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Standards for practice for registered nurses in Australia

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Summary This article describes the development of the inaugural Australian registered nurse standards for practice, incorporating the first review since 2006 of the National competency standards for the registered nurse (Nursing and Midwifery Board of Australia, 2006), for the Nursing and Midwifery Board of Australia (NMBA). In this multistage study, mixed methods were used by the research team to review literature, conduct a gap analysis of current registered nurse practice against the existing competency standards and consult widely. A large number,

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Person-centred practice;
Evidence-based practice;
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close to 10,000, stakeholders both internal and external to the profession were engaged in the redesign of the standards through interviews, two online structured response surveys, and two rounds of work-based observation of registered nurse practice.
The revised standards were endorsed by the NMBA in November 2015. These new standards foreground the ethical and relational nature of nursing and the significance of translating evidence into practice for quality outcomes. The resultant standards are similar in appearance and focus to other such standards that are in place internationally. Difference is evident in seven interconnected standards that outline registered nurse capabilities while allowing for progress in both the nature and context of practice. These standards extend for the first time to communicate the standard of practice for all registered nurses in Australia.

1. Introduction

The development and application of nursing standards are an important part of protecting the public, and achieving quality nursing practice outcomes (International Council of Nurses, 2013). Standards represent to the profession, government and the public the level of quality or attainment of actual practice that can be expected. Standards for registered nurses inform regulation (including registration), education, determination of a nurse's capability for practise, as well as guide consumers, employers and others on what to reasonably expect from a registered nurse. This paper reports on the review of the current National competency standards for the registered nurse (Nursing and Midwifery Board of Australia, 2006) and development of the registered nurse standards for practice in Australia conducted for the NMBA in 2014—2015.

1.1. Nursing standards

Nursing work has become visible as a constellation of professional competencies though the development of codes including competency standards. They were first introduced by the International Council of Nurses (ICN) in 1953, and in Australia in 1985 as part of the introduction of occupational standards generally, and in the transition of nursing education to the tertiary sector (Bryant, 2005; Chiarella, Thoms, Lau, & McInnes, 2008; Kennedy et al., 2015). Nursing standards are an important policy mechanism to convey professional standing and assist in defining practice and behaviour for regulation purposes, by government, regulatory authorities, education providers, employers and consumers (Benton, 2011; Chiarella & White, 2013; Chiarella et al., 2008). As such they serve as an abbreviated version of the body of knowledge of the profession and define skill requisites and behaviours. It is therefore important that while standards provide a means for professionals to manage uncertainty and know how to conduct themselves (Baer, 1986), in nursing they specifically need to accommodate the ever-changing complexities of health care, patient safety and service delivery as well as the workforce demands on the scope of nursing practice (Gardner, Chang, & Duffield, 2007; Health Workforce Australia, 2013b; Kennedy et al., 2015; Nelson et al., 2014). Developing nursing standards is also fundamental to partnering with consumers and providing person-centred health care. There is a growing body of evidence that recognises partnerships between health care professionals; patients, family members, carers and communities have a significant impact on patient outcomes and safety (Australian Commission on Safety and Quality in Health Care, 2012; Australian Commission on Safety and Quality in Healthcare, 2013).

The uses of nursing standards are dynamic and cross legislative, economic, professional, social and educational spectrums (Australian Nursing and Midwifery Accreditation Council, 2013; Benton, Gonzalez-Jurado, & Beneit-Montesinos, 2013; Duncan, Thorne, & Rodney, 2015). This has been particularly evident in the last decade where regulation has been required to ensure the competence of a globally migrating health and nursing workforce (Benton, Perez-Raya, Gonzalez-Jurado, & Rodriguez-Lopez, 2015; Sherwood & Shaffer, 2014). Regulation for the protection of the public requires prescribing and enforcing codes of practice that are relevant to the competencies needed for safe and effective practice (Benton et al., 2015; Hewitt, 2007). Internationally this function is performed by nursing regulators (International Council of Nurses, 2013), with all nursing regulators in developed countries providing various forms of practice standards, codes or guidelines (International Council of Nurses, 2009). Commonly these standards offer a functional approach in specifying a minimum or threshold level of performance such as required for entry to the profession and for practice in clinical roles. Some registered nurse standards are also reinterpreted by regulatory authorities for specific areas of practice such as education and administration or adult or children's nursing (College of Registered Nurses of British Columbia, 2012; Nursing and Midwifery Council, 2010; Nursing and Midwifery Council, 2015).

