Analysis of submissions

Consultation on the education programme standards and competencies for the nurse practitioner scope of practice

July 2016
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1 Executive summary

The Council began a review of the nurse practitioner scope of practice in 2014. An initial consultation focused on the scope of practice and a proposal to require more consistent education programmes with specified clinical learning hours.

In November 2015 the Council circulated a second consultation document which proposed new education programme standards, draft competencies and changes to the assessment of competence for registration for nurse practitioners. The Council also proposed that new nurse practitioners practise under supervision for one year. This document summarises the responses from the 54 submissions received.

Proposed changes to education programmes leading to registration as a nurse practitioner

The majority of submitters supported the draft education programme standards (78%). Reasons given included they would provide greater structure to nurse practitioner preparation, improve alignment between education and practice, and provide greater consistency between education programmes. Eight submitters (15%) also wanted the Council’s close involvement in the change to ensure optimal educational standards are maintained to give students the best preparation for nurse practitioner registration.

Submitters strongly supported the proposed practicum standards (83%). The reasons included the standards make the responsibilities of all the parties involved in supporting the practicum clearer. The involvement of the academic and clinical mentors in formative and summative assessments was supported. Nearly one third of submitters (31%) raised concerns about how, or if, the students’ supernumerary clinical learning hours and/or mentor support would be funded, or supported by employers. Twelve submitters (22%) were concerned that the supernumerary clinical learning hours would be a barrier, would exclude intern roles or were too short.

There was a high level of support for nurse practitioners as clinical teaching staff (81%) with many submitters agreeing that nurse practitioners would be the ideal clinical teachers and mentors/ supervisors. Feedback suggests that the term “clinical teacher” was interpreted by many to mean the clinical mentor or supervisor within the practicum setting rather than the “academic mentor” or clinical lecturer employed by the educational provider.

Most submitters (65%) did not support clinical teaching/mentorship being limited to nurse practitioners and thought nurse academics, medical and other clinical staff would also be required depending on the specialty area and geographic location. The pool of experienced nurse practitioners was not considered large enough to provide both clinical teaching and clinical mentorship for students at this time. Fifteen submitters (29%), including most educational providers, specifically supported nurse practitioners being part of the tertiary education provider teaching team even if a nurse practitioner clinical teacher for each student’s practicum could not be achieved. This would provide role modelling and guidance to students on the level of nurse practitioner practice.

There was strong support for the assessment methods outlined in the draft standards (83-91%) as effectively guiding student learning and assessing nurse practitioner candidates’
competence. The portfolio of learning and clinical log were well supported (91%). The observation in practice was identified as an important assessment that required nurse practitioner involvement and the preparation of the clinical mentor as an assessor (91%). The validity and the costs associated with developing and running the simulated-scenario-based assessments and viva voce clinical assessments were of significant concern for a few submitters and attracted slightly less support (87% and 83% respectively). A few submitters suggested more guidance on the assessments be provided by the Council and other assessment methods that could be used. Feedback on other standards is included in Appendix 2.

Proposal to change the assessment process for nurse practitioner candidates for registration

Submitters supported the assessment of competence of nurse practitioner candidates within the education programme before registration as a nurse practitioner (65%). However, only a small minority supported Option 1 alone (17%). More submitters (74%) agreed with Option 2 (the assessment of competence of nurse practitioner candidates within the education programme and a portfolio submitted to the Council for assessment before registration). Many submitters commented that the Council should complete the final assessment of candidates for registration as nurse practitioners (44%). The reasons given were the role of the Council in maintaining public safety, the conflict of interest for educational providers to ensure students achieve qualifications, and the inability of multiple educational providers to consistently assess clinical competence to the appropriate consistent standard. The delegation of assessment to educational providers was identified as “cost-shifting” to educational providers or students rather than reducing costs. A few submitters commented that Option 2 was a good transition strategy until educational providers were confirmed as consistently and accurately able to assess competence for registration.

Most submitters supported all three requirements to ensure the consistent assessment of nurse practitioner candidates (57%). Involving suitably qualified members of the multidisciplinary team (MDT) and practice representatives was most strongly supported with some commenting that this is already happening to some extent, particularly during the practicum (80%). Some raised the requirement for appointing, monitoring, training and the funding of these assessors. The Council’s role in setting standards for assessment and closer moderation of the education programmes was supported by submitters and linked to greater assurance of consistency of assessment between programmes (74%). External moderation of assessment by other educational providers received the lowest levels of support (65%) associated with submitters concerns about possible conflict of interest or alliances between providers.

The draft competencies for nurse practitioners

There was a high level of support for the draft nurse practitioner competencies. Eighty-five per cent of submitters agreed that the draft competencies reflected new nurse practitioners’ knowledge and skill, and 82% agreed that the draft competencies provided enough detail to guide educational requirements and student assessment. Some submitters sought the inclusion of more New Zealand-specific content and specific prescribing-related knowledge and skills, and also offered wording suggestions.
Proposal for newly registered nurse practitioners to practise under supervision for one year

There was strong support (87%) for newly registered nurse practitioners to practise under supervision for one year. Some issues related to implementation of this requirement—including the definition of supervision, access to supervisors, funding support, and the proposed assessment of competence by the supervisor (at the end of 12 months)—were raised.
2 Introduction

2.1 Background and Council decisions leading to this consultation

The Council began a review of the nurse practitioner scope of practice and prescribed qualification in 2014. The initial review focussed on the scope of practice and whether it was correctly positioned in relation to future health needs, service delivery changes and the introduction of registered nurse prescribing in primary health and specialty teams. The Council proposed a new scope of practice statement that clearly articulated the role of nurse practitioners, removed registration in a specific area of practice and focussed on the clinical leadership role of the nurse practitioner (Nursing Council of New Zealand, 2014).

The Council also consulted on the educational preparation for nurse practitioners and proposed that it require a nurse practitioner programme with specified clinical learning hours and programme outcomes. This was to enhance the preparation of nurse practitioners by increasing dedicated clinical learning time, creating more consistency between programmes and aligning nurse practitioner preparation with the new qualification\(^1\) for registered nurse prescribing in primary health and specialty teams.

There was general support for the Council’s proposals and it decided to broaden the scope of practice (see below) and make changes to the education programme standards including specifying a minimum of 300 protected (outside the student’s paid work) hours of clinical learning time and specifying programme outcomes (Nursing Council of New Zealand, 2015).

New scope of practice for nurse practitioners

(Note: the Council plans to introduce this new scope of practice when the education programme standards and competencies are finalised).

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 work autonomously and in collaborative teams with other health professionals to promote health, prevent disease, and improve access and population health outcomes for a specific patient group or community. Nurse practitioners manage episodes of care as the lead healthcare provider in partnership with health consumers and their families/whānau. Nurse practitioners combine advanced nursing knowledge and skills with diagnostic reasoning and therapeutic knowledge to provide patient-centred healthcare services including the diagnosis and management of health consumers with common and complex health conditions. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic and laboratory tests, prescribing medicines within their area of competence and admitting and discharging from hospital and other healthcare services/settings. As clinical leaders they work across healthcare settings and influence health service delivery and the wider profession.

2.2 An overview of the current consultation

Following these decisions, in November 2015 the Council consulted on new draft education programme standards for master’s programme leading to registration as a nurse practitioner.

\(^1\) A postgraduate diploma in registered nurse prescribing for long- term and common conditions.
These standards were designed to require education programmes that would support the broader scope of practice and lead to students being better prepared to register as nurse practitioners at the end of the programme. The Council proposed standards for student assessment, mentor support and clinical learning (the nurse practitioner practicum) (see Appendix 5).

Students would be required to develop advanced skills across more than one setting. The Council emphasised the importance of partnership between education and practice and co-design of practice experience, and preparation of the student before the practice experience. This approach seeks curricular, teaching/learning and assessment practices that integrate formal and work-based learning to enhance tertiary students’ experiential learning opportunities and orientation to ‘real world’ professional practice. The partnership between students, workplace organisations and educational providers aims to enhance graduates’ employability/work readiness (Martin, Rees & Edwards, 2011).

The Council also proposed new competencies to reflect the new scope of practice statement and to provide educators (and other assessors) with greater detail to develop the programme and to assess students’ clinical skills and knowledge during and at the conclusion of the programme (see Appendix 6). To provide additional support for new nurse practitioners, the Council proposed they practise under supervision for one year.

Based on the new standards for education programmes, including assessments of clinical competence, the Council proposed two options for changes to its registration process:

1. assessment within the education programme; and
2. assessment within the education programme and submission of a portfolio to the Council.

The Council also asked about strategies to ensure consistency of assessment of clinical competence by the different programme providers.

The consultation process

The consultation document was sent to 419 organisations and individuals across the health sector. A consultation online questionnaire was developed to assist submitters to provide feedback. This paper summarises the submissions received.

Fifty-four written submissions were received. There were 37 submissions from organisations and groups and 17 individual submissions.

Submissions were made by a range of organisations and individuals including 11 individual and group submissions from nurse practitioners (see Tables 1 and 2).
Table 1: 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>Educational providers</td>
<td>8</td>
</tr>
<tr>
<td>Non-governmental organisations</td>
<td>4</td>
</tr>
<tr>
<td>Primary health organisations (PHOs)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of submissions</strong></td>
<td><strong>34</strong></td>
</tr>
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</table>

Table 2: 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>8</td>
</tr>
<tr>
<td>Individual nurse practitioners</td>
<td>9</td>
</tr>
<tr>
<td>Groups of nurse practitioners</td>
<td>2</td>
</tr>
<tr>
<td>Groups of nurses</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

The comments made by submitters have been analysed and are presented in themes under the sections of the consultation. 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.
3 Proposed changes to education programmes leading to registration as a nurse practitioner

The Council proposed new education programme standards for master’s programmes leading to registration as a nurse practitioner (see Appendix 5). These standards were designed to specify programme requirements that would support the broader scope of practice and lead to students being better prepared to register as nurse practitioners at the end of the programme. The Council proposed standards for clinical learning (the nurse practitioner practicum standards- section 9, Appendix 5)\(^2\) and student assessment (section 8, Appendix 5).

The Council emphasised the importance of partnership between education and practice to integrate formal and work-based learning to enhance the students’ experiential learning opportunities. Student assessment included strategies to involve practice partners in formative and/or summative student assessments. The standards specify particular assessments be used within programmes to assess the competence of students. A variety of assessments allows triangulation of evidence and the assessment of different competencies, i.e. knowledge, technical skills and communication skills by written and verbal means.

The Council also proposed that the clinical teaching staff for each student’s practicum be nurse practitioners with expertise in a relevant clinical practice area and an academic qualification in education or equivalent learning and teaching experience (Standard 2.5, Appendix 5).

3.1 Support for the proposed new education programme standards

The majority of submitters supported the new education programme standards (78%) and a more consistent preparation for nurse practitioner candidates (see Chart 1). The Council asked for specific feedback on the standards related to the practicum, student assessment and nurse practitioners as clinical teachers. These were all well supported although many submitters raised concerns about funding/resources for the increase in practicum hours, the student assessments and the lack of nurse practitioners available to be clinical teachers. This section summarises the responses to the draft educational standards.

\(^2\) Currently the Council does not set standards for clinical learning (practicum).
Chart 1: Submitter support for the draft education programme standards

The reasons given for supporting the new standards were they would provide greater structure to nurse practitioner preparation including clinical skill development (4, 5, 14, 42) and improve alignment between education and practice. The standards would provide greater consistency between education programmes (5, 12, 13, 15, 20, 45). They were considered comprehensive and detailed (38, 39, 46), and would guide educational providers and/or students regarding the competency standards expected of nurse practitioners (49, 54). Recognising the registered nurse prescribing qualification as a stepping stone into the nurse practitioner programme was also supported (24, 28).

The proposed standards provide scaffolding for a strong focus on advancing theory combined with advancing clinical skill development in selected practice settings. Furthermore the need for alignment with the standards and between educators, students and health sector providers will prepare nurses for autonomous prescribing as NPs in contemporary contexts and for the future (42, University of Otago).

I think it is an improvement on the current system. It provides structure to the NP training programme and provides consistency in training (5, Individual nurse).

It is pleasing to see the plan to staircase students as RN prescribers into the NP programme. It makes good sense to develop nurses in a staged manner and allows them to progress as they feel ready without limiting prescriptive authority to nurse practitioners (28, Massey University).
3.1.1 Support for the Council’s involvement in implementing the new standards

Eight submitters who supported the draft programme standards also wanted the Council’s close involvement in the change to ensure optimal educational standards are maintained to give students the best preparation for nurse practitioner registration (15%). They cautioned that the Council’s involvement was necessary for public safety and to ensure standards for nurse practitioners did not decline over time (18, 20, 29, 34, 35, 39, 42, 45).

It is important to have a greater consistency in NP preparation with clear indications/direction to university programme coordinators regarding educational and clinical preparation for the role. This will ensure that the preparation will be consistent throughout NZ… We believe the NCNZ needs to remain fully involved in the accreditation [process]. It would be a backward step if the accreditation process was completely farmed out to other services (university/DHB’s etc) which would result in inconsistencies regarding accreditation practices, and carries the real concern regarding conflict of interest with universities potentially competing for the most successful NP programme rather than ensuring that the NP applicant is consistently rigorously critiqued (34, Starship Nurse Practitioner Group).

We think the proposed changes will need support and time to imbed. Providers will need guidance during their implementation phase - during this time perhaps a Council staff member could be involved in the education provider’s decision making process about nurses qualifying as an NP, for example… (20, Te Pou o Te Whakaaro Nui).

Two submitters supported the Council’s oversight being extended to the practicum requirements (42, 45).

…Well paid clinical/university supervision, and NCNZ oversight of the process is required in order to ensure that the nurses are being exposed to a wide variety of presentations in their area of practice … (42, University of Otago).

Further feedback on the role of the Council is included in section 5 (Ensuring a consistent standard of assessment for all nurse practitioner candidates).

The following three sections summarises submitters’ responses to questions about some of the key standards. The feedback on the remainder of the standards can be found in Appendix 2.

3.2 The nurse practitioner practicum

The Council proposed standards for the nurse practitioner practicum (see section 9, Appendix 5). These included the educational provider’s role in negotiating the practicum with the clinical provider, ensuring clinical mentors are appropriately prepared for their role and providing practical guidance and support to students and mentors. Students are required to develop learning goals and mentors are required to assist the students to...
develop advanced skills across more than one setting. The Council has emphasised the importance of partnership between education and practice and the co-design of practice experience.

There was a very high level of support with 45 submitters (83%) agreeing with the nurse practitioner practicum standards (see Chart 2). Submitters supported the proposed standards but suggested clarifying the responsibilities of students, educators and employers further. Nearly one third of submitters (31%) raised concerns about how, or if, the students’ supernumerary clinical learning hours and/or mentor support would be funded, or supported by employers. Twelve submitters (20%) were concerned that the supernumerary clinical learning hours would be a barrier, would exclude intern roles or were too short.

Chart 2: Support for the practicum standards

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Did not answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>83%</td>
<td>4%</td>
<td>13%</td>
</tr>
</tbody>
</table>

The reasons given for supporting the standards included the greater clinical learning time and the clearer responsibilities of all parties involved in the nurse practitioner practicum.

The practicum clinical experience supports the transition to the nurse practitioner scope through integration and application of knowledge and facilitates assessment of competence (27, Individual nurse).

…they appear to clearly outline the obligations of the tertiary provider and staff, health organisations involved in placements, clinical supervisors and candidates (39, Royal New Zealand Plunket Society (Inc)).

3.2.1 Support for clearer responsibilities for the practicum

There was support for extending the responsibilities of educational providers to include a greater role in facilitating clinical placements, negotiating students practice experience with
the clinical provider and ensuring clinical mentors are suitably prepared for their role and sufficiently supported so students have effective learning experiences (28, 30, 45).

**TEPs and students are currently at the mercy of the practice environment in which the student is employed to offer a satisfactory learning and supervisory experience for the practicum.** The quality of these environments varies enormously and is complicated by the employment relationship. Ideally, NP candidates would complete their practicum hours in a practice context that is not their regular place of employment, however this is not always practical...Certainly clarifying the supernumerary status of the student during the practicum would facilitate a clinical experience in more than one setting (28, Massey University).

Several submitters identified healthcare providers as needing to take greater responsibilities for students’ practicum experiences. Three submitters suggested making the role of health providers more explicit in the standards (42, 44, 49). One identified an MOU with the district health boards (DHBs) as critical to relationships and supporting successful practicums (26).

…there are implications for the health provider sector with increased onus for their role in supporting candidates, alongside educators, as student learners in their capacity as supernumerary and in the provision of more than one suitable clinical practice setting. (42, University of Otago).

…A Memo of Agreement (MoA) with the local district health board is essential to ensure that NP practicum requirements are in place. A focus in section 9 is strengthening the education provider’s relationship with the local health provider to improve the experience and commitment to NPs. It is vital that education providers work in partnership with the local DHB’s and community to meet their projected workforce plan requirements (26, Eastern Institute of Technology).

One submitter suggested that educational providers focus on teaching, learning and assessment responsibilities, and that greater responsibility should be taken by students and their employers in the organisation of practicum placements (52).

…We do not consider it is feasible for an education provider to negotiate on behalf of the nurse practitioner candidate. The role of education providers is to assess and approve clinical mentors and practice placements negotiated by the candidate and their employer. This should be documented in an agreement signed by all parties...Given that non-nurse practitioner mentors will be outside the employ of the education provider we do not consider it should be the education provider’s requirement to ensure that the mentors are orientated to the nurse practitioners role/scope of practice (52, Victoria University of Wellington).

**3.2.2 Clarify funding for the practicum hours and mentor support**

Nearly one third of submitters (31%) raised concerns about how, or if, the students’ supernumerary clinical learning hours and/or mentor support would be funded, or supported by employers. For 12 submitters the increased clinical learning time and the requirement for minimum hours to be supernumerary (as specified in the standards) were of concern (8, 13,
Some wanted clarity regarding how the increased costs would be met, i.e. by the student, the employer or by Health Workforce New Zealand as the funder of clinical training. Support was expressed for funding to follow the student regardless of the employment setting.

