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IMPLEMENTATION PRINCIPLES FOR NURSE PRACTITIONER CREDENTIALING IN THE AUSTRALIAN CAPITAL TERRITORY

DISCUSSION PAPER

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AUTHOR NOTE

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ACT Health acknowledges the Traditional Custodians of the land, the Ngunnawal people. ACT Health respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. ACT Health also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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Introduction

This discussion paper provides an overview of the nurse practitioner (NP) workforce, reviews recent work that examined the NP workforce in the Australian Capital Territory (ACT), and identifies how existing credentialing policies have been operationalised in the ACT. This paper then proposes high-level principles for employers to consider when credentialing a clinical scope of practice for individual NPs across both the public and private health sectors in the ACT, as relevant to the *Health Act 1993* (ACT). Such principles not only have the potential to enhance public protection, but may also enable greater workforce flexibility and transferability by enabling NPs to work to their full scope and potential within the Territory.

In 2015 the Australian Commission on Safety and Quality in Health Care (ACSQHC) published guidelines[1] for credentialing and defining scope of clinical practice for health practitioners. Those guidelines are widely used by the public health sector, as well as private hospitals, for accreditation purposes. The guidelines serve as the foundation for institutional credentialing policies, whose primary aim is to assure the public that employees are suitably trained and competent to practice. Therefore, the ACSQHC guidelines play a key role in protecting the public from harm whilst enabling clinical practice.

The 2015 ACSQHC guidelines specifically recommend "formal credentialing of health practitioners undertaking unsupervised practice" (ACSQHC, 2015, p. 5). Along with medical and allied health practitioners, it specifically names NPs as a workforce that requires employer credentialing. Nurse practitioners are Registered Nurses (RN) holding an endorsement by the national nursing regulator to practise in an advanced clinical role. They are authorised to independently perform advanced and comprehensive clinical assessments, diagnose medical conditions, request and/or interpret diagnostic tests, prescribe medicines, and refer to medical and allied health practitioners within their scope of clinical practice[2]. Currently there are over 2000 NPs endorsed to practice by the Nursing and Midwifery Board of Australia (NMBA), with 54 nominating the ACT as their principal place of practice[3].

Targeted consultation with key stakeholders was undertaken in the formation of this discussion paper and associated tools, to assure their relevance to NPs and health organisations in the ACT. It is anticipated this paper will serve as a springboard for discussion, and serve as a useful resource for NPs and their employers when considering published guidance on credentialing processes. Tools developed to help operationalise NP credentialing principles, as well as a list of stakeholders engaged in consultation can be found in the Appendices.

1 ACSQHC. (2015). *Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners.* ACSQHC: Sydney, NSW. Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf (safetyandquality.gov.au)

2 Nursing and Midwifery Board of Australia [NMBA]. (2021). *Nurse practitioner standards for practice.* Australian Health Practitioner Regulation Agency [AHPRA]. Nursing and Midwifery Board of Australia - Nurse practitioner standards for practice - Effective from 1 March 2021 (nursingmidwiferyboard.gov.au)

3 NMBA. (2021). *Registrant data.* AHPRA. Nursing and Midwifery Board of Australia - Statistics (nursingmidwiferyboard.gov.au)

Background

After publication of the 2015 ACSQHC guidelines, public health services and private hospitals rapidly began instituting policies to align with standards[4] requiring credentialing of individual health practitioners to practise within a defined scope of practice. However, this rapid move towards credentialing was not seen in other private health services, such as general practices or other private primary healthcare settings. The reasons for this are multifactorial:

- The ACSQHC, as the statutory authority, had not yet developed accreditation standards[5] for private primary healthcare settings;
- Many Australian general practices operate under their own standards[6], which do not require healthcare practitioners to have a formal credentialing process; and
- Some organisations and health practitioners in the private primary healthcare sector view mandated formal credentialing processes as regulatory overreach, as well as a burdensome and expensive process to undertake.

In addition, it appears neither the peak NP professional association, nor nursing at large was consulted on the 2015 credentialing guidelines published by ACSQHC. Instead, the lens informing those guidelines was heavily influenced by a single health profession who likely did not understand the practice requirements or professional issues faced by the broader nursing workforce. The credentialing framework assumes the issues faced by the NP workforce are similar to the medical workforce, in that there are limited barriers precluding NPs from working to their full scope of clinical practice. However, a recent NP workforce and employer survey conducted in the ACT[7] demonstrated that extensive practice barriers preclude NPs from performing core and supplemental activities required of their employed roles. Such practice barriers commonly include the ability of NPs to prescribe medicines or request diagnostic tests to their full scope of clinical practice, barriers which medical practitioners largely do not experience. The survey findings are extensively supported in the peer-reviewed and grey literature[8,9,10]. Therefore, a universal ACSQHC credentialing framework for health practitioners, which aims to both protect the public and enable clinical practice, requires special consideration in its application to the NP workforce.

The ACSQHC is currently consulting on revised credentialing guidelines, which are now being reviewed by peak nursing bodies. However, it is likely that current and future guidelines will not account for

4 ACSQHC. (2021). *The national safety and quality health service standards: Clinical governance standard.* Clinical Governance Standard | Australian Commission on Safety and Quality in Health Care

5 ACSQHC. (2021). *The national safety and quality primary healthcare standards.* National Safety and Quality Primary Healthcare (NSQPH) Standards | Australian Commission on Safety and Quality in Health Care

6 Royal Australian College of General Practitioners [RACGP]. (2020). *Standards for general practices* (5th ed). RACGP: Melbourne, VIC. https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/5th%20edition/Standards-for-general-practice-5th-edition.pdf

7 Helms, C. (2021). *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey* [Report]. ACT Government.

8 Smith, T., McNeil, K., Mitchell, R., Boyle, B., & Ries, N. (2019). A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia. *BMC Nurs, 18*(1), 14. https://doi.org/10.1186/s12912-019-0337-z

9 Karimi Shahanjarini, A., Shakibazadeh, E., Rashidian, A., Hajimiri, K., Glenton, C., Noyes, J., Lewin, S., Laurant, M., & Colvin, C. (2019). *Barriers and facilitators to the implementation of doctor-nurse substitution strategies in primary care: a qualitative evidence synthesis* (Vol. 4). Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD010412.pub2

10 Birks, M., Davis, J., Smithson, J., & Lindsay, D. (2019, Aug). Enablers and Barriers to Registered Nurses Expanding Their Scope of Practice in Australia: A Cross-Sectional Study. *Policy Polit Nurs Pract, 20*(3), 145-152. https://doi.org/10.1177/1527154419864176

implementation issues unique to the NP workforce. Instead, local employer knowledge of jurisdictional issues relating to scope of clinical practice and the NP workforce is required to appropriately enact ACSQHC credentialing guidelines. Approximately 75% of the Australian NP workforce works in the public service[11], where formal credentialing frameworks have already been implemented for accreditation purposes. Therefore, it is timely to reflect upon the implementation of the ACSQHC credentialing framework in the ACT public service, to better understand its relevance to the NP workforce and better inform its potential application to the private primary healthcare sector.

