Analysis of submissions

Consultation on the scope of practice and qualifications

Nurse practitioner

November 2015
Contents

1 Executive summary .................................................................................................................. 3
  1.1 Scope of practice .............................................................................................................. 3
  1.2 Education programme .................................................................................................... 4
2 Introduction ............................................................................................................................... 7
  2.1 Analysis of submitters ...................................................................................................... 7
3 Scope of practice ......................................................................................................................... 8
  3.1 Support for nurse practitioner being a broad generic scope of practice and the removal of the restriction to a specific area of practice (Question 6) .................... 8
  3.2 Focus on leadership within clinical practice in the proposed new scope of practice statement (Question 7) .................................................................................................. 17
  3.3 The inclusion of advanced nursing skills and knowledge in the proposed new scope of practice (Question 8) .............................................. 23
  3.4 Proposed new scope of practice for nurse practitioner (Question 9) ......................... 28
4 Education programme .............................................................................................................. 38
  4.1 A dedicated master’s programme with a broad focus for nurse practitioner preparation (Question 10) ......................................................................................... 38
  4.2 The Council specifying clinical learning time within the programme for nurse practitioners (Question 11) ......................................................................................... 46
  4.3 Clinical learning time in addition to the prescribing practicum (a minimum of 150 hours) (Question 12) ................................................................................................. 52
  4.4 Employer support to complete a practicum with supernumerary hours (Question 13) 57
  4.5 Requirements for the clinical learning hours should be specified by the Council, e.g. mentor criteria, setting, competence or other assessments (Question 14) ........ 60
  4.6 The ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ as a prerequisite for nurse practitioner programmes (Question 15) .... 65
  4.7 The Council setting the programme outcomes for nurse practitioner programmes (Question 16) .............................................................................................................. 72
  4.8 Draft programme outcomes for nurse practitioners (Question 17) ........................... 75
  4.9 The Council’s role in accrediting tertiary courses and programmes that do not lead to nurse practitioner or registered nurse prescribing (Question 18) .......................... 79
Appendix 1: List of submitters .................................................................................................... 84
Appendix 2: Scope of practice and prescribed qualifications for nurse practitioners ........... 86
Appendix 3: Suggested changes to the scope of practice by submitters ............................... 87
Appendix 4: Legislative framework .......................................................................................... 90
Appendix 5: Education programme standards for the Postgraduate diploma in registered nurse prescribing for long-term and common conditions ..................................... 92
Appendix 6: Responses to consultation questions .................................................................... 98
Executive summary

A review of the nurse practitioner scope of practice and prescribed qualifications began in 2014 to ensure the role remains safe, flexible and appropriate to meet health needs. The health care environment has changed considerably since the nurse practitioner was introduced in 2001. This review seeks to ensure the scope statement adequately describes the health services the nurse practitioner provides in the light of these changes and that it sufficiently differentiates the nurse practitioner from advanced registered nurse roles.

Following preliminary consultation with the sector, in December 2014, the Nursing Council circulated a consultation document discussing nurse practitioner in relation to projected health needs and service delivery changes and the introduction of further registered nurse prescribing. The Council also consulted on the educational preparation for nurse practitioners to explore if changes should be made as a result of proposed changes to the scope and the proposed introduction of the postgraduate diploma in registered nurse prescribing. This document summarises the responses from the 63 written submissions received.

1.1 Scope of practice

There was a high level of support from submitters for the Council’s proposed changes to the nurse practitioner scope of practice. The proposals to broaden the scope of practice, emphasise clinical leadership and advanced nursing skills and knowledge, and the new scope of practice statement were generally well supported by submitters.

Seventy-seven per cent of submitters favoured a broad generic scope of practice and removal of the requirement for registration in a specific area of practice. The reasons given were that a broad scope will increase flexibility to meet health needs, decrease employer confusion about the role and increase its utility in health services. Nurse practitioners were viewed as having the ability to regulate their own practice rather than requiring a specific area in their scope of practice. Some submitters did not support a broad scope of practice and some supported registration in broad population groups.

There was strong support (77%) for the focus on leadership in the scope of practice to be on clinical practice. The role was seen as being primarily clinically focused and the present leadership requirements were seen as too onerous, particularly for new nurse practitioners. There was support from some submitters to retain aspects of leadership including policy development and professional activities at a national or regional level.

The majority of submitters (61%) supported the new scope statement as providing more clarity about the nurse practitioner scope of practice and role in health services. Many submitters had suggestions for changing the wording of the scope statement with some objecting to wordiness and repetition. There were some submitters who thought the statement about diagnosis went too far and others who believed it did not go far enough. A few submitters wanted the provision of ‘medical services’ added to the statement.
1.2 Education programme

There was a high level of support for the Council’s proposals to introduce a programme specifically for nurse practitioner with specified clinical learning hours and programme outcomes. There were mixed views on the need for employer support to complete the clinical learning hours. The majority of submitters did not support the ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ as a prerequisite for nurse practitioner programmes. Most submitters wanted the Council to retain its role in accrediting tertiary courses and programmes that do not lead to registration in the nurse practitioner scope of practice or registered nurse prescribing.

The proposal for a dedicated programme with a broad focus was supported by 75% of submitters. It was seen as standardising the provision of programmes across the postgraduate providers and the skills of nurse practitioners. It would also provide a clear educational pathway for registered nurses to prepare to become nurse practitioners. Some flexibility in the programme for acute care, specialty papers and mental health was discussed by some submitters.

The majority of submitters (72%) supported the Council setting clinical learning time within the nurse practitioner programme. Consistent dedicated learning time was seen as leading to greater consistency in nurse practitioner skills at the end of the programme. Some submitters cautioned that this could be a barrier for some nurses to complete the programme. Others argued that funding was required for this model. A few submitters suggested employed ‘registered nurse’ hours in the existing role were relevant. A few submitters did not support this proposal as they believed no evidence was provided to support making a change to the existing programme.

Most submitters supported the Council specifying the number of clinical learning hours. The majority (21) supported 300 minimum total hours including the prescribing practicum, with a small number supporting up to 500 hours for individual nurses. Fifteen submitters supported 500 or more total hours.

The majority (61%) of submitters agreed a student must have employer support to complete a practicum with supernumerary hours. However, many submitters who answered ‘yes’ to this question also commented that the support should not be mandatory. Although most indicated that employer support was ideal, they indicated the possibility for a student to complete the clinical learning without employer support in a practice area where they were not employed should be retained.

Many submitters supported other requirements for clinical learning as important for the Council to specify as well as the number of hours. These included mentor criteria, clinical and professional supervision, the clinical placement or setting requirements, the types of assessments and portfolio development.

The majority of submitters did not support the ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ as a prerequisite for nurse practitioner programmes (54%). One reason given was that as a prerequisite qualification it was too restrictive and limited the pathways to becoming a nurse practitioner. Some submitters stated that registered nurse and nurse practitioner prescribing were different and required
separate pathways. Other submitters saw clear benefits in nurse practitioners completing this prerequisite programme in standardising the preparation for all prescribers and broadening nurse practitioner preparation.

The majority (74%) of submitters supported the Council setting nurse practitioner programme outcomes. Many submitters stated this would lead to greater consistency between the providers and benefit nurse practitioner preparation. One submitter supported close alignment between the programme outcomes and the nurse practitioner registration process. Some education providers objected to the Council setting outcomes as they saw this as their role.

The majority (65%) of submitters supported the draft programme outcomes proposed by the Council. There were some suggested changes to the wording. These included alignment with Level 9 learning outcomes on the NZQA framework and a stronger focus on interdisciplinary skills. Some education providers did not see the setting of outcomes as the Council's role.

Most submitters (56%) supported the Council maintaining its role in approving all postgraduate tertiary clinical nursing programmes. It was seen as part of the Council’s wider regulatory role of ensuring a standard for public safety. The link between Council approval and Health Workforce New Zealand (HWNZ) funding was raised as an important issue as well as the implications for career advancement in the profession into roles other than nurse practitioner. There was support from some submitters for the Council to cease approval of other programmes as it was seen as inconsistent with the role of a regulatory body and unnecessary as other bodies approved these programmes.

Since its inception the role of the nurse practitioner has continued to evolve. As we look to the future, our members realise that with an ageing population and a dwindling rural population, there will be considerable demands placed on the delivery of health care. We believe the role of the nurse practitioner will become increasingly important in our health system. It is crucial that the Nursing Council regularly reviews the scope of practice and qualifications for nurses. The Nursing Council must ensure the appropriate skill set for nurse practitioners is developed and continues to be relevant, and that any funding barriers and employment difficulties are addressed (43, National Council of Women of New Zealand).

Having a more focused scope and education programme will mean it is easier for health professionals and employers to understand the NP role and the potential for this role in providing health care and improving access across diverse population groups. This role is especially helpful with helping to manage the increasing health demands and the need to consider different models of care (37, Hutt Valley District Health Board including primary health care).

This is good for the profession and will be good for the nation and overall health care will be improved. It creates good opportunities particularly in primary community care for enhanced working. This will become increasingly important as the population ages (12, Individual nurse).

Access to primary health care, remains a significant issue in rural New Zealand. The tyranny of distance and lack of GP’s in rural parts of New Zealand means that these communities are still not having their health needs met. The potential for NPs to play a
critical role in addressing these health disparities is well understood. The NP role was introduced with the policy intention of improving access to primary health care in underserved rural communities. However the relatively low number of NPs in New Zealand suggests that this goal is not being realised to its full potential. We think that more should be done to increase the number of NPs in rural communities, and that this goal should be a key focus of the Council’s review (62, Rural Women New Zealand).
2 Introduction

Between December 2014 and February 2015 the Council consulted on the scope of practice and qualifications for nurse practitioners. The consultation document was sent to 522 organisations and individuals across the health sector. This paper summarises the written submissions received. A consultation questionnaire was developed to assist submitters to provide feedback.

2.1 Analysis of submitters

A total of 63 written submissions were received. There were 43 submissions from organisations, 8 from groups and 12 individual submissions. A list of submitters is in Appendix 1.

Submissions were made by a range of organisations (see Table 2) and individuals including seven individual and group submissions from nurse practitioners.

Table 1: Types of individual and group submitters

<table>
<thead>
<tr>
<th>Type of respondent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual nurses</td>
<td>6</td>
</tr>
<tr>
<td>Individual nurse practitioners</td>
<td>2</td>
</tr>
<tr>
<td>Individual doctor</td>
<td>2</td>
</tr>
<tr>
<td>Individual other</td>
<td>2</td>
</tr>
<tr>
<td>Groups of nurse practitioners</td>
<td>5</td>
</tr>
<tr>
<td>Groups of nurses</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Table 2: Types of organisational submitters

<table>
<thead>
<tr>
<th>Type of respondent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional organisations</td>
<td>13</td>
</tr>
<tr>
<td>District Health Boards</td>
<td>8</td>
</tr>
<tr>
<td>Education providers</td>
<td>7</td>
</tr>
<tr>
<td>Non-governmental organisations</td>
<td>3</td>
</tr>
<tr>
<td>Regulatory authorities</td>
<td>3</td>
</tr>
<tr>
<td>Other organisations</td>
<td>3</td>
</tr>
</tbody>
</table>
Primary health organisations (PHOs) 2
Consumer groups 1
Government agencies 1
Maori health provider 1
Private hospital provider 1
Total number of submissions 43

2.1.1 Analysis of submissions

The comments made by submitters have been analysed and are presented in themes under the proposal questions. Quotes have been selected to illustrate these themes. A list of submitters and their assigned numbers can be found in Appendix 1. Many submissions contained mixed responses. These have been represented where possible.

Five submitters did not answer the yes/no questions, so could not be included in this data, but their comments have been included in the general analysis.

3 Scope of practice

There was a high level of support from submitters for the Council’s proposed changes to the nurse practitioner scope of practice. The existing scope of practice and qualification can be found in Appendix 2. The responses to the proposals to broaden the scope of practice, emphasise clinical leadership and advanced nursing skills and knowledge, and a new scope of practice statement are outlined below.

3.1 Support for nurse practitioner being a broad generic scope of practice and the removal of the restriction to a specific area of practice (Question 6)

Since 2001 nurse practitioners have been required to register in and practise in a specific area of practice which appears on their practising certificate.

The Council proposed removal of the specific area of practice from the scope of practice would reduce barriers to the flexibility and utility of the nurse practitioner role within health care. This would enable nurse practitioners with a broad, flexible scope of practice to work across services to meet the needs of a changing population and health service. This would also recognise the experience and expertise of the nurse practitioner develops over time and would enable their scope to broaden as their practice evolves and extends over time.

Seventy-seven per cent of submitters (see Chart 1) favoured a broad generic scope of practice and removal of the requirement for registration in a specific area of practice. The reasons given were that a broad scope will increase flexibility to meet health needs,
decrease employer confusion about the role and increase its utility in health services. Nurse practitioners were viewed as having the ability to regulate their own practice rather than having a specific area of practice in their scope of practice. Some submitters did not support a broad scope of practice and some supported registration in broad population groups.

Chart 1: Support for nurse practitioner being a broad generic scope of practice and the removal of the requirement for registration to be restricted to a specific area of practice

![Bar chart showing support percentages](chart.png)

### 3.1.1 A broad scope will increase flexibility to meet health needs

The reasons given for supporting this change included the increased flexibility to meet health needs (2, 21, 22, 25, 33, 35, 37, 39, 40, 42, 43, 52, 53, 56).

![NCNZ family care](quote.png)

We support this as a generic scope of practice provides for flexibility across the care continuum and the NP is not restricted to one specific disease state or system. Our patients these days have many co-morbidities and a broad generic scope would permit the more holistic care management of the patient (33, Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer).
Population focus is best: Allows for progress as population needs change and will then ensure that access to health services is flexible for those who need them… NP are advanced holistic clinicians and should be trained in a broad scope so they can address the health needs of the whole whanau especially when working in rural clinics and home environments…. As an NP gathers clinical expertise and consolidates practice within the chosen area of practice it becomes evident that their practice needs increase, in some instances there may become a need to broaden their scope to accommodate patient and organisational need (40, Te Tai Tokerau nurse practitioners).

A broad scope was also seen as improving access to care for hard-to-reach populations including rural communities (19, 37, 38, 39, 40, 56, 62).

A broad scope enables the nurse practitioner to be flexible and work across a wide variety of practice settings, responding to health needs as and where they occur. All practice settings involve care of people with long term conditions and the management of common conditions. By removing restrictions of specific area of practice the nurse practitioner can improve access to care especially in the hard to reach population (39, Nurse Practitioner Group-Hawkes Bay District Health Board).

RWNZ strongly supports the removal of the requirement for registration to be restricted to a specific area of practice. Lack of access to health care in rural areas, means that nursing practice in these areas is inherently generalised. NPs in rural areas must be flexible to a broad range of areas so that they can effectively meet the diverse health needs of the populations they serve, and to truly make an impact on patient health outcomes in these areas (62, Rural Women New Zealand).

Many submitters supported the removal of the requirement for a specific area of practice to be included in the nurse practitioner’s scope of practice because they thought it was too restrictive and the removal would enable greater flexibility of practice to meet changing health needs (22, 26, 33, 38, 39, 40, 41, 43, 44, 46, 47, 57, 59).

We support this change because a broad scope is enabling…nurse practitioner may consider conditions or treatments outside of their specified area of practice … the restricted scope of practice does not allow them to put that learning into practice … a youth health NP working in family planning, for example, cannot work with clients aged over 26 years without working under Standing Orders or needing to go through the Nursing Council to expand the scope (26, Family Planning).

We agree with the overall principle for a less specific scope of practice for nurse practitioners. We support the removal of the requirement for the registration to be restricted to a specific area of practice. It is important for patients, particularly those in rural areas with more limited access to health services, that their healthcare practitioner is able to provide services that are appropriate to that setting (59, Pharmacy Guild of New Zealand).

It will create more flexibility and allow NP to fill service gaps of the future as and when needed rather than just the here and now. The health workforce is mobile and somewhat unpredictable in the foreseeable future. The NP role needs to capture opportunities and this
will not be achieved by having restricted profiles / scopes for individual NPs (22, Tairawhiti District Health).

3.1.2 A broad scope will decrease confusion and increase utility

A broad generic scope was seen as leading to greater consistency in the skill set of nurse practitioners and following this a greater understanding and acceptance by the public and employers. This in turn would lead to greater utility of the role (16, 25, 40, 42, 45, 46).

All scopes of practice have a generic base of knowledge specific to that particular scope of practice. Further specialised knowledge or skills specific to a particular population, health issue or environment develops concurrently or post registration. With nurse practitioners (NP) there is expected to be a wealth of knowledge and experience in the registered nurse scope however new NPs will be working as beginners with a new or enhanced, set of skills e.g. diagnostic reasoning and prescribing. The general public and potential or actual employers should have confidence that new NPs have a skill set which enables safety with activities particular to their scope no matter what their back ground area of practice. All NPs should have a standard of skill based around their competencies (45, New Zealand Rural General Practice Network).

This will allow NP’s to have broad scopes from which to practice - ultimately benefiting the populations we serve. It will also reduce the need for NPs to go back to Nursing Council if their roles change and expand. Broadening the scope and responsibility allows NPs to be more supportive and mentor other NPs in both clinical practice and in prescribing. Hopefully, this will make NPs more attractive in a job market that doesn’t place unnecessary restrictions on a NP should they wish or need to move geographically or wish to work in a related but different area (42, College of Emergency Nurses New Zealand/ NZNO).

A broader nurse practitioner scope was seen as reducing confusion with the clinical nurse specialist role (CNS) (44).

Supported as defined scopes are not enabling. • Gives the ability to be a broad yet still focuses in on certain groups. It removes confusion between the NP role and the Clinical Nurse Specialist (CNS) role. • NPs have the insight to regulate their own practice so a specific area of practice is not necessary. Practice broadens with experience and NPs do need to respond to the changing service delivery needs within their organisation (44, Nurse Executives of New Zealand (NENZ)).

3.1.3 Nurse practitioners can regulate their own practice within a broad scope

Eight submitters commented that nurse practitioners were educationally prepared to have the insight to regulate their own practice so a specific area of practice could be removed (5, 10, 14, 31, 44, 46, 51, 57).

I think that the restriction to a particular area of practice should be removed. In fact I am not sure how a NP in a General Practice could function if she could not see “all comers”. There would be a requirement, as with doctors (and with all clinical practice), to know one's own
limitations and when to ask for advice, and this would protect the public from incompetent practice (10, East Health Trust Primary Health Organisation).

Nurse practitioners are educated and have the insight and understanding to develop their own practice and not undertake activities outside their competence, very similar to medical practitioners. Nurse practitioners are responsible for determining what medications and treatments they are competent to prescribe. Experience and expertise develops over time. Self-definition may be useful but not mandatory to define scope at registration (51, MidCentral District Health Board: Group of senior nurses).

Four submitters agreed that nurse practitioners should self-define their specific area of practice at registration but that this did not need to be included in their regulated scope of practice (9, 47, 51, 55). It could be redefined by the nurse practitioner as their skills and experience developed.

It is realistic that RNs applying for NP will have an area of practice they reflect through the application evidence. However the historic focus on 'restricting' the practice of NPs to limit prescribing should be removed. An NP application and registration needs to be to the scope of practice and level of practice and not limited by the practice focus at the time of registration. The population the applicant works with will determine the evidence submitted against each NP/Advanced practice competency. If the population (including life span) changes with time and experience and population needs the NP needs a registration that enables that. However if the NPs area of practice/population does not change with ongoing practice development the generic broader scope will not be problematic (47, Capital and Coast District Health Board).

Self-definition may be useful but not mandatory to define scope at registration (51, MidCentral District Health Board: Group of senior nurses).

The College supports a broad scope of practice for nurse practitioners. We expect that NPs will deliver broad and comprehensive care to their client group. We do however agree that many NPs may then practice with a more defined population group or patient group Nurse practitioners are therefore able to determine their practice against client or patient need and under a broad scope (55, College of Nurses Aotearoa New Zealand).

3.1.4 Support for registration in broad population groups

Eight submitters supported nurse practitioners registering in broad population groups similar to the Canadian model (30, 54) i.e. Family (primary health care), Adult or Child Health areas (25, 31, 40, 47, 49, 55). Other submitters suggested population groupings such as primary health and acute care (16), paediatric and adult (21).

Acknowledgement of nurse practitioners whose roles will broaden as they develop new skills, meet the need of their population they care for and generally continue to grow into their roles - reduces need to go back to nursing council to extend their role of practice (this might be different if they were moving right outside their scope i.e. child health acute care to chronic care of the elderly - due to the above comment it would still be useful and potentially safe to have a their scope defined broadly as was currently stated in the document - child
and youth, aged care, generalist across lifespan (30, Starship Children’s Hospital Nurse Practitioners).

It is our view that broad area of practice designations would best reflect current nurse practitioner (NP) practice. Broad designations such as primary health care, or acute care would reflect the population expertise that the NP has acquired through education and experience. This will limit confusion regarding the role of the NP as the clinical lead with authority to independently manage clinical care (16, University of Auckland School of Nursing).

Support NP to be within two scopes of practice, Paediatric and Adult (18+). Support a broad generic practice within these scopes, e.g. not restricted to specific clinical areas. This would allow for a flexible workforce which can be an issue with the current restricted scopes of practice, and at the same time allow for focused training to ensure the NP acquires in-depth training and skill development within the broader scope of practice (21, Taranaki District Health Board).

The College of Registered Nurses of British Columbia clarified that nurse practitioners are educated in that province in one broad generic scope – Family nurse practitioner (23). Preparation with a primary care focus was supported by other submitters (14, 29, 51).

This is the model in British Columbia and our perception is that it is a common model in the rest of Canada. We work with a broad generic scope of nurse practitioner (NP) practice. We face similar challenges to New Zealand with an ageing population with a large burden of chronic illness. In British Columbia, improving access to services and health outcomes for aboriginal peoples is a priority. …For our province of approximately 4.7 million people (2013), we have 3 masters-level NP education programs that educate family nurse practitioners. Each of the 3 program admits 15 NPs per year. However, we also register NPs educated in other jurisdictions in the adult and paediatric streams. The family NP is educated to provide health care services to all ages… Most NPs work in primary and community settings but some do work in acute care specialties in hospital environments. Most NPs working in acute specialties had a background in the specialty as an RN (23, College of Registered Nurses of British Columbia).

NP’s should be educationally prepared to work from a base of primary health care and be able to work across the boundaries of specific areas of practice and transitional care (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

There were some suggestions that a broad scope was appropriate in some contexts, e.g. primary care, but a specific focus was needed in others, e.g. tertiary hospitals, mental health (3, 19, 20, 28). Even within a specific area a broad preparation would be useful particularly including the older adult (3). Two submitters commented on the inappropriateness of restricting nurse practitioners to cultural groups (10, 20).

I believe that NP education is an advanced study in a specific area. To me, it’s like specialist nursing practice. So I believe that nurse practitioners should be registered in specific areas of their own choice, skills and interest. However I DO NOT support restriction in regards to cultural groups. For example, Maori, Pacific or other cultural groups. Because I strongly believe that a NP should be culturally competent to manage all the population groups. So,
as far as I am concerned, in the table 1: Matrix of areas of practice, the population groups should be only Pediatrics (or child and youth), Adult, Older adult and lifespan. And I support the existing specialty areas on this table, however family/whanau can be included in the primary health care specialty rather than classify as a population group (20, Individual nurse).

My perspective is that of a NP working in a tertiary level hospital and if it is accepted that this is an environment suitable of employment for an NP then a specialty focus is essential as this is how the services are divided up within the in-patient setting (this would also be true of the RN who only becomes more broadly focused by moving around different specialty areas). Education of prospective NP’s can however have a broader focus to acknowledge the life span changes - given the increasing older population this is clearly an area where more time can be spent understanding their unique needs (3, Individual nurse practitioner).

I believe there could be an expansion to some roles for example primary care where NP’s may work across several areas of the current matrix, but some areas are highly specialised and the skills and pharmacological knowledge not easily transferable to another area e.g. Neonatal Nurse practitioner (28, Neonatal Nurses College of Aotearoa/NZNO).

Mental health was noted as a particular area of practice where a narrower scope might be supported (19, General Practice New Zealand).

3.1.5 Do not support a broad scope

Seventeen submitters (28%) did not support a broad generic scope of practice for all nurse practitioners (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 17, 32, 48, 50, 63). These were mainly individuals and medical groups who have a strong vocational scope of practice model.

The reason given for this was the development of breadth would be to the detriment of having expertise in a specialist area. There were also concerns that nurse practitioners would no longer be highly skilled ‘specialists’ but intermediately skilled generalists. There was recognition that the existing matrix was too limiting (48).

