FNOPI

FEDERAZIONE NAZIONALE ORDINI PROFESSIONI INFERMIERISTICHE

CONSENSUS CONFERENCE

Consensus Document

English version 2023

SUMMARY

Introduction to the final Consensus Document and research areas

The dynamic nature and the continuous evolution of the Italian National Health Service has led to the redefinition of the demand as well as the supply capacity of the healthcare market. In particular, the progressive ageing of the population and the increase in life expectancy, as well as the concurrence of multiple chronic and degenerative diseases, are all elements that strongly affect the current healthcare scenario. Moreover, the emergency generated by the COVID-19 pandemic has revealed how the traditional organisational model is unable to effectively respond to the population's healthcare needs. In response to these changes, and in consideration of the renewed national and European regulatory framework, such as the National Recovery and Resilience Plan (NRRP), several corrective actions have been implemented, such as the introduction of new healthcare models and nursing roles (e.g., the Family and Community Nurse).

The new healthcare paradigm focuses on the implementation of territorial proximity networks and in the near future envisages the establishment, where not present, of “Community Houses” and “Community Hospitals”, shifting healthcare settings from traditional care providers, such as acute hospitals, towards more sustainable and accessible territorial organisations that can foster health and social care integration and the continuum of care.

Given these considerations, it is clear how necessary and natural it is to further develop the nursing profession, its competency profiles, and the roles played in the various social and healthcare facilities, as well as the educational courses that can support and foster this change.

The purpose of the *Consensus Conference* promoted by the National Federation of the Orders of Nursing (FNOPI) was to facilitate discussions with the main institutional stakeholders involved in the current reform processes to reach an agreement on the definition of highly complex current health issues affecting nurses’ professional role. In particular, the following were investigated:

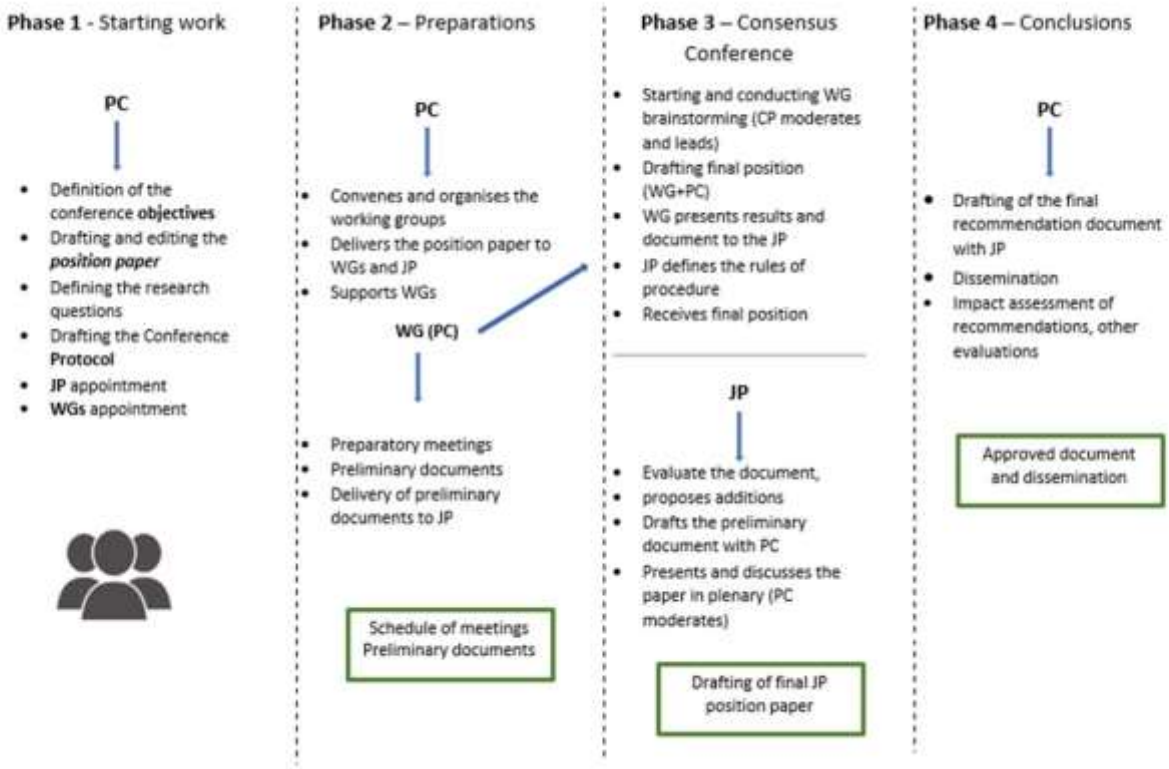
A. the new demands of the Italian National Health Service in the light of the regulatory developments of the last months and the changes introduced by the NRRP;

B. the evolution of the nursing profession and the changes concerning healthcare organisations in response to the new healthcare needs of the population;

C. the revision of the nursing training framework in response to the emerging core and specialised training needs.

The initiative was launched by the FNOPI Executive Board in December 2021 with the establishment of the Promoter Committee (PC) including four main phases, as shown in Figure 1.