We have concerns regarding employer support which is very mixed between employers and particularly with regard to some DHBs currently. Any additional requirements or potential added costs may provide some employers with excuse as to why they won’t support developing or potential NPs (8, Group of Advanced Nurses).

…more clarity is needed regarding funding models that will support these arrangements between education providers, students and provider organisations. The 300 learning hours, where the student is supernumerary, would need to be funded by the student or the provider organisation… (44, Waikato Institute of Technology).

The increased clinical learning time will result in demands on workloads and resources of health sector employers who support candidates. Support for release time to enable NP students to be supernumerary during practicum, and the costs associated with having a student in placement for an increased number of hours, will need to be met somehow. Currently financial support goes to DHBs through the Health Workforce. This funding supports organisations like Family Planning to offer student placements and clinical training. Ensuring funding is available to support the increased hours for NP placement is essential. Funding must follow the student and be appropriately allocated to their mentors to enable adequate access to suitably qualified NPs and medical staff (30, Family Planning).

Eleven submitters commented on the need for health professionals to be prepared and reimbursed for their clinical mentor role, and some commented on which organisations (health and/or education) should be responsible for these costs (21, 30, 32, 37, 39, 40, 42, 45, 46, 47, 52).

…Employers of NPs acknowledge the time and effort that goes into training but they are also aware of the impact on clinical time in practice and that compensation will need to be factored into this. We cannot expect already busy NPs to do a considerable amount of extra work without recompense. (It is our understanding that GPs usually receive payment for this level of supervision) (40, New Zealand Rural General Practice Network).

…It is noted that the educational provider is also responsible for “ensuring that clinical mentors are appropriately educated for their role”, but the level of skill and form of this is not apparent. This may well require additional cost to the educational provider, which has not been considered, and not all medical or nursing staff would have available time to attend additional training activities should such be developed (37, Group of Senior Emergency Department Nurses, Christchurch Hospital).

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3 Health Workforce New Zealand funds postgraduate training to develop the workforce. HWNZ has contracts for the provision of training with district health boards (DHBs), tertiary education providers and other health provider organisations. The current specification requirements and eligibility criteria for HWNZ-funded nursing programmes can be found at [http://www.health.govt.nz/our-work/health-workforce/investment-and-purchasing#nursing](http://www.health.govt.nz/our-work/health-workforce/investment-and-purchasing#nursing).
3.2.3 Questioning of the requirements for the practicum hours

Twelve submitters (20%) were concerned that the supernumerary clinical learning hours would be a barrier, would exclude intern roles or were too short. Three submitters commented on the requirement that the practicum must be a minimum of 300 “protected hours” (outside of the student’s paid work hours) (standard 9.2) and that students were required to be supernumerary while on placement (standard 9.9) (33, 36, 54). Seven submitters suggested the words “outside of the students paid work hours” were not clear and should be changed to include the option of gaining practicum clinical experience in a nurse practitioner ‘intern’ role (14, 27, 31, 39, 42, 44, 47).

…There are NP students who are employed as NP Interns and their job is to learn and develop their skills to become a NP. Suggest a change to: ‘outside of paid work hours in which the student is practicing in a RN scope of practice and/or not practicing in an employer recognised NP internship role’. It is important to utilise the time dedicated to intern roles which will and can be more than 300 hours (31, Nurse Executives New Zealand).

Five submitters did not agree that the 150 hours for the registered nurse prescribing practicum should be credited to the 300 protected hours required for nurse practitioner as the level of knowledge required for safe prescribing as an nurse practitioner is different (14, 28, 31, 41, 47). One submitter commented that a minimum of 500 hours was required to develop competence at nurse practitioner level (14).

We are in support of these standards, with the addition of a statement of a minimum of 300 and a recommendation for 500 hours of practice as per the NP Training Programme developed and funded with HWNZ. We wish to emphasize that the designated prescriber competency is very different than the independent authorised prescribing competencies of NP. It is important that all students have a minimum of 500 hours to develop competence at the NP level of practice during their NP MS programme (14, University of Auckland).

3.2.4 Requirement for the practicum to include two clinical practice areas

One of the entry requirements for the nurse practitioner practicum (as outlined in draft standard 4.1) is the student’s need to “have identified and have access to two areas of clinical practice in which to develop the advanced skills and knowledge required for nurse practitioner practice. One area should be relevant to their intended area of prescribing practice and the other should broaden their clinical learning experience”.

Two submitters sought clarification about what ‘area’ referred to (37, 49). Did it mean another specialty area? Challenges this criteria may pose to students (and employers) were noted by four submitters (13, 36, 42, 49).

Some group participants considered this may be challenging with the day to day work demands. However it was agreed this opportunity would certainly grow the experience and broaden clinical learning of NP candidates (36, Group of Hutt Valley DHB and primary health care nurses).
Other themes related to assessment within the practicum and the mentor’s role in assessment can be found in section 3.4 (Proposed assessment methods).

3.3 The role of nurse practitioners as clinical teachers and mentors

The Council proposed in draft standard 2.5 that the clinical teaching staff for each student’s practice experience be qualified nurse practitioners with expertise in a relevant clinical practice area and an academic qualification in education or equivalent learning and teaching experience. This proposal reflected the Council’s wish to have lecturers who understand the clinical requirements involved in preparing, supporting and monitoring students during their practice experiences.

The feedback suggests the term “clinical teacher” was interpreted by some to mean the clinical mentor or supervisor within the practicum setting rather than the “academic mentor” or clinical lecturer employed by the educational provider. This section covers feedback on nurse practitioners as clinical teachers and clinical mentors.

There was a high level of support for nurse practitioners as clinical teaching staff (80%) with many submitters agreeing that nurse practitioners would be the ideal clinical teachers and mentors/supervisors (see Chart 3). Most submitters (65%) did not support clinical teaching/mentorship being limited to nurse practitioners and thought nurse academics, medical and other clinical staff would also be required depending on the specialty area and geographic location. The pool of experienced nurse practitioners was not considered large enough to provide both clinical teaching and clinical mentorship for students at this time.

Chart 3: Support for nurse practitioners to be the clinical teaching staff

| Do you support nurse practitioners as the clinical teaching staff for each student’s clinical experience? (Question 10) |
|---|---|---|---|
| Yes | 81% |
| No | 11% |
| Did not answer | 7% |
3.3.1 Support for nurse practitioners as clinical teaching staff

Nurse practitioners' ability to support students' clinical learning because of their own understanding of the breadth and complexity of the scope of practice was identified by 25 submitters (47%) (3, 4, 5, 6, 14, 16, 17, 22, 26, 27, 28, 29, 30, 31, 34, 35, 37, 38, 39, 42, 44, 46, 47, 49, 53). Fifteen submitters (28%), including most educational providers, specifically supported nurse practitioners being part of the tertiary education provider teaching team even if a nurse practitioner clinical teacher for each student's practicum could not be achieved. This would provide role modelling and guidance to students on the level of nurse practitioner practice (4, 14, 16, 19, 22, 25, 26, 27, 28, 38, 40, 42, 44, 45, 46).

The NP educator supports the development of the NP skill set needed to practise at an NP level. … There is often confusion about the difference between Clinical Nurse Specialist clinical competency and NP clinical competency. Therefore, it is essential that currently practising NPs provide oversight and guidance to ensure that the student expands their practice into the NP scope of practice (14, University of Auckland).

NZNO supports the requirement for clinical teaching staff to be qualified nurse practitioners… this may be challenging in some specialty areas but the broadening of the scope should negate the need for specialist nurse practitioners in each area of specialty practice… this is an appropriate approach to take moving forward (49, New Zealand Nurses Organisation).

In addition a nurse practitioner clinical teacher would encourage students to develop a nursing model of advanced practice (17, 37, 43).

When feasible this will be vital to progress, so to develop advanced nursing practice independently from a medical model (17, Individual nurse).

3.3.2 Not enough nurse practitioners to be clinical teachers and mentors

Thirty-five submitters (65%) were concerned that there are currently not enough nurse practitioners to take on teaching/mentor roles. The reasons given were the lack of experienced nurse practitioners, they do not have the skills or qualifications, they do not have the specialty experience or they do not work in the same location as the student (2, 3, 5, 7, 8, 10, 11, 13, 14, 18, 19, 20, 21, 24, 25, 26, 27, 29, 30, 31, 32, 33, 34, 35, 36, 37, 39, 40, 42, 43, 46, 47, 49, 52, 54). The requirement for nurse practitioners to have an academic qualification or equivalent experience as a prerequisite for clinical teaching roles was seen as a barrier by 11 submitters (3, 7, 11, 25, 30, 34, 35, 37, 39, 47, 52).

In some regions in particular, it may be very difficult to obtain sufficient qualified and experienced NP’s who also have the required educational qualifications. “Academic staff are qualified for their level of teaching with a tertiary qualification higher than the programme of study being taught.” Family Planning questions whether there are enough NPs in New Zealand with the required education qualifications to fulfil this requirement (30, Family Planning).
One educational provider discussed the challenges of the academic context, and the pressures associated with these roles, and suggested nurse practitioners be “professional teaching staff” so they are not required to contribute to university research outputs (52).

Clarity is required regarding what is meant by nurse practitioners are the clinical teaching staff, as their qualifications and role responsibilities can mean they can be viewed as either academic (lecturers) or professional clinical teaching staff. University requirements require lecturers to also be active researchers, but do not expect the same of those who are professional teachers… While the intention is ideal, we consider that in the present environment the expectations for the nurse practitioners in academic programmes are not feasible because they do not accommodate that there are presently too few nurse practitioners; university academic employment requirements mean that academic staff need to meet Performance Based Research Fund (PBRF) expectations; and unreasonable pressure would be placed on nurse practitioners to maintain their own required clinical load…(52, Victoria University of Wellington).

Ten submitters were concerned that nurse practitioners working as clinical teachers would not have experience in relevant clinical practice areas to effectively support, guide and monitor their students (13, 14, 20, 27, 35, 37, 39, 42, 43, 46).

Given the broad range of NP areas of practice currently and for the future, there may not be the exact match of NP for areas of practice (39, Royal New Zealand Plunket Society (Inc)).

We consider this to be vital, however we hold some concerns about current capacity, especially within mental health and addictions. To date we are aware that there are 6 NPs with a mental health scope of practice (20, Te Pou o Te Whakaaro Nui).

Submitters also suggested that nurse practitioners may face difficult choices associated with their commitments to serving their client populations and the need to maintain their clinical practice and/or clinical teacher roles (18, 25, 29, 31, 34, 37, 39, 54).

…We want our NPs in practice not all in education (31, Nurse Executives New Zealand).

The focus at this stage needs to be building and consolidating the role of Nurse Practitioners across the sector over the next 5-10 years. Particularly in areas of need due to low clinician availability and reducing inequity in high needs communities. There would however, be a role for mentoring and supporting students through this process and once qualified though this would be dependent on NP availability (54, Pan Pacific Nurses Association New Zealand).

Thirteen submitters suggested that the requirement to have nurse practitioners as clinical teachers could jeopardise students’ access to nurse practitioner programmes and/or place pressures on the current education programmes (8, 18, 19, 26, 29, 31, 36, 37, 39, 40, 42, 52, 54).
Sounds good idea and very useful but in reality might be difficult to instigate especially in South Island where NPs spread out and less of them including in rural areas. Important not to put more barriers in way of Nurses becoming NPs (8, Group of Advanced Nurses).

3.3.3 Medical practitioners and other health professionals as clinical teachers and mentors

Twenty-one submitters (39%) suggested medical practitioners and other health professionals should continue to be clinical teachers and mentors (10, 13, 18, 19, 22, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 37, 39, 42, 45, 47, 52). Some suggested this was a temporary solution until the numbers of nurse practitioners increased, and others emphasised the benefits of students learning from, and learning to work collegially with, other health professionals at a nurse practitioner level. Some specified such teachers should be ‘vocationally registered medical practitioners’ while others suggested doctors and/or other healthcare professionals.

We support NP candidates using a range of interprofessional colleagues/teachers including NPs, doctors and RNs. Whilst we acknowledge that NP mentorship is important for the professional practice aspects of role development, NPs do not work in isolation, they work in a diverse team. Therefore it is important that NP students learn to interact at an advanced level with the team in which they will be working. Even solo practice NPs work with teams across service and geographical boundaries in regard to referrals and discussions about their patients. We recommend professional mentoring of NPs where this is possible. We also recommend informal peer support with NPs in other parts of NZ. It is essential to have NPs on the teaching team in the postgraduate programmes and all NP candidates must have NPs involved in their learning during their programme, however due to the shortage of NPs it may not be possible for each NP candidate to have an NP as their clinical teacher... (26, Eastern Institute of Technology).

NPs may be the clinical teaching staff for a student’s clinical experience. However, currently for many NPs in training, there will not be a suitably qualified/experienced NP in their area of expertise or even in the country, for this to occur. Ensuring mentoring and clinical teaching from medical colleagues is imperative for the training, future proofing and collegiality required for the success of the NP position. (35, College of Emergency Nurses New Zealand (NZNO)).

The nurse practitioner role as an assessor of clinical competence is discussed in the next section.

3.4 Proposed assessment methods

The Council proposed standards related to student assessment in the Draft education programme standards for the nurse practitioner scope of practice (see section 8, Appendix 5). Two of the draft standards (8.4 and 8.10) proposed specific assessments for use within programmes to assess the clinical competence of students.

... 8.4. The use of a variety of assessment approaches to evaluate competence in the application of knowledge and skills at the required level and as required for professional practice as a nurse practitioner including:
a. portfolio of learning and clinical log of practice experience
b. simulated scenario based assessment
c. viva voce clinical assessment
d. observation in clinical practice settings.

... 8.10. Comprehensive summative assessment of the student’s achievement of the Competencies for nurse practitioners on the completion of the programme. This assessment includes a comprehensive summative clinical viva voce within the student’s nominated area of practice by suitably qualified members of the multidisciplinary team and should demonstrate achievement of the programme outcomes.

The Council also proposed formative and summative assessments within the practicum (see section 9, Appendix 5).

There was strong support for the assessment methods outlined in the draft standards (83-91%) as effectively guiding student learning and assessing nurse practitioner candidates’ competence (see Chart 4). The portfolio of learning and clinical log were well supported (91%). The observation in practice was identified as an important assessment that required nurse practitioner involvement and the preparation of the clinical mentor as an assessor (91%). The validity and costs of developing and running the simulated-scenario-based assessments and viva voce clinical assessments were significant concerns for a few submitters and attracted slightly less support (87% and 83% respectively). A few submitters suggested more guidance on the assessments be provided by the Council and other assessment methods that could be used.

Some of the feedback related to assessment within the practicum (in clinical practice) has been included in this section.

**Chart 4: Support for assessment methods**

<table>
<thead>
<tr>
<th>Assessment Method</th>
<th>Support Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. portfolio of learning &amp; clinical log</td>
<td>91%</td>
</tr>
<tr>
<td>b. simulated-scenario-based assessment</td>
<td>87%</td>
</tr>
<tr>
<td>c. viva voce clinical assessment</td>
<td>83%</td>
</tr>
<tr>
<td>d. observation in clinical practice settings.</td>
<td>91%</td>
</tr>
</tbody>
</table>

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Do you support the assessment methods outlined in 8.4 and 8.10 of the draft education programme standards? (Question 9)

- **Yes**: 91%
- **No**: 9%
- **2%**
- **11%**
- **6%**
- **11%**
- **0%**
- **9%**
- **Did not answer**: 0%
3.4.1 Support for the assessment methods

There was a high level of support for all four methods of assessment proposed in the standards. A variety of ways of assessing nurse practitioner candidates’ competence was supported. Many submitters commented that the four assessments would provide triangulation of evidence, consistency, and the level of reassurance needed for public safety (11, 13, 15, 17, 21, 29, 33, 40, 41, 42, 44, 45, 47, 54).

A range of assessments allows triangulation of examples of practice and experience. The different methods allow for the assessment of the competencies through various means. The level of expertise expected of the NP role requires a stringent assessment process in order for the newly trained NP to be rigorously assessed in preparation for practice. The level of autonomy required of the role cannot be underestimated and public safety needs to be assured through a robust system of assessment (40, New Zealand Rural General Practice Network).

The specified assessment strategies of portfolio, simulated clinical assessment, viva voce and practice observations, provide a comprehensive review of the MN candidate’s competence and capability for practice at the NP level (44, Waikato Institute of Technology).

Ten submitters commented on the benefits of these assessment methods to support the students’ learning as well as being effective assessments of competence. Submitters supported the value of realistic and fair forms of assessment to provide formative feedback to guide students and provide confidence in their practice when registered (4, 8, 16, 26, 27, 33, 36, 43, 49, 54).

Regular assessments / observation during placements in the clinical setting is extremely valuable will provide ongoing progress reports – identifying strengths or key deficits, early and continuously; this is important to appropriately shape the students learning. The key here would be to utilise appropriate, standardised assessment tools (43, Kidz First Neonatal Care Clinical Nurse Specialist Team).

NZNO supports the proposed standards relating to student assessment. A variety of assessments will ensure candidates have the opportunity to demonstrate competence in a number of different ways. As students will have differing strengths, using varied opportunities for assessment is a fair and equitable approach (49, New Zealand Nurses Organisation).

3.4.2 Observation of clinical practice

This method was strongly supported (91%) and was noted as an improvement on current programme assessment methods. Some submitters supported nurse practitioner assessors in all clinical assessment processes but particularly during observation in clinical practice settings. Nurse practitioner involvement (as either the clinical or academic mentor) was deemed essential because students, employers and other health professionals did not always understand the role/scope sufficiently (28, 31, 33, 44, 47). One submitter
commented that the nurse practitioner can assess the generic advanced practice skills of the student regardless of the specialty setting (36).