By broadening the scope the Nurse practitioner is no longer an expert, but a generalist with a broad range of intermediate level skill base. The Nursing Council wishes nurse practitioners to take on more of a lead clinical role and as such their education should be focused on the clinical needs that they deal with specifically. To broaden the scope does not seem in keeping with the time spent training and the attainment of high level skills (32, New Zealand Society of Anaesthetists).

We believe the inclusion of a broad description of the area of practice for the NP such as “older adult “adds clarity and value to the scope of practice. At present most nurses working towards an NP role do this within an area of clinical practice that holds a special interest for them. They have become experts in their field as they have concentrated and expanded their clinical knowledge and expertise within the area that holds their personal interest. It is our opinion that if NP wish to extend or change their field beyond their original scope of practice, resubmission of a portfolio that demonstrates the expansion of their clinical expertise and knowledge is a reasonable expectation. We also believe that there is a risk attached by having a generic scope of practice of losing the focus that this is an advanced nursing role and not a “mini doctor” role. We also believed that it is not the scope of practice
that limits the NP’s ability to work across service boundaries but that this is more influenced by funding streams and current models of care (17, Group of nurses).

The National Committee of ANZCA does not support the nurse practitioner being a broad generic scope of practice, or the removal of the requirement for registration to be restricted to a specific area of practice. The nurse practitioner role recognises that prolonged clinical exposure to a specific area of medicine produces valuable expertise with limited scope, and therefore nurse practitioners require very limited oversight in their area of scope. Broad exposure (such as that achieved by junior doctors in the house surgeon years) produces broad knowledge which lacks depth and expertise, and therefore requires oversight. If a nurse practitioner gains additional expertise in an expanded or additional field, the current system allows for the expansion to be appended to their registration. However, the National Committee of ANZCA recognises that the current definition of nurse practitioner areas of practice set out in the matrix on page nine of the consultation document is potentially limiting. Rather than having a broad generic scope of practice, the Committee considers that redefining the current scopes could increase flexibility for nurse practitioners, while maintaining the requirement for in-depth expertise in a particular area of medicine (48, Australian and New Zealand College of Anaesthetists).

The College is concerned about the proposal to remove reference to specific areas of practice from the scope. We understand that this proposal has been made because the status quo is perceived as a barrier to flexibility. The College considers that the purpose of a scope of practice is to provide clarity and to provide patients with confidence that the practitioner treating them has expertise in the relevant field of health. If they are having eye surgery then they want to know that their surgeon is an ophthalmologist, not trained as an urologist.

In our view, a scope of practice should delineate the area of practice in which one is trained and competent. The proposed definition does not do this. A nurse practitioner has undertaken additional training and experience which enables them to practice independently in their area of expertise. The College submits that it is important that the area of NP expertise is reflected in their scope of practice.

In addition to failing to provide useful information to patients and to other health professionals, a broad scope also leaves NPs open to employer demands that they undertake tasks they do not feel that they are trained to do. This risk is heightened in the current environment of cost cutting and DHB deficits.

The College submits that instead of introducing flexibility by means of a broad scope of practice, the Council should instead provide a pathway that allows an NP to move more easily from one defined vocational scope of practice to another (63, Royal New Zealand College of General Practitioners).

The College of surgeons does not support a broad scope of practice that is undefined. An undefined broad scope of practice may lead to practitioners practising outside their specialty area and without sufficient training, experience and continuing professional development (50, Royal Australasian College of Surgeons).

PCNZ agrees to the nurse practitioner scope being a generic scope but believes it should still require their specialisation to be part of registration within that scope. Nurse practitioners are specialists and have specialised clinical knowledge, skills and understanding relevant to their area of prescribing practice. This requirement should be
reflected in the scope of practice but the specialist area they work in should be part of the registration requirements within the scope (9, Pharmacy Council New Zealand).

Given this role needs to provide assurance to the public of “subject matter expert” there is concern that a generic scope, for example right across the age spectrum from pediatrics to aged care is far too broad. Concern a lack of clinical exposure across this wide spectrum will be insufficient to equip the NP to manage the complexity of diagnosis, assessment and prescribing treatment for potential neonates, paeds, adults and the care of older people (10, East Health Trust Primary Health Organisation).

3.1.6 Impact on existing nurse practitioners and candidates

A few submitters commented on the uncertainty of how the proposed scope changes might impact on current nurse practitioners or potential nurse practitioner candidates who had completed clinical master’s papers (14, 15, 44, 51). One submitter suggested keeping the current pathway for five years (24).

For NP’s who are already registered and have a narrower area of practice such as diabetes or respiratory, what impact will the proposed changes have to their registration and practice. There is no mention of this in the current document that we could identify (14, Intern and Nurse practitioner peer review group and 51, MidCentral District Health Board: Group of senior nurses).

It is entirely the right stance going forward. In supporting this stance the future roles are almost exclusively located in primary and community settings or with targeted groups with chronic diseases. We also need to consider how we will support nurses who entered this scope under earlier conditions and have narrower specialist scopes. This may be a future barrier to NP employment as may be Clinical Nurse Specialists in the tertiary sector without broad scopes. We would not change the employment of these nurses currently employed as NP but would not employ new Nurse practitioners with narrow areas of practice in preference for CNS roles for highly specialist roles (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

There are a number of nurses like myself who have completed most of the pathway towards Nurse practitioner where the focus has been on a specific area of practice. Many of my ‘cohort’ will not be in a position to ‘redo’ academic work or ‘redefine’ our area of employment to meet the new pathway proposed…. I would like the current pathway with specific area of practice to remain in place for a period of up to 5 years to allow those of us that have already invested considerable time and energy to complete the process as it was when we began. I do believe it is feasible for a ‘new’ concurrent pathway to be developed in this time for nurses starting on the Nurse practitioner journey (24, Individual nurse).
3.2 Focus on leadership within clinical practice in the proposed new scope of practice statement (Question 7)

The Council proposed an emphasis on clinical leadership activities such as guiding and influencing care and improving the health outcomes for a population group and removing the requirement for leadership in education, management, research and policy development from the scope statement. These leadership skills could be included in the competencies for nurse practitioners.

Some concern was expressed in the pre-consultation process that the current statement of expectation for leadership may be too broad. Clinical leadership is considered one of the cornerstones of nurse practitioner practice in many countries (Nursing and Midwifery Board of Australia (NMBA), 2012) and differentiates the nurse practitioner scope from that of the registered nurse. Some stakeholders felt the broad requirements in the last sentence of the scope statement were too high for a new nurse practitioner and possibly detracted from the primary focus of the role which is clinical practice. Demonstrate leadership as consultants, educators, managers and researchers, and actively participate in professional activities, and in local and national policy development.

There was strong support (77%) (see Chart 2) for the focus on leadership in the scope of practice to be on clinical practice. The role was seen as being primarily clinically focused and the present leadership requirements were seen as too onerous, particularly for new nurse practitioners. There was support from some submitters to retain aspects of leadership including policy development and professional activities at a national or regional level.

Chart 2: Support for the focus on leadership within clinical practice in the new proposed scope of practice statement

3.2.1 Focus of the role should be clinical practice

The reasons given were an agreement that the focus of the role should be clinical practice and meeting the needs of patients. Other leadership activities were seen as important but should not distract from the primary focus.
NPs are first and foremost ‘practitioners’. They need leadership skills but these need to be aligned with their clinical role as primary care providers and with meeting the needs of their patients. This includes advocacy and improving health outcomes (23, College of Registered Nurses of British Columbia).

Clinical leadership is a main focus of the NP- the use of direction and delegation may be a key feature of the way of working. Leadership can also be seen as the provision of an expert nursing opinion. In a broader sense NP’s can be leaders in their contribution to working parties, consultation documents, research, National Nursing body’s education and through challenging the boundaries/ restrictions that legislation places on nursing. This should be tempered with the notion that these other activities do not distract from the core activity of caring for patients (46, Nurse Practitioners New Zealand).

Other domains of leadership competence such as in national policy development will require different skills and cannot be expected to be within the toolbox of all NPs (19, General Practice New Zealand).

Six submitters (20, 26, 44, 51, 55, 57) supported leadership within the scope as this was seen as a key point of difference from the CNS role.

This differentiates the NP from the CNS. A demonstration of knowledge and leadership in the area of practice across the community (local) /regional/ national is appropriate for an NP
• Retain leadership in nursing research but remove leadership in education and policy development. • What differentiates an NP from a prescribing CNS is the breadth of the NP scope, the complexity of their patients with often multiple diagnoses, and the leadership role they have within their service and organisation (44, Nurse Executives of New Zealand (NENZ)).

A focus on clinical leadership across a community, district, region and at a national level is integral to the Nurse practitioner role. However, other leadership areas will develop for Nurse practitioners over time. The focus on leadership, combined with the complexity of their patients, are key points of difference between a Clinical Nurse Specialist with prescribing rights and a Nurse practitioner (51, MidCentral District Health Board: Group of senior nurses).

3.2.2 New nurse practitioners need to focus on clinical leadership

Six submitters (2, 14, 31, 40, 42, 55) supported the change because they thought new nurse practitioners needed to be able to focus primarily on clinical leadership. The requirement to undertake other leadership activities before registration could detract from learning the clinical role (14, 43).

Current expectations are too broad. For the novice NP, being able to focus more on clinical leadership means less distraction from their clinical role and learning. It is too easy to become bogged down with many projects that are not directly clinical related (31, Individual nurse).

Leadership requirements currently in place are one aspect that separates the nurse practitioner role from the clinical nurse specialist role. Newly educated nurse practitioners need a comprehensive understanding of the health system, which develops through
leadership roles and involvement in policy development. The purpose of requiring four years’ experience in a specific area of practice is to ensure that a candidate is an experienced registered nurse. The leadership requirements ensure that the candidate understands the multiple facets of health care and is prepared to make changes to that system through any of the channels of education, leadership or policy making and these skills are essential for a nurse practitioner. However we also note that there are and will be NPs for whom leadership is not part of their practice because they choose or prefer to focus entirely on exemplary clinical practice (55, College of Nurses of Aotearoa New Zealand).

Focus on clinical leadership is integral to the NP role. However, other leadership areas will develop for the NP over time. New opportunities will arise due to the position. The current leadership requirements prior to achieving NP registration can distract from the concentration required for the NP clinical role (14, Intern and Nurse practitioner peer review group).

3.2.3 Present leadership requirements are too onerous

Four submitters (3, 17, 25, 26) stated that the time and resources required to support nurse practitioners to achieve the broader requirements of the role were onerous for employers and pulled the nurse practitioner away from the clinical care of patients.

The NP role is primarily a clinical one and I would support the changes that encourage clinical leadership and clinical education. The expectation of provision of leadership in research, policy development etc. often pulls the nurse away from the clinical setting and as such detracts away from their primary value as a clinician (3, Individual nurse practitioner).

We are of the opinion that one should be able to expect NP’s to demonstrate clinical leadership within their area of specialist interest. Other examples of leadership such as research or policy development as mentioned in the consultation document could be included but should not be compulsory. The individual NP has the choice if they wish to demonstrate their abilities in these areas as part of their portfolio. We also discussed this point from an employer perspective and found that the time demand involved with these requirements reduces the clinical time of the NP. This can negatively influence the employer’s view on the value of NP’s as investment to deliver care (17, Group of nurses).

We support the focus on leadership within clinical practice. Organisationally, and from the perspective of individual nurse practitioners, Family Planning has found it challenging to find opportunities and activities that meet the current scope’s wide criteria of leadership, particularly within a specific area of practice. Time and financial constraints can make this difficult, as employers may be unable to afford the burden of costs related to the current leadership requirement. We agree that leadership activities that are clinically focused on guiding and influencing care and improving the health outcomes for a population group should be the minimum and are sufficient for the NP wanting to focus on clinical work. Broader leadership elements may be a focus for an individual NP, but the scope should remain flexible to allow diversity in how NPs show leadership. Retaining a focus on leadership is important because it differentiates the NP from the CNS role, for example (26, Family Planning).
Being a primary lead for education and research may be appropriate at some stage/s in an NP’s career but stating that NP’s should “demonstrate leadership as consultants, educators, managers and researchers ....” adds a considerable level of pressure to the NP role to perform such a high level broad range of functions in an ongoing manner which may contribute to burnout over time. NP’s although functioning at an advanced level should not have to be engaged in every activity in the health arena (25, Individual nurse).

3.2.4 Retain policy development and professional activities at a national or regional level

Five submitters (25, 28, 39, 40, 41) thought that working as leaders at a regional or national level was an important component of the nurse practitioner role and should be retained within the scope statement. Policy development and other professional activities were seen as important components of the role and the nurse practitioner’s ability to negotiate change in services for the benefit of their population group (41, 55).

We support the focus on clinical leadership as a core competency for nurse practitioners at a local and National level. Nurse practitioners individually, have differing strengths across the domains of education, as managers and researchers. We support these functions as being important components of leadership for nurse practitioners but the main focus should be on clinical leadership with the ability to provide influence and collaboration at a National level. Working at a national level in whatever capacity that may occur influences national policy development and helps to raise the profile and visibility of nurse practitioners (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

We think that NP leadership is required within the profession at a local and national level and consider that involvement in policy development is an important component of this leadership. We would suggest, therefore, that some reference to participation in professional activities, at local regional and national levels remain within the scope statement. We agree that the remaining leadership elements could be contained within the competency statements however currently each competency must be met with some evidence at desk audit and panel review of portfolio. We would therefore suggest that research activities could be omitted. This does not preclude the NP engaging in research activities if they so choose (41, Auckland University of Technology).

Clinical leadership is paramount to the NP role. I do see research and policy development still being important within the leadership framework too (28, Neonatal Nurses College of Aotearoa/NZNO).

A sound knowledge of policy development and health politics is essential if an NP wants to influence or achieve change in health policy. I believe it is essential to support the development of leadership skills within the NP practice as a differentiating factor between NP and other nursing scopes. It would seem appropriate to be able to agree that new or developing NP may not have these aspects secured within their practice at the outset but these aspects provide vision to support professional growth and development and a capacity for future leaders in health. I would like to see a modified statement related to the demonstration of leadership across related health domains at the least some reference to participation in professional activities, at local regional and national level should remain within the scope. In relation to these aspects remaining in the competencies and not in the
3.2.5 Retain the full leadership components

A minority of submitters wanted all components of leadership retained as in the previous scope statement (see Appendix 2).

Two submitters supported the retention of the previous requirements for leadership to include education, management, research and policy development. However, one of those submitters commented that in some settings team leadership would usually be provided by the doctor.

Because nurse practitioners practice across various settings, their clinical leadership needs to be further defined within the setting. In a hospital setting we expect that the clinical leader of a multidisciplinary team would have the appropriate training and also take ultimate responsibility for the care of the patient – this would usually be a doctor, unless this has been delegated elsewhere by a doctor. In a rural setting nurse practitioners will often be the most qualified person caring for a patient and in this instance they will be the clinical leader. We agree that leadership activities that are clinically focused on “guiding and influencing care and improving health outcomes ... etc.” should be the minimum expectation. Where nurse practitioners are the lead clinicians they need retain their requirements of leadership in education, management, research and policy development to be effective (32, New Zealand Society of Anaesthetists).

I DO NOT support a NP has been restricted on/is focusing only on leadership within clinical practice. Nurse practitioner is an advanced nursing area, which should fit anywhere in nursing profession. As I am concerned, a NP should be equipped with skills to act as clinician, educator, manager or researcher. And they should be practicing in these areas depends upon individual interests. However they should have advanced skills in all these areas and that should be the main difference between NP (an ADVANCED practice), other specialist nurses and other nurse prescribers (an EXPERT practice) (20, Individual nurse).

Four submitters supported the breadth of nurse practitioner leadership requirements being outlined in the competencies (40, 41, 47, 50).

Nurse practitioners must show leadership within clinical practice but this should not diminish from the impact on the leadership in other areas related to the NPs area of practice or impact on the nursing profession itself. This is often achieved through advocating for the population, representation on committees and policy/service provision changes. The NPs clinical leadership impacts on the practice development of others. Therefore it is essential the competencies do focus on leadership and contribution through research, management and policy etc. Practice development at the NP level impacts on practice and outcomes that are broader than their own case load practice (47, Capital and Coast District Health Board).

Leadership should be one of the competencies required of nurse practitioners, with a focus on leadership and not leadership being the focus. Competencies in addition to leadership
should include; clinical nursing expertise, technical skill, communication, professionalism, teaching and scholarship, and collaboration (50, Royal Australasian College of Surgeons).

We agree that the remaining leadership elements could be contained within the competency statements however currently each competency must be met with some evidence at desk audit and panel review of portfolio. We would therefore suggest that research activities could be omitted. This does not preclude the NP engaging in research activities if they so choose (41, Auckland University of Technology).

3.2.6 Other comments on the wording of leadership within the scope of practice

Four submitters (10, 25, 53, 58) commented that the new scope statement does not mention leadership explicitly and that greater emphasis and description are needed.

Feedback received from members suggests the new statement is not clear in its leadership application and needs to go further and be more specific regarding leadership. There should be some reference to influencing and informing clinical services – leadership is not only at the level of individual patients, but leadership within the clinical team, clinical services (working with others) and within the profession. There needs to be acknowledgement of the role of undertaking audit and monitoring, of quality and governance to inform service development and profiling the role of advanced nursing practice within the profession (58, New Zealand Nurses Organisation (NZNO)).

The new proposed scope appears to lack any specific mention on leadership as part of the NP role. I believe NP’s practice at an advanced level and therefore leadership should be inherent in the role. As the NP role is primarily a clinical role leadership should be focused on clinical aspects of the role such as leading care, offering a consultative role on clinical issues, teaching and mentoring other health professionals in the clinical setting. NP’s should be highly collaborative with other functions such as education and research and participate at a local and national level (25, Individual nurse).

Three submitters (25, 40, 49) preferred an emphasis on clinical and quality improvement based research.

While there should be a clear emphasis on the clinical aspects of the role, clinical leadership is also an integral component of advanced practice and should still be demonstrated in some way, especially local or regional. An emphasis on clinical and quality improvement based research is preferred as opposed to being required to lead or being involved in more theoretically framed research (49, MidCentral Health nurse practitioners).

Two submitters commented that it was not necessary to state leadership requirements in the scope of practice because it was implied (10) or because it was the role of doctors (27).

The definition provided is too wordy and quite ambiguous. It is already assumed that NP’s will have higher level knowledge and skill including research, clinical and education. Not sure there is a need to focus on leadership as the level of scope already defines this (10, East Health Trust Primary Health Organisation).
We welcome the Nursing Council’s proposal to remove the statement on clinical leadership in the proposed new scope of practice. It is our view that doctors are in the best position to assume the role of clinical leadership of multidisciplinary teams. This view is also reflected in the Consensus Statement on the Role of the Doctor and is shared by the Canadian Medical Association and the American Academy of Family Physicians (27, New Zealand Medical Association).

Six submitters thought that, in addition to clinical leadership, teamwork and collaboration are important (15, 22, 25, 39, 48, 50).

The National Committee of ANZCA agrees that it is reasonable to focus on clinical leadership in the definition of nurse practitioner scope, and that requiring leadership in education, management, research and policy development may be too broad an expectation to apply to every registered nurse practitioner. Most nurse practitioners practice in primary care and mental health, and clinical leadership is an important attribute for these areas. However, the National Committee also considers that the real mileage for health in New Zealand communities will come from improved team performance in the healthcare system. This means that any expectations for clinical leadership should also be balanced with expectations for team work and collaboration, and acknowledgement that nurse practitioners will also work in teams where another health practitioner has delegated authority for the team (48, Australian and New Zealand College of Anaesthetists).

Leadership is important now more than ever - and in the full sense of the word: professionalism, behaviour, advanced practice, accountability, taking responsibility and ownership, team work and collaboration. In the existing sentence I would drop the word “consultant” and replace it with “clinician” (22, Tairawhiti District Health).

3.3 The inclusion of advanced nursing skills and knowledge in the proposed new scope of practice (Question 8)

The Council proposed adding an emphasis on the advanced nursing practice of the nurse practitioner, i.e. their ability to use their advanced nursing knowledge and skills to provide flexible, innovative, holistic and individualised care working in partnership with the client, community or population group. This is not evident in the current scope of practice statement in Appendix 2.

There was a high level of support for this question (89%) (see Chart 3), although much of the feedback was restricted to commenting on the word “advanced” or “advanced nursing skills and knowledge”. Submitters did not generally comment on whether descriptions of “advanced nursing” should be included in the scope of practice.
3.3.1 Support for “advanced nursing skills and knowledge” within the scope of practice

A few submitters commented on the changes to the wording of the scope of practice making it more holistic or keeping the focus on nursing rather than being a ‘mini doctor’ (14, 22, 33, 43).

*Emphasis on advanced nursing skills and knowledge gives a holistic aspect to the proposed new scope of practice. It also differentiates the Nurse practitioner’s scope from the Registered Nurse scope (43, National Council of Women of New Zealand).*

*Yes as this provides greater visualisation of the NP role and clearly identifies this as not being a ‘mini-medical’ role. Keeps the focus on nursing with the inclusion of ‘advanced nursing skills and knowledge’ (33, Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer).*

Many submitters supported the use of advanced practice as a way of differentiating the nurse practitioner from the registered nurse scope of practice (9, 10, 14, 15, 18, 19, 21, 23, 25, 28, 35, 40, 41, 42, 43, 44, 49, 50, 51).

*A clear statement that advanced practice, informed by advanced education and clinical experience is the cornerstone of NP scope of practice makes it clearer to the sector about the NP role and provides some differentiation from other nursing scopes of practice (49, MidCentral Health nurse practitioners).*

*Advanced nursing skills and knowledge are essential and will help to differentiate a nurse practitioner from a registered nurse or registered nurse first surgical assistant (50, Royal Australasian College of Surgeons).*

*The group were divided on this. Some respondents did not support the use of the word “advanced” as it described the NP scope in relation to that of an RN whilst it was in fact a completely separate scope of practice and should not be compared with others. Others felt that this was appropriate as it clearly differentiated the NP and RN scope, which was important to the public (19, General Practice New Zealand).*
Some submitters supported the use of “advanced” rather than “expert”, which is in the current SOP and is commonly associated with PDRPs (Professional Development and Recognition Programmes), and which has a lower educational requirement (25, 35, 47, 52, 56).

It is an improvement to remove the word ‘expert’ and focus on the advanced nursing skills and knowledge. The words “beyond the level of the RN” are useful for this focus (47, Capital and Coast District Health Board).

The current scope of practice statement uses the term “expert nurses”. This term is associated with the Professional Development and Recognition Programmes in New Zealand, where a registered nurse can attain expert level and considered an “expert” nurse, but may not necessarily have advanced nursing knowledge and skills associated with postgraduate education programmes. Nurse practitioners demonstrate advanced nursing skills and knowledge associated with the completion of Master’s level preparation (52, Eastern Institute of Technology School of Nursing and 56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)).

There is a level of confusion within nursing and the wider health sector on clinical roles and within the PDRP system on "expert" Registered Nurses versus a Clinical Nurse Specialist. This is largely due to the lack of a clearly defined scope for CNS roles. Adding another nursing level (NP) adds to the complexity of understanding the differences in operational levels. The word "advanced" should be limited to the NP role description and perhaps other wording such as "extended practice" or "expert" should be applied to differentiate the other existing roles for RN's or the development of a CNS scope of practice could be developed to further differentiate the roles and enhance understanding (25, Individual nurse).

Several submitters supported the more frequent use of “advanced” within the scope statement (16, 53, 58).

It is difficult to see the advanced component within the new scope: this needs to be more clearly articulated. The proposed scope could, technically, describe RN competencies. The word advanced needs more frequent usage in the narrative (53, Victoria University of Wellington).

NZNO support the proposed new scope of practice for nurse practitioners. NZNO believe it is essential to clearly articulate the difference between a NP and other nurses who may practice at an advanced level. The proposed new scope articulates a number of these differences, but feedback from member groups suggests a stronger statement could be made regarding the role NPs have in diagnosing and managing care of complex patients with multiple morbidities and/or multiple diagnoses, the clinical leadership role they have within their service, and the advanced component of their role: the word advanced needs more frequent usage in the narrative. Technically, the proposed scope could describe RN competencies (58, New Zealand Nurses Organisation (NZNO)).

One submitter thought the phrase “advanced knowledge and skills” should be explicit, not implied (39).
We note that the wording of the new scope does not specifically include the wording of advanced nursing skill and knowledge, rather it is implied. As nurse practitioners we are constantly striving to achieve expertise and are actively using advanced skill and knowledge to do this and this should specifically be mentioned in the document (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

3.3.2 Other suggested wording related to advanced skills

Four submitters suggested adding “medical skills” or “medical services” to the scope of practice. This was seen as clearly differentiating nurse practitioners from registered nurses (16, 44, 46, 57).