Figure 1. Synopsis of Consensus Conference phases



The Jury Panel (JP) received and discussed the preliminary consensus document drafted by the Working Groups (WGs) during the Consensus Conference held in Rome on 23rd June 2022. This final Consensus Document was produced by the JP, in which the positions and proposals resulting from a majority vote, are summarized.

Jury Panel Members

- **Tonino Aceti** – *President of Salutequità*
- **Pier Giovanni Bresciani** – *Occupational Psychologist and Lecturer at the University of Urbino "Carlo Bo"*
- **Silvio Brusaferro** – *President of the National Institute of Health in Italy*
- **Davide Caparini** – *Finance Counsellor of the Lombardy Regional Government and President of the Regional Health Sector Committee*
- **Bruno Cavaliere** – *President of the Italian Society of Nursing Directors*
- **Salvatore Cuzzocrea** – *President of the National Observatory for Education of the Italian Ministry of University & Research and Rector of the University of Messina*
- **Carlo Della Rocca** – *President of the Standing Conference of the Faculties and Schools of Medicine & Surgery – Dean of the Faculty of Pharmacy and Medicine at the "La Sapienza" University of Rome*
- **Claudio Costa** – *Coordinator of the technical healthcare workforce at the Veneto Regional Government – Support Group Member for the Regional Health Sector Committee*
- **Tiziana Frittelli** – *President of the Italian National Federation of the Regional Health Authorities - General Director of the San Giovanni Addolorata Hospital in Rome*
- **Silvio Garattini** – *President of the "Mario Negri" Institute of Pharmacological Research*
- **Domenico Mantoan** – *General Director of the Italian National Agency for Regional Healthcare Services (AGENAS)*
- **Letizia Maria Melina** – *Secretary General of the Italian Ministry of University and Research*
- **Paolo Petralia** – *Vice-President of the Italian Federation of Hospitals(FIASO) - General Director of the ASL4 Local Health Authority of Chiavari, Ligurian Regional Health Service*
- **Francesco Quaglia** – *Director of the Department of Health and Social Services of the Liguria Regional Government*
- **Luisa Saiani** – *President of the Standing Conference of Healthcare Professions – Professor of General and clinical Nursing Sciences at the Diagnostics Department of the University of Verona (MED/45)*
- **Rossana Ugenti** – *Head of the General Directorate for Healthcare Professions and Human Resources of the National Health Service - Ministry of Health.*

The changing demands of the National Health System in response to the regulatory developments of recent months and the challenges introduced by the NRRP: a glance beyond the pandemic emergency

Working Group 1

The recent socio-demographic changes in the Italian population call for new organisational models in the Italian National Health Service (NHS). In fact, the emerging needs of an increasingly ageing population, affected by chronic diseases, sometimes coexisting in the same person, as well as the needs generated by the bean-pole composition of the family and the widening of social gaps, all need to be addressed. At the same time, we are witnessing worrying evolving dynamics of the health workforce characterised, among others, by the higher average age, intent to leave the profession and, more generally, by the shortage of active health workers.

This scenario is also worsened by the low attractiveness of the nursing profession, which now requires the implementation of measures aimed at reforming and boosting professional identity and at reorganising and recognising the role played in healthcare facilities. In particular, it is imperative to invest on nurses by defining (i) new resources for the system as a whole, (ii) new career ladders in the field of clinical practice and (iii) a concrete economic enhancement of the profession, consistent with the advanced of skills acquired throughout the career advancement.

This scenario has been further emphasised in the emergency context triggered by the Covid-19 pandemic, which highlighted the urgency of redesigning the prerogatives, structure and functions of the Italian national health service, so as to provide more agile and customised responses to the public, with an eye on the development of community care to be pursued through the implementation of inter-professional networks.

Socio-demographic reference framework

Demographic evolution and structural changes

The general trend of population reduction observed since the 1960s was compounded by the impact of the pandemic. In fact, 2020 was characterised by a very few births (404,000) and large numbers of deaths of (746,000), resulting in a negative balance of 342,000 only in 2020. To this decline, a further critical element must be added, namely a negative migratory balance of more than 40,000, which generated a 384,000 reduction in the resident population.

