Background document
Kōrero whakamuri
Hangarau

Registered nurse prescribing review
and
Nurse practitioner scope of practice review
including
Amendments to nursing education programme standards

September 2025

Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Contents |Ngā ihirangi

Background | Kōrero whakamuri

This document discusses the background to the registered nurse (RN) prescribing and nurse practitioner mātanga tapuhi (NP) scope of practice review, amendments to the nursing education programme standards, and how the proposed changes were developed. A shorter summary of the proposed changes and key elements for feedback is available on the consultation webpage *available here*.

New Zealand, and specifically the context for nursing regulation, is currently undergoing significant change. By setting standards and competencies, regulating accordingly, and monitoring their implementation, we guide how nurses learn and work. The standards and competencies we set must reflect the nature and requirements of nursing in New Zealand, now and into the future, and enable the growth of the domestic workforce where possible. We must also be able to quickly adapt to unforeseen developments. Through this, we foster public trust and confidence in the safety and competence of the nursing profession.

The NP scope of practice was approved by the Nursing Council in 2001 and has not been reviewed since. However, the associated education standards and competencies were last reviewed in 2017, with the removal of the restriction on NPs practising in a specific area of practice. It is now timely to review the NP scope of practice to reflect the evolving NP role. In addition, considering the NP scope alongside the newly developed and published enrolled nurse and registered nurse scopes of practice will ensure alignment and a coherent pathway to advanced nursing practice.

RN prescribing was last reviewed in 2016 alongside legislative changes. This consultation proposes a separate scope of practice for RN prescribers in preparation for the introduction of the planned Medical Products Bill.[1] A distinct and separate scope will provide greater clarity to the public and enable a coherent pathway between the registered nurse, NP prescriber, and NP scopes of practice.

1 *https://www.health.govt.nz/regulation-legislation/regulating-medicines-medical-devices-and-natural-health-products*

Part One: Registered nurse prescribing | Wāhanga tuatahi: Nēhi rēhita - tuku rongoā

A comprehensive literature review on RN prescribing is available *here*.

RN prescribing in New Zealand has evolved significantly since its introduction in 2011, beginning with designated prescribing for diabetes health nurses. Legislative developments, including revoking earlier regulations and establishing new frameworks in 2016, have expanded RN prescribing in primary health and specialty teams, and community settings. While small adjustments to the structure and function of nurse prescribing have occurred in the intervening period, no substantial review of RN prescribing has been undertaken to date.

While RN prescribing in New Zealand has been in place for more than 10 years, the number of registered nurse prescribers has been slow to increase. RN prescribing has been shown to be safe and effective, and there is now an opportunity to develop a clearer pathway and scope of practice to more fully embed RN prescribing in practice.

Under the Medicines Act 1981[2] (the Medicines Act), a designated prescriber is a health professional such as a registered nurse, pharmacist, or dietitian, who is authorised to prescribe any specified prescription medicines or any specified class or description of prescription medicines specified by the Director-General of Health. They must complete a relevant qualification, undertake relevant ongoing training, and prescribe in consultation with and under the supervision of an authorised prescriber. This compares to an authorised prescriber (such as an NP or medical practitioner) who can independently prescribe any medicine relevant to their scope of practice, does not require supervision, and has full prescribing rights under the Medicines Act.

All nurse practitioners are authorised prescribers, while registered nurse prescribers have completed advanced education and work in contexts that allow them some prescribing rights. Registered nurse prescribers fall into the groups described here.[3]

There are currently two levels of designated prescribing for registered nurses in New Zealand:[4]

1. **RN prescribing in primary health and specialty teams** – prescribe from a list of medicines for common and long-term conditions within a collaborative team setting so the nurse can consult a medical practitioner or NP if the patient's health concerns are more complex than their level of competence, experience, and education. They are required to complete a postgraduate diploma and practicum experience. The education pathway for RN prescribing in primary health and specialty teams is closely aligned[5] with and can be credited toward NP master's programmes.
2. **RN prescribing in community health** – practising in community health settings, can prescribe a *limited number of medicines* for minor ailments and illnesses in normally healthy people without significant health problems, following a work-based education programme in approved regions. They

2 *Medicines Act 1981*

3 *NCNZ (June, 2025) quarterly date report* (pg7)

4 *NCNZ website*

5 The postgraduate diploma for nurse prescribing includes three of the pre-requisite papers for the NP master's programme.

are expected to work in a collaborative team, use decision support tools, be familiar with current best practice information, and have the support of colleagues.

Additional pathways exist for nurses to supply medications such as emergency contraception, Hepatitis C medications, and vaccination authorisation.

Note, the RN prescribing in community health and other authorisations, including emergency contraception, Hepatitis C medicines and vaccination authorisation, are not part of this consultation process.

International nursing jurisdictions

Internationally, nurse prescribing models vary significantly, ranging from independent prescribing, where nurses assume full clinical responsibility (as seen in the UK), to collaborative or supplementary prescribing, which involves supervision or partnership with medical professionals. Some countries also allow prescribing under strict protocols or for administration-only scenarios. International comparisons can be found here.

Registered nurse prescribing workforce data

At the end of June 2025[6], there were 1,584 RNs with some form of prescribing rights (excluding NPs)[7]. This compares to 1,374 at the same time last year, an overall increase of 210 nurses or 15%. Of all registered nurse prescribers, 13% identify as Māori and 5% report a Pacific ethnicity.

