Q6: Do you support the assessment of competence of nurse practitioner candidates within specified education programmes as outlined in the Draft education programme standards?

Yes,

Please give your reasons

The significant elements we can see for the health sector and practising NPs are the requirements for the sector to support the 300hrs for students to be supernumerary and the strengthening of agreements between education, clinical mentors (NPs), and health service providers (DHBs, PHOs, IPAs) to support the students’ education. The strengthening of expectations of summative assessment procedures on students is a strong feature of the proposal. The approach outlined is commensurate with the assessment processes of our degree.
Q7: 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?

a. Involving suitably qualified members of the multidisciplinary team and practice representatives and/or 
   - Yes

b. External moderation of assessments by other education providers and/or 
   - Yes

c. Setting standards for assessment and closer moderation by the Council. 
   - Yes

Please give your reasons or any other suggestions

This document provides greater specificity of the relationships required for effective learning by the tripartite, that is; student, educators and the health provider sector. The health provider sector will need to be aware of the increased onus for their role in supporting candidates as student learners in their capacity as supernumerary and in the provision of more than one suitable clinical practice setting. There will need to be substantial agreement from the profession and support from health sector employers to enable NP’s, vocationally trained medical practitioners and MDT or practice representatives to be released to contribute to the increased mentoring and assessment requirements proposed. Cementing external moderation as a requirement of all programmes is a strength. We agree with ensuring the Council has final responsibility for registration. There could be tension between the student and educational provider and this addition would distance any conflicts and also ensure NCNZ were ultimately making the final judgement. At the basis of this change is the need to have a structured NP programme that supports both the student and provides clear direction to the supporting clinicians and educators. We feel this needs to come from NC in a similar way that MC controls the education and registration of doctors. There needs to be clarity around the expectations and the level of practice for candidates to progress into the NP role, including recognition of this from employers that the RN role and NP roles differ significantly.
Q8: Do you support the candidate also submitting a portfolio of learning to the Council?

Yes,

Please give your reasons

This step is favoured as it ought to provide a visible measure of consistency and rigour that every candidate must undergo. We strongly recommend that the NCNZ assessor contacts prescribing referees personally for the feedback on the applicants suitability and competence to practice as an NP. The portfolio should rightly include case studies, letters of support, academic transcript, evidence of practice hours, professional development record and activities and CV. NPs who contributed to our submission believe it is essential that the NCNZ retains oversight of the final step of the NP registration process to ensure consistency. The delay of 20 days is negligible in regard to the current process of which takes 6+ months and should not be a barrier to their involvement.
**Q9: Do you support the assessment methods outlined in 8.4 and 8.10 of the draft education programme standards?**

<table>
<thead>
<tr>
<th>Assessment Method</th>
<th>Support</th>
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<tbody>
<tr>
<td>a. a portfolio of learning and clinical log of practice experience</td>
<td>Yes</td>
</tr>
<tr>
<td>b. simulated scenario based assessment</td>
<td>Yes</td>
</tr>
<tr>
<td>c. viva voce clinical assessment</td>
<td>Yes</td>
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<tr>
<td>d. observation in clinical practice settings.</td>
<td>Yes</td>
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</tbody>
</table>

Please give your reasons

Yes, we support all listed elements. This will provide a method of triangulation from a variety of points in time and methods of assessment to enable the NP student to demonstrate competence to practice. Developing and enacting rigorous, valid and suitable assessments for a range of populations eg, 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 compelling 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.
Q10: Do you support nurse practitioners as the clinical teaching staff for each student’s clinical experience?

Yes,

Please give your reasons
We support this in the first instance and where practicable, and support the caveat that where necessary the mentor can be a ‘vocationally qualified medical doctor’ (draft Programme standard 9.3). The use of Medical Practitioners poses a challenge as they gain recompense for medical students but not NPs. Currently limited opportunities exist for NP students to work alongside practising NPs in many areas of NZ and practice settings, and to make this provision feasible financially health provider support will need to be guaranteed. As NP clinicians and educators we often see situations in which potential NP candidates and their employers and/or clinical leaders do not fully understand the true scope of advanced practice and confusions continue around CNS and NP clinical roles and competency. Oversight and guidance from practising NPs will help to ensure NP candidates develop their practice into the NP scope.

