Report on the consultation of registered nurse prescriber and nurse practitioner scope of practice statements and education standards

February 2026

Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Contents

Introduction

Background to this consultation

Under the Health Practitioners Competence Assurance Act 2003 (the HPCA Act), the Nursing Council (the Council) of New Zealand's purpose is to protect the safety of the public by providing mechanisms to ensure that nurses are competent and fit to practise. Setting scopes and standards is part of the foundation for that protection. The Council regularly reviews scopes of practice, education standards and standards of competence to ensure they reflect global and national trends and contemporary practice for the nursing profession.

Between 23 September and 24 October 2025, the Council consulted on proposed changes to the scope of practice statement and education standards for nurse practitioners (NPs). At the same time, the Council consulted on a new scope of practice statement and education standards for registered nurse (RN) prescribers.

Summary of submissions

This report summarises feedback from 144 submissions received through this consultation. Respondents gave feedback from a range of practice areas, regions, employment settings, length of experience and personal circumstances.

The feedback has been divided into three overarching areas reflective of sentiment: supportive, neutral and critical:

- **supportive feedback:** the proposals are necessary, accurate and safe for nurses and patients
- **neutral feedback and suggestions**: the intention of the proposals is welcome but needs to be refined
- **critical feedback:** the proposals are too prescriptive or too relaxed.

This report also summarises feedback from the perspectives of the following groups:

- Māori
- Pacific peoples.

Methodology

This consultation was open to submission via multiple means. Respondents were able to submit via an online survey using the platform SurveyMonkey. The survey received 100 complete responses. Respondents also had the option to submit via email. For email submissions, the Council provided a template of questions (in Microsoft Word document format) which were identical to the survey questions (Appendix 2). Respondents also submitted to this consultation through letters sent via email. There were 44 responses received by email.

Table 1: How submissions were received

Mode of submission	Number
Survey	100
Email	44
Total	**144**

This report is the result of mixed-method analysis. Quantitative data was collected using SurveyMonkey and Microsoft Excel, and where submitters explicitly answered the closed-ended questions in their template submission. A coding framework was developed to thematically analyse qualitative data. This data was then analysed using NVivo qualitative analysis software. Analysis was conducted by three team members who undertook a peer review process of the qualitative data analysis. This report includes results of both qualitative responses and quantitative analysis.

Limitations

Survey participants were invited to answer all questions and were also given the option to skip questions. Therefore, answers to questions have a variable response rate and responses to specific questions were not received from all stakeholders.

Additionally, respondents were given the option to submit via email. Some organisations submitted through their own letter format and did not provide direct answers to the consultation questions. Unless explicitly stated, no answer has been inferred. Due to this, these organisations' answers are not included in the quantitative analysis, but all qualitative feedback is analysed in this report.

Some survey responses were started but not submitted (incomplete responses). This analysis considers only 'complete' (submitted) responses. It has been assumed that if submitters wished their feedback to be included for consideration, their survey would have been completed and submitted. However, a scan of incomplete survey responses did not find any trends or themes that were not already apparent in the completed responses.

The completed survey submissions include those where no qualitative data was available (i.e. respondents answered multiple-choice questions but did not provide any comments). As a result, the quantitative data reflects greater agreement or disagreement compared to the qualitative sentiment expressed in respondents' comments.

Consultations often receive more criticism than support since stakeholders are more likely to give critical qualitative feedback. Quantitative feedback is not reflective of overall sentiment; the qualitative summaries should be read in combination with the accompanying quantitative data, provided in graph form at the beginning of each section.

Finally, this report is a summary of submissions. While some specific quotes and examples have been used, this does not indicate that other feedback for this report was excluded (except for feedback that was out of scope, as outlined below). The Council has read and considered all feedback.

Out of scope

This consultation received responses that were out of scope and not related to the proposed scope statements and education standards for NPs and RN prescribers, or the Council's remit. However, all feedback has been noted by the Council and will be used to inform other work programmes where relevant.

Out of scope responses included:

- feedback related to prescribers in diabetes health and registered nurse prescribers in community health
- prescribing by class and requests for medicines to be added to the approved list
- feedback on continuation prescribing
- naming conventions and abbreviations for NPs and RN prescribers
- the supported first year of practice for NPs and the Nurse Practitioner Training Programme
- concerns related to NPs in mental health and the protection of mental health consumers
- options for online learning delivery
- requests to hold or slow down the implementation of the proposed changes
- comments on the consultation design.

How to read this report

This report uses several acronyms:

- RN – registered nurse/s
- NP – nurse practitioner/s
- APC – annual practising certificate
- RPL – recognition of prior learning.

Table 2 outlines terms used in the report to represent a range of respondents who submitted similar feedback.

Table 2: Classification of responses

Term used	Numbers/range of respondents
Few	2-5
Some	5-10
Several	10-20
Many	20+

Executive summary

In total, the Council received 144 responses to the consultation – 115 submissions from individuals (80% of respondents) and 29 (20%) submissions from organisations.

Demographics – individuals

The Council received 96 individual responses via the survey, and 19 individual responses via the email template. Not all respondents answered all questions, and some percentages have been rounded up or down. Respondents were able to make multiple selections so the total percentage will exceed 100%.

Respondents were asked what best describes their role:

- 43.5% (50) were NPs
- 16.5% (19) were RN prescribers in primary health and specialty teams
- 13.9% (16) were nurse leaders
- 13.0% (15) were RNs on an NP or RN prescribing pathway
- 7.8% (9) were nurse educators
- 7.0% (8) were RN prescribers in community health
- 3.5% (4) were members of another regulated health profession.

Respondents who were nurses were asked where they gained their qualification:

- 84.3% (81) gained their qualification in New Zealand
- 11.3% (13) gained their qualification in another country.

Respondents were asked to identify which ethnicity or ethnicities they belonged to:

- 80.0% (92) New Zealand European
- 10.4% (12) Māori
- 5.2% (6) Chinese
- 5.2% (6) other
- 3.5% (4) other European
- 1.7% (2) did not want to state their ethnicity
- 0.9% (1) Cook Island Māori
- 0.9% (1) Tongan
- 0.9% (1) Indian
- 0.9% (1) Filipino
- 0.9% (1) other Asian.

Respondents were asked which region they lived in:

- 23.5% (27) Auckland
- 12.2% (14) Wellington
- 12.2% (14) Canterbury
- 7.0% (8) Northland
- 6.1% (7) the Bay of Plenty
- 5.2% (6) Hawke's Bay
- 5.2% (6) Taranaki
- 5.2% (6) Southland
- 4.3% (5) Waikato
- 5.2% (6) Nelson-Marlborough
- 3.5% (4) Manawatū-Whanganui
- 3.5% (4) Otago
- 2.6% (3) Gisborne
- 2.6% (3) the West Coast
- 0.9% (1) overseas.

Demographics – organisations

The Council received 29 complete responses from organisations via the online survey and emailed templates. Four organisations submitted via the survey, and 25 organisations submitted via email. One organisation submitted via both methods but was counted as a survey submission as it was received first. Appendix 2 includes a breakdown of the organisations that submitted and summarises their overall responses.

Most organisations did not use the template or state their type of organisation, so the most appropriate type has been assigned:

- Professional organisation: 7 (24.1%)
- Service provider: 6 (20.7%)
- Education provider: 5 (17.2%)
- Nursing representative group: 2 (6.9%)
- Overseas nursing regulator: 2 (6.9%)
- Membership organisation: 1 (3.4%)
- Human rights group: 1 (3.4%)
- Government agency and health service provider: 1 (3.4%)
- Government agency: 1 (3.4%)
- Clinical network: 1 (3.4%)
- Professional leadership network: 1 (3.4%)
- Leadership group of senior nurses: 1 (3.4%).

Overall level of support

Across the consultation, most respondents supported the direction of the proposals, particularly the updated scope statements. Quantitative feedback showed:

- broad support for the RN prescriber scope of practice, with around three-quarters of respondents supporting the proposed scope overall
- broad support for the NP scope of practice, with around three-quarters of respondents also supporting the proposed changes
- varied levels of support for the education standards, especially where proposals involved reducing minimum experience requirements, removing set clinical hours, or changing how NP readiness for registration would be assessed
- Individuals were consistently more supportive than organisations across most questions.

Key themes from qualitative feedback

Qualitative responses help explain the quantitative results and highlight why support was strong in some areas and more cautious in others.

Supportive themes

Many respondents welcomed the proposals as a way to better reflect contemporary nursing practice and improve access to care. Where respondents supported the scopes of practice and education standards, many provided limited or no comments to articulate their reasons.

Common themes from those who commented were:

- welcoming the expanded RN prescriber scope, viewing it as a means to improve access to care and better align with modern nursing practice
- considering the changes to be clear, practical and beneficial for workforce flexibility
- seeing the requirements for experienced prescriber access as positive safeguards
- supporting the NP scope's emphasis on advanced education, leadership and cultural safety
- helping to clarify the distinct roles of RN prescribers and NPs
- acknowledging the value of simulation as a complement to clinical learning when appropriately used.

Suggestions and areas for improvement

Many respondents who supported the proposals also suggested refinements. Common suggestions included:

- clearer explanations of how RN prescriber and NP roles differ, particularly for employers, other health professionals and the public
- more guidance on what is meant by access to an 'experienced prescriber' within the RN prescriber scope, and how clinical support and supervision should work in practice

- suggestions for the NP scope to more clearly articulate autonomy and diagnostic authority, and to better reflect the diversity and impact of NP roles
- recommendations to strengthen the inclusion of NP leadership in upholding Te Tiriti o Waitangi, Kawa Whakaruruhau, and cultural safety
- flexibility in education standards and simulation requirements to support access, for example for nurses in rural areas or who are working part-time
- clear national approach to assessment and moderation to ensure consistency and fairness across education providers.

Critical feedback

Critical feedback tended to focus on public safety, role clarity and professional standards, rather than opposition to the roles themselves. Key concerns included:

- strong opposition to reducing experience requirements, particularly for nurse practitioners, with many respondents viewing extensive clinical experience as essential for safe, autonomous practice
- concerns that removing minimum clinical hour requirements for RN prescribers could lead to inconsistent training quality
- widespread concern that blurred boundaries between RN prescribers and NPs could confuse the public and employers, and risk unsafe expectations or role substitution
- objection to shifting decisions about NP readiness for registration entirely to education providers, with many respondents valuing the Council's independent oversight as a safeguard
- concerns that some proposals could unintentionally weaken the distinctiveness and credibility of the NP role
- education programme lead requirements might be unrealistic, potentially hindering recruitment and clinical currency.

Feedback by organisation type

Service providers tended to be more supportive, particularly of the RN prescriber scope and NP scope, supporting many or most of the education standards. Feedback generally showed interest in improving service delivery, access and clinical workflow, and a tendency to view expanded and flexible scopes positively.

International regulators tended to be more supportive. They strongly supported the RN prescriber scope and viewed the NP scope as aligned with international standards. They also provided recommended refinements to some standards. Their interest was in international consistency, and they were broadly aligned with the intention of the proposed changes.

Professional leadership networks were broadly supportive of the scopes and education standards, especially the NP scope, though they frequently called for more experience prior to NP entry.

Clinical networks tended to be very supportive of both scopes and the changes to education standards, often seeing clear clinical benefits.

Education providers tended to raise concerns. Education providers generally wanted stronger safeguards, clearer wording, and higher or more consistent experience requirements.

Government agencies were more supportive of the RN prescriber scope and education standards but more critical of proposals related to the NP scope and standards. These organisations emphasised system-level impacts, costs and competency safeguards.

Professional organisations/nursing representation groups voiced strong concerns about the NP scope or experience requirements. These groups tended to be supportive of progression pathways but sceptical about reduced experience requirements and clarity of NP scope boundaries.

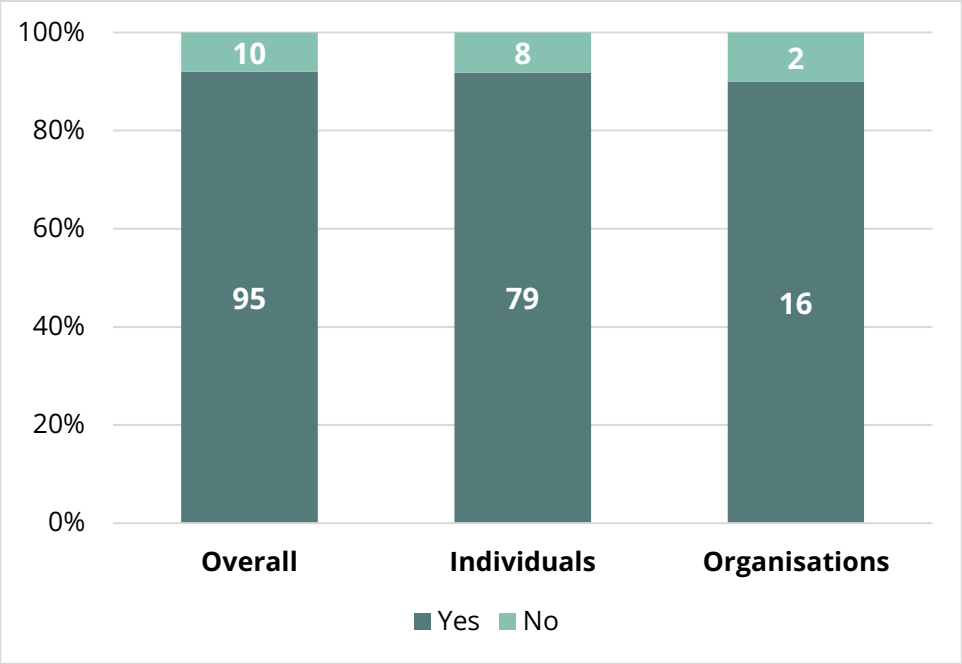
Organisations concerned with human rights and patient protection tended to be critical where patient autonomy or consent impacts were perceived.

Section One – Registered nurse prescriber scope of practice

Most of the feedback on the proposed RN prescriber scope of practice came from respondents who are not authorised to prescribe medicines. Of the 85,462 nurses with annual practising certificates in Aotearoa New Zealand, 1,571 are prescribers.[1] This consultation received 25 complete responses from RN prescribers. While all feedback from individuals has been analysed together, responses from RN prescribers are specifically highlighted. Compared to overall responses, feedback from RN prescribers indicated stronger support for the RN prescriber scope of practice.

Registered nurse prescriber scope builds on the RN scope

Figure 1: The RN prescriber scope builds on the foundations of the RN scope. Is this clear in the RN prescribing scope?



Individual feedback

Only two individual respondents provided comment on this question. They both expressed opposition to RN prescribing becoming a separate scope of practice from the RN scope due to the potential blurring of boundaries with the NP scope.

[1] Nursing Council of New Zealand Annual Report 2025

Organisation feedback

Five organisations made comments on this question.

Supportive: recognition and appreciation of the relationship

Yes, it is clear that the proposed registered nurse prescriber scope builds upon the foundations of the existing registered nurse scope. The statement explicitly references that it is "built on the platform of the registered nurse scope of practice," and the additional educational and professional requirements clearly extend from, rather than replace, that base scope.

Nurse Executives Aotearoa

Supportive: progression and pathway

The NMBA agrees that the scaffolding of the registered nurse (RN) scope of practice and the RN prescribing scope of practice promotes the delineation and progression between the current RN scope of practice and the intended RNP scope of practice. It also explicitly states that the RNP scope is developed on the platform of the RN scope, reinforcing that prescribing authority is an extension of foundational nursing competencies.

Nursing and Midwifery Board of Australia

Neutral and critical: scope clarity and wording

The relationship between the RN prescribing scope and the foundational RN scope is not clearly articulated. While the RN prescribing scope is intended to build upon the foundational registered nurse scope, this connection is not made sufficiently explicit in the current documentation. Clear articulation of this relationship is essential to ensure professional boundaries are maintained, support safe and effective practice, and help both health professionals and the public understand the continuities and distinctions between the two roles. Greater clarity in how prescribing builds on RN competencies would support consistent role interpretation across settings and reinforce safe practice frameworks.

