in the healthcare system. I have kept some data in respect of this over the years to demonstrate the value of NPs:

(a) When I was working as a NP at the Gympie Hospital, I conducted a review of the amount of money my treatments generated. In a year, working 0.8 full time equivalent hours, I generated $800,000 in episodic funding just with the patients I saw and treated.

(b) When I was in the minor injury and illness clinics in Kallangur Satellite Hospital, I calculated that I earned the clinic between $7,000 - $10,000 a day from just the patients I saw. Over the period of one calendar year using the Q27 ABF Model Price Weights I calculated that my activity generated $2,064,203.12 in revenue.

51 NPs are more than just expensive nurses. NPs, by the nature of their autonomous practice, generate significant sums in revenue and make an extremely valuable contribution to the health care system.

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How NP work has changed

Pressures on the health care system

52. Fundamentally, the biggest change in NP work in my practice has been the decline of primary health care in Australia. Since the COVID-19 pandemic, there has been a big decline in the primary health care workforce including a decline in the number of GPs. There's also a shortage of beds in emergency departments and there are resulting pressures on acute systems to discharge people sooner, and to re-direct these patients, who often have complex health needs, to primary health care settings. Urgent care clinics have been established to try and re-direct appropriate cases away from EDs to relieve pressure on hospitals.

53 People are also living longer, so people have more chronic conditions. There are rising levels of diabetes, higher rates of chronic heart disease and we're living in an obesity crisis. This has meant that the complexity and acuity of patients presenting to me, and being cared for by NPs like me, has increased. Caring for sicker people takes more time. People these days are presenting with more health concerns. These concerns all require assessment, diagnosis, management and education. A lot of work is done diagnosing underlying conditions, considering family history and risk factors and intervening early to improve long term outcomes.

54. NP practice is founded in nursing theory and focused on holistically treating the whole person. We're working hard to counteract the technocratic, efficiency-driven models that is so present in other care settings.

Patient expectations and associated challenges

55. As patient complexity and acuity has increased, patient expectations have also increased. Patients have always expected care to be affordable, accessible and effective. Generally, there used to be a lot more respect shown towards health practitioners but this has waned over the years.

56. Nowadays, many patients have looked up their symptoms online before they visit the clinic. It takes a lot more time to explain diagnoses and treatments when patients have already researched what their diagnosis is and what their treatment 'should' be.

57 Ensuring that patients have good health literacy is important to me and a critical part of NP practice. I want to ensure that patients understand their condition before they leave the practice. Being more holistic and being able to take the time to explain things to patients is one of the great things about nursing. One of the most common pieces

of feedback I receive is that a doctor has never taken this much time to explain things to me.

58. The increase of patient expectations and the decrease in respect, has also resulted in more incidences of patient violence and occupational health and safety issues. In my practice, I saw aggression every day when working in emergency departments. Common examples include verbal abuse, threats, and physical violence. My own wife no longer works clinically as a registered nurse due to developing complex PTSD from multiple episodes of workplace violence.

59 Where I currently work, violence is not as bad as some other places but it does happen. In isolated communities and emergency departments (two areas that I have worked a lot in) psychosocial hazards and violence are a big concern. Things have definitely become worse in the last ten years or so, and there has been a real change in workloads and patient behaviours in the years following the COVID-19 pandemic.

60 Patients are facing cost of living pressures, and are being exposed to reactionary material on social media. This has meant that violence is a big issue facing NPs and nurses in general. The rise in methamphetamine use has also increased violence. A colleague of mine in the Emergency Department at Gympie Hospital was struck in the chest by a man in a drug induced psychosis and that colleague died from a resulting cardiac event.

Settings within which healthcare is being delivered

61. Given the adaptability of NPs, we are often used to fill gaps in the healthcare workforce. Just this last Christmas, December 2025, I was contacted by the Executive Director of Nursing and Midwifery at Mackay Hospital and asked to manage their chronic disease management clinic for four weeks over Christmas because they couldn't find a doctor to do so. I couldn't do it because I couldn't leave my role at Camooweal, but it shows you how in demand I am as a NP. I am called on to back-fill doctors on leave, but there's never anyone to back-fill me. NPs are indispensable to our ability to staff the health system.

62 At Camooweal, we ran a health-based ambulance program. There was no paramedic in our clinic, so as a NP I attended road traffic accidents and other incidents that would traditionally be a paramedics role. I also did more home visits, mobility assessments and ordered mobility aid equipment, all tasks that are typically done by an Occupational Therapist but there were none. In my role at Camooweal, I led the provision of NP led

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health care in more and more settings to fill gaps in the delivery of healthcare to that community.

Increasing skills and responsibilities

63. My level of responsibility has increased a lot over the years. I now conduct multiple procedures I did not do a few years ago. For example, I currently do an ultrasound guided regional nerve block that was previously considered a procedure for a MO. In ED, I have done lumbar punches. I also have intubation skills, which I would not do in my regional practice, but would do in a trauma setting. I have also gained further specialist skills in palliative care and chronic disease management.

64 Increasing my specialisation and scope of practice to meet the needs of the people I am caring for is a critical part of my NP practice. NPs are in demand in multiple settings, but particularly in isolated settings like Camooweal and other remote Aboriginal and Torres Strait Islander communities, because we are so willing to gain new skills and broaden our practice. NPs are well placed to do this, as we are often more adaptable than doctors. Doctors are often constrained in their training opportunities by limited opportunities, and I have heard, from resistance of their professional bodies. NPs, by contrast, enjoy more freedom to train and expand their scope of practice obtaining further education as needed.

65 As NPs, the restrictions placed on medications that we can prescribe have been reduced. The recent Federal Government changed the requirement of a shared care model for many medications including blood thinners and certain opioids. Also, many medications were previously only able to be prescribed by a NP as continuing therapy only, but now can be commenced by the treating NP. This, together with the removal of collaborative agreements, demonstrates a growing appreciation and respect for NP scope of practice. Other areas of change include the recognition of NPs as surgical assistants in 2025. Participating NPs have access to Medicare Benefits Schedule items for surgical assistance services on the same basis and at the same rates as medical practitioners. This slow progress has improved the ability of NPs in addressing the health needs of our patients.

Training and education

66. The level of ongoing training and education required of NPs is very significant. I am always learning, reading and attending conferences. It is a lot more than the 30 hours of continuing professional development required by AHPRA. I estimate that I do more than 100 hours of further training every year. There are two reasons for the need for

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additional training. *First*, NPs have been called upon to work within models that have broader scope practice than previously required. *Second*, with the varied presentation of patients, additional training is vital. I would be a poor practitioner if I did not try and continue my professional development. Most of my professional development is at my own cost and in my own time.

67. I also teach on top of my usual duties. I have written two subjects for education courses at the Australian College of Nurse Practitioners. I have written chapters for a textbook. I have also taught at the University of the Sunshine Coast.

Changes to the regulation of NP practice

68. There has been an increased rigour in the requirements to become a NP. I know this from my work assisting NP candidates obtain their endorsement in recent years.

69. To become a NP, you need to do a minimum of 5,000 hours of advanced practice nursing. Advance practice nursing hours are hours of work at an advanced level in your earlier role as a RN, for example as a Clinical Nurse Specialist or a Clinical Nurse Consultant. You need these, in addition to formal study, to be endorsed as a NP.

70 The scrutiny around what constitutes advanced practice nursing has increased significantly in recent years. The NMBA has become more rigorous in what is required of NP candidates. In the past, including for me, mentoring and leadership work would have counted towards your minimum 5,000 hours. Now there's a much greater focus on clinical contact with patients. You can't count hours spent as the head RN triage nurse, for example, as advanced nursing practice. The 5,000 hours have to derive from direct patient care at an advanced specialised level (for example, as a RN diabetes educator).

71 Additionally, you must separate your clinical placement hours that count towards the qualification from the hours that demonstrate your history of advanced practice nursing.

72 All of this means you must have an extensive career as an experienced RN, operating at an advanced level, in addition to the Masters NP qualification, before you can qualify to be endorsed as a NP.

73 From then on, you must maintain that endorsement with extensive continuing professional development.

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Signed by:
[redacted]
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Jason Moloney
18-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF SAMANTHA BEATTIE

I, Samantha Beattie of [redacted] say:

Qualifications and work history

1. I have been a Nurse Practitioner (**NP**) since 2019. I currently work as a NP at the Cygnet Family Practice Urgent Care Clinic and the DGB Pharmacy. I also work as a NP in my own business, MyDiabetes.

2. I am a member of the Australian College of Nurse Practitioners and the Australian Nursing and Midwifery Federation.

Qualifications

3. In 1997, I completed a Bachelor of Arts in Politics (Hons) at Latrobe University.

4. In 2005, I completed my Bachelor of Applied Science (Nursing) at the University of Tasmania.

5. In 2009, I completed a Graduate Certificate in Diabetes Education at Curtin University.

6 In 2010, I completed a Graduate Diploma in Clinical Education at The University of Tasmania.

7. In 2013, I obtained my Credentialled Diabetes Educator qualification from the Australian Diabetes Educator Association.

8. In 2015, I obtained my Certified Insulin Pump Trainer qualification at with Medtronic Diabetes.

9. In 2019, I completed a Master of Nursing (Nurse Practitioner) at Flinders University.

10. That same year, I was endorsed by AHPRA as a NP. To be endorsed as a NP, I had to demonstrate 5 years of continuous advanced practice nursing. I did this by reference to my earlier work as a Diabetes Educator. To become endorsed in 2019 there were

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three criteria to meet, this has changed since then. First, you had to hold an (unrestricted) Registered Nurse registration with AHPRA. Second, complete 5000 hours of advanced nursing practice in the previous 6 years. Third, completing a Master of NP from an appropriate tertiary institution.

11 In 2023, I completed the Mid-Career Nursing Leadership Certificate at the Australian College of Nursing's Institute of Leadership. The Australian College of Nursing Leadership Program develops nurses to lead beyond clinical practice and influence health systems, services, and policy. The program focuses on strengthening strategic thinking, clinical governance, and the ability to lead teams and organisational change within complex healthcare environments. Through a combination of leadership education, mentoring, and applied workplace learning, participants build skills in leading self, leading others, and leading systems. The program is designed to support experienced nurses to translate their clinical expertise into effective leadership that improves healthcare delivery, workforce capability, and patient outcomes.

12 In 2024, I completed an Advanced Wound Closure Certificate at the Benchmarque Group.

13 In 2025, I completed my National Certificate in Reproductive and Sexual Health for Doctors with the Family Planning Association of Australia.

14 In 2025, I completed a Company Directors Course at the Australian Institute of Company Directors.

15 In 2025 I became a member of the Obesity Federation and commenced training with The Strategic Centre for Obesity Professional Education (SCOPE). This training is continuous and self-directed and eventually leads to certification.

16 I hold several professional memberships to support my clinical practice and governance positions. I am an Australian Diabetes Educators Association (ADEA) – Credentialled Diabetes Educator member of the Australian Diabetes Educators Association (ADEA). I am a member of the Australian College of Nurse Practitioners (ACNP). I am an Associate member of the Australasian College for Emergency Medicine (ACEM). I am a member of the Australian and New Zealand Obesity Society (ANZOS). I am a member of the Endocrine Society of Australia (ESA). I am also a member of the Endocrine Nurses Society of Australasia (ENSA).

17 To maintain my Nurse Practitioner endorsement each year, I am required to complete 30 hours of continuing professional development. On top of my minimum CPD

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requirements I also complete additional training to support obesity, endocrine and sexual health clinical practice.

Work History

18. From 2006 to 2017, I worked as a Registered Nurse (**RN**) in emergency, acute and chronic settings as follows:

    (a) From 2006 to 2015, I worked as a RN on the Surgical, Oncology, Medical wards and the Emergency Department and Diabetes Service at Launceston General Hospital. All positions were worked 0.6 to 0.8FTE

    (b) From 2014 to 2015, I worked as a RN on the Angiography Suite at Launceston General Hospital.

    (c) From 2016 to 2019, I worked as a Nurse Unit Manager (**NUM**, RN) and Clinical Nurse Consultant (RN) at the Northern Integrated Care Service. I was Clinical Lead of and Nurse Unit Manager of the Northern Integrated Care Service and the THS Diabetes and Endocrine Service, with responsibility for the management of physical, human and financial resources across the services. The role included workforce leadership, service coordination, clinical governance and oversight of multidisciplinary diabetes and endocrine care across the region. During this period, I also maintained a clinical workload while completing a Master of Nursing (Nurse Practitioner) full time, balancing advanced study with operational leadership and service delivery. I worked more than a fulltime load during these years.

    (d) From 2019 to 2023, my role was eventually reduced to NUM and Diabetes Clinical Nurse Consultant at John Morris Diabetes and Endocrine Centre, removing the management of the Northern Integrated Care Service.

    (e) After gaining endorsement as a Nurse Practitioner in 2019 following completion of a Master of Nursing (Nurse Practitioner) I continued to work as a RN. From 2019 to December 2023 I continued employment with the Launceston General Hospital in Registered Nurse roles while simultaneously working and operating a private Nurse Practitioner practice providing specialist diabetes and metabolic health care. Since leaving the Launceston General Hospital in 2023, I have worked independently as a Nurse Practitioner across a range of private healthcare organisations and community-based services.

    (f From 2023 to now, I have been employed as a NP in primary health at Cygnet Family Practice in the Urgent Care Clinic. This work typically involved

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diagnosing and treating urgent injuries and/or escalating care (for example, lacerations and soft tissue injuries, fractures, animal bites, foreign body injuries, burns, minor dislocations, stable mechanical injuries), wounds, infections and respiratory illness. I worked part-time for a period at the Cygnet Family Practice and now do regular backfill shifts.

(g From 2024 I have worked as a NP in outreach primary health with the South East Tasmanian Aboriginal Corporation (SETAC). I provide specialist Nurse Practitioner services with the SETAC, delivering culturally safe diabetes and chronic disease care within an Aboriginal Community Controlled Health Organisation. This work is provided through fortnightly clinic sessions, telehealth and ambulatory care (approximately 20 hours per month). The role involves clinical assessment, diagnosis, prescribing and management of diabetes and related metabolic conditions, working closely with Aboriginal health workers and primary care teams to support continuity of care. Clinics focus on improving access to specialist diabetes expertise for Aboriginal and Torres Strait Islander people in regional communities, with an emphasis on culturally responsive care, patient education and strengthening Community-led models of health service delivery.

(h From April to October 2025, I was employed as a NP in residential aged care at Huon Regional Care (Franklin Facility), Calvary Sandhill (South Launceston), Glenara Lakes (Youngtown), Calvary Riverside Views (Riverside), Regis Norwood (Norwood) and May Shaw (Scottsdale). I did this work through an agency called Access Aged Care. I was employed under a casual contract and worked between 24 and 40 hours a fortnight. In this position, I completed a regular round seeing all the residents, just as a GP does, ensuring continuity of care. I assessed each resident's care needs, diagnosed particular conditions and set a course of treatment. A few examples of the care I provided as a NP in this setting are as follows:

(i Reviewing residents with acute deterioration, managing chronic disease and frailty-related conditions, prescribing and deprescribing medications, and coordinating care with general practitioners, nursing staff, families and allied health teams. Work included advance care planning, palliative and end-of-life care discussions, wound and infection management, and supporting clinical decision-making for facility staff. The role required autonomous practice, clinical documentation, care planning and follow-up, with a focus on reducing

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avoidable hospital transfers and supporting safe, person-centred care within the residential aged care setting.

19. In my role as NP with Access Aged Care I also worked in their Telehealth Service. This work involved providing Nurse Practitioner services via telehealth to residents in residential aged care facilities, delivering remote clinical assessment, diagnosis and management of acute and chronic conditions in collaboration with onsite nursing staff. The role involved reviewing residents with clinical deterioration, managing infections, medication changes and chronic disease exacerbations, prescribing and deprescribing medications, and providing clinical guidance to facility nurses. Consultations were conducted using digital health platforms with review of clinical notes, observations and pathology, supporting timely medical decision-making and continuity of care. The role focused on improving access to medical care for aged care residents, reducing avoidable hospital transfers and supporting safe, coordinated care within residential facilities.

20 From January 2025 onwards, I have worked part-time as a NP in Urgent Care and Primary Care at Complete Care Pharmacy. I began working three days a week (24 hours) and reduced that to two days (16 hours) in April when I started with Access Aged Care. I provide Nurse Practitioner services within a Complete Care Pharmacy clinic, delivering walk-in primary and urgent care in collaboration with pharmacy staff. The role involved independent clinical assessment, diagnosis and management of minor acute illnesses and injuries, prescribing and medication management, and provision of treatment at the point of care. Responsibilities included triage of presenting conditions, management of infections and minor injuries, wound care and procedural treatments where appropriate, chronic disease support, and coordination with general practitioners or emergency services when escalation was required. The service operated as an accessible primary care point within the pharmacy setting, improving timely access to clinical assessment and treatment while supporting safe medication use and continuity of care.

21 Since 2015, I have been running my own private practice. I initially ran MyDiabetes as a Credentialled Diabetes Educator providing assessment, education and clinical management for people living with diabetes and related metabolic conditions until I became and NP. Since becoming an NP in 2019, MyDiabetes is a Nurse Practitioner–led specialist diabetes service now providing comprehensive diabetes and endocrine care including clinical assessment, diagnosis, prescribing, medication optimisation, metabolic health management and support for diabetes technologies. Care is delivered through longer consultations that allow detailed review of glucose data, treatment

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plans and patient education, with the service working collaboratively with general practitioners and other specialists rather than replacing primary care. I provide these services through regular face to face and telehealth private practice clinics, typically working approximately 20 hours a week within MyDiabetes.

My work with Enrolled Nurses (ENs)

What ENs contribute

22. I worked with and supervised many ENs throughout my time as a NUM (RN), from 2016 to 2019 at the Northern Integrated Care Service and 2019 to 2023 at the John Morris Endocrine Centre.