NP’s are Master’s prepared advanced clinical nurses who work within broad areas of practice incorporating advanced diagnostic knowledge and medical skills into their advanced nursing practice. They are regulated, autonomous health practitioners who assume full clinical responsibility for patients, working both independently and in collaboration with other health care professionals to promote health, prevent disease and manage people’s health needs. They provide a wide range of assessment and treatment interventions, including diagnosing, ordering and interpreting diagnostic/laboratory tests, prescribing medicine administering treatments/therapies, admitting and discharging from hospital and other healthcare settings (16, University of Auckland School of Nursing).

This makes it explicit that the NP role operates at a high level incorporating expert knowledge underpinned by academic application. • Agree with “advanced nursing skill and knowledge” but it needs further expansion to include “advanced nursing skill and knowledge that enables them to provide both nursing and medical services to patients”. • The terminology ‘advanced’ is confusing in the workplace. NP should not be described in relation to the RN scope, they are different roles the same as RN and EN are different. Perhaps words like “broad”, “well-integrated” or “nursing skills and knowledge appropriate for the scope of practice” (44, Nurse Executives of New Zealand (NENZ)).

This is a question of semantics, if clinical Nurse Specialists have advanced skills then do NP’s have the right to claim they are "expert", how do we define the different level of skill to differentiate from CNS, expert (Level 4 PDRP) nurse? Or do CNS have enhanced skill level and NP’s have advanced? What defines the NP Scope of practice is that NP’s meld the role of nursing and knowledge and skills previously the sole domain of medicine and so offering not only nursing but medical services (46, Nurse Practitioners New Zealand).

We agree with the words “advanced nursing skill and knowledge” but think it needs further expansion to include “advanced nursing skill and knowledge that enables them to provide both nursing and medical services to patients” (57, Critical Care Complex- Counties Manukau District Health Board).

Two submitters thought the scope should describe advanced skills rather than advanced nursing skills (32, 48).

The Committee agrees that the proposed new scope of practice should articulate advanced skills. The Committee supports referring to these as “advanced” skills rather than “advanced nursing” skills as referred to in the consultation document, as the skills outlined are generic.
rather than being attached specifically to any particular domain (such as nursing, medicine or pharmacy) (48, Australian and New Zealand College of Anaesthetists).

The advanced role of nurse practitioner requires maintenance of a higher skill level. This statement “their ability to use their advanced nursing knowledge … community or population group” applies to all health professionals. We suggest a change of term from client to patient, which is more appropriate (32, New Zealand Society of Anaesthetists).

3.3.3 “Advanced nursing knowledge and skills” is not helpful/necessary within the scope of practice

Two submitters commented that the Council should focus on what the public need to know when developing the scope of practice rather than professional preferences.

The HPCAA 2007-09 review outlined the principles for developing or reviewing scopes, and these included defining scopes to protect public health and safety rather than responding to professional preferences. Criteria to guarantee public safety and quality of practice when extending prescribing rights includes education, registration, restriction of prescribing authority to the scope of practice, monitoring and communication of information between health practitioners. Prescribing inherently increases the risk to public safety so the scope of practice for advanced practitioners should clearly differentiate between the skills required at this level and those for entry or mid-level practitioners (9, Pharmacy Council of New Zealand).

The proposed new scope of practice is far too wordy. Essentially the public simply need to know what the difference is between the Registered Nurse and Nurse practitioner. This could be reduced to the extract below from the new scope of practice consultation document. Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a registered nurse. Again need to clarify the scope in relation to mental health below: Utilising of the mental health education credentialing process. High importance of Clinical Supervision (10, East Health Trust Primary Health Organisation).

One submitter thought that differentiation from the registered nurse scope by using the word “advanced” was confusing and other terms should be used to describe nurse practitioner skills such as "broad", "well-integrated" or "nursing skills and knowledge appropriate for the scope of practice" (15). Another submitter supported “advanced critical thinking, experiential skills and knowledge to benefit patient access and outcomes” (22).

The terminology advanced is confusing in the workplace despite the previous work in this area. Nurse practitioner is a separate scope to registered nurse and so should not be described in relation to RN scope, any more than a registered nurses is more 'advanced' than an enrolled nurse. Suggested changes are more difficult but perhaps words like "broad", "well-integrated" or "nursing skills and knowledge appropriate for the scope of practice". Perhaps our need to put a relational context on the NP role is at the heart of our difficulties (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).
Not sure that the words described in the consultation document really describe the essence of the work of a NP. Other than "assess, diagnose and prescribe" all RNs should work "innovatively, flexibly and holistically". I think it is more the art of nursing being applied to work collaboratively with the patient / whanau but also within a multidisciplinary team using advanced critical thinking, experiential skills and knowledge to benefit patient access and outcomes (22, Tairawhiti District Health).

Other submitters were of the opinion that some registered nurses could also use advanced nursing skills and knowledge so this wording does not differentiate the nurse practitioner from the registered nurse scope of practice (22, 45, 46, 55).

The College is supportive of this inclusion with a caveat. We note that as currently written it does not add any additional clarity. A registered nurse who has completed a postgraduate diploma and becomes a designated prescriber might well consider they are using advanced skills and knowledge and it would be useful future proofing to sharpen the distinction. One point of difference might be the use of or adherence to more formulaic or algorithm based prescribing for RNs compared with the autonomous clinical judgment of the NP prescriber (55, College of Nurses of Aotearoa New Zealand).

Advanced nursing skill and knowledge must be a pre requisite, however it must be recognised that RN’s can also legitimately claim advanced practice without necessarily having an NP registration (45, New Zealand Rural General Practice Network).

3.4 Proposed new scope of practice for nurse practitioner (Question 9)

The Council has proposed the following scope of practice statement. Submitters were asked to consider whether it is an adequate description of the scope of practice and clear for employers, nurses, the public and others who work in the health sector.

Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practise beyond the level of a registered nurse. Nurse practitioners provide a wide range of health care services to people and communities, including the diagnosis and management of common and complex medical conditions. Nurse practitioners may work autonomously and in collaboration and consultation with patients and with other health professionals, including medical practitioners, to provide and improve access to coordinated, comprehensive, quality health care. Nurse practitioners may manage episodes of care and may be the primary care provider or work as part of a team.

Nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient centred, innovative and flexible care. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic/laboratory tests, prescribing medicines, administering treatments/therapies, admitting and discharging from hospital and other health care services/settings. They work in partnership with individuals, families, whānau and communities across a range of settings. Nurse practitioners may work with a specific patient group or community, and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs.
The majority of submitters (61%) (see Chart 4) supported the new scope statement as providing more clarity about the nurse practitioner scope of practice and role in health services. Many submitters had suggestions for changing the wording of the scope statement with some objecting to wordiness and repetition. There were some submitters who thought the statement about diagnosis went too far and others who believed it did not go far enough. A few submitters wanted the provision of “medical services” added to the statement.

Chart 4: Support for the proposed new scope of practice for nurse practitioner

<table>
<thead>
<tr>
<th>Support</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>61%</td>
</tr>
<tr>
<td>No</td>
<td>21%</td>
</tr>
<tr>
<td>Did not answer</td>
<td>18%</td>
</tr>
</tbody>
</table>

### 3.4.1 Support for the proposed scope statement

Reasons given for supporting the statement included that it provides greater clarity about the work of nurse practitioners. This will improve understanding of the scope of practice by the public, employers and other health professionals.

- The new scope appears to clearly define the depth of the work NP’s undertake without limiting their flexibility or being to descriptive (2, New Zealand Institute of Rural Health).

- The proposed SOP has an improved clinical focus and clearly articulates the role (21, Taranaki District Health Board).

- The proposed scope explains the role more accurately. It provides clarity for employers, and also to GPs - who need to better understand the role - this will provide for more support from GPs and encourage uptake of NP positions in primary care (5, Waitakere Union Health Centre).

- It gives a good overview of capabilities and accompanying legislation It allows the public to have better understanding of what a Nurse practitioner is (51, MidCentral District Health Board: Group of senior nurses and 14, Intern and Nurse practitioner peer review group).

- It will as it develops strengthen our profession and also improve timely access to investigation or intervention for patients. It will also enhance MDT working. Meets government priorities of better sooner more convenient (12, Individual nurse).

- It seems lengthy on initial reading but there isn’t anything that I felt could be removed and it couldn’t be written in a more succinct way. I particularly like the Nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and
practice to provide holistic, patient centred, innovative and flexible care. I think this sums up my interpretation of the NP very well. It is the advanced knowledge and skills practiced from an experienced nursing perspective that make the role what it is (28, Neonatal Nurses College of Aotearoa/NZNO).

No issues with this proposed scope (46, Nurse Practitioners New Zealand).

The College supports the scope of practice (55, College of Nurses Aotearoa New Zealand)

Many submitters supported the statement and did not propose any changes to the wording. About half the submitters suggested wording changes. Many of these were minor and have been collated in a table on pages 36-37. The changes proposed or discussed by a number of submitters are outlined below.

3.4.2 Reduce or re-order the proposed scope statement

Seven submitters commented that the new scope of practice was too wordy and should be more succinct (10, 19, 26, 38, 39, 40, 54).

The statement is quite long and wordy dare I say flowery; 127 [words] verses 195 [words]. Some aspect appear repeated but using different language i.e. provide a wide range of health care services to people and communities then at the bottom “work in partnership with individuals, family (whanau) and communities across a range of settings” these statements are very similar ? combine them in some fashion. This statement is prescriptive and will leave no one in doubt as to what the NP can do from a clinical perspective (40, Te Tai Tokerau nurse practitioners).

Nurse practitioners may work with a specific patient group or community and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs – We feel this statement is not necessary with the removal of specialty practice areas and is a duplication (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

The proposed new scope of practice is far too wordy. Essentially the public simply needs to know what the difference is between the Registered Nurse and Nurse Practitioner. This could be reduced to the extract below from the new scope of practice consultation document. Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a registered nurse. Again need to clarify the scope in relation to mental health below: Utilising of the mental health education credentialing process. High importance of Clinical Supervision (10, East Health Trust Primary Health Organisation).

Several submitters suggested changes to the proposed scope of practice that removed repetition or reordered the scope. These can be found in Appendix 3.

3.4.3 Other suggested scope statements

Two submitters preferred the existing scope statement with one proposing changes to its wording (40, 54).
One submitter presented a scope statement that was significantly different from the proposed scope statement (45).

An alternative statement may be NP’s practice as expert clinicians and as authorized prescribers with legal authority beyond the scope of RN’s having undertaken an advanced program of post graduate education, clinical training with demonstrated competency. NP’s base themselves within current research and best practice demonstrating advanced clinical skills of assessment, clinical diagnostic inquiry, ordering and interpreting diagnostic and laboratory investigations, determining and administering treatment and therapies including prescribing medicines, referring to and consulting with other clinicians across the healthcare contexts and including admissions and discharge from hospitals as necessary. They are able to manage common, complex and chronic health care needs of individuals, family and whanau, communities and populations. NPs can work independently and collaboratively across the sectors and disciplines related to health care to promote health, prevent disease and manage illness, improve access and remove inequalities in health care. NPs are considered leaders within the nursing sector able to provide mentorship, education to other nurses and demonstrate innovative solutions to practice (45, New Zealand Rural General Practice Network).

3.4.4 Suggestions on how ‘leadership’ should appear in the scope statement

Seven submitters (25, 31, 38, 41, 40, 47, 58) commented on the need to include leadership within the scope with varying perspectives on how it should be done. Some argued that an expectation of leadership to improve patient outcomes was a minimum.

Within the first sentence there should be mention of leadership skills i.e. “NP’s have advanced … training, leadership skills and the demonstrated….” (25, Individual nurse).

NPs have the potential to work in a variety of situations requiring a range of leadership abilities… we suggest including elements of leadership which accompany clinical leadership e.g. management, and involvement in local, regional and or national levels. NPs are well positioned to have a strong voice within the profession and this requires emphasis (41, Auckland University of Technology).

Please note it is self-limiting with the focus only on clinical practice without a focus on leadership in the NPs area of practice to improve population outcomes. The words “area of practice” could still be used even with a broader Scope of Practice statement as less onerous than the leadership in the profession. While the revised scope is important for demarcating the difference in the RN/NP level of advanced practice it is limiting in the absence of leadership or contribution to research, policy and the profession. The CNS (or NS used in some DHBs) is the senior practice role many NP Candidates leave once NPs. The KPI for the CNS (and other senior nursing roles) require leadership beyond practice and the direct clinical work and follow up with patients. The ordering of diagnostic/laboratory tests needs to be separated. The focus of diagnostic tests is broader and use of a / indicates the same focus. It needs to be clear that diagnostic ordering is required (therefore needs employer support beyond lab orders. The wording prevent disease could also be to reduce disease or disease burden or impact. Prevent is a tall order when considering the focus on older and chronic illness for NP addressing anticipated increasing gaps in the futures (47, Capital and Coast District Health Board).
NZNO recommend inclusion of a stronger statement regarding the role of NPs in diagnosing and managing the care of complex patients in the proposed new scope of practice; NZNO recommend inclusion of a stronger statement regarding the leadership capabilities of NPs; NZNO recommend including greater reference to advanced practice; Feedback received from members suggests the new statement is not clear in its leadership application and needs to go further and be more specific regarding leadership. There should be some reference to influencing and informing clinical services – leadership is not only at the level of individual patients, but leadership within the clinical team, clinical services (working with others) and within the profession. There needs to be acknowledgement of the role of undertaking audit and monitoring, of quality and governance to inform service development and profiling the role of advanced nursing practice within the profession (58, New Zealand Nurses Organisation (NZNO)).

3.4.5 Comments on the diagnostic extent of the nurse practitioner scope of practice

Concern was expressed by three submitters that the statement does not go far enough with the diagnostic role (57, 44, 58).

It does not address the diagnostic role nurse practitioners have in diagnosing and managing care of complex patients with multiple morbidities, multiple diagnoses or the clinical leadership role they have within their service (57, Critical Care Complex- Counties Manukau District Health Board).

Other submitters stated that the wording goes too far with regard to diagnosis of complex conditions.

The NZMA has reservations at the proposed extension of the scope of practice to include “the diagnosis ….of complex medical conditions”. While we are aware that the current scope of practice for nurse practitioners already encompasses diagnosis, we do not believe that an extension to this aspect is warranted. Nurse practitioners are an important part of the health care team but we do not feel that they should substitute for a fully trained doctor, particularly where the diagnosis of complex medical conditions is concerned. The education and training of doctors and nurse practitioners are substantially different, and doctors and nurse practitioners are not interchangeable in providing the full depth and breadth of services. The Consensus Statement on the Role of the Doctor, endorsed by 14 organisations, identifies diagnosis as a key feature of a doctor’s expertise in medical practice (see Attachment 1). The statement emphasises that doctors must take ultimate responsibility for medical decisions and diagnoses in situations of complexity (27, New Zealand Medical Association).

Not entirely. We do not support nurse practitioners taking responsibility for diagnosis and management of “complex medical conditions” (page 12). We have concerns about nurse practitioners making independent diagnosis of complex medical conditions, especially outside their area of speciality. We submit that the tasks of diagnosis and initiation of treatment of patients with all but the most common and simple of conditions remain a medical role, due the medical training that doctors undertake in anatomy, physiology, pathology, diagnosis, and therapeutics over many years. As in our answer to question 2, the settings where the nurse practitioner has the ultimate responsibility need further definition. We note the statement “nurse practitioners may manage episodes of care and may be the
primary care provider or work as part of a team” (p12). This statement is too general. We acknowledge that nurse practitioners are the primary care provider in some settings (rural for example), but further definition on what settings apply would avoid a perception that nurse practitioners could replace doctors in a setting where doctors are available. We also suggest a change to the wording to acknowledge that nurse practitioners work alongside other health professionals in a multidisciplinary approach – to avoid a perception that a nurse practitioner provides complete care for patients, which is not an accurate representation (32, New Zealand Society of Anaesthetists).

The Pharmacy Council submitted that the role of autonomous primary diagnostician was not clear within the scope.

PCNZ partially agrees with the wording of the new scope but notes that some wording could be clarify intent. The revised scope suggests that nurse practitioners will be primary diagnosticians. It also indicates that at times they may work autonomously. What is not clear are the checks and balances around their prescribing practice if in fact these two things are true. If they are not to be the primary diagnostician, but will prescribe according to a confirmed diagnosis, this should be clarified in the scope (9, Pharmacy Council of New Zealand).

3.4.6 Comments on the use of the word “may”

Seven submitters (52, 56, 15, 29, 39, 30, 44) commented on the use of the word “may” within the scope and suggested it was too tentative.

The proposed scope of practice, however, seems to be tentative, in that in some places it states “may” which implies nurse practitioners may not undertake certain activities. It is more appropriate to have an enabling statement rather than weaken the scope of practice with some aspects that nurse practitioners “may” do (52, Eastern Institute of Technology School of Nursing).

‘Nurse practitioners should/will manage episodes of care and may be the primary care provider or work as part of the team”. This strengthens the role and distinguishes in the workplace as these nurses can direct and manage care independently (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

One submitter (25) supported the word “may”.

The proposed new scope provides more flexibility in the role and potentially reduces the pressure felt to practice at a "super nurse" level constantly and this is provided by the use of the word “may” throughout the statement (25, Individual Nurse).

3.4.7 Comments on the blend of diagnostic, therapeutic and nursing practice

Three submitters (34, 36, 28) supported the statement that nurse practitioners “blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient-centred, innovative and flexible care”.
The new scope clearly defines the work an NP carries out the wording in paragraph 2 around ‘blending’ skills is an accurate description of NPs function at this level (34, Grace Hospital).

Particularly likes how it emphasises blending nursing values, knowledge and practice into the scope. This is great to identify the role is more than being medically focused and is a strong point of difference and value (36, Primary Health Care Nurse Reference Group- Hutt Valley).

It seems lengthy on initial reading but there isn’t anything that I felt could be removed and it couldn’t be written in a more succinct way. I particularly like the nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient centred, innovative and flexible care. I think this sums up my interpretation of the NP very well. It is the advanced knowledge and skills practiced from an experienced nursing perspective that make the role what it is (28, Neonatal Nurses College of Aotearoa/NZNO).

Three submitters removed this phrase from their supplied alternative scopes and three left it in.

3.4.8 Other comments on the proposed scope statement

Two submitters wanted to emphasise collaboration and teamwork (27, 48) and another thought that working autonomously should be removed from the scope in favour of collaboration and integration (63). Another suggested this was already eloquently described.

We submit that the Nursing Council consider rewording the proposed new scope of practice such that it makes it clear that collaborative and integrated health care teams are the preferred models of care, particularly in the primary care context (27, New Zealand Medical Association).

The Committee recommends that the proposed new scope includes more emphasis on collaboration and working as part of a multidisciplinary team. It is essential for any health practitioner to be able to work effectively in multidisciplinary teams that may be led by another health practitioner group. To foster a team based approach to healthcare, it would be useful to recognise in the new scope the importance of the ability to follow, as well as the importance of the ability to lead (48, Australian and New Zealand College of Anaesthetists).

It explains the NP role more accurately combining the traditional roles, knowledge and skills of nursing and medicine. Of particular concern medically has been the old wording of “works independently” which has created significant barriers to acceptance and understanding of an NP role. **The new scope very eloquently describes how an NP “may work autonomously and in collaboration and consultation with...” and very importantly “as part of a team”**. This will certainly help understanding of the role (25, Individual nurse).

One submitter (10) commented that the scope of practice statement, as well as being too wordy, described the role of a primary care registered nurse.

No, there is a need to clarify this. Much of the narrative describes broadly the scope of the Registered Nurse when considering the diverse role of the Primary Health Care Nurse.
There needs to be much shorter/ punchier bullet points to differentiate the differences between the two. Currently it’s too wordy. For example, many RN’s in Primary Care do the following as described in the Consultation document: provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic/laboratory tests, administering treatments/therapies, admitting and discharging from hospital and other healthcare services/settings. They work in partnership with individuals, families, whānau and communities across a range of settings. Nurse practitioners may work with a specific patient group or community and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs. Therefore, let’s focus on what is different from the role of the Registered Nurse/ Practice Nurse (10, East Health Trust Primary Health Organisation).

One submitter (53) thought the scope should focus more on action and procedures permitted by law.

The proposed scope reads more as a role description. Our understanding is that a scope of practice should specify actions and procedures permitted by law for a specific profession and outline restrictions on the role, based on experience and educational qualifications (53, Victoria University of Wellington).
### 3.4.9 Other suggested wording changes

<table>
<thead>
<tr>
<th>Proposed wording change</th>
<th>Submitters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include partnership veers away from a self-management patient focus (last sentence) which negates concepts of participation, partnership and self-determination.</td>
<td>39, 54</td>
</tr>
<tr>
<td>Include advanced nursing skill and knowledge.</td>
<td>39, 58</td>
</tr>
<tr>
<td>Change medical conditions to health conditions – medical implies a medical model.</td>
<td>39, 19</td>
</tr>
<tr>
<td>Remove medical practitioner replace with health practitioners.</td>
<td>39, 26, 37</td>
</tr>
<tr>
<td>Remove administering treatment. Nurse practitioners are the authors of management plans and treatments regimes and do more than administer a treatment plan which would be more fitting to a registered nurse role.</td>
<td>39</td>
</tr>
<tr>
<td>Support the inclusion of admit and discharge which are important components of the episode of care.</td>
<td>39</td>
</tr>
<tr>
<td>Wonder if getting a bit too specific when adding admitting and discharging from hospital (may not be generic across all NPs to do this within their area of practice) suggest removing this.</td>
<td>40</td>
</tr>
<tr>
<td>Specifying the advanced education requirement (i.e. Masters-level qualification).</td>
<td>26, 17, 29, 46, 38</td>
</tr>
<tr>
<td>An additional elements identified in a recent global symposium on advanced practice are the presence and utilization of complex decision making skills with the intent of providing access to health care – these elements are absent in the presented scope.</td>
<td>56</td>
</tr>
<tr>
<td>The first sentence needs to be removed as it is redundant in the context and perhaps replace with something like &quot;NP is a legislated scope of nursing practice with the authority to practice within published competencies of the role&quot;. The current statement belongs in the educational framework rather than the scope and again is relational to the RN scope through the inclusion of the word &quot;advanced&quot;.</td>
<td>15, 44</td>
</tr>
<tr>
<td>NPs work in broad area of practice.</td>
<td>17</td>
</tr>
<tr>
<td>However, we think it is essential that the word ‘safe’ should be included in this description (co-ordinated, comprehensive, quality care).</td>
<td>29</td>
</tr>
<tr>
<td>should be &quot;principal care provider&quot; rather than &quot;primary care provider&quot; as this is ambiguous.</td>
<td>5</td>
</tr>
<tr>
<td>“main care giver”</td>
<td></td>
</tr>
<tr>
<td>Clear evidence of improved outcomes for patients should be paramount</td>
<td>63</td>
</tr>
<tr>
<td>&quot;Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a registered nurse&quot; add other advanced nursing roles&quot;.</td>
<td>18</td>
</tr>
<tr>
<td>Also the second to last sentence seems a little repetitive, perhaps use the word population and take out group or community?</td>
<td>20</td>
</tr>
<tr>
<td>The term &quot;legal authority&quot; is very important. This helps in further clarification of the differences between other nursing roles in advanced practice such as nurse specialist and acknowledges that the nurse is able to practice beyond the scope of the registered nurse such as authorised prescribing, some advanced skilled care and procedures etc.</td>
<td>30</td>
</tr>
<tr>
<td>Possibly change the word &quot;improve&quot; (line 7) to ‘facilitate access’.</td>
<td>33</td>
</tr>
<tr>
<td>I don’t like wording in sentence one, reads although justifying NPs against RNs whereas NPs are a significant extension of the RN. Opening should focus more on the reason for NPs - increasing access to care for those who need it, promoting health NOT practicing beyond level of RN.</td>
<td>40, 41</td>
</tr>
<tr>
<td>&quot;Nurse practitioners provide a wide range of healthcare services to people and communities, including the diagnosis and management of common and...&quot;</td>
<td>20</td>
</tr>
</tbody>
</table>
complex medical conditions. "In this, **acute and emergency situations** has not been mentioned.