1.2. Competency and nursing standards

Competence, though an elusive concept, is the foundation for most professional practice frameworks (Brownie, Bahnisch, & Thomas, 2011; Lester, 2014). Competence models vary from internal, individual and attribute approaches about what individuals know and can do, to external social and activity-based approaches that focus on the activities or functions that need to be performed competently (Eraut, 1998; Lester, 2014). A review of 40 professional standards in the UK found that competency standards alone lack the capacity to predict and communicate what the professional may need to be able to do, as well as convey the necessary professional characteristics in a manner ''that ensures

they are embedded across practice'' (Lester, 2014, p. 35). In nursing, there have been repeated attempts to set definitions and measure both entry to practice and continuing competency (Chiarella et al., 2008; Vernon, 2013). Competency standards in Australia and internationally have over the last thirty years shifted from an indication of the primary learning outcomes by which to benchmark entry to registered nurse practice (O'Connell, Gardner, & Coyer, 2014), to standards for other levels of nursing, such as enrolled nurses or nurse practitioners, as well as standards for numerous nursing specialties (Cashin et al., 2015; Edmonds, Cashin, & Heartfield, 2016). The shift to standards for practice is a concrete step that culminated from the progress in competencies, and the demands to describe clearly what is nursing practice within various regulated scopes of practice. This does not diminish the importance of competencies but instead describes the practice and the standard of practice to be expected of all registered nurses.

1.3. Australian nursing regulation

In Australia nursing standards are developed and approved by the NMBA. This occurs under umbrella legislation and national registration for health practitioners, which includes all nurses. This development in July 2010 brought together the state and territory health professional regulatory boards and 65 separate pieces of legislation into the Health Practitioner Regulation National Law Act 2009 (National Law) The nursing titles currently listed on the public register under the National Law are enrolled nurse, registered nurse and nurse practitioner. The National Law requires that registration standards must be developed about the requirements for professional indemnity insurance arrangements, criminal history, English language skills, continuing professional development and recency of previous practice. Section 39 of the National Law also specifies that codes and guidelines are developed to provide guidance to registered health professionals. As part of their mandate to ensure contemporary relevant standards are understood and used by nurses and midwives, the NMBA develop and approve standards for registration, codes of conduct and ethics, guides to professional boundaries, and standards for practice.

1.4. Aim

The aim of this paper is to outline the processes that informed the review of the National competency standards for the registered nurse (Nursing and Midwifery Board of Australia, 2006), and development of registered nurse standards for practice. The study design was to produce contemporary, relevant and useful standards for practice that reflect current practice and are not aspirational.

2. Methods

The study aim was achieved through three phases:

1. evidence and literature reviews, consultations with key stakeholders, analysis of gaps in the existing standards and observations of registered nurse practice,
2. consultations with stakeholders internal and external to the profession including government, health care consumers and the public, and
3. validation of the standards through a second round of observations of registered nurse practice.

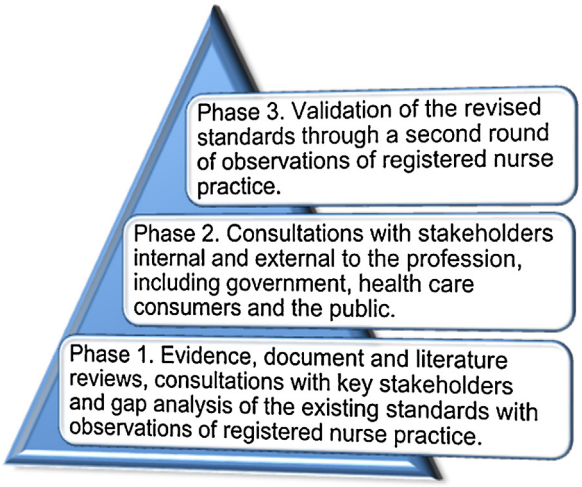

Figure 1 Representation of study phases and policy revision process.

Each phase had a distinct purpose and involved a range of methods. The findings from each phase informed draft-revised standards that were iteratively developed through the study (see Fig. 1). Phases one and two involved ongoing engagement with targeted key stakeholders, which included an open public consultation. Phase three enabled the third and penultimate draft standards to be authenticated through observations of registered nurse practice. Approval for the study was gained from the Human Research Ethics committee at Southern Cross University, and the relevant committees and approval processes for each observation site.