Table 1: Nurses with prescribing rights by quarter (2024-2025)

Nurses with prescribing rights, by quarter	June 2024	Sept 2024	Dec 2024	March 2025	June 2025
RN prescriber - primary health and specialty teams	586	597	630	664	655
RN prescriber - community health	492	518	588	613	656
RN prescriber - diabetes	45	45	43	43	43
RN prescriber - emergency contraceptive pill	251	245	242	234	213
RN prescriber – Hepatitis C	-	9	14	17	17
Total	**1,374**	**1,414**	**1,517**	**1,571**	**1,584**

Registered nurse prescribers in primary health and specialty teams predominantly work in primary health care and practice nursing settings. Many other practice areas also reflect community work, for example, family planning/sexual health and aged care. The second largest individual practice area is medical. This is likely to reflect diabetes nurse prescribing practice where registered nurse prescribers have been present since 2011.

A review of the data shows:

- the number of registered nurse prescribers is increasing across all forms of RN prescribing (except diabetes – this area of prescribing was removed in 2017 when RN prescribing in primary health and specialty teams was introduced. There are some nurses that remain practising with this authorisation.
- most registered nurse prescribers are clinically very experienced prior to taking up prescribing education.

6 NCNZ. (2025). *Quarterly data report*

7 excluding authorised vaccinators who the Council does not regulate and does not keep statistics on.

- while there is a need to continue to support increasing numbers of Māori-registered nurse prescribers and Pacific-registered nurse prescribers, the numbers are proportionately higher than in the total nursing workforce.
- most registered nurse prescribers work in some type of community setting.

What are we proposing?

The new Medical Products Bill will require prescribing to be managed through scopes of practice which is the basis for this proposal.

We are proposing a new and separate scope of practice for designated RN prescribing in primary health and speciality teams that will enable RN prescribing across the life span and across a range of settings. Community nurse prescribing will remain within the registered nurse scope of practice with authorisation by the Council to prescribe some medicines within their area of practice and level of competence.

This proposed new RN prescribing scope of practice statement is intended to support a more optimal scope of practice that is based on the following by:

- being built on the platform of the registered nurse scope of practice
- requiring completion of a postgraduate diploma or equivalent, which develops advanced scientific knowledge including pathophysiology, pharmacotherapeutics, and advanced assessment and diagnostic reasoning skills, to safely prescribe
- a requirement to have the clinical knowledge to prescribe medications consistent with the nurse's education, assessed competence, and relevant legislative requirements
- a requirement to undertake comprehensive assessments, diagnose and prescribe within their area of practice and competence
- a requirement to work in collaborative teams, must have access to an experienced prescriber, and seek guidance when appropriate.

A summary of specific proposed changes can be found in our consultation document *here*.

Proposed registered nurse prescribing scope of practice statement

The registered nurse prescriber scope of practice is built on the platform of the registered nurse scope of practice. Registered nurse prescribers must meet the Nursing Council of New Zealand's regulatory and professional requirements.

Registered nurse prescribers are required to have a postgraduate diploma or equivalent qualification that develops advanced scientific knowledge, including pathophysiology, pharmacotherapeutics, and advanced assessment and diagnostic reasoning skills, to safely prescribe.

Registered nurse prescribers have the clinical knowledge to prescribe medications consistent with their education, assessed competence, relevant legislative requirements, and meet the Nursing Council of New Zealand's standards of competence for registered nurse prescribing.

Registered nurse prescribers undertake comprehensive assessments, plan care, order and interpret diagnostic and laboratory tests where appropriate, and diagnose and prescribe within their area of practice and competence. Registered nurse prescribers work in collaborative teams, must have access to an experienced prescriber, and seek guidance when appropriate.

You can compare the proposed registered nurse prescribing scope of practice statement with the registered nurse scope of practice statement as set out below.

Registered nurse scope of practice statement

Registered nurses in Aotearoa New Zealand incorporate knowledge, concepts and worldviews of both tangata whenua and tangata tiriti into practice.

Registered nurses uphold and enact ngā mātāpono – principles of Te Tiriti o Waitangi, based on the kawa whakaruruhau framework and cultural safety, promoting equity, inclusion, diversity and rights of Māori as tangata whenua. These concepts also relate to Pacific peoples and all population groups to support quality services that are culturally safe and responsive.

Registered nurses are accountable and responsible for their nursing practice, ensuring that all health care provided is consistent with their education, assessed competence, relevant legislative requirements, and is guided by the Nursing Council of New Zealand's standards for registered nurses.

Registered nurses use substantial scientific and nursing knowledge to inform comprehensive assessments, determine health needs, develop differential diagnoses, plan care and determine appropriate interventions. Interventions are evaluated to assess care outcomes based on clinical judgement, and scientific and professional knowledge.

Registered nurses practise independently and in collaboration with individuals, their whānau, communities, and the interprofessional healthcare team to deliver equitable person/whānau/whakapapa-centred nursing care across the life span in all settings.

Registered nurses may also use their expertise in areas and roles such as leadership, management, education, policy, and research.

Conditions may be placed on the scope of practice of some registered nurses, dependent on their qualifications and/or experience, limiting them to a specific area of practice. Nurses who have additional experience and have completed the required education will be authorised by the Council to prescribe some medicines within their area of practice and level of competence.

Registered nurses are responsible and accountable for directing and delegating to members of the healthcare team. Registered nurses provide support and guidance to enrolled nurses.

Part Two: Nurse practitioner scope of practice review | Wāhanga tuarua: Mātanga tapuhi – arotake mahi whānui

A comprehensive literature review on NPs is available *here*.

