

Report on the review of the *Education programme standards for the registered nurse scope of practice*

August 2010

Executive Summary

In 2008 The Council requested that the *Education programme standards for the registered nurse scope of practice* be reviewed to ensure that their currency and efficacy in preparing safe and competent new graduate registered nurses. A comprehensive consultation process was initially undertaken within the sector. A draft set of standards were developed and these were circulated and available for consultation on the Council website during May and June 2010. The final *Education programme standards for the registered nurse scope of practice* standards were approved by the Council in July 2010.

Introduction

Under Section 12 of the Health Practitioners Competence Assurance Act 2003 ('the Act') the Council is required to prescribe, accredit and monitor the qualifications for each scope of practice prescribed under Section 11 of the Act. In 2008 The Council requested that the *Education programme standards for the registered nurse scope of practice* be reviewed to ensure they continued to prepare graduates nurses who were safe and competent to care for the public of New Zealand.

The last comprehensive review of the *Education programme standards for the registered nurse scope of practice* by Council had occurred in 2004 in response to the implementation of the Act.

First round of consultation

The first round of consultation involved focus group interviews either using the programme standards as a framework or a questionnaire. The questionnaire was trialled through the College of Mental Health Nurses website. The questionnaire consisted of five questions:

- what skills and knowledge do you think new graduates have (are good at) when they begin work?
- what skills and knowledge do you think new graduates do not have when they begin work?
- what changes have occurred in the clinical context over the last five years that should be considered in the undergraduate programme?
- how do you think the clinical area should support learning?
- what do you think needs to change in the undergraduate programme in relation to the structure and delivery of the programme and clinical supervision of students?

When consulting with education staff the programme standards were used as a framework.

There were five main information sources for the first round of consultation. In total over 500 individuals were interviewed:

- key nursing groups e.g. professional organisations, Directors of Nursing in DHBs and private organisations, national education groups (approximately 70 staff)
- four DHB regions including in patient facilities, primary health providers, mental health and aged care providers (approximately 460 staff)
- education providers related to the four DHB areas (approximately 50 staff)
- web based consultation (approximately 70 staff)
- other sources such as annual reports from nursing schools.

Consultation findings

The feedback received in the first round of consultation was analysed to identify the main points and themes. The summary for each group is appended (Appendix 1).

The following themes were commonly identified by groups and it was this feedback that was used as the base to develop the draft *Education programme standards for the registered nurse scope of practice*.

New graduates skill and knowledge base

The first question explored the skills and knowledge that new graduates had when they entered practice. A common finding was that the graduates had good questioning skills in practice and were good at asking questions and looking for answers. Some used the term 'inquiring minds' which was positive feedback as this is an expectation of bachelor degree preparation. Enthusiastic, keen and willing to learn were common descriptors of the graduates. Graduates also had good communication and cultural safety skills.

The second question explored the skills and knowledge that new graduates did not have when they entered practice. This question sought to identify what may need to be included or improved in the undergraduate programme to meet competence for practice.

New graduates lack client assessment and clinical decision making skills

The graduates' lack of ability and skill in client assessment and clinical decision making was a major theme that came through the consultation. The skill level varied across students with only some schools producing students who were confident and competent in these skills. This included clinical decision making and being able to identify when a client's condition had changed and then acting on the information. Being able to prioritise care was a commonly used term. This was reported by acute and primary health care staff. Staff in mental health also said that graduates ability to undertake a comprehensive mental health assessment and decision making to take appropriate

action needed to improve. It was acknowledged that clinical staff were not always good role models in this skill area but the feedback strongly identified that graduate skill level needed to improve.

Reality of shift work

The need to be more aware of the reality and the demands of constant shift work was a common theme. Many considered that new graduates were inadequately prepared for the reality of shift work and struggled to cope. While some suggested students undertake all shifts, including weekend shifts, during the programme this was recognised by most as a difficult area to address due to the student status of the students.

Pharmacology and medicine management in programme

Clinically based staff considered that pharmacology knowledge and the nursing role in medicine management was increasingly relevant to everyday practice and this area should be increased in the curriculum.

Other skills and knowledge lacking

Clinical groups considered that the following should be included in the curriculum:

- direction and delegation skills especially with second level nurses and unregulated workers
- team work - being able to work as a contributing team member such as being aware of their role and others. This related to the nursing team and the multidisciplinary health care team
- more focus on primary health care and less dominance on acute care in the curriculum.