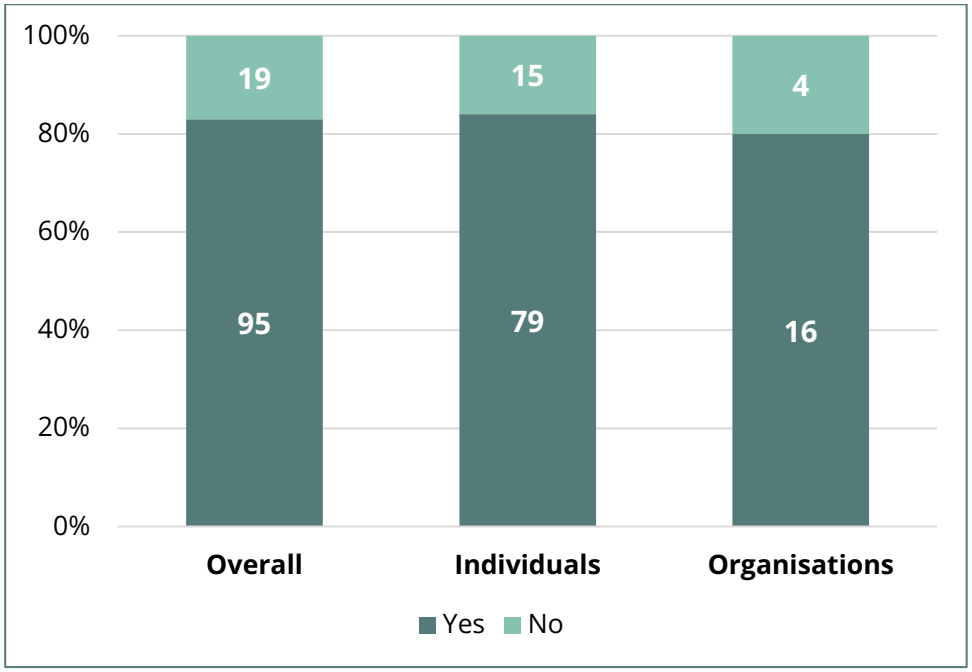
Nurse Practitioners Hawke's Bay

RN prescriber feedback

No feedback was provided by RN prescribers on this area of the consultation.

Registered nurse prescriber scope reflects registered nurse prescriber practice

Figure 2: Does the proposed scope reflect the key requirements of RN prescribing practice?



Individual feedback

Four individuals provided feedback on this area of the consultation. Feedback was mixed.

Supportive and critical: need for clarity and guidance

One individual respondent noted that the scope statement was "*succinct, clearly outlining what I do in my daily practice*" (RN prescriber), while another respondent stated that "*It's not very clear. Is confusing for employers to work out what we can do, what is within our scope and what isn't*" (RN prescriber).

Neutral: scope limits and alignment

One respondent suggested that "*retaining the common conditions statement can be refined to common conditions in the RN prescriber's area of practice'. This would be more clearly reflective of the level of prescribing expertise and preparation of a PG diploma level*" (NP).

Organisation feedback

Organisational feedback was largely supportive.

Supportive: broad and enhanced scope

A few organisations commented on the broad and enhanced nature of the proposed RN prescriber scope statement. These respondents agreed with the removal of the limitations on prescribing breadth including the removal of 'common conditions', as this will enable flexibility and is a more accurate representation of how RN prescribers practise.

Yes. The move from primary healthcare and specialty teams to a more general scope provides much greater flexibility and opens prescribing up for future development. The inclusion of 'access to an experienced prescriber' also supports collaborative prescribing, while not limiting practice.

Health New Zealand | Te Whatu Ora Office of the Chief Nurse

Supportive: accuracy and representation of RN prescribing

A few organisations provided feedback on the accuracy of the RN prescribing scope and agreed that it represented the key requirements of RN prescribing practice. These respondents noted that the scope statement identified the educational requirements, advanced knowledge and skills required, and the collaborative nature of RN prescribing practice.

The proposed scope appropriately reflects the key requirements of registered nurse prescribing practice. It identifies the necessary postgraduate qualifications, advanced clinical and diagnostic skills, and the expectation of working collaboratively within multidisciplinary teams. The inclusion of safe prescribing principles, alignment with legislative frameworks, and requirements for access to experienced prescribers further reinforce accountability and patient safety.

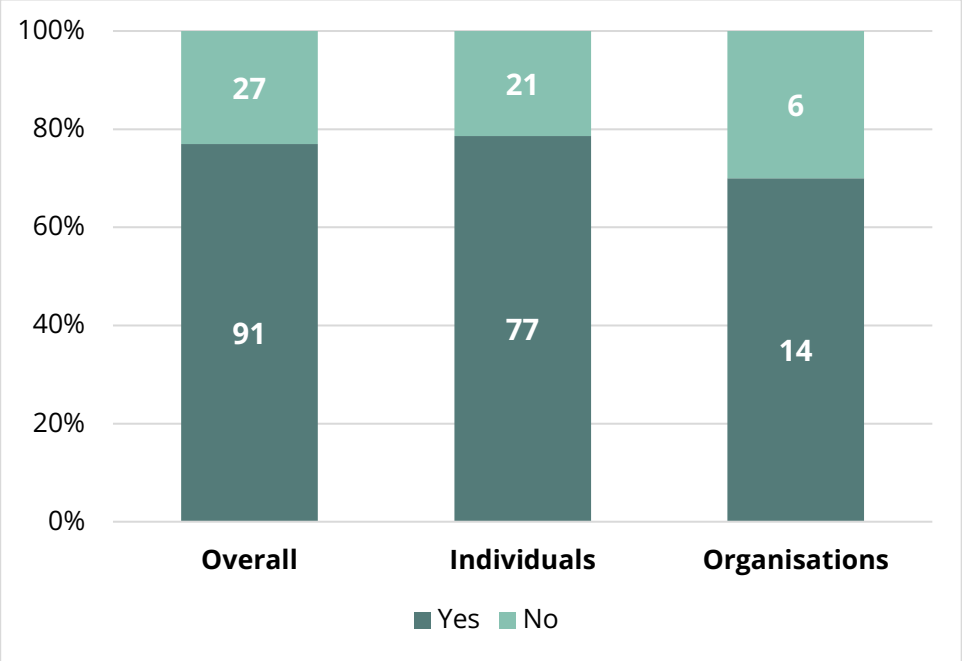
Nursing and Midwifery Board of Australia

RN prescriber feedback

Three RN prescribers provided comments on this area of the consultation. One RN prescriber expressed strong support for the accuracy of the scope statement and how it described their practice. Another respondent expressed that the scope statement for RN prescribers was not clear and that employers were confused about what is in and out of their scope.

Registered nurse prescriber scope statement overall support

Figure 3: Overall, do you support the proposed RN prescribing scope statement?



Individual feedback

A total of 36 people shared their perspectives regarding the RN prescriber scope statement, expressing both supportive and opposing views.

Supportive: scope content and emphasis

Several respondents provided comments on their overall support of the RN prescriber scope statement. Some of these respondents agreed with broadening prescribing limitations as they saw this as beneficial to both RN prescriber role development and their ability to meet the demands of their communities.

> ***I fully support expanding the scope of nurses of different skills/educational backgrounds/scopes to enhance the nursing workforce as a whole. I like the proposal of reducing barriers to providing care, especially in primary care.***
>
> RN on a NP or RN prescribing pathway

Other respondents noted that the scope statement was clear, practical and appropriate for the upcoming changes to the Medical Products Bill. One respondent expressed hope that the "*changes will help clarify the scopes of practice and responsibilities for the public and other healthcare providers and lead to better working outcomes for patients*" (RN prescriber).

Critical: safety and regulation

Some individuals expressed concern regarding the broad and expanded nature of the RN prescriber scope. A few of these respondents did not agree with no patient group limitations without further education, assessment and/or safeguards. Respondents did not see these changes as being safe for the public or for nurses and stressed the importance of stronger regulatory oversight.

> ***I do worry that expanding with no obvious limitations is potentially putting people at risk as you are basically suggesting they can prescribe like an NP without the extended education, OSCE or panel interview.***
>
> NP

One respondent stated that *"Clearer expectations around clinical supervision, collaboration and clinical governance are needed"* (NP and nurse educator). Another respondent advised that Council oversight would be needed to *"prevent exploitation or unsafe prescribing expectations*" (NP).

Critical and neutral: competence and patient safety

Some individuals strongly emphasised that the proposed scope statement relied too heavily on an individual RN prescriber's competence awareness, and this reliance could put patient safety at risk. A few respondents stated that "people don't know what they don't know" and that broader prescribing practice requires a depth and breadth of knowledge that RN prescribers are not sufficiently trained to have. A few respondents stated that the educational preparation for RN prescribers would not be sufficient for them to safely prescribe within their area of competence. Patient safety was a major concern of these respondents as they saw the broadening of prescribing limitations as leading to potential mistakes. These respondents expressed that the limitation of patient groups should be included in the scope statement.

> ***The RN prescriber role is the most vulnerable professionally and clinically. Relying on them to know the limits of their competence is somewhat paradoxical, given that we don't always know what we don't know.***
>
> NP and nurse educator

A few respondents expressed the need for improved clarity on the breadth of RN prescribing and definitions to be provided. These respondents stressed the importance of clear guidelines about where an RN prescribers' prescribing limitations are.

> ***The definition of a RN prescriber's 'practice and competence' needs to be further defined – who is monitoring this?***
>
> NP

Organisation feedback

Twenty organisations commented on the RN prescriber scope statement. Feedback from organisations was also mixed.

Supportive: scope content and expansion

Several organisations provided supportive feedback on the RN prescriber scope statement. This feedback supported broadening RN prescribing limitations, with a few organisations commenting on how this change will enable RN prescribers to provide improved care to a wider range of patients.

> ***Overall, we agree with the proposed changes to the Registered Nurse Prescriber scope of practice. We believe this reflects the contemporary practice changes for RNP, allowing a broader area of practice including the lifespan. We believe these changes will support access to health care in a timely manner and create opportunities for other models of care delivery for organisations to consider and increase options for health consumers.***
> Specialist Mental Health Service Te Whatu Ora Waitaha

The Aged Care Association was strongly supportive of this change as they saw that enabling "*our experienced RNs to undertake this advanced role will significantly improve timeliness of care, reduce hospital transfers, and enhance quality of life for residents*". The Ministry of Health and the New Zealand Society for the Study of Diabetes also submitted that they were in support of RN prescribing becoming a distinct scope of practice.

A few organisations that provided supportive feedback mentioned that safeguards included in the scope statement would facilitate safe prescribing practice. These organisations mentioned that educational preparation, collaboration and access to an experienced provider were appropriate requirements for the scope.

Health New Zealand | Te Whatu Ora Office of the Chief Nurse also supported including laboratory and diagnostic imaging in the scope statement. "*Being trained and able to order relevant investigations underpins safe prescribing practice and should be part of every RN prescriber's practice*".

Neutral and critical: safety, regulation and boundaries

Some organisations provided feedback that included some concern over the perceived lowering of safeguards for RN prescribing. A few organisations called for more detailed guidance around supervision, ongoing clinical support and integration into healthcare teams. These safeguards were seen as important for both patient safety and for role protection.

Clearer expectations around supervision, ongoing clinical support and integration into healthcare teams are needed. The current scope statement would benefit from greater emphasis on structured oversight, particularly for nurses new to the prescribing role. Well-defined supervision frameworks and clear lines of accountability are crucial to support safe practice and maintain public confidence. We recommend the Nursing Council include more detailed guidance on team integration, collaboration and access to clinical support, to ensure RN prescribers are well-supported throughout their prescribing practice.

Nurse Practitioners Hawke's Bay

A few organisations also expressed concern that without clear boundaries, the RN prescriber scope could lead to confusion with the RN scope. The New Zealand Nurses Organisation expressed the need for "*transparent progression from RN to RN prescriber to reinforce foundational nursing competencies and supporting safe, and incremental expansion of prescribing authority*". Victoria University of Wellington also pointed out the potential confusion in the levels of RN prescribing, as the RN scope will continue to include prescribing authority.

Critical: competence and risk

A few organisations expressed concern over the broadening of the RN prescriber's prescribing breadth through removing the current 'common conditions' limitation. These organisations expressed that the scope relied too much on the RN prescriber to know the limits of their competence and that they may end up practising out of their scope. The University of Auckland Nurse Practitioner Team suggested defining areas of competence in order to provide stronger safeguards.

It is currently unclear who is going to take responsibility for ensuring that the RN Prescriber is prescribing within their "area of practice" – is this going to be left to the individual nurse alone? This may create an unintended risk to patients, especially for inexperienced RN Prescribers working in a busy clinical setting where inappropriate prescribing expectations may be placed upon them.

University of Auckland Nurse Practitioner Team

The Ministry of Health also commented on the broad prescribing breadth, explaining that "*clarifying the breadth of prescribing practice areas will be important to ensure a more comprehensive understanding*". They suggested a focus on skills and learning outcomes rather than qualifications to better distinguish the RN prescribing scope from the NP scope.

RN prescriber feedback

Four RN prescribers provided comments on their overall support for the proposed scope statement. Their feedback stressed the importance of clear and strong measures to ensure public safety.

Emphasis on access to (an) experienced prescriber is important as this is a safety net for patients, as well as nurse prescribers, and allows confidence in the role and scope for the nurse. The proposed scope is also more definite and provides clarity.

Expanding RN prescribing aligns with contemporary nursing practice and international trends. I support the proposal to broaden the scope, provided that:
•safeguards and clinical governance structures are in place which are clear and succinct
•prescribing remains linked to both postgraduate education and competence assessment
•cultural safety and equity considerations are embedded in prescribing decisions.

Other comments

The Council received other comments on the following elements of the proposed RN prescriber scope.

Access to an experienced prescriber and clinical supervision

The Council received several comments in relation this proposal, ranging from supportive to critical.

Individual feedback

Emphasis on access to (an) experienced prescriber is important as this is a safety net for patients, as well as nurse prescribers, and allows confidence in the role and scope for the nurse.
RN prescriber

I appreciate the definition of authorised and designated prescriber may change and hence the terminology of 'experienced prescriber'. However, I wonder if this needs further extension.
Nurse leader

The reference to 'experienced prescriber' needs to be replaced with authorised prescriber.
NP

I do support nurses completing additional post-registration education at certificate and diploma level that allows nurses to extend their practice in different settings, but this must be supported by the necessary education and experience in their area of practice (at least two years), (and) appropriate supervision by a prescriber (either a nurse practitioner or medical doctor), to assess competence.

RN

Organisation feedback

Reflecting on the NMBA's recent implementation of the designated RN prescribing model, it may be beneficial to provide clear guidance on what constitutes an experienced prescriber and the criteria for when RN prescribers should seek clinical advice or support. While this level of detail may not be appropriate for inclusion within the scope of practice statement itself, the development of supplementary resources or guidance materials will support safe and consistent prescribing practice.

Nursing and Midwifery Board of Australia

While we broadly support the intent behind the proposed RN prescribing scope, we consider that it requires some refinement, particularly to strengthen clinical accountability, ensure prescribing occurs within a collective and multidisciplinary model, and reinforce the need for clinical supervision.

Royal New Zealand College of General Practitioners

Clearer expectations around supervision, collaboration and clinical governance are needed. What is the definition of an "experienced prescriber?" We believe there MUST be a named authorised prescriber within the collaborative team to provide oversight, particularly for those new to prescribing.

University of Auckland Nurse Practitioner team

Equity and Te Tiriti o Waitangi

The Council received a few comments in relation to equity and Te Tiriti o Waitangi.

Individual feedback

One RN prescriber respondent supported the broad RN prescribing scope provided that: "*Cultural safety and equity considerations are embedded in prescribing decisions".* This endorsement was further qualified by requirements for appropriate safeguards, robust clinical governance, postgraduate education and thorough competence assessment.

Organisation feedback

Two organisations expressed that the RN prescriber scope should include explicit statements around equity, Te Tiriti o Waitangi, Kawa Whakaruruhau and cultural safety.