Credentialing, Privileging and Scope of Practice

There is some inconsistency in usage of the term 'credentialing' as described by the ACSQHC, and the operational definitions described by professional bodies or employers. The ACSQHS definition of credentialing better aligns with the intent and purpose of a health service approving an individual's clinical scope of practice, as defined by the *Health Act 1993 (ACT),* for a specified role. The ACSQHC[12] defines credentialing as:

> *The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality health services within specific organisational environments.*

The Australian Nursing and Midwifery Federation (ANMF), the largest professional organisation for Australian nurses and midwives, does not appear to support credentialing as a local verification process. Rather, the definition as cited[13] by the ANMF states that credentialing should be regarded as:

> *…a central function of the regulatory system requiring "licensure, certification or authorisation by a national governmental agency". It is a term applied to "processes used to designate that an individual, program, institution or product have met established standards," as set by a national body.*

The primary difference between these two operational definitions is that the ANMF aligns credentialing with a *regulatory process* to define a *professional* scope of practice, which has already been established for NPs at a national level through the *Health Practitioner Regulation National Law Act 2009.* However, the ACSQHC defines credentialing as a *verification process* for an *individual* scope of practice that is operationalised at the employer level for a specified role. A *professional* scope of practice includes all activities an NP is legislatively authorised to perform, whereas an *individual* scope of practice are all those activities they are authorised to perform and *competent to do*.

In the ACT, s54 of the *Health Act 1993* specifically defines a clinical scope of practice as *"…the rights of the practitioner established by agreement between the practitioner and the health facility to treat*

11 Australian Government. (2017). *Factsheet: Nurse practitioners.* Department of Health: Canberra, ACT. https://hwd.health.gov.au/webapi/customer/documents/factsheets/2017/Nurse%20Practitioners%202017%20-%20NHWDS%20factsheet.pdf

12 ACSQHC. (2015). Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners. ACSQHC: Sydney, NSW. Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf (safetyandquality.gov.au)

13 Australian Nursing and Midwifery Federation [ANMF]. (2020). *Position statement: Credentialing for nurses and midwives.* ANMF. https://anmf.org.au/documents/policies/PS_Credentialling_for_Nurses_and_Midwives.pdf

patients or carry out other procedures at the health facility, or to use the equipment or other facilities of the health facility."

The ANMF's position is that additional credentialing processes to determine professional scope of practice at the employer level duplicate the regulatory process, are overly restrictive, burdensome, and differentiates these as "private credentialing". Indeed, health services should not attempt to replicate regulatory processes for a professional scope of practice, but simply assure themselves a health practitioner has undergone them by examining the national register for appropriate registrations and/or endorsements. Further, the ANMF position is that private credentialing at a local level "offers no assurance of safety and quality"[14]. Their concerns regarding private credentialing processes as being restrictive and burdensome have been independently validated through a recent ACT NP and employer survey and bears consideration when applying principles for credentialing NPs in the ACT.

A third term, privileging, perhaps lends greater clarity to these definitions and how credentialing in the ACT can be used by health services to validate an appropriate clinical scope of practice for specified roles. Privileging can simply be defined as a process that authorises a NP to perform a specific set of activities that an employer determines the NP is qualified to perform for a specified role[15]. Privileging has a different intent to credentialing as defined by the ANMF, as it does not set out to establish minimum competence to practice within the professional scope of practice of an NP, as that is a regulatory process assured by the *Health Practitioner Regulation National Law Act 2009*. Privileging assures a health service has done its due diligence and *verified* that an NP has the requisite qualifications, education, and/or experience to undertake activities required for a specified role within that health service.

Nurse Practitioner Activities

An NP is a registered nurse (RN) regulated by National law[16] through an endorsement process established by the nursing regulatory authority, the Nursing and Midwifery Board of Australia (NMBA). The NMBA establishes registration, endorsement, education, and practice standards for Australian nurses and midwives. The NMBA also establishes safety and quality guidelines for the nursing and midwifery professions. Nurse practitioners practise in over 50 different specialty areas and are found across both the public and private healthcare sectors in every Australian jurisdiction[17].

Nurse practitioners practise independently and collaboratively through an extended clinical nursing role within their individual scopes of practice. They may practice as sole practitioners (e.g., through a nurse-led primary healthcare practice), or as part of a larger multidisciplinary team (e.g., through a public hospital specialty service). The NP role reflects that of an RN working at an advanced level of

14 *Ibid.*

15 McMullen, P., & Howie, W. (2019). Credentialing and privileging: A primer for nurse practitioners. *The Journal for Nurse Practitioners, 16*. https://doi.org/10.1016/j.nurpra.2019.10.015

16 *Health Practitioner Regulation National Law Act 2009* (Cth) https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045

17 Gardner, A., Helms, C., Gardner, G., Coyer, F., & Gosby, H. (2020). Development of nurse practitioner metaspecialty clinical practice standards: A national sequential mixed methods study. *Journal of Advanced Nursing, 77*(3), 1453-1464. https://doi.org/10.1111/jan.14690

practice, but whose specific focus is on the provision of expert clinical care. This care includes the practice authority to independently and collaboratively perform the following *core activities:*[18]

- comprehensive and advanced health assessment
- diagnosis and treatment of medical conditions
- autonomous prescribing of medicines
- requesting and interpreting diagnostic examinations (e.g., blood tests and medical imaging examinations)
- independent referral to medical, surgical and allied health practitioners.

Core activities are typically what health services who implement the ACSQHC credentialing framework are vested in overseeing. Health services should consider credentialing NPs against a core scope of practice, which includes categories of medicines and diagnostic exams that are within the employed scope for *all* employed NPs. Care should be taken when considering credentialing NPs against individual medicines or investigations, as it is a time-intensive, unnecessarily restrictive, and expensive process. For example, NPs working within a discrete specialist role (e.g., diabetes, wound care or heart failure management) may only require credentialing to prescribe a limited number of preferred medicines, whereas NPs working in a generalist area of practice (e.g., walk-in centre or primary healthcare) may require an extensive list of hundreds of medicines. Credentialling against a core scope of practice for all employed NPs would decrease administrative burden, as well as enhance understanding of the NP role and its transferability within a context of practice.

