

Building the Architecture of Nursing Professional Identity: A Position Paper From Italian Scientific Societies at The Nursing Forum 2026

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Abstract

Introduction. The publication in the Italian Official Gazette (12 May 2026) of the decree activating second-cycle clinical Master's tracks (primary care; intensive and emergency care; pediatric) has reopened a long-standing question about how specialist practice and advanced practice can be combined in concrete professional exercise. Nursing scientific societies have a stake in this transition as cultural infrastructures that connect education, regulation, the labor market, and health-service implementation.

Objective. To develop a shared, policy-oriented position on how nursing scientific societies can contribute to the architecture of

professional identity in Italy, using the roundtable discussion held at The Nursing Forum 2026 as the primary deliberative material.

Methods. Documentary qualitative analysis of the full roundtable transcript (eight societies plus the chair) combined with reflexive thematic analysis and exploratory lexicometric analysis (word and n-gram frequencies, keyword-in-context, term co-occurrence). The position-development process was iterative, with checkpoint-based validation by the writing group.

Findings and position statements. Seven themes were identified, from which nine numbered position statements were derived, addressing professional identity as social mandate; the distinction and connection between specialist and advanced practice; competency frameworks as shared language; validation of specialist education; alignment of the new Master's degrees with workforce planning, accreditation and contracts; explicit workforce numbers; safe attribution and visibility in information systems; outcomes as the ultimate criterion; and scientific societies as cultural infrastructure.

Conclusions. Professional identity should be anchored in nursing's social mandate and made visible, accountable, and measurable. Scientific societies can connect education, competencies, accreditation, and policy, provided that workforce numbers and contractual recognition are addressed in parallel. This document is a position paper informed by a roundtable discussion; formal multi-society consensus would require the documented endorsement process described herein.

Keyword: Nursing, Professional Identity, Advanced Practice Nursing, Specialist Nursing, Scientific Societies, Competency-Based Education, Health Policy, Workforce Planning

Introduction

Across Europe, the organization of nursing education follows a three-cycle university structure, with the first cycle (the bachelor's degree) providing the foundation for professional preparation, and subsequent cycles articulating more advanced levels of practice (Cumming, 2010; Davies, 2017). In Italy, the field of nursing activity is defined by the convergence of three normative pillars: the professional profile (Decree of the President of the Republic 739/1994), the deontological code, and the educational curricula of basic and post-basic training, as established by Law 42/1999 (Legge Italiana n. 42/1999). Within this framework, the recent decree published in the

Italian Official Gazette on 12 May 2026 activated second-cycle clinical Master's tracks with three specialist orientations, i.e., primary care, intensive and emergency care, and paediatric care, alongside the reconfigured Master's degree in nursing science and the Master's degree in midwifery science (Ministero dell'Università e della Ricerca, 2026).

This development has crystallized a question that nursing scientific societies had already been discussing informally for several years, particularly since the post-pandemic period (Casey & O'Connor, 2022; De Caro, 2022; Fosah & Llahana, 2025; Kilpatrick et al., 2024; Morin Galfout et al., 2025): how can specialist practice and advanced practice be combined in a concrete, sustainable model of professional

exercise? The question is practical in its formulation, but structural in its implications. It concerns not only education, but also the position of nursing within an ecosystem composed of universities, professional orders, collective bargaining, and scientific societies: the actors that educate, regulate, define labor-market recognition, and provide cultural representation of specific or cross-cutting domains of nursing knowledge.

The Nursing Forum 2026, held in Florence (Italy), provided a deliberative setting in which this question could be addressed collectively within the Italian ecosystem. During the round table “The architecture of professional identity: scientific societies in dialogue”, eight Italian nursing scientific societies and the chair discussed the relationship between specialist education, advanced practice, competencies, professional visibility, and policy recognition. This position paper draws on the roundtable discussion as its primary source material and uses professional identity as its point of departure. Identity is understood not as a self-referential definition, but as the social recognition of nursing’s mandate.

As articulated by the chair:

“how society sees us is the true professional identity, regardless of what we think we are and do; we are, in fact, how well we manage to make ourselves visible in relation to our mandate — to respond well to the mandate that citizens have given us.” — Chair (AIIAO)

On this basis, the present position paper synthesizes the contributions of eight nursing scientific societies into a transparent, policy-oriented set of position statements concerning education, specialist and advanced practice, competencies, and the role of scientific societies in the architecture of professional identity.

Methods

Design and source material

We adopted a hybrid design appropriate to a position paper: documentary qualitative analysis of a single roundtable discussion (“Document Analysis,” 2018), complemented by exploratory lexicometric analysis to support transparency (Breyer & Schemmann, 2018; Tristl et al., 2015).

The primary analytic corpus was the full verbatim transcript of the round table “The architecture of professional identity: scientific societies in dialogue”, held at The Nursing Forum on 24 May 2026. The projected slide and the organizers’ briefing letter were treated as contextual sources rather than as part of the analyzed corpus.

Eight societies contributed substantive turns: AICO (surgical/operating-room area), AISLEC (wound care and skin integrity), ANIARTI (intensive and emergency care), the Accademia Scienze Infermieristiche (a discipline-oriented, non-clinical-area society), SIAN (nephrology area), ANIN (neuroscience nursing), ANIPIO (infection prevention and control), and SIMMED (clinical simulation). Following the round table, four additional societies—CNAI (Consociazione Nazionale Associazioni Infermiere/i), SIDMI (Società Italiana per la Direzione e il Management delle Professioni Infermieristiche), ANIMO (Associazione Nazionale Infermieri di Medicina) and SIN INF (Italian Society of Neonatology Nursing)—provided written contributions and participated in the iterative revision and endorsement process. Collectively, the societies involved in the round table and subsequent development of this document represent some of the most established and representative scientific and professional nursing organizations within the Italian nursing landscape. The chair’s moderation turns were retained, analyzed separately, and not counted as society positions. Figure 1 shows the methodological workflow adopted in this position paper.