RN prescribers improve access to health services, supporting equity within the health system. Including a statement that reflects this contribution, or that explicitly acknowledges the RN prescriber role in promoting equitable access to care/medications, would strengthen the scope and better recognise the intent of the role.

Kensington Health

We strongly recommend consistent inclusion of commitments to Te Tiriti o Waitangi, Kawa Whakaruruhau and cultural safety across all nursing scopes, reflecting the profession's foundational responsibilities in Aotearoa.

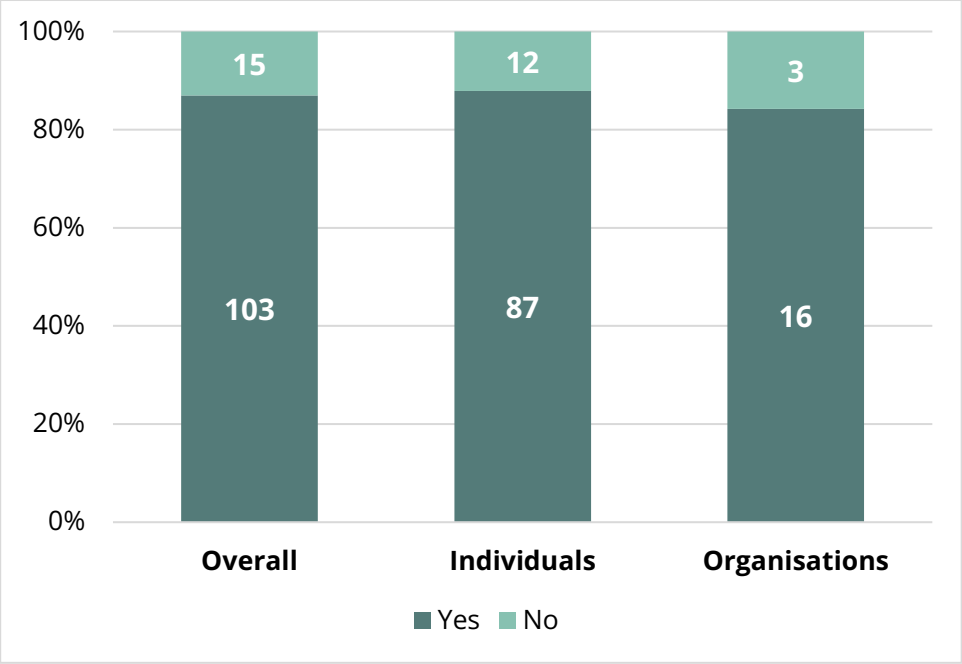
Nurse Practitioners Hawke's Bay

Section Two – Nurse practitioner scope of practice

Of the 85,462 nurses with annual practising certificates in Aotearoa New Zealand, 897 are NPs.[2] This section of the consultation received 40 complete responses from NPs. The consultation also received feedback from five organisations predominantly related to NP practice. While all feedback from individuals has been analysed together, responses from NPs are specifically highlighted. Compared to overall responses, feedback from NPs indicated a lower level of support for the NP scope of practice.

Nurse practitioner scope builds on the foundations of the registered nurse scope

Figure 4: The NP scope builds on the foundations of the registered nurse scope. Is this clear in the proposed changes to the NP scope?



Individual feedback

Fifteen individuals provided feedback on the relationship between the NP and RN scopes and whether the NP scope clearly built on the foundation of the RN scope. Most of these individuals did not agree that the NP scope built on the foundations of the RN scope, while others agreed with the principle and made suggestions on how this could be better articulated.

[2] Nursing Council of New Zealand Annual Report 2025

Supportive and critical: need for further distinction

A few individual respondents expressed support for the inclusion that the NP scope is built on foundational RN knowledge and skills but wanted to see a clearer distinction between the two scopes in the NP scope statement. These respondents echoed similar sentiments to those discussed above, warning against the two scopes being confused by employers, the public and other healthcare professionals.

> ***While NP is definitely built on the platform of registered nurse it is to a much higher standard, and I think this needs to be clear from the offset as the general public of medics reading this will just see registered nurse.***
>
> NP

Neutral: scope content

A few individual respondents recommended revisions to the NP scope statement to more clearly define how the NP and RN scopes are related. One individual expressed that they liked the section in the current NP scope statement "*particularly where it states the legal authority to practise beyond the level of a registered nurse"* (NP). The same respondent suggested the addition that the NP scope is built on and '*extends beyond*' the foundations of the RN scope. Another individual identified that there was no explicit connection to differential diagnosis and how this was built from the RN scope, and that diagnostic reasoning could be further emphasised in the NP scope.

Critical: distinction and role identity

Some individual respondents provided feedback that they did not agree that the NP scope builds on the foundations of the RN scope and asserted that they are distinct scopes of practice. A few respondents identified that the differences in advanced practice levels, autonomy and authority between the two scopes of practice are too substantial to closely connect them as demonstrated in the proposed NP scope statement.

> ***The proposed wording risks overemphasising the "builds on" concept at the expense of recognising NP practice as a distinct scope beyond the RN level. The NP role does not merely extend the RN scope, it represents a new and autonomous scope requiring mastery in clinical reasoning, leadership and systems-level thinking. This distinction must remain explicit to prevent confusion among employers and the public.***
>
> NP

A few respondents warned that the identified relationship between the RN scope and NP scope would confuse employers, the public and other healthcare professionals. Having clear distinctions between the RN and NP scopes was seen as integral for public safety and NP role recognition and protection.

I think (the) Nursing Council should emphasise more that NP is a different profession to RN or RN prescriber, therefore I do not see the point of stressing NP competencies are built on RN competencies as they do differ quite significantly.

RN prescriber on an NP pathway

Organisation feedback

Nine organisations provided feedback on the relationship between the NP and RN scopes, including whether the NP scope clearly builds on the RN scope in the proposed scope statement. Overall, organisational feedback was more supportive than that from individuals, although a few organisations raised similar concerns.

Supportive and neutral: continuity and progression

A few organisations supported the inclusion of the NP and RN foundational relationship in the NP scope statement. These respondents saw this inclusion as being beneficial to professional progression and continuity from the RN to NP scopes.

The NMBA agrees that the proposed NP scope explicitly states that it is built on the platform of the registered nurse scope of practice. This reflects the rationale provided which emphasises continuity with the RN scope while expanding autonomy and leadership responsibilities.

Nursing and Midwifery Board of Australia

A few organisations provided suggestions on how the continuity and progression from RN to NP could be enhanced. Health New Zealand | Te Whatu Ora suggested that the NP scope statement could include that the scope can also build on the RN prescriber scope. The Nursing and Midwifery Board of Ireland suggested that "*a more accurate and reflective description of this progression would be to frame the NP scope as a progressive upward step from that platform*".

Neutral: NP legal authority

Nurse Practitioners New Zealand asserted that the NP scope statement must include clearer language to distinguish the NP scope from the RN scope. This feedback was also expressed by Kensington Health which saw the retention of this part of the current scope as improving clarity.

We strongly recommend that the below statement remains within the new statement as this is a key defining sentence: 'Nurse practitioners have advanced education, clinical training, and the demonstrated competence and legal authority to practise beyond the level of a registered nurse.

Nurse Practitioners New Zealand

Critical: distinction and scope purpose

A few organisations did not support positioning the RN scope as the foundation on which the NP scope is built. They viewed this reference as being potentially confusing for the public and the broader health workforce. These organisations further reasoned that such a reference did not accurately portray the NP scope, which is characterised by advanced expertise in clinical reasoning, leadership, and system-level practice and influence.

The proposed scope is to "build" on the RN scope. Given NP is a separate scope of practice, we do not believe it is appropriate to refer the public and sector to other scopes on which to understand NP practice. This is likely to lead to confusion and poses a great risk to the profession of nursing and NPs. By building on the RN scope rather than explicitly stating in the NP scope, makes invisible those central capabilities of NP practice to promote health and wellbeing for communities.

Nursing Futures Taskforce

Feedback from nurse practitioners

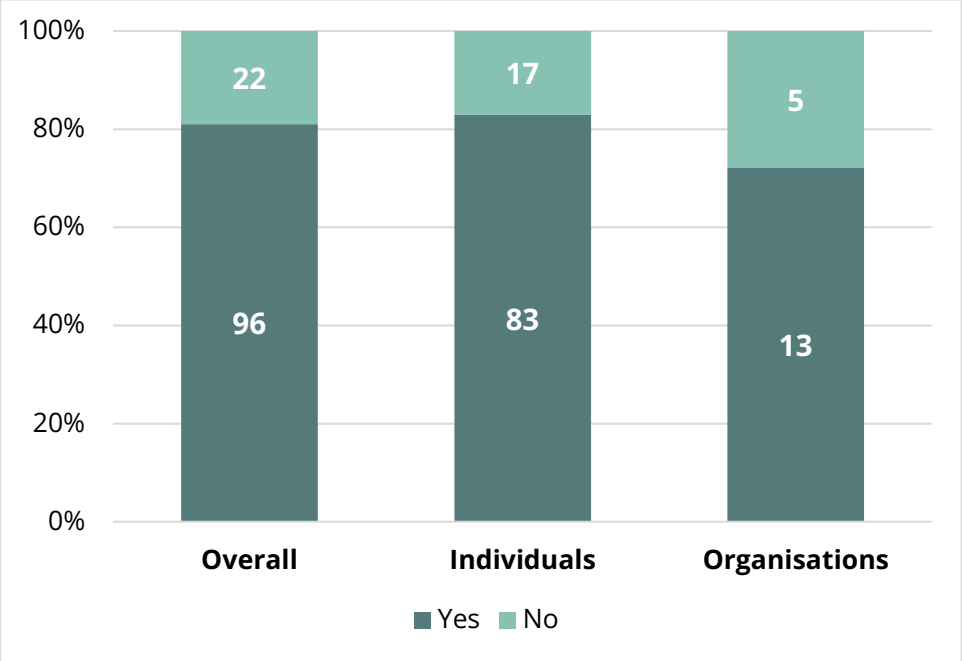
Six NPs provided comments on the relationship between the NP and RN scopes and whether the NP scope clearly builds on the foundation of the RN scope. The feedback received was largely neutral, with most NPs agreeing with the intention or purpose of this element of the scope statement but thought that there needed to be more explicit distinctions between the two scopes. These respondents highlighted the autonomous and advanced nature of the NP scope and its legal authority to practise beyond the level of an RN.

The nurse practitioner scope of practice is grounded in the registered nurse foundation but is a distinct, advanced scope characterised by autonomous clinical decision-making, prescribing authority and leadership in evidence-based practice.

No – while the NP is developed from the RN scope of practice and a professional nursing heritage, this statement does not clearly identify the NP as a distinct scope that is distinct from the RN.

Nurse practitioner scope reflects nurse practitioner practice

Figure 5: Does the proposed scope statement reflect NP practice?



Individual feedback

Twenty individuals provided feedback on whether they thought the proposed scope statement reflected NP practice. Most of these respondents were critical of the scope statement's accuracy or suggested revisions to improve its accuracy.

Critical: clinical mastery and advanced practice

Some individual respondents expressed that the revised NP scope statement lacked sufficient emphasis on the clinical proficiency and level of advanced practice that NPs hold. These respondents did not view the scope statement as accurately reflecting NP practice.

> ***The proposed statement incorporates leadership and research, but lacks specificity around clinical mastery, advanced diagnostics, and autonomous clinical decision-making that are core to NP practice. The emphasis on alignment with the RN scope risks downplaying the independent nature of NP work.***
>
> NP

A few of these respondents identified areas to strengthen, including the management of "*complex clinical ambiguity*", the delivery of "*longitudinal care*" (NP), and more emphasis on medical knowledge. Another individual stressed that the NP scope statement must reflect the "*NP's unique clinical authority to interpret diagnostics, make complex decisions, and lead therapeutic planning- none of which are adequately addressed in the proposed wording*" (NP).

Critical and neutral: authority, autonomy and leadership

Several respondents noted that the proposed scope statement did not adequately reflect NPs' authority, autonomy and leadership, and emphasised the need to strengthen these aspects. Respondents specifically highlighted the importance of including NP leadership in practice ownership, interdisciplinary teams and in designing and delivering health services.

> ***Mātanga Tapuhi are advanced clinicians and change agents who drive innovation, improve equity, and lead new models of care. The scope must make this purpose explicit and preserve the NP as the apex of advanced practice, combining expert reasoning, leadership and research capability. The Nursing Council is advised to reinforce the NP's role as a system-level leader. It is important to clearly differentiate diagnostic autonomy and leadership responsibility from RN Prescribers, embed governance safeguards to prevent role drift.***
>
> NP, nurse educator and nurse leader

One individual advised that "*by removing the fact we can be lead care providers you are muddying the description for our medical colleagues and the public. It needs to be clear that we can be lead care providers for patients*" (NP).

While these respondents stressed the importance of autonomy and leadership, one individual respondent expressed concern that *"the removal of collaborative aspects of practice detracts from a key aspect of NP practice"* (NP).

Conversely, a few individuals provided critical feedback about the emphasis on leadership included in the proposed scope of practice statement, commenting that it was excessive.

> ***I find it a bit odd the constant "clinical leaders". Nurse practitioners, whilst amazing, don't really "lead" the clinic as they still have a limited scope, and the legislation still limits them from working in a wider scope- e.g. no funding for maternity, they can't complete all medicals as a GP is specified as having to complete these. It just seems a bit odd, I guess.***
>
> Practice Manager

Critical and neutral: equity and population health

Some respondents noted that NP practice addresses inequities, commits to population health and benefits communities, which the revised scope statement omitted. They emphasised how NPs can improve access to healthcare, promote health and prevent disease, and play a pivotal role in advancing health outcomes at both individual and population levels. These respondents believed that this aspect of NP practice should be clearly specified in the scope statement.

> ***NPs are educationally prepared to evaluate multifaceted clinical scenarios, formulate wide-ranging differential diagnoses, and manage clinical uncertainty with confidence. In addition to direct patient care, the NP role encompasses leadership in designing and delivering health***

services that address equity, population health needs and system-level improvements. The NP scope of practice must clearly reflect this capability - this is not reflective within the proposed changes.
NP

Critical and neutral: scope wording

A few individuals provided suggestions for some of the wording in the scope statement. These suggestions included:

- removing the term "episodes of care" as "*this implies there is no role for NP as enrolled primary care providers or as providers in ARC facilities*" (NP)
- adding 'provides a wide range of comprehensive assessments, ***investigations*** and treatment interventions'
- altering the last sentence to "nurse practitioners ***may participate in*** research, healthcare design, policy, ***or*** education at regional, national *or* international levels" as the wording in the revised statement implies that an NP must be involved in all these activities.

One individual provided detailed revisions to the scope statement, suggesting grounding the statement in the four pillars of advanced nursing practice: clinical expertise, leadership, education and research.

Organisation feedback

Ten organisations commented on the extent to which the proposed scope statement reflected NP practice. Their feedback ranged from supportive to critical, and a few organisations also put forward suggestions to strengthen the statement.

Supportive: scope content and emphasis

A few organisations confirmed the revised NP scope statement accurately reflected NP practice, education, autonomy, leadership and impact. The Nursing and Midwifery Board of Australia noted the statement aligned with international standards.

The scope accurately reflects NP practice, highlighting advanced education, leadership, autonomous clinical decision-making, and cultural safety commitments.
Nurse Practitioners Hawke's Bay

Critical: advanced clinical role and expertise

Some organisations provided critical feedback on the revised scope statement, noting that it did not clearly capture the advanced clinical role and expertise of NPs. They emphasised the need to strengthen this aspect to better distinguish the NP scope from that of RN and RN prescribers.

The NP scope of practice needs to clearly articulate an advanced practice pathway that supports career progression and clarifies expectations for advanced clinical decision making. Without that, there is a risk that a lack of clarity that could dilute the distinctiveness of the NP role. Therefore, the scope should emphasise leadership, diagnostic authority, autonomous practice, advanced assessment, prescribing, and referral rights as appropriate, align with international standards, support workforce sustainability, advanced care delivery while the changes are timely and necessary to meet evolving health system needs.