Moreover, the impact of Covid-19 also had a disruptive effect on the life expectancy of the Italian population, which on a national basis has decreased on average by year,

with peaks of 2.5 years in Lombardy[1]. The progressive ageing of the population is raising great concern, mainly with respect to the overall resilience, and thus the sustainability of the healthcare systems. In particular, the over-75 population includes over 7 million people (they were about 5.9 million in 2010), equal to 11.9% of the entire population. Evidently, the pandemic had a negative impact on this specific segment of the population, being the most fragile in terms of general health conditions. In this regard, in 2021, 47.8% of the over-75 population was either multi-chronic or had severe limitations in terms of self-sufficiency. Taken together, these factors led to an increase in the number of elderly people without being matched by an evolution of the culture of ageing. The delay in the elaboration of this status from a biological, psychological, and relational point of view leaves the elderly randomly exposed to the events of life, without a network and a culture - of planning, organisation, and management - to support them on this journey

Lack of a culture for ageing (planning, organisation and management)

The health workforce

Between 2012-2018, the workforce in the health sector decreased by 25,808 units (-3.8%), due to turnover that remained consistently below the minimum replacement levels. Compared to 2012, there was a 4.9% decrease in public health expenditure on workforce, which equally affected physicians (-3.5%) and nurses (-3.0%). This reduction in workforce expenditure was due to the freeze on contractual procedures and other restrictions imposed on salary increases (Law No 122/2010 Art. 9 and Art. 17.). A further consequence of the low turnover of health personnel was the increase in the average age of Italian NHS employees, which rose to 50.7 years in 2018.

Trend of healthcare personnel and public healthcare expenditure shrinking

On the 31st December 2019, a total of 240,490 physicians; 332,818 nursing staff; 54,880 rehabilitation staff; 45,475 technical healthcare staff and 10,104 supervisory and inspection staff operating at various levels of care (primary care, rehabilitation, hospital, outpatient) were employed in the Italian National Health Service.

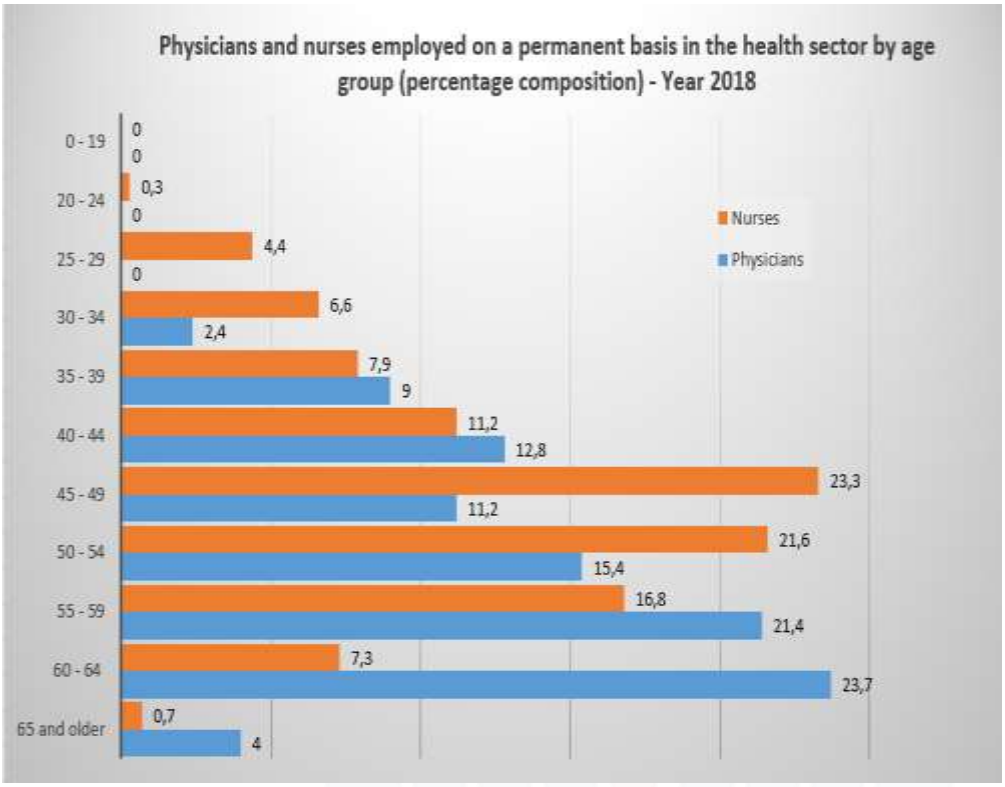
The average age of the nursing workforce is 47.4 years with an average of 19 years of service. The ratio in relation to the total population is 4.47 per thousand, which rises to 4.80 per thousand if we also consider hospitals recognized by the public sector. It should be noted that comparatively, in the public sector, medical staff have a higher average age than nursing staff[2] (Figure 2).

Staffing levels, average age and years of service of NHS nurses

[1] Text adapted from Anziani e Disabili: un nuovo modello di assistenza, edited by Brugnoli and Zangrandi, Studi e Ricerca Fondazione Sussidiarietà 2021 - chapter prepared on the basis of a report by Giancarlo Blangiardo, President of Istat. All figures are attributed to Blangiardo elaborations on Istat data.