Transcript preparation

The transcript was cleaned by removing disfluencies and fillers only where this did not alter meaning, while preserving verbatim any sentence used as a quotation. Speaker turns were normalized to society labels, and the chair’s moderation was distinguished from substantive contributions (Acocella & Cataldi, 2021). No correction altered the substance of any society’s position. Because the corpus is in Italian and the journal is in English, representative extracts are presented in English in the body of the paper, with the original Italian provided in the Supplementary Materials (Younas et al., 2022). Quotations are attributed to societies rather

than to individuals.

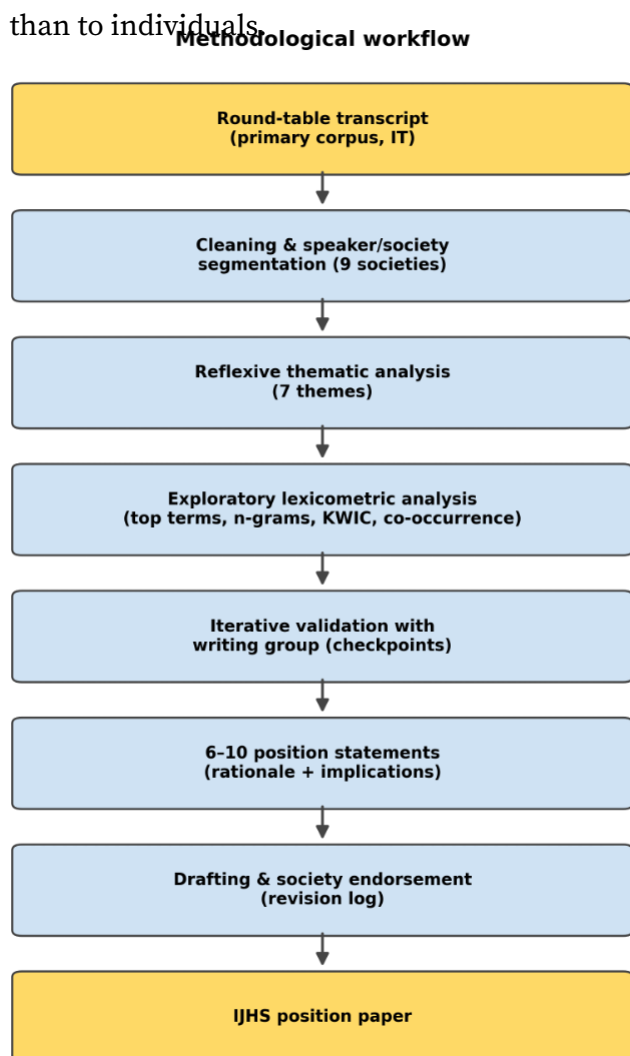


Figure 1. Methodological workflow, from the round-table transcript to the position paper.

Thematic analysis

We conducted a reflexive thematic analysis of the segmented corpus, identifying candidate themes inductively and validating them iteratively with the writing group (Braun & Clarke, 2022). Seven themes were agreed (See Section 3). Each theme was documented with a definition, contributing societies, and representative extracts in a thematic-analysis matrix (See Supplementary Materials).

Exploratory lexicometric analysis

To support transparency rather than to provide primary evidence, we computed word-frequency and n-gram (bigram/trigram) distributions over the society turns, keyword-in-context

concordances for salient terms, and a term co-occurrence network (Fielding, 2012). A word cloud is included as an illustrative figure only. Given that the corpus comprises eight substantive turns, all lexicometric outputs are descriptive and exploratory; no statistical inference is drawn from them.

Exploratory rhetorical-orientation analysis

An exploratory lexicon-based polarity measure was further computed (markers of constructive/proposal-oriented versus problem/constraint-oriented language per 100 tokens), with the seed lexicon fully documented for reproducibility (Supplementary Materials) (Fielding, 2012). This measure captures surface-level lexical polarity only. It is explicitly not a measure of speakers' emotions or attitudes, and (with only eight turns) supports no inference; it is reported solely as an exploratory descriptive signal (Guetterman et al., 2015).

Position-development and endorsement process

Themes were translated into numbered position statements, each with a rationale and implications for education, practice, and policy, and an indication of responsible actors (Fielding, 2012). Statements were approved point by point by the writing group. The transition from the round table to the position statements, and any subsequent endorsement by the participating societies, is tracked in a revision and endorsement log. Until documented multi-society endorsement is recorded, this document is designated a position paper informed by a roundtable discussion rather than a formal consensus statement.

Ethics statement

This work is a documentary analysis of a public professional roundtable discussion and a deliberative position-development process; it does not involve human subjects research.

Findings from the round table

The lexicometric profile of the corpus is consistent with the qualitative reading: the

most frequent content terms were societies, competencies, area, professional, identity, practice, advanced, Master, education, and patient; the most frequent bigrams included scientific societies, advanced practice, professional identity, Master's degree, critical care, wound care, specialist competencies, and depth of practice (Figure 2). Seven themes structure the findings (Figure 3).