New Zealand Nurses Organisation

Critical: leadership and role expectations

A few organisations provided critical feedback on the revised NP scope statement's emphasis on leadership. These organisations saw this emphasis as being excessive and detracting from the clinical element of the NP scope.

The NP scope has a stronger focus on leadership than previously. Not sure it accurately reflects the complexity of care delivered by a NP. Doesn't define area of practice and competence.

University of Otago

Health New Zealand | Te Whatu Ora highlighted that leadership is already established in the current RN scope of practice and that the emphasis in the revised NP scope implied that leadership could only be undertaken by NPs. They advised that *"the inclusion of '... national and international level' is also problematic and puts high levels of expectation onto NPs. While a few may take this route, we do not agree with its inclusion in the scope"*

The Royal New Zealand College of General Practitioners (RNZCGP) raised concerns about the emphasis on leadership and how it might impact the dynamics between NPs and GPs in practice. They identified the potential for scope creep between NPs and GPs.

We are concerned that the level of emphasis on expanding clinical leadership for nurse practitioners may risk creating ambiguity between the nursing and medical scopes of practice, particularly in general practice settings. While we acknowledge that NPs bring valuable expertise to multidisciplinary teams, the proposed scope lacks sufficient clarity around the boundaries of NPs relative to that of specialist GPs.

Royal New Zealand College of General Practitioners

RNZCGP also expressed that the NP and GP scopes should complement and support one another, but that there must be clear boundaries in the NP scope statement to prevent "*fragmentation of care, duplication of services, or delays in appropriate diagnosis and treatment, ultimately compromising patient safety, and undermining continuity of care*".

Critical and neutral: scope wording

A few organisations provided suggested changes to some of the wording in the scope statement. These suggestions included:

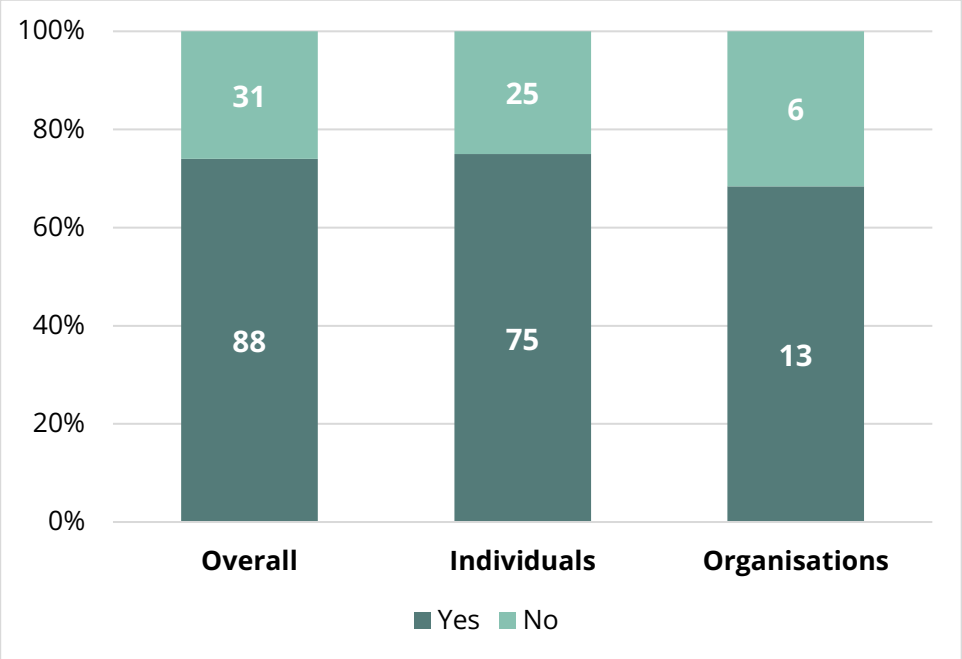
- adding a statement around NPs supervising RNs that are completing education for community prescribing or completing the Post-Graduate Diploma in Prescribing -Health New Zealand | Te Whatu Ora
- adding "*as well as an individual's overall healthcare as a lead care provider*" to the end of the second sentence in the second paragraph -Nurse Practitioners New Zealand
- adding 'combine advanced scientific knowledge, diagnostic reasoning, and critical analysis to diagnose and develop "*comprehensive*" therapeutic treatment plans, including prescribing medicines within their area of competence' -Nurse Practitioners New Zealand.

Nurse practitioner feedback

Eleven NPs commented on whether the revised scope statement reflected NP practice, mostly repeating sentiments expressed by individuals overall. They emphasised the need to strengthen references to NPs as advanced clinicians, leaders, autonomous and collaborative professionals, and to include their commitment to ethics, professionalism, honesty and integrity.

Nurse practitioner scope overall support

Figure 6: Overall, do you support the proposed changes to the NP scope statement?



Individual feedback

Fifteen individual respondents commented on the proposed NP scope statement. Some strongly supported the changes, while others shared concerns or suggestions.

Supportive: general statements of support

Several individuals expressed clear support for the NP scope statement, noting its clarity and positive impact on defining NP scope, though their comments were generally brief.

> ***Absolutely I am 100% in support of the proposal for NPs.***
> RN prescriber

> ***I like the clear description of the advanced education, commitment and contribution to health of the NP.***
> NP

Critical: distinctiveness and role definition

A few individual respondents submitted that they did not support the revised NP scope statement, citing that it devalued the NP role. They did not see the statement as adding value to the scope and highlighted that it would instead be confusing, as it blurred the lines between RN, RN prescriber and NP scopes of practice.

> ***The proposed scope statement seems limiting and minimising of the role of the NP, particularly when looked at alongside RN designated prescriber proposed scope.***
> NP and NP educator

One individual stressed the criticality *"of acknowledging and emphasising the importance of experience and the depth of post-registration education in the nurse practitioner scope, that prepares the nurse for diagnosis and safe prescribing*" (RN). Other individuals expressed that the scope statement was too limiting and not detailed enough.

Critical: safety and collaboration

A few individuals expressed concern that the changes to the scope statement were not focused on public safety and may be putting the NP scope at risk.

> ***There needs to be a focus on understanding limitations and seeking additional help or referral as needed. The Nursing Council needs to be about protecting patients and making sure that nurses, including nurse practitioners, have the right education to do the right roles.***
> Medical practitioner

One respondent submitted that to ensure patient safety, NPs must work collaboratively, be aware of the limitations of their knowledge and competence, seek guidance when necessary and practice within a defined area of practice.

Organisation feedback

Thirteen organisations provided comments on their overall support for the revised NP scope statement. The feedback reflects mixed views; some organisations expressed concerns while others expressed support.

Supportive, critical and neutral: scope breadth and emphasis

A few organisations submitted that they supported the revised NP scope statement overall. These organisations provided generally positive feedback on the content and focus of the statement.

A few organisations identified that the emphasis on the advanced clinical nature of the NP role was not strong enough in the revised NP scope statement. These organisations saw the distinct clinical element of NP practice as being the foundation to NP practice and it should therefore be clear and strengthened in the scope statement. The Nursing Futures Taskforce submitted that overall, the scope statement was light on detail and expressed that this could lead to "*considerable risk for the future*".

We are concerned that the proposed nurse practitioner (NP) scope of practice dilutes the core clinical focus that has always been central to the NP role. The revised scope places increased emphasis on leadership, research, and policy influence (at regional, national, and international levels). While we acknowledge the broad and valuable contributions that NPs make in these areas, it is crucial to recognise that these roles are underpinned and strengthened by advanced clinical expertise. Clinical practice is not a separate activity but rather the foundation that informs, enhances, and lends credibility to the NP's broader leadership, research, and policy work.

Child and Youth Nurse Practitioners

Health New Zealand | Te Whatu Ora identified that the statement should be clear that NPs hold a post-registration clinical master's rather than any master's degree. By clarifying the advanced educational requirements, the scope statement could more accurately reflect the advanced clinical qualifications and responsibilities of an NP.

Critical and neutral: scope clarity and boundaries

A few organisations commented that the language and detail were unclear and insufficient to distinguish the NP as a unique scope. These organisations warned that the lack of clarity could lead to confusion between the NP scope and the RN, RN prescriber and/or medical practitioner scopes of practice.

> ***We do not support the current proposed scope of practice statement for the nurse practitioner role. We feel that when comparing to the existing scope of practice statement, the new proposal dampens down the actuality of the nurse practitioner role and scope, and what is expected of this role in contemporary health care. Additionally, (it) does not clearly define or explain the difference between the registered nurse scope of practice and the nurse practitioner scope of practice.***
>
> Nurse Practitioners New Zealand

Supportive: autonomy clarified

A few organisations supported the revised statement for clarifying NPs' autonomy and recognising them as independent practitioners.

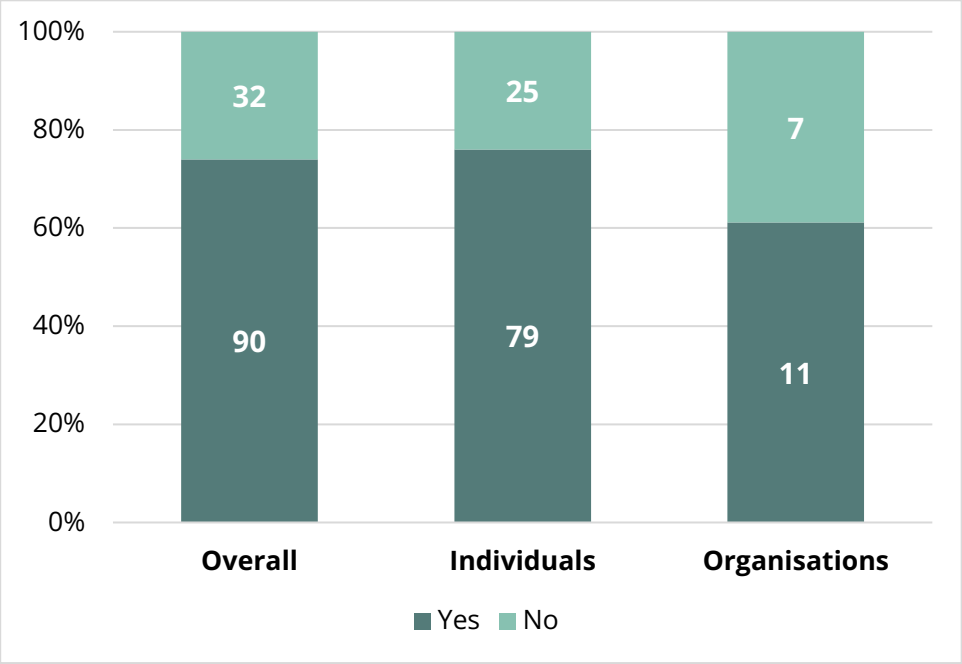
> ***The proposed updates provide clarity and flexibility to support nurse practitioners working in specialist areas, including palliative care. Recognising the broad, holistic, and autonomous nature of nurse practitioner practice aligns with the complex needs of people with life-limiting illness and their whānau.***
>
> Hospice New Zealand

Nurse practitioner feedback

Four NPs added comments to their overall feedback on the revised scope statement. The feedback from these nurse practitioners was varied; two offered supportive comments, while the other two respondents were more critical. Those in support of the statement provided general comments, with one NP expressing that it was clearer for the public. Critics argued that the statement weakened the scope, overlapped with the RN scope, and failed to clearly state the NP's purpose.

Difference between registered nurse prescribing and nurse practitioner scopes

Figure 7: Is the difference between the scopes of registered nurse prescribing and nurse practitioner clear?



Individual feedback

Forty-seven individuals commented on the clarity of the distinction between RN prescribing and nurse practitioner roles. Opinions varied, but most of this feedback was critical.

Supportive: clear differences

A few individual respondents provided feedback that the difference between RN prescriber and NP scopes was clear and highlighted that the NP scope is characterised by autonomous practice, allowing NPs to practise independently. RN prescribers were recognised as practising with the support of and access to an experienced prescriber, emphasising a key difference in their level of independence. One respondent identified the distinction in prescriptive authority as the main point of difference between the respective scopes.

> ***The NP scope is in-depth, extensive, and advanced, whereas the nurse prescriber scope is more prescriptive and adds the emphasis on access to experienced prescriber.***
>
> RN prescriber

Critical: blurring of boundaries and risk of scope creep

Many individuals provided feedback that the difference between the scopes of registered nurse prescribing and nurse practitioner was not clear and warned that this would lead to a blurring of boundaries and/or scope creep. These individuals saw the two scope statements as having too many similarities and being too closely aligned. Some of these individuals identified that while the RN prescribing scope had been enhanced, the NP scope had been diluted.

> ***There appears to be blurring with some forward creep of RN and some backwards creep of the NP scope.***
>
> NP and nurse educator

A few individuals expressed concern that the ambiguity between the two roles could be exploited by employers who may choose to hire RN prescribers to positions traditionally held by NPs to reduce costs. Such practices, they cautioned, could result in unsafe staffing arrangements, as RN prescribers might be allocated responsibilities beyond their scope and competence. Furthermore, these individuals warned that the revised scope statements risked undermining the value and distinctiveness of the NP role within healthcare teams.

> ***Scope confusion: Emphasis should be on nurse practitioner as the complete professional. Over-emphasis on prescribing as the endpoint of advanced practice with nurse prescriber will play into the potential for funders, planners, employers to reach for the quick fix, short education of registered nurses as a cheaper alternative, particularly in PHC settings.***
>
> RN

Some of these individuals identified that the shared terminology between the two scope statements was their main concern. These individuals called for this language to be changed or for further wording to be included in the RN prescribing statement to clearly identify its limitations and distinguish it from the NP scope, especially around the use of diagnosis.

> ***The proposed changes blur the distinction between the nurse practitioner (NP) and RN prescriber scopes of practice by incorporating terminology—such as advanced assessment and diagnostic reasoning—that traditionally reflects NP-level expertise. This lack of clarity undermines public and employer understanding of the roles and raises the question of why two separate scopes exist if they are indistinguishable.***
>
> NP

Other individuals focused on changes to the NP scope that could be made to further distinguish it from the RN prescribing scope. These suggested changes included:

- more emphasis on the leadership and expertise of the NP
- adding that NPs "legally practise beyond the scope of registered nurse **and** nurse prescribers"

- specifying the difference between authorised and designated prescribers
- adding that NPs supervise or have clinical oversight over RN prescribers.

Critical and neutral: need for clear differentiation for the public and other stakeholders

Some individual respondents expressed concern about how the differences between the RN prescriber and NP scopes were articulated in the revised statements and how this may be misunderstood by the public and other stakeholders. These individuals were particularly concerned about how unclear the differences might appear to those who were not familiar with RN prescribers and NPs.

> ***For those who are familiar with the scopes, it is clear. I think the question should be is this clear to those who are not affiliated to the nursing world including practice managers, GPs and the general public? The pressure for RN prescribers to practise outside of their scope needs close monitoring.***
>
> NP

One individual warned that the public will perceive the two scopes as the same and stressed that RN prescribing should remain within the RN scope of practice. A recommendation was also made that *"a publicity campaign outlining the roles would be helpful to support the boundaries of the roles and public understanding*" (NP).

Critical: pathways and progression

A few individuals provided critical feedback on whether a linear pathway from RN prescriber to NP should exist. These respondents emphasised that the two scopes are fundamentally different, particularly in terms of the educational requirements and the level of advanced practice involved. They argued that due to these clear distinctions, the RN prescribing scope should not be viewed as a transitional step or prerequisite on the pathway toward becoming an NP. Instead, both roles should be recognised as separate and distinct endpoints.

> ***RN prescribing is not a way point to NP, some do progress through both but there are some areas where RN prescribing will never be suitable: Old Age care and/or the setting will not be able to support an NP practicum. Furthermore, it denigrates the contribution that RN prescribers offer and does not value it is a destination that has its own worth.***
>
> Nurse educator

Organisation feedback

Twenty-one organisations provided comments on whether the difference between the scopes of RN prescribing and nurse practitioner was clear. The feedback indicated mixed views, with some organisations affirming clear differences between RN prescriber and NP scopes while others were critical.

