Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Tuhinga whai tohutohu | Consultation document

Review of enrolled nurse and registered nurse competencies Including amendments to the registered nurse scope of practice statement

December 2023

Ngā pātai whaitohutohu | Consultation questions

Name of organisation/submitter: Te Rōpu Kaiako Tapuhi/NETS

We may publish submissions on our website. Please check the box below if you would like your response to be kept confidential.

☐ *Please keep this response confidential*

Enrolled nurse competencies

Consultation questions	Your response
Question 1. Do you think the proposed enrolled nurse competencies are broad enough to cover all practice areas?	Yes ☐ No ☒
Comment	Five Pou could be reduced to four

Consultation questions	Your response
	Too broad – the competencies are mainly indicators or aspects of the education programme that have been taught in the EN curriculum. The competencies are too wordy. There are too many inconsistencies between the EN and the RN competencies. There should be an alignment of wording in the RN competencies. There needs to be consistency that competencies align to the same Pou as in the RN.
Question 2. Do you agree with the overall structure of the proposed enrolled nurse competencies?	Yes ☐ No ☒
Comment	Like the EN scope statement. Mainly positive response to the changes Team likes the inclusion of self-care to both competencies. Discussion was about held around including healthy self-care practices as opposed to those that may be deemed unhealthy. The document's structure is overwhelming with too many Pous and too many competencies - there is a disconnect between these. Te Reo needs to be recognised and included for each Pou title, aligning with the RN document.

Pou One: Te Tiriti o Waitangi	
Question 3. Do you agree with the scope and focus of Pou One: Te Tiriti o Waitangi?	Yes ☐ No ☐ Partly ☒
Question 4. What would you strengthen, change, or add to Pou One?	Some academics think EN and RN Pou should be named the same Some think they should be different because scope difference

	Like the competencies and the wording 1.1 Like that they refer to the articles as well as principles Need to ensure that there is an acknowledgement of Te Tiriti o Waitangi in the title as it sits within the RN document. 1.2 Remove the word colonisation as we are moving beyond this term – either delete or replace with updated terminology and include the models of health here 1.4 Can be part of 1.3 as this is key to effective therapeutic relationships 1.5 Models of Health - this should either be removed or be incorporated into 1.2 - (as noted above) This is part of the education of the EN program and does not need to be a stand-alone competency; leads more to an indicator.
Pou Two: Cultural Safety	
Question 5. Do you agree with the scope and focus of Pou Two: Cultural Safety?	Yes ☐ No ☐ Partly ☒
Question 6. What would you strengthen, change, or add to Pou Two?	Relevant competency 2.4 Would like some further clarity around sustainability practices This entire Pou needs to be rewritten. It needs the use of Te Reo in title of the Pou 2.1 "other priority groups" needs to be changed to "other groups/individuals." – it needs to value the community as a whole 2.3 Too wordy and needs to incorporate 2.4 2.4 Combine with 2.3 and re-word
Pou Three: Knowledge Informed Practice	
Question 7. Do you agree with the scope and focus of Pou Three: Knowledge Informed Practice?	Yes ☐ No ☐

	Partly ☒
Question 8. What would you strengthen, change, or add to Pou Three?	Clinical decision making should include: in collaboration with a registered health care practitioner 3.2 Comprehensive nursing assessment, not sure of the definition of comprehensive and the difference between EN & RN. 3.5 AI and digital health are technology therefore just need to say demonstrate knowledge and skills with technology 3.6 & 3.7 could be combined 3.1 Needs the inclusion of health literacy; however, if there was a communication Pou, then this would sit under that better. 3.2 and 3.4 need to be combined and re-worded. At present, each has "assessment" as a part of each and is an unnecessary repetition. 3.5 Why is AI mentioned? This is unnecessary as it is not used on the floor. This is happening in other areas – socially, academia, and in some businesses, not nursing. It seems to be inappropriate, and rather a "knee jerk" reaction to common public themes. 3.6, 3.7 & 3.8 need to be combined - all practice issues that do not need to be separate.
Pou Four: Professional Accountability and Responsibility	
Question 9. Do you agree with the scope and focus of Pou Four: Professional Accountability and Responsibility?	Yes ☐ No ☐ Partly ☒
Question 10. What would you strengthen, change, or add to Pou Four?	4.6 OK with mentoring and role modelling but not preceptoring BN students RN competencies 5.6, 57, 5.9 should be included here 4.3 Delete. This is a privacy breach and intrudes into the life of the individual. This has **nothing** to do with the Nursing Council. 4.5 Replace the word culture with environment – using the culture word confuses this with Pou 1and the intent behind this competency.
Pou Five: Partnership and Collaboration	