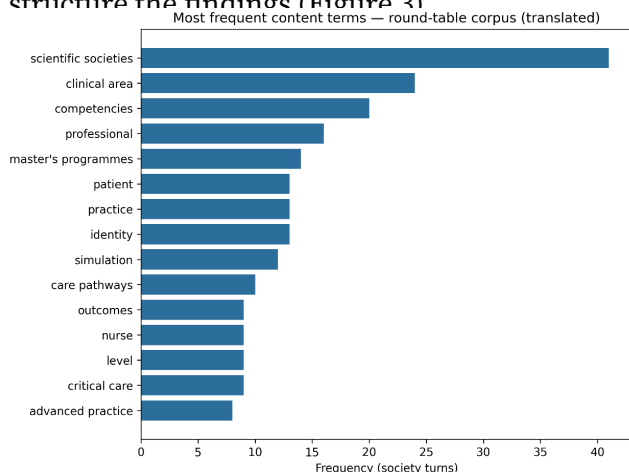


Figure 2. Most frequent content terms across society turns (translated labels).

of nursing's mandate and, therefore, as "something that must be made visible". The discipline-oriented society (ASI) stressed that the profession "disappears" if it does not make its specific contribution and use its own language, emphasizing the need for a clear, taxonomic language that can identify the specific health problems nurses address. Infection prevention and control colleagues similarly argued for unity as a precondition of identity. Across the discussion, professional identity emerged as dependent on several foundational prerequisites: a social mandate, a shared disciplinary language, recognized nursing knowledge, competency-based practice, coherent educational pathways, professional visibility, and collective representation through scientific societies, while respecting the institutional functions of professional orders, universities, and the competent regulatory authorities.

The common idea is shaped by the view that professional identity originates in the social function entrusted to the profession. Nursing exists because society recognizes a specific contribution to health and care outcomes.

Architecture of nursing professional identity - thematic map

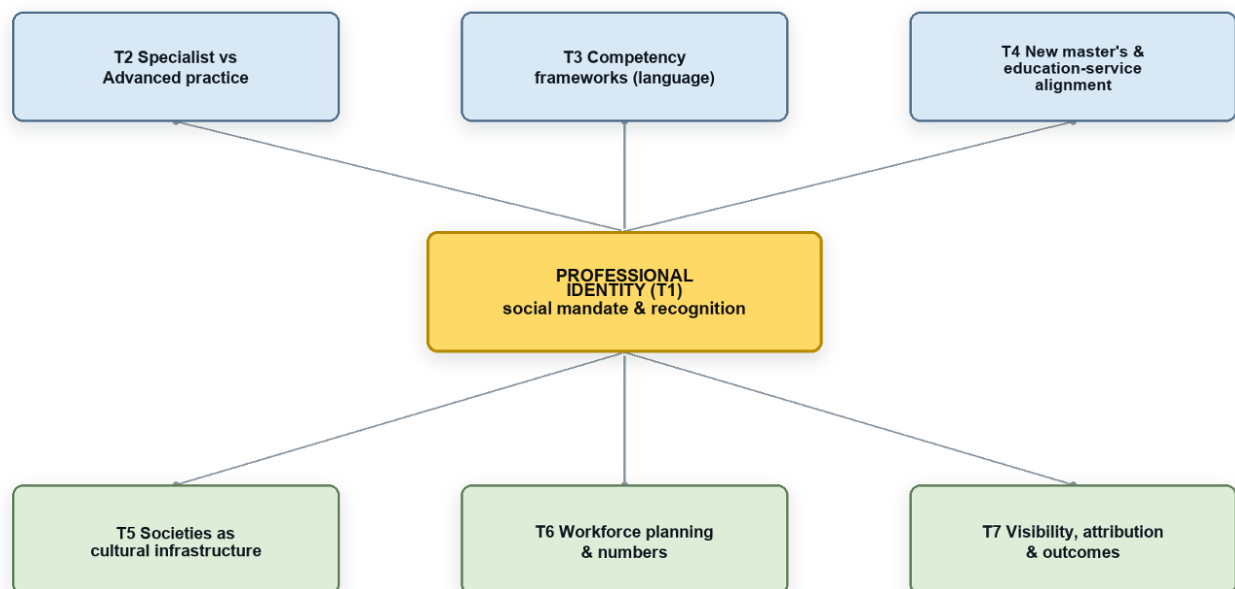


Figure 3. Thematic map: seven themes around professional identity.

Professional identity as social mandate and recognition

Identity was framed as the social recognition

Consequently, identity cannot be reduced to a list of tasks or organizational roles but must remain anchored to the profession's responsibility toward

citizens, patients, families, and communities. Professional identity requires a scientific and disciplinary foundation that distinguishes nursing knowledge from that of other professions while maintaining interdisciplinarity. Scientific societies play a key role in curating, updating, and disseminating this body of knowledge. This role should be understood as a scientific, cultural, and technical-professional contribution, not as a substitute for the institutional responsibilities related to representation, regulation, accreditation, or public workforce planning. In this regard, identity becomes credible when it is translated into competencies that can be observed, assessed, and entrusted. Competency frameworks therefore represent a bridge between disciplinary identity and professional practice.

CNAI contributed to the post-roundtable development of this position paper by sharing a written reflection that converged with the central premise that professional identity is rooted in the ICN definitions of “Nursing” and “Nurse”, highlighting that nursing encompasses autonomous and collaborative care, advocacy, and the promotion of a safe environment (Consociazione Nazionale Associazioni Infermiere/i & Network delle Organizzazioni Infermieristiche Italiane, 2023; White et al., 2025). From this perspective, professional identity cannot be reduced to role occupancy or task lists, but should be understood as the visible expression of a distinct nursing contribution, supported by disciplinary knowledge, clinical judgment, advocacy, and responsibility for outcomes. This definitional clarification is particularly relevant when distinguishing between generalist nursing, specialist nursing, and advanced nursing practice, which should be conceptualized as connected but not interchangeable levels of professional development.

Considering post-roundtable contributions, SIN INF profoundly redefines the profession's social mandate through the lens of caring for vulnerable newborns and their immediate families. This integration establishes that the social responsibility of neonatal nursing is not limited to managing the extremely high level of technological complexity typical of intensive care. Rather, it is fully realized through the provision of holistic and safe care grounded in Family-Centred Care and in highly advanced care models integrated into approaches such as Case Management or Primary Nursing.

Identity must also be supported by a National Human Resources Plan that guarantees dignity, safety, and the value of human capital, recognizing that a well-supported nursing workforce is essential for the sustainability and equity of the Italian National Health Service.

