Ophthalmic advanced practice nursing roles in New Zealand

Abstract

Aim: To obtain a snapshot of ophthalmic advanced practice roles and how/why they developed in New Zealand.

Methods: The survey tool used was an adaptation of one designed and utilized in the UK to gain a 'snapshot' of advanced practice roles in ophthalmic nursing in the UK. The survey consisted largely of pre-coded questions with the opportunity for free text. The survey is made up of two sections, one requesting information about what the roles are and the other about role preparation and education. Ethical approval was obtained from the Regional Ethics Committee for the survey.

Results: The findings reveal that advanced practice roles are well established in ophthalmic practice in New Zealand. The roles are predominantly part time with most combining two or more roles, with most roles expanding since implementation. Preparation for the roles was varied with some requiring no education while others were required to have post-graduate papers; several of the respondents have undertaken post-graduate education.

Discussion: The main driver for the development of advanced practice roles was policy driven with the implementation of Reduced waiting times for Public Hospitals Elective Services. The most common advanced role undertaken is that of cataract; this is not surprising with the amount of negative publicity ophthalmology services have received for long delays in treatment. Nurses who wish to hold the title of Nurse Practitioner in New Zealand must complete an approved masters degree and this may contribute to the number of nurses undertaking post-graduate study. Planning for the roles was multidisciplinary in the majority of cases.

Conclusion: Advanced practice roles in ophthalmic nursing in New Zealand are well established with nurses, in partnership, driving change and service development to achieve targets and benefit patients.

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areas of practice, which appears to coincide with the expansion of post-graduate education for nurses being more freely available. However, we are still in a state of transition.

As well as educational opportunities there are perhaps three main pieces of legislation that contributed to the conditions for implementation of advanced practice roles in New Zealand. First, the Ministerial Taskforce on Nursing (1998) which was tasked with looking at strategies that prevented registered nurses from providing a more innovative, effective, efficient, accessible healthcare service. Second, the implementation of the NP framework in 2001, and finally the introduction of Reduced waiting times for Public Hospitals Elective Services (Ministry of Health [MoH], 2000). The major recommendation from The Ministerial Taskforce on Nursing (1998) was ‘to release the potential locked up in the nursing workforce’ (Ministerial Taskforce on Nursing, 1998: 27) and highlighted that opportunities may exist for nurses to extend their roles and to participate in planning and delivery of care, as nurses are often an under utilized resource (Raynel, 2002). The NP framework (2001) provided a framework and scope of practice as well as a process for assessment with the first NP appointed the same year. The MoH 2000 prescribed a maximum waiting time of 6 months for first specialist appointment and treatment and the provision of care for this growing demand was unlikely to be the sole province of medical staff. Nurses were ideally placed to take up the challenge to expand their practice, particularly in areas of speciality practice such as ophthalmology.

The only nationally recognized advanced nursing practice role is that of NP with the implementation of the NP Framework in 2001. The New Zealand Nursing Council oversees the implementation of the NP Framework within strict parameters laid out within the guidelines. However, when it comes to advanced practice roles in the clinical setting the title of ‘Nurse Specialist’ is the most common role. Although nurse specialist is not a designated scope of practice many hospitals have implemented these roles with local policy and practice guidelines. There is also some discussion about whether all nurses working in advanced roles hold their positions not as a result of demonstrating advanced practice characteristics, but rather through entitlement (Hickmott, 2007).

**Ophthalmic practice in New Zealand**

It has been suggested by Marsden (1999) that ophthalmic nursing is a ‘Cinderella speciality area’ of practice and this is certainly true in New Zealand. Ophthalmic nursing has minimal if any hours within the nursing curriculum within tertiary institutions in New Zealand, as do many small speciality area of practice (Raynel, 2002), and it is only once nurses begin to practice that they are exposed to the complex speciality that is ophthalmic practice. In 2000, many ophthalmic departments had waiting lists for first specialist assessment and treatment of up to 2 years and the challenge was how to comply with the MoH directives that no patient was to wait longer than 6 months. This provided previously unheard of opportunities for ophthalmic nurses to explore expanding practice into advanced practice roles, as colleagues in the UK had done in the early 1990s. Furthermore, there was an injection of capital from MoH Elective Services for the trialling of innovative changes to patient care models and many ophthalmology departments utilized this additional funding to trial nurse clinics. A business case was required to implement these clinics, but if they were successful the employer was committed to continuing this service. The only example documented in the literature of an advanced practice role is that of a glaucoma nurse specialist clinic which clearly demonstrated that nurses undertaking advanced or expanded roles could impact positively on the waiting list numbers (Slight et al, 2009). However, there is a significant amount of anecdotal evidence that there are several advanced practice roles within New Zealand that were developed as a result of these MoH directives. Undertaking a survey into advanced practice roles in New Zealand would reveal what the rationale for the implementation for these roles was and whether MoH Elective Services directives did indeed act as a catalyst.