[2] Data from the General State Accounts.

Figure 2- Nurses and physicians employed in the healthcare sector



Source: Istat elaborations on RGS-Igop data

Types of job contracts in the NHS

The shortage of 'permanent' staff is partly compensated by resorting to staff with non-standard or temporary contracts. Currently, the incidence of these types of contract compared to permanent contracts is 7.7% for physicians and 6.1% for nurses[3]. While there are no significant gender differences among nurses, among physicians, women have more unstable jobs (10.2% compared to 5.6% of men). The use of non-standard job contracts for these healthcare professionals has been growing in recent years; in 2012 it was 6.3% for physicians and 3.6% for nurses.

Nursing in the international context

Looking comparatively at the international context, as far as the number of active nurses is concerned, Italy ranks near the bottom among European countries: with 58 nurses per 10,000 residents, it is ahead only of Spain (57.4), Cyprus (53.8), Poland 51.0), Latvia (45.7) and Bulgaria (43.7). Germany and France have about twice as many nurses as Italy[4].

While most OECD countries have approximately 3 nurses for every physician, in Italy this ratio is 1.5, the same as in Cyprus, Latvia and Spain. It should be noted that among the EU countries the highest nurse/physician ratios are in Luxemburg (3.9), Belgium (3.5), France (3.3) and Slovenia (3.2).

[3] ibidem.

[4] Data provided to international bodies in February 2022 and related to 2021 show approximately 455 thousand nurses registered with the FNOPI, of whom approximately 370 thousand are active (62.6 nurses for every 10 thousand residents). The estimate of active nurses is carried out using COGEAPS data and selecting those professionals who have obtained at least one ECM credit in the last 3 years.

So far, the shortage of nursing staff is not adequately compensated by the potential of newly qualified nurses: Italy has approximately 20 newly-qualified nurses per 100,000 residents compared to 44 in OECD countries. The scenario is different when it comes to physicians: Italy ranks in line with the OECD average (13 physicians for every 100,000 residents).

Regarding the attractiveness of personnel from abroad, in our country the percentage of nurses who graduated abroad is 4.8% (6.1% OECD average), while only 0.9% of registered physicians (1.4% of active physicians) graduated abroad (17.9% OECD average)[5] .

New challenges for the NHS: Digital Innovation

General rethinking of healthcare service delivery through digital innovation

The lessons learnt during the pandemic have made it clear that a sustainable, resilient and equitable healthcare system cannot do without redesigning the care system by exploiting digital innovation. The digitisation and innovation efforts envisaged by the NRRP, however, must be inevitably paired with investments in skills, technologies and change management tools. It is imperative that the digital transformation should not be a matter of 'mere' digitalisation of processes, but that it should involve a real redesign of how health services are accessed by citizens and delivered by health professionals. Moreover, the spread of digital solutions will make it possible to generate a considerable amount of data that can be used by the stakeholders involved in the care processes, even if belonging to different organisations. The development of an effective digital health ecosystem therefore requires a considerable strategic planning effort, the acquisition of specific skills, and significant investment in the incremental development and integration of identified technological solutions. Unavoidably, the technical training of all professionals, aimed at acquiring the so-called digital skills, will require the review of the training paths for professionals, beginning with the university curricula that are currently inconsistent with the operational context of reference.

Physicians' relationship with other health professions

Upgrading of roles as a motivational lever and management tool to contrast the so-called "Great Resignation"

A further essential step to contrast the increasing burden of chronicity and the progressive reduction in the workforce of some medical specialties is to overcome the taboos that in Italy are still associated with the concepts of skill mix and task shifting. According to OECD and Eurostat data, in Italy there is a surplus of more than 25,000 specialists, but a shortage compared to the EU averages, particularly of emergency physicians and general practitioners.

It is a matter of enhancing the health professions by rethinking the necessary skills (skill mix) and substituting roles (task shifting) or flanking (task evolution) other

[5] OECD data https://stats.oecd.org: cautiously assessing the data on the mobility of professionals between countries, which present problems of comparability, it appears that in 2018 there were approximately 6,000 nurses registered abroad but graduated in Italy, 64.5% of whom work in the United Kingdom, 20% in Switzerland, 7.5% in Belgium and 5.8% in France.

health professions. If this takes place according to an adequately designed healthcare pathway, adequately tracked and supported by digital technology, the benefits will lead to the improvement of the quality of care.

Nowadays, the skill mix/task evolution model involves not only physicians and nurses as was originally the case, but also healthcare workers or caregivers who can be teamed up with nurses, notably in home care activities. This change in roles and accountability, if well designed, could restore the "feeling of worth" that is nowadays a key element in overcoming, or at least counteracting, the so-called "great resignation" phenomenon of many health workers.

Redesigning health policies and regulations

Health policies should be redesigned to include actions that improve and rationalise health and social care pathways, in particular the citizen should be guided in the use of services and supported along diagnostic, therapeutic and care pathways.