In New Zealand, the introduction of NPs into the health workforce in the early 2000s was intended to improve access to health care and promote health equity by delivering a culturally safe model of health care that bridged biomedicine and nursing. The current scope statement for NP was approved by the Nursing Council in 2001, and the education standards and standards of competence for NP were last reviewed in 2017.

NPs have advanced education, clinical training, and demonstrated competence and legal authority to practise beyond the level of a registered nurse. NPs bring a nursing paradigm to their advanced role, which includes understanding the socio-economic and cultural context of the lives of whānau and extending access to health care to a wide range of patients. NPs also bridge gaps in service delivery and meet the health needs of their local populations, improving access and reducing inequalities in health (Carryer & Adams, 2016; Adams et al, 2022). Internationally, there has been recognition of the role of the NP in primary health care in strengthening and improving access and outcomes, particularly for underserved communities and those with more complex needs (Brownwood & Lafortune,2024; Smith, 2022; Baten & Wehby, 2022).

To become an NP In New Zealand, there is a requirement to register with the Nursing Council of New Zealand[8]. Currently, applicants must complete four years of experience in the area of practice they intend to work in as an NP, obtain a master's degree through a Nursing Council-accredited programme, submit a competency-based portfolio demonstrating mastery of six NP competencies, and undertake an oral panel assessment through the Council. Annual practising certificates are required to demonstrate safety to practise and their NP competencies, including evidence of professional development and practice hours, every three years.

There is strong international evidence of the value of the NP role through multiple studies and systematic reviews which evidence the positive impact on clinical and service-related outcomes: patient satisfaction, waiting times, management of chronic diseases and cost-effectiveness in all care settings and population groups (Htay & Whitehead, 2021). Studies demonstrate that NPs in primary health care have equivalent or better patient outcomes than other providers and are potentially cost-saving (Jennings et al, 2015). International research has also found that NP roles are a positive way to retain and recruit nurses and develop advanced nursing roles (Bryant et al, 2017).

In 2014, an amendment to the Medicines Act enabled NPs to become 'authorised prescribers'. This created the ability to prescribe controlled drugs, special authority medications, and issue standing orders for other healthcare professionals. In 2015, other legislative changes[9] occurred, enabling NPs to carry out functions

8 *NCNZ website*

9 including introduction of the Health Practitioners Competence Act Amendment Bill and the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill. Once passed, these legislative amendments revised the wording from "medical practitioner" to "health practitioner" or included the designation of NP alongside medical practitioner (MOH, 2023).

previously restricted to medical practitioners such as certification of death and cremation and signing sick leave certificates.

In 2017, after an extensive consultation process, the Council revised the NP competencies and education programme standards to reflect and recognise the diverse contexts in which NP practise, and to encourage their growth and proficiency across different healthcare environments. These changes included:

- the removal of the restriction on NPs practising in a specific area of practice – enabling NPs, as advanced practitioners, to self-regulate and practise within their areas of competence and experience
- revision of the education programmes for NPs to establish a consistent educational and clinical learning standard
- expansion of the scope of clinical knowledge for NPs to include developing advanced skills in multiple settings.

Despite these changes, the initial growth of the NP workforce was slow, with only 150 NPs registered in the first 13 years by 2015 (NCNZ, 2020).

Since 2016, there has been government funding of an NP training programme (NPTP) that focuses targeted funding on the final practicum year. The purpose of the NPTP was to reduce some of the barriers to NP education and therefore increase the number of NPs. Health New Zealand (HNZ) is planning to fund an NP training support scheme from 2026 to 2030 with the aim of encouraging NP candidates to complete the final practicum year with a specific focus on increasing the number of NPs in primary health care.

The number of NPs has almost doubled since March 2019. However, NPs represent only around 1% of the nursing workforce in New Zealand with a disproportionately low number of Māori and Pacific candidates applying for entry to NPTP. This highlights the need to identify these nurses earlier and address barriers for Māori and Pacific nurses on the pathway to becoming an NP (Malatest, 2018; Malatest, 2024).

International nursing jurisdictions

The growth of the NP workforce differs significantly between countries. In the United States (US) and Canada, where the role of NP was established nearly 60 years ago, NPs are now generally well accepted and integrated into healthcare teams. The number of NPs has more than doubled in the US and Canada over the past decade. In 2022, NPs represented over 8% of all registered nurses in the US and about 3% in Canada.

Australia, Ireland, the Netherlands and New Zealand, where the NP role was established 20 years ago, have also accelerated the growth of the NP workforce over the last decade. However, these NPs still only represent a relatively small proportion of all nurses (Brownwood & Lafortune, 2024; Maier et al, 2016).

International comparisons can be found *here*.

Roles and area of practice

Internationally, there are differences in the breadth of practice of NPs across countries, with some having defined areas of practice that restrict the practice area, and others being more general across conditions. In many countries, there is an established scope to manage patients with chronic conditions. Fewer countries provide NPs with the ability to manage a wider range of patients, regardless of their condition (Savin & Newberry, 2023). In New Zealand, the NP's scope of practice is broad, and NPs currently define their area of practice at registration.

The US and Canada have the following specific 'streams' of practice for NPs:

- Canada – family within a primary health care focus, adult with or without specialisation, paediatric with or without a clinical area of specialisation, neonatal, anaesthesia, and mental health (Miller et al, 2023).
- US – psychiatric-mental health, women's health, family, adult-gerontology acute care, adult-gerontology primary care, and paediatric (AANP, 2022).