Changes in the clinical context

Changes included the move to team nursing and the multidisciplinary team approach to care. Other changes commonly identified were higher acuity and increased co-morbidities of clients in primary and secondary care; increased complexity of care and treatments; a greater skill mix in staff and a move to team based nursing models. The changes were often related to a need to increase specific skills and knowledge e.g. client assessment skills; prioritising actions; team work; pharmacology.

Registered nurse supervision in clinical placements

This question was considered important as learning in clinical placement time is so central to the programme. A dominant theme was the need for a registered nurse/preceptor who was enthusiastic, good role model and trained to teach and assess the students and who was supported in their role. The feedback strongly reflected that registered nurses should be involved in teaching nurses. There needed to be consistency in contact between the nurse and student. A number of groups asked for more involvement of the registered nurses in the assessment of students. Many argued that the preceptor model was no longer viable and many expressed support for the Dedicated Education Unit model.

Question 5 explored the changes that participants considered needed to be made to the programme structure and delivery and also the supervision of the students.

Increase clinical placement hours

The topic of clinical placement time was of wide interest and common themes were to increase clinical placement hours and have longer clinical placements in an area. There was no call to reduce clinical placement hours.

Better collaboration

The need for increased communication and collaboration between education and practice areas was a strong theme. Clinical staff said they worked with different levels of students from a number of schools, often at the same time, and the information provided by schools was often minimal. They asked for much clearer information around the expected learning outcomes and assessment expectations to guide the registered nurses and the students. Some said that input from the education staff for students was minimal in the clinical context and asked for more consistency.

Up to date teaching staff

Another strong theme was the need for all education staff to have current knowledge and skills of the specialty area they were teaching. This related to staff teaching theory and staff, including casual or part time staff, teaching in the clinical context.

Standardisation between programmes

The need for greater consistency and some standardisation between schools and the programmes was a common theme and some called for a national curriculum. There was concern that schools had different academic standards and expectations in specific graduate outcomes e.g. client assessment and decision making skills previously mentioned. More consistency would help nurses teaching students and enable students to transfer between schools more easily.

Education staff feedback

The consultation with the education staff generated some commonalities with the clinical nursing groups but also showed some differences.

Retain 1100 clinical placement hours

There should be no reduction in clinical hours. The education groups asked for the standards to be clearer around what 'clinical or practice hours' meant and challenged the need for the standards to identify clinical placement areas and more flexibility was requested.

The educators generally agreed that simulated hours should not be included in the 1100 clinical practice hours. Simulated learning had increased, especially with blended learning delivery of programmes, and some schools have very sophisticated simulation learning laboratories.

Involve registered nurses in assessment

The supervision of students in clinical was an ongoing issue with the preceptor model no longer working and the Dedicated Education Unit model working well in some areas. Registered nurse supervision was variable. The educators agreed clinical staff must be involved in student assessment and while the education staff should retain overall responsibility the registered nurses must co-sign with education staff. Some suggested that a national clinical assessment tool be developed to increase reliability and to also help the involvement of clinical staff. Again this supported the clinical nursing group feedback.

The education staff acknowledged that while some clinical placements may not be good learning environments for students the shortage of clinical placements meant that they have to be used and it was difficult to give honest feedback as education was dependant upon clinical placements for the programme.

Reduce variability in academic standards

The educators agreed with the clinical nursing groups that there was variability between schools in relation to the learning expectations at the various stages of the programme and the skill and knowledge level of the graduate. While the educators did not support a national curriculum they suggested greater clarity in the standards to identify the academic levels expected within the programme and the expected skill and knowledge of the graduate. The content list included in the standards was not useful.

The educators supported the clinical nursing groups call for the curriculum to increase content on team work, direction and delegation; microbiology and pharmacology and medication management to link with any changes in the registered nurse role.

Standards to support programme leaders

One of the most dominant themes was that the programme standards, especially standard 1, should support schools to maintain the quality and robustness of their programme. They felt that the business model of education, including financial restraints, sometimes overrode the school's decision making on programme development and decisions on student progress. They asked that a number of standards were strengthened to help schools defend their position and decision making with senior institute managers.