Professional identity should develop longitudinally through undergraduate education, postgraduate specialist preparation, advanced practice pathways, and continuing professional development. Fragmented educational systems risk generating fragmented professional identities. Identity cannot be sustained if nursing contributions remain invisible in organizational processes, information systems, workforce planning, and outcome measurement. Visibility is therefore not a consequence of identity alone but an enabling condition of it.

Theme 2 — Specialist versus advanced practice: horizontal breadth and vertical depth

Several societies distinguished a horizontal axis (breadth of specialist application across an area) from a vertical axis (depth and professional autonomy). The intensive-care society illustrated the horizontal axis by technical complexity of care (for example, prone positioning, extracorporeal therapies, continuous renal replacement therapy) and the vertical axis by the exercise of autonomy in higher-order decisions oriented toward patient outcomes beyond the intensive care unit. Evidence relating to neonatal nursing care shows that specialist and advanced practice cannot be reduced to technological complexity alone. Advanced skills in neonatal nursing integrate clinical judgment, interpersonal and educational skills, infection prevention and continuity of care, demonstrating that the depth of the practice stems from the integration of multiple areas of expertise rather than from the accumulation of isolated tasks. The discipline-oriented society invoked the novice-to-expert trajectory (Benner, 1984), noting that a specialist entering a new clinical context is still, in expertise terms, a novice, and warning that:

“advanced nursing practice risks becoming a limited medical practice.” — Accademia Scienze Infermieristiche (ASI).

During the post-roundtable refinement, CNAI

noted that this distinction is included in the European Federation of Nurses Associations (EFN) 3+1 matrix and the ICN guidelines as well (European Federation of Nurses Associations [EFN], 2024; Schober et al., 2020). In this regard, specialist practice usually involves in-depth competence acquired through post-basic education in specific clinical areas. In contrast, globally Advanced Practice Nursing (APN) represents an extended and expanded level of professional practice (scope of practice), requiring at least a Master's degree (Laurea Magistrale - 120 CFU) and a dedicated scope of practice. APN therefore integrates expert knowledge, complex decision-making skills, and expanded autonomy, including pharmacological prescribing authority, and should not be confused with task shifting or simple medical delegation.

Drawing on Benner's Novice to Expert framework, ASI argued that specialist competence and expert competence should not be considered synonymous (Benner, 1984). Specialist competence refers to the acquisition of knowledge and skills within a specific clinical field, whereas expertise represents the progressive development of clinical judgment, contextual understanding, and interpretative capacity through experience. From this perspective, advanced nursing practice should be conceived as the progressive development of nursing expertise rather than merely an expansion of technical functions or the delegation of medical activities. Expertise integrates disciplinary knowledge, reflective practice, clinical judgment, research, and professional autonomy, and should therefore remain firmly grounded in the epistemological foundations of nursing. This perspective reinforces the distinction between specialist preparation and advanced practice, highlighting that professional growth is characterized not only by increasing complexity of practice but also by the maturation of disciplinary identity and responsibility.

Theme 3 — Competency frameworks as the operational language

A recurrent position was that competencies, rather than titles or certificates, should be the unit of professional definition, and that competencies become definable when linked

to a concrete health outcome. The wound-care society put it directly:

"[...]more than a matter of titles or certificates, what matters is competencies — certifying competencies; as in many European countries, scientific societies must and can certify these competencies." — AISLEC

At the same time, SIN INF emphasizes, in a post-round-table contribution, the urgent need to develop advanced expertise in neonatology and pediatrics. This model not only addresses the clinical-technological complexity of intensive care units but also redefines Family-Centered Care, making relational and therapeutic education competencies for families integral to safety protocols and infection prevention.

Concrete examples were offered: the intensive-care society described a core-competence set built on the Synergy Model and the Tuning framework (Gobbi & Kaunonen, 2018; Nania et al., 2021), defining eighteen competencies anchored to patient, family, organizational and professional outcomes; the nephrology society structured its competencies on the European Specialist Nurses Organizations (ESNO) framework across three levels (horizontal, specialist and advanced) (European Specialist Nurses Organisations [ESNO], 2015). The surgical society's reference framework is the European Operating Room Nurse Association (EORNA) Common Core Curriculum for Perioperative Nursing, structured on five Core Competency Domains (European Operating Room Nurses Association [EORNA], 2019).

The Synergy Model's premise — that patients' characteristics drive nurses' competencies, with optimal outcomes when the two are matched — was treated as a means of giving competencies concrete, outcome-anchored meaning.

The progressive increase in life expectancy has driven an epidemiological transition characterized by a shift in the burden of care from acute to chronic-degenerative diseases. Within Internal Medicine units, this phenomenon is leading to a metamorphosis of the patient population: the acute event is no longer the exception, while the elderly patient with multiple comorbidities and complex clinical care is the norm. Against this backdrop, the Italian Association of Internal Medicine Nurses (ANIMO) aims to redefine the Levels of Care

Intensity, rendering rigid organizational models obsolete and requiring advanced and specialized competencies.

A significant contribution in this area has been made by ANIPIO, which has developed a competency framework for nurses specializing in infection prevention and control. Healthcare-associated infections (HAIs) remain among the most common and preventable adverse events in healthcare settings. At the same time, antimicrobial resistance (AMR) has emerged as one of the most pressing global public health challenges and is expected to exert an increasingly substantial impact in the coming decades, according to the World Health Organization (World Health Organization [WHO], 2022, 2023).