Overcoming the medico-centric paradigm that characterises the Italian NHS

Regulations should focus above all on a change of the medico-centred paradigm of the Italian NHS, which is mainly oriented towards the treatment of conditions, with extreme splitting into specialisations, moving towards a system led also by graduates of other health professions, with real projects for the holistic health of the individual.

Given the workforce shortage, it is essential to address the issue of the exclusivity allowance for nurses as well, in line with what is already in place for medical personnel. In addition, we believe it is advisable to allow professionals in the nursing sector of the Italian NHS to perform freelance activities by signing of company-level agreements that enable them to conduct also private practice in addition to their job in the hospital with *ad hoc* agreements negotiated with the various healthcare institutions.

In addition, to lessen the workload on specific professions, the current regulatory reform process should aim at broadening the scope of competencies of registered nurses, in particular by providing for prescribing basic medical devices and follow-up services.

JURY PANEL CONCLUSIONS

1. **We deem it necessary to identify the nursing services to be included in the Essential Levels of Care (LEA) annexes, which define the set of services that can be provided and their respective codifications.**
2. **We agree that the remuneration system should recognise the specificity of the role played by registered nurses in healthcare organisations.**
3. **We believe it is necessary to envisage, and therefore regulate, nursing prescriptions for medical devices required for the provision of care (e.g. incontinence aids, minor prostheses, etc.) as well as commonly used medications (e.g. over-the-counter drugs...) and/or drugs to ensure therapeutic continuity in chronic conditions.**
4. **We agree that it is necessary to overcome the exclusivity restrictions of registered nurses employed by the National Health Service in order to strengthen the health provider network, also with a view of extending their role in the community, taking into account the needs to maintain the stability of the system.**

Work Group 1

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The evolution of the nursing profession and changes in health care organisations in response to the new public health demands

Work Group 2

In agreement with what has also been described in the first part of the final consensus document (cf. Workgroup 1), we believe that in the near future the competencies performed by the nursing profession must be developed for a better quality of care, thus driving the shift from a performance logic towards that of taking responsibility for care of the patient as well as for the overall "care system". As anticipated, the development of advanced managerial and clinical competencies, in any field, can significantly impact the identity and sense of belonging to the professional community, also by acting on economic remuneration based on results.

Development of the skills needed to take charge of the care recipient.

To achieve these objectives, it is necessary to act on some fundamental points of the professional and organisational system, in particular: to design a new perspective of the nursing professional both vertically (hierarchical/management line) and horizontally (development of professional roles/line of the clinic). Within this framework, our proposal recommends interventions:

- **In the vertical/management line**, nursing directors shall be included in the company's strategic management (subject to amendment of Law 502 of 1992), holding roles of equal hierarchical level with the executive management (see resolution of the Emilia Romagna Regional Government and the proposal of the Lombardy Regional Government). Furthermore, it is necessary to clearly identify the manager role in charge of the nurse director who, both in the hospital and community setting, will be able to define the methods and tools for the governance of organisational and care complexity by developing innovative models for the provision of quality care. In this regard, the guideline drawn up by Italian Society of Nursing Directors in 2020 is to be considered a comprehensive document[6]

Strengthening of the coordinator role with appropriate qualifications (Master's degree instead of 1st level Master course)

- Likewise, **nursing ward managers** will have to acquire more knowledge and skills in care management as they are employed in increasingly complex organisations that require specific core competencies, in particular for the

[6] The said document provides for the following role functions: Guarantees responses to the needs of nursing, midwifery, rehabilitation, technical health care and prevention, with appropriateness, quality, professional effectiveness and operational efficiency; Concurs to ensure care pathways for fragile and chronic persons in compliance with LEAs and standards envisaged on a national and regional level ; Commits to providing customised and quality care to users by reviewing the organisation of work.; Fosters multi-professional team work and interdisciplinary relations in diagnostic, therapeutic, clinical care and rehabilitation pathways; Participates in guaranteeing the management of processes through the analysis, planning and re-engineering of care, care-giving, prevention and health promotion pathways and takes an active role in the promotion of innovation.; Promotes and implements research, organisational wellbeing, safety culture, clinical and professional risk reduction and supports staff motivation.; Encourages partnerships and alliances with citizens and patients. ; Encourages comprehensive care models for the individual and the use of goal-oriented planning methodologies, paying attention to economic sustainability.; Builds networks within the organisation with middle management, between different organisations on the same territory and between different regions to share practices.

integration of professionals according to the needs and demands of the diverse stakeholders. That is why the master's degree is the most suitable training pathway to qualify for this managerial position. This pathway will enable the acquisition of knowledge and skills useful for developing innovative models of care for the management of clinical and organisational complexity[7].