Update staff requirements

Staffing was also a common theme and there was a wide range of staffing models utilised across schools. The education staff agreed that all staff should be well prepared for their teaching role and that standard 4 should be updated and relate to all staff including staff employed to cover clinical teaching.

Programme Reports

Schools are required to submit an annual report to the Council. Ten annual reports for 2008 were reviewed for this project. These reports supported the common themes identified by the education group.

Draft standards and consultation round 2

Based on the findings of the first round of consultation a set of draft standards was prepared. The draft standards were accepted by the Council with some minor changes and prepared for consultation.

A web based consultation process was then undertaken on the draft standards. The standards were posted on the Council website for a six week consultation period ending on 30 April 2010.

Twenty nine submissions were received from the following groups:

Type of submitter	Number
Individual nurse	3
District Health Board	2
Professional organisations	7
Educational Institution	11
Government Department	1
Nurse educator groups	3
Private hospitals	2
Total	29

Almost half of the submissions (13) were received from educational institutes/individuals and they often reflected the same viewpoints and comments. The submissions from the DHBs and clinically based organisations/agencies (8) were more disparate and included a wider range of comments.

The feedback was analysed. Any recommendations for changes in the draft standards were considered in relation to the findings of the first round of consultation undertaken to prepare the draft standards. This step was critical as this first round of consultation had been comprehensive and involved over 500 individuals and wide range of nursing groups across practice, education, management and professional contexts.

Summary of findings and action

The feedback is appended in a more detailed format in relation to each of the draft standards and shows the weight of the feedback and any resultant changes to the draft standards (Appendix 2).

Overall the feedback was very positive and many submitters stated their support for the draft standards. Some commented that the draft standards had greater clarity than previously and reflected the current education and practice context. Several submitters pointed out that a number of policies for the undergraduate programme are contained in the *Handbook for nursing departments offering programmes leading to registration as a registered nurse (November 2007)*. The handbook has been reviewed and where possible the pertinent information has been integrated into the current draft standards to promote consistency of information.

Feedback on Standard 1: agreed with increased head of programme responsibilities; this feedback supported the findings of the first round of consultation.

Standard 2 generated the most comment : main issues centred on how to describe the content of the curriculum and the areas that students were required to undertake for clinical experience hours; the inclusion of national health priorities and current health care trends and health practices would keep programme current. This feedback supported the findings of the first round of consultation.

There was a lot of support for the identification of some specific graduate outcomes in Standard 2; disliked the link to PDRP as this was an employer based programme.

The content of the curriculum has been reframed using the four domains of competence for the registered nurse scope of practice (Competencies for registered nurses, December 07) as a framework. Maori health and nursing theory/ concepts has been added in response to five submitters from across education, practice and professional groups.

Clinical placements and clinical hour requirement: 1100 clinical experience hours, exclusive of simulation hours, was supported by all except one submitter. This feedback supported the findings of the first round of consultation. The clinical placement list was more contentious. The clinical placement requirements have been rewritten using a lifespan and health care context approach. Several education providers challenged the 360 hour requirement for the final clinical placement and requested 300 hours as this suited the programme structure. The criterion was left unchanged.

The opportunity for students to 'specialise' within the programme (criterion 2.5) was seen as conflicting with the comprehensive expectations of the programme. This was not the intention of the criterion and as it was being misinterpreted it has been deleted.

Good support for Standard 3: the standard reflected the current staffing models in the education sector. This feedback supported the findings of the first round of consultation.

Almost half the education submitters suggested that Standard 4 included a criterion that required students to have access to simulated learning facilities to ensure safety in the clinical experience. As this was focussed on safety of students and clients and also reflected current teaching modes a criterion has been added in this standard. A definition of simulation has been included in the glossary.

Standard 5: many education submitters said the need for each student to have an individual learning plan was impractical and unnecessary as every student had to meet Council requirements and this was monitored by school processes. The criterion was therefore deleted. The meaning of 'supervision' in clinical was challenged and this has now been defined in the glossary.

There was minimal feedback in relation to Standard 6. Many education submitters said a registered nurse with a current practicing certificate should be on any appeal panels. Currently in some schools non-nurses have been making decisions on appeals and this may pose some risk to public safety. Therefore this requirement has been added.

Standards approved

Based on the feedback some changes were made to the draft standards.

The final *Education programme standards for the registered nurse scope of practice* were submitted to Council and approved in July 2010.