Question 11. Do you agree with the scope and focus of Pou Five: Partnership and Collaboration?	Yes ☐ No ☐ Partly ☒
Question 12. What would you strengthen, change, or add to Pou Five?	5.1 good competency and RN competency 5.2 should read the same as it includes the healthcare team. This entire Pou needs re-writing or deleting and being replaced with communication which is not in this document 5.1 already mentioned in 1.3 and 4.2, so not needed here 5.2, 5.3 5.4 & 5.5 – this would be better placed in Pou 3 or 4
Other comments	
Question 13. Do you have any other comments?	**Poorly constructed document.** There is no communication Pou – communication is only mentioned twice in this entire document – which is appalling given the fact that EN practice does have the need and the ability to communicate in the role. There is no mention of empathy, compassion respect, or sensitivity - all of which ALL nurses should possess and demonstrate in practice. Yet, these are mentioned in the RN document. Nor is there any mention of documentation, privacy, confidentiality and the ability to access information of others as well as ensuring that communication needs are met at all levels – patient as well as colleagues. The role and scope of the EN should be valued and recognized along with their RN colleagues. However, this document **fails** to do that. Needs to have more alignment with the wording in the RN document Some of the competencies are too wordy, or a vague and this in turn will make it difficult to understand. Need to make a guide to show examples or indicators.

Registered nurse competencies

Consultation questions	Your response
Question 14. Do you think the proposed registered nurse competencies are broad enough to cover all practice areas?	Yes ☐ No ☒
Comment	There are some concerns about the number of competencies. This will mean additional time when working with ākonga to complete formative and summative assessments. Also, more time pressure on RN's completing PDRP or appraisals using the competency template. Time pressures equate to cost and increased pressure for ākonga and demands on staff. Overall happy with the 6 pou and the new standards/competencies outlined and feel they align far better than the current competencies with our Te Raukotahi Framework which includes 6 principles of Manaakitanga, Wairuatanga, Whanaungatanga, Pukengatanga, Rangatiratanga, Kotahitanga and Ukaipoutanga, As with the current competencies they need to be utilized and contextualized to an area eg. MH, PHC and acute care.
Question 15. Do you agree with the overall structure of the proposed registered nurse competencies?	Yes ☐ No ☒
Comment	For any RN role the teaching and learning role is not described. For example, the professional responsibility of mentoring and teaching the next generation of nurses. There is a need to consider the order of the competencies, particularly Pou 3. Pou 4 and 5 overlap e.g., 5.1 compassion and empathy echoed in 4.2 – should merge Pou 4 and 5. Pou 4 – no mention of the multi-disciplinary team or in the document. Pou 5 – too detailed, patronizing regarding the RN communication roles. Competencies do not reflect the