Much like medical practitioners, an employed NP may have additional *core activities* required of their role, particularly if their role has a heavy emphasis on procedural work. Examples include those NPs who undertake cystoscopies, deep suturing, vein harvesting or endoscopies as part of their employed scope of practice. These examples highlight how some invasive or diagnostic procedures undertaken independently by NPs are associated with a high risk of morbidity, mortality, or cost. However, as they fall outside the typical scope of practice of RNs within a specified area of practice, they would benefit from credentialing to enhance public protection.

Health services should consider State or Territory-based legislative authorisations when looking to credential NPs, as there are examples of *core activities* that are within the capability of NP-directed care, but currently outside legislative authorisations in the ACT. At the time of writing this document, those restrictions primarily relate to limited medicines. For example, NPs may have the knowledge and skill to prescribe Appendix D Medicines, which include medicines used to treat psychosis or treatment-resistant acne, but are prohibited from doing so due to the lack of appropriate legislative authorisations in the ACT. Likewise, they may have the knowledge and skills to perform medical terminations of pregnancy before nine weeks' gestation, but are currently prohibited from doing so in the Health Act 1993.

In addition to *core activities*, NPs are expected to undertake *supplemental activities* as relating to their individual scope of practice. Supplemental activities are required to reduce unnecessary duplication of care, improve systems efficiencies, and improve the overall experience of healthcare consumers as they intersect with the health system[19]. For example, a *supplemental activity* might include the

18 NMBA. (2021). *Nurse practitioner standards for practice.* AHPRA. Nursing and Midwifery Board of Australia - Nurse practitioner standards for practice - Effective from 1 March 2021 (nursingmidwiferyboard.gov.au)

19 Helms. (2021). *Outcome evaluation on nurse practitioner policy and legislation in the Australian Capital Territory.* ACT Government.

completion of official documentation, such as workers' compensation certificates or driver's license medicals arising from an NP providing a comprehensive assessment, diagnosis and treatment plan for an individual. Like *core activities, supplemental activities* facilitate the NP role and are enabled through legislation and/or policy.

Again, health services need to be aware of State or Territory-based legislative authorisations that may be required to credential NPs to perform specific *supplemental activities*. For example, NPs may have the practice authority to perform comprehensive assessments required for boxing sport medical clearances but are unable to authorise paperwork to fulfill requirements for the Controlled Sports Act 2019. Similarly, NPs may have the knowledge and skills to diagnose death in a patient but currently do not have the practice authority to authorise a death certificate.

Therefore, health services must ensure credentialing committees understand inherent requirements of anticipated NP roles within the organisation, and have expertise in understanding jurisdictional legislation, regulation and policy that specifically affects NP practice. Credentialing committee members should have the necessary skills to evaluate the NP role and its legislative requirements. Further, they should also be able to identify and implement planning strategies that enable the NP workforce to achieve its potential within the organisation and the health system at large, whilst protecting the public.

Credentialing committees should consider that, like other health practitioners, NPs will grow and evolve their scope of practice through time. This evolution in practice may require periodic credentialing review. An NP's scope of practice at initial endorsement should not be the same scope of practice they have when they retire from the profession. It is incumbent upon the NP to ensure they undertake purposeful continuing professional development to address professional and regulatory requirements, as well as evolve as a practitioner to meet dynamic patient and health system needs. The NMBA's *Decision-Making Framework*[20] and *Safety and Quality Guidelines*[21] can be used to assist NPs and employers to safely and effectively expand and/or change NP scope of practice.

Finally, students enrolled in NP education programs require a minimum number of integrated professional practice experience hours[22]. Those hours are undertaken as clinical training under the supervision of a NP or medical practitioner and assist in consolidating theoretical knowledge relating to NP *core activities* in the clinical context. Due to the relative size and distribution of the NP workforce, most of this clinical supervision is currently undertaken by medical practitioners. As medical practitioners may not fully appreciate the responsibilities or regulatory requirements associated with the clinical education of NP students, they may not be familiar with the entry-level practice expectations of an endorsed NP. This can result in suboptimal clinical learning and teaching outcomes that negatively impact upon readiness to practice, as well as future workforce growth and capability.

20 NMBA. (2020). *Decision-making framework for nursing and midwifery.* AHPRA. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx

21 NMBA. (2016). *Safety and quality guidelines for nurse practitioners.* AHPRA. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/Safety-and-quality-guidelines-for-nurse-practitioners.aspx

22 Australian Nursing and Midwifery Accreditation Council [ANMAC]. (2015). *Nurse practitioner accreditation standards.* ANMAC. https://www.anmac.org.au/standards-and-review/nurse-practitioner

Ultimately, NP education programmes are accountable for the clinical training of NP students. However, health services play a role in assuring appropriate clinical supervision of the NP student occurs whilst they undertake integrated professional practice experience hours. This requires the health service to provide adequate support for both NP students and their supervisors in the clinical environment. Such support promotes positive clinical learning and teaching outcomes, as well as safety and quality in the provision of healthcare. Therefore, credentialing committees should consider whether the clinical training of NP students is within an individual practitioner's current scope of practice, and what policies and supporting systems would be required to enable safe, effective, and transparent supervision of NP student clinical learning and teaching.

Credentialing in the ACT

Public sector nursing and midwifery credentialing committees are mandated through notifiable instruments approved by the ACT Minister for Health. Section 56 of the Health Act 1993 (the Act) refers to these as "scope of clinical practice committees" and are a critical quality assurance process in public health services. Part 5 of the Act outlines facilities that are required to have a credentialing committee, as well as the roles, scope and functions of such committees. Health practitioners specifically named in the Act requiring credentialing in those specified facilities include dentists, doctors, eligible midwives, and NPs.

Private sector health services in the primary healthcare sector do not currently require formal credentialing committees. Only ACT public health facilities, health professional organisations or special purpose quality assurance committees specifically named by the Minister for Health through a notifiable instrument are required to have a formal credentialing process. ACT public health facilities that currently have formal credentialing committees for nurses and midwives include Calvary Public Hospital Bruce and Canberra Health Services.

Credentialing is accomplished through local committees and policies established by each public facility. A review of available policies relating to NP credentialing was conducted, which revealed the following.