In the US, practice and licensure laws regulate the degree to which the NP can practise. The American Association of NPs defines three types of practice authority for NPs:

- Full: permits NPs to evaluate patients, diagnose conditions, order and interpret diagnostic tests, and initiate and manage treatments (including prescribing medications)
- Reduced: can require collaborative agreement with another health provider for NPs to provide patient care or can limit one or more elements of NP practice
- Restricted: requires career-long supervision, delegation or team management by another health provider for NPs to provide care in at least one element of NP practice.

In the US, NPs are educated broadly and must pass a final exam before registration (Roberts & Knestrick, 2023). The Netherlands also stipulates streams of general and mental health, but other countries in our review do not define specific streams or areas of practice (Lownie et al, 2023).

In Australia, due to the individual scope being determined by the individual NP, their employer, and legislation, there are many variations of practice, even for those who are educated and practising in the same specialty area. Australia now has more than 50 different NP specialities (Helms & Boase, 2023; Helms et al, 2016). Challenges regarding these differences led to the development of 'metaspecialities' (groups of specialities or subspecialities), which provide a framework for the development of NP students and their clinical scopes of practice (Gardner et al, 2021).

Nurse practitioner workforce data

As of end June 2025[10], there were 910 NPs with an annual practising certificate. Of those, 91 (10%) identified as Māori and 16 (2%) identified with one or more Pacific ethnicities.

Table 2: Nurses with current annual practising certificate by quarter

Scope of practice	Jul-Sep-24	Oct-Dec-24	Jan-Mar-25	Apr-Jun-25
Registered nurse	80,313	82,419	82,106	80,719
Enrolled nurse	2,473	2,471	2,459	2,446
Nurse practitioner	805	859	897	910
Total	**83,591**	**85,749**	**85,462**	**84,075**

10 NCNZ. (2025). Quarterly data report

In 2024-25, the NP workforce gender balance reflected the nursing workforce, with 10% being male. The profile was also older than the nursing workforce, with 54% aged 50 years or older compared to 29% of the entire nursing workforce. This reflects a more experienced cohort of nurses. The majority (70%) of these nurses have been practising as a nurse for more than 15 years.

As of 31 March 2025, 46% of NPs reported working in primary care or community services, and 44% reported working in HNZ (Te Whatu Ora) employment settings. A smaller number of NPs report working in aged residential care (5%), Māori service providers (3%), and self-employed (5%). Around a quarter of NPs (26%) practise in multiple employment settings.

What are we proposing?

The proposed changes to the NP scope of practice reflect the Council's objective to modernise the current scope statement. The proposed changes to the NP scope of practice statement are based on the following:

- It is built on the platform of the registered nurse scope of practice
- Positions NPs as leaders in the development and delivery of healthcare services
- NPs are advanced practitioners, educated at a minimum of master's level
- NPs provide clinical leadership and manage episodes of care
- That the expanded nature of autonomous practice requires NPs to provide a wide range of assessment and treatment interventions
- NPs apply a combination of advanced scientific knowledge, diagnostic reasoning and critical analysis to diagnose and develop therapeutic treatment plans in partnership with health consumers and whānau
- NPs prescribe medicines within their area of competence
- Leads or contributes to research, healthcare design, policy, and education at regional, national and international levels.

A summary of specific proposed changes can be found in our consualtion document *here*.

Proposed nurse practitioner scope of practice statement

The nurse practitioner scope of practice is built on the platform of the registered nurse scope of practice. Nurse practitioners role model commitment to Te Tiriti o Waitangi, kawa whakaruruhau and cultural safety. Nurse practitioners must also meet the regulatory and professional requirements set by the Nursing Council of New Zealand.

Nurse practitioners are leaders in the development and delivery of healthcare services. They are advanced practitioners, educated at a master's or doctoral level, and have the required competence to provide clinical leadership and manage episodes of care. The expanded nature of autonomous nurse practitioner practice requires them to provide a wide range of comprehensive assessment and treatment interventions.

Nurse practitioners combine advanced scientific knowledge, diagnostic reasoning, and critical analysis to diagnose and develop therapeutic treatment plans, including prescribing medicines within their area of competence. They are accountable for ensuring evidence and research inform their decision-making. This is done in partnership with health consumers and whānau.

Nurse practitioners lead or contribute to research, healthcare design, policy, and education at regional, national and international levels.

You can compare the proposed nurse practitioner scope of practice with the current scope as set out below.

Nurse practitioner scope of practice statement[11]

Nurse practitioners have advanced education, clinical training, and the demonstrated competence and legal authority to practise beyond the level of a registered nurse. They 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. They 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.

Nurse practitioners 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.

11 *Notice of Replacement and Revocation of Notice for Nurse Practitioners* (2017).

Part Three: Nursing education programme standards | Wāhanga tuatoru: Ngā hōtaka mātauranga tapuhi

The Council is responsible for ensuring that New Zealand's nursing education providers deliver programmes that graduate safe and competent nurses to practise in the New Zealand healthcare context.

Education providers are regularly monitored to ensure programmes remain relevant, educationally sound, and can respond to the increasing complexity and rapid changes in health needs and services across New Zealand.

The Council has a role in supporting the future workforce by ensuring education standards enable a flexible workforce to meet health needs and deliver quality health services. Nurse competencies and standards must have credibility with the profession and other stakeholders. This includes the international nursing community and regulators in other jurisdictions where nurses may wish to work.