Consultation questions	Your response
	teaching and learning roles of the RN working with undergraduates and new colleagues. The term “caring” and “empathy” missing in the pou especially Pou 3. Too many, need to reduce number of competencies, will be difficult to attract nurses to complete PDRP and also transition students may not be able to meet some of them. Main queries are: 1. Clarity around which of the competencies student nurses would be expected to meet – some of the new competencies such as 3.1 don’t feel like they sit at a student nurse level and it would be good to be able to see clear progression from a transition student to a new graduate through the competencies 2. Would like to see indicators to each competency – I imagine this is coming later. 3. We like the competency around self-care 3.13 – although perhaps viewed differently for each individual it is important to be at the very least aware of this and how it may impact or come across on patients. 4. Feel like a lot of the competencies could be joined – perhaps we will see this when they reduce the number. The pou structure is a good concept to use, however the some pou’s need to be deleted, for example, pou 4 as the competencies can fit clearly into other competencies and thus they do not need their own pou. The proposed competencies are OVERWHELMING.

Pou One: Te Tiriti o Waitangi, Ōritetanga and Social Justice	
Question 16. Do you agree with the scope and focus of Pou One: Te Tiriti o Waitangi, Ōritetanga and Social Justice?	Yes ☒ No ☐ Partly ☐
Question 17. What would you strengthen, change, or add to Pou One?	Agree that pou 1 and 2 stay separate. Pou not clear – health inequities for Māori in particular?

	1.2 Broader than Te Tiriti including stigma. State social justice for Māori. 1.2 could be the indicator for 1.1. 1.3 Term "experts" – questionable term. Use tino rangatiratanga? 1.4 Competency not a fit for pou 1 – perhaps pou 2? 1.5 Nurses are not responsible for the healthcare team – it needs to be as nursing profession – our own practice between patient/person/whānau. Like "gives effect". Relevant to nursing practice Language needs to be reviewed, not sure BN students and new grads would have a good understanding of the meaning of critical consciousness No mention of the articles/principles as it does in the EN pou. 1.2 Consider reviewing the word challenge. 1.1 Change "gives effect" to "Implements". How would you show an example of this from clinical practice? People can only give theoretical views on this; needs to be more clinical relevant. 1.2 Delete; same or similar as 2.2; just different words. How would you show an example of this from clinical practice? 1.3 Delete. How would you show an example of this from clinical practice? If a patient is experiencing an acute illness episode, they would not be able to or willing, at most times to show they expertise in promoting their self-determination. What if it is a client with an acute psychotic break in psych ICU? This is non-sensical. Believe this is from the public consultation documents for the repealing of the MH Act. Professional development needs to move to Pou 6 or Pou 4. 1.5 What is meant by "continuous professional development" and how does a nurse ensure that the healthcare TEAM adheres to the ToW? How would you show an example of this from clinical practice?
Pou Two: Kawa Whakaruruhau and Cultural Safety	
Question 18. Do you agree with the scope and focus of Pou Two: Kawa Whakaruruhau and Cultural Safety?	Yes ☐ No ☐ Partly ☒

Question 19. What would you strengthen, change, or add to Pou Two?	Muddled – move cultural safety to pou 3. The intention of kawa whakaruruhau is not clear. Keep cultural safety separate from kawa whakaruruhau. 2.1 The term bias could be removed – beliefs, values, attitudes – bias is one of the concepts of cultural safety along with power, being regardful of difference etc… 2.2 A general definition of cultural safety suffices. The current 1.3 is improved. Naming priority groups is problematic for omissions. Practices – spelling error presented as practices. 2.3 Linked to pou 1 Title should delete the and and replace with a slash: Kawa Whakaruruhau / Cultural Safety 2.3 and 5.4 could be one competency Pou 2 & Pou 4 could be combined Pou 2 needs to be about how we prove we are culturally safe in practice and needs to be described so it can be clearly operationalized. 2.1 Does this competency only refer to cultural supports? 2.2 Why are these groups identified as a "priority"? Priority implies a ranking system. What about refugees? Homeless families? Street entrenched/street attracted people? Delete the word "priority". Also, 1.2 and 2.2 are same or similar as when we practice in a CS manner, we challenge ourselves and others and most definitely in situations of racism, discrimination, etc. 2.3 - Move to Pou 1. Additionally, te ao Maori or the Maori world as we understand it and can be focused on 3 areas: Te Reo, Tikanga and Te Tiriti (University of Otago, *https://www.otago.ac.nz/maori/world*) , so why is tikanga mentioned separately?
Pou Three: Pūkengatanga and Excellence in Nursing Practice	
Question 20. Do you agree with the scope and focus of Pou Three: Pūkengatanga and Excellence in Nursing Practice?	Yes ☐ No ☐ Partly ☒
Question 21. What would you strengthen, change, or add to Pou Three?	Stopping at assessments tools – needs to go broader to the entire nursing assessment/process. 3.1 Term differential diagnosis – that is advanced nursing practice. Add in nursing – diagnosis.