Appendix 1 Summary of main themes from consultation round 1

Appendix 2 Summary of findings, and action, from consultation round 2.

Summary of Trends – BN Standards Project Consultation January 2010

Skills and knowledge new graduates have	Skills and knowledge new graduates do not have	Changes in clinical context that should be considered	How clinical area should support student learning	What needs to change re structure, delivery of programme & supervision of students
Professional organisations 4				
Questioning and finding answers	Team work Direction & delegation Unprepared for reality of shift work Increase assessment skills and clinical decision making especially around changes in pt condition	Higher acuity More complex health care context e.g. more agencies Skill mix including unregulated care givers DEUs are good Preceptors are trained to teach	Preceptors must be trained to teach & most are Preceptors must have good assessment and communication skills so they can role model & teach students	More clinical hours Work all shifts More preceptor support from education/school staff Teachers must have current knowledge and skills of their specialty area
Directors of Nursing; Nurse advisors ; senior management approx 40				
Questioning and finding answers Patient assessment skills and clinical decision making (though varies across schools and should be strong in this area) Communication skills Keen and enthusiastic Very positive re new grad programme	Direction and delegation especially when working with second level workers Patient assessment skills and clinical decision making – need to be at highest level to pick up changes in pts condition (primary care as well as acute care)	Unregulated workforce Team Nursing higher acuity Increased co-morbidities Increased pressure, decreased time Multicultural workforce	Good RNs are key to good learning Need higher visibility of education staff Preceptor model not always working due to skill mix, part time, casual staff. DEU model working well.	(may have several schools, several levels of students – have to have clarity) Simulation must not replace clinical hours More clinical time More collaboration between education and clinical Clearer guidelines for clinical learning and

	Team work		Clearer documentation from schools (learning needs, assessment information)	assessment Preceptor model not working More consistency across schools – not just in clinical learning expectations but also academic standards of students) Clinical staff must be involved in student assessment Longer clinical placements Need increased flexibility in schools – timetabling, semesters, shifts etc More primary health care focus
Students approx 30				
		Team Nursing Less clinical placements available	Supportive preceptors critical to learning Access to computers Consistency of preceptors DEUs good Need support for preceptors from education staff	Supervision of students – often minimal Consistent tutor supervision Afternoon shifts not good learning ; no night shifts – v poor learning National curriculum – get similar standards across schools; allow students to transfer with more ease Flexibility to meet student issues e.g. child

				care
New graduates approx 150				
<p>Communication skills – feel very comfortable</p> <p>Pt assessment skills – varied across students, 2 aspects - were not taught adequately in school or they were not consolidated in clinical</p> <p>Cultural safety</p> <p>Questioning skills</p> <p>Enthusiastic</p> <p>Strong support for new grad programme</p>	<p>Pharmacology knowledge</p> <p>Direction and delegation</p> <p>More child health and maternity</p>	<p>Higher acuity</p> <p>Team nursing</p> <p>Part time workforce; inconsistency of preceptors</p>	<p>Good preceptor – interested, trained to teach, interested, knows learning expectations</p> <p>A single reference point needed for the student</p> <p>Consistency of preceptors</p>	<p>Must be taught by staff who are clinically current with good current knowledge in spec area – applies in theory and clinical teaching</p> <p>More clinical placement time; longer clinical placements especially last one.</p> <p>Standardize curriculum</p> <p>Closer collaboration and communication between education and practice</p> <p>Clear guidelines of what expected to learn in clinical – guide students, clinical staff and clinical teachers</p> <p>Students to be involved in programme evaluation</p> <p>NetP programme great</p>
New Graduate & PDRP co-coordinators approx 50				
<p>Questioning</p> <p>Critical thinking about practice</p> <p>Confident and competent, enthusiastic</p> <p>Assessment skills and clinical decision making</p>	<p>Direction and delegation</p> <p>Evaluation of care and practice</p> <p>Need to have a logical, systematic clinical decision making model in their heads and be</p>	<p>Multicultural health care team</p> <p>Some cultures not used to preceptor role and there are cultural clashes</p> <p>Skill mix</p>	<p>Need to value preceptors</p> <p>Positive RNs as role models</p> <p>Need very good collaboration between education and clinical</p>	<p>Better collaboration & communication between education and practice; better preparation of clinical staff and clinical areas (so many different levels of students,</p>