In Italy, both the National Action Plan on Antimicrobial Resistance (PNCAR) 2022–2025 and the National Prevention Plan 2020–2025 identify healthcare-associated infections and antimicrobial resistance as major public health priorities, calling for robust surveillance and infection control systems (Ministero della Salute, 2020, 2022). At the European level, the European Center for Disease Prevention and Control (ECDC) has established core competencies for infection prevention and control professionals, explicitly recognizing specialist infection prevention and control nurses as integral members of prevention programs (European Centre for Disease Prevention and Control [ECDC], 2013). The competency framework developed by ANIPIO operationalizes these recommendations by translating them into observable, outcome-based competencies, consistent with the competency-based approaches promoted by other scientific societies.

From this perspective, the competency frameworks developed by scientific societies should be regarded as tools for scientific and professional guidance, useful for fostering a common language, the comparability of training programs and consistency between training and practice. They do not replace university regulations, institutional accreditation processes or the regulatory functions of the competent bodies.

Theme 4 – New clinical Master's degrees and education–service–contract alignment

Societies welcomed the new clinical Master's

tracks but warned of misalignment between education, service accreditation, job descriptions, and contracts. The chair noted that, unlike medical specialties – for which accreditation rules embed a required quota of specialists per operating unit – nursing specialization is:

“[...] not in the genetic code of accreditation”
– Chair (AIIAO)

so that the number of specialists required remains invisible, and professional assignments struggle to move from a virtuous exception to a systemic rule. The surgical-area society added two issues: first, the lack of a specialization program in the surgical field, as foreseen in the consensus document (Federazione Nazionale degli Ordini delle Professioni Infermieristiche [FNOPI], 2023), which creates a gap with other areas and leaves an entire healthcare sector without specialized nurses who would be responsible for managing entire parts of the surgical process, a highly strategic process like the surgical pathway. The second issue is a temporal caution: two to three years will be needed before the first master's-level specialists graduate (DM 159/2026) (Ministero dell'Università e della Ricerca, 2026), more time to reach a critical mass that services can absorb, and for a long time, in the surgical area, if the gap with the other specialization will not close quickly.

CNAI contributions in the post-roundtable development of this position paper further suggest that educational reform should be accompanied by a systematic integration of universities and the National Health Service, including stronger clinical-academic partnerships, the development of clinical teaching roles, and clearer correspondence between educational pathways and actual functions within services. Without such alignment, specialist and advanced education risks generating titles without roles, or expectations without contractual and organizational recognition. From this perspective, specialist and advanced pathways should present explicit links between post-basic education, recognized expertise, service needs, and employment conditions.

Considering the content of the roundtable discussion, the perceived issue is therefore not only the quality of the new educational pathways, but also the need to accompany these innovations with a broad institutional dialogue involving

universities, scientific societies, professional orders, regions, employers, and the competent authorities, avoiding role overlaps and fostering progressive alignment between education, service needs, and professional recognition.

Theme 5 — Scientific societies as cultural infrastructure and inter-society collaboration

Societies positioned themselves as cultural infrastructures rather than corporate actors, with a role in promoting scientific quality, producing knowledge, proposing competency frameworks, and offering non-binding expert review of educational pathways. Beyond validating educational pathways and supporting inter-society collaboration, scientific societies were recognized as key actors in preserving and advancing nursing disciplinary knowledge. The discussion highlighted their role in strengthening professional identity, supporting the development of expertise, and promoting shared conceptual frameworks across different fields of nursing practice. The Nephrology Society (SIAN) argued that, given the qualitative heterogeneity of existing Master's degrees, scientific societies could provide specialized expertise and forms of scientific support, where requested or agreed upon with universities, without, however, considering such contributions as an institutional validation of university programs. The simulation society described clinical simulation as a strategic educational infrastructure and a means of building a common, interprofessional language, noting that simulation "is the moment in which specialization meets integration". The chair repeatedly emphasized inter-society collaboration as essential to the credibility of the profession's collective voice (for example, in producing guidelines and good-practice documents). In line with this perspective, ASI further highlighted that scientific societies contribute not only to preserving nursing disciplinary knowledge but also to advancing the discipline through conceptual development, scientific debate, and the generation of new disciplinary knowledge.

Within this framework, the role of scientific societies should be clearly distinguished from that of professional orders, universities, and public institutions: societies contribute evidence, expertise, methods, and proposals; institutional bodies retain their respective responsibilities

for representation, regulation, planning, accreditation, and formal recognition.

Theme 6 — Workforce planning, numbers and system sustainability

Defining competencies, several speakers noted, implicitly raises the question of how many specialist and advanced nurses are needed. The discussion referenced approximately 20,000 programmed nursing places against roughly 17,000 enrolments, and a parallel debate on expanding medical places to 30,000, as figures reported during the Forum. Competence, in this reading, is also a matter of "who does what" within the National Health Service and of the workforce composition required to sustain it.

CNAI brought to the forefront, in its post-roundtable, some critical data, highlighting the dramatic nursing shortage in Italy. Compared with European benchmarks, Italy faces a substantial nursing shortage. Although estimates vary according to the benchmark and calculation method, ranging from well over 100,000 nurses in some comparative analyses to the 65,000 shortfall reported by the Corte dei Conti (Relazione sul Rendiconto Generale dello Stato 2024), the convergence of these figures indicates that the shortage is structurally significant and cannot be reduced to a merely technical dispute over absolute numbers. CNAI stressed that bridging this gap is not just a clinical necessity but an economic imperative: global evidence shows that every dollar invested in health and the nursing workforce yields a return of 2 to 4 dollars (ICN, 2025). Therefore, defining competencies and "real" advanced roles must be coupled with urgent, structural investments to retain experienced professionals and attract new generations, preventing the hemorrhage of nurses to the private sector or abroad.

Beyond educational pathways, the discussion emphasized that specialist and advanced practice require explicit workforce planning mechanisms capable of determining how many professionals are needed, in which clinical areas, and at what level of expertise (Caruso & Stievano, 2026). In this perspective, competencies are not merely educational constructs but instruments for organizing service delivery, defining professional responsibilities, and ensuring the long-term sustainability of the National Health Service. The question of specialist and advanced

practice, therefore, becomes inseparable from a broader reflection on workforce composition, skill mix, and the allocation of professional responsibilities across the healthcare system.