23. ENs made an important contribution to the running of our Endocrine Outpatient Clinic at the John Morris Centre. They were the ones who took all the initial details from the patient, i.e., noted down their weight and health history, and measured their kidney function, blood glucose and blood pressure.

24 Having had their initial consult with an EN, the patient would then see the specialist doctor. The specialist would be in a much better position to efficiently manage the patient and assess their symptoms on account of the EN's notes. The specialist would assess, diagnose and form a treatment plan for the patient, and then transfer them back to the EN who would be the one to explain how the course of treatment prescribed worked. For example, it would be the EN (not the specialist) who would provide the patient with a continuous blood glucose monitor and explain to them how to use it.

25 It was apparent to me, as the NUM overseeing the Endocrine Outpatient Clinic, that everything ran smoother and was generally more comfortable for patients because of this initial meeting with an EN. I often observed that patients loved seeing ENs because ENs had the time to sit down and have a conversation with the patient, a holistic conversation, about their health care needs.

26. Additionally, patients who initially met and were managed by an EN, prior to being transferred to the specialist care team, tended to have better outcomes. This is because there was more than one point of contact in their care team.

27. ENs at the Endocrine Outpatient Clinic also maintained all the equipment. This was a very important job and was critical to the running of the clinic.

EN progression

28. With time in the role, many of the ENs I worked with developed specialist skills. Working as a NUM at Northern Integrated Care Service and the John Morris Endocrine

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Centre, I observed the following general trajectory in EN skill progression over the years:

(a) The brand new EN, straight out of their Diploma qualification, had a theoretical understanding of what was required but lacked the necessary practical skills in, for example, taking a finger prick correctly or drawing a microscopic sample. ENs didn't walk onto the job with those skills, they had to be trained on the job and spend an amount of time practising to get those tasks down. ENs at this stage are subject to complete supervision and mentoring

(b) After around 6 months in the role, ENs generally began using the technology in the clinic under supervision, for example the machines that measure blood sugar levels (AIC1) in haemoglobin. Additionally, by this point in time, new ENs were generally competent in taking a blood sample correctly and drawing microscopic samples for screening purposes.

(c) After around 12 months in the role, the EN would be independently competent in operating most of the relevant technology. The EN would be able to independently and competently prick someone's finger, measure blood pressure, conduct continued glucose monitoring of blood sugar levels and check the person's insulin pump. The EN would also have a decent understanding of what these measurements meant in the whole context of the job. What I mean by this, is that the EN, with appropriate guidance and mentoring, would begin to communicate these results to the patient in an appropriate manner (i.e. explaining the numbers without value judgments and using Diabetes codified language).

(d) After approximately 2 years in the role, I generally observed ENs to be independently competent across all the technology used and in all aspects of the job including communicating with the patient.

(e) After a few years in the role, in addition to operating independently, the EN became responsible for maintaining and calibrating all the equipment that was being used in the clinic. It was their responsibility to ensure the treating specialists had as much as they needed.

(f) From approximately 4 years on, and depending on the person, the EN often began to practice at an advanced level in a specialist manner. Having established their EN practice in endocrine and diabetes assessment over many years, many of our ENs went on to complete advanced training in interacting with and understanding the technology, interrogating the results and

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determining when escalation was required to an advanced practice nurse (like a NP or a RN credentialled diabetes educator).

29. In my view, the ENs I worked with were not sufficiently recognised for their specialist skills they developed over time.

Why EN progression is important

30. Over my time working as an NUM (RN) and NP, I have observed that nurses will leave a role or even the profession where there is no opportunity to progress financially. In my view, and based on what I have seen in twenty years of nursing, pay structures that enable ENs to progress are an important factor in keeping ENs in the profession.

31. In my view, it's important we maintain the EN workforce. Healthcare isn't just about doctors and registered nurses. Healthcare is a broad collective of health professionals. ENs are the anatomical part of that machine. Their contribution and skill development needs to be recognised.

What NP work entails

32. NPs are advanced practice nurses, with specialist clinical skills, that work autonomously in testing, diagnosing and treating the patient.

33. In my practice I combine the nursing and medical aspects of the NP role. I practise as a nurse in that I provide holistic care and take the time to understand the broader context of a patient's life and health. At the same time, I practise with full clinical responsibility for diagnosis and treatment planning. Any diagnosis I formulate and any treatment plan I adopt is my clinical decision, and I remain professionally responsible for it. I implement treatment plans including prescribing medications and monitoring the effects of those treatments. My role requires advanced knowledge of pharmacology, pathophysiology and chronic disease management.

34 By way of example, I recently saw a patient who presented for management of diabetes. During the consultation I reviewed her blood glucose data but also conducted a broader clinical assessment. I observed that she was significantly overweight, breathless and had poorly managed asthma and elevated cholesterol. Rather than addressing only the presenting issue of blood sugar levels, I conducted a full clinical review, adjusted her diabetes management, commenced treatment for hyperlipidaemia, reviewed her asthma medications and discussed weight management and lifestyle interventions. This type of consultation reflects the holistic approach of NP practice, where multiple interacting health conditions are assessed and treated together

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35. The NP's role is a continuation of the skills developed as a specialist RN, but still amounts to a complete gear shift. You learn a great deal in the Masters qualification with advanced training in diagnostic reasoning, clinical pharmacology, advanced health assessment, pathophysiology and evidence-based management of complex health conditions. These skills have been further developed and consolidated through clinical practice and continuous clinical training after endorsement. You develop and cement these skills once you start practising as a NP.

36 As I gained experience as a NP, my clinical judgement and efficiency in managing complex presentations has increased significantly. In my first year of practice, I relied heavily on structured clinical reasoning frameworks developed during my training and a professional network of senior clinicians including Nurse Practitioners, Pharmacists and Doctors. With experience I have become more confident and efficient in diagnosing conditions, prescribing medications and managing full episodes of care independently. Always consistent in my practice also is my reflective and reflexive practice. I am always driven to review cases with peers to check my own decision making and expand my learning.

37 The manner of autonomous practice as a NP is substantially different from practice as a RN. As an RN, clinical observations and symptoms are assessed and reported to a medical practitioner who then makes diagnostic and treatment decisions. As a NP, I undertake those diagnostic and treatment decisions myself. For example, when I worked in on a cancer ward earlier in my career, as registered nurses we would collect observations and report symptoms to a doctor. Often as a registered nurse, we would have strong clinical suspicion and understand the urgency of treatment. While we might offer clinical insight, the responsibility for diagnosis and treatment decisions ultimately rested with the doctor. The shift in practising as a NP necessitates an advanced level of cognitive workload and a depth of professional responsibility.

38 Prescribing authority represents a significant step up in responsibility from registered nursing practice. As a NP I independently prescribe medications, initiate treatment regimens, adjust medications and monitor for adverse effects and interactions. These prescribing decisions require detailed knowledge of pharmacology and carry significant responsibility for patient safety. In practice the patients I see are often taking multiple medications for different conditions. This significantly increases the risk and then the complexity of decision making. Prescribing also carries significant professional and legal responsibility. When I prescribe a medication, I am accountable for the clinical decision and any consequences that may arise from that decision. This

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includes monitoring for adverse drug reactions, ensuring appropriate follow-up and adjusting treatment if the patient does not respond as expected.

39. Advances in pharmacology have also increased the complexity of prescribing decisions. In diabetes care, for example, there are now numerous insulin preparations and additional injectable medications such as GLP-1 receptor agonists. There are also medications used to protect kidney and cardiovascular function in patients with metabolic disease. Selecting the most appropriate therapy requires careful assessment of the patient's clinical profile and an understanding of how these medications interact with each other.

40. As a prescriber I must remain up to date with evolving treatment guidelines, new medications and emerging evidence. Maintaining this level of knowledge requires ongoing professional development and careful clinical judgement in everyday practice.

NP scope of practice

41. My scope of practice as a Nurse Practitioner includes diabetes and endocrine care, metabolic health and obesity management, and sexual and reproductive health. I also have additional training and skills in primary health care, urgent care assessment, aged care. My work involves clinical assessment, diagnosis, prescribing, chronic disease management and coordination of care across these areas. In applying for my NP endorsement, I had to demonstrate, by reference to relevant training and my advanced practice nursing experience as an RN in diabetes and endocrine disorders that I was competent in these specialisations. Since 2019 I have undertaken additional training and clinical experience in related areas, such as obesity and sexual and reproductive health to support the complexity of my patient base.

42 Nurse Practitioners are professionally accountable for ensuring they practise within their competence. While AHPRA does not require formal approval for each expansion of skills and practice, practitioners must be able to demonstrate that they have the training and experience necessary to practise safely in any expanded area. NPs have the flexibility to expand practice as needed. With that comes great responsibility. I take that responsibility very seriously. I am constantly undertaking training and clinical peer review to keep my clinical skills up to date.

43 For example, over 11 years working in primary health care (in my private health practice and in other roles), many post-menopausal women were presenting to me with (incidental) sexual health issues that were misunderstood by others to be simple urinary tract infections. I needed to upskill to best serve these patients. I completed

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additional training and experience, have attended national and international conferences and completed the Certificate in Sexual and Reproductive Health with Family Planning Australia.

44 AHPRA and the Nursing and Midwifery Board of Australia do not require me to seek prior approval each time my Nurse Practitioner scope of practice expands. However, I remain professionally responsible for ensuring that any expansion of scope is supported by appropriate education, training, skills and competence, and I must be able to produce evidence of that training and continuing professional development if required in an audit, credentialing process or regulatory investigation.

45. In my experience NPs are required to justify their scope of practice in ways that medical practitioners are not. I have frequently observed NPs being directed to practise "only within their scope" in circumstances where the practitioner is already trained and competent to provide the care.

Changes in NP work that I have observed

Greater demand for NPs in more and more settings

46. Increasingly, NPs like me are working in more and more healthcare settings and, in so doing, relieving the pressure on GP led primary healthcare. I have worked and currently work across a number of different settings as a NP, meeting community demand where access to GPs is limited.

47. In my work at Cygnet Family Practice Urgent Care Clinic, I deal with minor ailments, chronic disease flare ups and respiratory illnesses as well as responding to and escalating emergency presentations like traumatic injuries or sepsis. This is critical NP work because it's a rural setting with limited GP access, and the nearest hospital, while only 50km kilometres away, is via a road that is can be inaccessible and dangerous. Many of these patients elect to present at the NP led after hours Urgent Care Clinic rather than make the trip to or wait for a GP to see them.

48 I also work at Complete Care Pharmacy where they have consulting rooms in situ. In that setting I assess patients, make diagnoses and prescribe treatment where appropriate. This model improves access to care and allows patients to receive treatment without needing to wait for a GP appointment.

49 I have also worked as a Nurse Practitioner providing care to residents in residential aged care facilities. In this role I conducted clinical reviews of residents, managed acute deterioration and chronic illness, prescribed medications and coordinated care

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with nursing staff and families. This work helps reduce unnecessary hospital transfers and improves access to timely medical care for elderly residents in facilities that find it increasingly difficult to obtain GP access for their residents.

50 I have also worked with the South East Tasmanian Aboriginal Corporation (**SETAC**) delivering Nurse Practitioner-led diabetes and chronic disease care within an Aboriginal Community Controlled Health Organisation. This work improves access to culturally safe specialist care for Aboriginal and Torres Strait Islander patients.

51 Since I was endorsed, I have seen a marked increase in these kinds of NP led healthcare initiatives. In 2019 there were limited opportunities for NPs to practice within their full scope in my region. These days NPs like me are in demand and are encouraged to work to our full scope. I see more NP jobs advertised today than only 5 years ago.

52 Earlier in my career within the public hospital system I observed that NPs were often restricted to narrow specialty roles and in some roles could not undertake the clinical decision making inherent to the role. In contrast, in primary care settings NPs are increasingly encouraged to practise across a broader scope and to take responsibility for full episodes of patient care.

53 In my own Nurse Practitioner-led MyDiabetes practice I provide comprehensive metabolic and chronic disease care. Although patients may initially present for diabetes management, I assess the whole person and treat associated conditions such as, fatty liver disease, obesity and cardiovascular risk factors. These interconnected conditions require integrated care that is often difficult to deliver within shorter primary care consultations.

Greater patient acuity and complexity in care needs

54. I have seen a noticeable increase in the chronicity and acuity in the patients I am seeing. This is down to a few factors:

(a) Patients frequently present with multiple chronic health conditions that interact with each other. For example, I recently treated a patient who presented with diabetes, morbid obesity, had poorly controlled asthma and elevated cholesterol. They were experiencing housing insecurity and could not find a new GP. Managing this patient required addressing several interconnected health conditions simultaneously.

(b Complexity is not unusual with patient presentation.

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(c) One major factor is polypharmacy. Many patients, particularly older adults or people with chronic disease, are taking numerous medications prescribed by different clinicians over time. Each additional medication increases the risk of interactions, side effects and adherence problems. Managing these regimens often requires careful review, deprescribing and monitoring, which adds significant complexity to clinical decision-making.

(d) Another factor is fragmentation of care within the health system. Patients frequently see multiple providers across general practice, hospital services, allied health and specialist clinics. Information does not always flow smoothly between these services. As a result, clinicians in primary care often have incomplete records or must reconcile conflicting advice and treatment plans.

(e) Mental health conditions also contribute substantially to complexity. Anxiety, depression, trauma and substance use disorders can affect a patient's ability to engage with treatment, adhere to medication or attend follow-up appointments. Managing physical health conditions in the context of mental illness often requires additional time, trust-building and coordination of care.

(f) A further issue is health literacy. Many patients have difficulty understanding medical terminology, treatment plans or medication instructions. This can lead to incorrect medication use, missed follow-up or misunderstanding of diagnoses. A significant part of NP practice involves educating patients and ensuring they understand how to manage their conditions safely.

(g) There is also increasing complexity arising from chronic disease clustering, sometimes referred to as multimorbidity. Conditions such as diabetes, obesity, cardiovascular disease, fatty liver disease and sleep apnoea often occur together and influence each other. Treating one condition requires consideration of how it will affect the others.

(h) Another factor is social determinants of health, including housing instability, food insecurity, financial stress and limited access to transport. These factors can make it difficult for patients to attend appointments, access medications or follow treatment recommendations.

(i) Finally, the availability of healthcare services affects complexity. When patients cannot access timely care from a GP or specialist, they may delay seeking treatment until their condition worsens. By the time they present, the illness is more advanced and requires more complex intervention.

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55. Taken together, these factors mean that many consultations now involve managing not only a medical diagnosis but a network of interacting clinical, social and behavioural issues. This significantly increases the time, clinical reasoning and coordination required to provide safe and effective care.

56. This kind of bridging care, as described above, is part and parcel of my NP practice. Providing this type of bridging care is a routine part of my Nurse Practitioner practice. By addressing underlying health and social issues early, it is often possible to prevent deterioration that would otherwise result in hospital admissions or emergency presentations.

Greater patient education

57. A significant component of modern NP practice involves patient education. I spend considerable time explaining diagnoses, treatment options and preventative strategies to patients so they can understand and participate in their care.

58. Many patients now arrive at consultations having researched their symptoms online. This means clinicians must spend additional time addressing misconceptions and helping patients understand accurate medical information. Medical and technological advancements

Medical advancements have changed the role of NPs.

59. Medical advancements have significantly increased the complexity of prescribing and disease management. In diabetes care alone, there are now numerous insulin formulations and additional injectable medications such as GLP-1 receptor agonists. There are also many newer cardiovascular and renal protective medications that must be considered when treating patients with metabolic disease.

60 As a prescriber I must remain up to date with these medications and understand potential drug interactions, contraindications and appropriate treatment pathways. While these advancements have improved patient outcomes, they have also increased the complexity and responsibility associated with prescribing. Advances in technology have also changed clinical practice. For example, modern diabetes care frequently involves numerous continuous glucose monitoring systems and insulin pump therapy. Understanding each system, being able to interrogate and interpret the data and adjusting treatment requires additional time and highly specialised knowledge.

Regulatory changes

61. Over the past decade there have been several regulatory changes at both Commonwealth and Tasmanian level that have significantly affected the way Nurse

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Practitioners practice. These changes have gradually increased the autonomy of Nurse Practitioners and expanded the settings in which we are able to provide clinical care.

(a) One of the most significant changes occurred through the Health Legislation Amendment (Removal of Requirement for a Collaborative Arrangement) Act 2024. Prior to this reform, Nurse Practitioners were required to maintain a formal collaborative arrangement with a medical practitioner for patients to access services under the Medicare Benefits Schedule (MBS) and prescriptions under the Pharmaceutical Benefits Scheme (PBS). This requirement arose from provisions within the *Health Insurance Act 1973* and the *National Health Act 1953*. In practical terms this meant that even where a Nurse Practitioner was clinically competent to provide care independently, a formal agreement with a doctor was required before patients could access Medicare rebates or PBS subsidised medicines associated with NP care.

(b I was endorsed as a Nurse Practitioner in 2019 while these collaborative arrangement requirements were still in place. At that time, it was necessary for me to maintain formal collaborative relationships with medical practitioners for my patients to access Medicare rebates and PBS prescriptions linked to my consultations. This requirement created practical barriers to establishing Nurse Practitioner-led services and limited the settings in which NPs could practise independently. It created a significant barrier to patients receiving specialist care. The removal of the collaborative arrangement requirement in November 2024 has allowed Nurse Practitioners like me to practise with greater professional autonomy and provide services directly to patients without the need to maintain formalised agreements with individual doctors. Patients now have greater access to the care they need.

(c In Tasmania, the legal authority for Nurse Practitioners to prescribe medications arises under the *Poisons Act 1971* (Tasmania) and the *Poisons Regulations 2018* (Tasmania). Under these laws a Nurse Practitioner must be authorised by the Secretary of the Tasmanian Department of Health to possess, prescribe and supply scheduled medicines. Once authorised, a Nurse Practitioner may prescribe medicines within their approved scope of practice, including prescription-only medicines and certain controlled medicines where appropriate.