**Methodology**

This survey was intended to provide a snapshot of advanced practice roles that currently exist within ophthalmic nursing in New Zealand. The survey tool used was an adaptation of one designed and utilized in the UK to gain a ‘snapshot’ of advanced practice roles in ophthalmic nursing in the UK (Marsden and Shaw, 2007). The original survey tool was adapted to the New Zealand nursing environment with the primary change to the tool utilizing the New Zealand Nursing Council regulations for the registration of nurses, which differs from the UK. Otherwise the format and information sought was the consistent with two separate sections making up the survey questionnaire. The first section was specific to role development and support, speciality areas of practice and the percentage of time spent in the role. The second section asked for information about what, if any, educational preparation was required for the role.
and the support provided. Also whether there was on-going education and support once the role was established was solicited. Even though the survey consisted of mostly pre-coded questions there was also opportunity for free text comments.

The definition of advanced practice was the same as for the UK study, being ‘a role that is not one for which the nurse received education in their general or ophthalmic training and one that is seen as a new role for ophthalmic nursing with greater autonomy and accountability than would normally be expected’ (Marsden and Shaw, 2007: 122). Ethics approval to undertake the survey was gained from the regional ethics committee and the covering letter to the ethics committee included examples of the roles known to be undertaken within New Zealand. The survey was distributed at the annual ophthalmic nurse’s conference, in accordance with the UK survey. Nurses were encouraged to return the completed surveys, which were anonymous, over the 2-day conference.

Results and discussion
A total of 75 surveys were distributed with 52 returned and of those returned 17 had been completed by nurses who considered they undertook advanced practice roles.

Titles and parameters of the role
The 17 respondents identified nine different titles and remuneration ranged from salary step 3 to grade 8 on the Multi-Employer Collective Agreement (MECA) for those employed in the public health sector and individual agreements for those employed in the private sector (Tables 1 and 2). Respondents were either employed part time or undertook their role in conjunction with another role (n=10) the remainder were full time in an advanced role (n=7). Only two of those who worked full time identified undertaking only one advanced role, while the remaining four combined two or more roles. The most common advanced role identified for ophthalmic nurses in New Zealand is cataract nurse-led clinics (n=7).

Drivers of the roles
Respondents identified several reasons why advanced roles have been implemented and they differed depending on whether the position was based in a public or private institution. In the public health sector the major driver identified was the inability to ‘see patients in a timely manner’ thereby failing to comply with the MoH requirements for first specialist appointments timeframes (n=6) and follow up (n=2); followed by an increase in demand for technological investigations (n=3); the lack of ophthalmologist time (n=2); administration of sub-Tenon’s anaesthetic (n=1); and an identified gap in support for a specific group of patients (n=1). Whereas, in the private sector ‘a busy practice’ is seen as the main driver (n=2).

Role development: initial stages
Discussion with the multidisciplinary team with proposals in the form of business cases, utilizing international literature and expertise, were identified as the major impetus for the development of advanced practice roles (n=10). In all instances ophthalmologist approval was required and they were major influences on setting practice parameters. Only four respondents indicated that preparation for their role began prior to implementation while for another five this occurred within the first 6 months; four stated that they were experienced practitioners but gave no indication about preparation for the role; one was in the first year and the remainder provided no answer. Many of these roles have continued to evolve for example; increasing the number of nurse-led services (n=15) while the remainder identified no plan for expansion (n=2). Respondents identified an excellent working relationship between ophthalmologist and nurse, with buy in from management, as imperative to the successful implementation of their roles. Some respondents identified specific processes as contributing to role development including accessing international ophthalmic nursing literature (n=3); discussion and setting of parameters with ophthalmologists (n=2); visiting a major centre in the UK which had successfully implemented these roles (n=1); working with management to develop protocols prior to implementation (n=1); pilot programmes (n=1) and research leading to a successful proposal for implementation (n=1).