- **In the horizontal/clinical line**, it will be necessary to pursue the match between the demand and provision of specialized skills that can be acquired through diversified levels of training (hospital, regional and/or university) to be able to manage selected care processes for specific users. These professionals will be able to address the care demands arising from the changing health conditions of the population and their more complex needs (for example: stomatherapy nurses and nurse specialists in wound care, PICC device management Team, pain management nurse, infection risk, family and community nurse, surgery nurse, etc.). Particularly, it will be at the nursing master's degree level of responsibility to manage complexity both in inpatient and community-based patients. Nurses with a master's degree will practice with advanced skills and specialized knowledge, addressing the demands of patients and the organization itself.

Moving away from performance/task oriented logics, towards the implementation of organisational models supporting person-centred care and their caregivers

Even the **organizational context** in which health professional work should be redesigned to ensure also the humanization of patient care, as well as effectiveness and sustainability, in line with the changing socioeconomic and professional environment:

- Indeed, one of the most important quality conditions for an organizational setting is the humanization of care, which should be ensured to all patients. This means above all acting concretely on the principle that "time dedicated to relationship is caring time." A principle, the latter, made explicit only if the health care professionals involved in the organization are numerically adequate for the actual needs, if they have optimal working conditions, and if their skills are maximized and constantly innovated.
- It will be necessary to design and adopt organizational models that improve the organizational climate (organizational well-being).
- Organizational models for the delivery of nursing care will have to tackle the task-oriented logic and foster the development of high-quality contexts, whereby models and methods that ensure the implementation of person centred care.

[7] As far as management and organisational aspects are concerned, the document drawn up by SIDMI outlines the following role functions: Delivery of safe and quality care based on the best scientific evidence; Development of organisational models of care (hospital, community and proximity) supported by evidence and research; Participation in prevention programmes, health education and promotion of healthy lifestyles; Implementation and support of studies and research related to nursing; the identification of care outcomes; the definition of safe staffing; organisational well-being and any other process supporting data-driven management and the outcome of studies, including economic sustainability analyses of a data-driven direction and the result of studies, including economic sustainability analyses.

- The development of the nursing profession will also move away from mechanistic logic toward an organized system that would include nurse professionals within teams that are not only multiprofessional but, most importantly, strongly interprofessional in nature.

In summary, it is clear how the organizational context and the possibility of adopting qualitatively advanced models of care are strongly influenced by the nurse staffing levels. Currently, nurse staffing data, whereby patient outcomes, and staffing levels are associated with indicators of safety and quality of care, are macro-indicators that are already available in the literature and enable to inform decisions on this issue. In this respect, we believe it is essential to abandon the logic of “minutes of care” (defining minimum organizational requirements), and adopt the logic of nurse-patient ratios.

Health care staffing defined by nurse/patient ratio

In order to achieve the definition of a common professional language, since the times are still not ripe for implementing more advanced systems (professional taxonomies), we recommend Italian Universities and nursing researchers to develop a Nursing Minimum Data Set (NMDS) that is capable of including a minimum cluster of nursing data with a high information content, to detect healthcare outcomes. The use of a national NMDS will also enable a better assessment of the "Essential Levels of Care" (Livelli Essenziali di Assistenza - LEA) through the evidence of outcomes related to hospital and community care interventions.

Involvement of Italian universities and nursing researchers in the definition of a *Nursing Minimum Data Set*

Moreover, the outcomes measured through the NMDS will provide useful indicators for the further improvement of the services included in the LEAs, thus supporting a better match between offer and demand. The requirement to measure the outcomes of care will also help to identify measurement scales to be adopted at a national level, thus providing an important contribution to professional debate.

It is deemed appropriate to adopt a more effective strategy in the management of healthcare support workers who, to date, are not under the control of nursing management. In this regard, it is worthy to point out that the entire governance of the non-professional group of healthcare support workers should be trained and managed exclusively by nurses. It is therefore considered necessary to introduce a register for healthcare support workers, whether they are qualified or not.

We recommend the adoption of a new naming that, in line with what already exists internationally, involves the introduction of a new type of support worker, called the "Certified Nursing Assistant" (CNA). The CNA will work under the supervision of the registered nurse (with a bachelor’s or master’s degree), who will remain in charge of the governance, monitoring and evaluation of the nursing care plan, delegating to CNAs the activities they can perform autonomously.

Creation of a National Register for Certified Nursing Assistants

Finally, we believe that the time is ripe for a different "inclusion" of the human resource management (HRM) system in Italian healthcare organizations.

Within this framework, there is the need to encourage and regularise a close collaboration between HRM officers, nursing managers and coordinators, as well as with the nurses themselves, and thus transform the challenges posed by the changes into opportunities, to redesign the HRM functions and practices and adjust them to the new working conditions.

Introduction (where necessary) and strengthening of HRM systems

The time is ripe for strategic HRM, referring to the necessary vertical connection between HRM functions and organisational strategy, as well as the horizontal coherence between HRM functions (assessment, compensation, and staff development systems). The main objective, of course, will be to optimise the utilisation of nursing resources to meet the strategic demands of the organisation.