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(d) The Tasmanian medicines framework was amended through the *Poisons Amendment Regulations 2025*, which amended several provisions of the *Poisons Regulations 2018*. These amendments expressly recognised the role of Nurse Practitioners as prescribers within the regulatory system. For example, amendments to regulation 24 clarified that prescriptions for certain narcotic substances requiring the Secretary's authority may be issued by a Nurse Practitioner as well as a medical practitioner. Other amendments confirmed that, in approved day treatment and day procedure centres, registered nurses and midwives may administer or supply certain medicines in accordance with the instructions of an authorised Nurse Practitioner. These changes reflect a clearer recognition of Nurse Practitioners as prescribing clinicians within the Tasmanian medicines framework.

(e In addition, earlier departmental prescribing guidance that governed Nurse Practitioner prescribing authorisations has been replaced over time with a regulatory approach that focuses on prescribing according to professional competence and scope of practice. In practical terms this means that authorised Nurse Practitioners can now prescribe medications relevant to their clinical scope, provided they maintain the appropriate training, competence and authorisation under the Poisons Act framework without needing to seek approval for each medicine individually.

(f In my own practice these medicines regulations enable me to prescribe and manage medications relevant to the treatment of diabetes, metabolic disease and related chronic conditions. My prescribing work includes initiating and adjusting insulin therapies, prescribing newer injectable diabetes medications such as GLP-1 receptor agonists and prescribing other medications used to manage cardiovascular and metabolic risk. These prescribing responsibilities form a substantial part of my clinical work and require careful monitoring of treatment effectiveness, side effects and interactions with other medications.

(g Taken together, these regulatory reforms have gradually shifted Nurse Practitioner practice toward greater autonomy within the healthcare system. Earlier regulatory frameworks placed structural limitations on NP practice through collaborative arrangement requirements and more restrictive prescribing structures. The more recent reforms recognise Nurse Practitioners as autonomous clinicians practising within their endorsed scope while remaining accountable to professional regulatory standards.

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(h) These changes have had a direct effect on my own clinical work. They have supported the development of Nurse Practitioner-led services across several healthcare settings in which I practice, including private specialist diabetes care through my MyDiabetes practice, urgent care services, residential aged care services and Aboriginal Community Controlled Health Organisations. In each of these settings I independently assess patients, diagnose conditions, prescribe medications and manage ongoing treatment within my scope of practice.

(i While these reforms have improved access to care for patients and expanded the role of Nurse Practitioners within the health system, they also involve increased professional responsibility. As a prescribing clinician practising autonomously, I am accountable for my diagnostic decisions, prescribing practices and patient outcomes. Maintaining this level of responsibility requires ongoing professional development, adherence to professional standards and maintaining appropriate professional indemnity insurance.

The risk of occupation violence has increased

62. NPs working in independent community settings may also face increased risk of occupational violence. Many NP clinics operate without the security infrastructure commonly present in hospital environments.

63. In my own work I often consult in small clinic rooms within pharmacies or private practice settings where there is no on-site security or emergency response system.

64 My experience working in emergency departments and other high acuity settings has given me skills in recognising and de-escalating potentially dangerous situations. Nonetheless, occupational violence remains a risk in community-based clinical practice.

Signed by:
[redacted]
EC605B6133F7447...
Samantha Beattie
19-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF LESLEY SALEM

I, Lesley Salem of [redacted], say:

Qualifications and work history

1. I have been a Nurse Practitioner (**NP**) for 23 or so years. I am currently working as a casual locum NP at Bourke Aboriginal Medical Service (**BACHS**).

2. I am a member of the Australian College of Nurse Practitioners and the Australian Nursing and Midwifery Federation.

Qualifications

3. In 1981, I obtained my General Nursing Certificate at Cessnock District Hospital.

4. In 1988, I obtained my Post Basic Renal Nursing Certificate at Royal Newcastle Hospital.

5. In 1996, I completed an Apheresis Course at John Hunter Hospital.

6 In 2001, I obtained my Graduate Certificate in Nursing Science – Apheresis at Adelaide University.

7 In 2002, I obtained my Graduate Diploma in Nursing Science at Adelaide University.

8 In 2003, I was endorsed as a NP. There were no university courses when I became an NP. I first had to provide a case study. I chose a transplant patient and the clinical steps I took to treat that patient. The Nursing Board reviewed my case study and then progressed to the next round. There was an oral exam in front of a panel for 3 hours answering clinical questions. I had to source letters from 5 specialists; they had to support my application and demonstrate how I worked in an advanced capacity. It was called the grandfathering system.

9. In 2008, I obtained my Masters in Nursing Science (Research) at Adelaide University.

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10. In 2016, I obtained my Graduate Certificate in Diabetes at Flinders University.

11. In 2024, I completed the Fundamentals of Opioid Treatment and the Opioid Treatment Accreditation Course at the University of Sydney.

Work history

12. From 1979 to 1981, I worked at Cessnock District Hospital as a General Nursing Student.

13. From 1981 to 2003, I held the following roles as a Registered Nurse (**RN**), working full-time hours:

    (a) From 1981 to 1984, I was employed at Cessnock District Hospital as a RN.

    (b) From 1984 to 1985, I was employed at Royal Newcastle Hospital (**RNH**) as a RN in the Orthopaedic and Renal Units.

    (c) From 1985 to 1987, I was employed at RNH as a RN in the Renal and Dialysis Units.

    (d) From 1988 to 1990, I was employed at RNH as a RN in the Renal, Dialysis and Transplant Units.

    (e) In 1990, I obtained Clinical Nurse Specialist (**CNS**) Status at the RNH.

    (f) From 1990 to 1991 I was employed at RNH as a CNS in the Renal Unit.

    (g) From 1991 to 1996, I was employed at John Hunter Hospital (**JHH**) and Wansey Community Dialysis Centre, as a CNS in the Renal, Dialysis, Apheresis, Transplant Unit.

    (h) From 1996 to 2003, I was employed at JHH and Wansey Community Dialysis Centre, as a CNS in the Renal, Dialysis, Apheresis, Transplant and Pancreatic Islet Cell Separation Unit. I was also a Member of the Disaster Management team.

14 I have been employed as a NP in the following roles, working full time hours:

    (a) In 2003, I was employed at JHH as a NP in the Department of Nephrology. I put a business case study together for my position.

    (b) From 2003 to 2009, I was employed at the Hunter New England Health Service (**HNE**) as a Nephrology NP looking after five Community Dialysis Centres in the HNE health service catchment area.

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(c) From 2011 to 2012, I was employed by the HNE as a NP in the Aboriginal Health Unit doing remote and rural outreach. I moved into this work because it focussed on preventative care.

15 In 2012, I left the Public Health System to locum in Aboriginal Medical Services across rural Australia. From 2012 to now, I have worked almost continuously as a locum across many different aboriginal medical centres across Australia. Given the number of times, I have worked as a locum over this period, I cannot recall precisely when I worked at any particular service or how many separate contracts I completed. That being said, I can say:

(a) In 2012, I was employed at Awabakal Medical Service as a generalist NP with a special interest in chronic disease prevention and management. I worked full-time in that position.

(b) From 2012 to 2017, I was contracted with Rural Doctors Association and Durri Aboriginal Medical Service (Kempsey), with a nephrology focus. Initially from 2012 to approximately 2015, I worked two days per week when contracted with them. After that from 2015 to 2017, I performed locum work for a week at a time.

(c) From 2012 to approximately 2020, I worked with Walhallow Aboriginal Corporation as a rural and remote generalist NP with a focus on chronic disease and general medicine. From 2013 onwards, I was contracted across their aboriginal medical centres. This was rural and remote generalist work with a focus on chronic disease and minor surgical skin procedures. I performed work as needed and when time permitted. I was contracted to this service many times over almost 10 years, generally working two weeks on one week off.

(d) From 2015 to 2018, I was contracted to Biripi Aboriginal Medical Corporation as a NP focusing on chronic disease and general medicine. I cannot remember when, but at one stage I worked there for six months continuously full-time. Otherwise, I worked there on locum contracts, generally working two weeks on one week off.

(e) From 2018 to 2023, I worked at Gidgee Healing Aboriginal Medical Service as a FIFO NP remote generalist, chronic disease NP and minor surgical procedures. Again, I locumed there numerous times. The contracts were two weeks on one week off.

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(f) From 2018 to 2023, I worked at Galangoor Duluwami Hervey Bay and Maryborough, as a Locum FIFO NP. Again, I locumed there at various times for around five and a half years. The contracts were two weeks on one week off.

(g) Since 2023, I have worked at Bourke Aboriginal Corporation Health Service as a FIFO NP chronic disease/generalist. Again, I have locumed there since then. The contracts are two weeks on one week off.

(h) Since 2025, I have worked at Brewarrina Aboriginal Medical Services as a casual locum NP. Again, I locumed there numerous times. The contracts are one to two weeks to cover the doctor on leave.

16 Over the years, I have held the following roles in government and on advisory bodies:

(a) In 2007, I was employed at the Department of Health as an Aboriginal Senior Policy Analyst. This was a par-time position, three days a week.

(b) Since 2008, I have been an advisor for the development of Indigenous resources at Kidney Health Australia.

(c) From 2009 to 2014, I was a part of the ANZDATA Indigenous Advisory group.

(d) From 2011 to 2014, I was employed at Kidney Health Australia as a part of the KCAT Kidney Check Australia Taskforce Advisory group.

(e) Since 2017, I have worked at NSW Rural Doctors Network providing cultural awareness training to incoming rural and remote doctors. I continue to provide education through this role when needed.

(f) I am currently on the Medicare Benefits Scheme review committee.

(g) I am often the representative for the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives at meetings with the Federal Government.

17 I have held the following teaching roles:

(a) In 2016, I was employed at Sydney University as a Lecturer for NP students. I taught culturally appropriate physical examination.

(b) Since 2003, I have mentored Nursing, Health Worker and Paramedic students through university programs that offer NP courses. I am still mentoring students and I have many come to work supernumerary with me in any location I am working at.

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(c) Since 2019, I have been employed at University of Technology Sydney as a Lecturer. I teach remote work, cultural safety and NP studies.

(d) From 2010 to 2023, I worked at Aboriginal and Torres Strait Islander Cultural Safety as a GP Synergy Lecturer.

(e) Since 2022, I have given lectures to nursing and medical students at the University of Adelaide.

Duties and responsibilities of a NP

18. Initially as a NP I worked in hospitals, typically working in silos specialising in Nephrology. Around 17-18 years ago, I made the move to primary health. I've spent the last 10 or so years working in rural and remote settings.

19. My work as a NP means I have a foot in medicine and a foot in nursing.

20 My clinical skills overlap with the clinical skills of a doctor. Just like a doctor, I autonomously assess patients, order and interpret pathology and imaging, diagnose health conditions, form a treatment plan, prescribe medications, refer patients to tertiary institutions and other health professionals and provide ongoing review and management of the patient's condition. The clinical tasks I perform in a primary health setting are the same as most doctors. For example, in my current role at the Bourke Clinic, I perform Implanon insertions, suturing and skin biopsies. I also treat emergency response, chronic disease, general health and proactively screen for health issues.

21. As a nurse, I have additional skills in dealing with patients, including tolerance, sympathy and empathy for the patient that is attending the clinic and their individual circumstances. Nurses provide care in a holistic way. I talk about this more below.

My clinical work as a NP in remote areas

22. I currently perform locum work in remote areas (for example, Doomagee and Mornington Island in the gulf area and Bourke in far North West NSW) where primary health clinics struggle to attract doctors. Most of the patients are walk-ins and do not have an appointment. We care for those who seek to be treated in the clinic. Ideally in the clinic there is a doctor, myself and a RN. I see the same presentations as the doctors. I work anywhere from two to six weeks on, two weeks off.

23 I treat a wide variety of patients in my role. I see patients who only need a prescription or minor surgical skin procedures, as well as patients who have complex chronic disease. There is a high rate of chronic diseases like kidney disease, liver disease and diabetes in all areas. I perform trauma suturing and treat patients with emergency

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presentation in categories one, two and occasionally three meaning very severe presentation.

24 I also treat patients in women's health. I do Implanon insertions and other types of contraception. I treat patients with hormone replacement therapy. I test women and see if they are low in B12, iron or other things and treat for any deficiencies. Women's health treatment is constantly changing.

25. I also have a lot of people with acute infection present to the clinic because, in a rural setting, they work a lot with animals. So, I often treat patients with sheep sores, q-fever and other unusual presentations from animal contact. I work with children, and in those children, there are high rates of rheumatic fever, scabies, bed bugs and strep infections.

My scope of practice as a NP

26. As a NP, I do the full assessment and treatment of the patient if it is within my scope of practice. If something falls outside my scope of practice, I'll refer the patient elsewhere. You need a broad scope of practice and an advanced level of clinical skill in order to work as a NP in remote areas.

27. My scope of practice as a NP is as a rural and remote generalist in primary health, emergency response and chronic disease management including preventative screening. I like to describe myself as a "remote generalist". Over 23 years I have expanded my scope of practice, usually to suit the location I'm in. For example, when I started doing rural work, my scope of practice quickly expanded to include trauma suturing and skin courses, mental health acute management, opioid withdrawal training and Implanon insertion courses. My scope of practice has continuously expanded to suit the needs of my patients.

28 I am constantly developing my practice to serve the people I am treating. I seek out external training and development courses wherever I can, either face-to-face or online. I have also been trained by GPs, either through supervision and mentoring, on how to do particular procedures and how to approach prescribing patterns for particular health issues.

29 For example, prior to beginning work in rural communities, I had to upskill in treatment for drug and alcohol dependence and trauma management. In respect of the latter, I had to learn how to treat stab wounds and to suture. I have also learnt how to take steps to prevent rheumatic heart disease in patients. I have consistently upskilled my practice to meet the needs of the location that I'm working in.

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Preventative health and holistic care

30. Our clinic does a lot of proactive work to prevent diseases. A large part of my job is encouraging bowel screening kits, full pathology testing, lung testing, self-collect HPV screening and free CT scans to diagnose problems before they become more acute.

31. As a NP, I provide excellent clinical care with the additional benefits of a nurses' approach and perspective. This means I do not focus solely on diagnosis and treatment. In the remote Indigenous communities I serve, educate and build relationships which is vital. As a NP, I started programs where we began to supply bread and other basic food items for patients. Members of the clinic and I visit schools to meet the children and their families. We go to the schools to treat impetigo (a highly contagious common bacterial skill infection, known as 'school sores') to prevent the children developing rheumatic fever and rheumatic heart disease (**RHD**). We go into the schools to help break down health prejudices in the community so that we can access and effectively treat these patients and they feel more comfortable coming to us.

32. More people in the Doomadgee community started visiting the clinic with their medical issues as a result of our school visits and various community engagement initiatives. These visits made the clinic more approachable for the community. Patients who were previously hesitant to attend the clinic, were less afraid to get vaccinations and other treatment because of this kind of community outreach.

33. This is important work because it means we can emphasise the importance of health and treatment and allow the patients to make better and more informed health decisions. I have often observed, generally speaking, that Aboriginal people in remote communities are a particularly difficult demographic to engage in health prevention and chronic disease management. It is essential that the nursing approach to care delivery is incorporated so the barriers are broken down.

34. As a NP, I play an important educative and advocacy role.

35. I've had a lot of success over the years in normalising healthcare in Aboriginal communities I have worked in as a NP. For example, I set up the Doomadgee primary health clinic in 2018. Within two years, we had a nurse working within and employed by the local school, working directly with the children. In doing this, we managed to combat some of the negative stereotypes that existed in the community around accessing healthcare – attitudes like "if you don't behave, I'll take you to the clinic and you'll have to get a needle".

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36. I've also advocated for the use of new techniques to prevent the spread of contagious diseases in remote communities. For example, I went to a conference where I saw a demonstration of a pre-operative wipe that kills Staphylococcal bacteria. It can also kill strep Group A Streptococcus (**Strep A**) preventing rheumatic fever. Both are common presentations in remote communities, and highly contagious. I suggested to the Menzies Institute that we begin a research project using this to stop RHD. At $4 a wipe, this a cost effective solution to an entrenched problem.

37 As a NP, I'm also conscious of the need to deliver clinical care to people in a contextually appropriate way. For example, in prescribing a course of diabetes medication, I also ensure the patient has a safe or correct way to store the medication in a way to keep it safe from others living in the same house (often there is overcrowding), a way of obtaining the medication and no cross reaction with concurrent bush medicine. This is what NPs like me mean when we talk about holistic healthcare; taking the time to get the full picture of the patient and tailor treatment appropriately.

Changes in NP work I have observed over time

Changes in clinical work

38. I have noticed an increased focus in recent years towards preventative medicine. I used to work in renal care and it was traditionally almost always looking after referrals to tertiary centres like hospitals, dialysis and end stage care. Now, there is a much greater focus on proactive work and managing chronic disease and proactive screening (pathology and imaging). Most kidney issues can be fixed or put in remission.

Regulatory changes

39. The end of the requirement for NPs to work in collaborative agreements with doctors was a big change. NPs can now work on their own. This has permitted NPs like me to work in locations where a doctor does not practice (usually rural or remote settings). Previously, as a NP I was subject to a collaborative arrangement with a doctor. This meant that if there was no doctor on site or online, I couldn't operate the clinic and I would have to turn patients away. This was a real problem, as there often wasn't a doctor available. These days I never have to shut the clinic. I can run it solo as the only NP on site.

Telehealth

40. Another change is that I have been increasingly focussed on telehealth. These days, about 30-40% of my practice is conducted via telehealth. Conducting episodes of care

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via telehealth is complicated. Doing telehealth appointments is a skill you have to develop. In the rural and remote settings that I work in, a lot of houses don't have internet, so these conferences are often conducted by telephone with no video. I did a course about how to effectively run a telehealth appointment. A lot of the patients in rural and remote settings have limited health literacy. I must use language they understand and ask specific and clear questions on telehealth. Over time, I have gotten much better at performing telehealth appointments.

