Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Enrolled nurse education standards (and amendments to registered nurse education standards)

Consultation analysis

Table of contents

Introduction

This paper summarises sector responses to our consultation [available here] on the enrolled nurse education standards and amendments to the registered nurse education standards (education standards). There were 101 responses to the education standards consultation in total, with 80 (79%) individual survey submissions and 21 (21%) written submissions.

The first two sections of this paper describe our respondents, followed by a discussion of consultation responses with each of the proposed changes to the education standards. Individual survey and written submissions are summarised throughout this paper.

Written response

There were 21 written responses with 20 from organisations and one from an individual. They included Te Whatu Ora Directors of Nursing (DONs), Te Pūkenga education providers, nurse educators in the tertiary sector, and New Zealand Nurses Organisation – including the National Enrolled Nurse Section, College of Emergency Nurses New Zealand, and the Mental Health Nurses Section.

We also received responses from the Office of the Chief Nurse Manatū Hauora, the Health and Disability Commissioner, UP Education and Youbee Limited (Healthcare Academy NZ), Health Informatics New Zealand, and the Nursing and Midwifery Board of Australia.

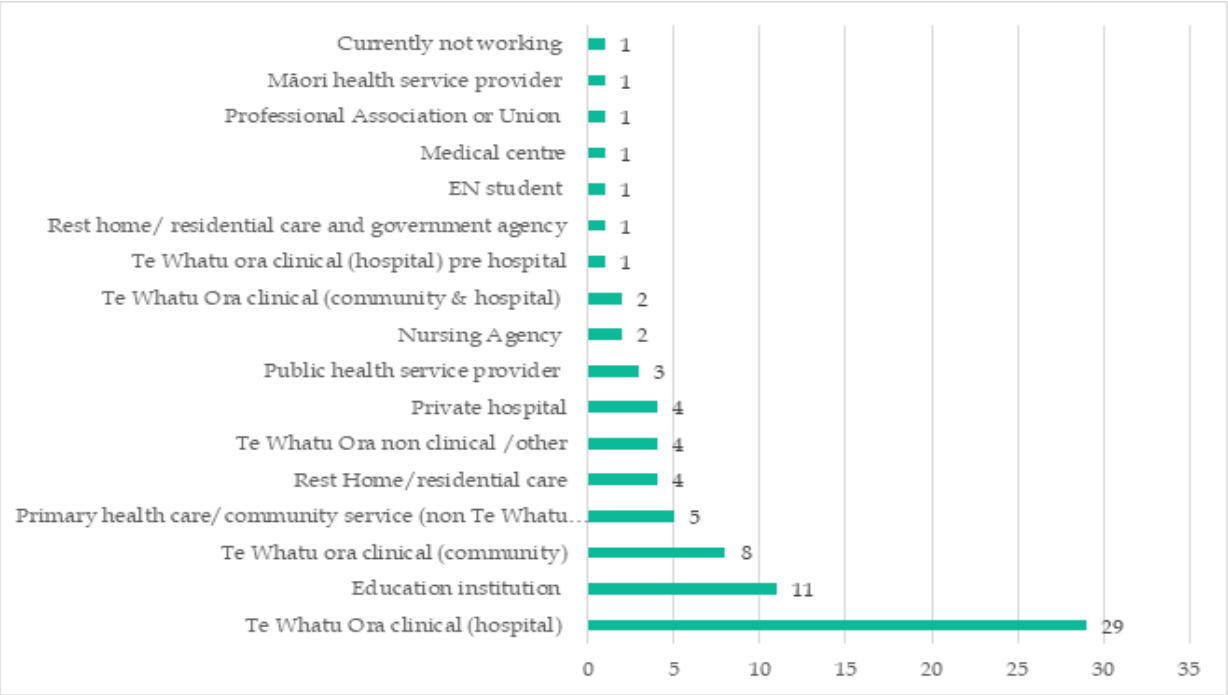
Survey response

There were 80 survey responses (having completed at least one consultation question), primarily from individual nurses (n=72/90%) with eight (10%) submitting on behalf of organisations. Of those who completed the survey, 35 (44%) identified as enrolled nurses and 30 (38%) identified as registered nurses.

Of the 80 survey responses, 10 (12.5%) identified as Māori, four (5%) identified as Pacific peoples, and five (6%) identified as having a disability. Twenty submitters (25%) noted that they worked in either a Māori or Pacific health service provider.

Seventy-nine (99%) submitters chose to self-identify their work areas, represented in Figure 1. Seventeen work areas were identified with 29 (37%) respondents identifying Te Whatu Ora clinical (hospital) as their work area.