- There was an imbalance in policies in addressing the two underlying purposes noted in the ACSQHS credentialing framework: protection of public and enabling practice.
- Policies often replicated requirements used for medical practitioners, without addressing scope of practice issues unique to NPs. For example, the inability of NPs to perform *core or supplemental activities* required of their roles because of facility policy or jurisdictional authorisations.
- A core scope of practice for NPs was not delineated for NPs within facilities.
- Committee representation did not necessarily reflect a skills-based committee, but rather an operational focus.
- Policies did not account for independent private sector practice, and would preclude some eligible private sector NPs from obtaining credentialing in the public sector.
- Policies failed to facilitate continuity of care (e.g., visitation privileges) for hospitalised patients, where the NP was their primary healthcare provider, as seen with general practitioners.

Although credentialing is mandatory for NPs employed in the public sector, the process is optional for those NPs in the private sector. However, if private sector NPs anticipate they will need to follow their patients across the continuum of care (e.g., community clinic to hospital as seen in transboundary models of care[23]) for continuity and safety purposes, they will be required to undergo credentialing with those institutions as defined in the Health Act 1993. Therefore, it is proposed that general principles are applied when credentialing of NPs across both the public and private health sectors. Such principles would protect the public and enable a flexible and transferable workforce that is working to their full scope and potential within the ACT.

23 Bail, K., Arbon, P., Eggert, M., Gardner, A., Hogan, S., Phillips, C., van Dieman, N., & Waddington, G. (2009). Potential scope and impact of a transboundary model of nurse practitioners in aged care. *Australian Journal of Primary Health, 15*(3), 232-237. https://doi.org/10.1071/PY09009

Credentialing Principles

Given the above information, it is recommended the following principles be considered when using the ACSQHC framework to credential NPs employed or engaged by a health service.

1. Credentialing prioritises public protection using available evidence, and with a right-touch regulatory approach[24] whenever possible.
2. *Core and supplemental activities* expected for NPs are clearly defined at the outset of employment or engagement for a specific role, so that credentialing processes appropriately assure the ability of NPs to meet patient, community, and health service expectations.
3. Credentialing should account for the fact that an NP may not have the required skills and experience for an employed role at the outset, but can be appropriately supported through direct and/or indirect supervision until competence is achieved in order to meet patient, community, and health service expectations.
4. Credentialing and re-credentialling should account for the fact that NPs are expected to grow and evolve their practice over time.
5. Credentialing processes should recognise the regulatory independence and individual accountability for scope of practice as relating to the NP role, and be implemented accordingly.
6. Credentialing should enable flexible and responsive healthcare delivery by establishing a core scope of practice for all employed NPs, with an approved supplemental scope of practice for individual NPs, as appropriate.
7. Credentialing for privileges that supplement the core scope of practice for employed NPs is only appropriate for high-risk or high-cost medicines, procedures, or diagnostic tests. A contextualised risk matrix to objectively assess risks and costs associated with those medicines, procedures and/or tests is recommended for health services, and should apply to *all* practitioners performing or requesting them.
8. Public sector credentialing should account for patients who choose NPs as their primary healthcare provider, affording private sector NPs the same provisions and visitation rights as general practitioners working in the private sector.
9. Credentialing committees should be skills-based, and have a firm understanding of employer requirements, as well as the jurisdictional regulatory authorisations that enable or limit *core and supplemental activities* required of the NP role.
10. Credentialing processes should only be used to clearly identify the core and supplemental activities that differentiate the role of the NP from that of an RN working to their full scope of practice.
11. Credentialing should recognise supervisor qualifications and/or experience required to support and supervise NP students.

24 Right touch regulation enables proportionate, consistent, targeted, transparent, accountable and agile regulation of the health workforce. It uses the minimum regulatory force to facilitate efficient and effective healthcare delivery, whilst prioritising protection of the public.

Application of the Principles

The draft credentialing framework, which includes this discussion paper on credentialing principles and related templates, has been developed for public and private sector employer use. Although non-compulsory, the principles and associated credentialing templates have been designed to:

1. promote safety and quality in healthcare through a universal credentialing process for NPs working in the ACT
2. contextualise credentialing processes appropriate for the NP workforce
3. improve understanding of the NP role
4. enable NP workforce mobility, capability, and growth.

This high-level credentialing framework is intended to provide evidence-informed guidance on effective credentialing processes for the NP workforce. It is not intended to replace existing operational processes (such as health service policies or procedures) that may already be effective in the aims of promoting public protection and enabling practice.

This framework reveals important contextual considerations when considering the NP workforce and application of credentialing processes arising from safety and quality standards in healthcare, including:

- *National Safety and Quality Health Service Standards* [Hospitals and related entities]
- *National Safety and Quality Primary and Community Healthcare Standards* [Community-based private primary healthcare entities].

Additional supporting documents for the NP credentialing framework include:

- Appendix A: Nurse Practitioner Credentialing Flowchart

  A high-level overview of a suggested credentialing process for public and private sector employers. The resource identifies significant considerations for the development of supporting policy that should be contextualised to meet individual health service needs.

- Appendix B: Nurse Practitioner Privileging Proforma

  A suggested template for use in credentialing processes, which may be adapted to suit individual health service needs. The resource outlines essential criteria to consider when credentialing the NP workforce.

- Appendix C: Risk Tool

  A supplementary tool designed to help employers identify and create proportionate credentialing policies and procedures when engaging or employing an NP that are reflective of their clinical risk profile.

Case Studies

The following case studies demonstrate how a territory-wide credentialing framework could be applied across both the public and private health sectors. They are presented to identify circumstances where a territory-wide framework has the potential to enhance safety and quality outcomes for patients in the ACT community.

Case Study 1

Jamie is a NP working in a stand-alone primary healthcare clinic. She provides a broad range of services commonly seen in a general practice including preventive health care, and care for acute illnesses and long-term health conditions for persons across the lifespan. Many of her clients use Jamie as their primary healthcare provider, and don't use a general practitioner for their primary healthcare needs.

On occasion patients require hospitalisation for their health needs. Jamie provides healthcare using a transboundary model of care for persons with long-term health conditions. This model requires Jamie to follow her patients across the spectrum of acute to primary healthcare, but she is unable to see her patient or provide clinical input when they are in hospital. At times, critical information about the patient's health journey can't be relayed in a timely manner to the hospital team and adverse outcomes have occurred to her patients. However, if a patient nominates a general practitioner (GP) as their primary healthcare provider, the GP can visit the patient in hospital and provide clinical input through a separate policy mechanism. Credentialing with the hospital could provide Jamie with visitation privileges, much like those seen with GPs. This would allow for better care coordination and enhanced safety and quality outcomes for her patients.

Benefits of Applied Principles

This case study exemplifies the application of **Principle 8**, which allows credentialed private sector NPs to see their patients when in hospital. It has the potential to realise the following benefits:

- enhanced patient safety and quality outcomes
- enhanced care coordination
- streamlined communication amongst treatment teams.