2.1. Phase one: evidence and literature review, consultation and gap analysis

EBSCO and Academic Search Premier databases provided access to available Australian and internationally peer-reviewed publications from 2004 to 2014. In addition to review and critique of the existing National competency standards for the registered nurse (Nursing and Midwifery Board of Australia, 2006), other relevant documents were accessed from web searches of Australian, Canadian, New Zealand, United Kingdom and United States professional and regulatory authority sites and relevant Australian state and national government departments. Search terms were nurse*, nursing, registered nurses, registration, regulation, protection of the public, self-regulation, practice, scope of practice, scope of nursing practice, competence, professional competence, roles and role delineation. Exclusion criteria were nurse practitioners, advanced practice, midwifery, enrolled nurses or licensed practical nurses, nurse managers, care technicians, and extended practice roles such as nurse anaesthetists. As the title 'nurse' was used

widely in this literature, attention was given to establish the level of nurse in each study and the relevance of the reported study outcomes. Papers about education for entry to practice or for continuing competence, and specific clinical competence development or assessment (e.g. wound care) were removed, along with papers about Australian regulation that did not generalise to the current national standards and regulatory framework.

Phase one also included telephone interviews and observations of registered nurse practice. In response to the invitation to participate senior nurses from all jurisdictions were interviewed. The one-hour interviews explored their critique of and views about the current registered nurse competency standards and their suggestions for revision.

Following site specific ethics and research approvals registered nurses in each state and territory were invited to volunteer to be observed undertaking routine clinical practice. A total of 44 observations in acute, community, mental health, aged, rehabilitation and disability settings were conducted by a small team of trained observers, themselves registered nurses. Using a structured observation tool based on the existing standards the following three types of evidence were sought for each standard:

- observations of behaviour
- thinking out loud (modus operandi thinking)
- documented evidence, including publications (artefacts).

These observations were single day snapshots of practice. They were not designed as interviews where nurses were asked to account for their practice directly against the standards. The design was to capture what could be directly observed and what surfaced in discussion related to the observation rather than broader discussion, or using the standards as a checklist to ask questions and generate responses not grounded in observed practice.

2.2. Phase two: consultations with consumers, the profession, and the public

Phase two consisted of key stakeholder consultation, open public consultation and health consumer interviews. Using the online survey software programme Qualtrics two iterations of draft standards were disseminated. The first version was to targeted NMBA stakeholders and the second iteration was disseminated as an open public consultation. Each group were asked the same questions. Promoted and accessible from the NMBA website these consultations provided information about the review and the opportunity to comment and suggest amendments. NMBA key stakeholders involved in the first consultation included relevant health department staff in Commonwealth, state and territory government and professional, specialty and industrial nursing organisations. Interviews were also conducted with ten health care consumers about their experiences and expectations of registered nurse practice. The consumer representative team member conducted these interviews and used the draft-revised standards with modified methodology from a consumer driven qualitative analysis too, *Real People, Real Data* (Consumers Health Forum of Australia, 2014) to map the consumer stories. Following analysis of data from these processes the second revised standards were produced and made available for public and professional comment resulting in the development of a third revised standard.

2.3. Phase three: validation of the draft standards

A final round of 35 observations of registered nurse practice was conducted using the same design as phase one. The structured observation tool was based on the third revised standards and provided the means to test that the standards were relevant and useful in capturing contemporary registered nurse practice. The observations were undertaken in a range of clinical and non-clinical settings that included management, education, academic and policy roles. Observations were conducted in each state and territory and in urban, regional and remote locations.

2.4. Data analysis

Team members used a series of evaluation techniques to review and analyse the documents including literature, interview survey and observation data. In accordance with policy research, analysis was conducted within the policy framework of scientific and technical knowing (in the traditional view of evidence), political knowledge, and practical and professional field experience (Head, 2008). Interviews were analysed and themed inductively (Hsieh & Shannon, 2005). Survey reports assisted in summarising respondent demographic information while making individual responses available for review. While there was some quantification of responses the overall analytical approach, in keeping with development based on defined cycles of action, was to seek convergence and divergence (Heron, 1988). Divergence assists in understanding the whole system of the enquiry area, while enough convergence of data or data sub-sets enables two or more research cycles and a more fully validated analysis (Heron, 1988, p. 46). Determining the weight of support or otherwise for the various draft standards assisted the team in analysis of any thematic consistency in the divergent or convergent responses. Further this approach made possible the consideration of single responses to any particularly pertinent issue that had not been surfaced by other respondents. A mixture of divergence and convergence was achieved in sufficient balance to give confidence in each iteration of the draft standards and a richness that would not have been available through counting alone.