Q11: Do you support the standards for the nurse practitioner practicum outlined in section 9 of the draft education programme standards?

Yes,

Please give your reasons
We support the standards as listed. As noted earlier, 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. We also query the sufficient availability throughout the country, of suitably qualified NPs as stated in 2.3 to contribute to the programmes.
Q12: Do you support the draft education programme standards?

Yes,
Please give your reasons
A significant element of preparedness for autonomous, independent practice in extended nursing roles is the supernumerary opportunities outlined in these standards. 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. The clinical leadership and clinical supervision roles for the body of NPs in NZ in supporting programmes and new graduates is clearly articulated, and thus NPs as a group will need employer/organisational recognition and support in fulfilling these roles. We agree the support for release time to enable NP students to be supernumary and the cost associated with having a student in placement will need to be met somehow. Currently financial support goes to DHBs (via HWFNZ), ensuring this funding follows the student and is allocated to their mentors will be critical. In theory increased utilisation and involvement of healthcare providers is most beneficial. However, in practice time and resourcing are issues, particularly in the private sector. At present this is undertaken through goodwill. Within large institutions such as secondary care the increased cost/expense is more easily absorbed and it is part of their contracts to actively be involved in teaching.

Q13: Any other comments related to the draft education programme standards?

The 300 hours need to be protected NP intern hours rather than RN hours- there is a significant difference in clinical expertise between the two different scopes (RN & NP). There needs to be a modelling (of sorts) of the medical training such as TI placements and then GP registrar placements with ongoing review of practice and summative assessments, learning seminars appropriate to scope etc. The Medical Schools have been doing this for years- we need to learn from them. Additionally, 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. The NP pathway is currently poorly funded which is in marked contrast to the medical degree.
### Q14: Do you agree that the draft competencies for nurse practitioners describe the knowledge and skills required of new nurse practitioners?

Yes,

Please give your reasons

These competencies do describe the knowledge and skill required however these are worded significantly differently from the current NP competencies without the background provided in the document as to why such changes have been proposed, concern was expressed by contributors that the Australian NP competencies are largely posed and without wide and timely discussion within the sector. 5.2 & 11.2 We query why aged care has been specified as not all NPs will work in this area, suggest health and disability are inclusive. Could be more generic to capture the differing areas NPs work and hence their consultation and referral to agencies is entirely reflective of this. 6.7 This requires rewording. Non pharmacological strategies should be discussed in their own right. It’s unclear if this related specifically to antimicrobials. Is this section specifically referring to antimicrobial stewardship? The judicious use of antibiotics? Unsure why this would be specifically mentioned as one classification of medication as there are many other instances where each class requires certain considerations. A generic approach would be more beneficial. 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 7.4 The wording here should be reflective of the differing input NPs have in regard to admission/discharge. 10.6 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. 11.2 This again lists elements inclusive of ‘disability and aged care policy’ unsure why this is listed as this may not be relevant to all NPs. 11.4 Advanced knowledge of Maori health and working in partnership with local iwi to contribute to improvements in health outcomes may be difficult to achieve in some settings.

### Q15: Do you agree that the draft competencies provide enough detail to guide education requirements and student assessment?

Yes,

Please give your reasons

The competencies are clearly articulated, and provide students and the public comprehensively and therefore give confidence in the scope of NP practice. See comments above.
**Q16:** Do you support newly registered nurse practitioners practising under supervision for one year?  

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<td>Please give your reasons</td>
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<td>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).</td>
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**Q17:** Any other comments related to the proposed draft competencies for nurse practitioners or the proposal for new nurse practitioners to be supervised for one year  

| Respondent skipped this question |