	3.3 That is cultural safety – belongs nicely. Incorporate pou 2 into pou 3 in relation to cultural safety. We are not the cultural experts – that is not a culturally safe perspective. 3.4 Critical digital literacy is a broader term – remove digital health and artificial intelligence – needs rewriting. 3.4 needs to link to technology used in healthcare for completing procedures, diagnostics, and documentation/recording of information. 3.5 We do not administer interventions. See current competency 1.1 superior. 3.6 Too detailed – current competency 1.4 superior. 3.8 Too detailed – the nursing process not presented in full. Current competency 2.1 is superior. 3.9 Continuous quality improvement – the RN care does not necessarily achieve equitable safe healthcare as an outcome. 3.10 Current competency 2.8 superior. 3.11 Makes competency 3.5 redundant. 3.13 Fits into professionalism. 3.1 Differential diagnosis ? does this need to be more nursing specific V medical 3.7 fits better in Pou 6 Like self-care Object to "scientific knowledge", change to "nursing knowledge". It seems that the panel tried to put everything to do with nursing care into Pou 3 and we don't have to; make it simpler for nurses on the front lines. 3.1 Delete "differential diagnoses" as nurses do not make these. Change to "nursing diagnosis" or "…to identify problems and inform the plan of care". 3.2 and 3.4 can be combined, it is unnecessarily verbose. 3.3 has already been addressed in Pou 1 and 2; unnecessary repetition. 3.4 Why is AI mentioned? Nurses on the floor do not use nor do they receive any reports/information based upon AI. It seems an unnecessary addition based upon what is currently happening socially and in academia. 3.4 is also very similar to 3.1. Suggest deleting 3.4. 3.9 Change wording from "culture of safety" to "environment of safety…" otherwise there is confusion regarding the word culture. 3.10 and 6.6 essentially refer to the same thing; combine into one competency. 3.13 Is an unnecessary competency and is intrusive into a nurse's personal life. How would you show an example of

	this from clinical practice? Does a peer take the nurse's word for it that they exercise, gets 8 hours sleep, meditates in order to achieve self-care? We all have our own personal ways to deal with stress and this, if it becomes a problem, is between the nurse and their manager, not Nursing Council until something happens and they are in front of the conduct committee. 3.5 & 3.6 could also be combined as both practice components.
Pou Four: Manaakitanga and People Centredness	
Question 22. Do you agree with the scope and focus of Pou Four: Manaakitanga and People Centredness	Yes ☐ No ☐ Partly ☒
Question 23. What would you strengthen, change, or add to Pou Four?	4.1 explain "integrated relational" not in glossary. 4.2 Same as 5.2. How could this be measured for PDRP? Current competency 3.1 a superior competency. 4.3 Like 4.1 repetitive. 5.2 a better competency. This pou could be removed and the competencies captured in other pou e.g. 3.11 captures 4.2 & 4.3 Delete entirely as each of the three competencies are or can be incorporated into others. For example, 4.1 can be incorporated into Pou 3. 4.2 can incorporated into 5.1 and 4.3 can be incorporated into Pou 5 as initiating a relationship and communication all begins with trust and respect for the person, family or whanau.
Pou Five: Whakawhanaungatanga and Communication	
Question 24. Do you agree with the scope and focus of Pou Five: Whakawhanaungatanga and Communication?	Yes ☐ No ☒ Partly ☐
Question 25. What would you strengthen, change, or add to Pou Five?	There are concerns about the number of competencies.