Case Study 2

Louise works for a large public sector employer as a NP in drug and alcohol services. She has been working for years within her multidisciplinary team, and is supported by robust clinical governance mechanisms that regulate her practice activities. She routinely screens for and treats drug and alcohol addiction in collaboration with her multidisciplinary team using a variety of pharmacologic and non-pharmacologic therapies.

Over the last few years, the needs of her health service have changed. There are increasing numbers of persons not only presenting in need of drug and/or alcohol treatment services, but also presenting with untreated blood-borne viruses (BBV), such as Hepatitis B and C. Louise was initially credentialed for her current scope of practice in drug and alcohol treatment, but her service would benefit from clinicians who can prescribe the highly specialised medicines used for the treatment of BBV. Her patients haven't sought care from other health care providers, and have increasingly sought her advice on the treatment of these conditions due to the stigma they experience when seeking care through other providers. Louise identified this growing need with her employer and, using the NMBA's *Decision Making Framework*[25], was able to safely expand her scope of practice into the testing and treatment of Hepatitis C. Louise undertook additional training in the treatment of BBV to be a safe and effective prescriber and was able to demonstrate this to the credentialing committee through her certification, as well as a proposed governance framework for complex patients. Her hospital privileges were amended to include this new aspect of her care. The net result was better care coordination and less siloing of care for highly vulnerable patients, who had their risk of transmission of the Hepatitis C reduced or eliminated.

Benefits of Applied Principles

This case study exemplifies the application of **Principles 4 and 6**, which allows credentialed NPs to expand scope of practice and provide responsive healthcare. It has the potential to realise the following benefits:

- enhanced patient safety and quality outcomes
- breaking down of care silos
- development of a transferrable skillset
- role satisfaction.

Case Study 3

Paul is a local GP who has found that his practice has become increasingly busy. He is interested in exploring innovative models of care using health practitioners that can complement his practice. Paul began discussing this with the other GPs in his practice and they agreed they would like to trial a NP service in their clinic. However, none of the GPs in the clinic had ever worked with a NP, or were familiar with the educational qualifications, regulatory frameworks, or safety and quality considerations for this workforce. They found a great candidate, but he was inexperienced in working in primary health care. However, he demonstrated great potential for growth into this complex and difficult area of generalist practice.

In collaboration with the GPs, the NP identified learning outcomes and milestones that would safely and effectively support him to expand his scope of practice into primary healthcare. The GPs and the NP used the credentialing framework to identify what essential requirements were required for the planned role, and developed a plan for greater privileges as the NP grew in their knowledge and confidence in primary healthcare.

25 NMBA. (2020). *Decision-making framework for nursing and midwifery*. Australian Health Practitioner Regulation Agency. https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx

His practice started in a narrow area of practice, but with mentorship and guidance, within a year was seeing a broad spectrum of patients. This resulted in a reduced workload for the GPs, with patients who were highly satisfied with their service.

Benefits of Applied Principles

This case study exemplifies the application of **Principles 2, 3 and 4**, which allows credentialed private sector NPs to work to their full potential within a safety and quality framework. It has the potential to realise the following benefits:

- clarity on role expectations and clinical governance for a growing primary healthcare workforce
- safety and quality controls for an innovative models of care
- flexible application allows the development of skills and knowledge acquisition over time
- enhanced understanding on the complementary nature of the NP role.

Next Steps

The following are suggested next steps for consideration and actioning by relevant health services, managers, employers and nurse practitioners.

1. **Publish the framework in the public domain to facilitate access by public and private health sector organisations.**

It is intended that the framework be used as resource by any organisation that employs or engages the NP workforce, to enable individual scope of practice and enhance safety and quality outcomes associated with the role.

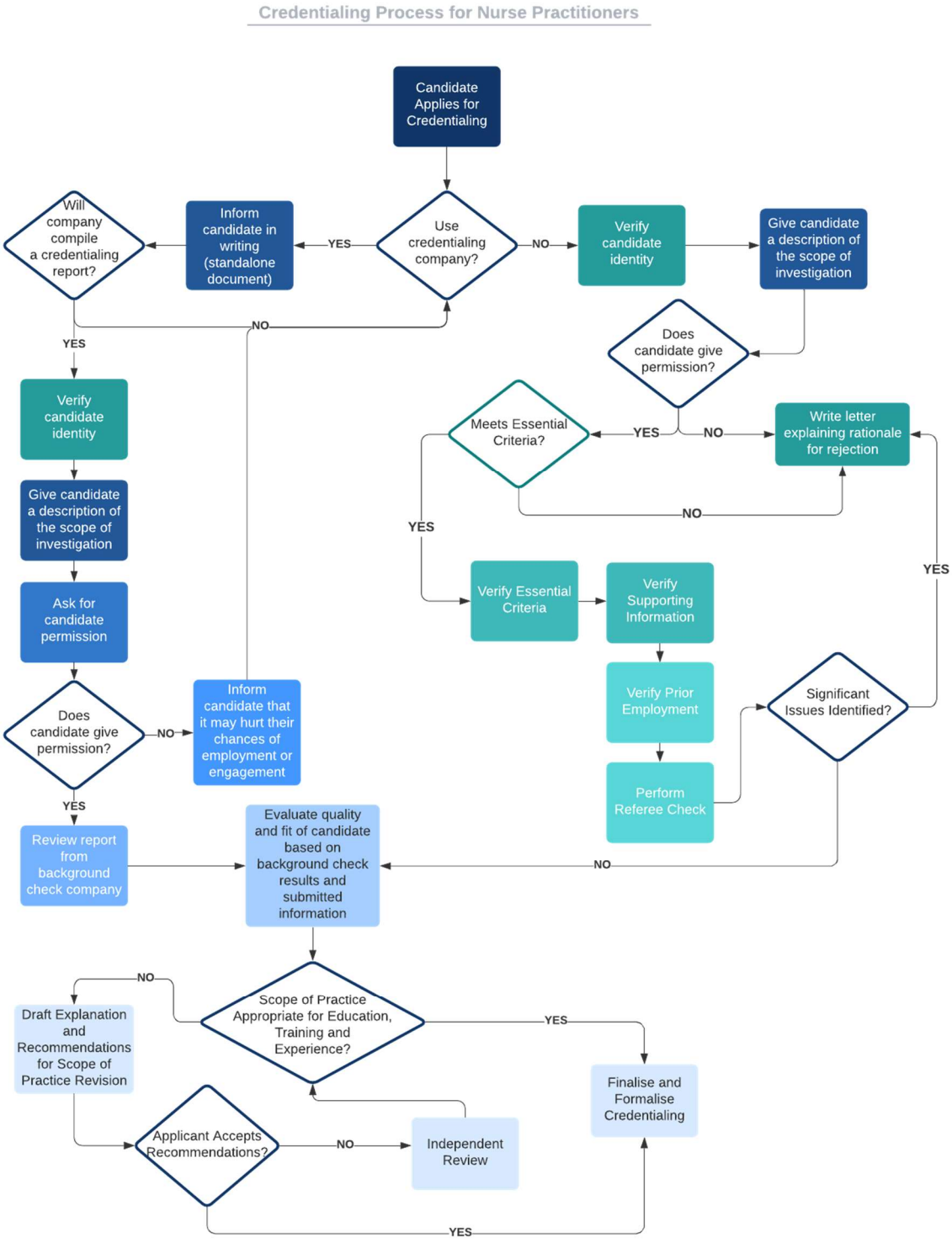
2. **Implement the framework in real-world clinical contexts of practice.**