41 Telehealth permits us to reach many more remote communities. A lot of the time, it's not safe for healthcare workers to attend these settings alone (there are dogs, snakes and other human hazards). This technology has really improved the number of people accessing healthcare. These days while I might initially have a telehealth consult with one patient, it's common for multiple family members to get on the call and start reporting their ailments. So telehealth reaches more patients with convenience.

42 Telehealth has also changed the kind of care I can provide in an emergency situation. Often, as the NP I can be on my own out here. There are emergency clinical skills that I am trained in but that I don't often do - things like resuscitation, intubation and intraosseous needles. These days, it's possible to call an emergency doctor via telehealth to guide me through these complex clinical tasks. I'm then able to put my training into action and do my best to save the patient.

43. Technology has enabled me to provide much greater levels of clinical intervention in emergency scenarios. The nature of my work, and my skills as a NP, have increased significantly as a result.

NPs in more settings

44. A big change I've noticed is that in the past NPs were generally employed in a hospital setting. These days, NPs like me are working in hospital settings and a lot more in the community. NPs are applying their considerable increase in clinical skills and knowledge to improve primary or community health services and provide care to more patients.

45 I have observed over many years working in healthcare that NPs are often engaged to fill a void. In the last five years, NPs like me are increasingly filling the void in primary health, especially in rural and remote settings. My extensive work as a locum NP demonstrates this.

46 There is an increase in the demand for NP services. These days, I get job offers three or four times a month. That wasn't always the case. As employers are better

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understanding our role and skill set as NPs, we are being sought out for primary health positions. When MBS improves the items we can access and creates equality for ‘like skills and diagnostics, we will be able to serve the Australian public to the full capacity we are trained for and we will increase our desirability to clinics as a financial asset.



Lesley Salem AM

18-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF LACHLAN TIMMS

I, Lachlan Timms of [redacted] say:

Qualifications and work history

1. I currently work as a Care Manager at Bolton Clarke Home and Community Support (**Bolton Clarke**), previously known as the Royal District Nursing Service. I started in this role in 2023. I manage a team made of up Enrolled Nurses (**ENs**) and Registered Nurses (**RNs**).

2. I am a member of the Australian Nursing and Midwifery Federation (**ANMF**).

Qualifications

3. In 2020, I completed my Bachelor of Nursing at the Royal Melbourne Institute of Technology (**RMIT**).

4. I am currently studying my Graduate Certificate of Community Nursing at Charles Darwin University.

Work history

5. From 2020 to 2021, while I was studying nursing, I worked as a Personal Care Worker at Healthcare Australia.

6. From 2021 to 2022, I worked as a Graduate Registered Nurse at the Epworth Hospital.

7. In 2022, I worked as RN in the Intensive Care Unit (**ICU**) at Western Health as part of the Western Health Discovery Program. This was a program designed to build specialist nursing skills.

8. From November 2022 to 2023, I worked as a District Nurse at Bolton Clarke.

9. From 2023 to now, I have worked as a Care Manager at Bolton Clarke.

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Community nursing at Bolton Clarke

10. Bolton Clarke provides community, sometimes referred to as home care, nursing services. Around 70% of the work is for aged care patients. Services are organised into Local Area Teams (**LATs**). The LAT provides care to a specific area. I am responsible for LAT 17 which covers an area from Elsternwick to Caulfield in Victoria.

11. Generally, there are six full time equivalent employees who work in a LAT. In my LAT I have ten nurses who fill these shifts in the Primary Nurse role. This role, once referred to as the District Nurse, is filled by both RNs and ENs. I work full-time, as do some other members of my team, but the majority work 3-4 days per work at 0.6 EFT.

12 As of February 2026, my team comprises:

(a) Five RNs with between 3 and 15 years' experience in nursing generally and between 1 and 10 years' experience in community nursing.

(b) Three ENs with between 3 and 10 years' experience in nursing generally and between 1 and 8 years' experience in community nursing.

13 In other teams, a small quantity of Personal Care Workers (**PCWs**) are also employed. My team is also on occasion staffed by other RNs and ENs engaged by Bolton Clarke to cover unplanned leave of other staff members.

14 Each primary nurse is responsible for a smaller area within the LAT and around 30-50 clients, with varying levels of care needs.

15 My role as Care Manager is to oversee and manage LAT 17. There is a Clinical Team Manager who sits above me who oversees LAT 15, LAT 16 and LAT 17. In 2025, I temporarily filled the Clinical Team Manager role when the Clinical Team Manager was on leave, once for two weeks and another time for four and a half weeks.

16 My role as Care Manager is split between work in the office and work on the road. Typically, I begin in the morning by logging on to the system and dealing with a number of follow ups from the day before.

17 I conduct a monthly audit of client files. This involves going through a client's file and ensuring that everything is up to date. For example, I will check if there has been a medication error in the last two months.

18 I meet with each of my primary nurses once every three months to discuss the team member's goals and what they want to achieve in the next three months and how I or Bolton Clarke may be able to assist achieving those goals.

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19. I will also check referrals of clients to our service. I'm looking to ensure new potential clients are safe and appropriate for us, and that our services are suitable for the client. My LAT receives most of its referrals from post-acute care at the Alfred or Caulfield Hospitals, or through My Aged Care (a federal Government service).

20 I also assist in managing and, where necessary, discharging complex clients. Sometimes a client's behaviour poses a safety threat to staff. I'll step in on these occasions and enact a behaviour plan. That plan will outline risks to the client of what could happen if we withdraw care. If necessary, I'll discharge a client from our service and discuss alternative services (for example, I'll try and organise free taxi travel to and from a GP clinic so the client can be seen in a safe and controlled environment).

21 Throughout my day, whether I am at a client's houses or in the office, I constantly receive calls from primary nurses/or nurses who are working in my area for the day asking for advice. A nurse may ring me and say, 'this person had a fall what do I need to do?'. Or, they might ask, 'this wound looks like it's deteriorating, can you have a look?'

22 I also double with staff a lot. Doubling is when I accompany a staff member on their visit to a client in order to teach them additional clinical skills or assist them in managing a complex client. For example, I have taught many ENs how to place catheters in men and women. I have also taught staff to insert supra pubic catheters. I also double with staff to review their clinical competencies (for example, if there has been an audit of a client's file and any deficiencies in care have been identified).

23 The Clinical Team Manager is mainly a supervisory and managerial role. The Clinical Team Manager oversees a "Work Group" which is made up of three LATs. For example, my LAT, is in Work Group 5 made up of LATs 15, 16 and 17. Generally, the Clinical Team Manager reviews RiskMan (an incident reporting tool) entries. If there was a medication error caused by a staff member, for example, then it would be logged as a RiskMan. The Clinical Team Manager's job is to investigate the incident report, and if necessary, provide appropriate training to the staff member. Serious incident reports are reported to the Aged Care Commission (for example, if lack of appropriate and correct treatment of a client's wound leads to sepsis or there was an infection that led to hospitalisation). The Clinical Team Manager reviews those incidents and manages the necessary response. They are also responsible for recruiting and terminating employees within the relevant LATs. As a Care Manager, I work with the Clinical Team Manager in recruiting nurses to my LAT.

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Enrolled Nurses working in community nursing

ENs as primary nurses

24. ENs often fulfill the role of primary nurse at Bolton Clarke. A primary nurse is a home care nurse responsible for the care of approximately 30 to 50 clients in a geographical area within a LAT. These are named 17(a), (b), (c) or (d) in my LAT. These 30 to 50 clients have varied needs that are met by the primary nurse.

25. The primary nurse visits some clients once a week, and other clients once every six weeks. The primary nurse is responsible for delivering clinical care to the client in their home consistent with the care plan. In addition to performing the primary nurse role, and doubling as required, the primary nurse attends to all follow ups.

26 Follow ups include a number of things. The starting point is for the EN to ensure the patient's orders are valid. This means ensuring the correct medication authority exists that matches what the client is taking. That medication authority needs to be in the correct format, and include a doctor's signature, provider number, date and the client's name.

27 When the client needs to have an indwelling catheter inserted, the EN primary nurse needs to ensure a procedure order is filled out by a doctor or a Nurse Practitioner (**NP**). The primary nurse EN also needs to ensure necessary funding for care is in place from the Commonwealth Government. If that funding is not in place, the primary nurse will seek review of the Commonwealth Home Support Package and request further funding from MyAgedCare as needed. The primary care nurse may also request the Aged Care Assessment Service to come out and review the client's needs. The primary nurse will check all Bolton Clarke assessments (completed biannually and annually) of the client are up to date. Finally, the primary care nurse might request the Care Manager report signs of clinical deterioration to the client's primary doctor.

28 There are a number of Bolton Clarke assessments that are done regularly. There is an annual health assessment that is done on each client head to toe. The primary nurse checks how the client is eating, their stomach, their bowels, whether they've had any falls recently and conducts a number of screenings and reviews. These include: a pressure injury risk screening, a home safety screening, a care plan review every 6 months, wound assessments, stoma assessments, indwelling catheter assessments, medication assessments, carer stress assessments, malnutrition assessments and a falls assessments. The primary nurse will determine whether the assessments are necessary based on the client's need and the primary nurse will also determine the frequency of these assessments.

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29. The primary nurse checks the medication care plan, ensuring there are no medication errors. If there are issues at the time of visit from a casual nurse the causal nurse will email or call the primary nurse who will usually complete the follow up or request the visiting nurse to complete the follow up. Sometimes the medication is in the client's home in a locked box with a code. The primary nurse will interact with the client and their next of kin and ascertain if there is any potential for the client to have overdosed on any earlier self-administered medication.

30 There is also a wound care plan if the client has wounds. Depending on what the wound looks like, that plan may change daily. A primary nurse's role also includes ordering the products for the wound. That would involve looking at the wound, taking notes and making sure there's enough supply of the appropriate products to treat the wound. The primary nurse will also request a referral to a wound specialist if there has been deterioration in the wound.

31 The primary nurse will update family members of the client on treatment and if there's anything that's needed. For example, the primary nurse will call the next of kin if a client needs a clock in their house to help orientate them to the time and minimise confusion. If there is no food in the home, the primary nurse will discuss this with the next of kin or their social worker to ensure the client is properly fed and there is enough food available. If the wound supplies are low and the primary nurse is waiting on a delivery, the primary nurse will provide the next of kin with a list and ask the next of kin to purchase supplies from the chemist.

32 The primary nurse will report any deterioration in a client's condition to the Care Manager. This includes reporting if the client is getting frail. The primary nurse observes the client's general health and their environment. For example, they take note if the client doesn't appear to have showered or if the house is unusually messy or there is food rotting in the fridge.

33. The primary nurse checks all notes on the client's file before going to see the client and makes their own notes following each visit. For example, the file may say that the house has hazards like a dog, or that you need to contact the client's next of kin 30 minutes before visiting the client or that you enter the client's house via XYZ.

Why ENs as primary nurses

34. Primary nurses at Bolton Clark tend to be a mix of ENs and RNs.

35. As a Care Manager responsible for overseeing my team of nurses, and allocating nurses to appropriate clients, I don't differentiate between ENs and RNs. Skill mix is

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more important than whether someone is an EN or an RN. Many ENs are very skilled clinicians. Generally speaking, I have noticed that ENs are often more thorough, particularly in their note taking, than RNs.

36 ENs are restricted in some ways:

(a) ENs can't create client care plans. The RN who admits the client to our service usually sets up the care plan. A client's care plan is reviewed biannually. ENs can conduct the care plan review, but they can't amend the care plan without first speaking to an RN.

(b) ENs must report signs of clinical deterioration to an RN (or immediately call 000).

(c) Likewise, as I am the supervising RN, my ENs must inform me if there's any other issue. For example, if a client has taken two tablets rather than one out of a Webster Pack, they would need to tell me. However, provided the client is clinically stable, an EN who is highly skilled will complete all appropriate follow ups and contact me simply to advise what they've done. These ENs contact me because they are required to. They don't need to escalate to me for assistance in what to do.

37 When a primary nurse EN needs or elects to speak to a RN, they typically consult me as the Care Manager. This is not unique to ENs in my team. Plenty of RNs in my team also call me.

38 In my role as the Care Manager, it is often hard to tell the difference between ENs and RNs performing the primary nurse role.

39 Community nursing is one of the settings where the differences between ENs and RNs is the smallest. I say this, by reference to my earlier nursing experience in ICU. In that setting, there is a noticeable difference between the clinical tasks an EN and an RN can do. For example, only RNs can administer IV medications.

40 There are no treatments or other tasks regularly performed by Bolton Clarke primary nurses that an EN cannot do. For example, both ENs and RNs in the primary nurse role regularly:

(a) Conduct observations and measure vital signs. For example, blood pressure, heart rate and respiratory rate. The primary nurse will also conduct a Doppler assessment (an ultrasound to measure blood flow through the legs, giving us a reading to see if we can apply compression and if so how strong the

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compression can be - compression therapy is beneficial for slow to heal wounds.)

(b) Administer medications by themselves. For example, medications contained in either a webster pack or the medication's original packaging. ENs can also administer subcutaneous injections such as insulin and Clexane. It's a requirement of EN registration that ENs work under the delegation of an RN but this is only necessary to the extent that there is any deviation from the care plan or there has been a medication issue (for example, a potential overdose);

(c Attend to catheters by themselves. For example, the primary nurse will, in the course of their duties attending to a client who has an indwelling catheter or suprapubic catheter, check the correct procedure order is in place, remove the old catheter, insert a new catheter, document the procedure conducted and then rebook the next visit. The primary nurse will do all of these steps independently.

(d) Conduct client follow up. For example, following up on medication orders, procedure orders, ordering wound supply orders and new catheters, and updating care plans.

(e) Communicate with the client's next of kin as needed.

41 I have been involved in recruiting staff to the primary nurse role at Bolton Clark. I have observed, aside from the above skill comparison, that there simply aren't enough RNs for this role to be exclusively filled by RNs. ENs make committed highly skilled primary nurses. They are a valuable part of our team and the nursing workforce.

42. ENs are also paid less in the role than RNs. This means there's also a commercial imperative for Bolton Clarke to staff at least a large proportion of the primary care workforce with ENs.

Progression of Enrolled Nurses in community nursing

Clinical skill progression in the primary nurse role

43. Commencing in the primary nurse role in a community setting is its own steep learning curve. Our primary nurses are out there on their own in clients' home. This presents its own set of challenges, and primary nurses have to exercise a lot of critical thinking skills.

44. There are a number of clinical skills that ENs get better at with experience in the primary nurse role.

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45. *First*, they improve their time management skills. In home care, there's a lot more freedom and independence than in a hospital setting. You drive yourself between appointments and you're responsible for efficiently organising your day so that you see all the clients on your list in an appropriate timeframe.

46 I have access to the notes taken by new primary care nurses. I can see on our electronic system when these notes are entered. I sometime see new primary care nurses adding to their notes after their shift late at night. Where I see this, I will have a discussion with the relevant nurse about the importance of better managing their time and taking notes as contemporaneously as possible.

47 Over time, I notice that the primary nurse's note taking skills improve. At first, nurses provide too much unnecessary detail in their notes which leads to inefficiencies. After one to two years, note taking improves.

48 I often notice that my ENs, in particular, take very good notes. Because their work is subject to a review by an RN, they are particularly conscious of the importance of documenting exactly what they did and why.

49 *Second*, is catheterisation. Catheterisation is generally a new skill for ENs starting at Bolton Clarke. Generally, they start by reading Bolton Clarke's policy. It's quite a strict policy. It covers the anatomy and how to practically insert a dwelling catheter (inserted through the urethra) or a suprapubic catheter (inserted near the belly button), the necessary steps and the risk factors.

50 The process from there is as follows: the nurse will watch me, or another experienced nurse, perform an insertion. Sometimes they might watch this multiple times. Then, when the nurse is comfortable, they will perform the insertion under supervision. Once the nurse has performed two consecutive catheterisations under supervision successfully, they'll be signed off as competent at this clinical skill and be permitted to do this solo.

51 An important part of the task is maintaining the sterile field. The catheter kit comes in a big bag and it's important that all of the components of the bag remain sterile to avoid urinary tract infections. This includes the catheter, numbing gel, sterile gloves etc. The importance of maintaining the sterile field is taught to RNs at university. ENs cover this in their Diploma briefly, but the EN graduates I have worked with lack practical experience in this.

52 Primary nurses, both ENs and RNs, are generally able to perform catheter insertions after observing one to three insertions, and then doing the insertion themselves under

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supervision one to three times. These nurses, both ENs and RNs, typically pick up this clinical skill six to 12 months after they have started in the role.

53. *Third*, is wound care. Wound care is another skill that nurses improve at with experience. One EN in my LAT has shown a strong commitment to furthering her skills in wound care. Around four years ago, and one year into holding the primary nurse role in my team, she began to focus on developing her wound care skills. She attended multiple classes at Bolton Clarke and started doing her own research. In the last two to three years, I have noted her expertise in this area. Lots of people at Bolton Clarke now consult her in respect of wound care. I'll allocate her the most complex wound care clients in our LAT, because I know that she is the most skilled.

54 *Fourth*, is hidden or soft skills. In community nursing there are a number of soft skills that improve with time.

55 The first one that comes to mind is managing interactions and expectations of a client and their next of kin. Sometimes, a next of kin can be dissatisfied and/or aggressive with the primary nurse. They might not understand why a treatment is being administered. Or they might be annoyed that the primary nurse is seeing their relative late that day. Sometimes the client themselves will be agitated, aggressive or annoyed. They might use derogatory language in the nurse's presence (racist remarks are common). The primary nurse is working alone, in an uncontrolled environment, so soft skills in deescalation are critical.

56 These situations can be difficult to manage for people new to community nursing, both ENs and RNs. With time in the role, you become better at managing people's discontent. Nurses new to community nursing struggle with this. This is a skill that can't be taught in the EN Diploma or the RN Bachelor degree. Treating a patient in their own home is also very different to treating a patient in an acute environment, with other healthcare staff and security around.