Education and organization
Eight nurses stated their preparation for the role was a combination of studying at post-graduate level

<table>
<thead>
<tr>
<th>Table 1. Professional designation</th>
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<tr>
<td><strong>Titles</strong></td>
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<tr>
<td>Registered nurse</td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
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<tr>
<td>Ophthalmic nurse</td>
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<tr>
<td>Speciality ophthalmic nurse</td>
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<tr>
<td>Clinical nurse</td>
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<tr>
<td>Charge nurse manager</td>
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<tr>
<td>Nurse counsellor</td>
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<td>Nurse practitioner</td>
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<td>Technician</td>
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</table>
and ‘in-house’ training, while the remaining nine respondents had in-house training only. The time allocated to theory teaching also varied with one identifying no days while another had 64 days with four others having between 1 and 4 days. However, nine respondents have completed an ophthalmology post-graduate speciality practice paper at a tertiary institution. The ophthalmology post-graduate paper is not a stand alone ophthalmic qualification but one paper within a post-graduate qualification.

Seven nurses received full support from their employer to undertake education (fees and time), while another was partially funded; two received no funding and the remainder did not answer. A post-graduate qualification was a pre-requisite for five respondents with 10 stating that it was not a requirement. A wide variety of timeframes were identified for in-house training in both groups from ‘no training, got the manual out and worked it out’ to 5 years, with several nurses (n=5) receiving between 2 and 6 months of training. The majority of in-house training was undertaken by the ophthalmologist (n=9), followed by other nurses (n=6) and the remainder being undertaken by an orthoptist or by the nurse themselves. Several nurses indicated that the training was on going.

Since the advanced practice roles have been implemented the majority of respondents 94% (n=16) identified that their roles have expanded with only one indicating that their role has not expanded and that there were no plans for expansion in the future. However, only three identified that the change was formal, with eight identifying that the change was not planned, and the remaining five did not respond. Also 41.5% (n=8) identified that change was collaborative either with medical staff or other senior nursing staff. Increased knowledge and assessment skills and technological advances (n=9) were identified as the major rationale for change.

Competence and completion of ‘training’ was assessed by the ophthalmologist for eight respondents, while others did not provide an answer (n=3), and the remainder gave a variety of answers including: no one, passing course, consensus and self. Competence was assessed in a variety of ways with audit being the most common (n=6), followed by supervision and assessment (n=3) and supervision only (n=3), whereas some had never been assessed (n=2). Completion of training was decided mainly by the ophthalmologist (n=8) with one respondent each stating clinical director and credentialing team, orthoptist, peers/self and no one. When asked if they felt competent in undertaking their roles, again there were a variety of responses with the majority stating they felt competent (n=10), others who felt partially competent (n=4), whereas some stated they did not feel competent (2).

**Supervision and support**

Nurses felt that supervision was generally sufficient with only two indicating that they had insufficient supervision. However, several issues were raised about the support received that impacted on the ability to learn and become adept clinically such as: lack of support from senior and other nurses; the impact of regular workload; lack of training time; lack of management buy in; and relying on junior medical staff.

This questionnaire is only a snapshot of advanced ophthalmic practice roles in New Zealand and is

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**Table 2. Remuneration**

<table>
<thead>
<tr>
<th></th>
<th>Steps</th>
<th>Grades</th>
<th>Comprehensive</th>
<th>Proficient</th>
<th>Private</th>
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<tr>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Registered nurse</td>
<td>1*</td>
<td>1</td>
<td>2*</td>
<td>1*</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td>1*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ophthalmic nurse</td>
<td></td>
<td></td>
<td></td>
<td>1*</td>
<td></td>
<td></td>
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<tr>
<td>Speciality ophthalmic nurse</td>
<td>1*</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clinical nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1*</td>
<td>1</td>
</tr>
<tr>
<td>Charge nurse manager</td>
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<td></td>
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<tr>
<td>Nurse counsellor</td>
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<td></td>
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<tr>
<td>Nurse practitioner</td>
<td>1</td>
<td></td>
<td></td>
<td>1*</td>
<td></td>
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<tr>
<td>Technician</td>
<td>1</td>
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*Identified advanced practice constituted the whole of their role

Nurses MECA payment scales
limited because of the size of the sample. However, although this is a limited sample, issues identified are likely to be common to nurses providing ophthalmic care throughout New Zealand. It is apparent that the major driver for the implementation of advanced practice roles has been policy led, primarily the implementation of *Reduced waiting times for Public Hospitals Elective Services* (Ministry of Health, 2000) although advanced practice in the speciality clearly began prior to this.