Figure 1. Survey submitters work areas



Generic education standards

Consultation question:

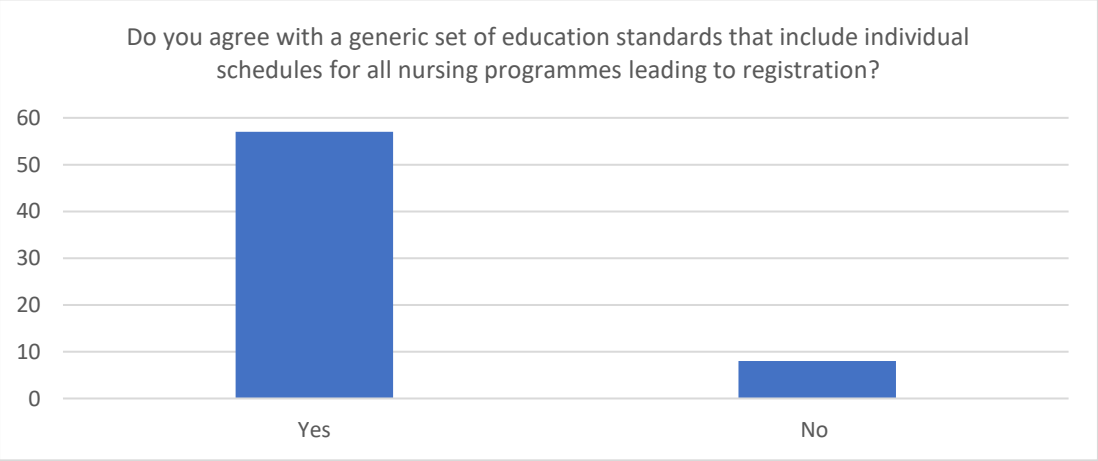
Do you agree with a generic set of education standards that include individual schedules for all nursing programmes leading to registration?

What changes would you suggest to this proposal to make it more meaningful for nursing education providers and programmes?

Survey response

Overall, there was positive support from across the sector to the proposed changes to the educations standards structure. Of the 65 responses to this question, 57 (88%) agreed and eight (12%) disagreed.

Figure 2. Generic set of standards survey response



Respondents commented that a generic set of education standards that include individual schedules make sense, as they provide for more programme consistency and standardisation, with some noting the need for meeting local needs where appropriate. However, some stated the variability of clinical learning environments for learners and the need for more consistency to support the students' learning experience.

There was a call for pathways and a bridging programme to support enrolled nurses to enter the Registered Nurse Bachelor of Nursing programme. A significant number of respondents advocated for the introduction of bridging programmes from EN to RN, and more general comments related to transition into practice, on-the-job training, earn-as-you-learn models, and more support for learners in practice. Some respondents noted more focus was required on specific areas of nursing in the education standards such as mental health and other specific topics such as pharmacology.

Written response

Overall, respondents supported the proposed changes to the generic education standards and individual schedules, although some respondents requested more detail, clarification, or guidance in some areas. Many viewed the standards as reflecting the broadened role of ENs and the education preparation required but also recognised that preparation for EN preceptors would be needed.

Respondents recommended not viewing the EN and RN programmes in isolation, with the generic education standards structure providing support to any future transition, staircasing or bridging programmes. The generic standards were viewed as supporting education providers to become more familiar with one set of standards.

There was concern raised that there seemed to be little distinguishing the EN and RN programmes with no clear differences between levels of education, and there was a call to see specific requirements for each be more evident. It was also noted there appeared to be a sense of reducing academic integrity or qualifications with these standards.

What we heard:

"Agree - fair and reasonable to align generic education standards for the tertiary sector. There is a level of generic education standards and then a specialised section – by that RNs will require more in-depth education in some areas, that will reflect the difference in qualification and scope of practice."

"Generic education standards are a key component to ensuring that all undergraduate nurses receive consistent education and program content".

"The separate programme schedules will then provide a focus that is entirely dedicated to each profession."

"Unfortunately, the 'generalness' does not flow to the places of employment."

"Allow enrolled nurses to do bridging course to become registered nurses instead of doing the 3-year course."

"I hope there is a gap or a path that experience of EN can go to become an RN in the future. This is because too many ENs have many experiences in clinical placement in hospital fields. Those ENs are confident to do nursing practice in a safe environment."