<table>
<thead>
<tr>
<th>We suggest a <strong>change of term from client to patient</strong>, which is more appropriate.</th>
<th>32</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education of others</strong> is part of the role as well.</td>
<td>1</td>
</tr>
<tr>
<td>They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic/laboratory tests, prescribing medicines - <strong>and non-pharmacological treatments</strong> - administering treatments/therapies, admitting and discharging from hospital and other healthcare services/settings.</td>
<td>16</td>
</tr>
<tr>
<td>The ordering of diagnostic/laboratory tests needs to be separated. The focus of diagnostic tests is broader and use of a / indicates the same focus. <strong>It needs to be clear that diagnostic ordering is required</strong> (therefore needs employer support beyond lab orders). The wording <strong>prevent disease could also be to reduce disease or disease burden or impact</strong>. Prevent is a tall order when considering the focus on older and chronic illness for NP addressing anticipated increasing gaps in the futures.</td>
<td>47</td>
</tr>
<tr>
<td><strong>Change consultant to clinician.</strong></td>
<td>22</td>
</tr>
</tbody>
</table>
4 Education programme

There was a high level of support for the Council’s proposal to introduce a programme specifically for the nurse practitioner with specified clinical learning hours and programme outcomes. There were mixed views on the need for employer support to complete the clinical learning hours. The majority of submitters did not support the ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ as a prerequisite for nurse practitioner programmes. Most submitters wanted the Council to retain its role in accrediting tertiary courses and programmes that do not lead to registration in the nurse practitioner scope of practice or registered nurse prescribing.

4.1 A dedicated master’s programme with a broad focus for nurse practitioner preparation (Question 10)

Under the Health Practitioners Competence Assurance Act 2003 the Council is responsible for approving and monitoring education programmes leading to registration in a scope of practice (see Appendix 4). At present nurse practitioners must complete a clinically focused master’s degree programme approved by the Council as part of the nurse practitioner prescribed qualifications. The Council developed Standards for Advanced Nursing Practice programme (with/without prescribing) in 2001\(^1\). These programme standards are still used today to approve and monitor programmes. They contain specific requirements related to “assessment, prescribing and monitoring processes”, and an assessment of the student against the competencies for nurse practitioners, but otherwise devolve responsibility to the education providers to determine graduate outcomes.

The Council noted that these programmes now have a wide range of purposes and do not focus solely on the preparation of nurse practitioners. The Council proposed a dedicated nurse practitioner programme become the educational qualification for registration as a nurse practitioner.

This proposal was supported by 75% of submitters (see Chart 5). A dedicated programme with a broad focus was seen as standardising the provision of programmes across the postgraduate providers and the skills of nurse practitioners. It would also provide a clear education pathway for registered nurses to prepare to become nurse practitioners. Some flexibility in the programme for acute care, specialty papers and mental health was discussed by some submitters.

---

4.1.1 Support for a dedicated programme with a broad focus

The reason given by many submitters was that a dedicated programme with a broad focus would enable nurse practitioners to develop the advanced skills needed to meet population and health service needs (16, 19, 34, 39, 46, 57, 58).

**NPNZ support a broad dedicated Masters programme for Nurse practitioner preparation.** It needs to be broad to reflect the broad scope of practice and focus in on the critical reasoning skills required for assessment, diagnosis and treating illness (46, Nurse Practitioners New Zealand).

**NZNO support a dedicated Masters programme with a broad focus for nurse practitioner preparation.** NP education must be broad in order to ensure development of the required NP critical thinking and leadership skills needed to ensure NPs meet their patient population needs and the changing service needs of their organisation (58, New Zealand Nurses Organisation (NZNO)).

The broad focus is important as it gears the nurse towards an appropriate level of skill and knowledge to work at the advanced clinical level (34, Grace Hospital).

We support a dedicated programme that provides specific guidance for NP preparation and which includes a requirement for clinical mentorship and supervision. A broad overall focus on advanced clinical skills such as advanced health assessment and physical examination, biologic science focused on clinical pathophysiology, and clinical pharmacology are the components which have broad international concordance for inclusion. Additionally, some preparation regarding a specific clinical population would be valuable in development of expert clinical knowledge (16, University of Auckland School of Nursing).
4.1.2 Benefits of a dedicated programme include consistency of preparation, nurse practitioner skills and a clear educational pathway

A dedicated programme was also seen as standardising the skills of nurse practitioners and improving their employment opportunities (14, 43, 58).

A dedicated Masters programme will help ensure employers have a greater understanding of the fundamental skills of every NP – this will enable greater employment opportunities and the ability for NPs to be more mobile in seeking employment (58, New Zealand Nurses Organisation (NZNO)).

A dedicated Masters programme will give broader employment opportunities and in the future will enable the Nurse practitioner to move with ease into new expanded areas of health service (43, National Council of Women of New Zealand).

A dedicated nurse practitioner programme was seen by many submitters as improving standardisation and consistency across postgraduate providers (19, 34, 39, 43, 63).

Standardising the requirements across the universities will provide equality amongst providers, and a consistency of outcomes. Cross crediting of papers across universities is not easily achieved with some universities and this would hopefully improve with standardisation of content. It will also allow mentors to have a greater understanding of student's requirements if their master’s qualification was through another provider (34, Grace Hospital).

To date there have been a variety of pathways to reach Nurse practitioner status depending on which of seven tertiary institutions the nurse enrols at in New Zealand. NCWNZ members believe the Nurse practitioner course must be more uniform, with syllabus content uniform throughout New Zealand. A dedicated Masters programme will give broader employment opportunities and in the future will enable the Nurse practitioner to move with ease into new expanded areas of health service (43, National Council of Women of New Zealand).

The varied career intentions of more recent candidates for the Master in Nursing programme give rise to a risk that the programme will not fulfil the needs of potential NPs. This is a particular issue in the current environment of competitive university funding based on the numbers enrolled. Having a dedicated programme would be one way of ensuring that the time and energy that potential NPs devote to completing the Masters is useful preparation for the role (63, Royal New Zealand College of General Practitioners).

We feel that a dedicated program will ensure consistency across the tertiary institutes offering a clinical masters and will make sure that future NP’s are graduating to a consistent standard. As part of the program, NP candidates should be able to submit their portfolios by the end of the degree (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

Another reason given by many submitters for supporting a dedicated nurse practitioner programme was the reduction of confusion for nurses regarding the required preparation (2, 14, 28, 37, 43, 51).
A dedicated Masters’ [programme] with broad focus will reduce confusion and give greater confidence to nurses undertaking this pathway. Also will give broader employment options and in the future allow easier access to populations if NP can move easily into new expanded roles (14, Intern and Nurse practitioner peer review group).

I support a clinically focused Masters paper for NP preparation. The requirements pathway needs to be clear from the outset of training as some nurses are completing Masters programmes that are not considered appropriate by nursing council. Clarification of a dedicated pathway would avoid this happening (28, Neonatal Nurses College of Aotearoa/NZNO).

There has been some confusion on which courses to take and how to proceed so a dedicated master’s program for NP will give more clarity and uniformity for those wishing to become NP’s. It will also make it easier for cross crediting or recognizing overseas NP qualifications. There does need to be some flexibility in order for there to be an area of “specialty” included so that NP’s can gain knowledge in areas they may intend to specialize or have more interest in (2, New Zealand Institute of Rural Health).

Yes we agree as currently we consider NP preparation is lost in the education system (37, Hutt Valley District Health Board including primary health care).

4.1.3 Standardise but allow flexibility

Several submitters supported a dedicated programme but within a broader master’s degree. Some expressed the view that the nurse practitioner programme should be restricted to the last four papers or comprise core papers. This was to facilitate maximum flexibility around papers that nurses may have taken for other professional/career purposes and these could be cross credited (14, 21, 47, 51, 53).

Papers up to Masters level need to be flexible as many nurses do not make a decision to obtain NP until they have completed a post graduate qualification. It can be too restrictive for nurses who do not want to make the decision until after achieving Diploma level. As well it is not responsive to environmental/organisational changes which may result in unacceptable delays in establishing NP into an identified role. Once a nurse achieves Diploma level then a decision can be made regarding NP focus. Also following completion of Master degree, two practicum papers - advanced practice and advanced prescribing would be recommended to complete NP. Also support an internship program is built into the NP program (21, Taranaki District Health Board).

While we support better preparation for the NP we are concerned at the focus of this from the time of commencing PG study. This should only occur in the last four papers. We agree with a broad focus in NP education. It is not untypical for the PG study to inform the practice development and eventual focus on NP registration. However the development and commitment of the RN and the employer will not always be aligned at the time of commencing PG study. We see a risk to RN workforce development if only those who have employer support can commence PG study when many others with NP aspirations may not commence on a NP ‘dedicated masters’. Staff need options in PG study to enable later entrance to the NP pathway with employer support. In some cases for a range of reasons staff may later in their PG pathway determine themselves they no longer see the NP role as
the optimal career pathway. Similarly other staff may end up having to complete additional papers or needing to change PG options to enable NP application when original PG option was not in a dedicated NP programme of study. We appreciate there will be similar papers within a dedicated NP Masters and clinical/other nursing masters but it is important there remains some flexibility in the paper options staff take. The core papers required can be clearly specified (47, Capital and Coast District Health Board).

We support a broad clinical Masters programme with a dedicated nurse practitioner pathway within it (53, Victoria University of Wellington).

The College of Registered Nurses of British Columbia (23) suggested that some papers could be shared with other master’s-level students. It has both a written and Objective Structured Clinical Examination (OSCE) before registration.

The competencies required of a diagnosing and treating (including prescribing) practitioner are distinct from those of other nursing roles and need their own educational foundation. There are some masters-level advanced nursing practice theory courses, however, that can be shared with other masters-level nursing students. In British Columbia we have success with this approach. In addition to a written examination, the College of Registered Nurses of B.C administers an Objective Structure Clinical Examination (OSCE) to test application of NP knowledge, skill and judgement (23, College of Registered Nurses of British Columbia).

Rural Women New Zealand cautioned that the programme needs to remain accessible for nurses in rural communities.

RWNZ supports the establishment of a dedicated nurse practitioner education programme. We think a dedicated programme could go some way towards encouraging an increase in NP numbers, by making registration requirements clearer. However we think it is imperative, that any prescribed qualification pathways remain accessible and reasonably achievable for RNs in rural areas. The NP role was introduced with the primary goal of improving access to primary health care in underserved rural communities (Rural Women New Zealand, 62).

4.1.4 Include specialty papers or pathways

Several submitters wanted papers in the nurse practitioner’s specialty to be included in the master’s programme (2, 16, 18, 30, 39, 42).

There does need to be some flexibility in order for there to be an area of “specialty” included so that NP’s can gain knowledge in areas they may intend to specialize or have more interest in (2, New Zealand Institute of Rural Health).

As long as it includes the specific papers and clinical placement for specialty areas. It would need to be standardised for accreditation purposes. There may be a danger of it being ‘watered down’ in the bid to be generic and this may pose difficulty down the track in terms of monitoring competencies and CPD (18, Regulatory authority).

There are principles of the nurse practitioner role that can be viewed as generic however there MUST be the opportunity for those working towards more specialised areas to be able to focus on their population - this is so important for those in child and family health, aged care or other areas. This was greatly lacking during some of our experiences in NZ.
especially as the curriculum generally focuses on caring for adults and we all needed to focus on child/adolescent and family care. There are some unique differences and therefore the Masters programme must allow for this. It is mentioned in the consultation document that the "Post graduate diploma in registered nurse prescribing for long term and common conditions" qualification may become a prerequisite for nurse practitioner programmes. This qualification appears to be taught from an adult focus such diabetes, cardiac disease, older adult etc. Again we would question how this qualification would be made relevant for the paediatric/ family populations – for example paediatric / family focused long term and common conditions could include immunisations, tx of glue ear / ear infections, bronchiectasis, septic arthritis, Rheumatic fever, eczema, skin infections and other potentially long term illness resulting from the impacts of socioeconomic deprivation.

Personally, when paying for University education, do not want to have to sit through lectures about adult diabetes and chronic obstructive respiratory disease, i.e. things that are not at all relevant to the paediatric population (30, Starship Children’s Hospital nurse practitioners).

Agree as long as it doesn’t disadvantage nurses who have already completed a clinical Masters. There needs to be the ability within the programmes for nurses to focus on their specialty e.g. emergency nursing (42, College of Emergency Nurses New Zealand/ NZNO).

One submitter argued for a separate pathway for nurses in acute care (51).

Some nurses suggested that clinically focussed postgraduate papers for example advanced assessment and clinical decision making are more primary care focused. This will allow for the development of appropriate advanced assessment skills that will enhance the nurses skill set required to become a Nurse practitioner in primary care. However, appropriate educational pathways still need to be available for Nurse practitioners working in acute care settings. The education programme therefore, must be fit for purpose: that is to meet the changing needs of their population and the service needs of the organisation (51, MidCentral District Health Board: Group of senior nurses).

Another submitter argued that papers were too acute focused (14).

Members of the group also asked that the university papers relating to clinical practice (e.g.: advanced assessment and clinical decision making) are more primary care focused. This will allow for the development of appropriate advanced assessment skills that will enhance the nurses skill set required to become an NP. Some nurse’s experience in the past found that such papers had a very secondary care and ICU focus which had little relevance to primary care. Nurses felt they had limited skills in assessment of some areas such as eyes, skin cancer or some musculoskeletal conditions. Therefore an intensive trainee intern programme may address these issues more easily (14, Intern and Nurse practitioner peer review group).

Three submitters (14, 19, 43) questioned where mental health would fit within the programme.

However, NCWNZ wonder whether Mental Health will fit with a broad focus for Nurse practitioner preparation. We believe establishing a definite pathway incorporating Mental Health into the Primary Health would be preferable (43, National Council of Women of New Zealand).
4.1.5 Retain other education pathways to nurse practitioner

Two submitters did not support the proposal and thought that difficulties related to the programme resulted from employers’ reluctance to use Health Workforce New Zealand (HWNZ) funds for release time (52, 56).

The dedicated Masters programme and associated questions in this consultation document seem to be an “either/or” proposition; that is, there is a dedicated programme which may preclude other options for becoming a nurse practitioner, or the status quo remains. The latter, it is noted on page 3 of this consultation document seems to be the impetus for this proposal, in that (among other things) there are “… difficulties accessing education, clinical training and mentorship, difficulties finding employment …”. In NETS experience, there is more at times an issue around the reluctance of employers to use HWNZ funds for clinical release time, and reluctance to support nurse practitioner roles as they are more expensive than clinical nurse specialist roles. We have made further comment in relation to this issue in question 13, employer support to complete a clinical practicum (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS) and 52, Eastern Institute of Technology School of Nursing).

4.1.6 Interpretation of “dedicated” meaning one programme or one provider

Some submitters interpreted a dedicated programme to mean one programme delivered by one provider and expressed concern that this was too limiting nationally (15, 19, 29, 44).

A dedicated pathway rather than a separate programme. New Zealand is too small to sustain this model and if we centralise to one or two institutions there is risk that the learning will be separated from the communities in which the roles evolve (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

One respondent supported a dedicated NP pathway but expressed concern re the centralisation of training to one educational institution, noting a possible separation from the needs of the communities the role would serve (19, General Practice New Zealand).

We support a clinically focused Masters with a broad focus. However, we are unclear about what is meant by ‘dedicated’ in this context. Clarification of ‘dedicated Masters Programme’ is required. We consider one problem with the word ‘dedicated’ is that there still needs to be flexibility as students need some areas/topics of choice as options to choose within a degree. For example, they may have exemptions/credits from prior study; they may wish to up-skill in a specialty area, e.g. rural practice, or paediatrics/child health from primary health care in a GP practice. We would not be supportive of a single programme undertaken by only NPs as this has the potential to limit the geographic spread of programmes aligning with areas of need for NPs, and raises issues of sustainability and viable options for study for many nurses (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

Support a dedicated pathway, but not a separate programme. We are too small a country to sustain this model and if we centralise to one institution there is risk of dislocation from the communities that the roles will serve (44, Nurse Executives of New Zealand (NENZ)).
Two submitters did support one standardised programme (22, 45) with a limited number of providers (22).

A dedicated programme provides consistency and legitimacy within the sector. Evolution of the programme requires consistency within the NP profession and having one dedicated programme enables that (45, New Zealand Rural General Practice Network).

Flexibility for employment opportunities; meet demand as it changes; whilst creating a standardised programme. Possibly this should be via just 2 tertiary education providers (one on the north island and one on the south island) (22, Tairawhiti District Health).

4.1.7 Other considerations

Some submitters raised the issue of a suitable master’s pathway for nurses who don’t want to be nurse practitioners (33, 39).

Yes as many nurses who complete the current Masters programmes at most academic institutions are required to undertake some type of practicum paper as a compulsory paper, yet the RN has no desire to be a NP. A broad focus and large range increases the knowledge base and background to enhance the role. Academic institutions have set unrealistic expectations with compulsory papers and have little flexibility to those not wishing to do a practicum and yet the academic institution demands the employer supports the individual with practicum support even if there is no organisational support for this role. So a dedicated Masters programme for those wishing to be prepared as an NP would be invaluable with one of the expectations being the submission of an NP portfolio within 6 months of that programme or potentially even as part of the programme (33, Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer).

The program should have flexibility to include a specialty paper of the NP’s choice. Regardless of the area of practice, all NPs should be able to practice across different environments and settings and require a broad focus to do this. There needs to also be provision for registered nurses who wish to increase knowledge that allows them to practice to the top of their scope and but don’t have any intention of progressing to NP. We propose two pathways for Master of Nursing – 1) Nurse practitioner Master of Nursing and 2) Master of Nursing (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

Two submitters advocated for nurse practitioner candidates to train alongside GP registrars (11, 40).

It cannot be stressed enough that basic nursing training has no training in diagnosis and graduate nurses who have particular desire to focus in the area should be directed to consider entry to medical school (we have two very good ones). This being said, there is a place for selected, able RNs to train alongside GP registrars in accredited training practices to achieve vocational scope in Family Medicine (General Practice) (11, Individual Doctor).

I think there is some value in how GP registrars are prepared and feel that this model could be used for NP programme. First 12 months following completion of Masters to preparing for Nursing Council. GPEP Year 1 The first 12 months is referred to as GPEP Year 1 and is primarily an intensive clinical programme to prepare you for safe practice. You are attached
to an accredited teacher in an approved teaching practice for (usually) two six-month attachments where you see patients and receive one-on-one teaching. You also attend day-release seminars and workshops, primarily in small groups facilitated by medical educators. The attachments give you the experience of being in ‘full-time general practice’ with the support of a teacher and provide opportunities to reflect on the learning that takes place. You spend most of your time seeing patients in the teaching practice. This provides the main basis for learning, although other activities besides consulting may be appropriate. We encourage diversity of attachments. You will sit clinical and written examinations at the end of GPEP Year 1. If you successfully complete Year 1 and the GPEP clinical and written examinations, you will become a member of The Royal New Zealand College of General Practitioners. Membership can be held for up to five years while still in training (40, Te Tai Tokerau nurse practitioners).

One submitter believed the programme should include interprofessional practice (41).

However within the current health care settings, there is a critical need for interprofessional work. Any Masters programme for NPs requires a clear pathway with a broad focus for nurse practitioner preparation within a programme which has a commitment to interprofessional practice (41, Auckland University of Technology).

4.2 The Council specifying clinical learning time within the programme for nurse practitioners (Question 11)

The Council proposed that it should specify clinical learning time within the nurse practitioner programme. The Council currently does not require a ‘practicum’ in the current programme standards. However the Council does look for evidence of supervised practice and evidence against the prescribing competencies completed by a prescribing mentor when reviewing nurse practitioner applications for registration. All present programmes offer a practicum. These vary in focus and in the hours required (160 to 325) for mentoring and for clinical learning. There was strong support during the pre-consultation for a significant component of clinical practicum hours/time within the programme. It was considered that the clinical learning time should be separate from a nurse’s paid employment hours, and should include supervision and require employer support. Protected clinical learning hours are a key component of nurse practitioner programmes internationally and are considered crucial as nurses develop advanced clinical decision making and develop the skills needed to undertake the nurse practitioner scope of practice.

The majority of submitters (72%) (see Chart 6) supported the Council setting clinical learning time within the nurse practitioner programme. Consistent dedicated learning time was seen as leading to greater consistency in nurse practitioner skills at the end of the programme. Some submitters cautioned that this could be a barrier for some nurses to complete the programme. Others argued that funding was required for this model. A few submitters suggested employed ‘registered nurse’ hours in the existing role were relevant. A few submitters did not support this proposal as they believed no evidence was provided to support making a change to the existing programme.
4.2.1 Support for specified learning time or ‘internship’

There was a strong theme in the submissions that this would ensure greater consistency between education providers and better prepare nurse practitioners leading to consistent development of skills and knowledge (9, 16, 18, 20, 21, 25, 29, 34, 35, 36, 37, 39, 44, 45, 51).

Consistency across training programs is important to provide reassurance to employers about the robustness of the NP training. Clinical learning time allows the embedding of theory into practice and is key to ensuring acceptable training standards are achieved. Clinical learning will also ensure skills and knowledge are developed to practice effectively and competently at the advanced level of NP. Therefore minimum hours should be specified to achieve the above (21, Taranaki District Health Board).

Yes, this will improve the consistency between providers and improve the performance of NPs delivered from the programme (34, Grace Hospital).

PCNZ sought comment from pharmacist prescribers as to the value of specifying clinical learning time within the programme. Pharmacists who have successfully completed the prescribing programme would endorse the need for specific clinical learning time as part of the nurse practitioner’s experiential learning. As part of the learning cycle it would encourage students to think more deeply, develop critical-thinking skills, and transfer their learning into action. It gives them an opportunity to discover more about both the practical limits and the wider applications of their new knowledge as they begin to take what they learned in one situation and use it in another, demonstrating what they have learned (9, Pharmacy Council of New Zealand).

Some submitters supported this as it was the Council’s role (10, 17, 28, 36) and consistent with international standards (17, 22).

Yes, the same rationale applies. Nursing Council must provide a “gatekeeper” QI role to protect the public. Nursing Council therefore must remain fully committed to the measure of learning time allocated to training for NP’s (10, East Health Trust Primary Health Organisation).
Yes, it is important for the NCNZ to set and guide clinical learning time / or the standard for the NP programme. NCNZ have a role in regulation and registration (36, Primary Health Care Nurse Reference Group- Hutt Valley).

We agree that NCNZ has an important role in setting the required standard for learning and advising on clinical learning time. As an independent monitoring body for nurses NCNZ should monitor and recommend the standard against what is done internationally. This could support NZ NP in their registration as NP in other countries (17, Group of nurses).

It is currently lacking and would be in line with international comparisons. It is also a fundamentally important way of learning (22, Tairawhiti District Health).

Other submitters supported this requirement and described it as an internship or apprentice model (17, 25, 31, 46, 48, 49, 54).

We support the suggestion of a dedicated master’s programme that include a minimum number of hours clinical learning time as well. Changes to the way in which future NP are prepared should include a period of internship. The end result of the learning period should be registration with NCNZ as NP. We are mindful of the fact that each newly registered NP should have a period where additional supervision is provided to support the transition from RN/ CNS role to NP (17, Group of nurses).

A broad based programme seems reasonable, with an apprentice model underpinning the acquisition of the scope specific skill set (48, Australian and New Zealand College of Anaesthetists).

I would like the programme to be part of an internship, so that the majority of learning/education is on the job and inclusive in work hours (31, Individual nurse).

Yes this is imperative and was the basis of a paper written by NPAC-NZ and the concept was supported by the sector at the time. RN and NP are different scopes of practice and therefore need specific programmes. Yes, NCNZ should specify hours otherwise there is the potential for too much variability (49, MidCentral Health nurse practitioners).

Having recent experience of completing a clinical Masters programme and preparing myself to achieve NP status I strongly believe the current academic papers on their own do not prepare nurse sufficiently for NP status. Ideal programme - an internship which combines academic and clinical training concurrently. Competency standards set by NCNZ for consistency. Curriculum developed and standard across training institutions which allows the nurse to identify if required level of competence for role reached. Employer support for training programme mandatory. Clinical mentors identified as part of acceptance onto course. Internship is a collaborative agreement for employment to undertake the course and its requirements with a job at the end of it. All clinical and academic work is undertaken in the internship hours there should be no need for nurses to achieve requirements on their days off as can occur now (25, Individual nurse).

### 4.2.2 Specified clinical learning time supported but could be a barrier

Several submitters supported clinical learning time but were concerned that barriers already exist for nurses to complete practicums including a lack of funds to pay a mentor or to allow
release time for the nurse (15, 29). This was identified as a problem particularly in general practices which are private businesses (33, 40). Others were concerned that prescribed clinical release time might create a bigger barrier to gaining employer support or for nurses in rural areas (2, 62).

However, there are potential barriers to this particularly with funding, release time and backfill for the RN undertaking the clinical learning time. This is particularly evident in the private sector / private business model of operation e.g. general practice (33, Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer).