Any changes to nursing education standards for programmes leading to registration need to address current and projected health needs of the New Zealand population. Changes to nursing scopes of practice, competencies, and education standards also need to recognise the composition of the health workforce, particularly the roles of regulated health professionals and non-regulated workers.

Health care and service delivery constantly change over time. However, over the last five years, the education and health sectors have experienced significant change and disruption which have had a major impact on nursing education and providers. This change has occurred in addition to social and cultural change – such as more awareness of Te Tiriti o Waitangi and the need to address health inequities – as well as financial pressures, which have challenged nursing education providers to deliver in this context.

The impact of this rapid and comprehensive change is particularly evident in the previous polytechnic sector which merged into a single Te Pūkenga entity in 2020 based on the Reform of Vocational Education.[12] This institution is now being dismantled under a further period of significant restructuring.

National review of nursing education in New Zealand

Change and disruption, while challenging, also provide opportunities for change. This year, the Council commissioned an independent and comprehensive review of nursing education. The last comprehensive review of nursing education was undertaken for the Council by KPMG almost 25 years ago.[13]

This review will consider how nursing education is shaped and delivered, to ensure ongoing relevance and preparation of safe and competent practitioners in all scopes of nursing registration. A new blueprint for nursing education can enhance flexibility for providers, allowing innovation to flourish to meet health system needs while continuing to maintain the quality and relevance of nursing education.

12 Reform of vocational education. (RoVE, 2019).

13 KPMG. (May,2001). Strategic review of undergraduate nursing education.

Quality education practice

In 2020, the Council published an evaluation of the evidence related to best practice in nursing education, including information on other health professions, to ensure nursing graduates are well prepared to meet future population health needs. A summary of the themes from this engagement process are *available here*.

The Council considers quality clinical learning to be a positive, diverse, and well-planned educational experience. This requires well-prepared preceptors, mentors, and supervisors who work consistently with a student to achieve incremental knowledge development through reflective practice, constructive feedback, and active, supported participation in person-centred care. This incremental acquisition of knowledge and skills is robustly assessed at the appropriate level by the education provider, in collaboration with the preceptor, mentor or supervisor, and the student.

There is limited published empirical evidence to determine the optimal number of practice learning hours needed to ensure safe and effective nursing practice with no conclusive evidence that higher numbers of practice learning hours result in better outcomes. There is an argument that a requirement for a set number of clinical hours is arbitrary, where a more outcomes-based approach would prioritise quality over quantity and allow flexibility in how practice learning is structured to better account for the different paces and ways that students learn (Palmer et al, 2024).

The Council considers simulation to be a fundamental element of teaching and learning in programmes leading to registration as an enrolled nurse, registered nurse, registered nurse prescriber or nurse practitioner. Simulation is now used throughout the programme of study to underpin theoretical learning and prepare students/ākonga for the clinical setting. The Council expects that simulation facilities will be appropriately resourced and meet contemporary healthcare simulation standards.[14]

The Council accepts the definition of simulation developed by the International Nursing Association for Clinical Simulation and Learning (INACSL): "any education strategy that creates learning conditions designed to resemble a real-world situation that students may encounter." [15] The fidelity of each simulation teaching and learning occurrence needs to reflect learning objectives.

Definitions and terms used for healthcare simulation continue to vary with modality (simulation equipment or methodology) and fidelity (degree of realism) used interchangeably.[16] The INACSL does not dictate a level of fidelity but level of realism and the degree to which the simulation replicates the real clinical event; this event includes physical, psychological, and environmental elements. For simulations in which a high degree of realism is desired, the primary goal of the simulation-based learning should be to allow students to immerse themselves in experiences that most closely match those encountered in clinical practice.

There is a limited but growing body of evidence supporting the use of simulation based learning within NP programmes. Simulation has the potential to address the challenges of access to clinical environments and clinical supervision and can provide clinical training for NP students in a safe, controlled environment. Simulation based learning increases students' knowledge and confidence, and students report satisfaction with simulation in various situations providing a valuable tool for developing knowledge and skills.

In the US, the National Organisation for Nurse Practitioner Faculties strongly supports the use of high-fidelity (HFS) simulation in NP education as a vital tool for enhancing clinical competency and meeting national standards. They have recently developed a comprehensive guide to NP simulation and provide

14 https://www.inacsl.org/healthcare-simulation-standards.

15 INACLS Standards Committee et al. (2025). Healthcare simulation standards of best practice™ facilitation. Clinical simulation in nursing.

16 Carey JM, Rossler K. The how when why of high fidelity simulation. 2023 May 1. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan–. PMID: 32644739.

best practice standards for simulation in NP programmes to ensure consistency and quality across NP education providers. HFS can include online components such as virtual platforms, virtual reality and tele-debriefing. HFS is also used widely in other disciplines such as medicine and physician assistant education.

International nursing education context

Registered nurse prescribing programmes

International comparisons of nurse prescribing have identified considerable variation in the practice of nurse prescribing in different countries (Wilkinson et al, 2011).[17] The legal, educational, and organisational conditions under which nurses prescribe medicines vary considerably between countries. These conditions range from situations where nurses prescribe independently to situations in which prescribing by nurses is only allowed under strict conditions and the supervision of physicians.

The International Council of Nurses (Stewart, 2021) describes several different types of prescribing including prescribing to administer, protocol, supplementary/dependent (collaborative), and independent, noting the differences between countries reflect the diversity of healthcare systems, the maturity of nursing within the system, and the role of government regulation and influence over policy.