Supportive: clear differences

Some organisations provided feedback that the difference between the RN prescribing and NP scopes was clear. These organisations highlighted the clear difference in the level of autonomy, educational preparation, prescriptive authority, advanced practice and scope focus and breadth.

The scope of practice between RNP and NP accurately reflects the different levels of autonomy and clinical expertise.

Specialist Mental Health Service Te Whatu Ora Waitaha

Supportive and critical: pathways and progression

Some organisations commented on the clarity of the pathway and progression from RN prescriber to NP, with the feedback received reflecting opposing reviews. A few organisations were strongly supportive of a clear pathway from RN prescriber to NP. These organisations supported the alignment of education standards to provide a structured and coherent route for career progression and practice advancement.

The proposals clarify nursing scopes of practice and align education programme standards in order to provide a coherent pathway for increasingly advanced scopes of practice from registered nurse (RN) to registered nurse prescriber (new scope of practice), to nurse practitioner (NP).

Australia New Zealand College of Anaesthetists

On the other hand, a few organisations argued against establishing a direct pathway from RN prescriber to NP roles. They believed these two positions are too different for one to lead into the other.

The review should reinforce the distinct nature of each scope rather than suggest a linear pathway. RN Prescribing represents an extension of the RN scope, whereas the NP scope is a distinct, autonomous scope of practice. Both pathways require clearly defined educational, supervisory, and regulatory frameworks, but they should not be viewed as sequential or hierarchical steps.

University of Auckland Nurse Practitioner Team

The Nursing Futures Taskforce cautioned that a straightforward progression could narrow the NP's scope and education to primarily biomedical areas such as assessment, diagnosis and prescribing, potentially overlooking how NPs can advance health equity and advocate for social justice. Additionally, they noted that this biomedical emphasis might "*disproportionately affect Māori and Pacific RNs and fails to acknowledge the breadth of NP practice to transform primary healthcare service delivery and access*".

Critical: blurring of boundaries and risk of scope creep

Some organisations noted that the revised scope statements could blur boundaries and cause scope creep, and they advised that clearer differentiation between the scopes was required to prevent these risks.

In operational practice, these boundaries can become blurred, highlighting the need for clearer communication, workforce planning, and role education at organisational and sector levels.

University of Auckland School of Nursing Faculty of Medical and Health Sciences

Nurse Practitioners New Zealand highlighted the shared terminology around diagnosis between the two scopes. They recommended that 'diagnose' should remain within the NP scope as the "*education and preparation adequately support this term's utilisation*" and that 'differential diagnosis' is better suited in the RN prescriber scope.

Critical: role protection and positioning

Some organisations voiced concerns about the unclear distinction between the two scopes, suggesting it could expose RN prescribers to exploitation by employers and undermine the status of NPs. They highlighted that a lack of clear role differentiation might allow employers to assign RN prescribers to roles traditionally reserved for NPs, thereby threatening both groups. They emphasised the need to uphold clear and well-defined boundaries to ensure the ongoing protection of both the RN prescribing and NP scopes of practice.

We run the risk of RN prescribers being put at risk by working beyond scope and also devaluing the NP role if RN prescriber is seen as a 'cheaper' option.

Otago Community Hospice

Critical: need for clear differentiation for the public and other stakeholders

Some organisations expressed concern that the ambiguity and crossover between the RN prescriber and NP scopes might lead to a lack of understanding of the scopes by the public, employers and education providers. These organisations highlighted the need for clear guidance and differentiation between the scopes to illustrate the distinct and unique scopes.

For the public, it could be very difficult to distinguish the difference between the two scopes with change in focus for RNP to areas of practice and away from LT and common conditions.

University of Otago

The Aged Care Association suggested that the Council should "*develop practical case studies or guidance documents illustrating how the two roles can collaborate and complement each other in a community-based setting like aged residential care*".

Registered nurse prescriber feedback

Four RN prescribers shared views on how the RN prescriber scope differed from the NP scope. Some felt the distinction was clear, noting limited prescribing authority and a focus on access to an experienced prescriber for RN prescribers. However, one saw the difference as minor, while another suggested the Council should further clarify that NPs are a separate profession from RNs or RN prescribers.

Nurse practitioner feedback

Eighteen NPs provided feedback on whether the difference between the NP and RN prescribing was clear. This feedback was largely critical of the difference between the two scopes. A few NPs warned that the similarities and shared language between the scopes would lead to a blurring of responsibilities and a lack of understanding from those who are not familiar with the scopes. A few NPs warned that the similarities between the two scopes and the lack of understanding might lead to RN prescribers being employed in roles that were previously held by NPs. A few NPs also commented on the need to further distinguish the NP scope from the RN prescribing scope.

Defining areas of practice

Respondents were asked how they would define broad areas of practice. This question was asked to help inform the upcoming review on standards of competence and continuing competence requirements, which may include requirements for changing areas of practice for nurse practitioners.

Thirty respondents (including organisational and individual submitters) provided suggestions for how broad areas of practice could be defined, with most identifying clinical practice areas, life course stage or population group as the most appropriate descriptors. Some had different suggestions, such as using the major domains of nursing, i.e. education, leadership, clinical, and research. Some respondents opposed any move to defining areas of practice.

Changing areas of practice

Nine respondents commented on this topic. These respondents noted some risk to patients if NPs or RN prescribers shifted areas without training and education in the new area of practice, wanting to know how this was going to be managed, and suggesting the addition of specific guidance on how to transition safely.

Other comments

The Council received other comments on the following elements of the proposed NP scope.

Autonomous practice

Individual feedback

> ***I support the changes which seem clear to me. However, I wonder if the ability to practise independently should be stated more clearly and earlier in the statement.***
>
> NP

Organisation feedback

Some organisations suggested that the NP scope statement should more clearly define and elaborate on NP autonomous practice and its implications for NPs, colleagues and employers. This focus was considered essential for safeguarding the NP scope and for enhancing broader understanding of NP scope parameters. This emphasis was also seen as being important in distinguishing the NP scope from the RN prescribing scope. The University of Otago's Department of Nursing requested a clear distinction between "independent" and "autonomous".

> ***The scope needs to explicitly support ownership of practices and clinical leadership roles of interdisciplinary teams. Autonomy is stated, but greater clarity is needed to reduce the risk of misinterpretation and limitation on NP practice imposed by other professions, governments and health organisations.***
>
> Nursing Futures Taskforce

A few organisations emphasised that collaboration should not be removed from the revised NP scope statement. These organisations strongly recommended that the emphasis on autonomy must be balanced with an emphasis on collaboration. The lack of collaboration in the statement was seen as a risk to patient safety.

While it is appreciated what the term 'autonomy' is trying to create within the NP role, it is important to notice that 'autonomy' brings risk. It is suggested that this is amended to 'collaborative-autonomy'. In medicine, autonomous work has proven to be incredibly risky for patients – we need to learn from medicine's mistakes.

College of Emergency Nurses

The Royal New Zealand College of General Practitioners (RNZCGP) also expressed this concern and warned "*that the proposed framing may unintentionally imply independent or hierarchical leadership, rather than collaborative, team-based care."* The RNZGP called for the scope statement to include a balance of autonomous and collaborative practice to ensure that NPs *"continue to work as part of multidisciplinary teams, with structured access to senior clinical support, particularly in general practice where the complexity of care demands close collaboration".*

Doctoral degree

Three organisations submitted critical feedback of including the option of NPs being educated at a doctoral level as well as at a master's level. All organisations saw this inclusion as being unnecessary and inappropriate.

Completing doctoral level study for the purposes of NP preparation is inappropriate. These programmes are not designed to prepare nurses for advanced clinical practice.

University of Auckland Nurse Practitioner Team

Health New Zealand | Te Whatu Ora commented that the option might be misinterpreted as a requirement for NP registration. They also questioned why the Council was "*raising the bar*" to a doctorate when this isn't included in the medical scope. These sentiments were echoed by the Ministry of Health.

Equity and Te Tiriti o Waitangi

Individual feedback

A few individuals noted the inclusion that NPs role model commitment to Te Tiriti o Waitangi, Kawa Whakaruruhau and cultural safety, but did not see this element as being sufficiently expressed in the scope statement. These individuals expressed that not only do NPs model this commitment, but they also advance health equity, model social justice and improve access to health care and that this should be reflected in the scope statement.

While Te Tiriti o Waitangi is mentioned, it does nothing to explicitly acknowledge the transformational role of NPs in delivering primary healthcare (in its fullest and broadest sense) to improve health equity and access to health care. It fails to imply holistic practice and how NPs develop not only their biomedical skills in the NP scope but also their competencies to deliver advanced "nursing" practice to ensure social justice.

RN and nurse leader

Organisation feedback

A few organisations strongly supported the inclusion of NPs commitment to Te Tiriti o Waitangi, Kawa Whakaruruhau and cultural safety. These organisations considered this commitment essential to NP practice, noting that it also supports a commitment to equity.

We acknowledge and strongly support the inclusion of Te Tiriti o Waitangi, awa Whakaruruhau (cultural safety), and partnership with whānau as integral to NP practice. These are essential and welcome foundations that must remain central to all scopes and educational frameworks.

Child and Youth Nurse Practitioners

RN prescribing as a prerequisite for NP

Two organisations proposed that successful completion of the postgraduate diploma in RN prescribing should be established as a prerequisite for entry into nurse practitioner education. Nurse Executives Aotearoa endorsed this requirement, believing the postgraduate diploma would better prepare NP candidates for the advanced clinical and prescribing responsibilities involved in NP practice.

It is not clear whether RNs need to have a PG Dip prescribing before becoming NPs. We support this as a prerequisite for entering the NP master's or entering NP practicum year.

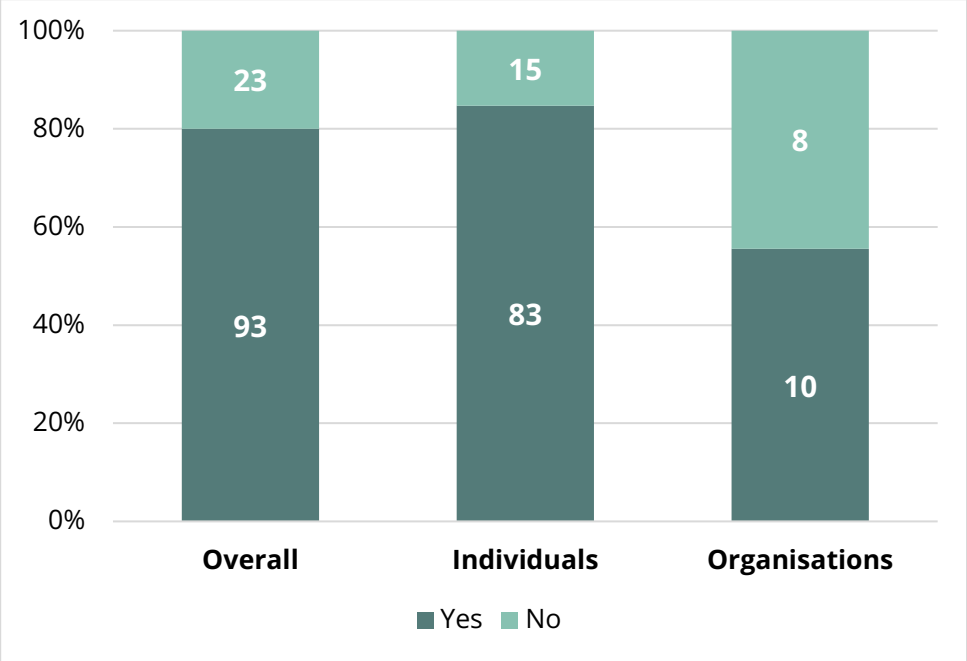
Health New Zealand | Te Whatu Ora

Section Three – Education standards

This part of the consultation addressed education standards for RN prescribers and NPs. While all feedback from individuals has been analysed together, responses from RN prescribers and NPs are specifically highlighted.

Clinical learning requirements for RN prescribing

Figure 8: Do you support the clinical learning requirements for RN prescribing?



Individual feedback

Seven individuals commented on whether they supported the proposed changes to the clinical learning requirements for RN prescribing. This feedback was largely critical, with a few individuals offering alternative requirements.

Critical: retention of minimum hours

A few individuals submitted that they were not supportive of removing the minimum number of clinical hours in RN prescribing education and the shift towards a focus on competence.

> ***I believe there should be a minimum number of hours for the nurse prescriber to complete as part of the education, rather than the wording of 'arbitrary' / 'outcomes-based' approach.***
> RN prescriber

One individual highlighted that "*a level of direction is needed to optimise protected time for supervised practice*" and suggested that the standard might be revised to allow recommendations of up to 150 hours (nurse leader).

Critical: potential for inconsistencies in application

A few individuals raised concerns about relying on competence assessments for clinical evaluation and noted potential inconsistencies in applying the proposed standard. One individual expressed discomfort about the thought of prescribing mentors assessing RN prescriber competence, as there might be a risk of inaccuracies. Another individual expressed concern regarding assessors signing off against the RN prescriber competencies while not being aware of the scope of practice. The same individual also warned that there was a risk of a conflict of interest with employers assessing RN prescriber students.

Removing the 150-hour practicum offers flexibility for learners, however, it can play into the predictable problem of health employers not facilitating the support, moderation or monitoring that we know is a problem in a number of settings.

RN

Organisation feedback

Four organisations provided feedback on whether they supported the proposed changes to the clinical learning requirements for RN prescribing. These organisations were mostly critical of the proposal.

Critical: importance of defined hours

A few organisations stressed the importance of having defined clinical hours as a means of ensuring consistency and clarity in the training process for RN prescribers.

Agree with the sentiment about set clinical hours for RN prescribing role being arbitrary, but it does give clear guidance to support training RN prescribers with setting up an appropriate and supportive clinical practicum with their employers, who may not understand the training and education requirements, especially in primary care.

Kensington Health

Kensington Health also highlighted that having the minimum hour requirement *"bolsters professional and public confidence in the advanced training of RN prescribers"*. These organisations viewed the minimum-hour requirement as a crucial tool in determining whether an RN prescriber student has met the requirements for the scope.

Critical: risks related to removing minimum required hours

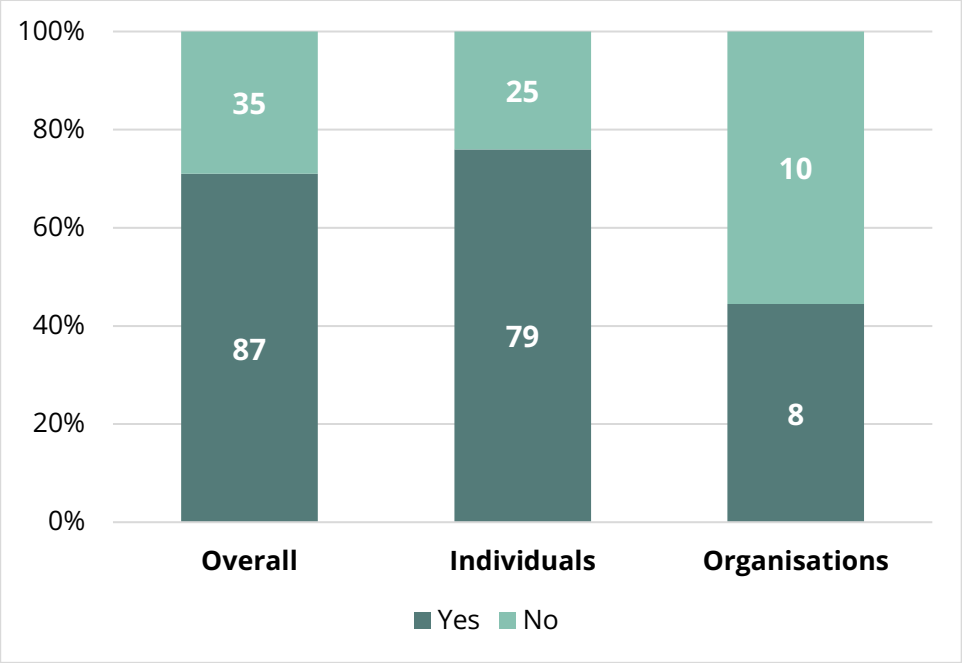
A few organisations warned that removing the minimum required hours might cause inconsistencies and lower RN prescriber education quality. The Nursing Futures Taskforce also expressed concern regarding the potential of RN prescriber competence being assessed by health organisations and private health providers without oversight.