3. Findings

3.1. Phase one findings

There was little evidence when viewed through the lens of scientific and technical analysis from this phase to guide the standard redevelopment. Review of the National competency standards for the registered nurse (Nursing and Midwifery Board of Australia, 2006) and analysis of available literature, interviews, and observations of registered nurse practice focused attention on several areas. Issues of significance for nursing standards included patient or

person-centred care, the increasing consumer participation in health care, the challenges registered nurses face with quality and safety and translating evidence to practice.

Literature affirmed changes to the health care team, health care environment and nursing roles and scopes in the decade since the standards were last reviewed (Benton, 2011; Benton et al., 2015; Health Workforce Australia, 2013a). Person-centred practice was evident as a globally accepted quality and safety strategy with partnerships and teams recognised as nursing and interprofessional inclusive of the person or patient (Australian Commission on Safety and Quality in Health Care, 2012; Luxford, Piper, Dunbar, & Poole, 2010; Poochikian-Sarkissian, Sidani, Ferguson-Pare, & Doran, 2010). Interprofessional practice was an important concept (World Health Organization, 2010) to balance with person-centred practice in a manner that made more transparent the contemporary and autonomous registered nurse role (Eagar, Cowin, Gregory, & Firtko, 2010; International Council of Nurses, 2008).

Though few evaluations or critiques of the Australian competency standards exist, political analyses examined the influence role of the standards in professional development and education (Grealish, 2013; Kako & Rudge, 2008). There are also reports of the standards limitations in expression of cultural sensitivity (Chenoweth, Jeon, Goff, & Burke, 2006). Further limitations with the competency standards were identified in the review of the document and from interviews. The standards were a mixture of behavioural and role based competencies with 287 items (domains, standards, performance indicators or cues) for consideration. Omissions identified in some interviews were professional independence, the full scope of practice, outcomes of nursing practice, and caring and compassion. Others suggested that the language needed to be strengthened to make nursing leadership and the complexity of care more visible. There was concern about ambiguity in the standards with reports of nurses holding themselves accountable for only those aspects of the standards that they were most familiar with, or that required little critical thought. Some concepts such as collaboration were prominent in the competency standards as part of interprofessional practice. Collaboration was used 23 times with ten separate references to practice planned with others in the treatment team. This emphasise on the team, more so than on the person receiving care, was reported as potentially obscuring the nurse's responsibility for the thinking and doing that was their nursing practice, and that should occur before such work was considered in the context of the team.

Generating a foundation for standards around nurse related patient outcomes was confounded by a lack of evidence, other than for specialist roles and in some limited fields of practice (Walsh, Page, & Gesler, 1997). While there is evidence that nurses bring to practice knowledge from multiple sources nursing is still in the early stages of implementation of research-based knowledge (Vernon, Chiarella, & Papps, 2011). Mapping of relevant standards internationally from similar countries showed commonality in the core areas used to standardise registered nurse practice (see Table 1). These standards internationally describe generic professional attributes land often entry level aspects of registered nurse practice.

3.2. Gap analysis from observations of registered nurse practice

The data from the 44 observations of clinical practice showed registered nurses active in conducting assessments, delegation, supervision, provision of care, collaboration, documentation, communication particularly providing information to patients, and working in health care teams (see Table 2). Registered nurse practice was most visible in actions responding to the immediacy of episodes of patient care. There was much evidence of appropriate supervision and delegation. Where patient confidentiality or occupational safety was breached there were clear and appropriate examples of nurses asserting their responsibilities (asking the person to stop sharing that information or to use the appropriate protective equipment). Less obvious was a more developed responsibility for the oversight of patient care by others, leadership of the patient's experience, evidence-based practice, evaluation of practice outcomes and resource management. Acknowledging the limitations of a clinical focus, a small sample and the challenges of observational data (Denscombe, 2010), there were very few examples of these nurses influencing change such as though research, policy or guideline updates. The registered nurse role in the planning of nursing care in consultation with others, and in response to individual, family or carer's educational needs was clearly evident. What was not clear was whether the drivers for this planning activity related to patient preference or organisational demands of throughput.

In summary, key findings that informed the development of the first draft-revised standards ensured that the relevance to practice would accommodate advanced and specialist scopes of practice. References to communication and active engagement with patients and teams were strengthened with collaboration and partnerships including cultural competence. Research, evidence-based practice and evaluation were also to be important features of the revised standards.