In the United Kingdom (UK), Ireland, the Netherlands, Sweden, Denmark, New Zealand and, recently, Australia, nurse prescribing ranges from independent prescribing in the UK (graduate qualification and no or some limitations to medicines) to different types of supplementary prescribing in the Netherlands, Australia, New Zealand and the UK (graduate or postgraduate qualification with prescribing practice overseen by a medical or NP and with limitations on the types of medicines that are able to be prescribed based on a list or the prescriber's area of practice.). Some countries have multiple levels of prescribing (Maier, 2019).

In 2023, the UK Nursing and Midwifery Council removed some of the requirements for the length of time a nurse must be in practice prior to commencing a prescribing course with an expectation that increasingly nurses would be 'prescribing ready' on graduation from an undergraduate programme.[18] For community prescribing, there are no specific years of practice requirement prior to entry to the course of study. For independent prescribing, the nurse must have completed one year of practice before applying and, once qualified, can prescribe any medicine on the British Formulary (MacVicar, 2024).

The two UK levels of prescribing are as follows:

- community practitioner nurse – able to prescribe from a limited community formula after completion of a vocational course
- independent nurse prescribing – requires the nurse to undertake a vocational course (of which some credits may be credited toward a master's degree but the course is not necessarily a full postgraduate certificate or diploma).

Ireland and Switzerland have also expanded access for nurse prescribers to their full formularies although they require a postgraduate qualification (Maier, 2019).

Prescribing in the US is largely restricted to advanced practice registered nurses (NPs, nurse anaesthetists, nurse midwives, and clinical nurse specialists) although the level of prescriptive authority depends on each state's legislation. In Canada, prescribing is restricted to NPs with varying formularies depending on the province.

A summary of information is available *here*.

---

17 *Medicines (Designated Prescriber: Nurse Practitioners) Regulations 2005 (SR 2005/266) (as at 01 July 2014) Contents – New Zealand Legislation*

18 *Standards for prescribing programmes - The Nursing and Midwifery Council United Kingdom*

Nurse practitioner programmes

Currently, there are no global education standards for NPs despite the International Council of Nurses' recommendation in 2002 for a master's level education as the minimum requirement internationally. Most countries now require a Master of Nursing (MN) minimum requirement, with the US intending to move to all NPs graduating with a Doctorate of Nursing Practice in 2025 (Gardner et al, 2021).

Internationally, there are inconsistencies between, and often within, countries regarding the requirements for admission into NP training programmes (Carter et al, 2018). The majority of countries require the applicant to already have a bachelor's degree in nursing, nursing registration, and a minimum number of practice hours as a nurse (Baten & Wehby, 2022). The exception is Finland where a minimum number of hours as a registered health professional is required (three years of nursing practice or practice in a related field, for example, physiotherapy or midwifery). The US requires the applicant to have a nursing registration upon entry but does not stipulate a minimum number of practice hours. In the US, some courses offer direct entry that allows non-nurses to concurrently obtain their registered nurse and NP licensure (Elvidge et al, 2024).

In the countries identified within our review with a minimum number of required clinical hours within the NP programme, the total number of hours ranged from a minimum of 300 hours in Australia to 2,000 hours in the Netherlands. Across countries, the average number of clinical hours within the NP programmes is 500 hours.

New Zealand, Australia and Ireland are the only countries identified within our review that have a requirement for clinical experience within a specified area of practice. Ireland requires a minimum of three years recent post-registration clinical experience in nursing or midwifery (within the last five years) and an equivalent of one year's full-time experience in the specific area of clinical practice where the nurse will be prescribing and practising prior to registration. Australia also requires two to three years of equivalent full-time experience in the nurse's specified area of practice within the last five years. Finland and some programmes in the US have an entrance exam requirement prior to admission into the NP programme (Smith, 2022).

The setting of clinical placements also varies within countries. In Canada and the USA, clinical placements are generally outside the NP candidate's workplace and cover a broad range of clinical settings and practice. Programmes in Australia, New Zealand, the Netherlands, and some programmes in Norway require candidates to complete clinical hours within their workplace (Smith, 2022).

The current New Zealand requirement of four years of experience in the area of practice has been reported as a barrier to registration (Hicks et al, 2018). Other challenges for New Zealand NP development include the panel assessment process to gain registration. This process does not align with other countries (Mounayar & Cox, 2021) and may be considered arduous and burdensome, particularly for those who practise in rural settings and are more isolated from NP support.

Registration process in other countries

Currently, only NPs registered in the US and Canada are deemed to have equivalent qualifications to New Zealand NPs. NPs registered in Canada and the US are first required to register as a registered nurse in New Zealand and then gain experience and mentorship in New Zealand before submitting a portfolio of evidence to the Council. They then undertake a panel assessment against New Zealand NP competencies prior to registration as an NP.

A summary of information is available *here*.

What are we proposing?

The proposed changes to the education standards for all nursing programmes, leading to registration with the Nursing Council, are designed to be flexible and future-focused for education providers.

We propose integrating the accreditation and monitoring standards for RN prescribing and NP programmes (revised 2024) with the generic nursing education programme standards leading to registration as an enrolled or registered nurse (2024).

This will result in one set of education standards, available *here*.