Registered nurse prescriber feedback

One registered nurse prescriber provided feedback on the proposed changes to the clinical learning requirements for RN prescribing. This RN prescriber submitted in support of the minimum number of hours rather than the proposed changes.

Registered nurse prescriber years of experience

Figure 9: Do you agree that registered nurses should complete two years in the area of practice they intend to prescribe in before registration as a nurse prescriber?



Individual feedback

Nineteen individuals provided feedback on whether they supported the proposed changes to the years of experience requirement for registered nurse prescribing registration. All feedback was critical, with no support expressed by individuals.

Critical: the value of experience

Some individuals emphasised the value of RN experience completed before RN prescribing registration and strongly opposed reducing this requirement. A few of these individuals commented on the need for broad, deep and varied experience. For these individuals, quality

post-registration experience as a registered nurse was essential to ensure they are competent and safe prescribers upon completion of their education.

> ***I am concerned about the length of time of minimum 2 years in the area the nurse should prescribe in. This means they have likely only done one year of competent practice after completing their year a new grad. I believe this is insufficient time to gain the adequate skills, maturity and nursing knowledge to safely prescribe with the intended extended scope of practice.***
>
> NP

Critical: concerns about reduction

A few individuals expressed concerns regarding the implications for RN prescribers and public safety resulting from the proposal to reduce the required years of experience. These individuals raised potential risks that might arise from who they saw as inexperienced RNs becoming RN prescribers.

> ***I do feel that for a new grad that would be stressful to undertake if pressured to do OR they themselves lacked the insight into the pressures it would involve. Also, it would impact on patient safety.***
>
> Nurse educator

One individual warned that employers might exploit this requirement to "*get a registered nurse who can do a task to assist the medical team rather than a professional who has broader expertise*" (RN).

Critical: support for no changes

A few individuals submitted that they would like the years of experience requirement to remain the same, as it sufficiently prepares RNs for RN prescribing education and practice.

> ***Ideally, RNs will have worked for at least 3 years post-registration before undertaking PG prescribing papers to ensure adequate clinical experience.***
>
> NP

Critical: flexibility in full-time equivalent requirement

A few individuals were critical of the requirement for entry to the registered nurse prescribing programme of study; students/ākonga must have completed one year working at least 0.8 full-time equivalent in clinical practice. These individuals called for a reduction of the full-time equivalent requirement or for flexibility to accommodate students/ākonga with other responsibilities.

What is the evidence for 0.8 FTE? Suggest 0.6 FTE could be sufficient – work, life, family balance, female-dominated profession.

NP

Organisation feedback

Eleven organisations provided feedback on the proposed changes to the years of experience requirement for RN prescribing registration. Most of the organisations that provided feedback were critical of the proposal, but one organisation provided strong support.

Critical: value of experience

A few organisations submitted that raising standards and requiring the same or more experience prior to RN prescriber registration was crucial to ensure competence, safety and readiness for an expanded scope of practice.

The proposed reduction in required clinical experience in an area of practice for entry into NP and RN prescriber programmes is concerning. Both scopes involve a significant step beyond the RN role, requiring advanced clinical reasoning, autonomous decision-making, and high-level prescribing skills. Two years of prior experience may be insufficient to develop the knowledge, confidence and resilience needed to practise safely.

Kensington Health

Critical: concerns about reduction

A few organisations highlighted their concerns regarding the proposal to decrease the years of experience requirement for RN prescribers. Organisations highlighted the risk to public safety of less experienced RNs becoming RN prescribers as this might increase the risk of clinical errors.

Concerns include the reduction in required clinical experience for RN prescribing to two, which may be premature and pose safety risks as nurses may still be developing core clinical skills.

Nurse Practitioners Hawke's Bay

Kensington Health also warned that the proposal could increase *"professional overwhelm, and reduced readiness for leadership responsibilities, potentially undermining public and professional confidence in the advanced practice workforce"*.

Critical: barriers and flexibility

Some organisations identified that the 0.8 full-time equivalent specification in the years of experience requirement might be a barrier to prospective RN prescribers. As many new graduate nurses are employed at 0.6 full-time equivalent, the proposal could prevent or delay their commencement of RN prescribing education. Health New Zealand | Te Whatu Ora

recommended that the requirement should be changed to an equivalent of a minimum of two years of full-time practice.

Critical and neutral: clarity and definitions

Some organisations mentioned specific areas of the proposal that needed clarification or further definition. These areas included:

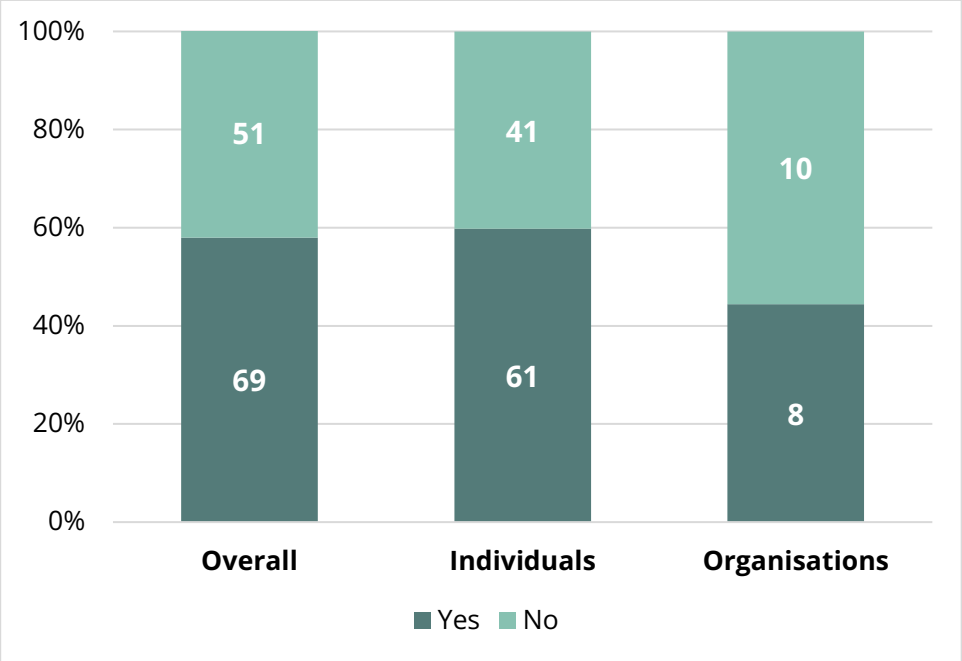
- when years of experience begin (Victoria University of Wellington and University of Otago Department of Nursing)
- how the area of practice in which an RN intends to prescribe will be determined, and who will determine this (Victoria University of Wellington and University of Otago)
- the type of clinical practice required (University of Auckland Nurse Practitioner Team).

Registered nurse prescriber feedback

Five RN prescribers commented on the proposed changes to the years of experience requirement. Most of these RN prescribers commented about how crucial prior RN experience is for RN prescriber registration. A few RN prescribers suggested more flexibility in practice requirements due to overlapping skills and knowledge in many areas.

NP years of experience

Figure 10: Do you agree that NPs should complete two years in their chosen area of practice before registration?



Individual feedback

This part of the consultation received substantial feedback from forty-five individuals regarding the requirement for NPs to complete two years in their specialty before registration. Responses to this proposal were largely critical, reflecting a range of perspectives.

Critical: value of clinical experience

Many individuals expressed how important and valuable clinical experience as an RN is before becoming an NP. These individuals expressed similar sentiments as those who commented on the experience requirement for RN prescribers, but more strongly emphasised the importance of advanced practice clinical experience. These individuals were particularly concerned that the requirement might enable a newly graduated RN with two years of experience to become an NP. Two years of experience was seen as an inadequate foundation to transfer into NP education and registration. Individuals highlighted that, along with specialty practice, leadership, research and teaching experience were vital to prepare RNs for the advanced role. The level of expertise that NPs hold was mentioned by several individuals, with this level only being achievable over a significant period. Some of these individuals recommended that the requirement should remain as it is, while others preferred to see it increased and strengthened.

I do not agree that 2 years "working in their chosen area of practice" is long enough to be ready to start advanced training to be a nurse practitioner. After 2 years of work experience, many RNs are unlikely to have the appropriate clinical experience, professional maturity, clinical competence and insight to be ready for this enormous step.

NP and RN

Critical: impact on NP role and profession

Several individuals asserted that lowering the experience requirement for NPs could harm both the role and the profession. A few individuals expressed concerns that the proposal could lower the perceived quality of the profession, reduce public trust in healthcare, and diminish NPs' standing within healthcare teams, particularly compared to medical colleagues. The extensive experience that an NP brings as a healthcare professional is invaluable, and diminishing this experience would lessen their role and their impact on health outcomes. A few of these individuals also recommended that this requirement remain unchanged or be increased and strengthened.

This change undermines the integrity of the NP role and risks weakening the credibility we have worked hard to establish.

NP

Critical: concerns about reduction

Several individuals expressed concerns regarding the reduction in the years of experience requirement for NP registration. A few of these individuals identified that this proposal might lead to RNs becoming NPs before they were ready. These NPs would be at risk of struggling when they began to practise or of making errors.

> ***In the current NZ context for NPs, NPs are experienced senior nurses. Currently set at 3 years, this should be the minimum. With proposed changes, there is an opportunity for inappropriately experienced nurses to complete registration.***
>
> NP

Critical: need for clarity

A few individuals asked for further guidance on what type and level of practice were required before NP registration. They highlighted that the experience required should be patient-facing clinical experience.

Critical: flexibility in full-time equivalent requirement

Several individuals raised the same concerns regarding full-time requirements for RN prescribers. These individuals saw this requirement as a barrier for prospective NPs and recommended that this should be more flexible or set at 0.6 full-time equivalent.

Organisation feedback

Fifteen organisations provided feedback on the proposed changes to the years of experience requirement for NP registration. While their feedback did include some criticism, a few organisations provided some supportive comments.

Supportive: internationally qualified NPs

A few organisations provided positive feedback on the requirement of one year of practice needing to be completed in New Zealand. These organisations recognised that this inclusion made the pathways to registration in New Zealand clearer for internationally qualified NPs.

> ***The requirement for one year of nursing practice in New Zealand at a minimum of 0.8FTE seems to be targeted specifically at IQNs. The requirement seems appropriate for registered NPs from other accepted jurisdictions.***
>
> Victoria University of Wellington

Critical: concerns about reduction

A few organisations expressed their concern about the reduction in the requirement and how it might impact patient safety. These organisations warned that less experienced NP candidates might not have the broad and advanced knowledge base to be able to practise competently and safely as NPs. Most of these organisations recommended that the requirement should remain at a minimum of four years.

> ***The rationale of reducing entry to two years to remove barriers and enable a more expedited pathway increases clinical risk to patients who may have nurses who are underqualified to undertake NP practicum.***
>
> University of Auckland Postgraduate School of Nursing

Critical: clinical readiness and standards

A few organisations affirmed that two years of experience were not sufficient to clinically prepare an RN to become an NP. The Nurse Practitioner Team at the University of Auckland emphasised that clinical readiness involves more than simply counting years of experience. They recommended that "*clinical capability needs to be defined and assessed through more robust, standardised indicators akin to GPA benchmarks, so that clinical readiness is transparent, measurable, and equitable across candidates and programmes*". Given the advanced responsibilities and wide-ranging scope of practice associated with the NP role, it was essential to assess clinical readiness to ensure competency and protect public safety.

Critical: need for clear differentiation

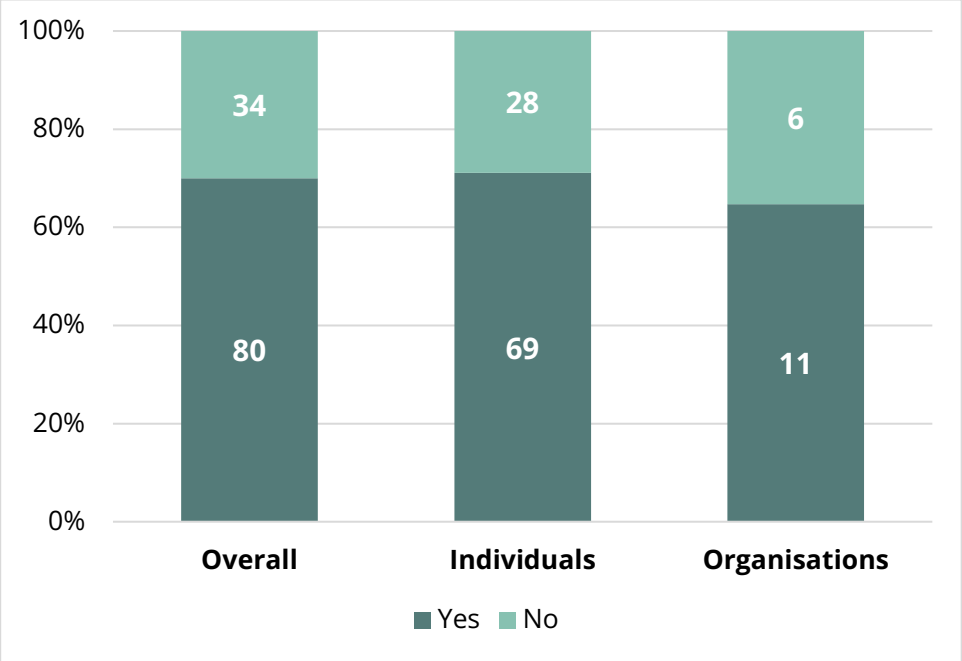
A few organisations identified that the wording in the standards needed to be clearer to better articulate the experience required for entry into NP education and what is required for NP registration.

Nurse practitioner feedback

Twenty-two NPs provided feedback on the proposed changes to the years of experience requirement for NP registration, with all feedback being strongly critical. Several NPs argued that two years was insufficient to develop the depth of clinical judgement, leadership and advanced assessment skills required for safe, autonomous practice. These NPs emphasised that expertise comes through broad and varied clinical exposure, with some recommending at least 4–5 years of relevant, advanced practice experience before NP registration. A few NPs drew comparisons with medical training. There was concern that lowering requirements risked producing underprepared nurses, weakening professional standing and compromising patient safety. Overall, NPs supported maintaining or strengthening current standards rather than reducing them.

Programme lead requirements

Figure 11: Do you support the requirements for the programme lead?



Individual feedback

Nineteen individuals provided comments on the requirements for the programme lead. This feedback was mostly critical.

Critical: feasibility and barriers

Some individuals questioned the feasibility of the proposed requirements for the programme lead. These respondents saw the requirements as being unrealistic to achieve, creating an excessive workload for current programme leads and imposing barriers to anyone wanting to step into the role. Renumeration issues were also highlighted as the requirements might discourage NPs and RN prescribers from taking up the roles, preferring better-paid clinical positions. Recruitment was mentioned by respondents, who pointed out that these requirements would shut out otherwise suitable NPs from the position.

> ***I think it is aspirational to expect the programme lead to be a NP AND hold a doctorate AND work 0.8 FTE AND be clinically relevant AND understand tertiary education. There would not be enough NPs currently to fill these roles in NZ.***
>
> Nurse leader

Critical: clinical currency

Several individuals stressed the importance of programme leads being clinically current, with a few expressing concerns over the focus on academia. As one proposed requirement for the programme lead was to be working in the role at 0.8 full-time equivalent, they would be less or

unable to practise clinically. Respondents warned that a programme lead who was only active in an academic role might lose their understanding of the clinical settings in which NPs are practising.

> ***The programme lead also needs to understand what current clinical challenges the NP candidates are facing and therefore hold a current clinical job also.***
>
> NP

Critical and neutral: recommended changes

Some individuals provided suggestions to the proposed requirement, with a few recommending that the programme lead should be employed at 0.6 full-time equivalent.

Organisation feedback

Nine organisations shared feedback on programme lead requirements, echoing concerns from individuals and offering some unique viewpoints.