57 These situations can be diffused with a combination of appropriate direct communication, 'I'm here to assist you with X, I don't want to hear about Y', and deflection. I have observed that after the first two or three years in the primary nurse role, ENs and RNs improve at managing these types of situations.

58 Another hidden skill that nurses develop with time is the ability to move away from a task focused approach to delivering care in a holistic manner. For example, a nurse will take in the overall picture of a client's health, rather than simply administering a set care plan. They will note whether a client is wearing the same clothes as the day before, whether the client has body odour, whether a client has showered, whether

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there is food in the fridge or whether a client is less alert than usual. The primary nurse will take the time to assess all of these factors, rather than just administering medication and changing the client's dressings. The nurse will then feed this back and the care plan can be appropriately altered as a result. This is a superior model of care and is at the core of all nursing, but is particularly important in community nursing.

59. *Fifth*, is greater independence in the role with time. Nurses, be they ENs and RNs, who start in the primary nurse role are often keen to run any and every issue by me. I encourage this, as a means of assessing their skill level and overseeing the care they're providing clients. With time in the role, typically any time after the first year to three years, the primary nurse won't need to run anything by me. They'll keep me updated, consistent with their obligations, but the nature of the phone call will have changed. For example, in the case of a suspected medication overdose, rather than call me and ask what they should do, they'll call and tell me all the steps they've already taken to determine whether an overdose has occurred (i.e., what the vitals indicate) and what follow up (notification of doctor or transfer to hospital) they recommend.

My observations in respect of EN progression in the primary nurse role.

60. In my experience supervising primary nurses, ENs take to the role and perform it as competently as any RN. I have noticed that ENs, despite only having a Diploma qualification, are just as qualified in performing this role as their RN counter parts.

61. On occasion, ENs have demonstrated particular skill and expertise (for example in note-taking and wound management) as if, I infer, to demonstrate that they are just as capable as an RN. There still exists an old school nursing culture that distinguishes based on the nursing hierarchy and labels an EN 'just an EN'. I don't subscribe to this.

62. My ENs take the responsibility and independence of their roles seriously. They are diligent in their duties and highly skilled.

63. There is definitely skill development for ENs whilst on the job, as there is for all nurses new to community nursing. Generally, I notice that an EN will be independently competent in all aspects of the job to a high standard after about three or five years in the role. It is at this point that I notice ENs are able to problem solve more and care for their clients with minimal involvement from me as their Care Manager.

64. The period of time is less if the EN comes to the primary nurse role with relevant nursing experience. For this reason, Bolton Clarke typically recruits nurses with multiple years nursing experience in other settings.

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65. Bolton Clarke runs a graduate program for both RNs and ENs. Graduate nurses have a big book of clinical skills that they spend the year having signed off. In my experience supervising these nurses at later stages of their career, this graduate program (or another graduate program in a different nursing setting) provides the best foundation for new nurses to develop their clinical skills. Nurses with a background only in agency nursing tend to need further support in developing their skills on recruitment to the primary nurse role.

66. Experienced ENs in the primary nurse role, typically with six plus years' experience in nursing, teach other nurses in the Bolton Clarke orientation program (six weeks for new recruits). These ENs can also double with other primary nurses, be they ENs or RNs, in teaching on the job in client's homes.

Why EN pay progression points are important

67. As a Care Manager supervising ENs, I support EN progression through multiple pay points over time.

68. Were all ENs in my team paid a flat EN rate, there is a real risk ENs with multiple years' experience would leave community nursing. Why would they stay when at six plus years' experience in the role, they are paid the same as the EN they are teaching in the orientation program or doubling up with to teach clinical skills?

69 None of the ENs in my team have been appointed to the Advanced EN rate. I know of one EN who applied and was knocked back.

70 Financially compensating experienced ENs fosters an environment where ENs are encouraged to stay on in their roles and contribute to the skill development of other nurses.

71 I have spoken with some of the ENs in my team about whether they want to go and do their RN qualification. They tell me that going to university isn't a viable option for them. They have family responsibilities and financial pressures. Completing the 800 hours of placement, in particular, and incurring the general costs of studying isn't an option.

Signed by: [redacted]
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Lachlan Timms
17-03-2026

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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF JULIE MCGRATH

I, Julie McGrath of [redacted] Queensland [redacted] say:

Work history and qualifications

1. In 1978, I completed my training at Calvary Hospital in Cairns. The training was done on the ward over 12 months. When I completed my course, I was registered by the Nurses Registration Board. I worked from 1979 to 1989 in theatre working in all areas including scrub, scout, anaesthetics and recovery gaining many clinical skills.

2. From around 1999 to 2000, after taking a break from the profession, I worked as an Assistant in Nursing at Mareeba Hospital while completing a re-entry course. I also completed a Medication Endorsement and a Theatre Certificate with the College of Nursing in NSW. I worked from 2000 to 2007 in theatre at Calvary Hospital again in all surgery specialities and areas, regaining my clinical skills.

3. From 2007 to 2014, I worked as an Enrolled Nurse (**EN**) at Townsville University Hospital (**TUH**).

4. In 2008 or 2009, while working in Mental Health at TUH, I completed an Advanced Diploma of Counselling and Family Therapy which focused on Mental Health issues including Schizophrenia, Bipolar Disorder and Major Depressive Disorder. This involved many sessions of education in the Mental Health Unit alongside clinical experience in the unit over 4 years.

5. From 2014 to now, I have worked for Mater Hospital Townsville. I work in theatre, as an EN in Anaesthetics.

6. From October 2024 to January 2025, I was contracted to work for three months as an EN at Clarence Correctional Centre. I took leave from the Mater Hospital for the three months to perform this role.

7. I am a member of the Queensland Nurses and Midwives' Union (**QNMU**).

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My work as an EN in anaesthetics

8. As an anaesthetics nurse, I assist the anaesthetist in theatre.

9. The anaesthetist uses an anaesthetics trolley (where the anaesthetic drugs are stored) and an airway trolley (where the airway equipment is stored) to administer the anaesthetic, to keep the patient unconscious during their procedure. Part of my role is to ensure that all the drugs and equipment required for the surgery, and any emergency that may occur, are at hand in the trolley. I check all the drugs and equipment before the surgery and at the end of the surgery. It is the anaesthetist's role to administer all drugs. Medication is always administered by the anaesthetist. The anaesthetist also uses an anaesthetic machine, that attaches to the airway equipment (including ventilator and gases) to keep the patient unconscious and measure their vital signs, during surgery. It is part of my role to check that machine, before and after surgery, to ensure it is in good working order, and that any emergency equipment is available for use. The anaesthetist prepares their own notes. At the end of the day, I make sure the notes are printed and filed in respect of each case. When dangerous drugs like oxycodone and fentanyl are taken out of the drug cupboard, I double sign the drugs with the anaesthetist.

10. Prior to the anaesthetist coming into theatre, I check that we have the correct patient, correct surgeon and are about to conduct the correct surgery. I observe the patient throughout the surgery and check for any warning signs. Sometimes, the anaesthetist gets tied up with something and part of my role is reminding them of something or making them aware of something I have noticed.

11. In this role, I don't really interact with RNs or other ENs. Technically, as an EN I am subject to the supervision of an RN. There is always an RN in theatre but they tend not to have any experience in anaesthetics, so they don't play a role in supervising my work.

Skill progression in my role

12. I have observed that the work of ENs has changed a lot over time. EN work used to be a lot more basic. The expectation of ENs has changed a lot.

13. We are expected to have a much greater depth of knowledge than we did when I first started. For example, I have an in-depth understanding now of how the drugs the anaesthetist is administering work. I didn't learn this when I did my EN training, I learnt this with time on the job and through the courses I completed while employed as a nurse. Another example is that as an EN I am now required to be proactive in

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monitoring the patients and raising concerns. Back in the day, I never had to do that. I just performed my tasks at the direction of the anaesthetist.

14. In the last decade or so, there is much greater emphasis on the anaesthetic EN monitoring the patient's body language and psychological state (for example, whether they're frightened). As an EN these days, I carefully monitor this and determine when to say something to the surgeon or anaesthetist.

15. I have taken it upon my myself to learn new skills and complete courses. For example, I completed advanced life support training. ENs typically don't do this but I thought it would assist me in paediatric cases. In the training, you conduct simulations. I knew completing these, and learning these practical skills, would assist me in emergency situations. I am the only nurse assisting the anaesthetist, and he or she is concentrated on what they're doing. It's my role to think ahead and anticipate the anaesthetist's needs. I knew it would be helpful for me to have done the training in the event a patient required advanced life support. Mater Hospital permitted me to do the training but, as I am an EN, they wouldn't give me the certification.

16. The longer you work the more you learn and the great awareness you have as an EN. After working for a long time, I became much better at communicating with the anaesthetist and being aware of when to speak up. I became more aware of the dynamics in theatre and was able to be a much more effective communicator. These days I'm more aware of what my role is, what is normal and how I can usefully assist.

17. As an anaesthetics nurse, the nature of the work I do has changed with time and so to have my skills and responsibilities. The following are some examples:

    (a) After 10 years of being an EN, I started using new technology like Bispectral Index (BIS) monitors which are specialised medical devices used in anesthesia. These monitors analyse the EEG signals from the brain to measure the depth of a patient's sedation, I also started assisting the anaesthetist with preparing for the insertion of arterial lines, which allow better access to patient arteries for real time blood pressure monitoring of sick patients.

    (b) After 12 years, I began administering IV fluids and IV medications, taking blood, and doing female catheterisations. I completed in house training at TUH for this.

    (c) After 14 years of being an EN, I began assisting the anaesthetist in preparing for the insertion of central venous lines. By way of example, these lines are used to give access to larger veins in order to administer larger amounts of

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fluids at a faster rate. I began working in the Cardiac or Lung theatre, where these devices were in use, so there was an expectation that you were able to understand and assist with these devices.

(d) Around 2020, anaesthetists started to use high flow oxygen in surgery. As an anaesthetist EN, this meant I had to understand how to use it, pull it apart and put it back together. If there was a malfunction, I had to know what to do to fix it. I also had to understand why it was being used.

My work as an EN in Corrections

18. My work in the Corrections Centre involved providing general nursing care to the inmates. There are multiple emergency presentations in the Corrections Centre. People would come in with boils, scabies, rashes, ulcers and other issues that required dressing. Other times, inmates who presented to the clinic had been stabbed or had been in a fight. I also administered injections.

19. The job also involved medication management for the inmates. Per my scope of practice, I was able to follow treatment plans that had been put in place. I was not able to administer dangerous drugs but I was able to administer medications like antibiotics.

20. Many of the inmates had chronic issues. It was important to develop a rapport with the inmates so that you could treat them properly. I met 1-on-1 with inmates, assessed their presentation and then referred them on to the Doctor. Once a particular course had been approved, I administered a lot of this treatment myself.

21. As an EN in this setting I had a much greater level of independence. While technically I was subject to the supervision of an RN, I was never actively supervised by an RN in my tasks. I mostly just went straight to the Doctor.

[redacted]

Julie McGrath
19-03-2026

Docusign Envelope ID: 0F4725C2-AFD9-437B-99E8-FF87B046A3DB

IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF JADE BARCLAY

I, Jade Barclay of [redacted] say:

Work history and qualifications

1. In 2014, I completed my Diploma of Nursing at TAFE in Toowoomba.

2. From 2012 to 2014, I worked as a Personal Care Worker (**PCW**) while completing my Diploma.

3. From 2014 to now, I have worked as an Enrolled Nurse (**EN**) at St Andrews Hospital in Toowoomba on the following wards:

   (a) From 2014 to 2019, I worked in the medical and palliative care ward. I worked 0.9 Full Time Equivalent (**FTE**) hours until around 2019.

   (b) From 2019 to 2021, I worked in the endoscopy unit 0.6 FTE and on the medical and palliative care ward 0.3 FTE.

   (c) In 2021, I moved to 0.6 FTE in endoscopy and 0.2 FTE in surgical admissions. I have remained in these roles since.

My work as an EN over the years and across different wards

Starting out as an EN

4. My first role in healthcare was as a PCW in aged care. In that role, I showered, fed and provided other basic nursing care to patients. As an EN, in addition to conducting these tasks, I administer medication and conduct observations.

5. I learnt extensively about medication and how to conduct observations in my EN Diploma. I had a good base level understanding in respect of medications and observations when I started in 2014 on the medical and palliative care ward.

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6. My first shift on the ward was supernumerary, meaning that I was engaged in addition to the normal workforce, to enable me to shadow other nurses. After that shift, I started working on the ward. The work I was doing as an EN was a lot more skilled, and necessitated a lot more responsibility, than the work I did previously as a PCW.

Developing my skills in observations

7. Observations are a key part of EN clinical practice and patient safety. On my first shift, I took a patient's blood pressure and it was critically low. I then assisted in moving that patient into the Intensive Care Unit.

8. Basic observations are things like blood pressure, oxygen level, respiration rate, temperature and pulse. These were things I learnt how to do in the Diploma, but I did improve at taking them with more experience. As I worked on the ward and took these observations regularly, I got better at it.

9 As I observe a patient, I complete an Adult Deterioration Detection System Chart (**ADDS Chart**). The ADDS Chart sets out a number of different criteria and includes some causes for concern. The observations in an ADDS Chart include respiratory rate, oxygen saturation, oxygen flow rate, systolic blood pressure, heart rate, temperature, behaviour and consciousness. The ADDS Chart sets out a scoring detail for all the different observations and you add these together to get a score. After conducting the ADD Chart observations, I determine if the patient fits into the normal range.

10 In addition to the above, as I shower a patient I observe their skin and identify any wounds or other potential issues. I've conducted observations across the different units I have worked on.

11 In the medical and palliative care ward, in addition to standard observations, I learnt how to perform neurological observations. If someone has had a fall or had some kind of issue with their brain, there are additional neurological observations to conduct. These neurological observations are things like the Glasgow coma scale. These neurological observations measure the patient's pupil size, reaction, their limb power both in legs and arms, and their other vital signs. I was taught how to do these observations by the Registered Nurses (**RNs**) I worked with on the ward.

Developing my skills in medications

12. As an EN, I administer all basic medications. For example, if a patient is on blood pressure tablets, or Lyrica (an anticonvulsant medication), I administer this medication to the patient myself. Diabetes medication and some other medications have to be administered with an RN. I also need to be with a RN to administer IV medication.

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However, most of the medication provided to patients on the ward is standard and I am able to administer it myself.

13 I had to be deemed competent to assist RNs with administrating intravenous (**IV**) medicine. To be deemed competent, I had to assist in the provision of 20 IV medications. These were a combination of push medications, IV antibiotics, and IV fluids. After I had successfully assisted on 20 separate occasions, I was deemed competent by the nurse educator on the ward in this clinical task. I have to refresh this competency in IV medicine every year.

14. There was a nurse educator employed on the medical and palliative care ward. She approved each of my competencies in new medical skills. She also checked my competencies as they required refreshing. In the first few years the nurse educator would mark you off on completing procedures, such as syringe drivers, medication competency and wound management.

My work on the medical and palliative care ward

15. I learnt a lot of new clinical skills in my initial five or so years as an EN working on the medical and palliative care ward. I detail some of these below and, where possible, document when it was in my time on the medical and palliative care ward and in the context of my career as an EN, that I gained these additional clinical skills:

(a) I learnt how to use a <u>syringe driver</u>. The syringe driver is a subcutaneous syringe that goes into a patient's skin. You need two nurses to administer it. The syringe driver delivers pain relief medication, sickness medication, and typically has a sedative like Midazolam. These are typically dangerous drugs. Syringe drivers are used if patients can't swallow or are too unwell to interact with staff. Syringe drivers are usually used on patients nearing the end of their life. I learnt how to use a syringe driver after around six months on the ward (also six months into my career as an EN). I learnt that skill with a nurse educator and was approved by them as competent. I renew that competency every year.

(b I learnt how to do a <u>bladder scan on patients with a catheter</u>. A bladder scan is done on patients after they have had a catheter removed to check whether their bladder is working properly and whether the catheter can safely stay out. Again, in the first year I was on the ward and as an EN, I was taught by the nurse educator how to do this scan and the nurse educator deemed me competent.

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(c) I learnt to perform blood transfusions with a RN. I was taught how to do this and was deemed competent by the RNs I was working with on the ward in my first year on the ward and as an EN.

(d) Finally, I learnt how to perform vacuum dressings. A vacuum dressing is a dressing that stays on for multiple days. To learn this skill, the hospital ran a workshop, and having completed the workshop a nurse educator deemed me competent. I was deemed competent in my second year on the ward and as an EN.

My work on the endoscopy unit

16. I have learnt many clinical skills in the endoscopy unit and have taken on additional responsibilities whilst employed on that ward. Some examples of this, and the timing of when I acquired these new skills and additional responsibilities, is as follows:

(a) Within the first couple of weeks of starting in the endoscopy unit, I started assisting the surgeons in performing biopsies on polyps and lesions. I was taught what to do by two senior nurses working in the unit and then they approved my competency.

(b) After six months in the unit (and around five years as an EN), I started assisting surgeons in performing bronchoscopies. A bronchoscopy is a scope that looks into your lungs. It took me around six months to establish competency in this skill. I observed around four procedures. I then doubled with a nurse two or three times, and after the senior nurses approved me as competent, I started assisting surgeons performing bronchoscopies myself.

(c) After three years in the unit (and eight years as an EN), I started assisting doctors in performing specialty scopes like an endoscopic ultrasound (**EUS**). This is an ultrasound of the digestive tract of a patient, that looks into the pancreas for lesions or cancer. These were not done in the hospital until around five years ago. I learnt how to assist in these when they were introduced to the hospital. Only one of the doctors performed this work at the time; an EUS is not a common procedure to start with but now is an essential scope for certain patients. I learnt how to assist in this procedure when a representative of the pharmaceutical company that produces the scopes came to the hospital and ran a workshop. Since then, although this was once a rare procedure performed infrequently, we now get more patients that need a EUS scope. An EUS scope is typically performed up to four times a week. As a result of my experience, I am able to assist the doctors when called on to do so.