3.3. Phase two findings: consultations with stakeholders

Responses from NMBA key stakeholders to the first draft of the standards were analysed along with health consumer experiences to inform a second version of the draft standards. Responses were received from 12 of the 18 NMBA stakeholder groups. Person-centred and evidence-based practice were supported and retained as foundational concepts. The design of seven interrelated standards with specific criteria applicable to the practice of all registered nurses was supported. They were described as 'appropriately higher order, brief, sensible and uncontroversial' (PC#9) and 'clear and concise and provide guidance without being overly prescriptive' (PC#3). These features were recognised to 'accommodate opportunities and flexibility for future changes to the scope of practice of the individual, to health care models and new and emerging registered nurse roles' (PC#7). There was some criticism that the standards were reductionist, limited in scope and were not aspirational. Familiarity with the existing competency

Table 1 Comparison of select international registered nurse standard domains.

Australia (2006)	Ireland (2005)[a]	UK (Nursing and Midwifery Council, 2010; Nursing and Midwifery Council, 2015)	US[b]	NZ (2012)	Canada (2014)[c]	Singapore (2011)	ICN 2002[d]
Professional practice	Professional/ ethical practice	Promote professionalism and trust. Professional values		Professional responsibility	Professional practice	Professional and competent practice. Responsibility and accountability	Professional, ethical and legal practice (includes accountability)
Critical thinking and analysis	Holistic approaches to care and integration of knowledge	Preserve safety. Leadership, management and team working	Evidence-based practice			Self-regulation. Nursing development.	
Provision and coordination of care	Interpersonal relationships. Organisational and management of care	Practise effectively Nursing practice and decision-making	Patient-centred care	Management of nursing care	Health and wellness	Knowledge-based practice. Resource management	Care provision and management
Collaborative and therapeutic practice	Personal and professional development	Prioritise people. Communication and interpersonal skills	Teamwork and collaboration	Inter-professional health and quality improvement	Nurse-client partnership	Collaborative partnership	
			Quality Improvement Informatics Safety	Interpersonal relationships	Changes in health		Professional personal and quality development

[a] An Bord Altranais have Competencies for Entry to the Register (An Bord Altranais, 2005) in general, psychiatric or intellectual disability nursing with children's nursing a post registration programme.

[b] The US has no national regulation. Standards for entry to practice and continuing education are regulated through professional groups. The areas listed are from the QSEN study and reflect those developed by the Institute of Medicine for all health professionals, with the addition of safety.

[c] Competencies for 'entry to practice' Canadian Registered Nurse Examination (Quality and Safety Education for Nurses, 2014). There is no national licence in Canada. Each province or territory has their own standards and competencies for nursing practice. Ten of these share the listed domains.

[d] ICN Competencies Framework to assist countries in the development of competency standards. Care provision includes key principles of care: health promotion, assessment, planning, implementation, evaluation and therapeutic communication and relationships. Leadership and management relates to interprofessional health care, delegation and supervision and safe environment. Professional, personal and quality development includes enhancement of the profession, quality improvement and continuing education. Nursing in the European Tuning study, (Bologna Process) has competencies to harmonize education (professional values and the nursing role, nursing practice and clinical decision making, nursing skills, interventions and activities, knowledge and cognitive competences, communication and interpersonal competences and leadership management and team abilities (Collins & Hewer, 2014).

Table 2 Observations by clinical area for phase one ($n = 44$).

	Phase one ($n = 44$)	Phase three ($n = 35$)
Academic, clinical education		3
Acute hospital unit (recovery, out of hospital care)	2	1
Community mental health and outreach, psychiatric triage, community assessment team	3	3
Primary health care, nursing in general practice	2	5
Emergency department	3	
General surgical		4
General medical	9	
Neurology	3	1
Nursing management		3
Oncology	1	1
Orthopaedic, acute spinal	3	1
Policy development		2
Psychiatry, inpatient services	3	1
Quality assurance		2
Rehabilitation and disability	10	4
Residential aged care	5	4

standards model was apparent in two requests to retain the competency model and focus on the clinical context. Many of the useful suggestions for improvement were incorporated in the subsequent iteration of the standards. Concepts such as therapeutic and professional relationships were clarified and terms such as person or people were used consistently rather than using patients and consumers. Suggestions for change that were not supported included making references to clinical practice or nursing care. The NMBA has one set of standards for all registered nurses regardless of the context of practice. An earlier decision in this study was to develop standards for the practice of all registered nurses regardless of the context in which they worked. Other feedback refuted requests to refer to aspirational and advanced nursing practice as this was outside study brief. Overall, findings informed the development of a second version of draft standards that were made available for public consultation.