We believe that the recruitment of nursing staff requires innovative/evolved criteria that enable to identify individuals capable of meeting specific organisational demands. Such approaches should not only consider the knowledge and experience of the applicants but also their potential (in terms of cognitive skills, personality, etc.). Consistently, the assessment systems should adapt to the context of operational complexity in which healthcare professionals operate on a daily basis, shifting away from a purely task-based logic, adopting an approach that envisages objectives in line with the role expectations expressed by the organisation.

JURY PANEL CONCLUSIONS

1. **We agree that nursing director should hold a position of equal hierarchical standing with the top management team so that he/she may participate in the strategic management of the healthcare organisation and govern the overall healthcare process.**
2. **We agree that the coordinator role should be held by appropriately qualified (Master's degree level) and experienced staff, and not merely a post-graduate certification.**
3. **We deem it appropriate to abandon healthcare organisation models that exclusively envisage performance/task-based logics, in favour of organisational models that support the taking charge of the person and his/her caregivers.**
4. **We consider it essential to introduce - and take into consideration - the nursing/patient ratio concept in establishing the healthcare staffing levels.**
5. **We agree on the need to involve Italian universities and nursing researchers to establish a Nursing Minimum Data Set, with the aim of comparing and measuring the outcomes of nursing care on a national level.**
6. **We agree that the position and role of a new health professional, trained and managed by expert nurses, to be included in the healthcare settings, should be established.**
7. **We agree that these certified nursing assistants should be registered in a national register managed by FNOPI, to safeguard the citizens and organisations that will benefit from their services.**

Work Group 2

FNOPI Executive Board representative

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Methodological expert

- Federico Ceschel – University of Rome "Roma Tre"

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- **Annalisa Mandorino** – Secretary General of the Active Citizenship Network (ACN) "CittadinanzAttiva"
- **Maria Mongardi** – President of the Italian Scientific Society of Risk Infection Nurse Specialists (Società scientifica nazionale infermieri specialisti del rischio infettivo - ANIPIO)
- **Marco Rotondi** – President of the Neurosystemics European Institute (Istituto Europeo Neurosistemica - IEN)
- **Laura Stefanon –** President of the Italian Nursing Association for Wound Management (Associazione Infermieristica per lo Studio delle Lesioni Cutanee - AISLeC)
- **Angelo Tanese** – Premiership Executive Member – Professor of Organizational Models and Human Resource Management – Master's degree course in Health Economy and Management and Technological Innovation – Online University "San Raffaele".

Updating nursing undergraduate and specialized education in response to emerging needs

WORK GROUP 3

Changes to the educational framework to meet new role expectations

The required changes to the current educational framework should be defined starting from the general consideration that care outcomes, as supported by international literature[8], improve when care is delivered by experienced and prepared nurses. However, the Italian scenario is characterised by the co-presence of two phenomena: the dramatic shortage of nurses on the one hand, and the low appeal for those accessing the nursing profession .

The education framework should provide:

Level 1 – A three-year Bachelor's Degree in Nursing and first level master courses/ post-graduate specializations

With the Bachelor's degree nurses qualify to practice their profession with the aim of providing scientific, methodological, technical and relational knowledge base to support clinical reasoning in the main health, illness, and end-of-life conditions and developing skills to help patient to maintain and/or increase their autonomy through self-care.

The three-year undergraduate curriculum could be followed by a post-graduate course focusing on specific technical, educational, relational, and rehabilitation skills aimed at managing care problems across various types of populations, settings, or diseases by completing a “Level I” master course or postgraduate program.

Changes required to update the Bachelor’s Degree in nursing and 1st level master courses/specialisation programmes

Changes needed:

- Update the education program for the Nursing Bachelor's Degree
- Convert the Paediatric Nursing Bachelor's Degree Program into a post-graduate Master’s Degree (Pediatric Nurse Practitioner with a Masters' Degree).
- Update the competency profile of the Bachelor graduate in nursing.
- Revise post-graduate master courses
- A Memorandum of Understanding between the Ministry of University and Research (MUR) and the State-Regions Conference on quality criteria and nursing education standards.
- Update the protocols of intent between Regions-Universities.
- Requirements for lecturers of the Bachelor’s Nursing Degree Program: mandate that one of the faculty members must be a full professor or a MED/45 researcher with a fixed-term contract.

[8] Aiken LH, Sloane DM, Bruynell L, et al; RN4CAST consortium. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet 2014; 383: 1824-30

Level 2 - Master's degree in nursing and 2nd level Master courses

The Master's Degree in Nursing and Midwifery Sciences, which was established under Ministerial Decree No. 270/2004 with the Ministerial Decree of 8th January 2009, has focused over time on developing mainly soft research, management and pedagogical knowledge and skills.