The contribution of scientific societies to this reflection should be understood as technical-scientific support for interpreting clinical-care needs, describing competencies, and defining criteria of appropriateness, while planning and regulatory decisions remain the responsibility of the designated institutional actors.

Theme 7 — Visibility, standardization, safe attribution, and outcomes

The final cluster concerned the visibility of nursing contributions in information systems and the safe attribution of standardized activities. The wound-care society observed that when a nurse's prescription is countersigned by another professional, the record of that activity enters the data flow of another profession rather than the nursing data flow, with consequences for how the nursing contribution is valued. The neuroscience society linked the new degrees to governing care pathways, prescribing devices, and managing follow-up processes under Decree 77/2022.

Under this theme, CNAI strongly advocated for the formal recognition of nursing prescribing authority as a core component of advanced practice. Drawing on ICN guidelines, CNAI argued that granting nurses the authority to prescribe medications, devices, and diagnostic tests improves timely access to care, reduces hospital admissions, and maximizes the healthcare team's efficiency, yet the actual reform of education does not seem to address this urgent need to improve access to care (Stewart et al., 2021). This authority must be legally protected and visible in national health information systems to accurately reflect the value generated by nursing care. CNAI has also argued that nursing work should no longer be treated as an indistinct cost component or a generic assistance layer, but should become visible through standardized terminologies (i.e. SNOMED CT), attributable data flows, and outcome-sensitive information systems. In particular, the use of recognized nursing languages and classifications may support the representation of nursing assessments, interventions, and outcomes in digital infrastructures, reducing the persistent under-recording of nursing value in health-

service datasets.

The scientific society ANIPIO has emphasized the need to develop and promote the Specialist Nurse in Infection Risk (ISRI) role, highlighting that specialist skills must be clearly recognizable, standardized, and traceable within organizational and information systems. From this perspective, the ISRI exemplifies advanced expertise focused on measuring outcomes, governing infection prevention and control processes, and generating data useful for documenting the impact of nursing care on patient safety. The ability to appropriately assign, record, and monitor these activities has been identified as an essential condition for ensuring visibility of the nursing contribution and for linking specialist competencies to clinical and organizational outcomes.

The position of ANIMO (Italian Association of Internal Medicine Nurses) addresses the core of today's healthcare challenge: the transition of care. With an aging population and the increase in chronic conditions, clinical complexity no longer ends at hospital discharge but extends into the community. To ensure true continuity of care, the community network cannot limit itself to basic services; it requires professionals with advanced skills. Shifting the focus of care to the community does not mean lowering the level of care, but rather enhancing expertise where the patient lives.

Across these themes, each post-round-table contribution adds a complementary perspective to the broader discussion (e.g., CNAI's comments), particularly around three interconnected propositions: nursing identity should be grounded in a clear definition of nursing care; specialist and advanced roles require explicit progression and recognition; and workforce sustainability depends on parallel action on staffing, leadership, education, and contractual visibility. Here too, the objective is not to attribute a regulatory role to scientific societies and professional associations, but to value the role of defining disciplinary standards, competency frameworks, scientific guidance, and criteria that may inform certification and accreditation processes, because their legitimacy lies in scientific expertise and professional knowledge development, useful for dialogue with institutions, healthcare organizations, and regulatory bodies.

Position statements

From the seven themes, the writing group

derived nine numbered position statements. Each statement is accompanied by its rationale and by implications for education (E), practice (P) and policy (Pol), with an indication of responsible actors.

Position statements should be read as scientific and professional contributions to the debate, not as legislative acts or as positions that replace the institutional responsibilities of the relevant institutional bodies, regions, or social partners. Their objective is to promote a collaborative, informed, and interinstitutional dialogue on the potential development of specialized and advanced nursing education.

Position statement 1 — Anchor identity in the social mandate

Statement. Nursing professional identity must be anchored in its social mandate: the capacity to make the nursing contribution to citizens' health visible, accountable, and measurable.

Rationale. Identity is the social recognition of the professional mandate; what is not made visible cannot be recognized, funded, or accredited.

Implications. E: emphasize disciplinary specificity and a clear, taxonomic professional language. P: document and communicate the nursing contribution. Pol: recognize nursing-attributable outcomes. Actors: societies, universities, professional orders, each within their respective functions.

Position statement 2 — Distinguish, and connect, specialist and advanced practice

Statement. Specialist practice (horizontal breadth across an area) and advanced practice (vertical depth and autonomy) are distinct and should be connected through explicit competency frameworks, progressive levels of expertise, and clearly defined degrees of professional autonomy, rather than being treated as synonyms.

Rationale. Conflating the two risks reduces advanced practice to a "limited medical practice" and obscures the clinical expertise that defines it. Advanced practice should be understood as the progressive development of expertise and professional autonomy rather than solely as the acquisition of additional tasks or functions.

This distinction is consistent with frameworks

that describe specialist nursing as in-depth competence within a field and advanced practice as an expanded level of professional practice with broader autonomy and decision-making.

Implications. E: curricula that differentiate levels (including novice-to-expert progression). P: define the scope and autonomy of each level. Pol: recognize levels in job descriptions and contracts. Actors: universities, societies, employers.

Position statement 3 — Use competency frameworks as a shared, outcome-anchored language

Statement. Scientific societies should co-develop, update, and validate competency frameworks in their domains, linking competencies to patient, family, professional and organizational outcomes (for example, Synergy, Tuning, ESNO, EORNA).

Rationale. Competencies become operationally definable when anchored to concrete outcomes; societies hold the clinical know-how that universities need.

