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NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

Nursing Council of New Zealand
By email: enreview@nursingcouncil.org.nz

Tēnā koe

Enrolled Nurse Education Standards & Amendments to the Registered Nurse Education Standards

Tōpūtanga Tapuhi Kaitiaki o Aotearoa, New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Nursing Council of New Zealand (*the Council*) proposed Enrolled Nurse *(EN)* Education Standards & Amendments to the Registered Nurse *(RN)* Education Standards.

NZNO represents nurses, midwives, students, kaimahi hauora and health workers on professional and employment matters. NZNO embraces te Tiriti o Waitangi and contributes to the improvements of the health status and outcomes for all people of Aotearoa New Zealand through influencing health, employment, and policy development.

NZNO is committed to upholding the articles of te Tiriti o Waitangi across all our work. Furthermore, we recognise and respect the right of Māori to have control over their own health and wellbeing. We support Māori in the effect of tino rangatiratanga, through self-determination and mana motuhake in the design, delivery, and monitoring of our work. We build enduring relationships and partnerships with our te Tiriti partners, so Māori are actively involved our decision-making.

NZNO has consulted with members about the Enrolled nurse education standards and amendments to the Registered nurse standards. Our response identifies issues and makes recommendations.

Background Section

Page 4 The Nursing Pipeline Programme was an early workforce initiative. NZNO questions its current activities since transitioning into Te Whatu Ora. We also question why this programme did not recognise or support EN's.

Page 5 The document speaks to the Council recognising challenges, is there an oversight here as there is no recognition of what it means to be a student learner.

The Standards

Page 6 The document is lacking in confirmed timeframes, a projected mid-2024 is rather vague.

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Page 7 A proposed reduction in minimum clinical hour requirements. There was little support for a reduction and therefore the current requirement for a minimum of RN 1,100 clinical hours remains. Why are we being asked the same question again? The proposal was rejected in 2022 and will be rejected again in 2023. Very little has changed in the past 12 months. Who are the nurse leaders that have been quoted in this document, please identify them and the organisations they represent rather than making sweeping statements.

Page 8 Council have stated implementation of the standards and the requirement for accreditation by education institutes commencing mid-2024. NZNO would appreciate viewing a detailed plan of the rollout processes and timeframes for each education institute to achieve accreditation. We note the new government have stated in their 100-day plan - *Begin disestablishing Te Pūkenga*[1].
How will this impact on the planned implementation of the standards?

Standard One: Te Tiriti o Waitangi partnership obligations

The Council have written about the Labour government's priority to lift the capability of the whole workforce. NZNO asks what are the priorities for the new government (the National, Act and New Zealand First coalition). How will this question be addressed as part of this consultation?

We also ask the question does the sector have the capacity and resources to deliver on this proposed standard? What is the back-up plan if this fails?

Standard Two: Safe care for the public

The use of the generic term Kaiāwhina[2] (described as the non-regulated workforce) alongside that of the regulated professions such as EN's, midwives or paramedics in this document is misleading. Each of those professions are regulated. Does this require clarification as they are not interchangeable?

2.2 To deliver the New Zealand diploma of Enrolled Nursing programme there must be a formal relationship with an institution offering a Bachelor of Nursing programme. What is the definition of a formal relationship? Do the programmes need to be geographically co-located? For example: the Enrolled Nurse Diploma programme in Auckland and the Bachelor of Nursing programme in Dunedin?

Furthermore, does this proposal open the door for private providers such as the Health Academy of New Zealand[3] to deliver on their proposed Enrolled Nurse programme as it currently does not have an accompanying Bachelor of Nursing programme?

The example of a Memorandum of Understanding may be perceived as a *gentleman's agreement* and not a legally binding contract. Is that a sufficient proposal or a simple example where providers can develop their preferred option with no consultation, minimum standards, and few requirements.

[1] https://www.rnz.co.nz/news/political/503534/government-confirms-its-100-day-plan
[2] https://www.tewhatuora.govt.nz/publications/health-workforce-plan-202324/ pages 58-59
[3] https://www.healthcareacademy.ac.nz/courses/enrolled-nursing-pathway-level-5

NZNO recommends the intent of these proposals are further clarified prior to being accepted and implemented.

2.4 NZNO recommends the inclusion of the NZNO Code of Ethics[4] to the list of documents proposed to support professional and ethical practice.

2.5 There is no mention of candidates being fully informed about the costs associated with participating in the programme.

2.13 & 2.15 The two statements appear to be very similar, they speak to exiting or removing ākonga / students, both have policies, but only one has a process. Does this require clarification?