The current context of the Italian healthcare system and the social and epidemiological changes require that nursing professionals acquire increasingly advanced knowledge and skills in order to respond effectively to both the emergence of new healthcare needs and the complexity of health and social care environments.

Orienting the Master's degree towards the acquisition of knowledge and skills for specific clinical areas

The need to refocus the Master's Degree towards the attainment of knowledge and skills for specific clinical areas is becoming increasingly evident. Therefore, following the Bachelor's degree, a Master's degree with a clinical focus is envisaged to gain deeper knowledge and advanced skills related in one specific area, through the integration of clinical expertise with research, organisational, and educational skills. We propose six areas: primary care and public health, neonatology and paediatrics, mental health and addictions, intensive and emergency care, medical care, surgical care.

Clinically specialised Master's degree nurses must be recognised for their role and activities, which are from those that have a Bachelor's degree, in line with what is already happening in many European countries (e.g. the possibility to prescribe certain medical aids).

With respect to managerial and educational contents: i) essential managerial notions must also be included in the clinical master's degree courses to enable to understand and run managerial processes for the good of the service users (coordination of services and healthcare areas); ii) the development of managerial/educational knowledge and skills for leadership roles and academic training must be warranted by specific post-Master's Degree programs, such as "2nd Level Master or other advanced courses.

The envisaged clinical areas for the Master's Degree programs, in accordance with Ministerial Decree no. 739/1994 are:

1. primary care and public health
2. neonatology and paediatrics
3. mental health and addictions
4. intensive and emergency care
5. medical care;
6. surgical care.

Amendments required:

- Review of the Master's Degree class SNT/1 (separate the Master's Degree in Nursing Sciences from the Master's Degree in Midwifery Sciences)
- New curriculum structure for the Master's Degree program (SNT1) in Clinical Nursing Sciences, subdivided into the 6 areas listed above
- Amendments to Law 43/06
- Update of the 2nd level Master course
- Master's Degree that enables to practice specific roles/activities

Changes needed to update the Master's Degree

Level 3 - Interprofessional Speciality Schools and PhDs

At the third cycle of higher education, following the Master's degree, the establishment of Inter-professional Specialisation Schools lasting at least three years is envisaged for the acquisition of specialisation in an area related to that achieved with the Master's degree.

Creation of Interprofessional Speciality Schools

The reconfirmation of the Doctoral Nursing Program, after the Master's degree, to develop nursing research skills and contribute to the publication of scientific papers in the field of nursing .

Finally, changes are deemed necessary in terms of legislation (e.g. Law 43/2006, Professional Profiles, etc.), public competitions, and job contracts so that the new professional profiles are consistently integrated and effectively increase the attractiveness of the profession at all levels. In particular, there is clearly the need to revise the professional profile of nurses (merging general nurses and paediatric nurses) and establish the competence profiles for nurses with post-graduate qualifications (i.e., Master's Degree on a specific clinical area).

Necessary changes in legislation

To ensure a response that is in tune with patients' complex demands, it is necessary to define the ratios between general nurses (i.e. with three-year undergraduate degree) and nurses with a Master's degree. It is assumed that the proportion of nurses with a master's degree should be at least 10-15% of those with a bachelor's degree.

JURY PANEL CONCLUSIONS

1. **We agree on the need to convert the Paediatric Nursing Degree Course into a specialised post-graduate qualification (i.e., nurses with a Master's Degree in Paediatrics and Neonatology).**
2. **We agree that there is a need to improve the quality of nursing education by proposing to the respective Minister a consistent recruitment plan that would enable to increase in the number of full-time professors of nursing, to avoid a negative impact on the other nursing degree courses currently running.**
3. **We reckon that Clinical Master's degrees should be developed in the following areas (most of which are already set out in the Ministerial Decree 739/1994): primary care and public health, neonatology and paediatrics, mental health and addictions, geriatrics, emergency intensive care, general medical care, general surgical care.**
4. **We agree that the development of managerial knowledge and skills for executive roles must be ensured by through dedicated post-Master's degree programs, such as "Level II" Master courses or other higher education courses.**
5. **We agree that the Clinical Master's degree is an qualification that entitles to practice as a nurse with advanced skills, as well as specific roles and activities that conducted by nurses with a three-year undergraduate degree (e.g. to prescribe certain types of medical products).**
6. **We deem it necessary to envisage the establishment of inter-professional speciality schools, for instance in the field of primary care and public health, or palliative care.**

Work Group 3

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- **Cesare Giovanni Moro** – President of the Italian Society of Mental Health Nursing Sciences (SISISM) – Nursing Manager of the DSM-D Community Services, Community Social Healthcare Centre of Treviglio Bergamo Ovest
- **Silvia Scelsi** – President of the Italian Association of Critical Care Nurses (ANIARTI)
- **Daniela Tartaglini** – Vice-president of the Italian Society of Nursing Directors (SIDMI)

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