In a perfect world clinical release time for the training NP would be ultimate, it would certainly strengthen their clinical application and aptitude, however consideration of the financial constraints and resource provision may not support this component. The financial constraints incurred from aligning formal clinical placement options may negatively impact on the employer’s willingness to undertake the supportive role in the training of the NPs. There is already much controversy related to the cost of training verses value for money or best bang for the dollar. In the current health climate and consideration of workplace competition from the PA model recently described for introduction within primary care it may be unlikely that the response will be positive from the health providers especially in PHC where they are often privately own practices. There seems a reluctance by some providers to support the NP role with many trainee NPs and authorised NPs not receiving appropriate remuneration. Yes setting a minimum requirement supported by our Nursing body provides consumer/public confidence. No: may become further barrier, already challenging to achieve clinical learning time with practicum paper and could become a further barrier (40, Te Tai Tokerau Nurse Practitioners).

The proposal for specified clinical release time, for example, could be a barrier for some RNs practicing in rural areas, who may need to travel some distance to meet this requirement. Issues with under–staffing in rural areas, may also make employers less inclined to support participation on an NP program (62, Rural Women New Zealand).

Other submitters commented that it is better to set a standard and that this would help ensure employer support (2, 39).

Specified clinical learning time will help to ensure consistent preparation for all NP candidates and will help to eliminate lack of employer buy in to dedicated clinical mentoring time. This will also ensure the NP candidate gains a broader experience in a variety of settings but we feel the majority of the clinical learning time should be in your chosen area of practice (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

4.2.3 Clinical learning time needs to be funded

Six submitters stated that clinical learning time needed to be funded by HWNZ (19, 29, 41, 44, 47, 51).

Respondents did support the Council specifying clinical learning time, noting the need for guaranteed support and funded time via HWNZ (19, General Practice New Zealand).
Guaranteeing and specifying clinical learning time would strengthen consistency and support access for nurses to enable skill consolidation at this level. However this would need to be accompanied by funding to enable nurses to be released. Consistency across programmes is more likely to achieve clarity for the public about NP preparation. Without funding the barriers will continue to exist (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

We are aware however of the challenge this will be for many health care settings particularly for those NPs working in rural settings. Additionally, such a move would require Health Workforce funding. Further, the financial constraints incurred from aligning formal clinical placement options may negatively impact the employer’s ability to undertake a supportive role in NP clinical supervision (41, Auckland University of Technology).

Guaranteeing supported and funded time via HWNZ would be the right direction, but if the time is not funded it would be a barrier (44, Nurse Executives of New Zealand (NENZ)).

If funding is going to support the clinical release/mentoring it should be determined by NCNZ/HWNZ. The current variance between programmes is problematic when staff within the same DHB are studying at different TEPs. NCNZ specify for EN, RN, NETP and should for NP to support recognition and understanding of the scope of practice. It is important employers support the practicum and this needs be funded to a higher level like RMO positions during the practicum (47, Capital and Coast District Health Board).

This is to ensure that a nationally consistent approach is taken. A wide range of experiences over time is needed, to become a competent and safe practitioner, along with appropriate mentorship. There needs to be more clinical learning time, in addition to the prescribing practicum. Employer support is ideal, but should not be mandatory. However, it would be very challenging to complete a practicum with supernumerary hours, without employer support. The Prescribing Supervisor should be kept, in addition to a mentor/s (51, MidCentral District Health Board: Group of senior nurses).

Two suggestions were made to look at other funded models such as vocational registration for doctors in sexual health care or further work be undertaken with HWNZ and the Royal New Zealand College of General Practitioners to develop a funded model (26, 54).

Educational preparation at this level is required to provide a stable basis on which to build advanced clinical practice. Ideally, NP candidates should already have a position set up so they can be supported through the process by their employer. In Family Planning’s experience, the main barriers are insufficient funding to pay the supervisor/mentor for the practicum, and the cost of release time for both supervisor and student to discuss and review cases. It would be helpful for the mentor and/or the candidate to be able to work outside their contracted hours and be paid for this. A good model is the Diploma for Sexual Health Care run by Family Planning, Auckland University and Sexual Health Services, which allows the doctor seeking vocational registration to work across the two clinical settings, with funding provided for this. This approach, if funded, would be ideal for Family Planning NPs. If the application process continues to be based on portfolio application, this should be incorporated into the final paper of the Masters programme. In addition, mentoring and support of the new NP needs to be in place for at least a year. Over time, as more nurses become NPs there will be more capacity available to provide support to learner NPs. Closer
alignment of curriculums across the universities would help to facilitate support among NPs (26, Family Planning).

4.2.4 Clinical learning hours vs employed hours

A few submitters argued that employed hours should be counted in the total clinical hours (5, 24, 30). Another submitter supported the learning that nurse practitioners do in their normal clinical role (26).

It is interesting to note as debate rages in the undergraduate programme regarding 'hours' vs competencies, the pathway for Nurse practitioner moves towards 'hours'. I do understand however why this has been suggested. There needs to be good guidelines so that the focus is also on quality not just quantity of hours. These hours also can be employed hours, otherwise needing to take time off employed hours to complete presumably unpaid hours elsewhere will be too much of a barrier for some potential Nurse practitioners. Again 'employed hours' require clear guidelines as to what can be 'counted' towards ‘clinical learning time’ (24, Individual nurse).

We do not agree that it is imperative all clinical learning time should be separate from a nurses' paid employment hours as this is not only likely to be a barrier but also require financial support and release time away from work. Many working towards the nurse practitioner role do this within their current role and when they get this registration have grown and developed the role to what is has become. Some are also fortunate to be supported and employed as being on the nurse practitioner pathway as part of their employment - this needs to be acknowledged and even encouraged (30, Starship Children’s Hospital Nurse practitioners).

There needs to be specified, and nationally set, number of experiential and supervised hours. However, whether this is part of the Nurses' paid employment, or additional, or at another Centre, should be left to the discretion of the Nurse and the employer, so long as a set of minimum standards and expectations are met in the individual clinical setting. There is benefit from experience and assessment in more than one environment (5, Waitakere Union Health Centre).

Yes, while acknowledging that the nurse practitioner candidate will continue to incorporate learning into their usual work and will be likely to work at a more advanced level in any case. We believe that regular and reliable mentorship is crucial to develop and tailor the clinical learning experience to the particular nurse’s needs. In our view, mentoring is cost-effective over time (26, Family Planning).

Nurse Practitioners New Zealand stated the opposite, that it needs to be clear that the student does clinical learning in an intern role rather than a registered nurse role (46).

There is a need to ensure that this time is spent with appropriately qualified people who understand the Nurse practitioner role and is working within the scope of practice that the student NP wants to practice in, in order that they can best meet the student NP’s needs. It would need to be ensured that the 150 hours of learning time were undertaken in an NP internship type role, rather than in the RN's current role (46, Nurse Practitioners New Zealand).
One submitter argued for some flexibility around the requirement based on the nurse’s experience (42).

Clinical learning time is key to consolidation of academic learning and application of knowledge to meet health care needs and role of NP. There may need to be some flexibility in this which is dependent on the individual nurse’s prior learning and clinical experience. E.g. a Clinical Nurse Specialist with 5 years’ experience would require lesser clinical learning time than a level 4 nurse completing a programme for NPs (42, College of Emergency Nurses New Zealand/ NZNO).

4.2.5 Do not support the Council to specify clinical learning time

While the majority of submitters supported the Council setting requirements / outcomes for clinical learning, some submitters stated they had mixed views (15, 44, 57, 58) or did not agree with Council setting the clinical hours (6, 23, 52, 56). Reasons given for not supporting this proposal were that, there was no evidence to suggest that the existing clinical learning hours were insufficient (52, 56), programmes are already approved and audited by the Council (38), this is not necessary in British Columbia (23), and the variability of potential nurse practitioners needs and employment situation and the potential barrier it could create (15, 44).

Programmes are already approved and audited by NCNZ; there appears to be no evidence that clinical learning hours are insufficient for those nurse practitioners already registered in this scope of practice (52, Eastern Institute of Technology School of Nursing).

Programmes are already approved and audited by NCNZ – this should be a focus of those audits. There appears to be no evidence that clinical learning hours are insufficient for those nurse practitioners already registered in this scope of practice (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)).

The support structures for each NP are varied so how would Council set a minimum number of hours for the development of practice and a portfolio. These roles are employed usually and not all employers can provide release for specific education practice hours (44, Nurse Executives of New Zealand (NENZ)).

4.3 Clinical learning time in addition to the prescribing practicum (a minimum of 150 hours) (Question 12)

Most submitters supported the Council specifying the number of clinical learning hours. A variety of hours was suggested ranging from a minimum of 150 hours to 1,000 hours. The question was asked for hours to be specified in addition to the 150-hour prescribing practicum but some submitters discussed total hours and others additional hours. The responses are difficult to collate for this reason and because many submitters gave a range of hours suggesting minimum hours at one end and maximum hours that may be required for some nurse’s depending on their circumstances. Some suggested in some cases the additional hours could be part of the nurses normal work role. The majority (21) supported 300 minimum total hours including the prescribing practicum with a small number supporting up to 500 hours for individual nurses. Fifteen submitters supported 500 or more total hours (see Table 3).
Table 3: Specified clinical learning time suggested by submitters

<table>
<thead>
<tr>
<th>How much clinical learning time should be included in the programme in addition to the prescribing practicum (a minimum of 150 hours)?</th>
<th>Submission number</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 hours</td>
<td>3, 21, 26, 30, 32, 34, 40, 42, 46</td>
</tr>
<tr>
<td>240 hours</td>
<td>52</td>
</tr>
<tr>
<td>250-300 hours</td>
<td>41</td>
</tr>
<tr>
<td>250-500 hours</td>
<td>47</td>
</tr>
<tr>
<td>300 hours</td>
<td>9, 31, 35, 37, 40, 41, 54</td>
</tr>
<tr>
<td>300-500 hours</td>
<td>37</td>
</tr>
<tr>
<td>320 hours</td>
<td>39</td>
</tr>
<tr>
<td>350-500 hours</td>
<td>36</td>
</tr>
<tr>
<td>500 hours</td>
<td>5, 16, 22, 29, 28, 32, 45, 50, 58</td>
</tr>
<tr>
<td>520-1,000 hours</td>
<td>2</td>
</tr>
<tr>
<td>700 hours</td>
<td>23</td>
</tr>
<tr>
<td>500-800 hours</td>
<td>25</td>
</tr>
<tr>
<td>10-11 weeks</td>
<td>10, 19</td>
</tr>
<tr>
<td>30% of time</td>
<td>1</td>
</tr>
</tbody>
</table>

4.3.1 Specify minimum hours as more will be a barrier

Many submitters supported an additional 150 hours (total of 300) of “protected clinical time” as a minimum requirement (3, 21, 26, 30, 32, 34, 40, 42, 46).

It is important that clinical learning time is paid hours and ring fenced to allow for skill development and embedding of knowledge. These hours would be protected hours for both NP intern and supervisor. This could be linked to mentoring requirements. If this occurred then 150 hours minimum would be acceptable (21, Taranaki District Health Board).

Some submitters stated more time was needed but this could become a barrier (41, 47), especially for rural nurses (29).

We support a specified number of hours of consolidated clinical learning time in a practicum and also for the programme to line up with international practice with regards to clinical hours. However, there are different implications for the number of hours that could be specified (cost, NP supervision etc). Nurses’, particularly in rural areas, need to be supported to meet the hours requirement. New Zealand applicants have a minimum of 4 years practice as an RN and this preparatory clinical exposure should be taken into consideration along with demonstrated ability to meet the NCNZ NP competencies (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

Agree with minimum - however more is needed and needs to be funded e.g. 250 - 500 hours. Please note unless funded increasing the hours will limit employer support and ability to provide clinical release and mentoring/supervision (47, Capital and Coast District Health Board).
We suggest up to 300 hours and a minimum of 250 hrs. Again there is a cost component which could be prohibitive and such a requirement would need careful consideration in order to fit with University programme requirements for a 240 point Masters programme (41, Auckland University of Technology).

Two submitters suggested a period of supervision/mentorship after registration (34, 46).

A minimum of 150 hours is reasonable, which given the prescribing practicum would give 300 hours of practice. It should be borne in mind that post-qualifying as an NP a further period of mentorship should be available in order to consolidate the novice NP practitioner, ideally with another NP or with a supervising Doctor (46, Nurse Practitioners New Zealand).

150 hours would be advantageous, any more than this would be difficult to achieve due to paid employment and study and could be a barrier preventing nurses progressing to NP registration. Perhaps a period of supervised internship post registration particularly in relation to prescribing would be beneficial (34, Grace Hospital).

The Pharmacy Council suggested standardising the clinical learning time with other prescribing programmes (9).

PCNZ believes it would be beneficial for prescribing programmes for non-medical prescribers to be standardised as much as possible. The post graduate qualification for pharmacist is equivalent to 600 hrs of study and includes a prescribing practicum. The prescribing practicum consists of 300 hrs and includes at least 20 x 7.5 hr. days (i.e. 150 hours out of the 300 hours) of supervised practice under a Designated Medical Practitioner (DMP) (9, Pharmacy Council of New Zealand).

### 4.3.2 More hours needed but depends on individual student circumstances

Other submitters thought more hours were needed with many suggesting up to 500 hours. (37, 39, 36, 5, 16, 22, 29, 28, 32, 45, 50, 58). Some suggested there should be flexibility about the additional hours (over and above the 300 minimum hours) based on the individual’s circumstances e.g. normal work hours might be counted in the additional 200 hours (32, 37, 40, 44, 56, 57).

We consider 150 hours to be too limited and developing confidence and competence around a broad generic Nurse Practitioner scope requires more time. We recommend 300-500 hrs. (minimum). It is difficult to place a fixed number on clinical learning requirements for NP candidates, as they need to identify and meet outcomes and for some this may take longer, and each NP candidate clinical learning needs should be reviewed individually (37, Hutt Valley District Health Board including primary health care).

We believe there needs to be more clinical learning time than 150 hours (excluding the practicum). There is an ability for some nurses to complete their Master’s as full time students therefore having no or very little clinical time to apply any of the knowledge learnt in the programme. However if the nurse is already working clinically in a practice setting and is already being mentored by a nurse practitioner, those normal working hours should be included in their clinical learning time without the requirement to do extra hours (57, Critical Care Complex- Counties Manukau District Health Board).
This depends on the types and levels of skills required but we suggest at least 500 hours of clinical time with a senior mentor is required for purposes of role-modelling and gaining basic experience in the expanded role. A level of competency needs to be met and is only signed off once this competence is demonstrated. A minimum period of practicum would be useful, and we suggest 150 hours (32, New Zealand Society of Anaesthetists).

4.3.3 Five hundred or more hours required

Some submitters supported 500 hours of specified time (5, 22) and others believed the New Zealand programmes should be similar to the international standard of 500 hours (16, 58, 50, 45, 29, 28).

We would suggest 500 hours total divided into 250 hours primary / community and 250 hours acute (22, Tairawhiti District Health).

Our recommendation is based on the need to provide sufficient clinical learning time. We have recommended two clinical practicum courses-taken in the final year of study consecutively. These courses build on previously acquired knowledge and provide support for clinical learning with a clinical supervisor in the appropriate area of practice. Advanced Nursing Practicum-Diagnostic reasoning focused on the area of practice the nurse will be applying for registration (250 hours clinical practicum component) Prescribing in Advanced Nursing Practice (250 hours clinical practicum component). This would provide a minimum of 500 hours over the year and this is in line with international consensus for clinical supervision for NP’s. Each student will be required to commit to supervised clinical practice time of a minimum of 16 hours per week (500 over the year) for each of the two practicum courses (16, University of Auckland School of Nursing).

A small number of submitters suggested more hours than this (2, 25, 19, 10, 39).

I think there should be 520 to 1,000hrs. If the Np candidate is to have a meaningful experience in practicing their skills in a supernumerary supervised learning environment they need enough time to experience a large range of conditions which needs a longer time frame than the minimum 150 hours (2, New Zealand Institute of Rural Health).

150 hours may not sufficiently prepare the NP for their future role. The clinical placement opportunities may not consistently provide the required experiences/ exposure. Therefore consideration should be given to propose a 10-11 week placement to ensure an opportunity is available to capture clinical experience (10, East Health Trust Primary Health Organisation).

Four submitters supported specified clinical learning time but were not sure how many hours were required (11, 17, 18, 19, 20).

Minimum of 150 hours - and this could only hope to cover a few clinical prescribing areas e.g. child ear health, contraception for healthy women, hypertension without comorbidities remember to treat you need to diagnose or at least understand the process of diagnosis and diagnosis is one of the greatest academic exercises we GPs ever do, and this has been granted after a competitive selection process (to medical school) six years of training the (last year of which was supervised prescribing) then a minimum of 1 year in hospitals before
registration with MCNZ. Even then the vast majority of GPs took many extra years of prescribing practice (in both senses of the word) within the relatively supervised environment of a hospital (11, Individual doctor).

4.3.4 Focus on competence not hours

Three submitters did not support the Council specifying clinical hours, believing the focus should be on demonstrating competence rather than completing hours (56, 55, 52).

The focus is on reaching competence not recording a specific time – could be more or less dependent upon context and student (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)).

The College does not consider that specified clinical hours can be linked to competency acquisition. We do however suggest that approval of NP programmes be closely linked to the education institution’s requirement of appropriate links to clinical practice to ensure the best opportunity for the student to be successful (55, College of Nurses Aotearoa New Zealand).

EIT’s advanced practicum has 240 clinical hours. Other clinically focused courses in the Master of Nursing programme have clinically based assessments, such as case studies – for example the advanced assessment and diagnostic reasoning course. Prescribing a minimum of 150 hours suggests a focus on time rather than on demonstrating competence (52, Eastern Institute of Technology School of Nursing).

The College of Registered Nurses of British Columbia does not specify clinical learning time but there is a national standard of 700 hours. It also requires education providers to provide evidence of how the clinical learning time enables students to develop the competencies. It also uses OSCE to determine when a student is safe to practise.

Preceptored or mentored clinical learning time is an essential component that is crucial to NPs learning to successfully apply and integrate new knowledge and skills. Although we expect NP education programs to have “a substantial clinical component”, the College of Registered Nurses of B.C. does not specify the amount of clinical learning time. This provides the educational institutions with some flexibility depending on the learning needs of students, the curriculum design and how the program is delivered. However, Canada has a generally accepted national standard of 700 hours of clinical time for NP clinical education at the master’s level. We would see this as a minimum and our programs exceed this minimum based on their own assessment of the nature and length of clinical learning time needed for students to achieve the competencies and Standards of Practice set by CRNBC. Please see the publication at the link below for this and other information. http://casn.ca/wp-content/uploads/2014/12/FINALNPFrameworkEN20130131.pdf. As part of the CRNBC review and recognition of nurse practitioner education programs, the educational institutions offering programs must provide evidence about the clinical time students have and how well this enables students to meet the competencies and standards of practice by the time of graduation (23, College of Registered Nurses of British Columbia).
4.4 Employer support to complete a practicum with supernumerary hours (Question 13)

The majority (61%) of submitters (see Chart 7) agreed that a student must have employer support to complete a practicum with supernumerary hours. However, many submitters who answered ‘yes’ to this question also commented that the support should not be mandatory. Although most said employer support was ideal, they indicated that the possibility of a student completing the clinical learning without employer support in a practice area where they were not employed should be retained.

Chart 7: Support for students having employer support to complete a practicum with supernumerary hours

4.4.1 Employer support is essential

Many submitters thought that employer support was essential to completion of the practicum (1, 2, 3, 7, 8, 9, 11, 14, 15, 17, 21, 22, 25, 26, 28, 30, 31, 32, 34, 46, 47, 50, 54). Some thought it was essential for the employer to be involved for the nurse to gain an effective learning experience.

It is the employer not the TEP [Tertiary Education Provider] providing the Clinical preparation. Joint work with the TEPs is required to ensure optimal clinical learning and role extension and expansion is achieved. It is also the employer who needs to ensure the Practicum is integrated into or supports NP Candidacy development leading to a NP role. HWNZ funding should be used with this assurance. This is why the practicum needs to be aligned to NP roles (47, Capital and Coast District Health Board).

Employer support for practicum is essential as portfolio development and employment depend on the relationship with the employer. Practicums require immersion in the role and therefore release time for the PG student. If not supported actively by an employer the student faces a large hurdle and excessive workload (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

With the following considerations: This recommendation is based on the obstacles described by many NP’s in gaining appropriate clinical mentorship. While employer support may not
be mandatory depending on the individual nurses' situation, this stipulation is helpful to emphasise the need for dedicated clinical supervisory time and that 'business as usual' is not sufficient for most NP's to gain the relevant experience. It is necessary to have access to clinical practic3e for the practicum, but not necessarily employer support. A NP student could do the practicum with a provider that is not necessarily their employer, but has agreed to provide clinical supervision. Support with funding will be helpful to free up time for the NP candidate to have the relevant clinical supervision (16, University of Auckland School of Nursing).

Other submitters supported employer support for the practicum as an indication that there would be a nurse practitioner position at the completion of the programme.

**Employer support is vital to ensure quality practicum is provided and well supported. Internship pathway should be developed and supported by the employer to ensure NP position is available at the end of the training program. This will ensure value for money on completion of the program (21, Taranaki District Health Board).**

Employer support is crucial so that both candidate and employer have an understanding of what is expected. Employers need to know the cost of supporting a NP candidate and to factor this into their planning. Written support from the employer must be gained prior to NP training to make it clear that a position will be available on completion. We are aware of several nurses who have had employer support to complete their Masters qualification. However, a NP position has not been available for them after completing the training, despite being registered as NP (26, Family Planning).

It is a very big step up to NP (from say CNS) and would be extremely difficult without employer support, not to mention having a job at the end of the training. Ideally an internship should be leading into a job, with the entire process well supported by the employer (31, Individual nurse).

This would ensure that these is employer buy-in to the process of the Nurse practitioner pathway, would indicate a willingness from employers to employ NP's at the end of the process and finally most people on the pathway will be working as senior nurses and attempting to do the NP Practicums on top of the required reading/ study and their usual workload would disadvantage many candidates (46, Nurse Practitioners New Zealand).

**Employer support for education, completion of postgraduate qualifications and ongoing professional development is essential (50, Royal Australasian College of Surgeons).**

### 4.4.2 Employer support should not be mandatory

The majority of submitters commented that although employer support was ideal it should not be mandatory (5, 6, 10, 12, 13, 16, 18, 19, 20, 23, 24, 33, 35, 36, 37, 38, 39, 40,42, 44, 45, 52, 53, 55, 56, 58).

**In B.C. clinical learning time is part of educational program requirements and not contingent on employer support. This model works well for us (23, College of Registered Nurses of British Columbia).**
Currently it would seem that without organisational support the NP candidate does not have the environment to complete the requirements of the practicum prescribing. The benefits of a supportive environment for students is noted in personal and professional growth and development of leadership capacity and vision. No. This is restrictive & creates a barrier for the NP candidate to access other appropriate supervision outside of their employment. Example: an NP candidate in a small rural community may need to access support from outside their current employment area. The focus should be on the quality & level of practicum supervision the candidate is choosing to be supervised by. Some nurses are self-funded and have no job secured when completed their NP so to do this may create a further barrier to engaging more NPs (40, Te tai Tokerau Nurse Practitioners).

The College does not consider that employer support should become a mandatory aspect of the student journey. We think that employers frequently lack the vision and courage to support the development of RNs to NP roles. The College however does consider that having employer support to complete a practicum would ensure that there is employer buy-in to the process of the Nurse practitioner pathway. Such support indicates a willingness from employers to employ nurse practitioners at the end of the process, and most people on the pathway would be working as senior nurses who would be completing the nurse practitioner practicums on top of the required reading and study; and usual workload. It would be very difficult to complete the hours without employer support but requiring it also excludes a nurse from being able to resign from a position and devote to full time study and arrange his or her own practicum. The College sees no advantage to excluding this option (55, College of Nurses of Aotearoa New Zealand).

A requirement for employer support has an associated potential risk for gate-keeping in terms of funding from HWNZ which is determined by District Health Boards. NETS has examples of students who have not been supported by employers for clinical release time to undertake the advanced practicum, as there was no defined nurse practitioner position. A dedicated Master’s programme to prepare nurse practitioners may not necessarily change employment opportunities as a nurse practitioner (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS))

There was also support for the clinical learning hours to be supernumerary (2, 9, 15, 16, 28, 29, 32, 45, 53, 58).

There must be employer support for the supernumerary hours as without it there will be extra pressure on the NP candidate to undertake the hours on top of their normal work load risking burn out or failure. Support from the employer indicates their valuing the nurse as a NP. There needs to be something in place to assist the employer financially to provide cover for the NP candidate’s position while they are getting their clinical learning time or to provide an extra RN within the service to enable the NP candidate to be supernumerary. This support also means there will be a dedicated NP role on successful completion (2, New Zealand Institute of Rural Health).