– as above, variable skills	able to apply Prioritizing care; assessing changes in pts health status and knowing what to do Reality of shift work	Team nursing is the reality now Higher pt acuity	Train preceptors better for teaching role	schools etc) Involve clinical staff more in student assessment and take more notice of their feedback More consistencies between education providers and programmes
Prof Org 4				
Accessing information and questioning skills Communication and people skills Keen, enthusiastic Good basic knowledge base	Need better pt assessment skills and recognizing changes in health status and how to act Prioritizing of care Team work Direction and delegation Time management Reality of shift work and being a RN Need more primary health care focus in curriculum More pharmacology	Increased acuity Increased complexity of pts and context Skill mix Team approach to care Aging workforce	More tutor input All need good preceptors; trained preceptors Support for preceptors DEUs are working well	Include RNs in student assessment Some standardization in documentation and expectations between schools and programme Better collaboration between education and practice No reduction in clinical hours or increase them Longer clinical placements Shift work More primary health care and more mental health – curriculum is predominantly medical model Teaching staff with expertise

College of mental health nurses website (50) new graduate mental health nurses (approx40) Clinical staff in mental health (7)				
<p>Communication skills, listening to pts Asking questions, questioning practice, researching answers Inquiring minds Cultural safety Enthusiastic and willing to learn Lesser number – working in a team</p>	<p>Prioritizing care Dealing with complex situations and seeing & understanding bigger picture e.g. unwell clients, changing situations, challenging behaviours, risk assessment Communication with clients – small number Confidence in own knowledge and skill</p>	<p>Higher acuity, more complex pts, more co-morbidities More community based care, higher acuity in community Focus on recovery model</p>	<p>Strong feedback that students should be well supported in clinical and have a right to be there and have positive learning experiences Very good supervision by preceptor/RN mentor, who is enthusiastic, teaches and involves the student. Must be taught by 'expert' clinician role models Closer collaboration between education and practice – expectations of learning are understood by all with clear guidelines More contact between education and clinical staff to discuss student progress Time for RNs to work with students</p>	<p>Ensure they work all shifts including w/end work to experience reality of shift work Increase clinical hours in mental health areas (no responses suggested reduction in mental health clinical hours) Ensure mental health content is taught by teachers who are up to date with current treatments & care (too many are not). Longer clinical placements in one area Better communication and collaboration between education & practice Good preceptorship; time allowance for preceptors Clinical teachers who know the curriculum and learning expectations (including what is taught in theory time) Active & visible education staff – involved with student &</p>

				clinical staff National curriculum
College board 7				
<p>All must have:</p> <p>Thorough documentation skills</p> <p>Talking to family Family assessment Group skills and teaching pt skills Mental health practice knowledge Te Reo</p>	<p>Mental health assessment (more specific than BATOMI) Must be able to demonstrate mental health assess. Decide in interventions after assessment communicate Must be able to do a good comprehensive assessment and then use that information and act upon it – decide what to do & the interventions Risk assessment</p>		<p>Student assessment should be joint process between preceptor & teacher – must be formal & RN should be included in written sign off</p> <p>St assessment forms – language often difficult in educational written info, very generic & needs to be more focussed - skill based assessments very useful to guide learning & assessment of students & can show different expectations at different levels</p> <p>Schools should connect with research centres & practice centres e.g. Werry Centre to keep curricula up to date curriculum & latest practice etc</p>	<p>Increase the theory and clinical component for mental health nursing. Ensure competency in mental health nursing. Some curriculums are not current e.g. intellectual disability; alcohol & drug issues; comprehensive approach. Recovery model must underpin all teaching Too many teachers are generalist and need to be specialist in mental health. Has to be collaborative between schools and clinical. Clinical placements are variable and need good teachers to teach in them Teachers should be role models, seen in clinical more. Joint appointments work well but not all schools use them – all agreed & wanted joint appointments used in</p>

				their facility. Some staff (especially clinical) are scared to fail students
Clinical staff – nurse managers, registered nurses approx 250				
Communication skills Confident and enthusiastic Good questioning skills Know how to access information	Patient assessment skills and clinical decision making around recognizing pt changes and what to do (includes prioritization of care) Critical thinking – see superficial learning Making the transition from student to RN/employees and demands of shift work – reality of shift work Team work Risk management	Higher acuity of clients Team approach to care; multidisciplinary team work IT changes Increasing demands on RNs for preceptoring constantly – different levels of students Part time work force Aging workforce International workforce	DEU model works well RNs must be involved in teaching and assessment RN role to role model for students Clinical staff need knowledge of learning expectations Trained preceptors	Child health placements needed in curriculum Do not reduce clinical hours any more Longer clinical placements especially final one NetP programme positive Collaboration with clinical vital Increase lecturer contact time with student & RN Up to date lecturers More joint appointments More primary health care focus in curriculum