This means that the generic education standards (2024) will include all programmes leading to registration with the Nursing Council. The generic education standards will be accompanied by individual schedules that set out standards that must be met for the delivery of the:

- New Zealand Diploma in Enrolled Nursing
- Bachelor and/or the Master of Nursing
- Postgraduate Diploma in Registered Nurse Prescribing
- Master of Nursing for Nurse Practitioner.

Nursing education programme standards

The review of education standards has considered:

- improved coherence between registered nurse, registered nurse prescriber, and nurse practitioner
- delivery of required papers across postgraduate qualifications
- regulatory barriers with a view to improving efficiency and expediting the pathway while ensuring public safety
- identified area of practice before entry to programmes
- clinical practice and practicum requirements
- assessment and registration requirements for notification to the Nursing Council register.

Key changes are proposed to the following:

Clinical learning and experience

- Clinical learning must include the use of contemporary healthcare simulation[19] and integrated learning in the clinical setting. Successful clinical learning completion for the postgraduate diploma for RN prescribing requires verification of simulated and supervised clinical learning, including assessment against the standards of competence for RN prescribing.
- Graduates of the NP programme must complete a minimum of 500 hours clinical learning of which 100 hours must be provided through relevant clinical simulation and 400 hours in a relevant clinical setting.
- A requirement of at least two years in the area of practice nurses intend to prescribe in before entry to the register as a registered nurse prescriber, with at least one year in a New Zealand healthcare setting before entry to the programme of study. NP candidates are required to have at least two years in a chosen area of practice, before entry to the register as an NP, with at least one year in a New Zealand healthcare setting before entry to the programme of study.

NP registration process

We also propose a change to the requirement for NP candidates to submit a portfolio of learning and complete an oral/viva[20] panel assessment before applying to a Nursing Council panel for registration. We propose that it is the responsibility of the education provider to inform the Nursing Council of NP candidates who have successfully passed the assessment and examination requirements, are considered fit to be entered on the register in the NP scope of practice, and identify the candidate's area of practice.

This means there will no longer be a need for a Council panel assessment. The Council will retain a level of external moderation for the Oral/VIVA assessment within the MN programmes to ensure national consistency and standards.

A summary of specific proposed changes can be found in our consualtion document *here*.

19 INACLS Standards Committee et al. (2025). Healthcare simulation standards of best practiceTM facilitation. Clinical simulation in nursing

20 Oral (Viva voce, meaning 'living voice'): The clinical viva examination is a method of assessing a student's/ākonga ability to use knowledge in a face-to-face examination encounter.

References – Ngā tohutoro

Adams, S., Oster, S., & Davis, J. (2022). The training and education of nurse practitioners in Aotearoa New Zealand: Time for nationwide refresh. *Nursing Praxis in Aotearoa New Zealand, 32*(1), 1-4.

Baten, R. B. A., & Wehby, G. L. (2022). Effects of the ACA Medicaid expansions on access and health by nurse practitioner scope of practice laws. *Nursing Outlook, 70*(2), 228-237.

Brownwood, I., & Lafortune, G. (2024). *Advanced practice nursing in primary care in OECD countries: Recent developments and persisting implementation challenges*.

Bryant-Lukosius, D., Valaitis, R., Martin-Misener, R., Donald, F., Peña, L. M., & Brousseau, L. (2017). Advanced practice nursing: A strategy for achieving universal health coverage and universal access to health. *Revista Latino-Americana de Enfermagem, 25*, e2826.

Carryer, J., & Adams, S. (2016). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. *Collegian Journal of the Royal College of Nursing Australia, 12*(1), 1-7.

Carter, M., Moore, P., & Sublette, N. (2018). A nursing solution to primary care delivery shortfall. *Nursing Inquiry, 25*(4), e12245.

Carter, M., Moore, P., & Sublette, N. (2018). A nursing solution to primary care delivery shortfall. *Nursing Inquiry, 25*(4), e12245.

Dugan, MA., & Lebo, C. A series of consecutive high-fidelity telehealth simulations for nurse practitioner students. *Nurse Educator* 2023; 48: 170-171.

El Hussein, MT., & Favell, D. Simulation-based learning in nurse practitioner programs: A scoping review. *The Journal for Nurse Practitioners* 2022; 18: 876-885.

Elvidge, N., Hobbs, M., Fox, A., Currie, J., Williams, S., Theobald, K., et al. (2024). Practice pathways, education, and regulation influencing nurse practitioners' decision to provide primary care: A rapid scoping review. *BMC Primary Care, 25*(182), 1-19.

International Council of Nurses. (2013). *Scope of nursing practice (pp. 2). Geneva, Switzerland.*

Gardner, A., Helms, C., Gardner, G., Coyer, F., & Gosby, H. (2021). Development of nurse practitioner metaspecialty clinical practice standards: A national sequential mixed methods study. *Journal of Advanced Nursing, 77*(3), 1453-1464.

Helms, C., & Boase, L. (2023). Transforming healthcare: The Australian nurse practitioner role. In S. L. Thomas & J. S. Rowles (Eds.), *Nurse Practitioners and Nurse Anesthetists: The Evolution of the Global Roles* (pp. 263-278). Springer.

Helms, C., Gardner, A., & McInnes, E. (2016). Consensus on an Australian nurse practitioner specialty framework using Delphi methodology: Results from the CLLEVER 2 study. *Journal of Advanced Nursing*, ***73***(3), 433-447.

Hicks, K. E., Rico, J., & Beauchesne, M. (2018). Core curriculum and competencies: A multisite analysis of postgraduate training programs for primary care nurse practitioners. *Journal of Professional Nursing, 34*(6), 454-462.