	5.1 How does the RN advocate with "calmness" – this is patronising. How does the RN gather evidence for this? 5.4 Matches 2.3. Could be generalized to all. RNs do not need this guidance. Some nurses really struggle with correct pronunciation, this competency could be absorbed into another and could focus on people making efforts towards learning correct pronunciation of Māori words and names. 5.5 Addressed in 5.3. Uses "plain" language. We use professional language. RNs do not need this guidance. 5.7 and 1.4 match. 5.9 Feedback to whom? 5.10 Has more of a workplace. Current 2.5 competency superior. 5.1 similar to 4.3 5.3 incorporates 5.5 delete 5.5 5.9 & 5.10 Implicit in the code of conduct and professional guidelines . Needs to include healthcare team same as EN 3.1 5.7 included in 5.8 delete 5.7 Move 5.4 to Pou 1 Competencies 5.1, 5.3 & 5.5 can be combined to make one fluid competency. 5.2 - how would you show an example of this from clinical practice? 5.4 This is more applicable to 1.1 or 2.3, therefore delete from Pou 5 and incorporate elsewhere. 5.5 Isn't this 5.3 already? Delete. It refers to "health literacy" but patient education, one of the CORE skills and tasks for nurses has been eliminated completely from the competencies. If we don't clearly educate our patients and clients, families and whanau, it is the revolving door scenario of them being unable to self-care and end up back in the health system in an acute stage of illness. 5.6, 5.7 & 5.8 could be combined and reworded.
Pou Six: Rangatiratanga and Leadership	
Question 26. Do you agree with the scope and focus of Pou Six: Rangatiratanga and Leadership?	Yes ☐ No ☐ Partly ☒

Question 27. What would you strengthen, change or add to Pou Six?	6.2 Rather than "influences" – "contributes to". Dumbs us down… 6.3 Well functioning RNS do not necessarily want to take leadership roles. 6.4 and 6.5 seem more appropriate for organizational management level than the average nurse on the ward and perhaps need to be removed? 6.5 Maintaining awareness? Not much of an achievement. Suggestion: "engaging with local, national and international…" 6.6 Repetitive from earlier competencies. 6.7 Repetitive Like reference to change agents 6.2 difficult for students to demonstrate 6.7 same as 3.10 delete 6.7 and add to uphold patient safety to 3.10 6.6 delete 6.2 How does an RN on the ward influence the development of the healthcare systems? What does this competency actually mean? Very grandiose wording and competency. Delete. 6.3 What about incorporating "contributing to team work" as many nurses won't have the opportunity to undertake a leadership role. This competency needs revision to ensure that all nurses in all roles may be able to show competency. 6.4 How would a nurse show an example of this from clinical practice? That they recycle at work? This is institutional policy and doesn't belong in competencies. Nurses adhere to their institutions policies which is 5.8. Delete. 6.5 What does this competency even mean? How would a floor nurse show competency? Delete. 6.6 Refers to 3.10, delete as it is repetition. The excellence in care is a repeat of 3.2. 6.7 Refers to 3.10, delete as it is repetition.
Other comments	
Question 13. Do you have any other comments?	Are RNs no longer interested in health promotion and patient education? No competencies address this important work. Too much change suggested at present while understanding the need for change in terms of the direction and delegation changes in relation to ENs, Te Tiriti o Waitangi and cultural safety. However, the changes throughout and creating more competencies takes away from the quality of the competencies.