Employer support for practicum is essential as portfolio development and employment depend on the relationship with the employer. Practicums require immersion in the role and therefore release time for the PG student. If not supported actively by an employer the student faces a large hurdle and excessive workloads (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).
With the following considerations: This recommendation is based on the obstacles described by many NP’s in gaining appropriate clinical mentorship. While employer support may not be mandatory depending on the individual nurses’ situation, this stipulation is helpful to emphasise the need for dedicated clinical supervisory time and that ‘business as usual’ is not sufficient for most NP’s to gain the relevant experience. It is necessary to have access to clinical practice for the practicum, but not necessarily employer support. A NP student could do the practicum with a provider that is not necessarily their employer, but has agreed to provide clinical supervision. Support with funding will be helpful to free up time for the NP candidate to have the relevant clinical supervision (16, University of Auckland School of Nursing).

Whilst this is highly recommended, as employer support is a very important component for nurses to enable release time and access to practicum in many instances, as does having employer support for identifying a role to move into on registration, not all nurses will see this as a necessary pathway. There will be nurses who engage in NP education and training with an intention to obtain a role independently once registered. We agree that there should be the ability to organise appropriate clinical access to complete a practicum (i.e. will not necessarily be the nurse’s current employer supporting clinical access, if this is inappropriate for the student). Nurses should be able to self-determine their future pathways as do RN’s currently and be able to negotiate access to suitable clinical practicum environments. We support nurses undertaking a practicum in a supernumerary role (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

Again employer support and funding for release time and supervision were identified as barriers in primary health (41, 49, 54).

We also recognise the challenge for the employers in health care setting. For rural nurses, this may prove to be prohibitive. Without organisational support the NP candidate does not have access to an environment in which to complete the requirements of practicum prescribing papers (41, Auckland University of Technology).

**4.5 Requirements for the clinical learning hours should be specified by the Council, e.g. mentor criteria, setting, competence or other assessments (Question 14)**

Many submitters supported the Council specifying other requirements for clinical learning. These included mentor criteria, clinical and professional supervision, the clinical placement or setting requirements, the types of assessments and portfolio development.

**4.5.1 Specify mentor criteria**

Many submitters suggested specifying clinical and professional supervision including mentor requirements (2, 15, 19, 21, 26, 30, 31, 33, 39, 42, 44, 45, 46, 49, 58). The mentor should be a sufficiently experienced nurse practitioner (where possible) to facilitate the nurse’s development into the nurse practitioner role, or a medical practitioner to assist with the development of diagnostic and therapeutic skills.
Mentor criteria: Qualified NP working within the area of learning or senior medical colleague (such as consultant of fellow), this would include having different mentors if moving through several services during the clinical learning practicum; such as working in ED / in cardiology / in primary/community health setting – need to have a mentor from within the different areas. Mentors need clear direction over clinical assessment points and have a process to follow should the NP student not demonstrate adequate competence (support also needed for the student NP where able to address any issues regarding relationship with the Mentor). There needs to be consideration of who would take responsibility for this - would the university that has developed the education program do this? (30, Starship Children’s Hospital nurse practitioners).

If clinical learning time is not with a nurse practitioner, the quality of the learning time can be variable. A Nurse Practitioner mentor should be the first option, followed by another authorised prescriber. If the prescriber is not a nurse each candidate must have access to a Nurse Practitioner as role model and advisor (44, Nurse Executives of New Zealand NENZ)).

Key requirements include that the mentorship must be within the nurse’s area of practice, and the mentor must have up-to-date registration. When considering requirements, we think it will be important to avoid adding too many requirements, as these could present barriers to attracting appropriate mentors (26, Family Planning).

In terms of mentor criteria, I think it would be ideal to have an NP act as the persons mentor in the first instance if and where possible. If a mentor is a doctor/physician/consultant, a session with them and other NPs to explain expectation of role, clinical requirements, level of skill and knowledge required would be helpful. Given there are still few NPs, it is not widely understood about their role, how it is different from that of a doctors and/or CNSs. The NP intern does not necessarily know how to articulate their needs early on. Currently, my understanding is that the NP internships are essentially different throughout the country and there is no standardised training guide/curriculum, and I think it would be helpful to have this formalised (31, Individual nurse).

We agree that there should be a mentor criteria that includes experience in the appropriate setting, with a determined time in their current role. Experienced NPs should be able to mentor new candidates once they have appropriate experience and length of time as an NP, i.e. 3yrs plus etc. Mentor criteria could be aligned or similar to the Mentorship that is offered to graduate doctors in the House Surgeon posts. We don’t agree that setting should be part of the criteria as there is benefit in learning in different settings (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

Mentorship is a cornerstone to success for NP candidates, it requires funding support in comparison and at the level for medical students in practice. NP candidates require access to clinical experience in relation to their area of practice, with opportunity during their training to have placements in other settings, such as that for vocationally registered general practitioner for example. It is expected that NPs will practice with a high level of skill therefore they require supported opportunities during their training to develop their practice, not as currently, from the goodwill of their medical and nurse practitioner colleagues with token gesture payments. Preceptor support, including clear assessment guidelines and competencies to be achieved need to be put in place (45, New Zealand Rural General Practice Network).
Mentor criteria- suitably qualified, hours the mentor may not need to be onsite but reasonable contact hours either face to face or through a platform that allows for mentorship/supervision to be productive and effective. Competencies need to be understood by the mentor so would suggest there being some sort of education package around this especially if the mentor is not a NP (46, Nurse Practitioners New Zealand).

Some specificity of what the learning hours cover i.e. clinical learning with patient present, non-contact such as teaching and one-to-one mentorship is recommended (49, MidCentral Health nurse practitioners).

4.5.2 Specify required assessments

Many submitters commented that assessments should be specified by the Council. These included the assessment of the nurse practitioner competencies (2, 16, 21, 29, 38, 47, 53, 58), including both formative and summative assessments (34, 37).

The NCNZ should be more prescriptive, to clarify these requirements. This makes it easier for NP candidates and employers. Recommend a midterm assessment of progress. Hours are limited and could be more outcome focussed. Another NP may be able to help with other assessments for the NP candidate (37, Hutt Valley District Health Board including primary health care).

Competence assessment undertaken by a nurse practitioner/authorised prescriber would be the ideal and if not available, then by an authorised prescriber and alongside access to an NP as a role model/mentor. Standardising some practicum assessments preparing RN’s for NP registration would strengthen consistency nationally across programmes. These assessments should be linked to NP competencies (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

Generic competencies need to be set by NCNZ to ensure consistency of training programs. However NP trainees should set area/speciality specific learning objectives with KPIs (21, Taranaki District Health Board).

Competence assessments throughout the practicum would be helpful by a specified clinical person nominated by the Nursing Council may be advantageous to ensure competency levels (34, Grace Hospital).

Activities undertaken during clinical learning hours need to be mapped/directed towards the specific NP competencies (53, Victoria University of Wellington).

One submitter suggested scenario assessment in the clinical setting (22) and two others the use of OSCE (23, 54)

Suggest that competence should be undertaken in the form of clinical scenarios where the student NP is critically assessed by a multidisciplinary team - including a consumer (22, Tairawhiti District Health).

NP educational programs are using high fidelity simulation and clinical examinations with patient actors (practice OSCEs) as a mode of laboratory learning to demonstrate whether a
A student can safely transition to working with patients (23, College of Registered Nurses of British Columbia).

Assessment of prescribing practice was identified specifically by three submitters (9, 40, 44).

Additional requirements to consider include influences on, and psychology of prescribing, prescribing in a collaborative healthcare team, examination skills, history taking, critical thinking and reflective practice (9, Pharmacy Council of New Zealand).

Ability to diagnose correctly, prescribe, refer for appropriate interventions (44, Nurse Executives of New Zealand (NENZ)).

A few submitters also recommended demonstrating competence through the use of clinical logs and suggested this be stipulated by the Council (3, 40, 41). The linking of the assessments to the competencies was seen as helping with the portfolio development required for registration.

Competency assessment / log books / mentor are all essential elements to ensure that the nurse has the necessary 'shop floor' skills to perform as an NP on registration. This is absolutely distinct from the capacity of a NP candidate being able to complete an academic course / papers. Being an A plus student in the University setting does not reflect the ability of that individual to perform in a safe, systematic and competent manner in the clinical setting... Sign off of key clinical skills in the clinical setting should deem as important as the capacity to achieve good grades at University (3, Individual nurse practitioner).

Development of a clinical log book to demonstrate the breadth of practice and reflective assessment of patients Mentors other than a clinical supervisor allows building of networks that can assist in the portfolio development process. Attendance of Professional development opportunities related to medication management and or prescribing (40, Te tai Tokerau Nurse Practitioners).

Development of a clinical log to demonstrate the depth and breadth of assessments, diagnostic reasoning and clinical practice, including a reflective consideration of client outcomes (41, Auckland University of Technology).

Tying this to competencies may be the simplest way for everyone and helps the candidate when it comes to NP portfolio development (55, College of Nurses Aotearoa New Zealand).

Two submitters cautioned that some assessments needed to be external (22, 25).

Consider external assessment - independent of anyone who knows the candidate or has contributed to their NP development. This could be incorporated into the assessment of competence stage (22, Tairawhiti District Health).

NCNZ should also specify assessment requirements and assessment i.e. portfolio and panel interview should be undertaken externally to training institution to avoid bias in achieving success rates (25, Individual nurse).

Another submitter argued that if the clinical assessment during the practicum was robust then panel assessment by the Council may not be necessary.
An NP should as an absolute bottom line be a safe and competent practitioner. The employer is usually the best person / organization to determine suitability of an individual to practically do their job. The University is usually the best group to educate these prospective NP’s but with clear outcomes set that ensure the candidate has the necessary practical skills etc. to perform the job alongside the academic acumen. Completing a master’s degree with an NP focus should not guarantee registration / employment unless that person can demonstrate (through their training, mentoring etc.) the capacity to function at the level of expert nurse. The number of NP’s trained should to a large extent reflect actual job availability on registering. If the above balance is achieved should the nurse still need to present a portfolio to NCNZ plus have a panel assessment (3, Individual nurse practitioner).

4.5.3 Broad scope requires clinical learning in more than one setting

Some submitters discussed whether the placement should be in a speciality area (28, 55) versus more than one clinical setting to support a focus on broad population groups (2, 16, 35, 40, 42).

If the Council is to adopt a broad generic scope of practice, speciality clinical learning hours should be specified and competence assessments for the speciality should be clearly defined. Clinical learning hours for a mental health nurse practitioner would be quite different to those required by a neonatal nurse practitioner (28, Neonatal Nurses College of Aotearoa/NZNO).

The setting needs to be relevant to the area in which, the NP candidate is planning to commence practice so they are best prepared for that area and can expand practice from a position of strength (55, College of Nurses Aotearoa New Zealand).

The setting needs to be conducive to best practice and enable relevant clinical experience to challenge the candidate (2, New Zealand Institute of Rural Health).

As the NP focus is on broad populations, it may be valuable for the student to work in a variety of settings to gain the necessary experience. This will likely be best managed by the educational provider in the practicum course/s (16, University of Auckland School of Nursing).

We agree with those described, but the setting should be able to include the NP candidates existing practice as well as other experience (35, Wairarapa District Health Board).

Demonstration and confirmation of appropriate workplace and clinical support I think a placement for 4 - 6 weeks elsewhere for the potential NP would be an idea (40, Te tai Tokerau Nurse Practitioners).

The settings could be broad to promote innovation and remove barriers in clinical learning, but would need to be relevant to the scope of the NP (42, College of Emergency Nurses New Zealand/ NZNO).

4.5.4 The quality of the clinical setting

Some submitters focused on the quality of the setting and recommended that the Council approve clinical placements through the accreditation and monitoring of education providers
The prescribing practicum must be focused, defined and within the shelter of an accredited (e.g. Cornerstone, or foundation programme) practice (11, Individual doctor).

There should be approval of the training institution by the teaching/training organisation; to that end the Council should insist on certification of departments within the hospital that want to be involved in training nurse practitioners (32, New Zealand Society of Anaesthetists).

The setting is essential. The dedicated Masters programme needs to fully explore suitable placements/secondments and clinical experience to provide a valuable learning opportunity with clear assessment criteria set by the appropriate institution and approved by Nursing Council (10, East Health Trust Primary Health Organisation).

4.6 The ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ as a prerequisite for nurse practitioner programmes (Question 15)

In October 2014 the Council made an application for registered nurse prescribing rights Designated prescriber: Registered nurses practising in primary health and specialty teams – with the proposed qualification a ‘Postgraduate diploma in registered nurse prescribing for long term and common conditions’ (see the Education programme standards in Appendix 5).

The postgraduate diploma contains requirements similar to the courses that nurse practitioners currently complete (pathophysiology, pharmacology, assessment and clinical decision making) including a 150-hour prescribing practicum. It also describes a broad focus on common long-term and other conditions rather than an exclusive focus on a specialty area. These changes create the potential for elements of the designated prescriber pathway and the nurse practitioner pathway to be the same.

This could broaden and standardise the preparation of all nurse practitioners. In the future some potential nurse practitioners will complete the postgraduate diploma and then apply for prescribing rights. They may choose to work as a registered nurse with prescribing rights for a significant period of time before continuing with the nurse practitioner programme. They would complete a prescribing practicum as part of the postgraduate diploma, not at the end of the master’s programme as occurs now. The need for protected clinical hours could be reduced by their prescribing experience as a registered nurse.

This postgraduate diploma programme is designed as a stand-alone qualification but it could also form the first year (120 credits) of the master’s programme (240 credits in total) for nurse practitioners. Making it a prerequisite programme could improve standardisation of the programmes. However, it could also limit the flexibility of the education programmes and may be seen as reducing access to education.

The majority of submitters (54%) did not support the ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ being a prerequisite for nurse practitioner programmes (see Chart 8). The reasons given were that as a prerequisite (10, 18, 32) or specify other accreditation standards such as Cornerstone in general practice (11).
qualification it was too restrictive and limited the pathways to becoming a nurse practitioner. Some submitters stated that registered nurse and nurse practitioner prescribing are different and required separate pathways. Other submitters saw clear benefits in nurse practitioners completing this prerequisite programme in standardising the preparation for all prescribers and broadening nurse practitioner preparation.

**Chart 8: Support for the ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ should be a prerequisite for nurse practitioner programmes**

![Chart showing support percentages for making the postgraduate diploma in registered nurse prescribing a prerequisite for nurse practitioner programmes.](chart)

**4.6.1 Postgraduate diploma in prescribing too restrictive as a prerequisite**

For some submitters having a prerequisite postgraduate diploma in prescribing was seen as being too restrictive and not allowing other pathways to nurse practitioner (17, 24, 26, 37, 45, 46, 47, 52, 53, 55). Some submitters argued strongly for a direct pathway to nurse practitioner that did not include registered nurse prescribing (17, 45, 47). Others believed there should be flexibility for other papers and qualifications to be included in the prerequisite papers (16, 24, 26, 52, 53).

‘...this may be the pathway for some nurses but others will progress towards NP status without having taken this step. This suggestion might also be limiting or irrelevant for some nurses wanting to become an NP, particularly when not practicing in that specific type of clinical area. We do believe that a nurse who does follow that pathway should receive recognition of this qualification when progressing towards NP qualification (17, Group of nurses).

While RN prescribing is a good pathway it should not limit RNs options or indeed what services grow NPs. In some organisations there may not be RN prescriber needed but with the broader focus of the NP and level of practice the NP role is a good fit (47, Capital and Coast District Health Board).

In general it does make sense for candidates to do this diploma first, and then to continue on to a Masters and NP application. It will be important, however, to reduce repetition of training for candidates, and to reduce cost and time barriers. A mandatory prerequisite postgraduate qualification may pose barriers for some candidates, particularly the financial costs. It is important that nurses can approach NP registration from various routes including those outside of the NP pathway. One concern is that this approach posits prescribing as
the way to prepare for the NP pathway; whereas prescribing is a tool that needs to be used by various clinicians and disciplines. We note that other health professionals, such as doctors and midwives, currently learn prescribing largely on the job rather than being fully prepared to prescribe by their undergraduate training alone (26, Family Planning).

The diploma gives nurses practice experience with diagnostic reasoning principles and use of commonly used medicines in a safe and supported environment. However it may also create barriers where nurses are not in a position to undertake RN prescribing (45, New Zealand Rural General Practice Network).

While it may be advantageous to have a post-graduate diploma in registered nurse prescribing for long-term and common conditions prior to commencing the NP pathway, it is too limiting for future NP’s who as “Authorised prescribers” will have a much wider formulary to prescribe from. It would also be potentially limiting in that there are a number of ways and routes that people have taken to get to the Nurse practitioner route- this is not necessarily about the papers/courses available but also about individual nurse’s career development/stages of life/ service developments (46, Nurse Practitioners New Zealand).

This is restrictive for those registered nurses who aspire to become a nurse practitioner in terms of completing courses relating to their specialty practice area. It adds a further potential barrier to the development of nurse practitioners (52, Eastern Institute of Technology School of Nursing).

No - this would be too restrictive. It could be used as one platform for RN prescribers who want to become NPs but NOT as pre-requisite for NP status/progression (53, Victoria University of Wellington).

While there will likely be considerable overlap, it will be unnecessarily restrictive to have the PG diploma be a prerequisite for NP. There are nurses who prepare for NP who will not wish to undertake registered nurse prescribing as part of their preparation. Additionally the long term and common conditions diploma is for adult focused NP’s. It would not be appropriate for child and youth health or Neonatal NP preparation. We believe that there should remain two distinctive pathways to allow the best flexibility for students. We have attached the Nurse practitioner proposal we developed which outlines our recommendations for Nurse practitioner preparation (16, University of Auckland School of Nursing).

Four other submitters did not agree with the broadening and standardising of nurse practitioner preparation through the completion of the postgraduate diploma in prescribing with a focus on long-term and common conditions believing this was irrelevant for acute care nurses (15, 44, 51, 57).

We do not support a postgraduate diploma in registered nurse prescribing for long term and common conditions being a prerequisite for NP programmes as this would be a barrier to many future acute care nurse practitioners wishing to work in the critical care areas such as intensive care, high dependency care and critical care outreach. • There should be a number of ways for nurses to develop towards an NP role, such as a post grad diploma with a prescribing paper and a practicum in their clinical area with a prescribing mentor. The postgraduate diploma in registered nurse prescribing for long term and common conditions should only be a prerequisite for nurses managing chronic diseases and single diagnoses/conditions in the community, which is its intent; it should not limit the educational
and clinical pathway for critical care nurses who as acute care NPs need to manage physiological instability of patients from multiple specialty areas with often multiple morbidities, multiple diagnoses and complex patient and family psychosocial needs (44, Nurse Executives of New Zealand (NENZ) and 57, Critical Care Complex - Counties Manukau District Health Board).

The content should be, but designating a programme designed for registered nurse prescribing for NP is the wrong direction of travel. At least a separate cohort on the programme is warranted as the size of the country does not support total separation of the programmes. The common conditions and long term conditions framework does not suit all the Clinical Nurse Specialist roles in tertiary care settings. Often our most skilled nurses prescribe complex medications under standing orders that they will not be able to prescribe as prescribers. There will be issues in that for the future for tertiary registered nurses (44, Nurse Executives of New Zealand (NENZ) and 15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

Several submitters were concerned that some nurses may be required to study irrelevant content i.e. outside population or specialty (30, 34) or that specialty papers should be included (48, 56).

This can only be done if nurses are able to focus on specific areas related to their practice such as child and youth, adult and/or aged care. There may be some that work across the lifespan in a more generalised role and therefore the conditions in the course need to allow for this. To date in NZ this has not been possible as the courses generally focus on adult conditions almost exclusively (30, Starship Children’s Hospital Nurse Practitioners).

No, every area of practice is specific and it would be more beneficial to focus on the needs in the area of specialty rather than some which may not be relevant (34, Grace Hospital).

The National Committee of ANZCA understands the nurse practitioner pathway to be experienced based and apprenticeship modelled, with formal education components undertaken to elevate practice further. Prescribing should be limited to the area in which the nurse practitioner works, as it will require specific knowledge relevant to the scope of practice, as well as knowledge of physiology and pharmacology. The basic physiology and pharmacology knowledge could be assessed within the master’s programme, and scope specific knowledge could be assessed separately, for example by scope specific papers within the master’s programme, or in the workplace (48, Australian and New Zealand College of Anaesthetists).

4.6.2 Nurse practitioner requires a different prescribing preparation

A number of submitters thought the education pathways should be different and distinct based on the breadth of the nurse practitioner scope compared with registered nurse designated prescribers (1, 5, 10, 15, 16, 19, 20, 21, 23, 25, 44, 54). Registered nurse prescribing was viewed as narrowly focused whereas nurse practitioner has a broad focus although some submitters wanted to retain a ‘specialty’ focus. A few submitters did see some overlap in the preparation between registered nurse prescribers and nurse practitioners (15, 16, 19).
It is a separate pathway, and the determinants and restrictions of prescribing in the two roles are quite different. Hence the training will need to be different (5, Waitakere Union Health Centre).

NPs have the ability to provide comprehensive care, not just focus on one disease state (1, Individual nurse practitioner).

These should be seen as distinctly separate programmes. Those NP’s exploring child and youth for example should not be required to focus on long-term and common conditions when they are required to be focusing on disease specific conditions relating to child and youth. Furthermore some nurses may have completed a different combination of courses before proceeding on a NP pathway. As described in the consultation document, this may become a barrier to those nurses wishing to access advanced education along a designated NP pathway and could also create duplication (10, East Health Trust Primary Health Organisation).

There was little support for this; however there was agreement that some content would be applicable for both groups and standardisation of education would be enhanced. Generally it was thought that the RN prescribing preparation should be different to that of NP (19, General Practice New Zealand).

It is difficult to know without reviewing the requirements of the diploma. It would be our expectation, however, that NP prescribing is approached at a different level than RN prescribing. NPs need education in prescribing that is broader and integrates prescribing with advanced health assessment, diagnosis and treatment (23, College of Registered Nurses of British Columbia).

Two submitters stated that the postgraduate diploma as a prerequisite would make the preparation too long (19, 21).

Diploma and NP must be two separate pathways otherwise the process to obtain NP is too long and may not be responsive enough to meet industry requirements. However it appears this would then take a nurse longer to reach NP qualification. CNS qualification should not be a step towards NP as they may have different focus from NP pathways (21, Taranaki District Health Board).

### 4.6.3 Benefits from a prerequisite postgraduate diploma in prescribing

Many submitters supported the prerequisite qualification and gave their reasons including:

- the need for all prescribers to have a similar preparation and understanding of long-term and common conditions, and the associated formulary for prescribing
- the huge benefit of having nurses gain experience as registered nurse prescribers before progressing to nurse practitioner status
- the benefits in terms of standardising the preparation for all nurse practitioners (2, 9, 25, 28, 32, 35, 36, 40, 41, 49).

PCNZ believes that an understanding of common long-term, chronic conditions should be a pre-requisite for all non-medical prescriber education whether or not this is required as a stand-alone post graduate qualification (9, Pharmacy Council of New Zealand).
It makes sense to make the post grad dip in prescribing to be part of the Clinical masters NP pathway. If the RN has already gained the post grad dip prescribing and had been utilizing it in their practice area they will have gained experience, knowledge and understanding of their practice and will be able to bring a rich source of knowledge to their NP Masters. If in the transition period between the old pathway and the new pathway a candidate has not taken the post grad dip in prescribing but has completed other similar papers there needs to be an ability for cross crediting and recognition of prior learning (2, New Zealand Institute of Rural Health).

I agree with a PG Dip as a minimum requirement for RN prescribing. The specification of papers should reflect the area of practice heading into. It should lead into or form part of the NP programme as nurses may want to further their studies and take on a NP role later (28, Neonatal Nurses College of Aotearoa/NZNO).

If they wish to prescribe they need to have this prerequisite. It will introduce a common learning outcome and level of knowledge necessary to understand drug therapy and future prescribing roles. Establishing a standard and quality of knowledge base is key to high quality nurse practitioners. Prescribing should be limited to where the practitioner works.

We suggest that after a year of nurse practitioners prescribing, from July 2014, the Nursing Council reviews its uptake and outcomes (32, New Zealand Society of Anaesthetists).

This provides clarity around a good pathway for NP candidates. There is value in having a practical mid way outcome such as RN prescribing, especially if decisions around being an NP candidate change. A PG diploma study and experience to gain RN prescribing is valuable (35, Wairarapa District Health Board).