3.4. Public consultation

The online public consultation was started 9977 times with 4259 (43%) surveys fully completed. Individual response rates to the 32 questions varied from 97 per cent to 21 per cent. Demographic questions asked about roles, age, areas of nursing practice and employment in nursing. (see Table 3). The text of each standard, criteria and glossary term was provided with the question 'Do you have any comments or suggested amendments?' Of those who commented, on average 92 per cent (SD = 2.81) of each response indicated that either no changes were required, or made positive supportive comments about the value of the content, intent and arrangement of the standards. There was consistency in requests to address the complexity of the language. Specifically, language was simplified in some of the glossary terms, in references to Aboriginal and Torres Strait Islander and other cultural groups, and references to people and persons in therapeutic and professional relationships. Many unsolicited descriptions were received about the barriers in achieving the standard of practice. These questioned the English language capability of colleagues and described management and supervision styles that featured bullying,

Table 3 Public consultation demographics.

Registered nurses ($n = 4413$)		
Yes	4040	92%
No	373	8%
Role ($n = 4412$)		
Registered nurse	2530	57%
Enrolled nurse	534	12%
Registered midwife	61	1%
Registered nurse and registered midwife	282	6%
Nurse practitioner	28	1%
Patient/client/consumer	7	0%
Employer	7	0%
Regulator	11	0%
Professional organisation employee	26	1%
Researcher	30	1%
Manager	370	8%
Educator/academic	199	5%
Policy developer	26	1%
Other health professional	171	4%
Other, please specify	130	3%
Age in years ($n = 4411$)		
25 or less	78	2%
26—30	217	6%
31—35	229	6%
36—40	259	7%
41—45	510	12%
46—50	647	14%
51—55	878	19%
56 or more	1593	33%
Nursing employment sector ($n = 4409$)		
Public health care facility	2402	54.48%
Private health care facility	1181	26.79%
University	88	2.00%
VET sector	28	0.64%
Professional nursing organisation	70	1.59%
Not currently working in nursing	231	5.24%
Other, please specify	409	9.28%

or a lack of resources (such as time, access to research or support for continuing professional development). Analysis of the findings from these consultations informed the third iteration of the draft standards ready for testing through observations of registered nurse practice.

In summary key findings from phase one that informed the development of the first draft-revised standards were a focus on the relevance to practice, that included accommodating advanced and specialist scopes of practice. References to communication and active engagement with patients and teams were strengthened with collaboration and partnerships that included cultural competence. Research, evidence-based practice and evaluation were also important features of the revised standards.

3.5. Phase three: validation of the revised standards

Using a tool based on the draft standards 35 observations were conducted of registered nurse practice in direct-patient care and non-patient care settings (see Table 2). All standards were observed in each observation. Analysis indicated particular areas for consideration as the use of research findings, fitness for practise, professional engagement and partnership. Many editorial changes were also made to assist interpretation and use of the standards.

Evidence-based practice is defined in the standards as accessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings into practice. This practice was apparent in the data as adhering to organisational policies and procedures and having access to, and sometimes accessing, a wider range of resources. Direct use of research findings was not observed. When asked what informed practice in the form of stimulating modus operandi thinking one registered nurse described conducting a work based literature review. Others had completed tertiary studies that encompassed reading research and one participant was undertaking a PhD. Professional journals, state health department or professional organisation updates were commonly cited sources of accessing research though there were no direct references to analysis of, or acting on research findings. Participants described being a part of teams where others used research. Similarly they reported the use of evidence as checking assessments or decisions with colleagues. Practicing within an evidence based approach was described; 'registered nurses [were observed] practicing within the [health] services current evidence based recovery model/strengths based practice focus' (V#1). However there was no awareness of the evidence that underpinned the model. About a third of the entries described evidence-based practice as practicing in accordance with the expected organisational or clinical guidelines. In very few cases did the nurse know about, or consider how research findings informed such guidelines e.g. '*IV line for neutropenic patient was changed due to being up for 24 hours. No policy in hospital relating to this, but [this was] best practice for the ward.*' (T#2). Data analysis also highlighted the need to review the phrase 'fitness for practise' as this was commonly misinterpreted as relating to the nurse's health and lifestyle, rather than their capability.

