Q6: 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?

No,

Please give your reasons
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. A broad focus needs to be defined further in order for us to comment more effectively.

Q7: Do you support the focus on leadership within clinical practice in the new proposed scope of practice statement?

Please give your reasons
Both no and yes. 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 maintain their requirements of leadership in education, management, research and policy development to be effective.

Q8: Do you agree with the inclusion of advanced nursing skills and knowledge in the proposed new scope of practice?

Yes,

Please give your reasons
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.
Q9: Do you agree with the proposed new scope of practice for nurse practitioner?

Please explain your reasons or suggest changes or alternative wording

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.

Q10: Do you support a dedicated Masters programme with a broad focus for nurse practitioner preparation?

No.

Please give your reasons

See question 1. The document specifically says that nurse practitioners are required to complete a minimum of four years of clinical practice in a specific area of practice as part of the prescribed qualification. As such they are an expert in a specific area, but by broadening the scope they are 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. A broad focus needs to be defined further in order for us to comment more effectively.
### Q11: Do you support the Council specifying clinical learning time within the programme for nurse practitioners?

**Yes,**

Please give your reasons

Clinical learning time should be defined in line with other models of health professional specialisation. We suggest at least 500 hours of clinical time with a senior mentor to ensure role-modelling and that the required basic experience is gained in the expanded role. While the Council can’t regulate the education nurse practitioners get it can regulate what clinical learning they must have. The Council should focus on the competencies it requires at the end of training - it should be involved in setting the standard for the end product and also the end of course assessment. The council could supply guidelines to the educators on how training should occur.

### Q12: How much clinical learning time should be included in the programme in addition to the prescribing practicum (a minimum of 150 hours)?

See question 5 – 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.

### Q13: Do you think that a student must have employer support to complete a practicum with supernumerary hours?

**Yes,**

Please give your reasons

There needs to be a balance between dedicated and protected teaching time and time that the student must spend out of hours studying. Defining the educational hours and level of mentoring/ supervision for clinical training is required so that employers can budget for this supernumerary time. A student and employer should jointly agree on the course of study.

### Q14: What other requirements for the clinical learning hours should be specified by the Council e.g. mentor criteria, setting, competence or other assessments?

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. Please see our suggested clinical time and end of study assessment points on question 5.

### Q15: 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?

**Yes,**

Please give your reasons

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.
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<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>Q16: Do you support Nursing Council setting the programme outcomes for nurse practitioner programmes?</td>
<td>Yes, Please give your reasons The Nursing Council has a key role in setting the standards, approving a training institution and making final assessments. If the outcomes are tightly linked to Nurse Practitioner competencies then the Council would be able to define the outcomes of the training. The Council must have a role in ensuring that the appropriate standard of training has been attained.</td>
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<td>Q17: Do you agree with the draft programme outcomes for nurse practitioner?</td>
<td>Yes, Please explain your reasons or suggest changes or alternatives 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.</td>
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<td>Q18: 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>Please give your reasons A common basic training for all nurses would be sensible regardless of their final destination. Allowing programmes to exist that do not comply with this standard would be pointless and wasteful. Tertiary education providers for nursing training need input from the Council to ensure the courses and programmes are useful and relevant. Note our answer to Q 11, the Council has a role in ensuring that the appropriate standard of training has been attained, and should define the outcomes of the training.</td>
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<td>Q19: Any other comments on the scope of practice or education programme?</td>
<td>We support the nurse practitioner role but would like to make some further points below and in our covering letter which forms part of our submission. The Nursing Council should ensure it publishes factual data about roles that nurses will undertake. We note there are some broad statements in the document for e.g. that nurse practitioners will increasingly work with older patients and patients with long term conditions etc. (page 4) and that they will have an increasing role in primary health care teams in rural areas. These statements could be misleading as this is as yet unknown. We question why a Clinical Nurse practitioner who could undertake a prescribing post-graduate course and work within a clinical team e.g. Pain, diabetics or coronary care would undertake more years of training to achieve a Masters and be a nurse practitioner, particularly without the support of their employer. We enlarge on this comment in our letter. We would be interested to know how and who will assess nurse practitioners to ensure they can demonstrate they have sufficient assessment and diagnostic skills in the specialist area they will prescribe in. Please see our covering letter to the Nursing Council chief executive where we provide further comment.</td>
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