…Observation in clinical practice settings by appropriate academic clinical staff during practicum/prescribing papers is notably lacking from current programmes (28, Massey University).

The group recommend the academic supervisor to observe practice/or delegate (e.g. NP may be consulted). Person to person observation is invaluable, and will strengthen the assessment. The group considers this is a gap currently (33, Senior Nurses at Wairarapa District Health Board).

Yes, where possible by a qualified NP. There is still a lack of understanding by nurses themselves, their employers and medical mentors/supervisors about the level and breadth of advanced practice required for NP practice (31, Nurse Executives New Zealand).

Two submitters were concerned about managing observation as an assessment strategy. This was associated with the low numbers of nurse practitioners (26, 30) and the educational provider’s ability to manage this as a summative assessment (52). One submitter supported the Council limiting opportunities to pass the practicum (draft standard 9.17) (31).

Limiting the NP student to 2 opportunities to pass the practicum sends a clear message of the requirement for demonstrated advanced clinical skills etc. and that not everyone can achieve NP status. This provides a further robustness to the training process and subsequent acceptance of the NP role (which still remains variable) (31, Nurse Executives New Zealand).

Three submitters commented on the need to support the clinical mentors’ responsibilities to teach and assess the student, including the new requirement for clinical mentors to “complete an assessment and professional declaration which confirms that in his/her opinion the student has met the skills and competencies required of the nurse practitioner scope of practice in collaboration with the academic mentor” (draft standard 9.15) (26, 45, 52).

There needs to be evidence that a clinical mentor contract is in place that is agreed upon by the academic provider, the mentor and the student. Mentors will need information and training on clinical mentorship expectations in relation to the clinical practice requirements for NP role development (26, Eastern Institute of Technology).

9.15 This is an increased responsibility for clinical mentors who have signed off competencies in some programmes for prescribing NP competencies only. The collaborative assessment of the student meeting NP scope of practice is important as the clinical mentor may not wish to sign a declaration for the RN meeting NP scope of practice for registration if this is the final component for NP registration required… (45, Capital and Coast District Health Board Nursing Leadership Group).

Some submitters wanted the assessment processes to be more clearly detailed in the standards, including recommending the benefits of more frequent assessment (8, 33, 43).
and clearer processes to ensure consistent and fair assessment of competence (20, 43, 52, 54).

The group recommends that the NP candidates should be evaluated earlier and not just at completion e.g. at set points along the pathway (33, Senior Nurses at Wairarapa District Health Board).

The key here would be to utilise appropriate, standardised assessment tools (43, Kidz First Neonatal Care Clinical Nurse Specialist Team).

3.4.3 Portfolio of learning and a log of practice experience

Submitters generally supported the portfolio as a learning and assessment tool, whether it was submitted to the Council (see section 4.1.3) or assessed within the education programme. Six submitters commented on the value of learning portfolios and clinical logs of practice experience to track and assess students’ learning (14, 22, 26, 36, 39, 54).

…A portfolio would provide a number of opportunities to view NP candidates’ level of academic acumen, application of theory to practice and critical analysis as well as meeting NP competencies. It is important to be able to validate competence, and maintaining a portfolio is one way of doing this. It also helps to uphold the integrity of the profession by providing a body of evidence that further supports the role (39, Royal New Zealand Plunket Society (Inc)).

…This clinical log provides evidence of how the students follow the NP competency standards of practice for the assessment, diagnosis, and management and follow up of patients, in addition to the identification of which NP practice standards the case addresses, and the time it took to undertake the assessment...(26, Eastern Institute of Technology).

Fifteen submitters commented on the usefulness of portfolios to demonstrate different aspects of candidates’ competence, including clinical skills and knowledge, reflection on practice, and leadership skills (4, 13, 14, 20, 22, 24, 27, 30, 32, 42, 43, 45, 46, 49, 54).

High quality examples are expected for all competencies including reflections of practice i.e. advanced communication and cultural competency weaved throughout the portfolio (54, Pan Pacific Nurses Association New Zealand).

3.4.4 Issues related to the simulated-scenario-based assessment and the viva voce clinical assessment

The majority of submitters supported these assessment methods. Three submitters questioned the value of simulated-scenario-based assessment depending on when this would occur within the education programme (28, 41, 52).
We agree that a variety of assessment approaches usefully triangulate evidence of an applicant’s competence, but see little value in simulated scenario based assessment unless it occurs during the programme in the assessment and clinical decision-making paper (28, Massey University).

Clearer details regarding these assessment requirements were requested by two submitters (36, 52), while others suggested either simulated scenario or viva voce assessment would suffice (39) and that real patients should be considered instead of simulated scenarios (36).

We agree that education institutions can undertake such assessments, but note in the definitions that these can be short or long. Short viva voce are referred to as OSCEs, yet our previous point indicates that OSCEs may also be simulated scenario based assessments. Addressing this confusion will require each of these assessments to have clear descriptions (52, Victoria University of Wellington).

Two submitters (5, 38) did not support the viva voce assessment as it was considered subjective and/or influenced by student performance.

...A viva voce clinical assessment does not reflect actual clinical practice and very much depends on how the candidate may perform on any particular day (5, Individual nurse).

Six submitters commented that these assessment strategies require significant resources to develop and would shift costs from the Council to educational providers and or students (30, 31, 37, 42, 47, 52). This concern is also covered in section 4.1.2, Rejection of Option 1: the Council’s role to assess nurse practitioner candidates.

Developing and enacting rigorous, valid and suitable assessments for a range of populations e.g. adult and paediatric, may provide challenges to educational providers and clinical practice resources however offer an opportunity for moderation across programmes. We believe these assessment elements are reasonable and will assist in compiling evidence of competence to practice and contain the rigour the public expects for gaining prescribing rights. In particular the adoption by all education programmes of moderators/assessors external to the educational institution to participate in assessment of the OSCEs and viva voce. Educational institutions will need additional funding to provide the OSCEs as the costs associated with setting up and running these types of assessments rigorously is quite significant. The document indicates that a core reason for suggested changes lies in the fiscal constraints associated with the cost of running panels and the difficulty in securing suitably qualified NPs for these roles. It could be argued that the suggested changes indicate a cost shift rather than a cost saving and that issues such the availability of suitably qualified NPs will not be addressed immediately (42, University of Otago).

3.4.5 Additional methods of assessment suggested

A few submitters advocated the use of additional or alternative assessment methods including objective structured clinical examination (OSCE), multi-choice question tests
Formative assessment of a candidates learning and training should be supported by the portfolio and in addition modular assessments through written (MCQ, short answer questions and dissertations or theses) assessment. Simulated clinical scenario based assessments and observation in clinical practice such as direct observation of procedures or practice (DOPs), are supported, as are viva assessments. RACS recommends the addition of 360-degree reviews of both nursing and non-technical skills. Summative assessment including both oral, written and observation of practice elements are encouraged (22, Royal Australasian College of Surgeons).

We also recommend workplace based assessments (rather than just observation) and advocate for chart reviews as useful, where appropriate, to the area of practice (51, Australian and New Zealand College of Anaesthetists).

4 Proposal to change the assessment process for nurse practitioner candidates for registration

In November 2015 the Council proposed that introducing new education programme standards (Appendix 5) would lead to greater consistency between education programmes. The Council proposed that the programme requirements (including formative and summative assessments of clinical competence) would be beneficial to the student and better prepare them to register as a nurse practitioner at the end of the programme. This would give the Council confidence to cease its panel interview assessment of nurse practitioner candidates.

The Council proposed two options to replace the panel interview. Option 1 was standards for consistent student assessment completed within the education programmes as discussed in the previous section. Option 2 was the same as Option 1 but the candidate would also be required to submit a portfolio of learning to the Council for assessment.

Submitters supported the assessment of competence of nurse practitioner candidates within the education programme before registration as a nurse practitioner (65%). However, only a small minority supported Option 1 alone (17%). More submitters (74%) agreed with Option 2 (the assessment of competence of nurse practitioner candidates within the education programme and a portfolio to bed submitted to the Council for assessment before registration). Many submitters commented that the Council should complete the final assessment of candidates for registration as nurse practitioners (44%). The reasons given were the role of the Council in maintaining public safety, the conflict of interest for educational providers to ensure students achieve qualifications, and the inability of multiple educational providers to consistently assess clinical competence to the appropriately consistent standard. The delegation of assessment to educational providers was identified as “cost-shifting” to educational providers or students rather than reducing costs. A few submitters commented that Option 2 was a good transition strategy until educational providers were confirmed as being consistently and accurately able to assess competence for registration.
4.1.1 Support for Option 1: assessment of nurse practitioner candidates within education programmes

The assessment of nurse practitioner candidates within education programmes was supported by most submitters. The reasons given included a greater alignment between the educational and clinical preparation for practice as a nurse practitioner and the ability to assess students over time using multiple methods especially observation of clinical practice (8, 14, 15, 20, 22, 24, 27, 39, 44, 47, 54).

The merging of the master’s programme and process for nurse practitioner (NP) accreditation will bring what currently appears as two distinct processes together, increasing the relevance of theory and practical experience into the individuals’ evolution towards becoming an NP. It will also reduce the current delay between completing a master’s degree and applying for NP status… (39, Royal New Zealand Plunket Society (Inc)).

There are clearly some advantages to the assessment sitting within education programmes. However some cautions must be considered.

- Teaching staff are invariably very busy and in maintaining the integrity of the NP assessment process, teaching staff/the training institute must be adequately resourced to pick up this additional task.
- There is concern that the focus will be weighted on academic performance and less so on clinical performance. Ensuring that assessors are actively and currently involved in clinical practice and that they are able to contribute to the objectives of the NP is important.
- There is felt to be some conflict of interest whereby the performance indicator for training providers is success. Producing or passing a higher number of NP than another institute may be seen as contributing to that success.
• There is concern that with assessment sitting within a training institute that becoming a NP comes to be seen as a progressive rite of passage in terms of an academic pathway, and/or that it will be little different to a PG qual with prescribing rights. Maintaining the integrity of the NP, it being a considered and clinical specialised pathway, is imperative (46, Matua Raki- Addiction Workforce Development).

Greater consistency of assessment processes between educational providers was seen as being beneficial to nurse practitioner development in New Zealand (11, 31, 40). The proposed educational pathway was identified as supporting effective assessment of clinical competence, and for some this was in contrast to the current NP registration processes (8, 14, 20, 24, 28, 31).

These standards allow for consistency across education providers and triangulation of assessment. This provides the public with a sound and robust system to 'produce' well educated and informed health practitioners to provide the New Zealand public with a high standard of care based on a well-structured nursing education system (40, New Zealand Rural General Practice Network).

A consistency amongst NP education programmes is very desirable as this will assist in the acceptance and understanding of the NP role particularly in burgeoning areas such as primary care. Programmes should be carefully managed to ensure a consistent standard. There are currently a number of programmes and it’s not always clear that outcomes are standard. The current panel interview is removed from the real clinical observation and does not enable full observation of the NP candidate’s abilities or areas for improvement (31, Nurse Executives New Zealand).

4.1.2 Rejection of Option 1: the Council’s role to assess nurse practitioner candidates

Fourteen (25.9%) submitters did not support the assessment of competence within education programmes (answered 'no' to question 6 – see Chart 5) (2, 4, 6, 10, 16, 19, 29, 33, 36, 37, 38, 43, 49, 52). Reasons included the assessment of nurse practitioner competence within the education programme was not sufficient to confirm a nurse’s readiness for nurse practitioner registration and has a different focus from educational assessments (6, 10, 16, 29, 33, 36, 37, 38, 43, 49, 52). Other reasons given included the role of the Council to protect public safety and the potential for conflict of interest for the educational providers between professional regulation and educational requirements (4, 6, 16, 29, 33, 36, 37, 43). Eight other submitters who answered ‘yes’ to question 6 also expressed reservations that this should be the Council’s role (15, 30, 34, 35) and there was a risk of conflict of interest for education programme providers (15, 21, 24, 28, 41).

There is potential for inconsistencies within the universities because often their focus is primarily on FTE students rather than high quality outcomes. This leads to inconsistencies with those being assessed and I believe safety should be the primary goal when registering nurse practitioners. I believe the Council should still have the final say. We are not at the standard of the university programmes offered overseas i.e US, currently and don’t have the pool of qualified NP’s to lead training so I am worried that making it purely education based could lead to conflict of interests (6, Individual nurse practitioner).
Eight submitters expressed concerns about the assessment of competence being delegated to educational providers who have other pressures and priorities apart from assuring competence for registration. If the integrity of the registration standard is not maintained it could lead to clinical risk and a loss of public confidence in the nurse practitioner scope of practice (4, 16, 29, 37, 40, 46, 49, 52). Some submitters also commented that the programme outcome measure of the number of students gaining registration as a nurse practitioner may create pressure to pass candidates (33, 39, 46, 49, 52).

NZNO recommends Nursing Council, as the regulatory body, should make the final judgement on whether a nurse can be registered as a nurse practitioner. While NZNO can see the benefits to assigning assessment of the Nurse Practitioner candidate to the education provider in terms of cost reduction, risks associated with conflict of interest remain high. Those involved in the education of nurse practitioners often become personally invested in supporting the student to complete the required programme of study and there is a small but real risk that this may bias their assessment of a candidate. Further, within the current education environment where funding is provided largely based on the numbers of students enrolled, there is a need for education providers to ensure their programme is seen as successful and with high graduation rates to encourage further enrolment. This competitive environment again means there is a small but real risk that students who may not make ideal nurse practitioners are recommended for registration. For these reasons, NZNO supports the inclusion of option 2 whereby a candidate also submits a portfolio of learning to Nursing Council. NZNO would also like to see this extended to include a face-to-face viva voce examination (49, New Zealand Nurses Organisation).

A few were concerned that a national independent assessment should be retained despite costs to the Council (3, 32, 34, 35, 37, 49).

Removing the independent, national assessment process has the potential to introduce a number of risks to the existing process.... Individual nurses undertaking the transition to NP, as well as the nursing profession as a whole, face risks in terms of loss of public confidence and credibility should adverse events occur or perceptions of bias or conflicts of interest present. These are also potential concerns for the educators and clinical supervisors who are ‘signing off’ the NP students. Clinical risks have the potential to impact patients (the public) should inadequate processes become apparent. Legal and ethical risks are present, with the educational institutions appearing to take on the burden, on behalf of the Nursing Council, by assuming responsibility for determining competency (37, Group of Senior Emergency Department Nurses, Christchurch Hospital).

It concerns me the Council are citing costs as being a reason for these proposed changes and would rather support an increase in initial NP application fee to cover these losses than a ‘watering’ down of the system to in order to ‘break even’ (3, Individual nurse practitioner).

Two educational providers also expressed concern at the educational providers’ ability to undertake the assessment of competence for registration (29, 52).
We agree standards are necessary to ensure consistency across education providers, but consider those provided are not sufficient on their own to ensure public safety. We are concerned about real or perceived conflicts of interest in terms of the student relationships with their programme provider, and the current very real pressure for education providers to pass students in a climate in which funding is based on student success. New Zealand evidence indicates that educational providers and clinical staff find it difficult to fail students at undergraduate level and therefore there is a possibility that the same challenges will occur with Nurse Practitioner candidates (52, Victoria University of Wellington).

Several submitters (30, 31, 37, 42, 52, 57) stated that Option 1 would decrease the Council’s costs but would shift significant costs to the educational provider or the student.

Assessments within courses would normally be related to specific course objectives as opposed to a whole qualification. To undertake a comprehensive summative assessment of student’s achievement of all the Competencies for nurse practitioner on completion of the programme will require educational institutions to be resourced differently to cover this cost. It is noted that a key reason the Nursing Council is consulting on this change is because of the cost of undertaking such activities. The current level of funding for such programmes would not sufficiently cover the additional the costs that the change would impose on educational institutions (52, Victoria University of Wellington).

4.1.3 Support for Option 2: candidates for registration submit a portfolio of learning to the Council

The Council proposed that nurse practitioner candidates submit a portfolio of learning to be assessed by a Council-approved assessor (a nurse practitioner trained in assessment requirements for registration). This process would mean that the Council would still make the decision about the competence of a candidate. It would reduce timeframes and costs associated with the panel interview assessment processes. It could be a transition measure while the confidence in consistency of education programme assessment increased.

This option was supported by 74% of submitters. Some submitters supported the candidate submitting a portfolio of learning to the Council because it was the Council’s regulatory role to have the final responsibility in registering nurse practitioners (15, 29, 33, 34, 35, 39, 40, 43, 45).

Just as the RN is signed off by the regulator so should the NP be. This is a significantly autonomous role and the regulator has ultimate responsibility for patient safety and some form of final assessment should be at the discretion of the New Zealand Nursing Council. This is the least time consuming assessment tool available to Council. Other assessment methods would rely heavily on significant financial and human resource input that is unsustainable with the increase in NP candidates. In summary, we don't believe there is any other assessment process that would be as appropriate as the portfolio of practice, without causing undue work and cost to the nurse and the Council (40, New Zealand Rural General Practice Network).
Others stated that the submission of the portfolio was a method for the Council to moderate the education programmes and ensure consistency/standardisation of preparation and assessment by tertiary education providers when the new standards were introduced (17, 27, 30, 33, 34, 35, 42, 43, 46).

Submission of a portfolio of learning by nurse practitioner candidates would retain council moderation of registration with reduced costs. The focus of education programmes relate to competency in clinical practice rather than leadership competencies. A portfolio would facilitate key stakeholders in the practice environment demonstrating support for the candidates transition to NP practice (27, Individual nurse).

There is a risk if the portfolio and interview are both stopped at the same time as a new educational programme is introduced, that there is the potential for NPs to be accredited who perhaps should not be. There are still NPs who pass desk audit and then fail at interview so the process is not 100% robust currently. Ensures that the NP learning is assessed by the Nursing council as a separate body from the NP Master’s program the student attended, and that this will go some way to addressing the potential conflict of interest, and ensure assessments of nurse practitioner candidates are completed to a consistent standard (34, Starship Nurse Practitioner Group).