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(d) I began to contribute to the development of better processes and procedures in my nursing team, by preparing bleeding baskets. A bleeding basket is a collection of materials that includes all of the equipment necessary to treat a patient if they have a bleed. So, if someone in the unit is having a gastric bleed or another bleed, we have special equipment ready to treat the bleed quickly. I set those up about 18 months after I started in the unit (and around six and a half years into being an EN). It was my idea to create these bleeding baskets and my boss, the clinical nurse coordinator of the Unit, thought it was a good idea and asked me to set up the baskets. There are now three ready to go in our unit.

(e After around two years on the unit (and seven years as an EN), I started inserting nasogastric tubes and nasojejunal tubes (thin flexible tubes that pass through the nose and oesophagus into the stomach or small intestine to deliver nutrients and medicine). Two senior RNs taught me how to do this task. I also attended a workshop led by a pharmaceutical company representative. I was approved as competent by the two senior RNs who supervised me performing these tasks independently.

(f After around one year on the unit (and six years as an EN), I learnt how to assist during an Endoscopic Retrograde Cholangiopancreatography (**ERCP**). An ERCP is a specialist procedure to examine a patient's bile duct, cystic duct and pancreatic duct to determine whether a patient has any gastrointestinal stones, tumours or blockages. I was taught how to assist in an ERCP by two senior RNs. They were the ones who subsequently approved me as competent, having supervised me perform this procedure independently.

17 I took the initiative to learn these competencies.

18 After a year and a half, I was classified 'On Call' in the unit. In order to be classified as On Call, a nurse needs to be able to perform all the key clinical skills independently. This includes assisting in ERCP, gastroscopy, colonoscopy and bronchoscopy procedures, as well as knowing how to treat a bleed or a food bolus (a small food mass stuck in the oesophagus). I am now able to apply all these advanced clinical skills in practice.

19 I also took the initiative to develop fact sheets and guidebooks for new staff around these competencies. I decided to prepare these factsheets, and was supported by my Clinical Nurse Consultant (**CNC**) unit manager in doing this, because I am often asked by other nurses how to do these tasks.

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20. We have had five new nurses start this year. The more explanatory material available to new nurses, the easier it is for me to assist them in learning new clinical skills Working with new ENs, be they in the first year of nursing or simply new to our ward, reminds me of what it was like when I started and how much I have learnt.

My progression as an EN

My progression as an EN generally

21. Over the years as an EN, I have gotten better at time management. I can do tasks quicker than I once could, for example I can check-in patients and have a quicker turn around between my patients. I have gotten faster at completing paperwork the more I've done it. I am more organised now and I can better anticipate how long things will take.

22 I can also better able at thinking ahead and determining whether I am going to need certain equipment. For example, if there is a big polyp, I know I might need a lifting solution (specialised equipment to move the patient) ready to go and the patient padded up for diathermy (a surgical technique involving electric currents). I can anticipate what might be needed in advance. I can then work with the nursing team to make sure all the equipment is to hand, so that if the polyp removal is required this can be done quickly. Another example of this is where the patient needs an oesophageal dilatation (a medical procedure to stretch and widen the oesophagus). I can anticipate this and speak with the doctor about what equipment to have at hand. Thinking ahead and anticipating what may occur and what equipment I will need to assist, enables the clinical procedure to be conducted more quickly and efficiently.

23 Further, as I have gained experience over time, I have taken on more responsibility around the unit. For example:

(a) I am now the de-facto team leader when all the RNs on shift are new. This means I take a lot of incoming calls and I make a lot of outgoing calls to doctors, including but not limited to phone orders (verbal instructions from prescribers). I also accompany doctors on rounds as needed.

(b) I am constantly answering questions from new staff. As I have a lot of experience, I am frequently asked questions by the newer staff about clinical skills and how the hospital works. This is why I took the initiative to create guides and information for new staff. I want to better assist them, and I also want to be able to do my own work with less interruption.

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24. I have progressed as an EN with time in the role as I have been exposed to more. For example, I now work with a doctor every Thursday in the endoscopy unit who does a lot of interventional procedures (minimally invasive, image-guided diagnostic or therapeutic treatment). Some of these procedures are less common, and I did not see them seven years ago when I started in the unit. Seeing the doctor perform these procedures has increased my familiarity with them and I am now able to assist him in conducting those procedures.

My progression as an EN working on the medical and palliative care ward

25. When I first started on the medical and palliative care ward as an EN, ENs and RNs worked together as a team attending to patients. The EN did the showering, bed making and a lot of the observations. The RN administered most of the medication. These days, all ENs have their own patient load; between one and six patients they are responsible for themselves. These days, I conduct observations and provide most medication by myself without supervision.

26 When I was brand new, I was unsure about a lot of things. For example, when completing observations, I used to take a much longer time to complete the ADDS Chart. Although the chart hasn't changed, I have gotten much better at filling it out and completing it in a timely manner.

27 It took me around two years or so to really progress my skills in the medical and palliative care ward. From two years onwards, I had a much better understanding of what was normal and what was not normal with patients.

28 For example, in the medical and palliative care ward, when I take a patient's blood pressure it's often very low. According to the ADDS chart, such a reading amounts to a medical emergency and I'm supposed to place a call to the Medical Emergency Team (**MET**). However, given the type of patients on the medical and palliative care ward, different procedures apply. The proper process on the medical and palliative care ward is for the patient to continue their treatment in the ward. I have the authority of the treating specialist not to act in accordance with the ADDS chart in that instance.

29 Patients commonly do not fit into the normal range on the ADDS chart. So, if you are looking after these patients for multiple days you get to understand their normal range. Further to the above example, even if a patient is not a palliative care patient, if I observe that a patient's blood pressure is always low and they are stable, I can determine that the low blood pressure is not a sign for concern, unless the patient displays other symptoms.

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30. It took me around two years to learn how best to interact with patients and families in palliative care and to find my feet in the role. Knowing what to do and say, and what not to say, in dealing with the families of palliative care patients is a skill. You learn this on the job, you don't learn this in the EN Diploma. I am now able to read people going through that hard time better than I once did. These days, I know what to say and when to back away.

31 With time in the role, I'm also better placed to explain to families why I am giving a patient a particular drug and what they should expect. Having the skills and experience to talk to families practically and sensitively about what to expect as their family member deteriorates is key. I have observed, over many years working in palliative care, that taking the time to sit with the family and talk them through in practical terms what is occurring, eases their distress at watching their loved one die.

32 It always affects me when we lose someone on the ward. Losing someone, particularly someone young, is very hard. With time in the role, I have learnt to compartmentalise the trauma of the work on the ward. You build up a tolerance, and skills in distancing yourself (as a person) from your work, so that you can leave the trauma at work at the end of the day. Initially this was hard, and I would often tell friends and family that I'd had a bad day. Over time you adapt to have a separate work life and home life. I have a strong network of colleagues on the ward that I decompress with. There is debriefing available that I call on in respect of particularly difficult cases. You get better at coping with loss, and accepting this is part of the job, with time.

33 My knowledge of medications has also increased over time. In my first six months on the medical and palliative care ward (and my first six months as an EN), I carried around a notebook. Every time I came across a new medication, I would write it down and research what it was and what it did. Within the first few months, I became familiar with the common medications. Then over the years, I have become familiar with more and more medications. Now, after two years, I can talk to family members and patients about most medications and answer almost all their questions.

My progression as an EN working in surgical admissions

34. I have also learnt new skills working in the surgical admissions ward. There are a wide variety of patients that come through surgical admissions. Patients for orthopaedics, cardiac catheterisation laboratory patients, and all the other theatres in the hospital come through surgical admissions.

35. Although the paperwork is broadly the same, there's a lot of additional information specific to the patient and the planned surgery to get across. For example, I have learnt

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how long patients need to fast for particular procedures or what preparation a doctor likes for a particular procedure. Each of the doctors issue comprehensive instructions about what kind of patient preparation they require. It took me about a month on the unit to be across these instructions and to efficiently take the necessary information from the patient on admission.

36 My experience over the years as an EN has taught me a lot about what is required to ensure patients receive proper care – specifically, how to assess what is normal and what isn't normal for a patient and when to escalate care.

37 In my current role on surgical admissions, I'm confident in communicating with the surgeons and anaesthetists about a patient's condition (for example, when someone awaiting surgery is in pain). When I first started as an EN, I might have lacked the confidence to disrupt the surgeon or anaesthetist (often already in theatre attending to other patients) to notify them of my patient's condition.

38 These days I won't hesitate and I can confidently and succinctly report what is occurring in respect of my patient awaiting surgery. For example, recently there was a patient in the ward for orthopaedic surgery. When I took that patient's observations, they had a very high temperature over 38 degrees. The patient was also tachycardic (their resting heart rate was faster than normal) and had high blood pressure. This was unusual for this young patient. I then performed a blood sugar test to check those levels and an electrocardiogram (ECG). I then took COVID-19 and flu swabs as the patient had a slight cough. I waited for all the results. I then rang through to the theatre to speak to the anaesthetic doctor, who then asked me to come to the theatre so he could see the results. The anaesthetic doctor asked me to put the patient in a holding bay and he would be out to check the patient once the last case in theatre was completed. The anaesthetic doctor then came out and discussed the patient's condition with them. As these observations weren't normal, it wasn't safe to proceed with the procedure that day and the procedure had to be cancelled. The patient was also directed to go to his GP for follow up care. If I hadn't known what a normal range of observations were or how to escalate review and care of the patient effectively under time constraints, the procedure would have been conducted as planned and the patient may well have had a bad outcome. I know, as an experienced EN, that it is critical for me to speak up and interrupt doctors in theatre when I have concerns for a patient and I don't hesitate to do so.

39 Talking to patients in surgical admissions is its own skill I've had to learn. When I admit a patient, I have to build rapport with that patient quickly. When they arrive, I have a

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quick chat with the patient, try to get to know them, make them feel comfortable and relaxed whilst also obtaining all the necessary information that will inform their surgical admission. As a nurse, I am constantly developing strategies to help the patient feel comfortable while also assisting doctors and surgeons by effectively collecting all the relevant information. To make the patients feel comfortable you have to have a friendly approach; most people coming to hospital are nervous and frightened. I build rapport by talking to the patient about something unrelated before getting into the paperwork. Some patients don't have a lot of contact with people so they're keen for a chat. I let them have a little chat first to put the patient at ease. I also find being able to have a laugh with the patients puts them at ease and they are more likely to be open to you and tell you the truth. I also take the time to listen to any concerns the patient has. Some patients elect to have a carer come in with them, in which case I make sure to involve the carer in the conversation.

Why EN progression through pay points matters

40. EN progression through pay points is important because a lot of the ENs have been around a long time, they are highly skilled and they are valuable on the ward/unit.

41. As my experience and work as an EN shows, ENs help educate and orientate new staff. In some areas, where we have the experience and skill to do so, ENs play a de-facto team leader role.

42 ENs who have been in the role for multiple years take on the responsibility of educating new ENs and RNs. I have played an important role on my ward/unit in establishing new processes and better supporting new staff.

43. Over the years, I have observed that ENs are a vital part of the hospital system. RNs are often very busy attending to paperwork and doctors orders, that take away their ability to perform on-hand patient care. ENs are there to primarily focus on patient care.

Why I elected not to become a RN

44. I have not completed my Bachelor of Nursing because I cannot take six months off unpaid to complete the practical placement part of the degree. Once I pay rent, food and bills there's not a lot of money left. I also do not want to do a placement when I already have twelve years' experience on the wards and units.

45. I am happy being an EN. Long standing ENs like me are a vital part of the nursing workforce. We bring skill, knowledge, and a commitment to patient care.



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IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF DARREN WALL

I, Darren Wall of, [redacted] South Australia, [redacted], say:

Qualifications and work History

1. I was an Enrolled Nurse (**EN**) for 13 or so years. In June 2025, I retired.

2. I was a member of the Australian Nursing and Midwifery Federation (**ANMF**) in South Australia while I worked as a nurse.

Qualifications

3. In 2008, I obtained a Certificate IV in Work Health and Safety from the Master Builders Association South Australia.

4. In 2009, I obtained a Certificate IV in Training and Assessment from TAFE South Australia.

5 In 2012, I obtained a Diploma of Enrolled Nursing whilst working at the Royal District Nursing Service.

6 In 2014, I completed a course "Administer and Monitor IV (Intravenous Medications)" at the Royal District Nursing Service.

7. In 2023, I completed a course in Cardiac Monitoring (Electrocardiogram rhythm recognition) at Healthscope.

8. In October 2022, I completed a course in Advanced Life Support at Australian Resuscitation Council Flinders Medical Centre.

Work History

9. From 1983 to 1993, I served in the military in the United Kingdom (UK). When I left the military, I was a Corporal.

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10. From 1997 to 2006, I worked as a prison officer in the UK. In 2006, I came to Australia.

11. From 2007 to 2012, I worked at United Water as a Health and Safety Advisor. I was made redundant from this role and used my payout to fund my training as a nurse.

12 From 2012 to 2013, I worked at Royal District Nursing Service as a Community Nurse. This was an EN role. I worked for approximately one year in this role. I worked part-time approximately 12 hours per week.

13 From 2012 to 2016, I worked at Flinders Private Hospital Cardiac Services as an EN. I worked in this role 0.9 Full Time Equivalent (**FTE**) per fortnight. I started working on the cardiothoracic ward (**cardiac ward**). Approximately 18 months into this role, I began to work 1-2 shifts per week in the Cardiac Emergency Centre, the "Chest Pain Centre". This lasted approximately 5-6 months. From then, and for at least two years, I worked exclusively in the Chest Pain Centre, until I left in 2016.

14 From 2016 to 2017, I took leave from nursing to return temporarily to the UK to care for my late Father.

15. From 2017 to 2025, I returned to work at Flinders Private Hospital Cardiac Services as an EN. I worked part time 0.9 FTE per fortnight. For the first 12 months, I worked split shifts in the Chest Pain Centre and on the cardiac ward. From 2018 onwards, I returned to work exclusively on the cardiac ward. Sometime around the COVID-19 pandemic in 2020, I reduced my shifts to 0.7 FTE.

Duties and responsibilities of an Enrolled Nurse

Royal District Nursing Service

16. My role as an EN at the Royal District Nursing Service (**RDNS**) was to go attend on clients in their home, administer medications in accordance with medication protocol, change wound dressings and occasionally assist clients with showering.

17. There was no immediate supervision of me as an EN in this role. I worked autonomously within my scope of practice. If there was a problem, I would call the Team Lead, a Registered Nurse (**RN**), at the RDNS base and they would advise me what to do over the phone. If there was a bigger problem, the RDNS would send out a RN to assist.

18 I was fully responsible for the care of my patients. I was trusted to make decisions and take the correct actions when necessary to maintain safety and deliver the correct treatments for the patient. It was a very responsible role. This was daunting at first but did ease with experience and building my own confidence.

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19. I would dispense medication to clients in accordance with the medication protocol. The medication protocol came from the RDNS organisation following the administration of medications as laid out by the ANMF and legislation set in law. We followed the eight Rs when giving medications to ensure no mistakes were made. These are Right Patient, Right Medication, Right Dose, Right Route, Right Time, Right Documentation, Right Reason, and Right Response.

20 I went about administering medication in the following way: I would ask permission of the client to administer the medication, I would ask the patient to give me their full name and date of birth, take the medication out of the locked container, check the medication against the care plan to ensure it was the correct drug for the correct client, and the correct dose being taken at the correct time, hand it to the client, observe them take the medication, and, finally, make a record to that effect on the care plan and medication chart. In advance of administering medication, I would carefully review the client's medications ensuring they were all correct and up to date. While the care plan is set by a doctor, as the EN administering the medication I was responsible for checking the care plan and ensuring the client received the correct medication. If I identified an issue with any medication listed, I would report that to the Team Lead immediately and wait for instructions. I had one occasion where a patient asked me to apply a cream to her back to help ease pain. I asked for advice as this was not documented in the medication chart. I was cleared by the Team Leader.

2 In my role at RDNS, I regularly dispensed medication without another nurse present. I generally didn't dispense medication on Schedule 4 (Prescription Only Medicines) or Schedule 8 (Controlled Drugs), so there wasn't any need to have a second nurse counter sign. If I did have to dispense Schedule 4 or Schedule 8 drugs, I would have another nurse present and we would both check the medication dosing was correct, as well as other drugs the patient was on. For anything that didn't require two signatures, I would follow the set protocol.

22 I worked alongside ENs, RNs and some Assistants In Nursing (**AIN**). AINs would come occasionally when I was at a client's house. They would perform daily living tasks like changing the sheets and showering the patient.

23 For occasional non-complicated wound care such as a skin tear that needed to be dressed, I would treat the patient. I would remove the dressing, clean the wound, take a photo of the wound and document what I cleaned it with. If I treated the wound with anything other than sterile water, I would document the treatment on a wound chart

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and in the patient's notes. Even if cleaned with sterile water all documentation was completed so as to show regular assessments of the wound.

24. On average I probably had eight or nine clients I saw on any given shift. I had to travel between clients and I would typically travel 30-40 kms each round. I would have a time I was supposed to be at that client's house, and I would have to work my route around those times. It was just me in the car by myself. I would register on an RDNS electronic system each time I clocked in and out of a client's home.

Flinders Private Hospital – Cardiac Services

25. I spent many years at Flinders Private Hospital, working as an EN on a 31-bed cardiac ward. Patients were admitted to the ward prior to having cardiac surgery, or for cardiac investigations. Patients would typically be admitted the day prior, have the procedure, stay in the Intensive Care Unit one to two days after and then be admitted to our ward where they would remain for anywhere between a week and a month.