Implications. E: scientific societies contribute clinical competence content to curricula and clinical placements/simulation, when involved by universities or within formalized collaborations. P: outcome-anchored competence assessment. Pol: possible reference to frameworks in technical dialogue and professional development processes, without giving such frameworks an automatically regulatory or accrediting nature. Actors: scientific societies, universities, professional orders, competent institutions, and healthcare organizations.

Position statement 4 — Validate specialist education, and preserve first-level Master's programs for horizontal competence

Statement. Given the potential heterogeneity of existing Master's degrees, scientific societies may be able to offer, in a collaborative and non-binding manner, technical and scientific support for the specialized content of training programs. The 60-ECTS first-level Master's degrees should be preserved as useful tools for developing transversal skills and clinical and professional development.

Rationale. Existing programs may differ in their aims, structures, and specialist contents. Scientific societies could offer expert input

or technical-scientific support on specialist content, upon request or agreement with relevant academic and institutional stakeholders, without constituting institutional validation of university master's programs.

Implications. E: Develop shared reference criteria for specialist training, as a guiding, non-prescriptive basis for dialogue, where appropriate. P: Support specialist training aligned with the needs of clinical care and the development of professional skills. Pol: Promote dialogue between scientific societies, universities, professional associations, and competent institutions. Actors: Scientific societies, universities, professional associations, and competent institutions, according to their respective roles.

Position statement 5 — Align the new clinical Master's degrees with workforce planning, accreditation, job descriptions and contracts

Statement. The three new clinical Master's tracks (Official Gazette, 12 May 2026) require parallel policy work to avoid misalignment between education, service accreditation, job roles and collective bargaining. The other three clinical Master's tracks (Mental health and addictions area, Medical Area and Surgical Area) (FNOPI, 2023) should be activated as soon as possible. A terminological clarification is essential: in the Italian system the second-cycle laurea magistrale (Master of Science) is supported by ministerial curricular tables (ordinamenti didattici) and fully satisfies the three guiding criteria of Law 42/1999 (professional profile, DM 739/1994; the current deontological code; and the curricula of basic and post-basic education), whereas one-year 60-ECTS Master's programmes correspond to postgraduate diplomas that fill cultural gaps in the curricula but are not supported by ministerial tables defining their content and are therefore valuable yet context-dependent deepening chosen by individual universities. In this light, it may be useful to initiate a shared reflection on the current interpretative and applicative relevance of Law 43/2006, with a view to clarifying the relationship between qualifications, specialist functions, advanced practice, and professional recognition.

Rationale. Without parallel governance, education risks outpacing the system's capacity to recognize and deploy graduates; conflating the MSc and the postgraduate diploma creates ambiguity about which qualification underpins

specialist and advanced roles.

Alignment should also include clearer integration between universities and services, and transparent progression routes connecting education, recognized competence, organizational role, and contractual recognition.

The reflection on Law 43/2006 should not be understood as a unilateral request for legislative revision by scientific societies, but as an invitation to a broad, cautious, and participatory institutional dialogue involving FNOPI, professional orders, universities, MUR, the Ministry of Health, regions, and social partners.

Implications. E: distinguish MSc degrees from postgraduate diplomas in qualification frameworks and educational language. P: define roles tied to the appropriate qualification, through shared processes with the competent professional, academic, and organizational institutions. Pol: promote dialogue on the possible harmonization of the regulatory and contractual framework, without formulating a prescriptive request for legislative revision, and assess ways of progressively recognizing specialist roles consistent with system needs. Actors: ministry, MUR, ARAN/social partners, regions, universities, scientific societies, FNOPI, professional orders, and healthcare organizations.

Position statement 6 — Make workforce numbers explicit

Statement. Defining competencies implies specifying how many specialist and advanced nurses are needed; these numbers must be made explicit in workforce planning and service-accreditation requirements.

Rationale. Unlike medical specialties, nursing specialization is not clearly recognized by accreditation quotas, keeping required numbers invisible and undermining the sustainability of the NHS.

Implications. E: align program intake with need. P: staffing models reflecting specialist roles. Pol: embed specialist-nurse quotas in accreditation and planning. Actors: ministry, regions, employers, scientific societies, professional orders, and other competent institutional bodies.

Position statement 7 — Ensure safe attribution and visibility in information systems

Statement. Standardized protocols and delegation/attribution models should protect safety while enabling appropriate use of specialist knowledge; the specialist and advanced nursing contribution (including autonomous nursing prescribing authority where applicable)

must become visible in information flows, prescriptions and quality indicators, within the limits and according to the modalities established by the current regulatory, organizational, and professional framework.

Rationale. When nursing activity is recorded under another profession's data flow, the nursing contribution becomes invisible and undervalued; standardization also enables appropriate delegation. Making the nursing contribution visible does not mean unilaterally changing attributions or responsibilities, but promoting information systems capable of accurately representing the work performed and the outcomes produced.

Standardized nursing terminologies and attributable documentation systems should be promoted as enabling tools for safety, accountability, and recognition.

Implications. E: train in protocol design and standardization. P: nursing-attributable data flows and prescriptions where authorized. Pol: information-system and indicator requirements that capture nursing contribution, through shared processes with institutions, healthcare organizations, and professional representative bodies. Actors: employers, regions, scientific societies, informatics governance, professional orders and competent institutions.

Position statement 8 — Define competencies and roles by outcomes

Statement. Competencies and roles should be defined by outcomes for patients, families, professionals and organizations — not by tasks or titles.

Rationale. Outcomes are the ultimate criterion; for example, healthcare-associated infections represent a major, measurable outcome burden that specialist roles can address. An outcome-oriented approach keeps the dialogue focused on quality, safety, and value delivered to citizens and patients, reducing the risk of corporate or merely advocacy-based interpretations.

Implications. E: outcome-based curriculum

design. P: outcome-anchored role definitions. Pol: outcome-based accreditation and indicators, to be developed within the appropriate institutional contexts and with the involvement of the competent actors. Actors: scientific societies, universities, employers, regulators, professional orders and healthcare institutions.