4.1.4 Support for portfolio assessment by the Council as a transition strategy only

Some of those who supported this option thought it would be a useful transition measure until consistency between the new education programmes was achieved and they became more consistently reliable and rigorous (4, 10, 29, 30, 33, 38, 47).

It is important to still keep the overall authority for Nurse Practitioner competence within the Nursing Council. This may be able to change to Education Providers at a later date but feel one change at a time is the smarter way to go. The public and many health professionals still are unaware of our role (certainly in my region) and when the training and registration process is explained they like to know that the NC are actively involved and oversee the process (4, Individual Nurse Practitioner).

Two educational providers suggested the use of an e-portfolio in both the summative (education based) and Council assessment (14, 25).

4.1.5 Rejection of Option 2: disagreement with the candidate submitting a portfolio to the Council

Some submitters thought this step would not be needed as the requirements in the standards would lead to consistency between programmes. Nine submitters (17%) indicated that nurse practitioners should only be assessed within the specified education programme, without the requirement of a portfolio submission to the Council (11, 12, 18, 21, 26, 28, 31, 35, 44). Some argued that educational providers can effectively assess candidates within the programme and would be sufficiently rigorous to confirm nurse practitioner competence without any additional scrutiny by the Council. The Council’s approval and monitoring of programmes would be sufficient oversight to ensure standards are upheld (including review
of completed NP portfolios held by TEPs). Submission of a portfolio to the Council was viewed as an unnecessary duplication of evidence of the assessments completed within the master’s programme (11, 12, 18, 28, 31, 44).

If the programme standards and moderation processes are adequately met there would be no need to also submit a portfolio to the Council. Portfolios could be held by the TEP for periodic audit by the Council (28, Massey University).

Academic process, student assessment and moderation (internal and external) as above should provide sufficient confidence in the outcome for NP candidates. Submission of a portfolio to NCNZ is an unnecessary step in this context (12, Bay of Plenty District Health Board).

Education providers are experienced in assessing the competence of postgraduate registered nurse students undertaking clinical modules. National and international external moderation of clinical modules, and Nursing Council audits have mandated this process in the evaluation of current Master of Nursing programmes. This assessment process requires experienced nurse practitioners to be centrally involved in the teaching, supervision and assessment of Master of Nursing students on the NP pathway (44, Waikato Institute of Technology).

Two submitters preferred closer moderation of candidate assessment within the education programme by the Council to the submission of a portfolio (21, 26).

I support the idea that competence can be assessed by the specific programme but there is a conflict in interest and there needs to be moderation. This moderation should be completed by NCNZ. Also, there should be a standardised process to complete the competence assessment which should cover a variety of aspects of the individuals capacity, as described in the draft, which includes verbal, written, scenario etc. Having a portfolio that is checked by NCNZ is not a good enough checking system and is doubling up. If standardised assessment which is moderated by NCNZ and delivered by Nurse Practitioners in the education programmes, there should be no major faults (21, Individual nurse).

5 Ensuring a consistent standard of assessment for all nurse practitioner candidates

In 2014 the Council suggested greater involvement by educational providers in the assessment of competence of nurse practitioner candidates. At that time key stakeholders from practice and education expressed reservations. The reasons for this were possible conflict of interest, the number and differences between Clinical Master’s programmes, and the assessment of competence to practise not being the role of education.

In 2015 the Council proposed the following requirements to address a potential conflict of interest (between educational achievement and assessment of competence to practise as a nurse practitioner) and to ensure a consistent standard of assessment.
Most submitters supported all three requirements (57%). Involving suitably qualified members of the multidisciplinary team (MDT) and practice representatives in assessments was most strongly supported with some commenting that this is happening to some extent already, particularly during the practicum (80%) (see Chart 6). Some raised the requirement for appointing, monitoring, training and funding these team members (20%), and some questioned whether other health practitioners would be able to effectively judge competence for the nurse practitioner scope of practice. External moderation of assessments by other educational providers received the lowest levels of support (65%) associated with submitters’ concerns about possible conflict of interest or alliances between providers. The Council’s role in setting standards for assessment and closer moderation of the education programmes was supported by 74% of submitters and linked to greater assurance of consistency of assessment between programmes. A consortium of education programme providers that assessed candidates by oral examination following completion of the programme was proposed as an alternative.

Chart 6: Support for proposed moderation requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Support Percentage</th>
<th>Did not answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Involving suitably qualified members of the multidisciplinary team and practice representatives</td>
<td>80%</td>
<td>9% 11%</td>
</tr>
<tr>
<td>b. External moderation of assessments by other educational providers</td>
<td>65%</td>
<td>20% 15%</td>
</tr>
<tr>
<td>c. Setting standards for assessment and closer moderation by the Council.</td>
<td>74%</td>
<td>13% 13%</td>
</tr>
</tbody>
</table>

A majority of the submitters (57%) supported all three requirements to assure consistent assessment standards and to minimise any conflict of interest (1, 3, 5, 6, 9, 12, 13, 15, 17, 20, 21, 22, 24, 25, 28, 30, 31, 32, 34, 35, 36, 38, 39, 41, 42, 44, 45, 46, 47). Two submitters did not support any of the suggested strategies (37, 43).
All three suggested requirements are essential for the health service employer and MDT to have confidence in the preparation and work readiness of graduates from a NP masters programme (45, Capital and Coast District Health Board Nursing Leadership Group).

5.1.1 Involve suitably qualified members of the multidisciplinary team and practice representatives

This requirement was the most highly supported by the submitters (80%). Some submitters recommended that the assessors would need to be carefully selected and should be the most appropriately skilled clinician available to assess the candidate’s particular area of practice (4, 28, 41, 44, 46, 54).

There is the potential for inconsistency of competence assessments leading to varied and potentially unsafe practice by NPs. Therefore the selection of suitably qualified members of the MDT and practice representatives is important (54, Pan Pacific Nurses Association New Zealand).

Relevant clinical expertise is essential in the final assessment for applicants whose area of practice is especially specialised and should be sought from the most appropriate and available source (41, College of Nurses Aotearoa (New Zealand) Inc).

Some submitters commented that this was happening to some extent already (4, 28, 29, 36, 44). One submitter suggested it could also be a strategy to raise awareness of the nurse practitioner role and build relationships (20).

Involving suitably qualified MDT members and practice reps does occur now but at a minor level and would be very useful to gain overall impression of the suitability of the NP candidate (4, Individual nurse practitioner).

At present, practice representatives such as vocationally registered medical practitioners are actively involved in student assessment as clinical preceptors/supervisors as part of the education programme. Their expertise is likely to be necessary in the final assessment for applicants whose area of practice is especially specialised and where there are few NPs with similar expertise. The associated costs of practice representatives/MDT examiners could be recovered from the candidate’s exam application fees (28, Massey University).

A few submitters expressed uncertainty about how MDT assessors would be appointed and monitored (8, 31, 34). Submitters also suggested the Council would need to provide guidelines for the selections and roles of assessors or more closely monitor assessments (25, 34). Others suggested the need for funding, resourcing and/or training to prepare and reimburse these assessors for their work (22, 28, 29, 41, 42, 52).

We agree that measures such as involving the multidisciplinary team and practice representatives will assist with addressing potential conflict but consider different funding arrangements will be required to address this. However, multidisciplinary members in
different regions may have different expectations. The role of other disciplines would need to be funded. (52, Victoria University of Wellington).

...Clinical viva examination by education providers may be more difficult to achieve in rural and/or remote locations. This may require need to use local Nurse Practitioners or GP mentors who would be willing to engage in examination process for local students which could conceivably create cost as they will require remuneration as well as training/education given to these providers (29, Auckland University of Technology).

Three submissions from medical professional groups recommended that the competence assessors should be completely independent from the education programme (22, 24, 51). One other submitter suggested the Council could establish a pool of nurse practitioners to support the assessment processes (30).

External scrutiny of education programmes and external scrutiny of competence and performance of nurse practitioners in training will provide confidence that up-coming nurse practitioners are appropriately trained and fit to practice. RACS believes that practitioners who are not involved directly in training should undertake any summative assessment process. The involvement of other suitable practitioners and education providers will provide suitable reassurance to patients and the community. Nursing Council input should be confined to the accreditation of education programs and standard setting (22, Royal Australasian College of Surgeons (RACS)).

A few submitters (23, 29, 48) did not agree with MDT members as assessors of competence because of doubts about their effective knowledge of the nurse practitioner role and the fundamental belief that nurses should be assessed by their own profession.

It is difficult to manage all potential conflicts of interest and/or assessment rigor internally – for example multidisciplinary colleagues may be highly skilled yet not have sufficient insight into complex requirements for Nurse Practitioner; assessors may have other service delivery agendas (29, Auckland University of Technology).

Assessment of NPs should be within the nursing community, not multidisciplinary (23, Hawkes Bay District Health Board Acute Care Nurse Practitioners).

5.1.2 External moderation of assessment by other educational providers

The majority of submitters (65%) supported the effectiveness of external moderation of assessment by other educational providers to minimise risk of bias and conflict of interest.

External moderation of assessments is a key aspect of the quality processes that is currently undertaken. Further involvement of the external moderator in the review of candidates for NP registration, as well as other experienced NPs would further strengthen external moderation (44, Waikato Institute of Technology).

Some offered suggestions including recommendations that external moderators should include assessment of students' competence in practice rather than “purely a paper exercise
of reviewing documents following student assessment" (31, 47), and suggested that external moderators should be involved in registration decisions (44, 47).

Some of those who rejected this strategy cautioned that external assessment by other educational providers may not reduce conflict of interest concerns (10, 37, 52) or felt that the Council would be more impartial (8).

…as education providers already have alliances with each other, consistent standards may not be met (52, Victoria University of Wellington).

Our preference would be for Council to have governance of processes as this seems the most suitable impartial body with no monetary or other incentive to influence their processes (8, Group of Advanced Nurses).

One suggestion was that external moderation should be completed by health professionals/MDT members rather than by other educational providers (54).

5.1.3 Setting standards for assessment and closer moderation by the Council

The requirement to have the Council setting assessment standards and moderating education programmes more closely was supported by 74% of the respondents. Supporting comments focussed on the suitability of the Council being more involved in this way as the body that approves programmes and registers nurses, and the independence of the Council when other organisations or individuals could be influenced by other interests e.g. an employer who does not support an employee becoming a nurse practitioner (8, 10, 18, 20, 23, 25, 31, 33, 34, 35, 36, 39, 40, 42, 44, 49, 54).

Some submitters suggested that the Council should be more involved in assessment and moderation processes than proposed in the consultation document, including providing clearer advice or guidelines for programme providers (29, 34, 42), and that the Council should closely monitor student selection and/or assessment of clinical competence (25, 33, 44).

Monitoring of education standards, including student selection and performance by Nursing Council would further strengthen the quality practices undertaken in the delivery of programmes across differing education providers (44, Waikato Institute of Technology).

Eight submitters (15%) did not support this strategy (4, 14, 26, 27, 37, 43, 48, 52). The reasons given were it is the educational provider’s role to set assessments not the Council’s (26, 52), closer moderation by the Council would incur more costs (4), none of these strategies would ensure there was no conflict of interest (27, 37), and there would be no problem if nurses were assessed by other nurses (48).
We note that the NCNZ is closely following the Australian NP accreditation model, which, on examination, does indicate a high degree of Council input into curriculum development through to involvement in actual course assessment. Based on the fact that tertiary education providers require a set standard of assessment at level 8 and 9 based on a set of graduate qualities, in addition to meeting the NCNZ NP competency standards, we are concerned that this intervention will become too prescriptive (26, Eastern Institute of Technology).

5.1.4 Other suggested approaches

Two submitters proposed that a consortium of educational providers should manage and host an oral examination after the completion of the education programme as the final assessment of competence for nurse practitioner candidates on a biannual basis (28, 41). A similar model was proposed by another submitter (14).

...A consortium of TEPs should manage and host the final assessment of candidates on a biannual basis. It is suggested that within a minimum period of perhaps 6 months of programme completion that candidates put forward by each TEP will apply to sit an oral exam that is hosted by one of the TEPs. Panels of nurse practitioners from contributing TEPs will be assembled to be the examiners, plus appropriate practice representatives/MDT examiners. The major advantage of such a move is to ensure consistency, minimize conflicts of interest and establish shared ownership of the process. Having a range of TEPs contribute examiners who will then agree on the examination content and process with input from the Nursing Council would create this advantage (41, College of Nurses Aotearoa (New Zealand) Inc).

Two district health boards (DHBs) suggested that DHB representatives (and the Nursing Council) should be involved in the assessment of competence (33, 36).

We still recommend that Nursing Council NZ are still a part of the assessment/registration process e.g. with regards to access of an appropriate NP/clinician assisting with assessment in the work place, in conjunction with a DHB representative/or in place of a DHB representative if unavailable. A combination approach is recommended during the assessment process, and as well as this the Nursing Council should be involved in the final oversight and approval of registration (33, Senior Nurses at Wairarapa District Health Board).

One submitter suggested a competence examination be held at the end of the practicum paper (signed off by clinicians and educators) (43).

Registration options have implications for future and current nurse practitioner candidates

The proposed changes to the registration process were seen as having implications for nurses who are currently working towards nurse practitioner registration and may have
already completed a qualification (2, 18, 25, 29, 35, 45, 47). The need for alternative registration pathways was identified.

There does...need to [be] processes for RN's like myself, who have completed most of the criteria for NP, to continue to finish under the criteria we started under. The education needs to be easily accessed in both North and South Island, without having to travel between Islands. This is important for those who live rurally who will have travel the most to get the support required to complete NP competencies... There needs to be processes for those who commenced under the current criteria to finish under this process without having to recommence study again. In this scenario, a portfolio of learning to the Nursing Council would be a useful tool (18, Individual nurse).

The 'grand parenting' process for RNs with NP Candidate experience and Clinical Masters needs to support NP registration. The reference to NP Programmes having credit recognition appears to address prior learning into a NP Masters. A clear pathway for RNs with Clinical Masters and practicums is required so RNs are not expected to repeat practicums (45, Capital and Coast District Health Board Nursing Leadership Group).

6 The draft competencies for nurse practitioners

The draft competencies proposed by the Council were developed following the earlier consultation on the scope of practice (see Appendix 6). They were designed to describe the skills and knowledge of new nurse practitioners, and to reflect the new scope statement and New Zealand legal and healthcare context.

The draft competencies reflect the nurse practitioner’s role as a leading healthcare provider. The number of competencies has been reduced from 20 to 11. The draft competencies are divided into ‘elements’ that describe aspects of each competency. The prescribing competencies are now integrated with other advanced practice skills and knowledge.

The Council sought feedback on whether the new competencies effectively describe the knowledge and skills demonstrated by new nurse practitioners, and whether they provide sufficient detail to guide educational requirements and student assessment.

There was a high level of support for the draft nurse practitioner competencies. Eighty-five per cent of submitters agreed the draft competencies reflected new nurse practitioners’ knowledge and skill, and 82% agreed the draft competencies provided enough detail to guide educational requirements and student assessment (see Chart 7). Some submitters sought the inclusion of more New Zealand-specific content and specific prescribing-related knowledge and skills, and also offered wording suggestions.
6.1.1 The draft competencies adequately describe nurse practitioner practice

Several submitters commented on how the draft competencies reflected the advanced clinical knowledge and practice demonstrated by nurse practitioners and were clearer and less repetitive that the current competencies (5, 8, 25, 31, 33, 36, 39, 45, 47, 49).

There are many nurses that currently practice at a very advanced level but are not NPs. These competencies clarify that the scope of practice for NPs is about advanced clinical knowledge and diagnostic expertise needed to safely practice at this advanced NP level. These competencies imbed the NP into a clinically focused scope of practice (31, Nurse Executives New Zealand).

Competencies and elements reflect NP requirements in the work place and reinforce the advanced clinical role. The reduction in repetition noted in previous competencies and indicators will be easier to work with in Programme/portfolio requirements. Language fits well with clinical practice (45, Capital and Coast District Health Board Nursing Leadership Group).

Emphasising nurse practitioners’ diagnostic skills, leadership, reflection on practice, broad area of practice and varied clinical contexts was also seen as a strength of the draft nurse practitioner competencies (4, 5, 18, 24, 25, 26, 49).

... The competencies protect the safety of the public. There is a strong emphasis on diagnostic capacity which will improve this aspect of NP practice (26, Eastern Institute of Technology).
Only two submitters (27, 52) made specific comments about how the draft competencies relate to the knowledge and skills required of newly registered nurse practitioners. Both were cautious about whether new nurse practitioners would be able to effectively demonstrate the leadership competencies.

As a Nurse Practitioner candidate, the draft competencies appear to clearly describe my understanding of the scope of practice. Leadership opportunities as outlined in competency 11 may be limited prior to registration and employment as a Nurse Practitioner (27, Individual nurse).

6.1.2 The draft competencies provide adequate guidance for educational requirements and student assessment

The draft competencies were supported by 82% of respondents as guiding the educational requirements for master’s programme providers and for conveying assessment standards clearly to nurse practitioner candidates (7, 8, 14, 20, 27, 33, 34, 35, 36, 39, 45, 52).

… the competencies contain … more descriptive terminology that [is] easier to interpret and apply to practice. This will mean that candidates will have a clearer idea of what they need to be achieving (39, Royal New Zealand Plunket Society (Inc)).

The competencies integrate clinical leadership and the advanced practice expectations well and therefore will provide a good template for programme revision or refinement (45, Capital and Coast District Health Board Nursing Leadership Group).

6.1.3 Suggested changes to the competencies

Competencies do not reflect the New Zealand context

The nurse practitioner draft competencies were adapted from the Australian Nursing and Midwifery Board (NMBA) Nurse practitioner standards for practice (2013). Six submitters questioned the relevance of the Australian standards for nurse practitioners in the New Zealand context: some of them linked this to practice differences between Australian and New Zealand nurse practitioners (13, 26, 30, 31, 42, 47).