The roles undertaken are varied, and interestingly only two nurses undertake a single role — the remainder who participated in this survey undertook more than one role. However, it is not surprising that nurses undertake more than one role as many of the ophthalmology services are very complex, with high patient volumes. Also if these nurses are envisaging that they would progress to NP in the future it is essential that they provide a wide range of assessment and treatment interventions within their scope of practice (Competencies for the nurse practitioner scope of practice, 2009). There were 12 separate advanced practice roles identified covering a wide range of sub-speciality areas (*Table 3*). One nurse stated that they undertook the following roles pre and post-operative cataract, glaucoma, acute assessment and treatment and diabetic assessment and grading, but it is not stated whether these were all nurse-led services. Unsurprisingly cataract is the most common advanced role undertaken by nurses as it is the eye condition that is given a high priority by the government and general public, having received negative publicity about long waiting lists on several occasions (NZ Herald, 2005; NZ Herald, 2007; Southland Times, 2008; NZ Herald, 2009). The remuneration and titles for nurses undertaking advanced practice roles are inconsistent and do not reflect the speciality knowledge that nurses bring to these roles or the contribution they are making to the provision of ophthalmic care in New Zealand. The advanced roles identified by the respondents would all be outside what is the expected scope of practice of a registered nurse in New Zealand. While New Zealand does not have specific competencies for ophthalmic nurses, the UK competencies are utilized as a reference document by many services.

It is evident that ophthalmic nurses in New Zealand are accessing education at post-graduate level with several nurses in this sample having completed post-graduate certificates and/or diplomas, many having completed a specific ophthalmology special topic paper at post-graduate level and two having completed masters degrees. One of the New Zealand nurses who identified that they hold a masters is currently the only ophthalmic NP in New Zealand with prescribing rights. This puts ophthalmic nursing at the vanguard as there are 31 NPs with prescribing rights in the country out of a total of 50 NPs in New Zealand (Nursing Council of New Zealand, 2009). It is interesting to note that post-graduate education was a requirement for several New Zealand nurses wishing to pursue advanced practice roles, although what the distribution is throughout the country cannot be determined from this sample. What is worrying, however, is that education for advanced practice roles in other cases involved learning on the job, picking up a manual as well as self teaching, and this clearly embeds some risk into these new roles. This is compounded by issues of lack of support and time for refining skills identified by some respondents and organizations, and their teams must be very careful that new roles are planned and resourced correctly before implementation so that the new services are robust and safe.

**Conclusion**

Although advanced practice roles developed, to a great extent, in response to MoH targets for FSA and follow-up appointments, nurses also saw this as an opportunity to implement advanced practice roles and to realise sustained changes in practice in line with colleagues in the UK. Endorsement (clinically and theoretically) by ophthalmologists was key to the successful implementation of these roles and an excellent working relationship was essential to the expansion of the roles. In the majority of cases a multidisciplinary approach in the setting up of

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**Table 3. Advanced practice roles**

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>Cataract (pre &amp; post-op)</td>
<td>7</td>
</tr>
<tr>
<td>Glaucoma clinics</td>
<td>6</td>
</tr>
<tr>
<td>Investigations (FFA, OCT, HRT etc)</td>
<td>6</td>
</tr>
<tr>
<td>Acute eye clinic</td>
<td>4</td>
</tr>
<tr>
<td>Pre-assessment clinic/cataract assessment</td>
<td>3</td>
</tr>
<tr>
<td>Minor surgical procedures</td>
<td>2</td>
</tr>
<tr>
<td>Retinopathy of prematurity</td>
<td>2</td>
</tr>
<tr>
<td>Diabetic photomonitoring</td>
<td>2</td>
</tr>
<tr>
<td>Botulinum toxin therapy</td>
<td>1</td>
</tr>
<tr>
<td>Uveitis</td>
<td>1</td>
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<tr>
<td>Conselling, low vision</td>
<td>1</td>
</tr>
<tr>
<td>sub-Tenon’s anaesthesia</td>
<td>1</td>
</tr>
</tbody>
</table>
Key points

- Advanced practice in ophthalmic nursing is flourishing in New Zealand.
- A wide variety of professional designations, remuneration and roles have developed in this complex specialty.
- Government policy has influenced the implementation of advanced practice roles in ophthalmic practice.
- Role development generally involves the multidisciplinary team and is embedded in business plans.
- Post-graduate education is an integral part of role preparation in more than half of the roles studied.

Ophthalmic nursing • Advanced practice • New Zealand • Role development

advanced practice roles was central to the success and a united professional front also ensured buy-in from ‘management’.

References

Funding boost for cataract surgery. Tuesday, May 3, 2005 http://www.nzherald.co.nz