Reasonable expectation as a baseline for any NP applicant working in Primary care family I can see that this would be of benefit for the future to support key health needs; it will ensure that NPs have a broad range of skills and knowledge that will be of value and benefit that will be applicable to the largest group of need and increase the value added component of the NP. Possibly, may encourage more to continue to become NPs (40, Te Tai Tokerau Nurse Practitioners).

We consider there is benefit in this however the PG Diploma title is too long. What is important here is the collection of papers which comprise the PG Diploma. We suggest a PG Diploma in Prescribing is sufficient. Within that PG Diploma, there needs to be papers which demonstrate knowledge and skill development in working with common and long term conditions. There are a range of professions who are aiming towards prescribing and this approach would strengthen the interprofessional work already noted as critical in the current health care settings (41, Auckland University of Technology).

### 4.6.4 Embed the requirements within the master’s programme

Others commented that as a prerequisite the postgraduate diploma in prescribing could be a barrier and it was better to include it within the master’s degree (13, 29, 33, 38, 39).

If the NP curriculum includes masters’ level learning then it should include prescribing for long term and common conditions as well. Making the Postgraduate Diploma in prescribing a pre-requisite only slows down the process and limits very capable candidates from entering straight into the master’s programme. Teach it there. Those who completed it prior
to the masters level curriculum could get credit for previous work done (13, Maori health provider).

It should be embedded but not a stand-alone pre-requisite (33, Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer).

NP programmes include prescribing in the Masters programme and meet the outcomes of this PG Diploma but not necessarily be a pre requisite, this may need to be staircased if becomes a pre requisite but feels too prescriptive (38, Otago Polytechnic).

We feel that Registered Nurse should be able to enrol in NP Masters without an academic Post grad prerequisite. The papers for post grad diploma will be part of the masters’ program (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

4.6.5 Retain flexibility for nurses who have already completed qualifications

There was concern expressed by some submitters regarding nurses who have completed their qualifications and who may want to become nurse practitioners that this pathway may be too inflexible (29, 30, 55, 56).

Candidates may have a PG Dip made up of some different papers initially (many current and past degree graduates will require a pathway ‘grand-parented’ to meet the new competencies). It may become the pathway in the future, but the education pathway should not be so limited and would lack flexibility (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

In addition all prior learning should be assessed as it may support the nurse to reach the course prerequisites as that institution may not be able to provide that same level of specific learning that a nurse on the NP pathway has been able to achieve elsewhere (30, Starship Children’s Hospital nurse practitioners).

In principle becoming a RN prescriber prior to embarking on study towards NP registration is sound, but a mechanism will be needed to support nurses who already have a completed clinical masters’ degree, and those whose area of practice is other than ‘long-term and common’ (55, College of Nurses Aotearoa New Zealand).

There are many nurses with a competed Masters who may seek to become nurse practitioners as roles emerge – limiting access to only this qualification would not be the best use of the workforce (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)).

Two submitters argued for flexibility for nurses with overseas qualifications who may contribute to the nurse practitioner workforce particularly in rural areas (14, 43).

There will be nurses wishing to join the programme from Overseas who have some papers who wish to cross credit or some nurses who only ever want to work with children. Needs to be flexible (14, Intern and nurse practitioner peer review group).

Looking to the future, with projected population changes, we consider Nurse practitioners will play an increasing role in rural areas, and as has been pointed out in the consultation document, the anticipated shortage of general practitioners (Royal New Zealand College of General practitioners, 2014) will see qualified nurse practitioners having an increasing role in
maintaining service levels and service delivery. New Zealand will be increasingly looking to nurses from overseas to help maintain levels of service. NCWNZ believe cross crediting must be considered at least with countries where the New Zealand Council of Nurses has strategic partnerships, such as with USA, Canada, Australia and Great Britain. There is a need for consistency for easier evaluation of educational standards and competencies as well as to ensure continuity of standards for our nurses and for overseas nurses coming to work in New Zealand (43, National Council of Women of New Zealand).

4.7 The Council setting the programme outcomes for nurse practitioner programmes (Question 16)

The Council proposed setting programme outcomes for nurse practitioner programmes. Currently graduate outcomes are specified by each different education provider and are often for the master’s programme as a whole, not the nurse practitioner dedicated pathway. It is proposed that the Council specify programme outcomes for nurse practitioner programmes to create more consistency. Greater consistency in programme outcomes will potentially lead to applicants being more consistently prepared for practice and for registration as a nurse practitioner.

The majority (74%) of submitters supported the Council setting nurse practitioner programme outcomes (see Chart 9). Many submitters stated that this would lead to greater consistency between the providers and benefits to nurse practitioner preparation. One submitter supported closer alignment between the programme outcomes and the nurse practitioner registration process. Some of the education providers objected to the Council setting outcomes as they saw this as their role but others were supportive.

Chart 9: Support for the Council setting the programme outcomes for nurse practitioner programmes

![Chart 9: Support for the Council setting the programme outcomes for nurse practitioner programmes](image)

4.7.1 Council setting programme outcomes will lead to greater consistency between programmes

The reasons given for support were that it was the role of the Council to improve consistency between programmes and that there should be a greater outcome focus for the
programmes. This would ensure equivalence and a clear pathway across all education providers (2, 5, 9, 10, 12, 13, 14, 18, 20, 22, 23, 26, 27, 29, 31, 32, 33, 35, 36, 37, 39, 47, 57).

This will create consistency and equivalency across the different institutions offering NP Masters’ program. This will also make it easier for the Council to assess competency and appropriate preparation (39, Nurse practitioner group- Hawkes Bay District Health Board).

We support the Nursing Council setting outcomes for nurse practitioner programmes as there are inconsistencies across education sites although the Nursing Council nurse practitioner application process does reduce the effect of any inconsistencies (57, Critical Care Complex- Counties Manukau District Health Board).

It would be ideal if we had consistent curriculums across the different education providers with consistent outcomes evaluated, along with maintaining council/external assessment at the end of an internship (31, Individual nurse).

This will establish clarity around expectations of the programme and is seen as part of NCNZ’s role to ensure a robust programme leading to registration (36, Primary Health Care Nurse Reference Group- Hutt Valley).

To provide consistency and credibility. However the programme must remain grounded in practice and improving patient access / outcomes (22, Tairawhiti District Health).

Yes this sets a good standard. The programme needs to be more outcome focuses than currently (37, Hutt Valley District Health Board including primary health care).

4.7.2 More closely align the programme outcomes and the registration process

The University of Auckland School of Nursing (16) submitted that the registration process could be more closely aligned with programme outcomes and that submitting the portfolio and an interview date with the Council assessment panel could be part of the NP programme completion requirements.

Partnership between the Nursing Council of New Zealand and its educational providers has been longstanding. We recommend that this continue. Nursing Council currently accredits nursing educational programmes and that partnership should continue to be collaborative to assure the desired outcomes are met. In the past, there has often been a long gap between when a student finished the prescribing practicum and NP registration (often a year or more). We propose a closer relationship with NZNC to avoid this long delay between education and registration in order for prescribing skills to remain current. We envision that Nursing Council collaborating closely with Nurse practitioner education programmes to expedite the registration process. We would like to develop a collaborative system whereby when a cohort of students finish their Master's degree, they will have also finished their portfolio and then have a date set for the panel interview as part of their NP programme completion requirements. The portfolio assessment and panel interview would continue to occur independently of the educational provider by the NZNC. This way the NZNC could better plan for NP's coming through and registration expedited by being part of the NP student completion expectations (16, University of Auckland School of Nursing).
4.7.3 Setting programme outcomes is the role of the educator

Those opposed to the Council setting nurse practitioner programme outcomes submitted that developing programme outcomes was the role of the school of nursing (18, 23, 29, 30, 41, 52, 56). Education providers submitted that based on the standards, programmes have an outcome focus on ensuring evidence is demonstrated against the nurse practitioner competencies. Some submitters stated the role of the Council is to accredit and monitor programmes (50, 52, 56) with one education provider submitting there were also academic considerations that sit within the Committee on University Academic Programmes (29).

The Nursing Council already approves and monitors master of Nursing Programmes against defined criteria as for the undergraduate programmes. This is a standards based common curricula principles approach with agility that accesses responsive variation rather than a fixed model (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)). We suggest that the Nursing Council scope statement together with the competency requirements is sufficient. It is the responsibility of the education provider to demonstrate their programme aligns with the stated scope and competencies (41, Auckland University of Technology).

This is the primary role of educational institutes under their legislation. The role of the nursing regulatory body is to review the outcomes to ascertain that the competencies and standards of practice are incorporated and that there is evidence to support their achievement (23, College of Registered Nurses of British Columbia).

The Nursing Council should concentrate on clearly identifying NCNZ requirements for the NP in NZ, once these are clearly articulated then Nurse Education programmes will be able to develop education pathways that support the development of these criteria (30, Starship Children’s Hospital nurse practitioners).

Two submitters stated that the programme outcomes should be set with the Medical Council or college (7, 11).

In support with medical council or college, I always support team effort- we are all in it together (7, Individual nurse).

Joint nursing and medical councils (11, Individual doctor).
4.8 Draft programme outcomes for nurse practitioners (Question 17)

The Council proposed the following programme outcomes in addition to those in the postgraduate diploma in registered nurse prescribing (see Appendix 5).

Following successful completion of the programme the student will be able to:

1) apply a broad base of theoretical and clinical knowledge and skill within a framework of nurse practitioner practice; demonstrate a high level of clinical proficiency in complex client situations; able to practice across healthcare contexts
2) apply critical thinking, problem and reflection to clinical diagnostic and prescribing decision making, and develop innovative solutions to practice in a healthcare setting
3) critically appraise scientific literature, integrate research findings into nurse practitioner practice and undertake research to advance practice
4) demonstrate a high level of interpersonal skill, communicate effectively and establish effective collegial relationships with interprofessional teams, work in consultation and collaboration with clients, whanau and communities
5) make informed decisions on use of diagnostic and therapeutic interventions by utilising current technology to inform practice; proactively seek new information and technologies to improve client outcomes
6) recognise the values intrinsic to nurse practitioner practice; demonstrate a commitment to lifelong learning through critical reflection, self-monitoring and is able to mentor and enhance the professional development of others
7) critique health policies from a population health perspective; understand legal and socio political issues in healthcare and understand organisational and funding/business influences on practice
8) demonstrate a sound understanding of current legislation, registration requirements as a nurse practitioner; work in an autonomous and accountable practice framework as a senior member of interprofessional teams; demonstrate high level clinical leadership and management skills
9) demonstrate achievement of the Nursing Council Competencies for the nurse practitioner

The majority (65%) of submitters supported the draft programme outcomes proposed by the Council (see Chart 10). There were some suggested changes to the wording. These included alignment with Level 9 learning outcomes on the New Zealand Qualifications Authority Framework and a stronger focus on interdisciplinary skills. Some education providers did not see the setting of outcomes as the Council’s role.
4.8.1 Support for programme outcomes

Those who supported the draft outcomes agreed they covered nurse practitioner practice requirements (3, 8, 11, 12, 16, 19, 23, 24, 25, 28, 35, 36, 37, 38, 39, 40, 45, 46, 55).

The draft outcomes outlined are comprehensive and very descriptive. They are consistent with program outcomes that are currently being used by NP programs across the country. In general the proposed program outcomes cover all aspects of practice and are consistent with the attributes of a practitioner at this level. Keeps standards and provides nurses with some assurance regarding content of courses being undertaken (40, Te Tai Tokerau Nurse Practitioners).

While we agree the draft outcomes are comprehensive and consistent with program outcomes currently contained within NP programs across the country. We refer however to our previous statement (16) regarding the responsibilities of the education providers (41, Auckland University of Technology).

The outcomes cover the elements of Nurse practitioner practice (46, Nurse Practitioners New Zealand and 55, College of Nurses Aotearoa New Zealand).

4.8.2 Suggested changes to the outcomes

Several submitters suggested some wording changes to the outcomes were required. These included increased pharmacology (9), greater emphasis on diagnostic role (46, 57, 58), more or less emphasis on outcomes 7 and 8 (22, 32), and quality improvement not research (54). The Pharmacy Council also suggested the Council consider whether there needs to be some option for an interdisciplinary prescribing programme (9).

Overall, the draft programme outcomes appear sufficient in all areas except pharmacological and pharmaceutical knowledge. The Pharmacy Council would encourage the Nursing Council to consider a future view where education programmes for non-medical prescribers are integrated and multidisciplinary e.g. courses could be offered jointly to pharmacists and nurses. Courses could be by both the Pharmacy Council and the Nursing Council. Although there are pros and cons to this approach and it may be challenging to provide a ‘one-size fits all’ programme, the knowledge and skills each profession brings to the programme would...
complement the other. Where the main challenge for pharmacists is a lack of ‘clinical’ skills, e.g. diagnosis, medical examination/consultation skills, clinical governance etc., the main challenge for nurses is likely to be pharmacological and pharmaceutical knowledge. Interdisciplinary interaction at the post-graduate level may overcome some of these challenges. This would also lead naturally to the development of generic prescribing competencies that are relevant to all non-medical prescribers (9, Pharmacy Council of New Zealand).

However points 7 and 8 are not proposed as part of the curriculum and is often lacking as a knowledge base in the candidate as are the potential candidate's behaviour and attitudinal traits. Other aspects to consider may be Patient safety and Contemporary Health policy in the 21st century. ?? psychometric testing (22, Tairawhiti District Health).

The majority are sound principles but the true value will be in how these outcomes demonstrate their usefulness. We note that the assessment of some of these draft outcomes will be difficult for e.g. “understanding legal and socio political issues”. Many places are using nurse practitioners as an alternative to a Medical Practitioner – draft outcomes 7 and 8 may not be relevant to the required skill set of a nurse practitioner (32, New Zealand Society of Anaesthetists).

We generally support the draft programme outcomes in the document however there should be more emphasis on the diagnostic role which is more than making informed decisions on use of diagnostic and therapeutic interventions (57, Critical Care Complex - Counties Manukau District Health Board).

One submitter commented on the wording of the outcomes as not being appropriate for Level 9 learning outcomes (29).

The draft outcomes broadly include areas that would be expected in a NP programme. However, there are some concerns about the level of these outcomes relative to those normally attributed to a master’s level activity and attributes. Secondly, the draft outcomes do not, as stated, contain all the outcomes needed to satisfy the academic degree outcomes. In #7 and #8 the word ‘understanding’ appears, and educationally it is considered a low level descriptor. Attributes such as the ability to ‘synthesis’, ‘evaluate’ and ‘integrate’ elements, resources, knowledge and/or services would be expected. Outcomes would need to be more specific about assessment in some areas, e.g. #7 and #3 (“undertake” research couldn’t be assessed in practicum) (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

Two submitters considered there needed to be a stronger focus on diagnostic skills (58, 46).

NPNZ supports the Nursing Council setting outcomes for Nurse Practitioner programmes after consultation as these are inconsistencies across the current pathways and across the current education providers. However everybody has to apply to the Nursing council in the end which requires some consistency, this may make desk audit a more routine element of the application. A stronger focus on the diagnostic role (including differential diagnosis) as part of the critical thinking element of practice. Critical thinking can be seen as what marks out someone as having Nurse Practitioner potential (46, Nurse Practitioners New Zealand).
NZNO support Nursing Council setting the programme outcomes for nurse practitioner programmes; and recommend greater emphasis on the diagnostic role of NPs in the programme outcomes and that greater detail is provided (58, New Zealand Nurses Organisation (NZNO)).

4.8.3 Educator’s role to set outcomes

A small number of submitters did not support these outcomes because it was not thought appropriate for the Council to set outcomes for postgraduate education programmes (15, 52, 56).

For the reason above the other draft outcomes, while broadly supporting the role, are not supported. The reason for this stance is that the education preparation is post-graduate and includes experiential learning. The undergraduate programme needs structure because the students are not already professional nurses and we are meeting entry to the profession standards. In PG study there is varied experience at entry and varied practice outcomes or ways of demonstrating practice. The reflection of that practice in a professional portfolio is at the heart of practice. The cost and effort of accrediting at the proposed level does not balance the benefits of the process which are not clear at this point (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

The Nursing Council already approves and monitors Master of Nursing programmes against defined criteria (52, Eastern Institute of Technology School of Nursing).

Rather than programme outcomes – these could be reformulated as the NP competencies within four domains … If there are issues with inconsistent outcomes from NCNZ approved NP programmes this should be explored to determine the exact nature of the concern. This would allow NCNZ to identify any gaps in effectiveness of current processes for ensuring appropriate standards and address accordingly (56, Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)).

4.8.4 Other suggestions

Two submitters suggested the Council should further simplify its guidelines for registration (10, 19).

Respondents were satisfied with the draft programme outcomes, considering it provided a robust evidence based framework to support nurses on the NP pathway. One PHO noted the Nursing Council guidelines for applicants updated 2014 should be shortened and simplified as the process is still complex and may present a barrier to potential candidates (19, General Practice New Zealand).
4.9 The Council’s role in accrediting tertiary courses and programmes that do not lead to nurse practitioner or registered nurse prescribing (Question 18)

If the Council’s proposals went ahead and there was a change in the qualification pathway leading to registration in the nurse practitioner scope of practice, the Council would no longer have a statutory role to approve other papers outside of the postgraduate diploma in prescribing and the dedicated nurse practitioner programmes. The Council would no longer have a statutory role to approve other papers within clinical master’s degrees. The Council’s statutory role is to ensure the safety of the public by setting prescribed qualifications and approving programmes that lead to registration in a scope of practice (see Appendix 4).

Most submitters (56%) supported the Council maintaining its role in approving all postgraduate tertiary clinical nursing education programmes (see Chart 11). The reason given was that it was part of the Council’s wider regulatory role to ensure a standard for public safety. The link between Council approval and HWNZ funding was raised as an important issue as well as the implications for career advancement in the profession into roles other than nurse practitioner. There was support from some submitters for the Council to cease approval of other programmes as it was seen as inconsistent with the role of a regulatory body and unnecessary as other bodies approved these programmes.

Chart 11: Support for Council accrediting tertiary courses and programmes that do not lead to nurse practitioner or registered nurse prescribing

4.9.1 Support for the Council to continue approving all postgraduate clinical nursing education programmes

Many submitters supported the Council continuing to approve programmes not leading to prescribing or nurse practitioner to maintain standards of postgraduate clinical education (1, 2, 5, 10, 16, 19 24, 25, 29, 33, 35, 39, 42, 45, 51, 53, 54, 55).
This was seen as important as it prepares nurses for a variety of nursing leadership and healthcare roles (25, 29, 32). Some submitters commented that it was considered within Council’s role of protecting public safety to maintain standards of clinical education (2, 10, 29, 39, 44, 51). Two submitters supported the Council maintaining its role of providing accreditation of courses leading to expanded practice for registered nurses e.g. first surgical assistant (9, 16).

We consider that accreditation of Advanced Nursing preparation is within the Nursing Council’s role. Advanced nursing studies contains knowledge contributing to developing RN practice and leadership in a wide range of nurses career areas e.g., clinical, management, and research from many PG papers/programmes. Advanced nursing knowledge and skills are beneficial in areas of nursing in which nurse prescribing may not necessarily occur such as Intensive care, tertiary hospital specialities, and some fields of mental health. Presently nurses applying for extended practice approvals have studied accredited courses/programmes (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

The Nursing Council of New Zealand is the regulatory authority who ensures a consistent standard of nursing education, in this country, that both the public and the profession can be assured of (51, MidCentral District Health Board: Group of senior nurses).

It is important that other programs are accredited by Council to ensure and maintain a uniformity of standards. This acknowledges and values that while not all nurses will want to prescribe or become NP’s they still expect programs to be of a certain standard (2, New Zealand Institute of Rural Health).

We believe the Council need to maintain a statutory role in accrediting tertiary courses for registered nurses for any clinically implicated programmes. This then ensures a consistent and appropriate clinical learning environment in NZ to enhance patient safety and negates the risk of inadequately educated and poorly prepared trainers from influencing the knowledge and skill within our health environment. Educators.academics/nurse leaders should be looking at setting programmes with consistency across the country provided by the guidance of the Council (39, Nurse Practitioner Group- Hawkes Bay District Health Board).

While there may be many nursing programmes offered by tertiary institutions which don’t lead to NP or registered nurse prescribing, there must be a process of accreditation and quality control to support the nurse and to protect the public. Nursing Council must maintain the role of “watchdog” in the absence of any other independent auditing, monitoring organisation for example the CQC (Care Quality Commission) UK (10, East Health Trust Primary Health Organisation).

For clinically focused educational programmes there remains a need for Nursing Council to provide accreditation that will ensure consistent standards nationally. There are currently several expanded clinical practice programmes such as Registered Nurse first assistant, and the newly proposed Nurse Endoscopy programme. It will be appropriate for Nursing Council to maintain a role in accrediting expanded practice nursing programmes (16, University of Auckland School of Nursing).
The issue of being able to cross credit papers in the nurse practitioner programme if not Council approved was raised by three submitters (44, 46, 52).

As nurses may take a circuitous route to NP registration, universities will need to be able to credit appropriate papers from other universities/polytechnics into the NP programme if the programme requirements have been met (44, Nurse Executives of New Zealand (NENZ)).

This consultation document suggests that the proposed nurse practitioner pathway is the only option that leads to registration as a nurse practitioner. A further issue relates to RPL, for example, for a registered nurse who has completed other level 8 courses, and subsequently wishes to become a nurse practitioner, the proposed prescriptive nature of the nurse practitioner programme could potentially mean completing a further 240 credit programme. The Council might need to consider if there should be a further scope of practice for registration as a clinical nurse specialist (52, Eastern Institute of Technology School of Nursing).

One submitter thought these courses involved continuing competence therefore the Council had a role under that provision of the Act.

Because these are still clinical programmes which nurses also use to demonstrate continuing competence requirements (33, Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer).

4.9.2 Approval linked to HWNZ funding

Some submitters were concerned that lack of Council approval may result in a loss of HWNZ funding. Several submitters raised issues around the funding of clinical education. Because HWNZ funds courses approved by the Council it was considered important for the Council to maintain a broader accreditation role (2, 14, 19, 26, 29, 36, 47).

Limiting accreditation to nurse practitioner or registered nurse prescribing programmes is likely to exclude many advanced practitioners from access to study and funding. There are implications around funding support and access in the current environment that impact on programmes and need to be considered (29, University of Otago, Christchurch, Centre for Postgraduate Nursing Studies).

We think the Council needs to accredit tertiary courses for nurses. This will enable courses to attract Health Workforce New Zealand funding. Also, a nurse may not plan at first to apply for NP registration, but may decide to later on, and in these cases it is important to have the ability to cross-credit education already undertaken (26, Family Planning).

Useful especially for HWNZ funding and there are many experienced nurses who want to study and improve knowledge and skills but not go onto NP. Also there may be no position within their organisation for NP – e.g. DHB seem to view CNS as the level they are most willing to employ and this level requires post grad papers (14, Intern and Nurse practitioner peer review group).

Yes, while NCNZ has a key role to play in maintaining public safety, they also provide philosophical support around resource development and education. We suggest there could be a tightening up of the oversight of publicly funded education (HWNZ), to allow improved
choice. We understand NCNZ accredits certain programmes, and not others, with some concern around this, and more work required in this area. Some disparities (36, Primary Health Care Nurse Reference Group- Hutt Valley).

HWNZ funding for the workforce needs to be broader than to a NP Masters. RNs and aspiring NPs should not be limited in accessing funding until the practicum. Workforce development is broader than clinical focused papers. If HWNZ criteria continues to rely on NCNZ accreditation then all PG Study needs to be accredited so accessible (47, Capital and Coast District Health).

4.9.3 Implications for career progression within the profession

Other submitters suggested it was a critical issue for the profession that needed more discussion in relation to other forms of nursing career progression (15, 22, 43, 44).

This depends on the context. There is such a wide range of knowledge that contributes to practice and a long running discussion of the need to consider accrediting leadership and other pathways to PG achievement in education and practice. This question deserves more consultation and discussion in its own right as there are many things to consider. The right decision for the profession is critical here and being the last question in a broader consultation about NPs does not cover this point well enough for that decision. There is the question of graduate entry programmes for instance (15, Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital).

We cannot want or need all RNs to be on a NP or prescribing pathway. The council must support career development for other types of nursing career progression - leadership, management, teaching, research, policy making (22, Tairawhiti District Health).

4.9.4 Some support for Council to cease approving other programmes

Some submitters did support the Council’s role in only approving programmes that were relevant to scope of practice and prescribing (13, 17, 18, 20, 21, 23, 28, 34, 37, 38, 41, 50, 57). The reasons they gave were the limits of the Council’s regulatory role and the role of other bodies in approving education programmes.