The competencies broadly describe the knowledge and skill required to be a NP. However they are very differently worded to the current competencies without the information provided in the document as to why such changes have been proposed. The draft competencies are heavily based on the Australian NP competencies and some members have questioned this. In general, New Zealand NPs perceive themselves as having greater autonomy of practice through NCNZ and legislation than their Australian colleagues (47, Nurse Practitioners New Zealand).

The draft competencies are heavily based on the Australian NP competencies. [We] question if the Australian NP competencies are relevant in the New Zealand context (30, Family Planning).
Seven submitters suggested that the draft competencies should be more explicit about New Zealand nurse practitioners’ commitment to the Treaty of Waitangi, cultural safety and/or cultural models of care to support Māori and Pacific people’s health (12, 26, 31, 39, 42, 46, 54).

…We would like to note that there is no specific reference to the Treaty of Waitangi… within any competency and wonder whether formal consultation and decision making re this has already occurred. We feel that the current draft competencies which considering Māori only within the context of population health has the potential to greatly adversely affect individual and whanau health outcomes. We would also note that the current draft uses the word whanau as an alternative to the word family; however how this word is used in isolation does not appear to be acknowledging a Māori world view (39, Royal New Zealand Plunket Society (Inc)).

We note the draft competencies are aligned to the Australian competencies for NPs. We believe that there are aspects of the competencies that require review, particularly around cultural safety (26, Eastern Institute of Technology).

Prescribing skills and knowledge are not adequately described

Two submitters suggested that the competencies for prescribing were not well described (29) and would be difficult to use to adequately assess a student’s ability (38).

One submitter expressed significant concerns about nurse practitioners’ diagnostic and prescribing-related knowledge and skills, and their level of autonomous practice as reflected in the draft competencies.

We are disappointed that the concerns raised in our previous submission to the Nursing Council on the scope of practice and qualifications for nurse practitioners have not been addressed. Specifically, we note that the new scope of practice has extended the scope of nurse practitioner diagnosis to include “the diagnosis…. of consumers with common and complex health conditions”. We believe that this extension of the scope of practice, as well as the proposed competencies relating to diagnostic capacity, reflect a fundamental failure to fully appreciate the complexity of the diagnostic process…Nurse practitioners are an important part of the health care team but they cannot 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. Doctors and nurse practitioners are complementary, not interchangeable, in providing the full depth and breadth of clinical services. While the Nursing Council has developed a comprehensive set of competencies relating to diagnostic capacity for nurse practitioners, we have concerns that several of the elements listed will be difficult to accurately assess and are unrealistic for this group of health practitioners.

We also continue to have concerns at the potential for inappropriate prescribing, particularly given the removal of the requirement to restrict nurse practitioners to a specific area of practice. Inappropriate prescribing is already a significant contributing factor in the development of antimicrobial resistance. Given that nurse practitioners are now an authorised prescribing group, we suggest that a specific competency relating to the appropriate use of antimicrobials be added to the domain relating to nurse practitioner prescribing. We also believe that cost considerations of inappropriate prescribing (and inappropriate ordering of laboratory tests) should be explicitly identified and addressed by the Council (50, New Zealand Medical Association).
Suggestions for changes to the competencies

A few submitters suggested editing the draft competencies to remove repetition or to reduce the number of competencies (30, 44, 47, 49, 52, 53). One submitter suggested that the competencies could use clearer and simpler language to support educational requirements and student assessment (49).

The competencies as they stand are satisfactory, however the 54 elements listed are too prescriptive and repetitive if all nurse practitioners are expected to meet all elements (52, Victoria University of Wellington).

Some submitters suggested wording to clarify competencies or to emphasise specific knowledge or skills that submitters identified as important for nurse practitioners’ practice. These comments are collated in Appendix 3.

7 Proposal for newly registered nurse practitioners to practise under supervision for one year

The Council proposed that all nurse practitioners should be required to practise under supervision in their first year of practice following registration. The novice nurse practitioners would be required to have regular case review and mentoring by an experienced nurse practitioner or vocationally registered doctor. The proposal included the expectation that at the end of the year the supervisor would complete a competence assessment, detailing the nurse’s competence to practise in the nurse practitioner scope of practice, and that this would be submitted to the Council.

There was strong support (87%) for newly registered nurse practitioners practising under supervision for one year (see Chart 8). Opportunities for case review and mentorship linked to increased public safety were cited as reasons for this support. Submitters raised issues about how the proposal would be implemented, including access to supervisors, funding support, and the proposed assessment of competence by the supervisor after 12 months.
7.1.1 Support for supervision of new nurse practitioners

Many submitters agreed that the proposal would benefit new nurse practitioners by ensuring they had dedicated periods of supervision. For some, supervision would give new nurse practitioners opportunities for reflection, debriefing and professional development. Others noted that as a Council requirement this would have to be supported by employers (4, 7, 8, 10, 14, 15, 16, 30, 32, 36, 42, 43).

Mentorship for the first year of practice assists in consolidating new skills, provides the new NP with an experienced colleague as a 'sounding board' in decision making, advisor and support for role development. With its focus on developing career progression, consolidated mentorship will advance the NP role at individual and collective levels, thus assisting with sustainability for the NP role and scope. We do think the year of mentorship post registration is an essential part of the transition from RN to NP and adds a layer of support and safety. Cementing this as a requirement ensures safe and supported development occurs during the transition year and is not reliant on the individual's personal circumstances and contacts (as it does now) (42, University of Otago).

Other submitters identified the challenges faced by newly registered nurse practitioners as they transitioned from senior registered nurses as a rationale for the year of supervisory support (5, 10, 11, 20, 28, 29, 30, 34, 35, 38, 39, 40, 41, 49).

This is crucial in order to support NPs in what is a significantly different role to that of the advanced RN role, in terms of autonomy and ultimately responsibility. Where the NETP program is seen as the best practice start so the 1 year supervision should be seen in the same light for new NPs. By providing this level of support we hope that more nurses will be encouraged to consider this role as it is often the "jump and hope you swim" impression at
The end of training that puts nurses off. With better initial support NPs can consolidate their practice in a supported environment resulting in a more confident practitioner (40, New Zealand Rural General Practice Network).

The link between supervision during the first year of nurse practitioner practice and public safety was made in six submissions (3, 15, 24, 29, 42, 49).

We support the close supervision of newly registered nurse practitioners for a minimum of one year for a number of reasons: The theory of practice may have been gained through the attainment of the qualification, but the reality of practising as an autonomous health provider is different and requires further reflection and honing of skills learnt. The benefits, to both to the practitioner and the public, of close supervision for a period of time is well recognised in medical training and now also in midwifery practice (24, New Zealand Society of Anaesthetists).

7.1.2 Implementation issues

Some submitters questioned how this requirement would be implemented, including how novice nurse practitioners would secure supervision and employer support, and who would be responsible for the associated costs (15, 25, 27, 31, 32, 46, 52, 54).

Regarding first year nurse practitioners needing supervision we agree entirely with this concept, however achieving this may be challenging in some cases depending in the general practice environment, this may need the new NP to go off site for supervision and will need employer commitment to ensure this happens and is funded. Financially this makes sense and maintains peer support. Employer support is meaningful and this would build confidence. It builds safety and recognises the importance of reflection (32, Nurse Practitioners at MidCentral District Health Board).

A greater level of detail for the proposed year of supervision was sought by a small group of submitters (14, 18, 37, 44, 54).

While there is general agreement as to the benefit of a further one year supervisory period for the novice NP, there remain several points that will require further clarification.
1. It is suggested that the distinction between direct supervision and case review be clarified to allow acknowledgment of the potential for distance supervision during this point, and to consider the implications if the new NP is in a position where they require a new clinical supervisor due to changed circumstances.
2. The ideal situation would be for the student’s supervisor to agree to continue the supervision during the first year of registration; however there are potentially situations where this may not be possible. This gives rise to the possible scenario where a new NP may not be able to find a replacement supervisor willing to ‘sign them off’ as competent. Whose responsibility is it to identify this individual? It is no longer the educational institutions, as the NP is no longer a student; is it the individual student or the NP’s employer?
3. This also then raises the question as to who is responsible for reimbursing the supervisor, and how many hours are required in this role.
4. It is suggested that this would reduce any potential risks to the public from the proposed
changes, however the risks and responsibilities of the supervisor in agreeing to certify competence without direct supervision need to be outlined.

5. Given existing concerns expressed by clinical mentors (in particular medical colleagues) about signing off trainee NPs, there may be issues associated with this process – in particular if there is a significant increase in the number of trainee’s, as suggested in the call for submissions.

6. It is felt that BOTH formal and informal supervision should be a requirement (37, Group of Senior Emergency Department nurses, Christchurch Hospital).

Some submitters wanted clarity about the type of supervision (informal or formal, direct or indirect, clinical or professional) (12, 21, 31, 37, 39, 44, 48, 52, 54).

We agree with the idea of supervision for an entry to practice year. However, further clarity is required regarding the type of supervision, the supervision arrangements and requirements. 1. Is the requirement for professional supervision (professional development) or Clinical supervision (direct supervision for knowledge & skill development) or both. 2. How would these supervision requirements be monitored or reported (44, Waikato Institute of Technology)?

Other submitters recommended that supervision should be named as mentorship (26, 28, 41, 42).

We agree that a first year of practice requires support as the new NP transitions fully into the role. However, the word ‘supervision’ can be problematic and suggest that ‘mentor’ is more appropriate. We understand the intent to be that a more experienced practitioner is available to support clinical decision making during the first year of practice, but that the newly registered NP is responsible for his/her practice (28, Massey University).

The supervisor completing a competence assessment for the Nursing Council at the end of the 12-month period was seen as problematic (27, 37), as was the idea that newly registered nurse practitioners would practise ‘under’ rather than ‘with’ supervision (12, 31, 45, 48).

We do not support the recommendation that a competency assessment is a requirement at the end of the first year of practice. The value added is not clear. Processes for raising competency concerns to NCNZ are already in place. NP’s also maintain their competency via the APC audit process (12, Bay of Plenty District Health Board).

An alternative view proposed that novice nurse practitioners should hold interim or provisional registration until the end of their year of supervision when their competencies are successfully demonstrated (22, 39).

… An interim registration could be allocated following the completion of an approved clinical masters which could be upheld on the completion of the internship. This process would provide structured additional support during the adjustment from a non-prescribing to a prescribing role, giving the newly registered NP the time needed to reflect on their evolving practice. It would be like a training wheel period where support is assured rather
than the NP feeling like a burden. It could also validate or veto the integrity of the education based registration process (39, Royal New Zealand Plunket Society (Inc)).

### 7.1.3 Rejection of supervision for new nurse practitioners

Three submitters rejected the idea that supervision was necessary for newly registered nurse practitioners (12, 48, 53).

...The risk is that supervision as proposed here will result in the medical aspects of nursing being privileged over the holistic, comprehensive, caring, observational, supportive and facilitative art of nursing praxis that evidence shows makes a positive difference to outcomes. Again, we would consider the need for clinical autonomy as an essential part of the nurse practitioner role. Supervision as defined here implies a real or perceived lack of confidence. The proposed supervision requirement seems excessive given that all nurse practitioners are registered and by necessity, experienced nurses (48, New Zealand College of Midwives Inc).
References


Appendix 1: List of submitters

1. Individual nurse practitioner
2. Individual nurse
3. Individual nurse practitioner
4. Individual nurse practitioner
5. Individual nurse
6. Individual nurse practitioner
7. Individual nurse practitioner
8. Group of Advanced Nurses
9. Individual nurse
10. Individual nurse practitioner
11. Individual nurse
12. Bay of Plenty District Health Board
13. Individual nurse practitioner
14. University of Auckland
15. East Health Trust Primary Health Organisation
16. Individual nurse practitioner
17. Individual nurse
18. Individual nurse
19. Hawkes Bay District Health Board
20. Te Pou o Te Whakaaro Nui
21. Individual nurse
22. Royal Australasian College of Surgeons
23. Hawkes Bay District Health Board Acute Care Nurse Practitioners
24. New Zealand Society of Anaesthetists
25. Southern Institute of Technology
26. Eastern Institute of Technology
27. Individual nurse
28. Massey University
29. Auckland University of Technology
30. Family Planning
31. Nurse Executives New Zealand
32. Nurse Practitioners at MidCentral District Health Board
33. Senior Nurses at Wairarapa District Health Board
34. Starship Nurse Practitioner Group
35. College of Emergency Nurses New Zealand (NZNO)
36. Group of Hutt Valley DHB and primary healthcare nurses
37. Group of Senior Emergency Department Nurses, Christchurch Hospital
38. New Zealand Hospital Pharmacists Association
39. Royal New Zealand Plunket Society (Inc)
40. New Zealand Rural General Practice Network
41. College of Nurses Aotearoa (New Zealand) Inc
42. University of Otago
43. Kidz First Neonatal Care Clinical Nurse Specialist Team
44. Waikato Institute of Technology
45. Capital and Coast District Health Board Nursing Leadership Group
46. Matua Raki - Addiction Workforce Development
47. Nurse Practitioners New Zealand
48. New Zealand College of Midwives Inc
49. New Zealand Nurses Organisation
50. New Zealand Medical Association
51. Australian and New Zealand College of Anaesthetists
52. Victoria University of Wellington
53. Individual nurse practitioner
54. Pan Pacific Nurses Association New Zealand
Appendix 2: Feedback on other education programme standards

Some submitters gave feedback on other standards. These are summarised below. Wording suggestions are included in Table 4 below.

Table 3: Feedback on other education standards

<table>
<thead>
<tr>
<th>Standard 2: Academic and teaching staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 2.10 “The coordinator of the nurse practitioner master’s programme will be a registered nurse with a current practise certificate and will have the authority and responsibility for decision making regarding:</td>
</tr>
<tr>
<td>- The entry criteria for student selection in order to meet requirements for fitness for registration in accordance with section 16 of the Act.</td>
</tr>
<tr>
<td>- An individual student’s progress, including academic and professional misconduct, through the programme in order to meet requirements of section 16 of the Act.</td>
</tr>
<tr>
<td>- The delivery and ongoing development of the programme.</td>
</tr>
<tr>
<td>- Processes are in place to enable early identification and support for students who are not performing well academically, clinically or who have fitness to practice issues. The education provider must demonstrate a process for exiting, or managing into alternative education pathways, students who are not achieving academic, clinical or professional outcomes, and who would not meet the requirements of section 15 &amp; 16 of the Act.</td>
</tr>
</tbody>
</table>

Three submitters suggested that the coordinators should be nurse practitioners (13, 30, 47) and one suggested the term “coordinator” should not be used as it was confusing (52). An educational provider commented on the difficulty of managing fitness to practise issues at the postgraduate level (28):

… the coordinator should be a nurse practitioner, particularly in light of the authority and responsibilities assigned to the role (e.g. delivery and ongoing development of the programme) (30, Family Planning).

… the [Council] needs to modify the language to say the person with the responsibility to coordinate the masters… “as using the word coordinator could be confusing… some education providers…[have] academic roles such as Course Coordinators, and it is the Head of School who has the authority and responsibility for decision making (52, Victoria University of Wellington).

Fitness to practice issues are not straightforward for TEPs at postgraduate level and there is a tension between employers who are not able to share information about employees and students who are at pains to prevent the TEP from finding out. As a TEP we are not able to act on formal fitness to practice issues that we do become aware of until it is resolved via the appropriate process with the Council or Disciplinary tribunal. If, however, a fitness to practice issue became apparent during an interaction or clinical assessment with a TEP staff member, we would be obliged under the HPCA Act to notify the Council of the concern… (28, Massey University).

Standard 3 Entry requirements to the master’s programme

Standard 3.3 “Applicants whose first language is not English must provide certified results of an IELTS score of 7.0 in the academic module (with no individual band below 7.0). They must also demonstrate the communication skills to be able to undertake the

One submitter recommended that standard 3.3 should be reworded so it did not exclude some New Zealanders and included other language tests.

The changing demographic profile of New Zealand means that there are many people whose first language is not English. Maori, Pacific peoples and the like born, raised and educated in New Zealand should not be expected to complete
practice experience requirements of the programme”.

an IELTS, but would be without modification of the wording here. Given that there are now a number of validated English language tests, we consider that this standard should be worded to say IELTS score of 7 or an equivalent approved English Language Proficiency results (52, Victoria University of Wellington).

### Standards 3 and 4: Entry requirements for the nurse practitioner practicum

#### Standard 3.2: “Applicants must have completed a minimum of three years equivalent full time relevant practice within the last five years (with at least one year of the three years of equivalent full time practice in New Zealand).”

#### Standard 4.1 “The student 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 intending to practice as a nurse practitioner in New Zealand….”

Two submitters questioned whether three years’ clinical experience was sufficient as a prerequisite for entry into nurse practitioner master’s programmes (20, 46).

… entry level at three years is inadequate... The focus of the NP along the nursing intervention continuum spans health promotion through to interventions for those with a range of multiple complex and long term health related issues This development and the core component to effective integrated care practice inherent in being a NP takes time and experience. It is felt that this cannot occur if entry is after just three years (46, Matua Raki - Addiction Workforce Development).

### 4. Entry requirements for the nurse practitioner practicum

#### 4.1 The student 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 intending to practice as a nurse practitioner in New Zealand.
- have a collaborative working relationship with a multidisciplinary team and have the support of a nurse practitioner mentor and a vocationally registered medical practitioner who will support her/him to develop the advanced skills and knowledge required for nurse practitioner practice.
- 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 two areas of clinical practice in

Could be very difficult for some geographical areas with some requirements-eg entry requirements. Making it more difficult and restrictive by putting in place barriers is counter-productive (8, Group of Advanced Nurses).