Critical: feasibility and barriers

A few organisations queried the feasibility of the requirements for the programme leads, citing that many programme leads would not be able to meet them. These organisations emphasised that programme leads typically assume additional responsibilities such as clinical practice and research. They noted that maintaining a 0.8 full-time equivalent requirement would not be feasible under these circumstances.

> ***The requirement for programme leads to be employed 0.8FTE into the role seems unrealistic – most of these clinicians are working clinically in addition to their academic roles (as NPs and RN prescribers are clinical roles).***
>
> NZNO College of Emergency Nurses

Critical: clinical currency

A few organisations stressed the importance of programme leads being clinically active and current. They saw the proposed requirements as imposing a barrier to being clinically current.

> ***NP's need to complete a clinical component to maintain registration, 0.8 in academia would limit this. I suggest that a clinically expert NP offers possibly more than an academic PhD-prepared course lead in some areas***
>
> University of Otago, Department of Nursing

Critical and neutral: preparedness for role

A few organisations supported the need for well-prepared programme leads but did not agree with all the proposed changes. While they recognised the importance of strong leadership in NP preparation, they opposed the specific approach suggested.

> ***Rather than stipulate FTE (the responsibility for which belongs to the education institution based on enrolled student FTE), the standards should focus on the key attributes of current clinical expertise, academic skills and knowledge for quality educational programme delivery.***
>
> Victoria University of Wellington

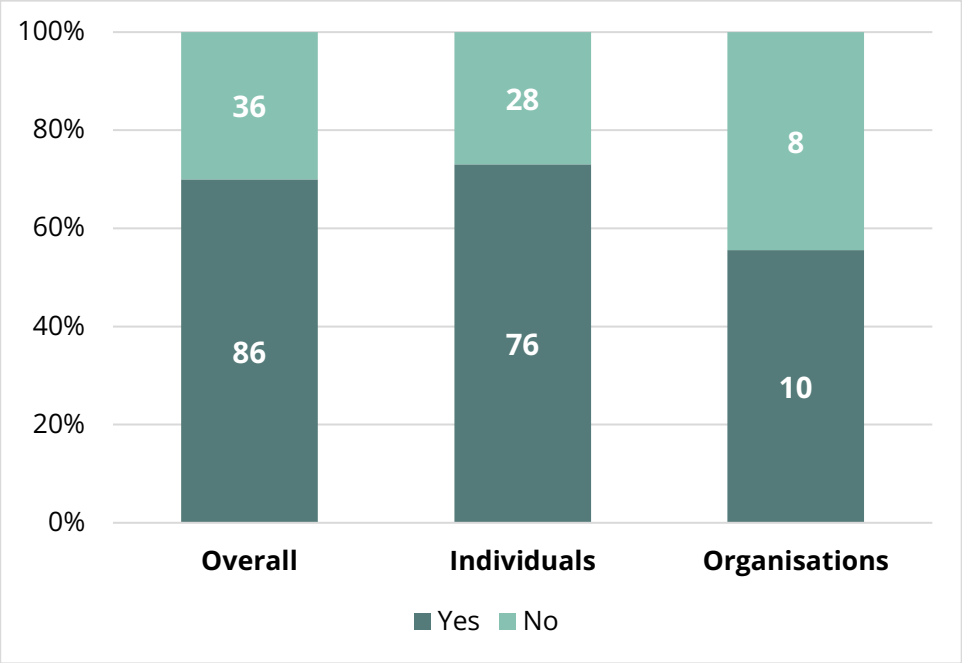
Nurse practitioner feedback

Sixteen NPs provided feedback on the programme lead requirements. NPs emphasised that programme leads must remain clinically current to understand the realities and challenges faced by NPs in practice, rather than being positioned solely in an academic role. A few expressed concerns that requiring a 0.8 FTE employment was not feasible, poorly aligned with current pay structures, and risked excluding highly capable clinicians while reducing clinical currency. They argued that master's-level education and relevant clinical expertise were more important than rigid academic thresholds. Overall, NPs expressed that programme leadership must balance academic credibility with up-to-date clinical practice to ensure high-quality, relevant NP education.

No RN prescribers commented on the programme lead requirements.

NP simulation and face-to-face clinical learning requirements

Figure 12: Do you support a minimum of 100 hours of simulation plus 400 hours of face-to-face clinical learning in the NP programme?



Individual feedback

Eighteen individuals commented on the proposed simulation and face-to-face clinical learning requirements for NP education. This feedback was mostly critical.

Critical: importance of in-person clinical learning

Some individual respondents stressed the importance of in-person clinical learning in response to the proposal of requiring 100 hours of simulation in NP clinical education. These individuals did not agree that simulation should be utilised over in-person learning, as it does not provide sufficient learning for the advanced practice. A few of these individuals expressed concern that the requirement for simulated learning hours might lead to a degradation of NP competence and pose a risk to public safety.

The requirement for 100 hrs of simulated learning is erroneous – if the 500 hours can be done in a clinical environment it should be, as this improves knowledge retainment and communication skills.

NP

Critical and neutral: role of simulation

Some individuals submitted that while they were critical of the requirement for simulated hours, they recognised that simulation could be a useful tool in education. Some felt simulation should supplement, not replace, face-to-face clinical learning. A few suggested making the 100 hours of simulation optional or adding them to the existing 500 hours of in-person training.

> ***While clinical simulation has value in assessment, it must not replace direct, face-to-face clinical supervision in the workplace. Simulation can complement the process—ideally outside the required 500 clinical hours—to provide academic critique and reduce bias. However, using it as a substitute undermines the integrity of clinical preparation and risks weakening the depth and authenticity of real-world learning.***
>
> NP

One individual highlighted that clinical reasoning is developed through high-quality supervision, feedback, and exposure to complexity, with simulation providing valuable support when it is "*purposeful and culturally codesigned Māori and Pacific clinicians*" (RN) to address scenarios not consistently available in all clinical placements, particularly in smaller or rural settings

Critical and neutral: access and flexibility

A few individuals highlighted access issues that would arise if simulated learning were to become a requirement. Rural NP students could find it difficult and expensive to travel to their education provider's simulation lab to undertake the required simulated hours. These individuals also suggested that the simulated hours should be optional.

> ***100 hrs of simulation will be difficult for rural nursing learning via distance learning, huge financial strain of travel and accommodation. Unless this can be done online somehow.***
>
> RN prescriber in community health

Organisation feedback

Fifteen organisations provided feedback on the proposed changes to the requirements for clinical learning in NP education, with this feedback being largely critical.

Critical: opposition to the required simulated hours

Some organisations expressed opposition to the proposal of requiring 100 hours of simulated learning in NP education. A few of these organisations cited the requirements as being too prescriptive, others expressed that the proposal was too vague, and that simulation needed to be better defined by the Council. A few organisations suggested that simulation should only be an option, as it does not replace face-to-face clinical hours.

The specific requirement for 100 hours of simulated learning in the NP practicum is not supported by the evidence presented in the Council's background and literature review documents. While we support the use of some simulation hours, 100 hours (2.5 full weeks) seems arbitrary and excessive. Technical skills for nurses who are already advanced in their practice would ideally be consolidated in their area of clinical practice.

Victoria University of Wellington

Critical: need to increase face-to-face clinical hours

A few organisations submitted that the overall clinical learning requirements for NPs were insufficient and should be increased. The New Zealand Nurses Organisation highlighted that as less experienced RNs are entering into NP education, strengthened clinical learning requirements are crucial. RNZCGP provided a comparison to the clinical learning that specialist GPs undertake, and the Nursing Futures Taskforce highlighted international standards for NPs. There was strong feedback from these organisations that enhancing clinical learning requirements was essential to upholding the quality and safety of NP education in New Zealand.

Given the complexity of primary care — we believe the current NP training requirements fall short of what is needed to ensure safe, independent practice, to uphold the proposed scope of practice. The College recommends that the Council review the adequacy of clinical training hours in light of the scope's expectations.

Royal New Zealand College of General Practitioners

Critical and neutral: need for flexibility

A few organisations called for flexibility in the clinical learning requirements for NPs and provided suggestions about how they could be improved. Otago Community Hospice advocated for the simulated hours to be optional, while the University of Otago's Department of Nursing suggested that the hours could be spread across the two years.

Nurse practitioners should be empowered to determine and self-assess their individual learning needs, rather than being bound by fixed simulation hour requirements.

Nursing and Midwifery Board of Ireland

Critical: resourcing

A few organisations queried how the required simulated hours would be resourced and how this might impose additional costs on education providers and students.

Simulation learning comes with additional programme costs (staffing, staff training in simulation, and consumables), and to students when attendance is required in person (travel, accommodation, childcare). The HPCA Act (s13) outlines the principles guiding the prescribing of

qualifications and states that qualifications may not impose undue costs on health practitioners and the public. In this case, we consider the proposal does impose undue costs.

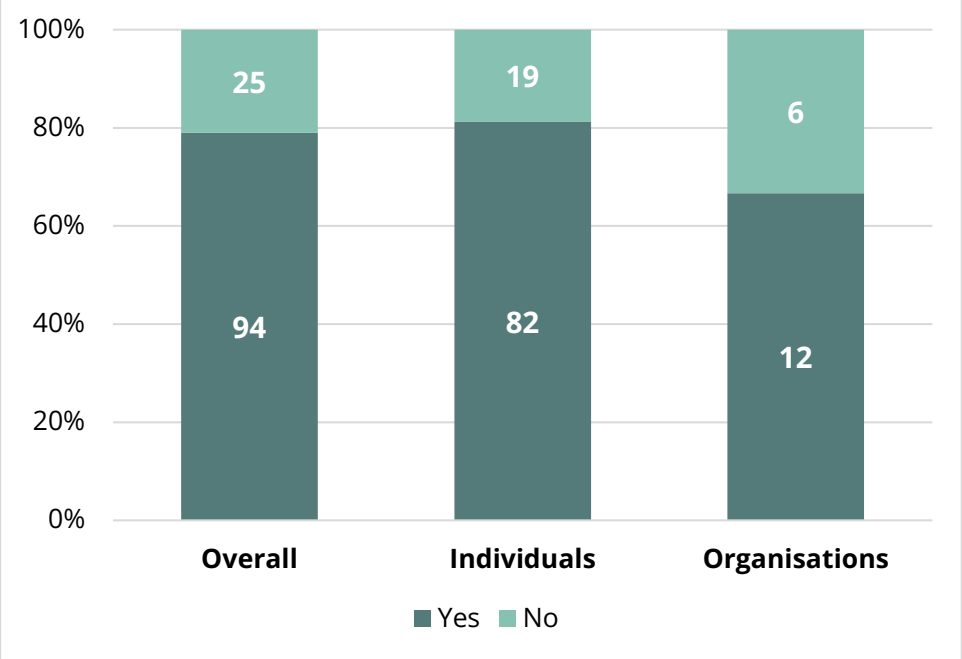
Victoria University of Wellington

Nurse practitioner feedback

Seven NPs provided feedback on this proposal, offering mixed perspectives. Respondents felt that while simulation had value, it should not replace real clinical hours, which offered deeper learning, authentic communication, and stronger clinical judgement. A few noted that required simulation could create barriers—particularly in rural, older-person, public health, or mental health settings where simulation was less accessible or less relevant. A few of these respondents were supportive of simulation but advocated for it to be optional.

Education provider notification to the Council

Figure 13: Do you support the requirement for the education provider to inform the Nursing Council of the nurse practitioner candidate's broad area of practice prior to registration as a nurse practitioner?



Individual feedback

Twenty-two individuals provided feedback in response to this section of the consultation. Most of these individuals did not provide feedback directly in response to the question that was asked. Rather, these individuals focused on whether the education provider should inform the Council that NP candidates have successfully passed the assessment and examination requirements and are considered fit to be registered as a nurse practitioner.

Critical: importance of the Council's oversight and assessment

Several individuals highlighted the importance of the Council retaining oversight of determining NP competence and registration and did not agree with this responsibility shifting to education providers. These individuals viewed the Council's role in determining whether an NP candidate fit to be registered as an NP as a tool for maintaining public safety, standards in NP practice and trust in the NP profession.

> ***The Council role in final authorisation of NP, although burdensome to some, provides a standard that supports public safety and integrity of the training program.***
>
> NP

A few individuals emphasised how the current registration process is important to NP candidates themselves. The panel assessment was explicitly mentioned as both a tool of validation and a learning experience.

> ***I disagree in removing the oral exam. The process of preparing for this is invaluable in improving articulation of diagnostic reasoning. This is able to be applied in clinical practice improving trust in the NP with other members of the healthcare system. This process also teaches clear communication that is clinical, not academic, which decreases clinical risk in practice.***
>
> NP

Critical: concerns about inconsistency and bias across education providers

Some respondents worried that inconsistencies among tertiary education providers could undermine the integrity of NP candidate assessment and lead to varied decisions. These individuals also identified that the proposal came with a risk of bias as education providers have an interest in passing students. These respondents advocated for the Council to retain the assessment to ensure its independence and impartiality.

> ***Regarding the educational institution informing Council of students that have passed and removing the Council panel interview, I am hesitant to agree with this, as I'm not confident that national consistency and standards will be upheld. I think there still needs to be an independent assessment of the candidates.***
>
> NP

Neutral: support for provider involvement with robust moderation

Some respondents expressed support for greater responsibility for education providers in the NP registration process if accompanied by:

- strong Council oversight
- clear, national moderation systems (e.g. a national examination)
- transparent standardisation across providers
- inclusion of external or Council assessors in viva processes.

Organisation feedback

Seventeen organisations provided comments in relation to education providers informing the Nursing Council that NP candidates have successfully passed the assessment and examination requirements and are considered fit to be registered as a nurse practitioner. While a limited number of organisations voiced support for the proposal, the majority raised concerns and expressed reservations.

Supportive and neutral: process clarity and cost

Some organisations expressed support for the proposed changes to the NP registration process. A few supportive organisations also identified areas that would need clarification, especially where the cost of the assessment would sit and the exact process that NPs would follow before registration.

> ***There also appears to be considerable cost transfer to students and to each school with respect to the final assessment of NP competence previously undertaken by a Council-appointed panel. While we welcome the change, more information is needed regarding what the Council is anticipating in terms of process and cost.***
>
> Victoria University of Wellington

Critical: importance of the Council's oversight

Some organisations stressed the crucial role of the Council in determining NP competence. These organisations expressed strong opposition to education providers determining whether an NP candidate is suitable for registration. The independent panel managed by the Council was explicitly mentioned by a few organisations as being an essential mechanism for safeguarding the integrity and consistency of the NP registration process.

> ***Removal of the Nursing Council panel for NP registration. This shifts accountability to the education providers. While we agree the current system of individual vivas for NP applicants are onerous and time consuming, we argue that the Nursing Council has the legislative responsibility for registering*** *NPs.*
>
> Nursing Futures Taskforce

Critical: concerns about inconsistency and bias across education providers

Some organisations echoed the sentiment of the individuals discussed earlier, warning of the inconsistencies among tertiary education providers and the risk of bias in NP candidate assessment.

> ***There is concern about the potential for disparity between providers as well as bias.***
> University of Otago Department of Nursing

Critical and neutral: need for a robust, nationally consistent assessment or moderation system

Some organisations supported a national exam for NPs, like those required for RNs in New Zealand and for NPs in Canada and the US.

> ***The College recommends that the Council retain the independent panel assessment or implement an equivalent national moderation process to ensure consistency, transparency and public trust.***
> Royal New Zealand College of General Practitioners

Critical: public safety, credibility and integrity of the NP role

A few organisations provided feedback on how the proposed changes to NP registration might impact public safety and the credibility and integrity of the NP role. These organisations warned that the removal of Council oversight in the NP candidate assessment process would remove a crucial safety measure for both NPs and patients.

> ***We strongly oppose the removal of the NP panel, which provides essential governance, peer review and professional oversight. Its removal risks undermining both the safety and integrity of NP practice.***
> Nurse Practitioners Hawke's Bay

Critical and neutral: need for clear governance, regulatory roles and responsibilities

A few organisations highlighted the significance of the Council's governance and moderation, should the proposed changes to the NP registration process be implemented. These organisations also requested further clarification regarding the Council's role in the registration process, emphasising its importance in ensuring transparency, fairness and safety.