Position statement 9 — Act as cultural infrastructure through inter-society and interprofessional methods

Statement. Scientific societies should act as cultural infrastructures — not corporate actors — working across societies and using shared methods such as clinical simulation and interprofessional education to build a common language and a robust professional identity.

Rationale. A credible collective voice and a shared identity depend on inter-society collaboration and on methods that make the nursing contribution visible in multiprofessional settings. The function of scientific societies is to produce professional culture, evidence, tools, and proposals, and to contribute to dialogue with relevant institutional, academic, professional, regulatory, and healthcare stakeholders, without overlapping with their respective institutional mandates. This role includes contributing to clarity around generalist nursing care, specialist practice, advanced practice, and professional scope, thereby strengthening the profession's scientific and public intelligibility.

Implications. E: joint, simulation-based and interprofessional education. P: shared methods and common language. Pol: societies as partners in the development of guidelines and policies, in coordination with competent institutional stakeholders. Actors: scientific societies, universities, professional orders, healthcare and regulatory institutions.

Policy implications

Taken together, the position statements imply coordinated action across the professional ecosystem. Universities should design clinically oriented Master's curricula with a strong disciplinary core and society-validated competency content. Scientific societies should formalize their role in defining, updating, validating, and endorsing competency frameworks and specialist training, without being configured as bodies

for the institutional accreditation of university qualifications or as representative bodies of the profession in an order-like sense. Professional orders should support the recognition of specialist and advanced roles, consistent with Laws 42/1999 and 43/2006. Collective bargaining (ARAN and the parties) and regional health services should translate qualifications into job descriptions, accreditation quotas and contractual recognition. Healthcare organizations should embed the nursing contribution into information systems, quality indicators, and accreditation requirements. Citizens and patients remain the ultimate reference point, since outcomes define the value of competencies and roles. The document therefore proposes itself as a scientific and cultural contribution to the dialogue, not as a binding political-programmatic platform. Any developments in governance, contractual recognition, accreditation, or legislative revision require appropriate institutional settings, participatory processes, and the explicit involvement of the competent actors.

Implementation roadmap

Short term (0–12 months). Scientific societies finalize and publish competency frameworks and criteria for scientific quality in specialist education; universities may take them into account when aligning new Master's curricula, within the scope of their autonomy and the existing educational regulations; a shared terminological standard is promoted to distinguish MSc degrees from postgraduate diplomas.

Medium term (1–3 years). The first master's-level specialists graduate; pilot projects may be launched to describe the need for specialist nursing competencies in services; information systems begin to better capture nursing-attributable activity; an institutional dialogue is promoted on the current interpretation of Law 43/2006 and its relationship with the new educational pathways, without assuming in advance the need for legislative revision.

Long term (3–5 years). Specialist and advanced roles may be progressively integrated into accreditation, contracts, and workforce planning, where this emerges from shared institutional processes and evidence of need; outcome-based indicators of the nursing contribution are routinely reported; and inter-society and interprofessional methods, including simulation,

are institutionalized in education.

Strengths and limitations

The principal strength of this work is its genuinely deliberative origin: a multi-society roundtable analyzed from a complete verbatim transcript, with a transparent, lexicometric- and reflexive-driven process. Limitations are equally important. The corpus is a single event with selected participation, and role-related framing may shape contributions. The lexicometric outputs are descriptive and exploratory, based on only eight substantive turns; the word cloud and the rhetorical-orientation measure are illustrative and must not be over-interpreted; in particular, the orientation measure reflects surface-level lexical polarity, not speakers' emotions or attitudes. A limitation of this work is that not all societies participating in the original roundtable discussion subsequently joined the authorship and endorsement process. The lexicometric outputs are descriptive and exploratory, based on only eight substantive turns; the word cloud and the rhetorical-orientation measure are illustrative and must not be over-interpreted. In particular, the orientation measure reflects surface-level lexical polarity rather than speakers' emotions, attitudes, or underlying positions. In this regard, this position paper is an initial step towards a more structured, formal multi-society consensus. A further limitation concerns the nature of the document: the position statements presented here should not be interpreted as institutional decisions or formalized political-programmatic requests, but rather as proposals for scientific reflection to be discussed with the relevant stakeholders. This clarification is particularly relevant to issues related to the relationship between Master's degree programs and first-level Master's degrees, the possible interpretation of Law 43/2006, and the role of scientific societies in supporting the definition of specialized competencies.

Conclusions

The architecture of nursing professional identity is best understood as the social recognition of nursing's mandate, made visible, accountable, and measurable. Specialist and advanced practice are distinct but connectable through outcome-anchored competency

frameworks.

Scientific societies and professional associations should contribute to disciplinary development, competency frameworks, standards, and scientific guidance; trade unions should represent employment conditions, contracts, protections, and labor-related negotiations; regulators and public institutions should define and oversee the legal scope, accreditation, authorization, and system-level governance. These functions are distinct and should not be conflated. However, effective nursing-system development requires a shared strategic direction among these actors, so that educational reform, professional recognition, workforce planning, and service innovation progress coherently rather than through fragmented or competing agendas.

Scientific societies can act as the connecting infrastructure linking professional identity, education, competencies, accreditation, and policy. Yet, sustainable implementation requires parallel action on workforce planning, explicit contractual recognition, and alignment between the new clinical Master's degrees and the operational needs of the healthcare system. Sustainable implementation requires parallel action on workforce planning, professional and contractual recognition, and alignment between the new clinical Master's degrees and the operational needs of the healthcare system. However, such action should be developed within appropriate institutional settings, through participatory processes, and through explicit dialogue among all actors involved. The position statements offered here are intended as a basis for shared action and as an invitation to the participating and patronizing societies to formalize their endorsement.

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