A robust selection of candidates for a NP educational programme with rigorous entry criteria e.g. strengthening of pre- requisite experience, demonstration of advanced nursing practice and application of knowledge to practice is recommended. Further supporting documents from overseas include http://sydney.edu.au/nursing/study/advanced/practitioner/index.shtml (39, Royal New Zealand Plunket Society (Inc)).
which to develop the advanced skills and knowledge required for nurse practitioner practice. One area should be relevant to their intended area of prescribing practice and the other area should broaden their clinical learning experience.

<table>
<thead>
<tr>
<th>Standard 5: Credit recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 5.8 Any qualifications from overseas must be authenticated and assessed by NZQA.</td>
</tr>
<tr>
<td>Standard 5.8 was seen as a possible barrier for nurse practitioner candidates by two submitters (28, 41).</td>
</tr>
<tr>
<td>The cost of a NZQA assessment is prohibitive for many nurses and seems unnecessary for qualifications that have readily accessible programme information available on the relevant university website (Australia for example). It would be helpful to TEPs if the Nursing Council could provide a list of countries from which qualifications can be accepted directly (28 Massey University).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 7: Programme content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two stakeholders advocated for increased mental health and addictions healthcare to be included in programme outcomes (40, 46).</td>
</tr>
<tr>
<td>...There is some concern that the current focus in the NP core papers tends to be on acute unwellness. The needs of mental health and addiction can get minimised within this. Suggest that equal emphasis be placed on MH and A, physical wellness, chronic care, care across the lifespan and primary care (46, Matua Raki - Addiction Workforce Development).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard 8: Student assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 8: “The programme provider demonstrates: ... 8.6 Ultimate accountability for the assessment of students in relation to practice experience... 8.9 Collaboration between the education provider, health service provider/s and other stakeholders involved in practice experience in selecting, implementing and evaluating assessment methods... 8.11 For students who have not completed a Postgraduate diploma in nurse prescribing before commencing the nurse practitioner master’s programme the assessment methodology tests all aspects of prescribing and must include a practical assessment and confirmation</td>
</tr>
<tr>
<td>One master’s programme provider sought clarification about standards 8.6 and 8.9.</td>
</tr>
<tr>
<td>8.6 What does having ultimate accountability mean? 8.9. Given that the Nurse Practitioner programmes including the assessment requirements are approved by education providers and education bodies and the Nursing Council it is unclear how collaboration would work in reality regarding selecting and implementing assessments. Collaboration could however take place regarding timing of activities, and the types of formative input students can and should receive, and who is responsible (52, Victoria University of Wellington).</td>
</tr>
<tr>
<td>Two submitters rejected 8.11 on the basis that this could create barriers for nurses who had not completed the postgraduate diploma in registered nurse prescribing before enrolling in the nurse practitioner master’s programme (14, 47).</td>
</tr>
</tbody>
</table>
of the student's clinical, physical examination and decision-making skills and confirm they meet the Competencies for nurse prescribers.

We do not agree with 8.11. All students entering the MS for NP should be treated the same and not have different requirements, regardless of whether they have been designated prescribers or not. NPNZ believe that having completed a postgraduate diploma in nurse prescribing should not be a prerequisite nor should the student have to meet the competencies for nurse prescriber as an inclusion criteria but rather a student requires a postgraduate diploma that includes clinical, physical examination and decision-making skills. (47, Nurse Practitioners New Zealand).

Standard 10: Programme evaluation and quality

Standard 10.1 “The tertiary education provider will be evaluated against the outcomes of the programme in relation to students’ subsequent registration as a nurse practitioner. 10.2 Regular evaluation of academic and clinical mentor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance”…

Two master’s programme providers cautioned against draft standard 10.1 by suggesting this could be an unfair measure of the programme quality (28, 52).

Although subsequent registration as a NP is an ideal outcome measure, it needs to take into account the fact that some students will not succeed… The specified admission criteria into the programme will address a student’s capability, but nurses, who are predominantly female, often have both young and elderly dependents…. There needs to be appropriate exit strategies from the programme that allows students to graduate with an intact qualification that does not reflect poorly on the overall quality of the programme” (28, Massey University).

Two submitters recommended that the wording for standard 10.2 should be revised to clarify the evaluation of mentor effectiveness (34, 35).

It will be the medical and nursing colleagues who are working alongside the NP in training or NP who will provide substantive feedback on the overall success of the programme in producing high quality NPs… In addition a change in wording throughout to specifically identify who the “other sources” that are providing feedback are. That these “other sources” will mostly be NP, senior nursing and medical colleagues working alongside the student NP and they will provide most of the feedback on the competency / skills and readiness of the NP student (34, Starship Nurse Practitioner Group).
<table>
<thead>
<tr>
<th>Standard number</th>
<th>Wording of concern/suggested changes</th>
<th>Submission number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Delete standard 2.1 because already covered in standard 3.2.</td>
<td>30</td>
</tr>
<tr>
<td>3.5</td>
<td>“…specific requirements <em>to be met</em> for right of entry to health service…” (add italicised words).</td>
<td>52</td>
</tr>
<tr>
<td>4.1, 9.2, 9.9</td>
<td>Cross reference these standards associated with resourcing.</td>
<td>30</td>
</tr>
<tr>
<td>4.1</td>
<td>“…have the support of a nurse practitioner and/or a vocationally registered medical practitioner…” (add italicised word).</td>
<td>14, 31, 47</td>
</tr>
<tr>
<td></td>
<td>Add “paid release time” to fourth bullet point regarding clinical practice areas for nurse practitioner practicum.</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>“…length of time since completion of qualification…”: range of length of time would be helpful.</td>
<td>20, 28</td>
</tr>
<tr>
<td></td>
<td>“…length of time since completion of qualification…”: wording needs to be clearer and specific time frames stipulated by Council to support cross crediting and consistency between education institutions.</td>
<td>52</td>
</tr>
<tr>
<td>6.2</td>
<td>“…duration of the programme…must include sufficient face to face contact time...: minimum face to face time needs to be clarified and supported as this appears to be an area where institutions are trying to cut back on costs”.</td>
<td>39</td>
</tr>
<tr>
<td>6.4</td>
<td>“The programme must have an advisory committee demonstrating partnership…”: Wording should be modified because it needs to concern not only an Advisory Committee but also ongoing consultation and dialogue.</td>
<td>52</td>
</tr>
<tr>
<td>8.10/ glossary</td>
<td>MDT referred to in standard, and 'interprofessional learning’ referred to in Glossary: “it would be helpful to use one term consistently to describe the health team”.</td>
<td>44</td>
</tr>
<tr>
<td>Standard 9</td>
<td>9.1 states “Risk management strategies in all environments where students are placed are regularly reviewed and updated.” Recommendations that standards are clearer so that all parties take responsibility for particular aspects of practicum organisation.</td>
<td>44, 54</td>
</tr>
<tr>
<td>9.2/ 9.4</td>
<td>9.2: Education providers negotiating practice experience - this needs to be more robust by detailing what and how many, as the proposed assessment process may be too open to interpretation. We suggest merging 9.2 and 9.4 for a better description”.</td>
<td>20</td>
</tr>
<tr>
<td>9.3</td>
<td>The student will have clinical mentoring from a nurse practitioner and/or a vocationally registered doctors who will support the student to develop the skills to practice as a nurse practitioner and an authorised prescriber: Concerns about resourcing nurse practitioners, therefore suggested wording change to reflect one or the other ie. “… have clinical mentoring from a nurse</td>
<td>14, 54</td>
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</tr>
<tr>
<td>Practitioner or a vocationally registered doctor …”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.4/ 10.4/ Glossary</td>
<td>“Re the varying language used to describe clinical mentoring, professional supervision, clinical supervision”: recommended clearer use of these terms, and suggestion that Te Pou’s resources on supervision for nurses might be helpful and inclusion of cultural supervision should be made more explicit.</td>
<td>20, 46</td>
</tr>
<tr>
<td>9.6/ 9.7</td>
<td>“While NZNO acknowledges that it may be difficult for Nursing Council to direct the activities of provider organisations, it may be helpful for points 9.6 and 9.7 to be standalone under a section entitled ‘Health provider organisation responsibilities’ or similar”.</td>
<td>49</td>
</tr>
<tr>
<td>9.8</td>
<td>“The student is allocated an appropriate workload and is able to demonstrate the competencies and management skills required for clinical practice: a guide for a minimum workload to ensure adequate clinical experience is achieved would provide clarity of expectations for the student and health provider organisation.&quot;</td>
<td>54</td>
</tr>
<tr>
<td>9.10/ 9.12</td>
<td>“NZNO notes point 9.10 indicates the student will develop learning goals and point 9.12 almost repeats the same point – point 9.10 could probably be deleted”</td>
<td>49</td>
</tr>
<tr>
<td>9.14</td>
<td>“Supervision and mentorship differ, a student may have a professional supervisor who is not the clinical mentor. It is important that these terms are not used interchangeably as if the same”</td>
<td>52</td>
</tr>
<tr>
<td>9.16</td>
<td>“The two bullet points related to the formal evidence that would need to be obtained to confirm a student has completed the 300 hours of protected clinical time should be combined.” &quot;Ensure a nurse practitioner with a current practicing certificate is employed within the programme to ensure that student’s progress satisfactory in their clinical learning and in completion of assessment requirements: Clarity of the nurse practitioner employment would ensure adequate support ie. stating the minimum FTE” “Provide the student and clinical mentors with clear and practical guidance on completion of the practicum …Inclusion of support for the viva voce clinical assessment ensures confidence and strength in aural presentation skills.” “we found the first and sixth bullet points don't read well”: clarification needed.</td>
<td>52, 54, 54, 20</td>
</tr>
<tr>
<td>9.17</td>
<td>“No student may be given more than two opportunities to pass the nurse practitioner practicum”: request for clearer wording, also request for time frame to complete programme, and addition to the standard to allow for case by case consideration where students have failed papers.</td>
<td>54</td>
</tr>
<tr>
<td>4.1 and 9.2</td>
<td>Family Planning recommends that paid release time is included as an entry requirement for the nurse practitioner practicum,</td>
<td>30</td>
</tr>
</tbody>
</table>
however, notes that the education provider should have a role negotiating paid release time alongside their role negotiating the overall practice experience. Section 9.2 states that education providers must “negotiate practice experiences and clinical mentors for each student and a process by which these are assessed as satisfactory prior to the commencement and for the duration of the programme.” Section 9.2 could be cross-referenced in section 4.1. Ensuring organisations have access to sufficient resources to support candidates is an important component of the practicum. The issue of adequate resources also pertains to section 9.9 “The student participates in the practice experience on a supernumerary basis”.

### Appendix 3: Table 5: Suggested changes to the wording of the draft competencies

<table>
<thead>
<tr>
<th>Competency (and element number)</th>
<th>Suggested wording additions/changes/editing</th>
<th>Submitters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1</strong></td>
<td><strong>Domain One: Assesses using diagnostic capacity</strong></td>
<td></td>
</tr>
<tr>
<td>Competency 1</td>
<td>We suggest the following wording for competency 1: “comprehensive, systematic, accurate and holistic health assessments”.</td>
<td>44</td>
</tr>
<tr>
<td>1.1</td>
<td>We suggest “…in-depth knowledge of human science to underpin a comprehensive, systematic and accurate health assessment.”</td>
<td>44</td>
</tr>
<tr>
<td>1.2</td>
<td>We suggest “Demonstrate comprehensive systematic and accurate skill in obtaining and interpreting relevant and appropriate assessment data to inform clinical judgement and differential diagnosis”.</td>
<td>44</td>
</tr>
<tr>
<td>1.1 and 1.2</td>
<td>Similar elements: 1.1 and 1.2 could be combined.</td>
<td>47</td>
</tr>
<tr>
<td>1.2 and 1.4</td>
<td>Element 1.4 repeats 1.2.</td>
<td>44</td>
</tr>
<tr>
<td>1.4</td>
<td>Should include &quot;substance use&quot;:</td>
<td>20</td>
</tr>
<tr>
<td>1.5</td>
<td>Could include a “strengths based, health promoting focus that identifies health care needs” rather than problems.</td>
<td>44</td>
</tr>
<tr>
<td>1.2 and 2.2, 1.3 and 3.4</td>
<td>Some duplication for example competencies 1.2 and 2.2, and 1.3 and 3.4.</td>
<td>49</td>
</tr>
<tr>
<td>Competency 3</td>
<td>Domain three that discusses the implementation of interventions could also emphasise the inclusion of ‘facilitating’ an intervention being carried out by another practitioner and the role of consult liaison.</td>
<td>46</td>
</tr>
<tr>
<td>3.1</td>
<td>(This) should focus on the synthesis of health assessment data. We suggest “Synthesise health history, clinical on assessment, and diagnostic investigation data to formulate differential diagnoses”.</td>
<td>44</td>
</tr>
<tr>
<td>3.1</td>
<td>Competency should include “social determinants of health such as housing and employment status, enrolment with a PHO”.</td>
<td>20</td>
</tr>
<tr>
<td>Competency (and element number)</td>
<td>Suggested wording additions/changes/editing</td>
<td>Submitters</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Domain 2 Plans care and engages others</td>
<td>4.4 Competency 4 refers to education and support of “… others to enable their active participation in care”. Element 4.4 requires more specificity on the delivery of appropriate modes of teaching. Suggested wording is “Uses appropriate teaching/learning styles that is delivered in a way conducive to the learning style of the health consumer and their family to provide … needs”.</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>4.4 Should include “health promotion”.</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>5.2 Why are disability services and aged care specifically mentioned in this section. We suggest “Consults with and/or refers to other health and disability care providers or services and community agencies at any point in the care continuum”.</td>
<td>30, 47</td>
</tr>
<tr>
<td></td>
<td>5.2 Competency 5 refers to working “… collaboratively to optimise health outcomes for health consumers/population groups”. An inclusion of working inter-sectorially would acknowledge that health alone cannot achieve health outcomes. Element 5.2 could be reworded “Consults with and/or refers to other services, disability services, aged-care providers, community agencies and organisations in other sectors as appropriate, at any points in the care continuum”.</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>5.5 Questioned relevance of 5.5 as practice competence, as this is not directly related to patient care.</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>6.7 This element seems to include two separate themes: 1) antimicrobial resistance and local resistance patterns; and 2) using nonpharmacological strategies. Whilst this is essential pharmacology knowledge, other elements not specified are also essential knowledge to prescribing practice. Why it is necessary to specify details in 6.7 as the competencies are inherent in 6.1, 6.2 &amp; 6.3. Also antimicrobial resistance is not particularly relevant for some areas of practice, eg palliative care.</td>
<td>13, 30, 42, 47.</td>
</tr>
<tr>
<td></td>
<td>6.8 This requires an additional statement regarding NPs awareness/ understanding of legislation surrounding misuse of drugs and prescribing for addiction. Not just able to recognise etc.</td>
<td>42</td>
</tr>
<tr>
<td>Competency (and element number)</td>
<td>Suggested wording additions/changes/editing</td>
<td>Submitters</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Prescribes, implements and evaluates therapeutic interventions</td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>The wording here should be reflective of the differing input NPs have in regard to admission/discharge.</td>
<td>42</td>
</tr>
<tr>
<td>8.2</td>
<td>(This) refers to maintaining … “relationships with people at the centre of care”. An element missing is the ability to demonstrate advanced communication skills ie. motivational interviewing. This is critical in establishing and maintaining relationships. Element 8.2 suggested re-wording “Demonstrates advanced communication capability by supporting, educating, coaching, motivating, counselling, advocating and working in partnership … interventions”.</td>
<td>54</td>
</tr>
<tr>
<td>Competency 9</td>
<td>(This) should include an element of practitioner self-assessment.</td>
<td>44</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Advances practice and improves health outcomes</td>
<td></td>
</tr>
<tr>
<td>10.6</td>
<td>We query whether the examples are beneficial. With the change to the omnibus bill currently to be read before select committee in Feb 2016, there will be other statutory requirements added to this LTSA, etc.</td>
<td>42</td>
</tr>
<tr>
<td>11.2</td>
<td>Why is ‘disability and aged care policy’ listed as this may not be relevant to all NPs.</td>
<td>30, 42, 47</td>
</tr>
<tr>
<td>11.3</td>
<td>(This) refers to participation … “in, and leads systems that support safe care, community partnership and population health improvements”. In Element 11.3 an additional comment that would add value is the familiarity of cultural models of care to be used appropriately when assessing need and working with communities with health inequities ie. Te Whare Tapa Wha and Fonofale models of care. Suggested re-wording “Incorporates advanced nursing knowledge and understanding of diversity, cultural safety and socio-economic determinants of health by understanding and utilising cultural models of care where able for assessment, planning and delivering healthcare services”.</td>
<td>54</td>
</tr>
<tr>
<td>11.4</td>
<td>Clarification needed about what is required to demonstrate ‘advanced knowledge of Maori health and working in partnership with local iwi to contribute to improvements in health outcomes’. Also this may be difficult to achieve in some settings.</td>
<td>31, 42</td>
</tr>
<tr>
<td>Competency (and element number)</td>
<td>Suggested wording additions/changes/editing</td>
<td>Submitters</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>11.5</td>
<td>“Who are ....‘other prescribers’?”</td>
<td>13, 30, 47</td>
</tr>
</tbody>
</table>

**General comments (competencies/ elements not specified by submitter)**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>“However, very medically focussed - no room for patient engagement”</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>“…Need to make health promotion role and ill health prevention more explicit to align to Ministry of Health and revised NZ Health Strategy”.</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>“• It is felt that there is a competency missing regarding values and attitudes and ensuring that the consumer/service user voice is heard.</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>• There needs to be the inclusion of addiction, concurrent with mental health. Addiction tends to get lost if it is assumed to be a component of mental health.</td>
<td></td>
<td></td>
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<tr>
<td>• To ensure integrated care practice the inclusion of wellbeing and social determinants of health, in addition the physical determinants are important.</td>
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</tr>
<tr>
<td>• Care should include be inclusive of contemporary health concepts, eg. Cultural responsiveness person centred, Whanau Ora, recovery and wellbeing, motivating behaviour and lifestyle change. Would be good to see this reflected in the competencies”.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Overall this appears an appropriate outline, however it is disappointing to see that while willing to acknowledge and draw on the evidence base of other professions, there is no reference to use of nursing theories, models, paradigms or research.”</td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>“Suggest that the cultural elements are reviewed by cultural expert advisory group as they appear “light” especially in context of Whanau Ora, He Korowai Oranga, aspirations of Pae Ora, equity focus”.</td>
<td></td>
<td>12</td>
</tr>
</tbody>
</table>
### Appendix 4: 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 the assessment of competence of nurse practitioner candidates within specified education programmes as outlined in the Draft education programme standards?</td>
<td>35</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>7. Do you think any of the following requirements will address potential conflict of interest and ensure assessments of nurse practitioner candidates are completed to a consistent standard?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Involving suitably qualified members of the multidisciplinary team and practice representatives and/or</td>
<td>43</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. External moderation of assessments by other education providers and/or</td>
<td>35</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>c. Setting standards for assessment and closer moderation by the Council.</td>
<td>40</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>8. Do you support the candidate also submitting a portfolio of learning to the Council?</td>
<td>40</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>9. Do you support the assessment methods outlined in 8.4 and 8.10 of the draft education programme standards?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. a portfolio of learning and clinical log of practice experience</td>
<td>49</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>b. simulated-scenario-based assessment</td>
<td>47</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>c. viva voce clinical assessment</td>
<td>45</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>d. observation in clinical practice settings.</td>
<td>49</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>10. Do you support nurse practitioners as the clinical teaching staff for each student’s clinical experience?</td>
<td>44</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>11. Do you support the standards for the nurse practitioner practicum outlined in section 9 of the draft education programme standards?</td>
<td>45</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>12. Do you support the draft education programme standards?</td>
<td>42</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>14. Do you agree that the draft competencies for nurse practitioners describe the knowledge and skills required of new nurse practitioners?</td>
<td>46</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>15. Do you agree that the draft competencies provide enough detail to guide education requirements and</td>
<td>44</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Did not answer</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>student assessment?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>16. Do you support newly registered nurse practitioners practising under supervision for one year?</td>
<td>47</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

Note:
The responses to question 13 can be found under section 3.
The responses to question 17 can be found under section 4.
Appendix 5: Draft education programme standards for the nurse practitioner scope of practice

Draft education programme standards for the nurse practitioner scope of practice

November 2015
Introduction and background

Under the Health Practitioners Competence Assurance 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 functions of the Council that relate to education and registration are set out in sections 12, 15, 16, 45 and 118 of the Act (see final section of this document).