This discussion paper and associated tools form a suggested high-level credentialing framework for ACT NPs working in a clinical context. It was developed through targeted consultation and intends to complement, as opposed to replace existing clinical governance mechanisms.

3. **Use the credentialing principles to tailor the framework to meet health service needs and meet evolving demand.**

Implementation of the framework affords opportunity for further refinement, to assure the complementary relationship of the framework and existing governance mechanisms. The suggested credentialing principles may be novel, challenging, and transformative for many within the ACT. Appropriately applied, the framework enhances greater understanding of the NP role and enriches workforce flexibility and capability into the distant future. The proposed credentialing framework and credentialing principles should be tailored to assure their relevance to individual organisations and contexts of practice. It is expected organisations using this framework will develop contextualised policies and governance mechanisms, which reflect the intent of the principles.

Appendix A: Nurse Practitioner Credentialing Flowchart



Appendix B: Nurse Practitioner Credentialing Proforma

Nurse Practitioner Credentialing Proforma

N.B. Terms that are *italicised* and in **bold** font are defined at the end of this document.

This document serves as a standard credentialing template that may be used across health services in the Australian Capital Territory. It broadly describes core and supplemental activities *all* employed and/or engaged ***Nurse Practitioners*** (NP) have the ***practice authority*** to perform ***independently*** through National registration and endorsement. Further, this template can be used to describe additional ***core*** and/or ***supplemental activities*** *individual* NPs are authorised to perform within their employed ***scope of practice***.

- If the applicant is providing information to a prospective employer to help determine suitability for a specific role *or* are seeking engagement with a health service, they should provide information relevant to their *individual* scope of practice.
- If the applicant is a current employee seeking credentialing/privileging within a health service for a specified role, they should provide information relevant to their *employed* scope of practice.

NOTE*: As with all health practitioners, NPs are expected to work within their individual competence and to their employed roles. They are expected to seek appropriate guidance when performing activities that are outside their usual practise, but are performed to expedite care, improve health system efficiency and/or improve the patient experience as they intersect with the health system. Appropriate guidance may include advice from a senior colleague, published guidelines and other evidence-informed sources, as well as approved policies. Although guidance may be sought from those sources, an NP is always individually accountable for decisions and actions undertaken as part of care provision.*

Applicant and Employer or Engaging Entity Details

Application Date			
First Name		Surname	
Date of Birth		AHPRA Number	

Employer *or* Engaging Entity to Which Application is Made	
Department/Division	☐ N/A
Purpose of Application	☐ To credential an existing employee for an NP role within a health service. ☐ To credential an NP seeking ***engagement*** with a health service. ☐ The provision of scope of practice information to a prospective employer that may help determine suitability for a specific NP role.

Nurse Practitioner Role Description

Position Title		
Primary ***Metaspecialty Focus***[26]	☐ Emergency and Acute Care ☐ Chronic and Complex Care ☐ Child and Family Health Care	☐ Ageing and Palliative Care ☐ Primary Health Care ☐ Mental Health Care
Area(s) of Practice (Specialty)	☐ N/A	
Context(s) of Practice	☐ Hospital ☐ Outpatient Clinic ☐ Community Health Centre ☐ Prison/Remand Service ☐ Aboriginal Health Service ☐ Hospice ☐ School/Academic Setting	☐ General Practice ☐ Specialist Practice ☐ Residential or Aged Care Facility ☐ Other Primary Healthcare Clinic ☐ Defence Force ☐ ***Transboundary***
Health Sector(s)	☐ Public ☐ Private	
Collaborative Arrangement[27]	☐ Employed or engaged by a medical practitioner or entity that provides medical services; OR ☐ Receiving patients on written referral from a medical practitioner; OR ☐ A signed written agreement with a specified medical practitioner(s); OR ☐ A specified arrangement written in the nurse practitioner's patient records.	

Eligibility Criteria

To be eligible for an NP role and clinical privileges, the applicant **must provide evidence** of having satisfied the following minimum criteria:

A.	Registration and ***Endorsement***	☐ Registration as a Registered Nurse on AHPRA's Register of Practitioners ☐ Nurse Practitioner endorsement notation on AHPRA's Register of Practitioners Does the applicant have conditions or undertakings on the register? ☐ Yes ☐ No

26 The metaspecialties are broad groupings of NP specialties with similar skill-sets, knowledge and/or expertise, which comprehensively reflect the diverse healthcare needs of population groups. Metaspecialties are not intended to be mutually exclusive. For more information see https://bit.ly/3zDUcl4

27 A collaborative arrangement is *only* required to prescribe Pharmaceutical Benefits Scheme (PBS)-subsidised medicines or access the Medicare Benefits Schedule (MBS). For further information see https://bit.ly/3xrHAvD

		NOTE: *If there are conditions or undertakings on registration and/or endorsement, the employer carries responsibility for considering these for credentialing purposes.*
B.	Referee	☐ A letter of reference or transcripts from education provider indicating the content of clinical courses; particularly of skills acquisition and programs. and/or ☐ A letter from a previous employer or senior colleague of the NP indicating work description, abilities and/or skills that were performed in previous employment.
C.	Cardiopulmonary Resuscitation	☐ Evidence of current Basic Life Support certification.
D.	Private Indemnity Insurance	☐ N/A - Covered under current employer indemnity insurance. or ☐ Applicant can supply evidence of sufficient cover.
E.	Credentialing and Billing History	**NOTE:** *If the applicant responds "Yes" to any of the questions below they should provide a supplemental response including details that will assist the credentialing committee in application decision.*
	☐ Yes ☐ No ☐ Yes ☐ No	Has an employer or engaging health service ever withdrawn or restricted your right to practise over concerns with performance, conduct, or health in Australia or overseas? Has the applicant ever had their billing rights with Medicare or other funding authorities suspended or cancelled due to findings of inappropriate billing or fraud?

