Submission to the Nursing Council of New Zealand
December 2015

Submission by the Graduate School of Nursing Midwifery & Health, Victoria University of Wellington.

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Thank you for the opportunity to make a submission on the education standards and competencies for the nurse practitioner scope of practice.

As a provider of postgraduate education for Nurse Practitioners candidates, the Graduate School is qualified and interested in the proposed changes. The submission has been collated by staff who teach in the Masters of Nursing Science. Staff include two part time nurse practitioners (one with a focus on youth health and one with a focus on long term conditions) and registered nurses with Masters and doctorates. The Masters includes an approved pathway for those interested in applying for Nurse Practitioners registration.

The submission is in two parts, answers to some of the specific consultation questions, and then comments on each of the standards listed in Appendix 2 of the consultation document. The submission mainly focuses on areas where we have a declared position on the proposed changes.

Part 1 - Consultation questions
4. At this point in time we do not give permission for this submission to be published on-line. We will however review this decision should a request be made.

5. We give permission for the Graduate School of Nursing, Midwifery & Health, Victoria University of Wellington name to be published.

6. Standards for consistent student assessment - We do not support Option 1 as outlined on page 6-7 and comment in part 2 on each of the assessment options in Standard 8. 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.
We do support the inclusion of portfolio development and preparation within an academic programme. However, there is a risk to public safety without an independent evaluation of a NP candidate’s competency in a real time situations.

The New Zealand national examinations for registered nurses ensure comparability across education providers and parity in student performance. We believe a similar national process should be maintained for all scopes of practice. At present this independent assessment is ensured by the Viva Voce examination.

7. 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. External moderation by other education providers could eliminate some conflict, but as education providers already have established alliances with each other, consistent standards may not be met. We do not support the council setting the standard for assessments, as this is the responsibility of the education providers.

8. Yes we support inclusion of a portfolio.

9. As indicated in Part 2 point 8 below we have some reservations regarding the assessments as presently described.

10. No we do not support nurse practitioners as the clinical teaching staff for each student’s clinical experience. However, we consider that this should occur where possible. See Part 2 point 9.

11 - We consider that this negotiation should be led by the candidate and their employer.

12. - We support some standards but would like modifications to others. Details provided in Part 2.

13. Specific comments on draft education standards are covered in the Part 2.

14. Yes with reservations. We feel that they go beyond the scope of a new nurse practitioner. For example, achieving 11.5 is unrealistic as this skill takes time to develop and consolidate. Similarly 11.6 comes with time and experience. Overall there are too many competencies and as they are stated they are more reflective of a job description and they are repetitive in nature.

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.
15. Yes, the competencies provide a good framework for guiding curriculum development and programme content.

16. Yes, provided it is indirect clinical supervision. Further clarification on cost, minimum hours and supervisor qualifications is required.

17. We support many of the proposed changes but consider that they will provide considerable more work and responsibility for nurse practitioner candidates, existing nurse practitioners, health service providers, clinical mentors and education providers. Such a shift in role and responsibility would require different funding arrangements take time to settle.

Part 2 - Specific standards
1. The Education provider - We support what is proposed here.

2. Academic and clinical teaching staff - We support the recommended standards for academic and clinical staff with the exception of 2.3 and 2.10.
   2.3 - 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.
   2.10 - We agree that Masters need to be coordinated, but consider the Nursing Council of New Zealand needs to modify the language to say "the person with the responsibility to coordinate the masters..." as using the word coordinator could be confusing. This confusion arises because the terminology in some education providers, for example Victoria has academic roles such as Course Coordinators, and it is the Head of School who has the authority and responsibility for decision making. We also consider it is important to identify and extend students who are excelling.

3. Entry requirements to the master's programme - We agree in principle with these standards, but would like 3.3 and 3.5 revised.
   3.3 - 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 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.
   3.5 - The wording needs to be clearer. For example it should reflect "specific requirements to be met for right of entry...."
4. **Entry requirement for nurse practitioner practicum** – We support these requirements.

5. **Credit recognition** – We support the cross crediting requirements, with the exception of 5.9.
   5.9 The wording needs to be clearer and stipulate the specific timeframe the Nursing Council considers reasonable. This will avoid education institutions having different interpretations. In the past, Victoria has declined to cross-credit in papers because of the time lapse since completion, only to find other institutions accept these qualifications.

6. **Programme structure and curriculum** – We support the structure and curriculum but recommend 6.4 be modified.
   6.4. Demonstrating partnership needs to concern not only an Advisory Committee but also ongoing consultation and dialogue.

7. **Programme content** – Not for consultation

8. **Student assessment** – We partially support the changes proposed regarding student assessment. We have particular concerns regarding 8.4, 8.9 and 8.10.
   8.4. We do not consider that these proposed assessments will entirely ameliorate conflict of interests, but they do provide a range of measures that allow for some independent assessment of competence.
   A. **a portfolio of learning and clinical log of practice experience** - We agree that education institutions can undertake the responsibility of assessing portfolios.
   B. **simulated scenario based assessment** – Patient scenarios are widely used in academic nursing programmes. Given that the consultation document (page 6) states that an OSCE approach is too costly and that they could only be held once a year we wonder whether the Nursing Council is using the terms OSCE and simulated scenarios interchangeably. It is unclear at what point in a programme this assessment would take place.
   C. **viva voce clinical assessment** - 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.
   D. **observation in clinical practice settings** - should not only be an approach to assessment, but should also be for learning education purposes. We consider there would be issues managing this type of assessment, unless the report from the mentor concerning meeting supervised clinical time would meet this requirement. This report would need to be part of the portfolio.

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.

8.10. As with earlier comments we consider that this is not the role of the academic institution. This assumes the acceptance of 'Option 1'. Assessments with in 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.

9. The nurse practitioner practicum – We partially support the proposal regarding the nurse practitioner practicum.

9.2 An employer of a student has the key role in identifying work place practicum mentors and experiences and a signed agreement about this should be given to the education provider. It is education providers and mentors responsibility to work with the student to identify areas for their development to ensure their individual programme is comprehensive.

9.3 We consider the need to have a nurse practitioner mentor may pose difficulties for nurses in some rural areas as there may not be anyone geographically or clinically available. Proving this mentoring would also impact on nurse practitioners own workplaces, and some back fill would be required to support this. There is a need to clarify in either guidelines or the standards whether nurse practitioners who are academics or clinical teaching staff are able to mentor students in their tertiary institutions if the student is studying in their area of practice.

9.5 We consider this is essential.

9.6 We consider this is essential.

9.12 The implication that the student, clinical mentor and academic mentor come together at the beginning the placement (earlier standards say two placements) may not always be feasible or affordable. We do however support that the learning goals are agreed by all parties.

9.13 Understandings of what is timely and specific feedback are open to interpretations.

9.14 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.
9.15 We note there is no mention here regarding authorisation to prescribe. We recommend that students be required to provide an additional document signed by the clinical mentor that confirms/attests to the candidates' ability to safely prescribe.

9.16. 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. 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. The suitability of clinical placements is assessed against the Nursing Council education programme standards. 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. We consider that the current funding to education providers would not be sufficient to implement the array of formative and summative assessments required. 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.

10. Programme evaluation and quality. We support the expectations regarding evaluation and quality with the exception of 10.1.

10.1 There needs to be clarification as to who will evaluate the education providers success or otherwise. Are the education providers going to evaluate themselves? This is another source of conflict of interest. Having students achieve registration is not sufficient own its own, reviewing public safety and performance over time is also required.