26 My duties included treating patients and reporting to the Clinical Nurse Specialist (an RN) and the Nurse in Charge (also an RN) and other members of the multi-disciplinary care team (for example, allied health staff like Doctors and Physios). I provided direct patient care, antiseptic wound care, administered oral medication, intravenous medication and cannulation of patients. I also admitted and prepared patients, educated them on procedures pre and post-surgery and on the importance of healthy habits. I conducted observations, maintained clinical notes and reported issues with a patient's condition to other members of the clinical team.

27 I worked under the supervision of an RN. We would care for ten patients between us. I conducted observations and assisted daily living alone, but any medications were administered together with an RN.

28 Sometime in late 2013 or 2014, I was approached to work as an EN in the Cardiac Emergency Centre, known as the "Chest Pain Centre". I started working one to two shifts per week and then worked there exclusively for two to three years before I went to the UK temporarily in 2016-2017. When I returned to work at Flinders in 2017, I resumed split shifts on the cardiac ward and in the Chest Pain Centre.

29 The Chest Pain Centre was a walk-in, emergency admission via the ambulance service or by direct referral by a doctor, 6-bed emergency department, downstairs from the main ward, especially for cardiac patients.

30 My work as an EN in the Chest Pain Centre included the following tasks: inserting cannulas, taking an electrocardiogram (**ECG**), referring for chest x-ray, liaising with the

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doctor on call, administering pain relief typically a Glyceryl trinitrate (**GTN**) spray under the tongue, documenting a patient's history and pain scale, and then implementing the care plan set for that patient by the doctor. Patients were either admitted to the cardiac ward from the Centre or sent home. Patients were given education by myself and other staff when discharged. If medications had been prescribed during the patient's admission to the Chest Pain Centre then scripts would be given to the patient.

My progression as an EN

Progression in my role in my time at RNDS

31. I learnt about medication and medication administration whilst studying my Diploma. I learnt the eight Rs of medication in the Diploma outlined above.

32. Over time, my understanding and knowledge of medications grew. As I was administering different drugs, I would look them up to see what each medication was given for and any adverse effects. So, my knowledge of medication grew with my experience.

33 My wound care skills also improved. As I was dealing with different types of wounds in practice, my skills improved. For example, my aseptic techniques improved with practice and my recognition of wounds healing or deteriorating also improved.

34 Before I started nursing, I worked in the prison system in the UK. So, my interpersonal skills, especially skills in de-escalation were quite good. But these skills really improved in my time nursing. I learnt to identify and understand the root causes for why someone was presenting a certain way. For example, when a patient was aggressive or non-cooperative, there was often an underlying reason that needed to be explored. These behaviours were often caused by the patient's fear of the unknown due to their condition. The patient often also lacked knowledge or understanding about the medications being administered. Once those things were explained to the patient, they often understood and calmed down.

35 Over time, I also became more confident in my own abilities. As a result of this increase in confidence, my interpersonal and professional skills improved. As I learnt more on the job, I became more confident that my training had given me the skills to carry out the work.

36 In later years, while working in the Chest Pain Centre at Flinders Hospital, I also conducted training for new ENs at the RDNS. This was a casual role secondary to my work at Flinders Private Hospital. I conducted training mainly on cardiac issues, ECGs,

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heart disease, circulation and electrical activity of the heart. I did this on a casual basis for 18 months throughout 2012 to 2013.

Progression in my role in my time at Flinders Hospital

37. When I first started as an EN on the cardiac ward at Flinders, I mostly performed assisted daily living tasks like showering the patient or washing the patient in bed, assisting the patient in going to the toilet, changing sheets and ensuring the patient was comfortably positioned in the bed and had access to fluids. The RN on shift and I would prepare and administer medications together. I would write end of shift notes in patient records, and these would be counter signed by an RN.

38 Once I'd been on the cardiac ward for 6 months, I was permitted by the NUM(RN) to administer medications (like Metoprolol and Atorvastatin that only required one signature) alone, without supervision. There were still injections and medications that needed to be countersigned (for example, Schedule 4 medications like Temazepam and Schedule 8 medications like Endine), so I would always administer those together with an RN.

39 My role and responsibilities as an EN at Flinders Hospital changed with time. With the support of my NUM (RN), I began to look after my patients more independently. For example:

(a) Approximately 12 months into my work on the cardiac ward, I began to remove sutures from a patient's abdomen. I learnt how to do this in my first year in 2012 and by my second year in 2013 I had gained the confidence to perform this task independently.

(b) Approximately 18 months into my work on the cardiac ward, I was permitted to make adjustments to reduce the pressure on a trans-radial (**TR**) band. In my second year, I developed the clinical skills to assess for myself whether the TR band needed adjustment and no longer needed to consult an RN in respect of this. Approximately 6 months later, my NUM(RN) began to permit me to make these adjustments myself, without consulting an RN.

(c Approximately 18 months into my work on the cardiac ward, I was told I could write patient notes without having them countersigned. Prior to this time, I always worked with an RN and they would counter sign any patient notes I prepared. Sometime late in my second year on the cardiac ward, and from then on throughout my career as a EN, I wrote these notes independently.

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(d) Approximately three or four years into my work at Flinders, so around 2014 or 2015, with the authorisation of my NUM (RN), I began to remove the central venous catheters (**CVCs**) on my own. I learnt how to do this task in my first year, 2012. By my second year, I had demonstrated my capability at the task by removing CVC lines under supervision. Once I had done five, I could perform this clinical task independently. This was not a clinical task commonly performed by ENs. Indeed, when I started as an EN on the cardiac ward, this was a task only senior RNs would perform.

40 As I progressed in my work as an EN on the cardiac ward, I was subject to less and less supervision. By the time I left the ward in 2014, and upon my return in 2017, I was responsible for caring for my patients alone (with the indirect support and authorisation of my NUM). If I had a concern about one of my patients, I'd report it to an RN, the Clinical Nurse Specialist (a senior RN) or I'd hit the Met Call Button to alert the Intensive Care Unit (ICU) team.

41 My EN role changed over the years, and my duties progressed, because I grew my clinical skills over time and demonstrated good judgment in the role. Each time I took on additional duties, I had the support of my NUM (RN) to do so.

42 Over the years, the gap between the work I was doing as an experienced EN and the work of junior RNs working alongside me got smaller and smaller. After a few years, I could carry out all roles a junior RN would do. I was often approached by junior RNs to answer questions on various actions or procedures. For example, when bloods should be taken post coronary angiograms, or when an ECG should be performed post an Atrial Fibrillation (AF) ablation.

43 I was approached by management to work in the emergency Chest Pain Centre. My role in the Chest Pain Centre was classed as a more skilled role and I believe it was offered to me as I had shown knowledge and skills that my manager felt could be enhanced and improved by working in this unit. The Chest Pain Centre could be quite hectic and physically and mentally challenging at times.

44 I viewed my 0.9 FTE appointment to the Chest Pain Centre as recognition of my advanced practice as an EN. Only experienced highly skilled ENs worked in the Centre. This was because of the severity of the presenting patients. Admitted patients had either had a cardiac event or were experiencing a cardiac event on admission.

45 The Centre was staffed by two nurses only, one RN and one experienced EN. I did plenty of tasks independently as an EN in this setting. For example, when the RN was on break, I was left in charge of the unit. If a patient presented to the unit over this time

it was my responsibility to insert a cannula and take a base line set of observations. I would also take bloods and an ECG, obtain the patients' history and a brief description of why they had come to the Centre. I would advise the on-call doctor of the patient's admission. I'd also call reception and inform them of the patient's admission so their previous case notes could be obtained. I would call for a portable chest x-ray to be taken. If needed I would call a Met Call (ICU response).

46 During these times, I was also responsible for administering a code STEMI. A code STEMI was a notification to all staff that there was a seriously ill patient. I would get a call on the red phone from an emergency ambulance letting me know a patient was on the way and suffering a heart attack. I had to take as many details, as quickly as a I could, and initiate the code STEMI.

47 In establishing my advanced level of EN practice during my time at Flinders, I did a lot of additional training:

(a) In 2013, I trained at Flinders Medical Centre to insert cannulas and take blood from patients. I had to do five of these under supervision to prove I could perform the task correctly. From then on, I did this independently.

(b) In 2014, I completed a manual handling course in the movement of patients at Ashford Hospital. I became the go-to person on the cardiac ward in the safe lifting of bed bound or obese patients. I was often asked by my colleagues to advise on how best to move patients due to disability or incapacity. If I saw something on the unit that wasn't being carried out correctly, I would speak to staff and demonstrate the best way of carrying out that task. I also provided organised training, not only for the cardiac unit but for the hospital in general, on designated training days. This was attended by all nurses (irrespective of their grade).

(c) In 2014, I did an intravenous therapy (IV) course at RDNS. This wasn't part of my original EN training, but it was something I considered was important to my practice. After completing this course, I was able to administer IV medications independently. This saved time for myself and colleagues. It also increased my knowledge of medications and their role in the treatment of conditions.

(d) In 2022, whilst working in the Chest Pain Centre, I was approached by Clinical Nurse (RN, Specialist) Julianne Jones to complete the Advanced Life Support (**ALS**) Course. This course focused on recognising signs of the deteriorating patient, conducting CPR and administering defibrillation. It was a nationally accredited course, that included prior study, a day's training and a practical

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test. I completed the course in 2022. Unfortunately, upon my return to work, I was told by Flinders that administering defibrillation was deemed by the hospital to be outside my EN scope of practice. I wasn't permitted to perform this task and the hospital never recognised my status as an EN accredited ALS. I nonetheless used the skills I'd acquired in this course in my work. These skills formed part of my advanced practice as an EN. For example, I used skills I learnt in recognising signs of the deteriorating patient in my patient observations from then on. I was able to recognise earlier, whether a patient was deteriorating or might be about to deteriorate. I was also adept at performing CPR when required.

(e In 2023, I did an online course in interpreting ECGs at Healthscope. Typically, ENs are only permitted to observe the ST-segment on an ECG. The ST segment can be an indicator of a cardiac event of disease. If the ST element is raised globally, it can indicate pericarditis. If the ST-segment is raised on certain ECG leads, it can indicate possible myocardial infarction. Once I had done this course, I was permitted to look at and interpret the broader ECG. I used my skills to identify discrepancies and would report my observations to the RN or Doctor.

48 In addition to developing my clinical skills, I got better at the 'soft skills' of nursing with time in my roles at Flinders. For example, my skill at putting patients at ease developed over time. I found that if you were polite and took time to explain things to patients that built trust. If you acknowledged what they were saying and gave time to listen that put them at ease, especially if you showed you cared and empathised with their situation.

49 I called on all my skills and life experience to assist me in being the best nurse I could be. Being ex-military, I could often have conversations with ex-military personnel and in some ways distract their train of thought from the present and make them feel at ease. I used my upbringing in the UK as a way of connecting with people who had come to this country, rather than being been born here.

50 Establishing shared experience was a technique I used to gain trust and build rapport with the patient. I always had a smile and would try to have a joke with the patient, which in most cases worked. I would often tell patients on the way to theatre that they had to take note of the route we were taking as they would have to find their own way back. This always seemed to lighten the situation.

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51. Most importantly, I would encourage patients, especially men, not to hold things in and to cry if needed and not be embarrassed. It's common for emotions to be very up and down after lifesaving surgery.

52 Working on the cardiac ward, the patients could stay a long time (up to a month). There was considerably less 'churn' or turnover on this ward than is typical on other hospital wards. As an EN working on this ward, I really developed rapport with my patients.

53 I got a lot better at these aspects of the job with time. Things that were daunting at first, like drawing up and giving injections, taking blood became a lot easier with time in the role. Working on the Chest Pain Centre was mentally challenging because it was a small unit I had additional responsibility and had to make more clinical decisions than I had in the past. For example, I had to decide if a patient was suitable for admission to the unit.

The need for career progression for ENs

Progression in my pay during my time as an EN at Flinders

54. In my role at Flinders, there were eight progression levels for ENs. Full time workers would advance the scale yearly. I was also given a one-off payment of $500 for completing the administration of IV medications course.

55. As an EN, there were always limitations on the scope of my practice. Despite my experience, and my progression in the role over the years, in the later years of my career I was held back by the fact that I was 'just an EN'.

56 I appreciate that I never went to university to become an RN, but I progressed in my skill development as an EN over the years and practised at an advanced level as a EN for a significant period of time.

57. I'm glad that I was able to progress financially through some pay points at least. Financial progression was an important part of my job satisfaction in the role. I do feel that my skills and experience could have advanced my pay to that of an Advanced EN level. I applied for this but it was never approved by my manager at Flinders, even though there was provision for this to be done.

Why I became an EN rather than an RN

58. I initially wanted to become an EN because it was only an 18-month course. I was 52 years old when I started, so I wanted to get into the learning process and get working as soon as possible. I wanted to make sure I enjoyed the job of being a nurse before committing myself to a university qualification.

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59. The time and expense involved in doing the Bachelor degree was a real factor in my decision to become an EN rather than an RN. The EN Diploma was only 18 months. To become an RN, I would have had to take on a HECS debt, work in unpaid placements and incur other general costs of studying.

60 I seriously considered becoming an RN later in my career but ultimately decided not to. I thought I might be too old to start studying again and personal circumstances at the time (including the deaths of multiple family members) prevented me from taking that step.

61. Approximately eight years into my nursing career, I started an Advanced Diploma (12 to 18 months study incorporating theoretical and practical components) but I elected not to complete it.



Darren Wall

18-03-2026

Docusign Envelope ID: ECF311C9-0354-4A5F-B89F-357375505C5F

IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation**

STATEMENT OF NICOLE MACKAY

I, Nicole Mackay of [redacted] Queensland [redacted], say:

Work history and qualifications

1. For 20 years, I worked as an Employment Consultant at the Commonwealth Employment Service and then at different job network agencies.

2. In 2012, I had a career change and began my studies to become an Enrolled Nurse (**EN**).

3. In 2014, I obtained a Diploma of Nursing (Enrolled/Division 2 Nursing) from the Queensland Institute of TAFE.

4. From 2014 to 2025, I worked as an EN on the East Ward of St Andrew's Hospital in Toowoomba.

5. I have been a member of the Queensland Nurses and Midwives Union (**QNMU**) since I began nursing.

6. For the past 6 months I have been working as an organiser at QNMU.

Duties and responsibilities of the Enrolled Nurse

7. My role as an EN on the East Ward of St Andrew's Hospital was to assist as part of a care team.

8. I worked in post-operative care on the ward. Each surgeon had a post-operative care pathway that we had to follow. The most important part of the job as a EN was following the care pathway for each patient. Each patient had different needs including assisted daily living (**ADLs**), like showering and assisting patients to go to the bathroom. We also did standard nursing tasks like changing the bed sheets.

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Wound care

9. One aspect of my role as an EN was conducting observations on patients and doing basic wound care. I could apply a standard wound dressing. Once I'd been working as an EN for around 6 months, I was able to tell when a wound was not progressing normally and when I needed to escalate that wound care to a Registered Nurse (**RN**) or a doctor.

10. I also did a course in vacuum wound dressing. I learnt how to do this at two years into my career as an EN. A new surgeon joined the hospital and we began using vacuum wound dressings, so it was useful to complete the course.

Medications

11. Patients also required medications. I would assist in providing the medications to the patients. By assisting, I mean it was my role to assist the RN to ensure that patients were given medications as per the medical charts and doctors orders.

12. I became an Endorsed EN, meaning I could provide medication, when I graduated from the Diploma. As an Endorsed EN, I would often complete a medication round on my own. This happened pretty much daily.

13 As an Endorsed EN, I can administer certain medications to patients on my own. These are medications that do not require two nurses to sign off. Drugs I administered that were on Schedule 4 (**S4**) or Schedule 8 (**S8**) had to be co-signed by a Registered Nurse (**RN**). S8 drugs are high dependency drugs like Endone, and Palexia. S4 drugs are drugs like Panadeine forte and Diazepam. Any other drug that was legally chartered in a Medical Chart, and not under the classification of an S4 or S8, I could administer on my own (e.g. Panadol, Nurofen, Hypertension, Anti-Depressants). I can also administer certain intravenous medications, subcutaneous and intramuscular medications under supervision of an RN.

14 Each time I administered any medication I used my professional clinical judgement to determine if the patient should be receiving this medication. Consistent with my professional obligations, I escalated to an RN if I believed a medication should not be given to a patient or a patient's medications had been charted incorrectly. For example, if I was administering an anti-hypertensive medication (a medication to lower blood pressure) and I noticed the patient already had low blood pressure, I would check with the RN or the doctor before administering the medication.

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Observations

15. Patient observation was also very important. As an EN, I would observe a patient post operation half hourly for the first two hours, then hourly for the first four hours then every four hours for 24 hours. Part of my role was to escalate any patient deterioration and any concerns I had after observing the patient. I had an observation chart that I would go through with each patient. If I had a concern arising from my observations, I would escalate my concern to an RN.

16 With experience in the role, you develop the skill and capability of knowing when to escalate. This included pressing the MET call button when there's a medical emergency. MET stands for Medical Emergency Team which is a team that resides in the Intensive Care Unit who would come into the ward if there was a medical emergency. It took me around 4 years to confidently press the MET call button without notifying an RN first.

17 New graduate ENs come out equipped to do ADLs, take blood sugars, conduct basic observations, complete basic wound care and have medication competency. ENs are expected to be able to do all these tasks and care for a patient.

18. With experience in the role, you get better at time management. As an experienced EN, I was able to juggle observations alongside all the other things I needed to do on the ward.

Patient load

19. As I progressed as an EN, I got more involved in the daily care plan and management of the patient load. After around 12 months, I got my own patient load when there was insufficient staff to do team nursing on the ward. For example, on night shift I had my own patient load. This showed me that the Nurse Unit Manager (**NUM**) had confidence in me. Team nursing is when I am paired with an RN or Clinical Nurse. In a normal shift, doing team nursing, I generally had around 10-12 patients that I would see every day. Of those patients, seven or eight would have had an operation in the previous 24 hours. This means after around 12 months, I coordinated regular observations amongst multiple patients and attended to multiple patients' needs each shift.