NOTE: *The following are not mandatory eligibility criteria but may be desirable and/or used to supplement and/or justify privileging requests. Applicants should attach any relevant supporting documentation with application.*		
F.	*Professional Association*	☐ Evidence of current membership with one or more professional nursing organisations.
G.	*Advanced Education*	☐ Other qualifications, certifications or continuing professional development relevant to this application.
H.	*Context and Scope Dependent*	☐ Evidence of current Adult Advanced Life Support certification ☐ Evidence of current Paediatric Advanced Life Support certification

Core Activities - Privileges

The following activities apply only if within the applicant's individual scope of practice and with appropriate clinical justification.	**Requested**	**Not Requested**
May carry out clinical activities that are currently granted to registered nurses at this entity.		

Screen patients and patient calls to determine need for medical attention.		
Screen allied health practitioner referrals and calls to determine need for medical attention.		
Screen medical practitioner referrals and calls to determine need for medical attention.		
Review patient records to determine health status.		
Take a patient history and perform a comprehensive physical examination.		
Formulate an accurate assessment, diagnostic evaluation, and treatment plan for initial and/or follow-up visits.		
Request *laboratory* screening and diagnostic studies.		
Request diagnostic *imaging* studies (Plain Film X-Rays).		
Request diagnostic *imaging* studies (Ultrasounds).		
Obtain specimens for and request commonly performed body fluid (blood, urine, sputum, and stool) analysis and cultures.		
Evaluate and document patient's response to therapeutic interventions; modify the plan of care to optimise outcomes.		
Identify normal and abnormal findings on history, physical examination and commonly performed screening and diagnostic studies.		
Initiate referrals to allied health practitioners or services (cardiac or pulmonary rehabilitation, social work, dietitians, physiotherapists, occupational therapists, etc.) to provide patients with holistic care.		
Initiate referrals to general practitioners and medical specialists to provide patients with holistic care.		
Provide ongoing education and counselling to patients and families regarding the disease process and management strategies in treating the disease process.		
Provide written correspondence, phone, and/or electronic communication to referring medical practitioners, other health care providers, and referring facilities regarding patient status or treatment plan.		
Request, obtain, possess, prescribe, de-prescribe, supply and/or administer Schedules 2 - 8 medicines within the constraints of ACT and NSW Legislation.		
Request, obtain, possess, prescribe, supply and/or administer S100/S85 medicines within the constraints jurisdictional legislation.		

Request and prescribe 'unapproved' therapeutic medicines or products through the Therapeutic Goods Administration *Special Access Scheme* Category B Application Pathway.		

Supplemental Activities

Providing a complete episode of care for all of the following activities may not be supported by ACT or Commonwealth legislation. "Prepare" implies the applicant can contribute towards completing the following documentation whereas "authorise" means they can legally finalise and sign the documentation.	**Requested**	**Not Requested**
Facility ***visitation privileges***.		
Prepare death certificates.		
Prepare and authorise patient discharge summaries.		
Prepare worker's compensation certificates.		
Prepare driver's license medicals.		
Prepare and authorise sick, carer's and/or attendance certificates.		
Prepare and authorise Claim for Disability Support Pension Medical Evidence checklists.		
Other:		
Other:		
Other:		
Other:		

Non-Core Activities – Privileges

Applicants may request (but are not required to do so) additional NP privileges to meet organisational, patient and/or population needs. The applicant and the organisation must certify the applicant has the appropriate training and experience to competently perform the special privilege functions requested.	**Requested**	**Not Requested**
Request the following advanced diagnostic *imaging* studies (MRI – Specifically named body areas and modalities):		
1.		
2.		
3.		
4.		
Request the following advanced diagnostic *imaging* studies (CT – Specifically named body areas and modalities):		

1.		
2.		
3.		
4.		
Request the following advanced diagnostic *imaging* studies (Miscellaneous):		
1.		
2.		
3.		
4.		
Perform the following interventional or other high-risk or high-cost procedures:		
1.		
2.		
3.		
4.		
Admit patients under named medical practitioner to the above-named employer and/or engaging entity: *(Attach a letter of support for each named medical practitioner)*:		
1.		
2.		
3.		
Discharge patients admitted under named medical practitioner to the above-named employer and/or engaging entity: *(Attach a letter of support for each named medical practitioner)*:		
1.		
2.		
3.		

☐ Yes ☐ No	Request, obtain, possess, prescribe, supply and/or administer blood products or their derivatives under the named medical practitioner: *(Attach a letter of support from the named medical practitioner)*

Verification

The applicant confirms they are a Nurse Practitioner endorsed by the Nursing and Midwifery Board of Australia and certify they:

- have the training, education, and experience to perform the privileges requested in this credentialing document and that they meet the threshold competency for the requested privileges.
- understand that by making this request they are bound by the applicable by-laws and/or policies of the employer or engaging entity with whom they are requesting credentialing.
- understand that by making this request they are accountable for understanding and being bound by the Acts and Regulations promulgated by Commonwealth and jurisdictional legislation with respects to Nurse Practitioner practice.
- verify the assertions and statements in this written credentialing agreement are true and correct to the best of their knowledge, information and belief. They understand that false statements are subject to penalties, including notification to the Nursing and Midwifery Board of Australia through the Australian Health Practitioner Regulation Agency. Such notification may result in the revoking of their endorsement and/or registration.
- understand this credentialing agreement shall terminate if and when (i) the named Nurse Practitioner is no longer employed or engaged by the above-named entity, (ii) the named Nurse Practitioner no longer holds registration and endorsement, or has conditions or undertakings on their practice (iii) the named Nurse Practitioner no longer holds private indemnity insurance coverage, (iv) the named Nurse Practitioner has an updated application approved as they expand their scope of practice, or (v) the parties mutually agree to terminate this agreement.