Education Staff 87**Standard 1**

Strengthen standard to support schools to exit 'unsafe' students; enable standards to be used to defend schools position
– very strong

Integrate standards for accreditation of schools into these standards

1.4 and 1.5 must be clearer as Education Act overrides. The business model of education prevails over Council requirements

Standard 2

Require education base/philosophy for each programme so that programme is underpinned by education theory
No national curriculum but need to enable easier transferability for students between schools

Standard 3

There is huge variability across schools in relation to depth, breath of expectations and knowledge and skill of graduates.

Makes it very difficult for clinical areas and transferring of students

Improve standards and criteria to show the academic level expected; Better curriculum descriptors would show the expectations in knowledge and skill development and application to practice

Identify the academic level expected in the content list – be more specific

Require matrix to show course outcomes, evaluation, programme to RN competencies

Criteria around pharmacology must reflect any change in RN role in pharmacology

New content: team work; direction and delegation; microbiology

High competition in Auckland for clinical places

Increase use of simulation but use of simulation as clinical hours?? – Majority said no; few suggested as year 1 clinical hours only

Be very clear what 'practice hours' mean; want flexibility in practice hours

Is there a need to identify the practice areas?

Need to increase primary care focus – focus remains acute care

Preceptor model of clinical teaching very difficult due to part time staff etc; clinical placements problematic – access, competition, RN supervision variable.

Clinical hours most difficult in mental health, maternal and child health

Standard 4

Must have RN in decision making role in the programme/school

All staff including clinical lecturers need education preparation

Standards should cover all staff – theory and clinical

Some said Clinical staff do not need professional development plan or masters degree

DEU model works

Standard 5

This standard very important in current climate especially for smaller polytechnics

5.3 evaluation of clinical placements tricky as rely on them to provide placements

Standard 6

Bring up to date to reflect current teaching & learning concepts & methods

Allow students to specialize early e.g. mental health, primary health care

Standard 7

Collaboration between education and clinical is critical

Clinical staff must be involved in student assessment but find it difficult to articulate

Education must retain overall responsibility// co-sign with clinical staff

Promote a national clinical assessment form to improve reliability (especially for final semester students)

Standard 8

OK

**Feedback on *Draft Education programme standards for the registered nurse scope of practice*
June 2010**

Total of 29 submissions were received. Number of submitters noted in brackets as education, professional or clinical.

Standard and Criteria	Feedback (submission group)	Action : considered in relation to findings of initial consultation
<i>Standard One</i>		
Criterion 1.3	Some policies are also found in <i>Handbook for nursing departments... Council publication Nov 07</i> (education 3)	Action : considered and these policies integrated in final draft standards
Criterion 1.4; 1.5	Strong support for Head of School criterion and responsibilities (education 4; clinical 1; professional 1)	No action. This strongly supported earlier consultation
Criterion 1.4	Add to head of school responsibilities re student progress, <i>including academic and professional misconduct</i> , through the programme ...	Action: change made as this recognises the current context of learning and expectations around professional behaviour and boundaries
Criterion 1.4	2 submitters (professional 1; clinical 1) requested stronger entry criterion as concerned that all students taken into programmes may not meet Council registration requirements	Noted: entry criterion are set by educational institutes.
Criterion 1.9	this criterion needed clarification and rationale (education 9; professional 2)	No action: rationale is to enable possible stair-casing from EN to RN qualification in the future.
<i>Standard Two : this standard generated the most feedback</i>		
Criterion 2.5	Opportunity to 'specialise' in the programme is in conflict with comprehensive nature of the programme; all students should complete the same programme and meet the same requirements in order to gain comprehensive registration (professional 2; education 2; clinical 2)	Action : criterion deleted