My role within the nursing team

20. As the EN, you're the most qualified nursing team member for the RN to delegate care tasks to. For example, on my ward, RNs would do the 8:00am and 2:00pm medication rounds, and ENs were delegated the 12:00pm round. My NUM started to delegate this round to me once I'd been approximately two years in the role.

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21. My work as an EN allowed the RNs time to perform other duties, take breaks and complete daily requirements. As an EN, I completed care pathway plans, made clinical notes, liaised with pharmacy on patient discharge, and liaised with doctors on their rounds.

22 While ideally RNs and ENs work together, this was not always possible. As an experienced EN, my NUM would often team me up with another EN or a graduate RN. In such a team, I would take the lead role.

23. As an experienced EN, new graduate RNs would often be allocated to work with me. I worked alongside them, showing them how the ward worked, how the daily routine goes, where things were located, introducing them to allied health staff etc. Once I'd been in the role two years or so, I was allocated graduate RNs and first year student RNs. I was responsible for educating them in everything relating to ADLs.

The importance of the EN role and a progression pathway

24. ENs are an important part of the care team alongside RNs.

25. I never contemplated becoming an RN. I had a career change at 40. Time was a big factor, as was the cost of doing a three year bachelor's degree. I was married with three children, one in high school and two in primary school. At the time, doing the 18 month EN qualification was a better option.

26 35 students started the EN Diploma but only half of us graduated. The TAFE Diploma might not be as hard as a university degree, but it was still a hard course. I remember that in terms of the medications component, you had to get 100% of the answers right to pass.

27 Throughout my nursing career, I was content being an EN. There were progression options, up to a point. This was enough for me. I progressed through seven different pay points and became as Advanced EN.

28 It wasn't feasible for me, given my age and my care responsibilities, to go and become an RN. I would have had to do the study part-time for financial reasons.

29 Based on my experience working on East ward, and now as an organiser at QNMU speaking with other ENs, I have observed that ENs tend to stay working on the same ward for lengthy periods. RNs typically have a different career path. They may move off the floor into a Clinical Nurse role or a NUM role where they have other responsibilities outside clinical duties. The fact that the ENs remain, often over many years, provides continuity.

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30. A lot of nurses are leaving nursing. We need RNs but we also need ENs. Not everyone needs to have a university degree. Without a progression pathway for ENs, I don't think I would have become an EN. Progression is important for attracting people to the industry.



Nicole Mackay
18-03-2026

Docusign Envelope ID: 31983074-F560-4709-85F7-006128E1C74C

IN THE FAIR WORK COMMISSION

Matter No: **AM2024/11**

Re Application by: **Australian Nursing and Midwifery Federation and others**

STATEMENT OF TERESA SATALICH

I, Teresa Satalich of [redacted] Victoria, say:

Work history and qualifications

1. I have been an Enrolled Nurse (**EN**) for 10 years. I am currently working as an EN at Autumn Care - Clovelly Cottage which is an aged care residential home. I also work as an EN at Let's Get Care where I provide in-home care to an elderly couple.

2. In 2004, I completed a Bachler of Science at the University of Melbourne.

3. In 2015, I completed my Diploma of Nursing at Box Hill Institute of TAFE.

4. In 2016, I started working at Autumn Care – Clovelly Cottage as an EN.

5. In 2019, I started working at Let's Get Care as an EN.

My work as an EN

Autumn Care – Clovelly Cottage

6. At Clovelly Cottage I perform the role of a Community Nurse. This role can be held by an RN or an EN. I work permanent part-time hours. I also pick up additional shifts as needed. My duties in this role are as follows:

   (a) I conduct a medication round of all the residents each morning. There are 38 residents, who all have different needs. My round generally goes from 7:15am to 10:30am. There are a lot of significant responsibilities required of me in completing the medication round. I detail these below.

   (b) In addition to ensuring I am safely administering all medication, I'm also connecting and checking in with residents. Over the years, I have observed that residents will not report health concerns to nurses unless those nurses take the time to build rapport and trust with them.

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(c) Before the round, I liaise with the Personal Care Assistants (**PCA**s) about the patients. The PCAs do more of the assisted daily living and hygiene tasks with the patients. I call the PCAs my eyes and ears. For example, the PCAs will often tell me that a patient is having some behavioural issues or some other abnormalities. The PCAs often notice issues in the patients skin and report concerns to me. Knowing this information before the round makes it easier

(d) Throughout the round I liaise with the care managers and note any signs of deterioration. For example, if a resident is more tired than usual, is eating less, has changes in behaviour, increased complaints of pain or presenting more confused. If I notice these signs, I will escalate the patient's case.

(e) If I am working a PM/night shift, I also attend to wounds. I dress new wounds if required, typically if they have sustained an injury such as a skin tear post fall and monitor whether or not a wound is healing or deteriorating. I do not assess wounds, I refer them to the wound nurse - who is an RN. I also complete a wound chart and take photographs of the wound for documentation, as well as create a worklog to ensure daily monitoring by the wound nurse the next day.

(f I conduct resident reviews. This is a review of the care plan where a Care Manager or an RN, the resident, occasionally their family and myself go through the care they are receiving. These reviews are usually done every three months. This involves sitting down with the resident, and often their family, and discuss the resident's care plan. Topics discussed include dietary preferences, meal sizes, general level and amount of care received from staff, pain management, changes they'd like to implement as part of their care routine, any suggestions for improvement, and it is an opportunity to raise a complaint.

(g I take note of any issues or changes. For example, sudden changes in the presentation of the patient and/or observations and escalate these to the RN on shift or the doctor. I'll also perform small non-pharmacological interventions immediately to assist these patients. Things like if their blood pressure is low, I will push fluid intake and elevate the patient's legs. If they are short of breath, I ensure they are sitting up and not lying flat. In addition, if they are in pain or vomiting, I provide appropriate medication. If I notice deterioration, I would also set up charting to more frequently monitor observations, pain, food intake or behaviours, depending what is applicable to how the resident is presenting.

(h For palliative care patients, I'll document clinical deterioration on the PACOP (Palliative Aged Care Outcomes Program) assessment tool.

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7. Completing the medication round is a significant responsibility. I always need to be alert on the medication round. It's my job to ensure the right medication is administered to the right resident at the correct time. To do this effectively, I have to carefully interrogate/check the chart is completed properly and the medication is correct. If I notice any errors, I flag them immediately to a doctor to review and edit. I cannot administer the medication if it is not charted correctly. The chart is set by the doctor. While the doctor has primary responsibility for the chart, I am obligated, as the nurse administering the medication, to check their work.

8 I also have to ensure the resident is in a fit state to take the medication. I ask myself the following questions: Is it safe to administer? Is the resident awake and alert? Is the resident a choking risk? Does the resident need a particular tablet ground?

9. I apply the "Rs" of medication. These are right medication, right dose, right patient, right time, right route, right documentation, right reason, right response and the right to refuse. It is critical to apply these "Rs" as they are the foundation of medication administration. They are applied to each resident each time a resident is administered a medication. They help prevent errors, and guide safe medication administration.

10 Some of the residents are provided with "packed" medication or medication in "sachets". This is when the pharmacist has prepared the medication for the resident and it is placed in the medication trolley before the start of the round. This medication can include Schedule 8, or restricted drugs. These drugs are things like Endone or Targin. I can administer these drugs myself if they have been "packed" for the round. All the packing is done by the pharmacist on instruction from the doctor. Schedule 8 drugs that aren't packed have to be signed out by two nurses including an RN. I can only co-sign in this instance. It is only after the drug has been co-signed by an RN that I can then administer the medication.

Let's Get Care

11. My EN work with Let's Get Care is different to my work in the aged care home. I'm engaged by Let's Get Care as an independent contractor. My only clients are a married couple. The clients are on a care package that their children self-manage. The couple has limited English proficiency so the fact I am bilingual and speak fluent Croatian is helpful. Initially, when I started working for the couple in 2019, I worked two to three hours twice a week and now I work closer to four hours twice a week. Sometimes, if they have had a hospital admission or it is slightly more.

12 My duties in this role are as follows:

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(a) I attend on a regular basis to perform clinical tasks. I conduct observations (for example, blood pressure), monitor blood sugar levels and provide stoma care for the husband. Stoma care involves changing and cleaning the stoma on a regular basis and making sure there are sufficient supplies of the necessary stoma products. I also conduct skin assessments and wound dressings when required.

(b) I instruct other carers who provide assistance to the couple on how to best care for them. I have made videos of how best to use particular equipment, for example how to support effective use of a Ventolin inhaler. These videos are referred to by family members, but also PCAs and other care staff the family engage.

(c) I monitor changes in their health. For example, if they change their blood pressure medication, I have a look at the effects and prepare notes for their cardiologist. The husband has early-stage Alzheimer's, so I am carefully monitoring that progression. The wife has short term memory loss. I talk with the family about what this means and how we can best support them through these changes.

(d I attend doctor's appointments. I transport the couple to and from these appointments. I do a lot of pre-planning with the family about what needs to be communicated to the doctor in order to make the most of these appointments. I discuss things like necessary interventions/changes to be applied at home to support their care goals with the doctor. These interventions are things like diet changes, implementing fluid restrictions or weight monitoring.

(e I conduct a care plan review every year with the couple's daughter and the case manager. As part of the care plan, we thoroughly review each section of the care plan, assessing the suitability of the current care needs, or if it requires updating. These topics include mobility, hygiene, medications, continence, risks, nutrition, skin integrity.

(f) I'm on call should there be any incidents that arise. There have been medication incidents in the past, where one of them has taken the wrong medication. There have also been minor falls in the past. I'm available to triage the necessary response including providing support, guidance and reassurance.

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My progression as an EN

13. I have definitely become more skilled overs my years working as an EN. I can give the following examples:

    (a) When I started doing the medication rounds at Clovelly Cottage, I would have to pick up every bottle to examine it and work out what medication was what. These days, I recognise all the bottles. The whole task of administering the medication has become a lot quicker as a result, and I can focus on more important aspects of this work.

    (b) My skills at completing the medication round effectively and efficiently have grown considerably. One look at the patient and I can now ascertain their level of alertness and whether it's safe to give the patient medication. I can also make modifications to the delivery method as necessary. For example, where safe to do so, I crush the medication to enable it to be taken with liquid or food. I have an excellent understanding of what medications can be crushed and which one's can't.

    (c I'm also much better at timing and organising the round. When I began as an EN, I would start in room 1 and go door to door. These days I'm much more nuanced in how I organise who I see when. I know that resident A often refuses medication in the morning, as he's still waking up and irritable, and so I'll arrange to see him later in the round. I know resident B likes to say good morning first, and have me open the blinds to let the sunlight in, before coming back to him later in the day with his medications. I facilitate this kind of individual preference, whilst also making sure the medications are all taken in the right order and at the correct intervals throughout the day. There's a lot of organisation that.

    (d I've also developed soft skills that assist me in completing the medication round effectively. I have learnt how to set a calm tone at the start of the day, so the resident doesn't feel bombarded. New nurses are often task oriented (i.e. "time to take your medication"). Learning to complete tasks while also being gentle and friendly is a skill that takes time to learn. For example, if I approach the tasks from that which is most critical to the resident (i.e. waking up gradually, being assisted to go to the toilet and then taking medication) things will be smoother. I can also pick up better on signs of resistance. For example, if I hold a glass of water out does the resident reach for it?

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(e) Another important skill I have developed is always respecting the dignity of the patients. For example, wherever possible, I place medication in the patient's hand rather than spooning it to them. It took me 12 months as an EN to really pick up on these things and begin integrating them into my work. By the time I was 4 or 5 years in the role, I had this side of the job down and these soft skills are now instinctive.

(f I have become better at noticing patient deterioration. I am much better now, as an EN with many years' experience, at reading pain cues and knowing when a patient requires further intervention, even when those signs are subtle. It is not possible to predict sudden acute deterioration a lot of the time, but with more gradual deterioration, there are a number of symptoms that I am now able to notice. For example, a decline in the patient's mobility, their ability to initiate tasks, their speech, their facial expression and other metrics prompt me to escalate treatment and get them help. I also notice change in general presentation overall. I monitor the patient's alertness, their response to verbal questions, or whether they are presenting differently. After a while these skills became instinctive and I now notice these things at a glance. It took me approximately three years as an EN to really develop these skills. I have observed, from working alongside other junior nurses, that it takes many years to be across this. Some nurses pick this up sooner than others, depending on the strength of their observational skills and how well they know the resident.

(g) I have become much better at time management. It took me around 2 years to become confident in time management and understand the different aspects of the job and how much time to dedicate to each. I have observed that new ENs really struggle with this.

(h) I have become a lot better at completing paperwork. Thorough paperwork is important, but excessive detail is cumbersome. Finding the right balance takes time and experience. I have observed that new ENs are regularly counselled about how to effectively write notes. I had this skill down 2-3 years into my role.

(i) As an experienced EN, I am much more skilled at dealing with behavioural issues. By this I mean violence and aggression, and attempts to abscond from the facility. When I started, this was one of the most confronting aspects of the job. A key skill that I have developed over a number of years is reading the mood of clients and communicating effectively. When I first started, I had a

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resident throw a glass of apple juice at me. In hindsight, I believe I could have approached that incident differently and it may have been avoided.

(j) I can now identify when residents are starting to get agitated. Of course it is impossible to prevent all behavioural incidents, but there are several important things that might prevent a behavioural issue. I notice a patient's confidence, body language, and their tone when they speak. Sadly, dementia patients often cannot communicate but they provide non-verbal cues. When I was new, I did not always recognise that. I also observe new nurses who do not always pick up on these non-verbal cues and don't know when it's important to create physical space between themselves and the resident. Understanding these non-verbal cues takes a lot of time. After around 1 or 2 years I felt like I could identify a lot of the common non-verbal cues. It took me around 4 or 5 years to really get a deep understanding of clients and how they might react to different things.

(k) I am also more resilient when incidents happen. When I started in aged care, sometimes it felt like I was just keeping my head above water. Now, I can move on more quickly and fill the necessary documents quickly.

(l) With time in the role, I developed much better skills communicating with and managing families. Some families can be very demanding and, occasionally, aggressive. New ENs lack the skills to effectively manage these situations. There are often cultural barriers at play, where English is not the EN's first language and they struggle to speak in a direct manner. I spend a lot of time unofficially mentoring ENs in how to do this. For example, when I started as an EN, and a resident had had a fall and I needed to call the family to inform them, I'd write out a whole script of what I was going to say. I'd pray they didn't have any questions for me. Looking back, that's now laughable. These days, I have the skill to confidently communicate in a factual way what exactly has happened and what we as a facility have done and will do in response. I think it took me one year in the role to put down my script and three years to be able to do this instinctively.

Developing my skills in palliative care

14. Palliative care has become a passion of mine. I've dedicated a lot of time to upskilling in this area in the last five years. I have been educating myself using resources, including resources published by the ANMF, to better understand medication, pain, patient deterioration in aged care and what to watch for.

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15. I've learnt a lot more about the acute terminal phase – recognising pain cues and how to maintain patient comfort levels to decrease agitation and restlessness. There are small things I can do as an EN to make the palliative care journey better. For example, I am always careful to ensure that patients' skin as well as their oral and mouth care needs are met. Doing these tasks consistently in a timely manner will make the patient more comfortable. Some patients respond well to light massage.

16 After five or six years working as an EN, I learnt how to recognise when a resident is heading into the palliative care phase. There are little signs like sleeping more or being less engaged when I come to see them that may indicate they're deteriorating. As an EN, I'm always observing the person and putting the pieces together.

17 When I first started as an EN, I was nowhere near as vigilant. I assumed that palliative care was about pain relief and that pain relief alone was sufficient. These days I understand that palliative care is a lot more than that.

18. I'm motivated to provide the best possible palliative care I can because I'm caring for residents, and their families, that I have built a relationship with. I want to be the best nurse I can be for them.

19. This is one of the areas where I think experienced ENs like me really shine. I'm the nurse on the floor. I don't have the same demands on me as the RN Nurse in Charge.

The importance of the EN role

Why I elected to become an EN rather than an RN

20. I came to nursing later in life, after many years as a stay at home parent. I have two children, one of whom has autism and required considerable assistance from me growing up. I completed my EN Diploma part-time around my commitments at home. Had I completed the RN qualification, this would have taken twice as long.

21. I never wanted to leave my role as an EN to obtain my RN qualification. I'm passionate about what I do and I love being an EN. I don't want to be the RN Nurse in Charge. I'd prefer to be on the floor interacting with residents one-on-one. Patient care is my focus.

Why the EN role matters

22. From what I have observed over the years, the EN role is an important role because we are the conduit between the PCAs and the RNs and Doctors. We're the ones that

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have the clinical skills to determine whether something a PCA has observed needs escalation to the supervising RN.

23. Furthermore, ENs like me are just as equipped to perform the Community Nurse role as RNs.

Lack of pay point progression for ENs in aged care

24. I earn Award rates at Clovelly Cottage. These days there are no more EN pay points, there's just one flat EN rate.

25. This means new ENs are earning the same amount as me, even though I have 10 more years' experience on them. I feel undervalued as a result.

26 Brand new RNs are also earning more than me. They start out with none of the skills I have referenced above. There is so much that you learn on the job in the Community Nurse role. I spend a lot of my time sharing my knowledge and experience with graduate RNs. I have observed there is also a high turnover of RNs in aged care, so there is often a constant stream of new recruits to teach.

27 I don't begrudge the individual, but it feels unfair that these new ENs and RNs are earning the same if not more than I am. If graduate RNs were inherently more valuable than me, I would have nothing to teach them.

28. I want to be valued for the skilled work I do, and the experience and knowledge I have acquired throughout my years as an EN. I am constantly learning and improving in my job and I think that should be reflected in the money I am paid.



Teresa Satalich