Applicants for registration as a nurse practitioner must complete a Council-accredited master’s programme and meet the competencies for the nurse practitioner scope of practice.

The education programme standards for nurse practitioner master’s programmes have the programme outcomes for the Postgraduate diploma in registered nurse prescribing for long-term and common conditions and Competencies for nurse prescribers (2014) embedded within them. This means that the qualification for Designated prescriber: registered nurses practising in primary health and specialty teams can be credited to a nurse practitioner master’s programme. It also means that there is a consistent educational foundation for both types of prescribers. It will also broaden and make more consistent the preparation for all nurse practitioners. Students can choose to complete the postgraduate diploma in prescribing and then complete the master’s programme or complete the prescribing practicum towards the end of the master’s programme. At completion of the master’s programme the student will also be expected to have completed an assessment against the Competencies for nurse prescribers (Nursing Council of New Zealand, 2014).

The provision of master’s programmes for nurse practitioners will be limited to tertiary education providers also providing the Council-accredited Postgraduate diploma in registered nurse prescribing for long-term and common conditions programmes as these qualifications have similar content and are required to be provided to a consistent standard.

Upon award of the qualification, graduates will be eligible to apply to the Council for registration as a nurse practitioner with prescribing rights as an authorised prescriber under the Medicines Act 1981.

The Council acknowledges the work of the Australian Nursing and Midwifery Council (ANMAC) Nurse Practitioner Accreditation Standards 2015 and Canadian Association of Schools of Nursing (CASN) Nurse Practitioner Education in Canada: National Framework of Guiding Principles and Essential Components (2012) that have informed and contributed to these draft standards.

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4 See (Nursing Council of New Zealand, 2014) Education programme standards for the Postgraduate diploma in registered nurse prescribing for long-term and common conditions.
Please note the sections in the standards shaded in grey have already been decided by the Council following the previous consultation. They are not being consulted on again but are included for completeness.

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 and a Postgraduate diploma in registered nurse prescribing for long-term and common conditions programme in New Zealand under sections 12(2)(a) and 118(a) of the Act (see Appendix 1).

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

1.4 The tertiary education provider must have a governance structure that supports high-quality teaching and learning, scholarship, research and ongoing evaluation across all learning settings.

1.5 Staff, facilities, online tools, equipment and other teaching resources are sufficient in quality and quantity for the anticipated student population and any planned increase.

1.6 Responsibility and control of programme development, monitoring, review, evaluation and quality improvement is delegated to the school with oversight by the academic board or equivalent.

2. Academic and clinical teaching staff

2.1 The Head of Nursing holds current registration as a registered nurse, holds a relevant postgraduate qualification, maintains active involvement in the nursing profession and has strong engagement with contemporary nursing education and research.

2.2 Students have sufficient and timely access to academic and clinical teaching staff, including nurse practitioners to support student learning.

2.3 Academic staff are qualified for their level of teaching with a tertiary qualification higher than the programme of study being taught.

2.4 Staff teaching and assessing nursing practitioner specific subjects, including those with pharmacology, advanced health assessment and
diagnostics (pathology and medical imaging) content, have relevant clinical and academic qualifications and experience.

2.5 Clinical teaching staff for each student’s practice experience are registered nurse practitioners with expertise in a relevant clinical practice area and an academic qualification in education or equivalent learning and teaching experience.

2.6 In cases where an academic staff member’s tertiary qualifications do not include nursing, their qualifications and experience are directly relevant to the subject/s they are teaching.

2.7 Processes are in place to ensure academic staff demonstrate engagement in research, scholarship and practice in the subject/s they teach.

2.8 Teaching and learning takes place in an active research environment where academic staff are engaged in research, scholarship or generating new knowledge. Areas of interest, publications, grants and conference papers are documented.

2.9 Policies and processes to verify and monitor the academic and professional credentials of current and incoming staff, including current practising certificates where applicable, and to evaluate their performance and development needs.

2.10 The coordinator of the nurse practitioner master’s programme will be a registered nurse with a current practising certificate and will have the authority and responsibility for decision making regarding:

- The entry criteria for student selection in order to meet requirements for fitness for registration in accordance with section 16 of the Act.
- An individual student’s progress, including academic and professional misconduct, through the programme in order to meet requirements of section 16 of the Act.
- The delivery and ongoing development of the programme.
- Processes are in place to enable early identification and support for students who are not performing well academically, clinically or who have fitness to practice issues. The education provider must demonstrate a process for exiting, or managing into alternative education pathways, students who are not achieving academic, clinical or professional outcomes, and who would not meet the requirements of section 15 & 16 of the Act.

3. Entry requirements to the master’s programme

3.1 Applicants must be a registered nurse with a current practising certificate and in good standing with the Council.
3.2 Applicants must have completed a minimum of three years equivalent full time relevant practice within the last five years (with at least one year of the three years of equivalent full time practice in New Zealand).

3.3 Applicants whose first language is not English must provide certified results of an IELTS score of 7.0 in the academic module (with no individual band below 7.0). They must also demonstrate the communication skills to be able to undertake the practice experience requirements of the programme.

3.4 Providers of programmes leading to master’s qualifications are responsible for establishing other entry requirements. Admission as a student to a master’s programme for nurse practitioners should be based on the evaluation of documentary evidence (including the academic record) of the individual applicant’s ability to undertake postgraduate study of professional practice leading to registration as a nurse practitioner (refer to New Zealand Qualifications Authority)\(^5\).

3.5 Specific requirements for right of entry to health services for practice experience including immunisation and police vetting.

3.6 Maori and Pacific students are encouraged to apply and are advised of, and have access facilitated to, cultural support resources.

4. Entry requirements for the nurse practitioner practicum

4.1 The student 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 intending to practice as a nurse practitioner in New Zealand.
- have a collaborative working relationship with a multidisciplinary team and have the support of a nurse practitioner mentor and a vocationally registered medical practitioner who will support her/him to develop the advanced skills and knowledge required for nurse practitioner practice.
- 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 two areas of clinical practice in which to develop the advanced skills and knowledge required for nurse practitioner practice. One area should be relevant to their intended area of prescribing practice and the other area should broaden their clinical learning experience.

5. Credit recognition

5.1 The education provider must have credit recognition policy that conforms with the Council’s policy.

5.2 Credit recognition involves recognising and giving credit for learning that has occurred as part of a qualification. This learning is measured against the learning outcomes of the master’s programme leading to registration as a nurse practitioner.

5.3 Each tertiary education provider must have a credit recognition policy and procedure against which to assess individual student applications. Credit recognition policies and procedures will be reviewed during the Council’s monitoring of the programme.

5.4 Credit recognition must be granted on the basis of a student’s qualifications. 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 and the Competencies for nurse practitioners.

5.5 Prior learning within a qualification may be cross-credited. However, all students must undertake the nurse practitioner practicum.

5.6 The Council retains the right to seek justification of any credit granted through the credit recognition process.

5.7 Statements of programme completion (academic transcripts) must outline any credit granted.

5.8 Any qualifications from overseas must be authenticated and assessed by NZQA.

5.9 Consideration should be given to the length of time since completion of the qualification when considering credit recognition.

6. Programme structure and curriculum

6.1 The master’s programme is equivalent to 2,400 hours of study including 240 credits. The master’s degree must comprise a minimum of 40 credits at level 9 with the remainder at level 8\(^6\). (Not for consultation).

6.2 The duration of the programme is expected to be aligned with the requirements for postgraduate-level qualifications and must include

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sufficient face-to-face contact time to enable students to learn alongside other students; 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.

6.3 The structure of the programme must encourage development of critical thinking and reflective practice and the application of research and theory to advanced practice. It must prepare graduates for the autonomy, clinical judgement, collaborative relationships and level of accountability in the nurse practitioner scope of practice. A map of the content against the Competencies for nurse practitioners and the Competencies for nurse prescribers that shows the links between learning outcomes, assessments and graduate competencies is required.

6.4 The tertiary education provider must ensure effective links are maintained with the nursing profession and other relevant stakeholders in the development of curriculum and the delivery of the programme. The programme must have an advisory committee demonstrating partnership with consumers, professional organisations, primary and secondary health providers and representatives of the communities where nurse practitioners may be employed e.g. rural, Maori, high needs.

6.5 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.

6.6 The curriculum addresses competencies related to interprofessional practice and provides educational opportunities to enhance knowledge related to interprofessional teaching, scholarship and practice. Partnerships are established within and across programmes and practice experience locations to support interprofessional education.

7. Programme content (Not for consultation)

Following the successful completion of the following programme outcomes for the master's degree for nurse practitioners, the student will be able to:

1. Demonstrate advanced knowledge of pathophysiology, pharmacology, assessment and diagnostic reasoning in relation to the clinical management of and prescribing for clients with long term and common conditions in New Zealand. This includes Maori and Pacific peoples and older adults.

2. Integrate a broad base of theoretical scientific and clinical knowledge and skill within a framework of nurse practitioner practice; demonstrate a high level of clinical proficiency in complex client situations and an ability to practise across healthcare contexts.
3. Apply critical thinking, clinical reasoning, and problem solving to determine differential diagnoses and apply advanced pharmacological knowledge when make prescribing decisions.

4. Critically appraise scientific literature, integrate research findings into nurse practitioner practice, and integrate research to advance practice and health services to develop innovative solutions across healthcare settings.

5. Demonstrate a high level of interpersonal skills: communicate effectively and establish effective collegial relationships with interprofessional teams and work in consultation and collaboration with clients, whanau and diverse communities.

6. Make diagnostic and therapeutic interventions utilising current technology to inform practice; proactively seeking and evaluating new information and technologies to improve client outcomes.

7. Recognise the values intrinsic to nurse practitioner practice; demonstrate a commitment to lifelong learning through critical reflection, self-monitoring and be able to mentor and enhance the professional development of others.

8. Critique health policies from a population health perspective; synthesise legal and socio political issues in healthcare and organisational, policy and funding/business influences on practice and health outcomes.

9. Demonstrate a sound understanding of current legislation related to nurse practitioner practice; work in an autonomous and accountable practice framework as a senior member of interprofessional teams; demonstrate high level clinical leadership and management skills.

10. Demonstrate achievement of the Council Competencies for nurse practitioner.

(Adapted from Curtin University: Master of Nursing (Nurse Practitioner) Learning outcomes)

8. Student assessment

The programme provider demonstrates:

8.1 A consistent approach to student assessment across teaching sites and modalities that is regularly reviewed and updated.

8.2 The level, number and context of assessments are consistent with determining the achievement of the stated learning outcomes.

8.3 Formative and summative assessment exist across the programme to enhance individual and group learning as well as inform student progression.

8.4 The use of a variety of assessment approaches to evaluate competence in the application of knowledge and skills at the required level and as required for professional practice as a nurse practitioner including:

a. a portfolio of learning and clinical log of practice experience
b. simulated scenario based assessment
c. viva voce clinical assessment
d. observation in clinical practice settings.

8.5 A range of instruments, validated where possible, are used in practice experience assessment to evaluate student knowledge, skills, behaviours and capacity to meet the Competencies for nurse practitioners.

8.6 Ultimate accountability for the assessment of students in relation to practice experience.

8.7 Evidence of procedural controls, fairness, reliability, validity and transparency in assessing students.

8.8 Processes to ensure the integrity of online assessment.

8.9 Collaboration between the education provider, health service provider/s and other stakeholders involved in practice experience in selecting, implementing and evaluating assessment methods.

8.10 Comprehensive summative assessment of the student’s achievement of the Competencies for nurse practitioners on completion of the programme. This assessment includes a comprehensive summative clinical viva voce within the student’s nominated area of practice by suitably qualified members of the multidisciplinary team and should demonstrate achievement of the programme outcomes.

8.11 For students who have not completed a Postgraduate diploma in nurse prescribing before commencing the nurse practitioner master’s programme the assessment methodology tests all aspects of prescribing and must include a practical assessment and confirmation of the student’s clinical, physical examination and decision-making skills and confirm they meet the Competencies for nurse prescribers.

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

9. The nurse practitioner practicum

9.1 Risk management strategies in all environments where students are placed are regularly reviewed and updated.

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7 ‘Suitably qualified members’ refers to health care professionals recognised by education and health service providers and clinical peers as having: sufficient qualifications, knowledge and skills to be considered an expert in a clinical field relevant to the scope of practice of the student; a thorough understanding of the role and scope of nurse practitioner practice; and appropriate preparation and training in undertaking student assessment. Nurse practitioners should be included as part of this team.
9.2 The nurse practitioner practicum component of the programme must consist of at least 300\(^8\) hours of protected (outside of the students paid work hours) clinical learning time within a collaborative health team environment. **(Not for consultation)** The education provider must negotiate practice experiences and clinical mentors for each student and a process by which these are assessed as satisfactory prior to the commencement and for the duration of the programme.

9.3 The student will have clinical mentoring from a nurse practitioner and/or a vocationally registered doctor who will support the student to develop the skills to practice as a nurse practitioner and an authorised prescriber.

9.4 The nurse practitioner practicum will include opportunities to further integrate academic theory with diagnostic and clinical decision making skills for more complex health consumers and to develop advanced leadership, collaborative and innovative clinical practice skills, working with population groups across more than one setting.

9.5 The education provider must have formal agreement with the organisations providing practice experience, including the allocation of clinical mentors and student assessment.

9.6 The health provider organisation agrees to provide a high quality practice experience and appropriate learning opportunities.

9.7 The health provider organisation supports nurse prescribing and nurse practitioner practice through policies, processes and continuing professional development. The organisation offers a range of learning opportunities, i.e. there is an opportunity to assess and provide nursing interventions for a variety of health consumers and an opportunity to work with professionals from other disciplines.

9.8 The student is allocated an appropriate workload and is able to demonstrate the competencies and management skills required for clinical practice.

9.9 The student participates in the practice experience on a supernumerary basis.

9.10 The student develops learning goals at the beginning of the practicum.

9.11 The student has an opportunity to demonstrate all the competencies when managing the nursing care for clients with complex needs.

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\(^8\) A prescribing practicum of 150 hours as part of the postgraduate diploma in prescribing may be credited as part of the 300 hours.
9.12 The student, clinical mentor and academic mentor complete a formative assessment at the beginning of the placement and the student then establishes learning goals.

9.13 The student receives timely and specific feedback.

9.14 The student is encouraged to assess their own performance and refine learning goals. The student and clinical mentor will meet regularly for supervision and case review.

9.15 The role of the clinical mentors in the nurse practitioner practicum is to:

- assist the student to further develop diagnostic and clinical decision making skills with more complex health consumers relevant to their proposed role as a nurse practitioner.

- assist the student to develop consultative and collaborative leadership and advanced practice skills for population groups across more than one setting.

- assess the achievement of the learning outcomes by the student, and confirm the completion of the equivalent of 300\(^9\) hours of protected (outside of paid work hours) clinical learning time.

- complete an assessment and professional declaration which confirms that in his/her opinion the student has met the skills and competencies required of the nurse practitioner scope of practice in collaboration with the academic mentor.

9.16 The role of the tertiary education provider in the nurse practitioner practicum is to:

- ensure a nurse practitioner with a current practising certificate is employed within the programme to ensure that student’s progress satisfactory in their clinical learning and in completion of assessment requirements.

- ensure non-nurse practitioner clinical mentors are oriented to the nurse practitioner role/scope of practice.