2.16 The nursing education provider ensures ākonga / students are not given more than two opportunities to enrol in a clinical learning course. NZNO questions *the two strikes, and you are out* rationale and the requirement for the Council to overturn the academic institutes decision to permit the student to return or remain the programme. Should this be increased to three or unlimited opportunities to support students in completing their chosen course of study?

Standard Three: Academic governance, leadership, and partnership

NZNO recommends Council include a statement reiterating their support for the stakeholders and ensuring engagement and consultation does not end when the key deliverables have been completed.

3.1 The criteria describing the Head or Lead of Nursing is very comprehensive but is silent on how they communicate with colleagues and how that is applied consistently across the sector and motu. NZNO recommends this be expanded on with examples.

3.6 The term stakeholder is used through the document but, it needs to be captured within the document with an actual list of who the stakeholders are. NZNO is represented at the table but invisible within the document.

3.8 NZNO recommends that lecturers / teachers in this statement have access to a Kaumātua or Kaihautū Māori for advice and support, while cultural supervision also needs to be available and funded.

[4] https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Code%20of%20Ethics%202019.pdf

Standard Four: Programme of study

Clinical placements, NZNO recommends a dedicated standard that articulates what they are, what they deliver for all parties and how they are monitored and evaluated.

4.8 Ākonga/students clinical learning experience is not undertaken in a clinical area where they are employed. This statement has significant disadvantages for many supporting to grow their own Health Care Assistants or EN workforces. For example: in rural and remote areas or in facilities such as Corrections. Many prisons are in rural areas so the future workforce will most likely be those committed and invested in those areas.

The nursing education programme includes:
Simulated learning to enable ākonga/students to develop clinical skills and professional capabilities prior to entering real life clinical contexts.

This statement does not set any limit on the number of hours being completed by simulated learning. Does this mean that other than the 240 hours spent in transition (direct patient contact / care) the remaining clinical learning hours could all be completed using simulation. The current standards requirement of no more than 200 hours of simulation must remain unchanged.

How will simulated learning be resourced? Will the quality of the Information Technology (IT), programmes on offer match with the simulation equipment (mannequins, audio visual, etc)? How will national consistency be achieved across the motu? How will the variation be managed between simulation laboratories and at what level will it be required?
A simulation laboratory is to practice and perfect, not used to replace a quality clinical experience.

Will the teaching staff be well educated in running simulation sessions? What is the protective policy around the adequate training of staff that assists key learning outcomes for nursing kaupapa and practice? For example, are the staff equipped to ensure that any IT programme is culturally appropriate to the New Zealand setting? Anecdotally we know that the chances of te Tiriti o Waitangi being an instrumental part of the simulation sessions are not high so that will rely heavily on the teaching staff to develop, integrate, and deliver.

Will educators and the Council develop tables that demonstrate the efficacy of this method of teaching? We need to avoid *dumbing down* the clinical experiences made available if we are to attract and retain the brightest and best. We need to ensure the spectrum of future nursing needs can be analysed and evaluated via simulation if it is to be used.

The Covid-19 Effect

The Covid-19 ākonga / students' generation experienced clinical placements but these were often disrupted by their own or their families' isolation requirements.

Online learning in the Covid-19 environment was a challenge for staff and ākonga / students. Good support from the education provider was required to ensure ākonga / students had access to devices and internet, but we know that for some there was much sharing of devices amongst family, internet access sometimes limited etc. While this enabled many ākonga / students to succeed, we recognise the experience of academic institutions where students who passed with an absolute

minimum of knowledge; perhaps in other circumstances they may not have and would have benefitted from repeating a course.

Clinical placements were significantly impacted. The DHBs and other providers were supportive in getting ākonga / students into placements but given the how busy the areas were and the impact of Covid-19 and existing nursing workforce shortages, in many areas the level of preceptorship available was not provided by nurses who had received formal training in preceptorship and placed additional pressure on a strained workforce.

Additionally, DHBs were minimising access to anyone other than patients and staff. This meant Clinical teachers were not allowed to visit students on site, let alone at the bedside supervision was done remotely via Zoom etc. Due to the workload issues much of the nursing care provided was via *tasking*, particularly for ākonga / students.

NZNO realises that adequate clinical placements are increasingly hard to find but this should not be the driving force for change. The quality of the simulation may vary, but the experience obtained by ākonga / students by being on clinical placement is essential in growing their confidence and familiarity with different clinical settings. If clinical placement providers were compensated appropriately then there might be more interest from organisations in participating.

NZNO does not support the proposed reduction in clinical hours reduction from 900 to 700 hours for the Enrolled nurse programme or 1,100 to 1,000 hours for the Bachelor of Nursing programme. This is already a significant shortfall of clinical hours and NZNO does not agree with any further reductions. Ākonga / students are completing their studies without the expected knowledge and skills for their first year of graduate nursing practice. We also question if the clinical hours were to be reduced how Council would evaluate the ākonga / students learning experience? Would it be an OSCE or a review of their completed clinical hours.