These registered nurses had volunteered to participate in the observations and demonstrated high levels of capability, performance and professional involvement. Active engagement with the profession was described as membership of professional and speciality organisations, preceptoring students and participating, coordinating, and in some cases, leading standard, audit or clinical development groups. One nurse proudly shared that they had '*recently applied and won a scholarship through the Australian College of Nursing to participate in a . . . course*' (S#6). Another nurse described professional engagement as '*I'm interested that's why I'm doing a Masters and am a college member*' (V#4). For another their professional engagement involved '*regularly assists in educating staff around immunisation records and infection control measures in the hospital. . . .recently completed a postgraduate degree in public health*' (N#1). Most of these nurses could describe their responses to regular (mostly annual) practice review sessions, while some sought out and provided feedback on a more regular basis and with colleagues as well as managers.

Observations of partnerships with patients or colleagues, suggested that partnering to share decision-making is underdeveloped for some nurses in some workplaces. Data highlighted how these nurses used varied and complex information to work autonomously and with others (doctors, social workers and on occasions with patients) to make decisions. Though there were few examples of how nurses went about making decisions with patients. One nurse described how they 'emphasised the importance of ''finding out the person's story'' before deciding on the pathway' (V#1).

4. Discussion

This review has built on previous descriptions of registered nurse competency to generate what Lester (2014) classifies as a 'second-generation' approach to professional frameworks in focusing on the capability for flexible and responsive practice. Capable practice is evidenced by registered nurse practice that meets the standard prescribed in the standards for practice. The revised standards are universal to all registered nurses in Australia. They focus on those issues that are central to the quality and safety of nursing practice (Australian Commission on Safety and Quality in Health Care, 2012; Luxford et al., 2010; Poochikian-Sarkissian et al., 2010), and on what it is that registered nurses do in their practice, without restriction to only some of the roles that a registered nurse may perform e.g. clinical. They are interrelated and facilitate evolving registered nurse practice. They are not limited to beginning nurses on entry to practice. In the standards for practice, person-centred practice and evidence-based practice are key principles. Person-centred practice is a fundamental part of evidence-based practice (Kennedy et al., 2015) and central to registered nurse practice. Person-centred practice is defined in the revised standards as collaborative and respectful partnership built on mutual trust and understanding through good communication. In person-centred practice 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 and control in their health care.

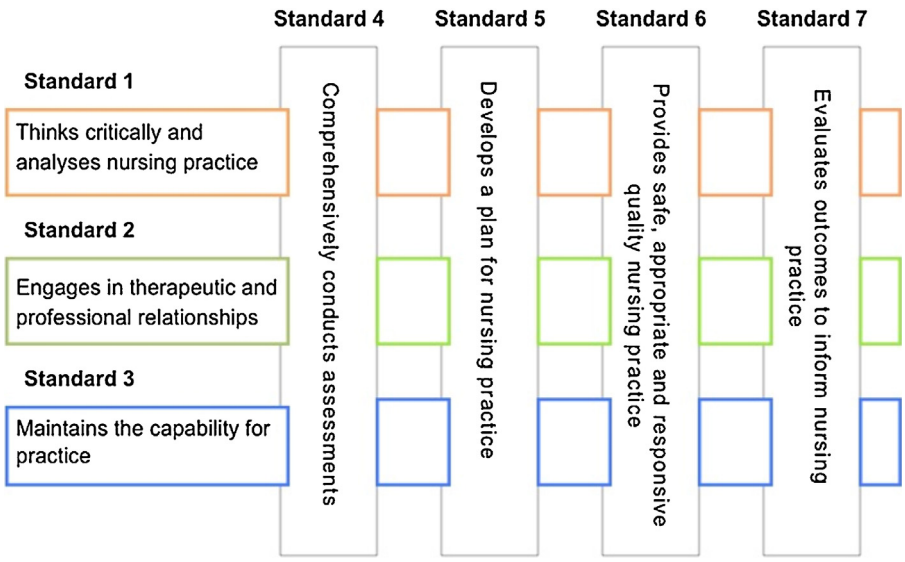

Figure 2 Diagrammatic representation of the registered nurse standards for practice.

Importantly person-centred practice recognises the role of family and community with respect to cultural and religious diversity. Evidence based practice is as previously discussed, defined for the purpose of these standards as accessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings into practice.

4.1. From competency and competency standards to standards for practice

Regulation needs to be proactive in sustaining, improving, and assuring professional standards rather than reactive in managing complaints and misconduct and responding to changing agendas (Benton et al., 2015; Hewitt, 2007). The NMBA move away from competency standards to standards for practice has facilitated the development of a more succinct set of standards for all registered nurses that state the capabilities of registered nurse practice. The previous competency standards developed in 2006 were important, though not limited to, preparation for entry to practice education. The competency standards were detailed in representing what the registered nurse needed to possess, know and/or do, with illustrative rather than inclusive examples of different levels of practice. This facilitated a 'smorgasbord approach' where nurses could selectively hold themselves accountable to only some, rather than all standards thereby obscuring the principle of their specification as standards for practice. The focus on clinical practice in those standards also provided little assistance to applying them to other registered nurse roles such as management, policy development, research or education.