	The cost of education to RNs to assist their use of the competencies – where does that go? To the health sector who are already stretched enough both financially and in terms of staff. How do these changes fit with the current and proposed unified BN curriculum? Is there a transition period or are RNs expected to run with it? How much notice will be given to academic staff to change the course content and assessment documents used in clinical placements? **Overall comments:** • The competencies are repetitious, verbose and many lack any clear indication of what is being sought as an example of practice by the bedside. • Empathy is repeated throughout and it is not a skill • The current competencies are challenging to a CAP nurse to complete. The proposed competencies would be extremely challenging and difficult for an IQN/CAP nurse to understand and complete. • Where are the ward nurses, the community nurses, the ones on the front line who would be using these proposed competencies on the RN competency review panel; the panel was/is loaded with too many members of management/leadership/education. • A guide to use alongside the competencies would be good with what nurses can do to show competency. This guide could be developed for all nurses who have separate competencies for their scope of practice (leadership, management, researchers, educators, staff nurses and other RNs who develop their own scope and competencies). • As educators, we struggle to get nursing students to write competencies or write appropriate ones and the proposed competencies will worsen the efforts of educators and students. • The pervasive thought would be how the proposed competencies would drive nurses out from nursing compounding the shortage we're already suffering. These proposed competencies may also lead nurses and peers to "make up" examples as they are very overwhelming. How did Australia manage their transition to their 40 standards (competencies)? **Themes:** • Good to review the competencies which was needing to be done. • Unwieldy expectations • Hard to operationalise • Lacks indicators to aid understanding; they help in the current competencies

	• There are gaps in the competencies, for example, patient education • Extreme overlap of concepts within the competencies • Some of the competencies are too wordy • Some of the competencies are patronising and judgemental – for example, the safe management • Some of the competencies would be difficult to complete for a peer assessment

Registered nurse scope of practice statement amendments

Consultation questions	**Your response**
Question 28. Do you agree with the proposed amendments to the registered nurse scope of practice?	Yes ☐ No ☒
Do you have any comments?	Not yet, the competencies require considerable review and amendment. There are some good aspects to the competencies, particularly the separation of kawa whakaruruhau to cultural safety and the inclusion of critical digital literacy (if this competency is reworded) and sustainability. The wording in the proposed RN scope of practice statement is clear and understandable and should be used in the competencies and the statement makes a good background for the competencies. It seems that the proposed competencies have been a situation in which the panel members thought of every possible thing a nurse could do and made them specific rather than a general statement to which a nurse can interpret (albeit without indicators) and show competency in practice. **Something to add:** Nurse also needs a more reflective approach, if you like, an opportunity to safeguard themselves in clinical scenarios where duty of care is compromised and when nurses are experiencing moral distress/fatigue can recognize this against the competencies. This section needs to possibly be separate within the competency document because I feel the framework also need to consider the sustainability of the nursing workforce; working in a sector where stress and burnout is evident and somewhere and somehow within the

Consultation questions	Your response
	NCNZ framework an opportunity to critically reflect and recognize and document how this has affected them and ongoing adaption to a complex adaptive system. I feel that this adaptation is unsustainable and therefore a provision within the document is recommended.
Question 29. What would you strengthen, change, or add to the proposed registered nurse scope of practice	I think some Clinicians need to be included in the writing and rewording of the competencies. Some of the competencies read as if the RN role is not fully understood and the capacity of the RN not acknowledged. For example, the whanaungatanga is too detailed and not necessary. **Possible ways to strengthen:** 1) Robust discussion with stakeholders – firstly, patient perspective/surveys, secondly, clinical leaders especially, senior RNs working within DHBs + PDRP coordinators (those RNs assessing nurse portfolios and educators), and lastly, engage with medical team (doctors) to consider their expectation of RNs and new roles within medicine. Set up a taskforce team with experienced clinical leaders to discuss what is currently happening within the healthcare system and how nurses are adapting to a complex adaptive system. Nurses are now expected to work at the "top" of their license/ registration with a lot more within the public and primary health sector.
Do you have any other comments?	