Htay, M., & Whitehead, D. (2021). The effectiveness of the role of advanced nurse practitioners compared to physician-led or usual care: A systematic review. *International Journal of Nursing Studies Advances, 3*, 100034.

Jennings, N., Clifford, S., Fox, A. R., O'Connell, J., & Gardner, G. (2015). The impact of nurse practitioner services on cost, quality of care, satisfaction and waiting times in the emergency department: A systematic review. *International Journal of Nursing Studies, 52*(1), 421-435.

Jeffries, PR,, Bigley, MB., McNelis, AM., et al. A call to action: Building evidence for use of simulation in nurse practitioner education. *Journal of the American Association of Nurse Practitioners* 2019; 31: 627-632. DOI: 10.1097/jxx.0000000000000335.

Effries, PR., & Slaven-Lee, P. *A Practical Guide for Nurse Practitioner Faculty Using Simulation in Competency-based Education*. Lippincott Williams & Wilkins, 2024.

Lownie, C. J., Vaccarello, A. M., & Kennedy, E. (2023). Exploring entry pathways towards nurse practitioner program admissions: A rapid review. *International Journal of Nursing Education Scholarship, 20*(1), 20240016.

MacVicar, S. (2024). Nurse independent prescribing: exploring the opportunities and challenges. *Nursing Standard, 39*(7), 40–45. https://doi.org/10.7748/ns.2024.e12304

Maier, C. B., Barnes, H., Aiken, L. H., & Busse, R. (2016). Descriptive, cross-country analysis of the nurse practitioner workforce in six countries: Size, growth, physician substitution potential. *BMJ Open, 6*, 1-11.

Maier, C. B. (2019). Nurse prescribing of medicines in 13 European countries. *Human Resources for Health, 17*(1), 95. https://doi.org/10.1186/s12960-019-0429-6

Malatest International. (2024). *Evaluation of the Nurse Practitioner Programme*.

Malatest International. (2018). *Evaluation of a nurse practitioner education programme*.

Miller, M., Prodan-Bhalla, N., & Marchuk, S. (2023). The NP role and practice in Canada. In S. L. Thomas & J. S. Rowles (Eds.), *Nurse Practitioners and Nurse Anesthetists: The Evolution of the Global Roles* (pp. 145-156). Springer.

Ministry of Health. (2023). *About the Health Practitioners Competence Assurance Act*. Retrieved from https://www.health.govt.nz/regulation-legislation/health-practitioners/about-the-act#:~:text=The%20Health%20Practitioners%20Competence%20Assurance%20Act%202003%20(the%20Act)%20is,and%20fitness%20of%20health%20practitioners

Mounayar, J., & Cox, M. (2021). Nurse practitioner post-graduate residency program: Best practice. *The Journal for Nurse Practitioners, 17*(4), 453-457.

Nursing Council of New Zealand. (2017). *Competencies for nurse practitioner scope of practice*. Wellington: Te Kaunihera o Aotearoa, Nursing Council of New Zealand.

Palmer, W., Reed, S., Hemmings, N., Julian, S., Bodea, M., Oaten Raluca., & Plotkin, L. (2024), Research report: Practice learning in nursing and midwifery education. An independent rapid review.

Registered Practical Nurses Association of Ontario (RPNAO). (2018). *Practically speaking: international comparison of registered practical nurse utilisation to identify best practice*.

Roberts, M. E., & Knestrick, J. (2023). The nurse practitioner in the USA: Role exemplars. In S. L. Thomas & J. S. Rowles (Eds.), *Nurse Practitioners and Nurse Anesthetists: The Evolution of the Global Roles* (pp. 131-144). Springer.

Royal College of Nursing. (2012). *Advanced Nurse Practitioner: An RCN guide*. London: Royal College of Nursing.

Sałacińska, I., Trojnar, P., Gebriné, KÉ., et al. A comparative study of traditional high-fidelity (manikin-based) simulation and virtual high-fidelity simulations concerning their effectiveness and perception. *Frontiers in Medicine* 2025; 12: 1523768.

Savin, M. K., & Newberry, D. M. (2023). Education standards, accreditation, certification, and regulation of

nurse practitioner practice. *Journal of the American Association of Nurse Practitioners, 35*(11), 725-730.

Smith, L. B. (2022). The effect of nurse practitioner scope of practice laws on primary care delivery. *Health Economics, 31*(1), 21-41.

Stewart, D. (2021). *Guidelines on prescriptive authority for nurses*. Geneva, Switzerland: International Council of Nurses, pp 13-14. *https://www.icn.ch/sites/default/files/2023-04/ICN_Nurse_prescribing_guidelines_EN.pdf*

The American Association of Nurse Practitioners. (2022). *NP fact sheet*. Retrieved from *http://aanp.org*

Tyler, D., & Schumann, L. (2023). American Academy of Nurse Practitioners Certification Board announces changes in the recertification program. *Journal of the American Association of Nurse Practitioners, 35*, 666-668.

Wilkinson, J., Carryer, J., Adams, J., & Chaning-Pearce, S. (2011). Evaluation of the diabetes nurse specialist prescribing project. Massey University: Palmerston North.

Yu, JH., Lee, MJ., Kim, SS., et al. Assessment of medical students' clinical performance using high-fidelity simulation: comparison of peer and instructor assessment. *BMC Medical Education* 2021; 21: 506. DOI: 10.1186/s12909-021-02952-w.