If the panel is removed, we urge the Nursing Council to establish external governance mechanisms.

Nurse Practitioners Hawke's Bay

Nurse practitioner feedback

Ten NPs provided feedback on the proposal for education providers to determine NP candidate suitability for registration. Respondents were concerned that giving education providers full responsibility for determining NP readiness could undermine consistency, with a few highlighting experiences where candidates met academic requirements but lacked clinical maturity, safety or professional judgement. They stressed that independent oversight remains essential to ensure robust, unbiased and equitable standards. These NPs viewed Council assessments as critical safeguards that protect public safety, uphold professional credibility, and prevent variability in programme quality.

Other comments

The Council received other comments on the following elements of the proposed education standards.

Academic mentors

Two organisations recommended ways to improve education standards and support academic mentors' roles. NPNZ recommended that the Council introduce a specific requirement for programme leads to employ a defined ratio of academic mentors to nurse practitioner candidates. This measure would help education providers sustain the crucial role of academic mentors within their programmes. The Nursing Futures Taskforce suggested that education standards clearly outline the responsibilities of academic NP mentors, including conducting site visits, collaborating with clinical supervisors and assessing candidate competence. These steps were deemed essential for upholding the integrity of the nurse practitioner workforce.

B grade requirement

Four individuals gave feedback on the proposed requirement to achieve a B average in the necessary papers before beginning clinical learning for RN prescribers and NPs. This feedback was largely supportive, with one individual asking for clarification on what 'prior to undertaking clinical learning' meant. One supportive individual highlighted that average grades are not an indicator of clinical competence and that a more robust assessment of competence should be undertaken to determine if a student is ready for clinical learning.

Two organisations commented on the proposed B average requirement, both advocating for higher standards. The University of Auckland's postgraduate nursing school suggested a B grade as the minimum for each required paper, while Health New Zealand |Te Whatu Ora recommended an overall B average or higher.

Direct entry master's degree for new nurses

Four organisations raised concerns about the lack of clarity in distinguishing between graduate-entry and post-registration master's degrees in nursing. NZNO questioned the fairness and relevance of requiring additional years of experience for master's graduates to become prescribers. The University of Auckland's NP team highlighted the absence of guidance on progression pathways for graduate-entry nurses, arguing that further study at the doctoral level was not appropriate for preparing for advanced clinical practice.

> ***With the existence of pre-registration master's degrees, it needs to be clear that this refers to a post- registration clinical master's degree, not any master's degree. RNs need to have sufficient clinical experience to ensure advanced practice capability. Any 'fast-tracking' of those with direct-entry master's could be problematic.***
>
> Health New Zealand | Te Whatu Ora

PG Diploma in RN prescribing questions

Three organisations requested clarification about RN prescriber education requirements, specifically whether a 'post-graduate diploma in RN prescribing' was mandatory or if completing the required courses was sufficient for registration. They also emphasised the need for flexibility in RN prescriber education to encourage participation and support progression to NP education. Health New Zealand | Te Whatu Ora emphasised their position that RN prescribing is a prerequisite for NP education.

Programme content

Three individuals provided suggestions on the content of the RN prescriber and/or NP education. These suggestions included:

- clarity around elective papers
- advanced health assessment, pathophysiology/diagnostics, and pharmacology before RN prescribing registration and transition to NP education
- whakapapa-centred care and Kawa Whakaruruhau.

Qualifications of academic staff

Four organisations commented on the qualification requirements for academic staff. The value of academic qualifications, particularly a master's degree, was strongly supported with a few

organisations emphasising it as the minimum requirement. The University of Otago's Department of Nursing expressed concern about any reduction in qualification standards and reinforced the need for academic teams to be master's-prepared, aligning with current expectations for educational rigour and clinical credibility.

> ***Education providers will ensure that their clinical teaching staff has a mixture of academic staff and staff that work actively between the clinical practice setting and an academic role. We feel it is of the upmost importance for clinical teaching staff and academic staff to be in a position to be able to share knowledge and expertise from current clinical practice as well as holding clinical currency on the contemporary challenges faced by the nursing workforce within the rapidly changing clinical landscape. This will help to provide rich perspective for educative curricula's development and delivery***
>
> Nurse Practitioners New Zealand

Recognition of prior learning (RPL)

Four individuals submitted feedback regarding the proposed standard requiring that each nursing education provider implement an RPL policy. All respondents expressed support for incorporating RPL requirements into the standards, while also recommending that more explicit scaffolding be integrated throughout all pre-registration nursing programmes.

The Ministry of Health identified that *"there is an opportunity for the Council to consider improved coherence at the entry level into nursing by staircase pathways for enrolled nurses (ENs) and from EN education programmes to RN education programmes".*

Feedback by group

Māori respondent feedback

Of the 85,462 nurses with annual practising certificates, 7% identify as Māori.[3] Out of a total of 115 individual respondents, this consultation received 12 submissions from individuals who identified as Māori (10% of respondents). Māori stakeholders were also regularly consulted during pre-consultation engagements. This feedback has been considered internally and will help to inform any changes and/or final decisions.

General feedback

The majority of feedback from individual submitters who identified as Māori was reflective of the overall themes previously discussed. Compared to overall sentiment, feedback from Māori was broadly reflective of similar patterns of criticism, neutrality and support.

Māori respondents were generally supportive of the proposed scope statements for both scopes of practice, but a few respondents did provide some critical comments. Māori respondents were also highly supportive of all the education requirements (82% - 100% agreement) except for one education standard. The lowest percentage of agreement from respondents who identified as Māori was for the years of practice requirement for nurse practitioners (45% agreement).

RN prescriber scope of practice statement

Most Māori respondents supported the RN prescriber scope statement, with a few offering positive comments on the proposals and the RN prescriber's role in improving access to health care.

Expanding RN prescribing aligns with contemporary nursing practice and international trends. I support the proposal to broaden the scope, provided that: safeguards and clinical governance structures are in place which are clear and succinct. Prescribing remains linked to both postgraduate education and competence assessment. Cultural safety and equity considerations are embedded in prescribing decisions.

RN prescriber

NP scope of practice statement

Although most respondents were supportive of the revised NP scope statement, a few did provide critical feedback or provide suggestions about how it could be enhanced. Comments on

[3] New Zealand Nursing Council Annual Report 2025.

the lack of commitment to ethical and professional standards, and values related to honesty and integrity were submitted. There was also a call for the Council to provide clear guidance to the public and medical colleagues on the NP scope and its autonomous nature.

The proposed scope statement seems limiting and minimising of the role of the NP particularly when looked at alongside RN designated prescriber proposed scope. I think the NP scope is underpinned by RN practice and NPs should be expected to model commitment to Te Tiriti.

NP and nurse educator

Difference between RN prescriber and NP scopes

A few Māori respondents suggested there was overlap and confusion about the boundaries of each scope. It was noted that while the distinction was generally clear to nurses, many other health professionals and the public lacked clarity regarding the NP role and its functions. Suggestions included providing more education to other health professionals and conducting a publicity campaign to improve public understanding and reinforce the boundaries of each role, as well as close monitoring to ensure RN prescribers do not practise outside their scope.

Clear to nurses, not clear to the public.

RN on a NP or RN prescribing pathway

Education standards

Respondents expressed mixed views on proposed changes to NP education and experience requirements. A few believed that substantial clinical experience is vital for building advanced skills and ensuring safe, credible practice, while reducing the experience requirement to two years was 'risky' and could undermine the NP role. Concerns were also raised about accessibility issues with simulation requirements for remote learners, the need for regular fitness-to-practise checks, and the importance of integrating whakapapa-centred care and interprofessional collaboration into education standards. A few supported maintaining the Council's oversight in the NP registration process.

Feedback from Pacific respondents

The consultation received responses from two nurses who identified as Pacific peoples. Due to the low response rate, an analysis of feedback from this group cannot be undertaken. One respondent provided supportive feedback on the RN prescriber scope being a distinct and advanced scope of practice. Pacific stakeholders were consulted during pre-consultation engagements. This feedback has been considered internally and will help to inform any changes and/or final decisions.

Appendix 1 – List of organisational respondents

- Aged Care Association NZ
- Australian and New Zealand College of Anaesthetists
- Child and Youth Nurse Practitioners Starship
- Citizens Commission on Human Rights
- College of Emergency Nurses New Zealand
- Health NZ | Te Whatu Ora
- Hospice New Zealand
- Kensington Health
- Ministry of Health
- New Zealand Nurses Organisation
- New Zealand Society for the Study of Diabetes
- Nurse Executives of Aotearoa
- Nurse Practitioners in Hawke's Bay
- Nurse Practitioners New Zealand
- Nursing and Midwifery Board of Australia
- Nursing and Midwifery Board of Ireland
- Nursing Futures Taskforce
- Oncology Haematology Nurse Practitioner Special Interest Group
- Otago Community Hospice
- Parkinson's New Zealand Charitable Trust
- Perioperative Nurses College
- Royal New Zealand College of General Practitioners
- Specialist Mental Health Service Te Whatu Ora Waitaha Canterbury
- Te Herenga Waka | Victoria University of Wellington
- The Royal Australian and New Zealand College of Radiologists
- University of Auckland, Postgraduate School
- University of Auckland, School of Nursing Faculty of Medical and Health Sciences
- University of Auckland, School of Nursing, NP Team
- University of Otago, Department of Nursing

Appendix 2 – Consultation response template

Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Consultation document | Tuhinga whai tohutohu

Proposed scopes of practice for nurse practitioners and registered nurse prescribers

Including amendments to nursing education programme standards
September 2025

Introduction | Kupu whakataki

The Council is seeking views on proposed scopes of practice for nurse practitioners and registered nurse prescribers, including amendments to nursing education programme standards leading to registration with the Nursing Council of New Zealand.

The consultation is structured into three parts – registered nurse prescribing, nurse practitioner, and education standards. You do not need to answer all questions. Please respond to the questions that are relevant to you.

How to submit

You can choose to compete a survey or you can provide more substantive feedback via this submission template.

If you have completed this template, please email it to consultations@nursingcouncil.org.nz by **5pm Friday 24 October 2025**.

What we will do with your submission

We will review and consider all feedback, which will inform advice to our Board. We will also publish a summary of the feedback on our website.

Template submissions may be published in part, or in their entirety, on our website. Please indicate below if you are happy for your submission to be published.

☐ Yes, you may publish any part of my submission.
☐ Yes, but please remove my name.
☐ No, you may not publish my submission.

Are you submitting on behalf of an organisation or individual?

I am submitting as an individual ☐ *Please go to Question 1*
I am submitting on behalf of an organisation or group ☐ *Please go to Question 6*

Submitting as an individual

Please complete the following questions if you are submitting as an individual. It is important for us to know about you so that we understand whose views are represented in submissions. This helps us to understand the impact of our proposals and ensure that any changes we make will work for different groups.

1. What is your name?

2. What best describes your role?
   - ☐ I am a nurse practitioner
   - ☐ I am a registered nurse prescriber in primary health and specialty teams
   - ☐ I am a registered nurse prescriber in community health
   - ☐ I am a registered nurse who only prescribes in diabetes health
   - ☐ I am a registered nurse with authorisation to supply the ECP or Hep C medicines
   - ☐ I am a registered nurse on a nurse practitioner or nurse prescribing pathway
   - ☐ I am a registered nurse
   - ☐ I am an enrolled nurse
   - ☐ I am a nurse educator
   - ☐ I am a nurse leader
   - ☐ I am a member of the public
   - ☐ I am a member of another regulated health profession. Please specify:

3. If you are a nurse, where did you gain your qualification?
   - ☐ New Zealand
   - ☐ In another country

4. What ethnic group do you belong to? Mark the space or spaces that apply to you.
   - ☐ Zealand European
   - ☐ Māori
   - ☐ Samoan
   - ☐ Cook Island Māori
   - ☐ Tongan
   - ☐ Niuean
   - ☐ Fijian
   - ☐ Other Pacific Peoples
   - ☐ Chinese
   - ☐ Fijian Indian
   - ☐ Indian
   - ☐ Filipino
   - ☐ Southeast Asian
   - ☐ Other Asian
   - ☐ Other European
   - ☐ I do not want to state my ethnicity
   - ☐ Other. Please state:

5. What region do you live in?
   - ☐ Northland
   - ☐ Auckland
   - ☐ Waikato
   - ☐ Bay of Plenty
   - ☐ Gisborne
   - ☐ Hawkes Bay
   - ☐ Taranaki
   - ☐ Manawatū-Whanganui
   - ☐ Wellington
   - ☐ Nelson-Marlborough
   - ☐ West Coast
   - ☐ Canterbury
   - ☐ Otago
   - ☐ Southland
   - ☐ Overseas

Submitting on behalf of an organisation or group

Please complete the following questions if you are submitting on behalf of an organisation or group. It is important for us to know about your organisation to understand the range of perspectives represented in submissions.

6. What is your name?

7. What is the name of your organisation?

8. What best describes your organisation?
   - ☐ A provider of health and/or disability support services
   - ☐ A nursing professional association, union, or other representative group
   - ☐ A non-nursing professional association, union, or other representative group
   - ☐ A government agency
   - ☐ Another organisation or group

Consultation questions | Ngā pātai whai tohutohu

Part One: proposed changes to registered nurse prescribing

This section relates to **registered nurse prescribing**. If you only want to submit on the nurse practitioner scope statement and/or nursing education standards, please go to Part Two and/or Part Three.

Consultation questions	Your response
1. The registered nurse prescriber scope builds on the foundations of the registered nurse scope. Is this clear in the registered nurse prescribing scope?	Yes ☐ No ☐
2. Does the proposed scope reflect the key requirements of registered nurse prescribing practice?	Yes ☐ No ☐
3. Overall, do you support the proposed registered nurse prescribing scope statement?	Yes ☐ No ☐
Please provide any other comments including reasons to explain your answers	

Part Two: proposed changes to the nurse practitioner scope statement

This section relates to the **nurse practitioner scope of practice**. If you only want to submit on registered nurse prescribing and/or nursing education standards, please go to Part One and/or Part Three.

Consultation questions	Your response
1. The nurse practitioner scope builds on the foundations of the registered nurse scope. Is this clear in the proposed changes to the nurse practitioner scope?	Yes ☐ No ☐
2. Does the proposed scope statement reflect nurse practitioner practice?	Yes ☐ No ☐
3. Overall, do you support the proposed changes to the nurse practitioner scope statement?	Yes ☐ No ☐
Please provide any other comments including reasons to explain your answers	

Clarity between registered nurse prescribing and nurse practitioner scopes of practice

These questions relate to both the registered nurse prescribing and nurse practitioner scopes of practice. If you only want to submit on nursing education standards, please go to Part Three.

Consultation questions	Your response
1. Is the difference between the scopes of registered nurse prescribing and nurse practitioner clear?	Yes ☐ No ☐
Please provide any other comments including reasons to explain your answers	

Part Three: proposed changes to the nursing education programme standards (standard six) leading to registration with the Nursing Council of New Zealand

This section relates to the **nursing education standards – standard six: programme of study**. If you only want to submit on the registered nurse prescribing and/or nurse practitioner scope of practice, please go to Part One and/or Part Two.

Consultation questions	Your response
1. Do you support the clinical learning requirements for registered nurse prescribing?	Yes ☐ No ☐
2. Do you agree that registered nurses should complete two years in the area of practice they intend to prescribe in before registration as a nurse prescriber?	Yes ☐ No ☐
3. Do you agree that nurse practitioners should complete two years in their chosen area of practice before registration?	Yes ☐ No ☐
4. Do you support the requirements for the programme lead?	Yes ☐ No ☐
5. Do you support a minimum of 100 hours of simulation plus 400 hours in face-to-face clinical learning in the nurse practitioner programme?	Yes ☐ No ☐
6. Do you support the requirement for the education provider to inform the Nursing Council of the nurse practitioner candidate's broad area of practice prior to registration as a nurse practitioner?	Yes ☐ No ☐
How would you define broad areas of practice?	
Please provide any other comments including reasons to explain your answers	