Nurse Practitioner Name:_____ **Date:**_____

Signature: _____

Authorised Person for Entity:_____ **Date:**_____

Signature:_____

Key Terms

The following key terms are defined to better contextualise the contents of this document:

Autonomous Practice	The authority to make decisions and the freedom to act in accordance with one's professional knowledge base. All nurses registered with the NMBA have this authority.
Core Activities	Those activities which all NPs have the practice authority to perform independently and collaboratively. These include: - Performing an advanced health assessment; - Diagnosing and treating medical conditions; - Autonomous prescribing of medicines; - Requesting and interpreting diagnostic examinations; and - Independent referral to medical, surgical and allied health practitioners. Core activities are enabled through contextual State/Territory based legislation and local policy.
Endorsement	Identifies those RNs who have demonstrated competence in meeting requisite experiential and educational requirements that fulfil approved standards, codes and guidelines for practice, which are published by the NMBA. Endorsement is granted to NPs if they have: - Current general registration as a RN in Australia with no conditions or undertakings relating to unsatisfactory professional performance or unprofessional conduct; - The equivalent of 5,000 hours clinical practice at an advanced level of practice; and - Have completed an NMBA-approved master's degree program of study leading to endorsement as an NP, or substantial equivalent. Legislation enables NPs to use their endorsement within a specific jurisdiction.
Engagement	In the context of credentialing, refers to a professional and collegial relationship between an individual healthcare provider with a business or entity, which does not have the intent of creating employment or financial compensation for work performed. Its purpose is to facilitate patient-centred health care through timely information transfer, the breaking down of healthcare silos, and expedited care.
Independence	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. Nurse Practitioners work collaboratively as part of a healthcare team and have the authority to diagnose and implement treatments without oversight from another health practitioner.
Metaspecialty Focus	A metaspecialty focus is the primary population group in which an NP practices, and is used only as a descriptor for their current practice. Metaspecialties are not mutually exclusive and NPs may practice across several metaspecialty areas, particularly as they grow and expand their practice through time by using the Nursing and Midwifery Board of Australia's *Decision-Making Framework.*
Nurse Practitioner (NP)	A Registered Nurse (RN) endorsed as an NP by the Nursing and Midwifery Board of Australia (NMBA). The NP practises at a clinically-advanced level of practice, meets and complies with the *Nurse Practitioner Standards for Practice,* is able to practice independently and has direct clinical contact. The NP title is legislatively protected under the *Health Practitioner Regulation National Law*, as in force in each State and Territory.

Practice Authority	Refers to all activities a *profession or role within that profession* is legislatively authorised to perform.
Scope of Practice	Refers to all activities an *individual* within a profession is both legislatively authorised to perform, and competent to do. A person's individual scope of practice may be more broadly defined than their *employed* scope of practice.
Supplemental Activities	Those activities which are required to reduce unnecessary duplication of care, improve systems efficiencies, and improve the overall experience of healthcare consumers as they intersect with the health system. Like core activities, supplemental activities facilitate the NP role and are enabled through legislation and/or policy. Examples include the ability of NPs to write discharge summaries after hospitalisation, authorise sick or carers certificates, as well as authorising medical evidence for a disability support pension through Centrelink.
Transboundary	First described by Bail et al. (2009)[28], a transboundary model of care is one that requires the NP to work with clients across venues and contexts of care, and provides "the basis for important improvements in care coordination, timely access to care, and in quality improvement in aged care settings". Since Bail's 2009 work, transboundary care has been applied beyond aged care to primary, secondary, and tertiary health setting models of care.
Visitation Privileges	These privileges recognise NPs as members of an individual patient's treating team. With patient consent, such privileges allow a patient's nominated NP to visit them and contribute to their care while admitted to a facility or institution, give access to the patient's clinical record at that facility or institution, and be provided with clinical information about their patients when requested.

28 Bail, K., Arbon, P., Eggert, M., Gardner, A., Hogan, S., Phillips, C., van Dieman, N., & Waddington, G. (2009). Potential scope and impact of a transboundary model of nurse practitioners in aged care. *Australian Journal of Primary Health, 15*(3), 232-237. https://doi.org/10.1071/PY09009

Appendix C: Risk Tool

Risk Tool for Credentialing Nurse Practitioners

The following diagram serves as a supplementary decision support tool that may be used to help determine the required clinical governance for an employed or engaged role. This tool aims to help employers identify and create proportionate credentialing policies and procedures when engaging or employing an NP that are reflective of their clinical risk profile.

Works autonomously in a multidisciplinary or group practice environment.	Works independently in a multidisciplinary group practice environment.	Works independently in solo practice.
Has a shared case load where a complete episode of care is shared amongst many health practitioners for a group or class of patients.	Has a mixture of own and shared case load for a group or class of patients.	Has a case load where a complete episode of care is independently managed by the NP, for a group or class of patients.
Responsible for care provision, but accountability for care primarily rests with an identified employer.	Responsible for care provision, but accountability for care primarily rests with an identified medical practitioner.	Solely responsible and accountable for care provision.
Works to clearly defined policies and procedures that comprehensively direct care provision.	Demonstrates increasing competency and independence to apply skills and knowledge from policies and procedures in the provision of care.	Independently interprets and incorporates published guidelines, clinical databases (for example, Therapeutic Guidelines, UpToDate Online, etc.), practitioner expertise, experience and peer-reviewed evidence in the provision of care.
Scope of practice is narrowly defined, with limited extensions to practice.	Scope of practice is generalist in nature across a single area of practice, with extensions of practice limited to that area.	Scope of practice is generalist in nature across multiple areas of practice, with broad extensions to practice across multiple areas.

Scope of practice includes procedures that have limited impact on morbidity and mortality.	Nurse infrequently undertakes procedures that have a high risk of litigation, mortality, or long-term morbidity in a patient.	Nurse frequently undertakes procedures that have a high risk of litigation, mortality, or long-term morbidity in a patient.
Majority of patients are clinically stable with rare presentations of significant cardiovascular instability.	A mixture of patients with clinical stability and instability are regularly encountered in clinical practice.	Majority of patients are clinically unstable with frequent presentations of significant cardiovascular instability.
Majority of patients in caseload have differentiated, straightforward clinical diagnoses.	A mixture of patients in caseload have differentiated and undifferentiated clinical diagnoses.	Majority of patients seen have undifferentiated, complex clinical diagnoses.

Appendix D: Targeted Consultation

Targeted consultation with key stakeholders was undertaken in the development of this discussion paper and credentialing framework, to assure its relevance to NPs and health organisations in the ACT. The author thanks the following organisations and individuals for their contributions to this document:

Name	Role and Organisation
Narelle Comer	Director of Clinical Services, Calvary Public Hospital Bruce
Matthew Daniel	ACT Branch Secretary, Australian Nursing & Midwifery Federation
Anthony Dombkins	Chief Nursing and Midwifery Officer, ACT Health Directorate
Karen Grace	Executive Director, Canberra Health Services
Ruth King	Senior Project Officer, ACT Health Directorate
Juliane Samara	ACT Chapter Chair, Australian College of Nurse Practitioners
Sarah Stewart	Senior Director, ACT Health Directorate
Laura Turner	Professional Officer, Australian Nursing & Midwifery Federation – ACT Branch