- ensure the clinical mentors have the education and experience appropriate to their roles, are familiar with the requirements of the programme, and have clear and practical guidance on their role in the assessment of the student against the Competencies for nurse practitioners.

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\(^9\) A prescribing practicum of 150 hours as part of the postgraduate diploma in prescribing may be credited as part of the 300 hours.
• work with the student and clinical mentors to identify the learning objectives and performance expectations for the acquirement of specific clinical and leadership skills.

• obtain formal evidence and confirmation from both clinical mentors that the student has satisfactorily completed at least 300\textsuperscript{10} hours of protected clinical learning time and has the skills and competence demonstrated in practice to meet the requirements of the nurse practitioner practicum and the \textit{Competencies for nurse practitioners}.

• provide the student and clinical mentors with clear and practical guidance on completion of the practicum, including:
  
  o the expectations for direct and indirect supervised practice. The supervised practice can involve student support and experience with other members of the team, other prescribers and external contributors;
  
  o use of mentoring techniques commensurate with student progress such as demonstration, observation and review of clinical cases;
  
  o requirements for formative and summative assessment of the student against the \textit{Competencies for nurse practitioners};
  
  o practical guidance, support and quality assurance of any summative assessments carried out by the clinical mentors on behalf of the education provider;
  
  o a structured workbook or portfolio for recording the completion of 300 hours in practice, achievement of learning outcomes and professional declaration that the student is competent to practice as a nurse practitioner;
  
  o a formal mechanism for ongoing discussion about student progress between academic staff, the clinical mentors and the student during the practicum.

9.17 No student may be given more than two opportunities to pass the nurse practitioner practicum.

\textsuperscript{10} A prescribing practicum of 150 hours as part of the postgraduate diploma in prescribing may be credited as part of the 300 hours.
10. Programme evaluation and quality

10.1 The tertiary education provider will be evaluated against the outcomes of the programme in relation to students’ subsequent registration as a nurse practitioner.

10.2 Regular evaluation of academic and clinical mentor effectiveness using feedback from students and other sources; systems to monitor and, where necessary, improve staff performance.

10.3 Practice experience is evaluated by students and clinical mentors at completion.

10.4 Evaluations are used by the provider to improve the quality of the practice experience.

10.5 Professional and academic development is provided for staff to advance knowledge and competence in teaching effectiveness and assessment.

10.6 Feedback gained from the quality cycle is incorporated into the programme in consultation with stakeholders, including healthcare consumer advocates to improve the experience of theory and practice learning for students.

10.7 Regular evaluation and revision of programme content to include contemporary and emerging issues surrounding nurse practitioner practice, health care research and health policy and reform.

10.8 Students and staff are adequately indemnified for relevant activities undertaken as part of program requirements.
Glossary

**Clinical mentoring** Mentoring is a process by which the mentor is able to support and help the student to develop their knowledge, skills, thinking and behaviours and thus problem solving and performance.

**Clinical teaching staff** Nurse practitioners employed for clinical and/or theoretical teaching.

**Competencies** Skills, knowledge and attitudes by which performance and professional conduct is assessed to obtain registration and maintain competence as a nurse practitioner.

**Curriculum** The full outline of a program of study, usually built around a conceptual framework with the educational and professional nursing or philosophies underpinning the curriculum and includes: the philosophy for the program; the program structure and delivery modes; subject outlines; linkages between subject objectives, learning outcomes and their assessment, and national competencies or standards of practice; teaching and learning strategies; and a workplace experience plan.

**Education provider** University, or other higher education provider, responsible for a program of study, the graduates of which are eligible to apply to the Nursing Council for registration or prescribing rights.

**Health Practitioner Competence Assurance Act 2003** The purpose is to protect the public by ensuring nurses are safe and competent to practice. This legislation covers the registration of nurses, accreditation of programmes, complaints, health and competence.

**Interprofessional learning** Occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

**Learning contract** Identified and agreed learning objectives for practicum including a plan for achieving and regular clinical supervision meetings.

**Patient centred Care** The patient/client and family (if applicable) are at the centre of care, and engaged in health care decision-making with the health care team. There is a focus on patient/client health care goals and needs, and there is a balance of health care team expertise and personal knowledge of the patient/client/family (CIHC, 2010c).

**Practice experience (practicum)** A clinical learning experience designed to practice and integrate advanced clinical skills, role identity and professional skills for nurse practitioner practice.

**Programme** The full programme of study and experiences that must be completed before a qualification can be awarded.

**Scholarship** Application of systematic approaches to acquiring knowledge through intellectual inquiry. Includes disseminating this knowledge through various means such as publications, presentations (verbal and audio-visual), professional practice and the application of this new knowledge to the enrichment of the life of society.
Supernumerary is where the student undertakes practice experience outside their employed position or when they are not counted in the staffing roster.

Supervision: This can be formal or informal. Formal supervision involves regular protected time spend with a mentor or supervisor to enable facilitated in-depth reflection on clinical practice, for example using case review. Informal supervision is the day to day communication and conversation providing advice, guidance or support as and when necessary

Student assessment Formative and summative processes used to determine a student’s achievement of expected learning outcomes. May include written and oral methods and practice or demonstration.

Viva voce clinical examination viva voce, meaning ‘living voice’, the clinical viva examination is a method of assessing students’ ability to use knowledge in a face-to-face examination encounter. Various titles for this assessment approach are used essentially all derived from two basic models. The ‘short case’ that focuses on specific skills or sub-skills and can take the form of an Objective Structured Clinical Examination (OSCE) or a case presentation on a specific clinical activity; this approach is usually a formative assessment. The ‘long case’ model is used as summative assessment. It seeks to examine the student’s ability to apply knowledge in an actual clinical situation. The long case exam requires the student to use professional communications skills to collect, analyse, synthesise and evaluate clinical information, to use differential diagnostic procedure and determine a management plan. The long case model assesses learning outcomes related to deep learning, application and synthesis of knowledge and high level clinical reasoning.
12 Qualifications must be prescribed

(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.

(3) A notice under subsection (1) may state that 1 or more qualifications or experience of 1 or more kinds, or both, is required for each scope of practice that the authority describes under section 11.

(4) An authority must monitor every New Zealand educational institution that it accredits for the purpose of subsection (2)(a), and may monitor any overseas educational institution that it accredits for that purpose.

15 Requirements for registration of practitioners

(1) The authority appointed in respect of a health profession may register an applicant as a health practitioner permitted to practise within a scope of practice if the applicant—
   (a) is fit for registration in accordance with section 16; and
   (b) has the qualifications that are prescribed, under section 12, for that scope of practice; and
   (c) is competent to practise within that scope of practice.

(2) An authority may, for the purposes of subsection (1)(b), treat any overseas qualification as a prescribed qualification if, in the opinion of the authority, that qualification is equivalent to, or as satisfactory as, a prescribed qualification.

(3) An authority may vary a prescribed qualification in any case where the authority—
   (a) proposes to limit the health services that the applicant will be permitted to perform; and
(b) is satisfied that the varied qualification is adequate—
   (i) for the performance of those health services; and
   (ii) for the protection of the public.

16 Fitness for registration

No applicant for registration may be registered as a health practitioner of a health profession if—
   (a) he or she does not satisfy the responsible authority that he or she is able to communicate effectively for the purposes of practising within the scope of practice in respect of which the applicant seeks to be, or agrees to be, registered; or
   (b) he or she does not satisfy the responsible authority that his or her ability to communicate in and comprehend English is sufficient to protect the health and safety of the public; or
   (c) he or she has been convicted by any court in New Zealand or elsewhere of any offence punishable by imprisonment for a term of 3 months or longer, and he or she does not satisfy the responsible authority that, having regard to all the circumstances, including the time that has elapsed since the conviction, the offence does not reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
   (d) the responsible authority is satisfied that the applicant is unable to perform the functions required for the practice of that profession because of some mental or physical condition; or
   (e) he or she is the subject of professional disciplinary proceedings in New Zealand or in another country, and the responsible authority believes on reasonable grounds that those proceedings reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
   (f) he or she is under investigation, in New Zealand or in another country, in respect of any matter that may be the subject of professional disciplinary proceedings, and the responsible authority believes on reasonable grounds that that investigation reflects adversely on his or her fitness to practise as a health practitioner of that profession; or
   (g) he or she—
      (i) is subject to an order of a professional disciplinary tribunal (whether in New Zealand or in another country) or to an order of an educational institution accredited under section 12(2)(a) or to an order of an authority or of a similar body in another country; and
      (ii) does not satisfy the responsible authority that that order does not reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
   (h) the responsible authority has reason to believe that the applicant may endanger the health or safety of members of the public.
45 Notification of inability to perform required functions due to mental or physical condition

(4) Subsection (5) applies to a person in charge of an educational programme in New Zealand that includes or consists of a course of study or training (a course) that is a prescribed qualification for a scope of practice of a health profession.

(5) If a person to whom this subsection applies has reason to believe that a student who is completing a course would be unable to perform the functions required for the practice of the relevant profession because of some mental or physical condition, the person must promptly give the Registrar of the responsible authority written notice of all the circumstances.

118 Functions of authorities

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:
(g) to notify employers, the Accident Compensation Corporation, the Director-General of Health, and the Health and Disability Commissioner that the practice of a health practitioner may pose a risk of harm to the public:
(h) to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession:
(i) to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession:
(j) to liaise with other authorities appointed under this Act about matters of common interest:
(k) to promote education and training in the profession:
(l) to promote public awareness of the responsibilities of the authority:
(m) to exercise and perform any other functions, powers, and duties that are conferred or imposed on it by or under this Act or any other enactment.
Acknowledgment

The Nursing Council acknowledges the kind permission of the Nursing and Midwifery Board of Australia (NMBA) to adapt The nurse practitioner standards for practice (2014).
Domain One: Assesses using diagnostic capacity

**Competency 1: Conducts comprehensive, relevant and holistic health assessments.**

*Elements*

1.1 Demonstrates extensive knowledge of human sciences and comprehensive/systematic health assessment.

1.2 Demonstrates comprehensive and systematic skill in obtaining and interpreting relevant, appropriate and accurate data including prior treatment outcomes, physical findings and diagnostic data to identify normal, at risk and abnormal states of health that inform differential diagnoses.

1.3 Assesses the complex and/or unstable healthcare needs of the health consumer\(^\text{11}\) including the impact of comorbidities through synthesis and prioritisation of historical and available data.

1.4 Demonstrates comprehensive skill in clinical examination and nursing assessment including physical, mental health, social, ethnic and cultural dimensions.

1.5 Actively explores the health consumer’s concerns, preferences, health behaviours, attitudes and priorities when identifying health consumer problems.

**Competency 2: Demonstrates timely and considered use of diagnostic investigations to inform clinical decision making.**

*Elements*

2.1 Demonstrates accountability in considering access, cost, clinical efficacy and the informed decision of the health consumer when ordering and/or performing selected screening and diagnostic investigations.

2.2 Accepts responsibility and accountability for the interpretation and appropriate follow-up associated with screening and or diagnostic test results.

2.3 Uses effective communication strategies to inform the health consumer and relevant health professionals of health assessment findings and diagnoses.

**Competency 3: Applies diagnostic reasoning to formulate diagnoses.**

*Elements*

3.1 Synthesises knowledge of developmental and life stages, epidemiology, pathophysiology, behavioural sciences, psychopathology, environmental risks, demographics, and societal processes when making a diagnosis.

3.2 Considers the health consumer’s expectations of assessment, diagnosis and cost of healthcare.

\(^{11}\) An individual who receives nursing care or services. This term represents patient, client, resident, or disability consumer. This term is used in the Health Practitioners Competence Assurance Act (2003).
3.3 Acts to prevent and/or diagnose urgent and emergent and life threatening situations.

3.4 Determines clinical significance in the formulation of an accurate diagnosis from an informed set of differential diagnoses through the integration of the health consumer’s history and best available evidence.

**Domain Two: Plans care and engages others**

**Competency 4: Educates and supports others to enable their active participation in care.**

**Elements**

4.1 Ethically explores therapeutic options considering implications for care through the integration of assessment information, the health consumer’s informed decision and best available evidence.

4.2 Respects the rights of the health consumer to make informed decisions throughout their health/illness experience or episode of care, whilst taking accountability to ensure access to accurate and appropriately interpreted information.

4.3 Assesses and contributes to health literacy by sharing knowledge with the health consumer and their family/whanau where relevant to achieve evidence-informed management plan.

4.4 Uses appropriate teaching/learning strategies to provide diagnostic information and health education that is relevant, theory-based and evidence-informed to meet health consumer and others learning needs.

**Competency 5: Works collaboratively to optimise health outcomes for health consumers/population groups.**

**Elements**

5.1 Leads and collaborates with other health professionals and agencies to ensure timely access and smooth transition to quality services for the health consumer.

5.2 Consults with and/or refers to other health services, disability services, aged-care providers and community agencies at any point in the care continuum.

5.3 Effects nursing practice and healthcare change using broad based skills including negotiating, consensus building and partnering.

5.4 Demonstrates nursing leadership skills to foster and maintain collegial relationships by communicating and engaging effectively and professionally with diverse groups and stakeholders to improve healthcare.

5.5 Articulates the nurse practitioner role and promotes nursing in clinical, political and professional contexts.
**Competency 6: Integrates evidence and applies principles of quality use of medicines and therapeutic interventions in planning care.**

**Elements**

6.1 Makes decisions about healthcare management and interventions informed by critical evaluation of relevant research findings.

6.2 Develops an individual plan of care and communicates this to health consumer and appropriate members of the healthcare team and relevant agencies.

6.3 Exhibits a comprehensive knowledge of pharmacology to make safe and appropriate risk-benefit prescribing decisions.

6.4 Works in partnership with the health consumer to determine therapeutic goals and options.

6.5 Verifies the suitability of evidence-based treatment options including medicines, in regard to commencing, maintaining/titrating or ceasing interventions.

6.6 Demonstrates accountability in considering access, cost and clinical efficacy when planning treatment, including medicines.

6.7 Critically evaluates the causes of antimicrobial resistance and the importance of incorporating non-pharmacological strategies and knowledge of local resistance patterns into prescribing practice.

6.8 Demonstrates the ability to recognise situations of drug misuse and drug seeking, and takes appropriate action.

**Domain Three: Prescribes, implements and evaluates therapeutic interventions**

**Competency 7: Prescribes indicated non-pharmacological and pharmacological interventions.**

**Elements**

7.1 Safely prescribes therapeutic interventions based on accurate knowledge of the characteristics and concurrent therapies of the health consumer.

7.2 Safely and effectively performs evidence-informed invasive/non-invasive interventions for the clinical management and/or prevention of illness, disease, injuries, disorders or conditions.

7.3 Leads care management by directing and supporting the contribution of health professionals and others.

7.4 Makes appropriate decisions regarding admission and discharge of health consumers from healthcare services.

7.5 Demonstrates professional integrity and ethical conduct in relation to therapeutic product manufacturers and pharmaceutical organisations.
Competency 8: Maintains relationships with people at the centre of care.

Elements

8.1 Demonstrates respect for difference in cultural, social and developmental responses to health and illness and incorporates health beliefs of the health consumer / community into care planning and implementation.

8.2 Supports, educates, coaches, counsels and works in partnership with the health consumer and their family/whanau where relevant regarding diagnoses, prognoses and self-management, including their personal responses to illness, injuries, risk factors and therapeutic interventions.

8.3 Advises the health consumer and their family/whanau where relevant on therapeutic interventions including benefits, potential side effects, unexpected effects, interactions, importance of compliance and recommended follow-up.

8.4 Discloses the facts of adverse events to the health consumer and other health professionals; mitigates harm and reports adverse events to appropriate authorities.

Competency 9: Monitors and evaluates the effectiveness of clinical interventions/ care.

Elements

9.1 Monitors, critically evaluates and documents treatments/interventions in accordance with health consumer- determined goals and healthcare system outcomes.

9.2 Considers a plan for appropriately ceasing and/or modifying treatment in partnership with the health consumer, and other members of the healthcare team.

9.3 Uses relevant tools to monitor and measure the effectiveness of strategies, services and interventions to promote safe practice.

9.4 Monitors and minimises risks to health consumers and healthcare service providers at the individual and systems level.

Domain Four: Advances practice and improves health outcomes

Competency 10: Accountable for independent advanced nursing practice.

Elements

10.1 Demonstrates responsibility and accountability for actions as a lead healthcare provider and when managing episodes of care.

10.2 Provides the full spectrum of healthcare services in relation to health consumer/population group including health promotion and protection, guidance and counselling, disease management, maintenance and restoration of health, rehabilitation and palliative care.
10.3 Articulates safe boundaries around a clearly defined area of practice and demonstrates timely referral and consultation when an issue is outside scope of practice, area of practice, experience or competence.

10.4 Self-monitors and critically reflects on nursing practice including through regular professional supervision, collaborative case review and audits of practice, including prescribing.

10.5 Continually reviews and updates advanced nursing knowledge and skills to ensure currency and adaptability to address broad and changing population health needs and to practice safely across healthcare settings.

10.6 Understands responsibilities and accountabilities when undertaking activities which have a statutory function for example, cause of death certification, authorised prescriber.

**Competency 11: Participates in, and leads systems that support safe care, community partnership and population health improvements.**

**Elements**

11.1 Applies knowledge of health systems, new technologies, policy and funding to advocate for innovative changes to healthcare services to improve access, equity of outcomes, quality and cost-effective healthcare.

11.2 Influences and critiques health, disability and aged-care policy and nursing practice through leadership and active participation in workplace and professional organisations.

11.3 Incorporates advanced nursing knowledge and understanding of diversity, cultural safety and socio-economic determinants of health when planning and providing healthcare services.

11.4 Demonstrates advanced knowledge of Maori health and socio economic disparities and works in partnership with local iwi/ Maori health providers to contribute to improvements in health outcomes.

11.5 Leads practice by educating and mentoring nursing colleagues including other prescribers.

11.6 Shares new knowledge and research through discussions, presentations, publications, and the development of best practice guidelines.