NZNO acknowledges the importance of clinical placements to support a ākonga / students' education by providing opportunities to learn, to apply theory to practice, develop safe clinical practice, understand the complexity of nursing, multi-tasking, work as part of a multi-disciplinary team, develop therapeutic relations, demonstrate culturally safe practice, and interact with patients, family and whānau. Additionally, all nurses RN / EN supporting ākonga / students should have completed a nationally recognised preceptor paper to support their feedback style and understanding of the academic requirements.

NZNO questions the need to reduce clinical hours or substitute clinical placements.

- Is this driven by expediency?

- Are clinical placements struggling to offer quality clinical teaching given the understaffing that is consistently occurring.

- Specialist services. For example: concerns have been raised where surgical services are being diluted by patient overflow (mainly medical). This in turn affects the number of specialist surgical treatments that are then available. Therefore, specialist nursing staff and students are affected in terms of experience given the overflow effects.

- Acknowledging that many nursing staff are telling us that they are exhausted that has a further effect on the quality of the teaching?

- Has the Council been in receipt of consistent lobbying from the educators about their struggle to meet the current hours?

- Recognising that another pandemic wave, natural disasters, or heatwaves could occur in the not-too-distant future, is this reduction in clinical hours either a practical or protective move? Are the educators and Council wanting the endorsement of the wider nursing population (who will hopefully read and discuss the background information to this proposal) so that they can meet statutory requirements for having consulted with the profession?

- Does there need to be more creative thinking to ensure ākonga / students are supported to obtain the clinical experience they need. Laboratory simulation could be a good thing in that it gives ākonga / students more opportunities to practice, but real-life clinical experience is vital. Do clinical placements need to be compensated accordingly and appropriately to make it more appealing as well as ensuring appropriate and consistent nursing leadership oversight.

4.11 Contractual agreements between the education provider and the clinical learning providers need to ensure quality placements form the basis of these agreements.

Standard Five: Ākonga/Student experience

5.9 Each nursing education provider has a recognition of prior learning (RPL) policy:
NZNO is concerned that each education provider has designated authority to determine a nurses RPL. Where is the national consistency, standards, and criteria? Do education providers need an advisory board to ensure consistently, transparency and fairness. The proposed policy is not in the best interest of training, recruiting, and retaining nurses in the workforce or supporting them to undertake further education.

NZNO recommends that all level 5 papers be approved for RPL. Furthermore, if an EN intends to undertake a Bachelor of Nursing programme they should be credited with the first year so that the programme is reduced to two years, not three as it is currently stands.

Standard Six: Ākonga/Student assessment

6.4 NZNO supports this statement to support Māori ākonga to undertake assessment in Te Reo or be precepted by a Māori nurse, but we question is it just aspirational, where is it demonstrated as to how this will be resourced and implemented?

6.5 The EN formative and summative assessments can be signed off as appropriate, by either an EN or RN. NZNO reinforces the need for the preceptors to be involved in this process to ensure consistency and appropriate knowledge and skill to complete this process.

Standard Seven: Emergency events

NZNO are concerned that the definition of emergency is very limited. When reviewing the Civil Defence Declared States of Emergency webpage[5] flooding, earthquakes and tornadoes were far more common than epidemics and for many who experience them, this is not reflected in the advice provided here.

Rārangi Kupu | Glossary of terms

There are various descriptions and definitions used when discussing clinical learning i.e., *clinical hours, clinical placement hours, clinical learning, quality placement learning, quality and clinical learning experience.*

Furthermore, *continuous transition* could also be included in the resulting confusion of wording. NZNO recommends consistent wording throughout the document and if not then clear each should be clearly defined and examples of how it is provided.

NZNO notes that the definition of quality clinical learning is vague and contains no information about how it relates to direct patient contact and provision of care. Does this need to be made explicit?

Conclusion

How will national consistency be achieved across the motu? How will the variation be managed between simulation laboratories and at what level will it be required?

A simulation laboratory is to practice and perfect, not used to replace a quality clinical experience.

NZNO acknowledges the significant amount of work that has been undertaken by all those involved and the progress to date. With a change in government and the potential for Te Pūkenga to be disestablished or recreated as another entity, we hope this work will progress to ensure our ākonga / students have an opportunity to become nurses while being supported by Council, education providers and stakeholders such as NZNO.

Thank you for the opportunity to contribute to your consultation process.

Nāku noa nā

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[5] https://www.civildefence.govt.nz/resources/previous-emergencies/declared-states-of-emergency