This does not seem to be consistent with the role of a nursing regulatory body. Similar to NZ now, we limit program recognition to those required for initial registration for a regulated scope of practice. There are other masters in nursing programs, e.g., programs that prepare clinical nurse specialists, that we do not review and recognize for the purposes of registration. However, to our knowledge, this does not compromise the programs in terms of eligibility for funding (23, College of Registered Nurses of British Columbia).

The Nursing Council mandated responsibility is for public safety. The current registration requirements and processes for EN, RN and NP are within their mandate. Education providers develop programmes which undergo stringent accreditation processes to meet the requirements of national bodies (CUAP, NZQA). It would be onerous for Nursing Council and Education providers to undertake accreditation of tertiary courses or programmes which are beyond the stated registrations (41, Auckland University of Technology).
The Council should not accredit tertiary courses that do not contain prescribing programmes if prescribing is part of a nurse practitioner’s responsibility (50, Royal Australasian College of Surgeons).

We do not believe Nursing Council should be accrediting tertiary courses or programmes that don’t lead to NP or RN prescribing as Nursing Council has a public safety role. As nurses may take a circuitous route to nurse practitioner registration, universities will need to be able to credit appropriate papers from other, universities/polytechnics into the nurse practitioner programme if the programme requirements have been met (57, Critical Care Complex - Counties Manukau District Health Board).

RAs normally only accredit courses which lead to health practitioner registration with the authority under the HPCA Act (18, Regulatory Authority).

The NCNZ role is more regulatory than focused on professional, with an emphasis on maintaining public safety (37, Hutt Valley District Health Board including primary health care).

Perhaps not monitored by the council, many programmes run well and there is supervision of universities and polytechs running these courses (34, Grace Hospital).

One submitter raised consideration of the Council’s workload and priorities (40).

This may reveal an area of uncertainty and may require revisiting in the future it may be dependent on the impact of the change in qualification pathway leading to registration in the nurse practitioner scope of practice to Council approval dedicated nurse practitioner programmes. With the Council’s current policy work & upcoming calendar commitments & staffing levels, will the Council have adequate time for this? One would not want to delay tertiary programs being offered or accredited. At some level however, I think the Nursing Council should be involved in nursing accredited tertiary courses but unsure at what level that involvement or accreditation level should be (40, Te Tai Tokerau Nurse Practitioners).
Appendix 1: List of submitters

1. Individual nurse practitioner
2. New Zealand Institute of Rural Health
3. Individual nurse practitioner
4. Anonymous submitter
5. Waitakere Union Health Centre
6. Individual other
7. Individual nurse
8. Individual other
9. Pharmacy Council of New Zealand
10. East Health Trust Primary Health Organisation
11. Individual doctor
12. Individual nurse
13. Maori health provider
14. Intern and nurse practitioner peer review group
15. Canterbury Directors of Nursing and the Nursing Directorate of Christchurch Hospital
16. University of Auckland School of Nursing
17. Group of nurses
18. Regulatory authority
19. General Practice New Zealand Nursing Leadership Executive
20. Individual nurse
21. Taranaki District Health Board
22. Tairawhiti District Health
23. College of Registered Nurses of British Columbia
24. Individual nurse
25. Individual nurse
26. Family Planning
27. New Zealand Medical Association
28. Neonatal Nurses College of Aotearoa/NZNO
29. University of Otago, Christchurch, Centre for Postgraduate Nursing Studies
30. Starship Children’s Hospital nurse practitioners
31. Individual nurse
32. New Zealand Society of Anaesthetists
33. Hawkes Bay Nursing & Midwifery Leadership Council and Hawkes Bay District Health Board Chief Nursing Officer
34. Grace Hospital
35. Wairarapa District Health Board
36. Primary Health Care Nurse Reference Group- Hutt Valley
37. Hutt Valley District Health Board including primary health care
38. Otago Polytechnic
39. Nurse practitioner Group- Hawkes Bay District Health Board
40. Te Tai Tokerau nurse practitioners
41. Auckland University of Technology
42. College of Emergency Nurses New Zealand/ NZNO
43. National Council of Women of New Zealand (NCWNZ)
44. Nurse Executives of New Zealand (NENZ)
45. New Zealand Rural General Practice Network
46. Nurse Practitioners New Zealand
47. Capital and Coast District Health Board
48. Australian and New Zealand College of Anaesthetists (ANZCA)
49. MidCentral Health Nurse Practitioners
50. Royal Australasian College of Surgeons
51. MidCentral District Health Board: Group of senior nurses
52. Eastern Institute of Technology School of Nursing
53. Victoria University of Wellington
54. Group of nurses
55. College of Nurses Aotearoa New Zealand
56. Nursing Education in the Tertiary Sector (Aotearoa NZ) (NETS)
57. Critical Care Complex - Counties Manukau District Health Board
58. New Zealand Nurses Organisation (NZNO)
59. Pharmacy Guild of New Zealand
60. Health and Disability Commissioner
61. Individual nurse
62. Rural Women New Zealand
63. Royal New Zealand College of General Practitioners
Appendix 2: Scope of practice and prescribed qualifications for nurse practitioners

Under Sections 11 and 12 of the HPCA Act, the Council has prescribed this scope and qualifications for nurse practitioners.

Scope of Practice – Nurse Practitioner
Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to diagnose, assess and manage people’s health needs. They provide a wide range of assessment and treatment interventions, including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests, and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whānau and communities across a range of settings. Nurse practitioners prescribe medicines within their specific area of practice. Nurse practitioners also demonstrate leadership as consultants, educators, managers and researchers, and actively participate in professional activities, and in local and national policy development.

Prescribed qualifications

(a) Registration with the Nursing Council of New Zealand in the Registered Nurse Scope of Practice; and
(b) a minimum of four years of experience in a specific area of practice; and
(c) the completion of an approved clinical master’s degree programme which includes demonstration of the competencies for advanced practice and prescribing applied within a defined area of practice of the nurse practitioner. The programme must include relevant theory and concurrent practice; or the completion of an equivalent overseas clinically focused master’s degree qualification which meets the requirement specified in (c) above; and
(d) passing an assessment against the nurse practitioner competencies by an approved panel.
Appendix 3: Suggested changes to the scope of practice by submitters

Added or moved words are indicated by italics. Removed words are indicated by strikethrough.

Suggested changes to the proposed scope statement

| Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a Registered Nurse. Nurse practitioners provide a wide range of healthcare services to people and communities, including the diagnosis and management of common and complex health conditions. They work in partnership with individuals, families, whānau and communities across a range of settings. Nurse practitioners may manage episodes of care and may be as the primary care provider or work as part of a team. Nurse practitioners may work autonomously and in collaboration and consultation collaboratively with patients and other health professionals including medical practitioners to provide and improve access to coordinated, comprehensive, quality health care. Nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient centred, innovative and flexible care. They utilise advanced nursing skill and knowledge to provide a wide range of assessment and treatment interventions, order and interpret diagnostic/laboratory tests, prescribe medicines, initiate treatments/therapies, and admit/discharge from hospital and other healthcare services/settings. They work in partnership with individuals, families, whānau and communities across a range of settings. Nurse practitioners may work with a specific patient group or community and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs. Nurse practitioners are nursing leaders who promote and actively participate in professional activities at local and national level (39, Nurse Practitioner Group-Hawkes Bay District Health Board). |
| Nurse practitioners have advanced education, clinical training and have demonstrated competence and legal authority to practice beyond the level of a registered nurse. Nurse practitioners provide a wide range of healthcare services to people and communities, including the diagnosis and management of common and complex medical conditions. Nurse practitioners may work autonomously and in collaboration and consultation with patients and with other health professionals, to provide and improve access to coordinated, comprehensive, quality health care. Nurse practitioners may manage episodes of care and may be the primary care provider or work as part of a team. Nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient centred, innovative and flexible care. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic/laboratory tests, prescribing medicines, administering treatments/therapies, admitting and discharging from hospital and other healthcare services/settings. They work in partnership with individuals, families, whānau and communities and other health professionals across a range of settings. Nurse practitioners may work with a specific patient group or community and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs (22, Tairawhiti District Health). |
Nurse practitioners are Masters-prepared, have had advanced clinical training, and demonstrate competence and legal authority to provide a wide range of healthcare services to people and communities, including the diagnosis, management and treatment of common and complex medical conditions. Nurse practitioners provide a wide range of assessment and treatment interventions; ordering and interpreting diagnostic/laboratory tests, prescribing medicines, administering treatments/therapies, admitting and discharging from hospital and other healthcare services/ SETTINGS. Nurse practitioners may work autonomously and in collaboration and consultation with patients and with other health professionals, to provide and improve access to coordinated, comprehensive, quality health care. Nurse practitioners may manage episodes of care and may be the primary care provider or work as part of a team. Nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient-centred, innovative and flexible care. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic/laboratory tests, prescribing medicines, administering treatments/therapies, admitting and discharging from hospital and other healthcare services/SETTINGS. They work in partnership with individuals, families, whānau and communities and other health professionals across a range of settings. Nurse practitioners may work with a specific patient group or community and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs. Nurse practitioners may work autonomously in partnership with patients, and in collaboration and consultation with other health professionals, to provide and improve access to coordinated, comprehensive, quality health care (26, Family Planning).

Nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a registered nurse. Nurse practitioners provide a wide range of healthcare services to people and communities, including the diagnosis and management of common and complex medical conditions. Nurse practitioners may work autonomously and in collaboration and consultation with patients and with other health professionals, including medical practitioners to provide and improve access to coordinated, comprehensive, quality health care. Nurse practitioners may manage episodes of care and may be the primary care provider or work as part of a team. Nurse practitioners blend diagnostic inquiry and therapeutic knowledge and skills with nursing values, knowledge and practice to provide holistic, patient-centred, innovative and flexible care. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic/laboratory tests, prescribing medicines - and non-pharmacological treatments,- administering treatments/therapies, admitting and discharging from hospital and other healthcare services/ SETTINGS. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse practitioners may work with a-specific patient or community group and may work across health settings and teams. They promote health, prevent disease and manage people’s health needs (16, University of Auckland School of Nursing).

Suggested changes to the current scope statement

Two alternative statements were suggested.

NP’s have advanced education, clinical training and the demonstrated competence and practice as expert clinicians and as authorized prescribers with legal authority beyond the
level scope of RN’s having undertaken an advanced program of post graduate education, clinical training with demonstrated competency. NP’s base themselves within current research and best practice demonstrating advanced clinical skills of assessment, clinical diagnostic inquiry, ordering and interpreting diagnostic and laboratory investigations, determining and administering treatment and therapies including prescribing medicines, referring to and consulting with other clinicians across the healthcare contexts and including admissions and discharge from hospitals as necessary. They are able to manage common, complex and chronic health care needs of individuals, family and whanau, communities and populations. NPs can work independently and collaboratively across the sectors and disciplines related to health care to promote health, prevent disease and manage illness, improve access and remove inequalities in health care. NPs are considered leaders within the nursing sector able to provide mentorship, education to other nurses and demonstrate innovative solutions to practice (45, New Zealand Rural General Practice Network).

NP’s are Master's prepared advanced clinical nurses who work within broad areas of practice incorporating advanced diagnostic knowledge and medical skills into their advanced nursing practice. They are regulated, autonomous health practitioners who assume full clinical responsibility for patients, working both independently and in collaboration with other health care professionals to promote health, prevent disease and manage people’s health needs. They provide a wide range of assessment and treatment interventions, including diagnoses, ordering and interpreting diagnostic/laboratory tests, prescribing medicine administering treatments/therapies, admitting and discharging from hospital and other healthcare settings (16 University of Auckland School of Nursing).
Appendix 4: Legislative framework

It is the role of the Council under the Health Practitioners Competence Assurance Act (the Act) to specify scopes of practice, qualifications and experience following consultation with nurses, professional organisations and organisations involved in the provision of health services (section 14).

Section 11(2) of the Act states the following:

A scope of practice may be described in any way the authority thinks fit … in 1 or more of the following ways:

(a) by reference to a name or form of words that is commonly understood by persons who work in the health sector:
(b) by reference to an area of science or learning:
(c) by reference to tasks commonly performed:
(d) by reference to illnesses or conditions to be diagnosed, treated or managed.

Section 12(1)(2) of the Act states:

1) Each authority must, by notice published in the Gazette, prescribe the qualification or qualifications for every scope of practice that the authority describes under section 11.
2) In prescribing qualifications under subsection (1), an authority may designate 1 or more of the following as qualifications for any scope of practice that the authority describes under section 11:

   a) a degree or diploma of a stated kind from an educational institution accredited by the authority, whether in New Zealand or abroad, or an educational institution of a stated class, whether in New Zealand or abroad:
   b) the successful completion of a degree, course of studies, or programme accredited by the authority:
   c) a pass in a specified examination or any other assessment set by the authority or by another organisation approved by the authority:
   d) registration with an overseas organisation that performs functions that correspond wholly or partly to those performed by the authority:
   e) experience in the provision of health services of a particular kind, including, without limitation, the provision of such services at a nominated institution or class of institution, or under the supervision or oversight of a nominated health practitioner or class of health practitioner.

Section 13 of the Act states:

In prescribing qualifications … each authority must be guided by the following principles:

a) the qualifications must be necessary to protect members of the public; and
b) the qualifications may not unnecessarily restrict the registration of persons as health practitioners; and

c) the qualifications may not impose undue costs on health practitioners or on the public.
Section 118 of the Act states:

The functions of each authority appointed in respect of a health profession are as follows:

a) to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies, or programmes:
b) to authorise the registration of health practitioners under this Act, and to maintain registers:
c) to consider applications for annual practising certificates:
d) to review and promote the competence of health practitioners:
e) to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners:
f) to receive and act on information from health practitioners, employers, and the Health and Disability Commissioner about the competence of health practitioners:
Appendix 5: Education programme standards for the Postgraduate diploma in registered nurse prescribing for long-term and common conditions

Introduction and background

Under the Health Practitioners Competence Assurance (HPCA) Act 2003 (the Act), the Nursing Council of New Zealand (the Council) is the authority responsible for the registration of nurses. In accordance with section 12 of the Act, the Council prescribes qualifications for scopes of practice. In addition the Act requires the Council to accredit these qualifications and monitor any New Zealand tertiary education provider that is providing such an accredited qualification.

The ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ will be an additional prescribed qualification for the registered nurse scope of practice for nurses who choose to apply for this prescribing authority.

The provision of ‘Postgraduate diploma in registered nurse prescribing for long-term and common conditions’ programmes will be limited to tertiary education providers also providing Council-accredited programmes which lead to registration as a nurse practitioner. This is because this qualification may become a prerequisite for nurse practitioner programmes.

Upon award of the qualification, graduates will be eligible to apply to the Council for an authorisation/condition to be included in their scope of practice enabling them to prescribe for long term and common conditions when the regulation under the Medicines Act 1981 comes into force.

Education providers may apply to the Council for accreditation of the ‘Postgraduate diploma in registered nurse prescribing for long term and common conditions’. Applications for accreditation will be assessed against the education programme standards in this document.

The Council gratefully acknowledges the Pharmacy Council of New Zealand (2011) for its kind permission to refer to, adapt, and reproduce its work, based on the standards first developed by the Royal Pharmaceutical Society of Great Britain (RPSGB) and adopted by the General Pharmaceutical Council (UK) for independent prescribing programmes in 2010.
1. **The education provider**

1.1. The tertiary education provider must meet the requirements as specified in the Act, Council policy, and as contained in these standards.

1.2. The tertiary education provider must be accredited by the Council to provide a master’s degree for nurse practitioner registration in New Zealand under sections 12(2)(a) and 118(a) of the Act.

1.3. The tertiary education provider must implement effective quality assurance and quality improvement systems, and demonstrate their application to nurse prescribing programmes. The programme must be approved/accredited through the relevant Committee for University Academic Programmes or NZQA-approval/accreditation process.

1.4. **Entry requirements for the prescribing practicum**

The registered nurse is required to:

- hold a current practising certificate and must have completed three years’ equivalent full-time practice in the area of practice she/he will be prescribing

- have a collaborative working relationship with a multidisciplinary team and have the support of a designated authorised prescriber (DAP), (a vocationally registered medical practitioner or nurse practitioner) as a mentor who will support her/him to prescribe

- undertake the practicum in an organisation that supports nurse prescribing through policy, audit, peer review and accessibility of continuing education

- have identified and have access to an area of clinical practice in which to develop their prescribing skills and have up-to-date clinical knowledge relevant to their intended area of prescribing practice.

1.5. The education provider must have a recognition of prior learning (RPL) policy that conforms with the Council’s policy. This must include the following:

1.5.1. RPL involves recognising and giving credit for learning that has occurred through previous experience. This may include qualifications, life experience, work experience or other educational experience. This learning is measured against the learning outcomes of the programme.

1.5.2. Each tertiary education provider must have an RPL policy and procedure against which to assess individual student applications. RPL policies and procedures will be monitored during the five-yearly monitoring of the programme.

1.5.3. RPL must be granted on the basis of a student’s individual qualifications and experience. The proposed individual programme to be undertaken by the student must be sufficient in theory and clinical experience to enable the student to meet the **Competencies for nurse prescribing.**
1.5.4. Prior learning may be cross-credited against the registered nurse prescribing programme. However, all registered nurses must undertake all assessments for the registered nurse prescribing practicum and praxis.

1.5.5. The Council retains the right to seek justification of any credit granted through RPL.

1.5.6. Statements of programme completion (academic transcripts) must outline any RPL granted.

2. Programme structure and curriculum

2.1. The postgraduate programme is equivalent to 1,200 hours of study including 120 credits\(^2\). A graduate of the postgraduate diploma must show evidence of advanced knowledge of pathophysiology, pharmacology, assessment and diagnostic reasoning in relation to the clinical management of and prescribing for patients with long-term and common conditions in New Zealand. The programme must include a prescribing praxis\(^3\) with a prescribing practicum component (i.e. period of learning in practice).

2.2. The duration of the programme is expected to be aligned with the requirements for postgraduate-level qualifications and must include sufficient face-to-face contact time to enable registered nurses to learn alongside other registered nurses; to share and consolidate their learning. Other ways of learning, such as distance learning and open learning formats, may be used provided they complement face-to-face contact time and attendance requirements.

2.3. The structure of the programme must encourage development of critical analysis and reflective practice, and provide registered nurses intending to prescribe with the knowledge, skills and attributes in the competency areas as described in the Competencies for nurse prescribers (see Attachment 2).

2.4. The tertiary education provider must ensure effective links are maintained with the nursing profession and other relevant stakeholders in the delivery of the programme.

2.5. The tertiary education provider has policies and practices which ensure the programme is underpinned by current research and scholarship in nursing, pharmacology, prescribing, education and health. The curriculum is based on national health priorities and contemporary health care and practice trends.

2.6. The programme describes the processes through which students learn. The modes of delivery and the teaching, learning and assessment methods are described.

---

\(^2\) The postgraduate diploma requires a minimum of 120 credits from levels 7 and above, with a minimum of 72 credits from level 8 (New Zealand Qualifications Framework). http://www.nzqa.govt.nz/studying-in-new-zealand/understand-nz-quals/postgraduate-diploma/

\(^3\) The prescribing praxis is to include content on the legal, regulatory, ethical and policy framework for prescribing in New Zealand.
2.7. The majority of assessments are to focus on the application of theory to common disease states, e.g. infection, diabetes, cardiovascular, respiratory. A minority of assessments may relate to a particular specialty.

2.8. The assessment methodology tests all aspects of prescribing and must include a practical assessment and confirmation of the registered nurse’s clinical, physical examination and decision-making skills.

2.9. The assessment requirements must be made explicit, in particular the criteria for pass/fail and the details of the marking schedule.

2.10. **Programme content**

Following the successful completion of the programme, the registered nurse will be able to:

- demonstrate advanced knowledge of scientific concepts and common pathophysiological processes
- understand the underlying principles of pathophysiology and clinical management of long-term and common conditions, e.g. cardiovascular disease, diabetes and related conditions, respiratory disease, common infections, anxiety and depression.
- critically analyse and interpret research-based knowledge regarding pathological changes in selected disease states
- apply client assessment skills and diagnostic reasoning at an advanced level in their practice within their scope of practice
- critically analyse clinical assessment findings, in relation to underlying pathophysiological processes. Analyse and generate solutions to clinical problems
- articulate advanced knowledge of client assessment and diagnostic reasoning to formulate a list of differential diagnoses or a diagnostic decision
- demonstrate knowledge of principles of pharmacokinetics and pharmacodynamics, and apply these to client variables (such as age and disease state)
- critically analyse pharmacotherapeutic indications for common classes of drugs for long-term and common conditions
- critically evaluate the causes of antimicrobial resistance and the importance of incorporating non-pharmacological strategies and knowledge of local resistance patterns into prescribing practice
- demonstrate the ability to identify contraindications, effects and drug interactions associated with the use of prescription, over-the-counter and complementary medicines and devices
- demonstrate the ability to recognise situations of drug misuse and drug seeking, and take appropriate action
- demonstrate the ability to perform a comprehensive medicines assessment and to make safe prescribing decisions within professional and regulatory frameworks.
2.11 Prescribing practicum

2.11.1 The prescribing practicum (included in the prescribing praxis paper) must be the final component of the programme.

2.11.2 The prescribing practicum component of the programme must consist of at least 150 hours of clinical practice under the supervision of an appointed designated authorised prescriber (DAP) in a collaborative health team environment. It will include opportunities to develop diagnostic skills, patient consultation and assessment skills, clinical decision-making and assessment skills, and monitoring skills.

2.11.3 There is a process to ensure the final assessment against the Council’s Competencies for nurse prescribers will be undertaken collaboratively between the DAP in clinical practice and academic staff.

2.11.4 The role of the DAP in the prescribing practicum is to:

- help the registered nurse to acquire knowledge and practical skills, particularly clinical assessment skills relevant to their proposed role as a prescriber
- assess the achievement of the learning outcomes by the registered nurse, and confirm the completion of the equivalent of 150 hours of supervised practice
- complete a professional declaration which confirms that in his/her opinion a registered nurse has met the skills and competence requirements of the competencies for nurse prescribers.

2.11.5 The role of the tertiary education provider in the prescribing practicum is to:

- ensure the appointed DAP has the training and experience appropriate to their role, is familiar with the requirements of the programme, and has clear and practical guidance on their role in the assessment of the registered nurse against the competencies for nurse prescribing
- obtain formal evidence and confirmation from the DAP that the registered nurse has satisfactorily completed at least 150 hours of supervised clinical practice and has the skills and competence demonstrated in practice to meet the requirements of the prescribing practicum and the competencies for nurse prescribing.
- provide the registered nurse and DAP with clear and practical guidance on completion of the prescribing practicum, including:
  i. the expectations for direct and indirect supervision in the practicum period. The supervised practice can involve registered nurse support and experience with other members of the team, other prescribers and external contributors;
  ii. use of mentoring techniques commensurate with registered nurse progress such as demonstration, observation and review of clinical cases;
  iii. requirements for formative and summative assessment of the registered nurse;
iv. practical guidance, support and quality assurance of any summative assessments carried out by the DAP on behalf of the education provider;

v. a structured workbook or portfolio for recording the completion of 150 days in practice, achievement of learning outcomes and professional declaration that the registered nurse is competent to prescribe;

vi. a formal mechanism for ongoing discussion about student progress between academic staff, the DAP and the student during the practicum.

No student may be given more than two opportunities to pass the prescribing practicum.
### Appendix 6: Responses to consultation questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Did not answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you support nurse practitioner being a broad generic scope of practice (like registered nurse and enrolled nurse) and the removal of the requirement for registration to be restricted to a specific area of practice?</td>
<td>44</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>7. Do you support the focus on leadership within clinical practice in the new proposed scope of practice statement?</td>
<td>44</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>8. Do you agree with the inclusion of advanced nursing skills and knowledge in the proposed new scope of practice?</td>
<td>51</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>9. Do you agree with the proposed new scope of practice for nurse practitioner?</td>
<td>35</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>10. Do you support a dedicated Masters programme with a broad focus for nurse practitioner preparation?</td>
<td>43</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>11. Do you support the Council specifying clinical learning time within the programme for nurse practitioners?</td>
<td>41</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>13. Do you think that a student must have employer support to complete a practicum with supernumerary hours?</td>
<td>35</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>15. Do you think the Postgraduate diploma in registered nurse prescribing for long term and common conditions should be a pre-requisite for nurse practitioner programmes?</td>
<td>16</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>16. Do you support Nursing Council setting the programme outcomes for nurse practitioner programmes?</td>
<td>42</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>17. Do you agree with the draft programme outcomes for nurse practitioner?</td>
<td>37</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>18. Do you think that the Council has a role in accrediting tertiary courses and programmes that do not lead to nurse practitioner or registered nurse prescribing?</td>
<td>32</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>

Note:
The responses to question 12 can be found in Section 4.3
The responses to question 14 can be found in Section 4.5