credentials

Pathway to credentials

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Abstract

The issue of credentialling infection control practitioners (ICPs) has sparked considerable debate and, at times, concern among the Australian Infection Control Association (AICA) membership. This paper seeks to discuss the relevant issues and inform readers on factors influencing the development of a credentialling process for Australian ICPs. In addition, it outlines the credentialling process, ratified by the AICA executive, that will be implemented for Australian ICPs. [AIC Aust Infect Control 1999; 4(4):21-23.]

Introduction

Specialist nurses are expected to provide expert advice to health-care workers, support staff, patients, visitors and members of the general public in relation to their area of practice. The credibility of this advice needs to be judged against an established standard, so that health-care workers, administrators and consumers alike can be confident the practitioner they consult is able to provide appropriate advice. One pathway to achieving that credibility is to establish a process for credentialling the specialist clinician. This paper will discuss the process as it relates to the infection control practitioner (ICP).

Background

Much has been written in the last decade about credentialling of advanced and specialist nurses. This can be attributed to the burgeoning of specialty areas of nursing and health care in recent years. According to Spencer:

> Credentialling is well recognised as a form of self-regulation of professionals at advanced and/or specialist levels ... As the International Council of Nurses (ICN) has consistently recommended, credentialling processes are most appropriately developed and implemented by the national professional nursing associations. This self-regulatory role of professional associations is in line with long-term developments in nursing internationally and in other disciplines around Australia[1].

Scully[2] states that, "in Australia, the concept of a coalition of national nursing organisations grew from deliberations on an Australian response to a document by the ICN entitled 'Which Way for Nursing Specialties?'. In November 1991, the Australian Nursing Federation hosted "a conference to explore and debate issues relating to nursing specialties ... Since then the National Nursing Organisations (NNOs) have continued, through consensus, to deliberate on issues pertinent to the nursing profession, such as postgraduate education, competency standards, credentialling and definitions[2]." AICA is represented in the NNOs.

The Royal College of Nursing, Australia (RCNA) is also attempting to further the issue of credentialling advanced and specialist nurses. "In August 1998 the RCNA held a National Summit on Credentialling for the Nursing Profession ... The aim of the summit was to provide an overview of the progress of credentialling in Australia and to open the debate to include the ICN's position of 'recognising and properly incorporating the legitimate roles and responsibilities of interested parties'[2]."

Spencer[1] asserts that "many nurses voluntarily seek this form of recognition, for personal achievement and to publicly demonstrate their continued competence." Styles[3], who is a well recognised authority on the topic of credentialling and nursing specialisation claims that:

[C]redentialling serves to:

- Designate specialist/advanced expertise;
- Inform consumers;
- Establish a national standard;
- Promote career advancement;
- Identify a community of experts.

In another publication, Styles[4] asserts it is also part of the process to qualify for independent practice.

Credentialling the Australian ICP

The issue of developing a credentialling process for the ICP was identified as important by AICA members at the national conference in Sydney in 1996. As a result, AICA convened a credentialling subcommittee in 1997.

In the 2 years since its inception, the subcommittee has published a proposal for a credentialling process[5]. It was suggested that a credentialling board be formed, comprising ICPs who had been invoked as life members of AICA for their commitment and contribution to the profession. The fact that the nascent board's members were ICPs with a wealth of experience and expertise in the discipline, but unlikely to undertake tertiary studies, meant that ICPs with the greatest experience would have their credentials conferred automatically through membership of the board.

The proposal recognised that the tertiary infection control courses now available mean the credentialling process for ICPs entering the profession now and in the future involves completion of an accredited tertiary course. ICPs currently working in the discipline and who have gained tertiary qualifications in areas related to the practice of infection control, or those who have completed similar courses overseas, could apply to the credentialling board for recognition of their qualifications.

The main function of the credentialling board will, however, be the review and endorsement of tertiary infection control courses. In this way, AICA's credentialling process will be in line with the recommendation of the ICN in that it is developed and implemented by the national association[1]. Further, AICA will be in a position to ensure that the content of the infection control courses offered is current and credible, and addresses all the competencies required by the ICP.

The recommendation that life members convene the nascent board was not well-received by some states and resulted in a number of them nominating their own representatives.

Some of the unwanted consequences were as follows.

- The fact that membership of the credentialling board automatically confers credentials.
- Representatives nominated to the board in the absence of standardised criteria, meaning the nomination process could not withstand public scrutiny.
- The possibility that some board members would be less experienced and have fewer credentials than ICPs submitting their professional portfolios for review.

What is the process?

Convening the credentialling board is the first priority, and it will be a two-stage process.

Stage 1

Given recent history, the only reasonable option that will withstand public scrutiny is to call for nominations according to the following criteria:

- AICA membership;
- tertiary qualifications at master's level or higher, and
- ability to describe how they can contribute to the process.

The AICA executive will review nominations and has responsibility for selecting four nominees as initial board members.

Stage 2

This will involve calling for AICA members who can fulfill the criteria for the professional portfolio and wish to sit on the board to submit a professional portfolio to the established board. Two AICA members able to meet the requirements and who have a desire to sit on the board will then be selected and recommended to the AICA executive for induction onto the credentialling board.

This will ensure that the board is composed of AICA members who have the skills, ability and experience to function effectively on it.

AICA executive members agreed to adopt this process at the recent strategic planning meeting in Sydney.

Once convened, the six-member board will report directly to the AICA executive. It will develop terms of reference and submit them to the AICA executive for ratification.

This means the credentialling subcommittee can be disbanded, its goal achieved.

Role of the board

As previously stated, the board will have two roles. Its primary role will be that of reviewing and accrediting tertiary infection control courses. This means academics developing infection control courses will be strongly motivated to involve ICPs in course development, which in turn will ensure the clinical relevance of courses and that educational programs meet the needs of industry.

Another function of the AICA credentialling board will be to provide a service to AICA members who, having practised as ICPs for a number of years, have already developed the skills, knowledge and experience necessary to be considered experts in their field. These ICPs may choose to seek formal credentials from the national association by submitting a professional portfolio to the board for assessment. If such ICPs can demonstrate that they meet the criteria developed by the board from those set down in the original proposal[3], they will be credentialled by AICA.

Thus, Australian ICPs will have three options in relation to credentialling. They can:

- undertake a tertiary infection control course accredited by AICA (courses are now available in Australia);
- submit their portfolio to the credentialling board if they believe they meet the criteria necessary to produce such a professional portfolio – if those portfolios meet the criteria to a satisfactory level the ICPs will be credentialled by AICA, or
- choose not to seek credentials, so no action is necessary.

Conclusion

To date, the progress of the credentialling subcommittee has been impeded to some extent by the failure of the AICA membership to examine the issues and seek a way forward. Despite the 1996 AICA resolution to develop a credentialling process, ICPs have not embraced credentialling as a step that will promote infection control as a specialty practice.

AICA will now have a method of identifying qualified experts in this specialty; thus, novice ICPs will know whether the person to whom they turn for advice is best able to provide that advice.

Similarly, health-care administrators will have a method of identifying those who have certified expertise in the specialty. This will act as a deterrent to the current practice of promoting staff from other arenas into this specialised area. Many of us know at first hand the extensive and unrealistic learning requirements we face under such circumstances.

Further, allied health professionals will have a method of identifying those with expertise in the specialty, in order to obtain accurate and appropriate advice in relation to the infection control aspects of their practice.

Finally, and most importantly, patients and members of the general public will know that infection control is in the hands of experts. This is necessary if they are to regain confidence in the ability of health-care service providers to deliver health care that alleviates their health problems rather than creating new ones.

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References

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