4.2. Implications for implementation of the registered nurse standards for practice

Clear definitions and standards are necessary to override the use of engrained or habitual views of nursing, such as nurses limited to the associate and helper role, that potentially risks that the nurses may not be represented sensibly in future health workforce planning scenarios (McCarty & Fenech, 2012). Registered nurses are health professionals who can assess (with people), plan, therapeutically intervene and evaluate care that is contemporary and based on evidence.

The strengths of this study are evident in multistage, targeted and open engagement with the professional and the public. The resulting standards are broad with a criterion approach that specifies the elements necessary to the regulated performance of that standard, without limiting the development of specialty and advanced practice within the regulated registered nurse title. The interrelationship of the standards is represented across horizontal vertical matrices (see Fig. 2.). There is also an onus of responsibility on the user of these professional standards, which inevitably differ from product or technical standards in that they cannot ever sufficiently detail in advance all the specifications that may affect quality. Professional practice standards do not enjoy the relative certainty that comes with the specified manufacture, installation and use of products to predict or determine safety. The diagrammatic representation of the standards is designed to alert users of the need to interpret the possibilities of how the standards connect with each other in the performance of practice. In doing so they aim to reflect the complexity and embedded nature of professional practice (Lester, 2014). Importantly, the design limits the opportunity to selectively choose only some standards or criteria as a basis for accountability and responsibility for practice.

These standards will come into effect in July 2016 with dissemination and communication important for the profession and the community. A significant number of responses were received in this study about the barriers to implementing the standard of practice appropriate for registered nurses and about the lack of collegial generosity in many workplaces. The use of research findings, demonstrating the capability for practise, and partnership with those who

are the focus of practice, may be new expectations or expressions of registered practice. In this context the implementation of the standards may require further explanation and support. Communication strategies, standards for education and consumer guides are examples of resources that will be key to effective implementation and understanding of the standards. Capability for practice in the standards refers to the complexities of practice performance and is about more than the health (physical or mental) capacity to perform. The registered nurses involved in the observational phases of this study demonstrated high levels of professional engagement, though other data suggests that professional engagement might also be a new expectation for some nurses.

4.3. Study limitations

Challenges in the study were associated with stakeholder diversity, single-day observations of a complex and variable role, online surveys and the need to balance subjective opinion from a diverse range of stakeholders. Viewed in the context of policy formation, all three lenses of political knowledge, scientific research-based knowledge, and field experience have been consciously included in this study (Head, 2008). As the distinction between policy and politics is not clear-cut, and in some languages not distinguished at all, this limitation might also be viewed as a policy strength (Buse, Mays, & Walt, 2005).

In the online surveys only small sections of the draft standards could be displayed at once. While a background paper and the draft standards were available to download, many respondents questioned the meaning of terms such as therapeutic or person, not realising that definitions were provided later in the glossary. Consultative processes may also be limited by participants inability to move outside their personal or professional sphere of thinking (Yen et al., 2011). This limitation can bias findings towards support of the status quo. Observers can also vary in what they bring to the data generation process (Denscombe, 2010). With one exception all observers were involved in both rounds of observations. Three observers were part of the standards drafting processes so had considerable background to interpreting the standards. Others were highly skilled and qualified specialists or generalists with relevant experience, mostly grounded in assessing undergraduate students against the National competency standards. This data varied accordingly from procedural bias to comprehensive insight into the skilled nuances of registered nurse practice. This variation supports the proposed standards for registered nurse practice in Australia.

5. Conclusion

The revised registered nurse standards for practice, developed through three iterations of clarification of constructs, offer a simplified set of seven standards applicable to the practice of all registered nurses in Australia. These standards communicate what is registered nurse practice and the standard required and hence assist registered nurses to practice to the quality and safety parameters of their regulated role. They will inevitably be used in different ways by nurses, education providers, regulators, employers and consumers, despite the common purpose being to communicate what is expected of registered nurse practice, that is, to communicate the standard for practice. Competency development will still need to occur particularly within the domains of education and advancing practice. The onus on the development of the competencies shifts to the education providers as they consider the relevant threshold learning outcomes of pre and post-registration education.

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