<p>Criterion 2.6</p> <p>Feedback on content bullet points in 2.6</p>	<p>The majority supported 'national health priorities and current practice trends'</p> <p>Remove the list as not comprehensive and too prescriptive (education 11)</p> <p>A number suggested the RN competencies should define the content</p> <p>Include nursing theory/ concepts and Maori models of health (professional 3; education 1; clinical 1)</p>	<p>Action : retained with minor wording change only</p> <p>Action: new criterion using the RN domains of competence as a framework for the curriculum content with some additions to reflect the current context of nursing and health care</p> <p>Action: this has been addressed by more descriptors and reference to the relevant Council guideline in criteria 2.5</p>
<p>Criterion 2.7</p>	<p>Majority either stated or implied they agreed with the specific graduate expectations. Several suggested all the bullet point expectations should be at the graduate level.</p> <p>Many also offered comments on the terms used: Liked the link to PDRP (clinical 2) Disliked the link to PDRP as this was RN and employer based (education 8; practice 1). Some suggested <i>'demonstration at a new graduate level'</i></p>	<p>Action: criterion retained with some wording changes (reference to PDRP removed). All expectations now at a graduate level. This strongly supported earlier consultation</p>
<p>Criterion 2.9</p>	<p>Majority of all responders, except one education submitter, said simulation hours should not be included in the clinical experience hours</p>	<p>No action. This strongly supported earlier consultation.</p>
<p>Criterion 2.11</p>	<p>Many different responses here and this probably highlights the difficulties in accessing clinical placements in some areas: No list of clinical placements (education 1) Combine acute medical and surgical (clinical 2; education 3)</p>	<p>Action: requirements for clinical experience redrafted to include a lifespan approach and health care contexts</p>

	Keep lifespan approach (clinical 2; education 3) Add intellectual disability (professional 2)	
Criterion 2.12	Majority support for 1100 hours of clinical experience; 1500 hours (professional 1; clinical 1)	No change This strongly supported earlier consultation.
Criterion 2.13	Support for 360 hours (education 1; clinical 1; professional 1) Strong support from education for 300 hours maximum to fit in with 15 credit courses (education 8)	No change: extended final clinical experience strongly supported in earlier consultation
Standard 3 Majority supported the changes to this standard and said the criterion were clearer		
Criterion 3.3	Several said that clinical teaching staff must hold a minimum of an undergraduate degree or equivalent (education 5; practice 2)	Action: criterion amended
Standard 4 Most comments re language – very helpful. Main feedback re simulation & the term has been defined so as not to exclude those schools with limited high technology simulation equipment		
Criterion 4.1	Rewording offered by several education providers to increase clarity of meaning	Action : rewording accepted and criterion changed
	The inclusion of a criterion regarding the need for students to have access to simulation facilities to ensure safety prior to clinical experience (education 6)	Action: included as criterion 4.2 This reflects current teaching and learning methods and is focussed on client safety
Standard 5		
Criterion 5.4	Majority of education disliked the need for 'constant supervision by an RN in clinical' (education 9; clinical 1). Many suggested using the term <i>direction</i> as defined by the Council	Action: 'supervision' defined in the glossary
Criterion 5.5	The use of user-friendly was disliked by three responders (clinical 2; education 1)	Action: a strong theme in the original consultation from clinical staff was that they were often unsure of student learning and assessment requirements and they found the generic language used by education unhelpful to guide teaching. This criterion has been rewritten to try and capture this feedback.

Standard 6	The majority of education submitters suggested that the following should be added: <i>if there was a student appeal there must be a RN with a current PC on the appeal panel.</i> Other comments were wording changes	Action: criterion included. Decision making by non-nurses may pose a risk to public safety so criterion added. 6.6 Change <i>school of nursing</i> to <i>Head of Nursing</i> . The intent of this criterion was that the 'school' retained ultimate responsibility for student assessment so the intent is not changed.
Standard 7	Consistent feedback from the education sector with 10 submissions advocating for the removal of the state examination. This was supported by one clinical group. The education groups also consistently suggested that each individual graduate was required to sign a statutory declaration that they were fit for registration in the registered nurse scope of practice under Section 16 of the Act rather than the Head of School.	No action. Outside project brief. No action: outside the project brief. Requirements for entry to the register are determined by the Council under Section 16 of the Act.