"I would like to encourage a bridging programme for ENs that would like to transition into RN. Currently a challenge paper only allows 6 months cut off the RN degree. Whereas the EN diploma is 18 months. You'd think an enrolled nurse would be able to immediately transition into the second year, second semester of the RN degree. Education standards currently make this very difficult for ENs to transition to RN."

"Issues for enrolled nursing students, graduate workforce – transition into practice and the relationships with employers. Key preparation for enrolled nurses who are going to be preceptors. ENs encouraged/allowed to do the preceptor programme – should be part of their development plan for the year/s. Open-ended standards – that is providers can interpret."

"The employer offers learning on the job, similar to an apprentice. Paid on the job. Having the education facility on site. This would draw more prospective persons of interest into enrolled nursing."

"I would like to see specific areas of nursing named in the education standards so that equal course content is given to all areas of nursing. I work in mental health. We are consistently receiving feedback from undergraduate nurses that their course content does not include mental health content which would prepare them for the work setting or indeed qualify them as being 'comprehensively trained."

"Maybe include even deeper theory learning and pharmacology into the DEN programme as there is currently no pharmacology paper and which leaves ENs coming into clinical rather unprepared."

"I would like to see tutor coverage where a student is for their protection as well as ensuring nursing standards are maintained."

Standard one – Te Tiriti o Waitangi partnership obligations

Consultation questions:

Do you agree with standard one and its criteria?

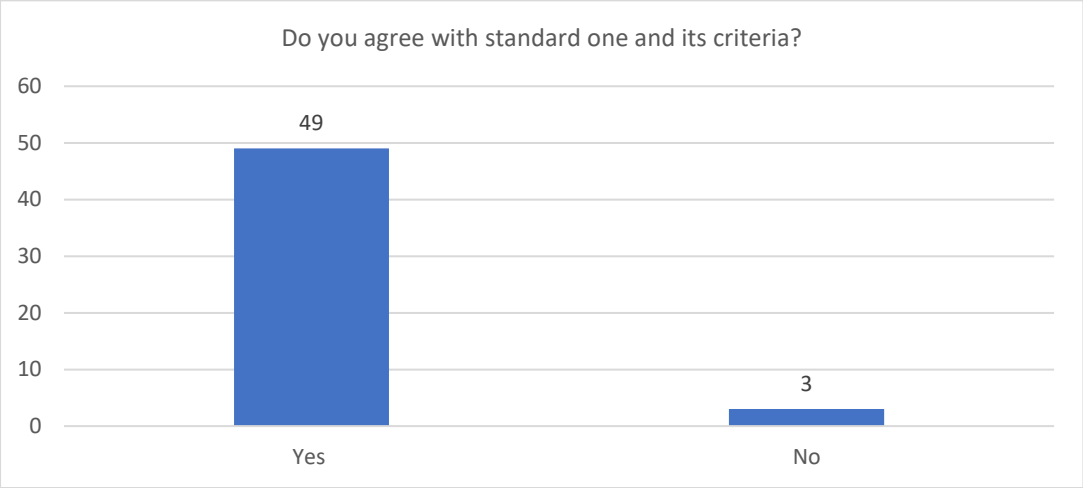
Do you think standard one will enable nursing education providers and programmes to meet their Te Tiriti o Waitangi obligations?

What changes would you suggest to standard one to make it more meaningful for nursing education providers and programmes?

Survey response

Overall, there was positive support for standard one and its criteria. Of the 52 responses to this question, 49 (94%) agreed and three (6%) disagreed.

Figure 3. Standard one survey response



Respondents supported the need for more emphasis of Te Tiriti o Waitangi, tikanga Māori, and mātauranga Māori in the curriculum, but also ensuring the application and assessment of this standard in practice. Respondents recognised the importance of having active partnerships with iwi, hapu, and Māori in a meaningful and authentic way.

Many respondents commented on the capacity and capability for education providers to be able to meet these standards and the investment required for educators and tutors to have the right professional development and skills. Recommendations were made regarding specific targets or key performance indicators by the Council to measure the growth of the Māori nursing workforce within the education system.

There was acknowledgement of the recent change of government and the impact on te ao Māori concepts being implemented. There were several comments regarding equality across all cultures, that New Zealand is a multi-cultural society, and there should be equal opportunity for all with no special conditions on race.

Further clarity was sought on the application of standard 1.3[1] and whether this was the role of the Council.

Written response

There was strong support from respondents in respect of the new standards and learning outcomes recognising the importance of Te Tiriti o Waitangi principles and partnership obligations including having active partnerships with iwi, hapu, and Māori in a meaningful and authentic way.

Many respondents commented that the commitment to Te Tiriti o Waitangi in the standards would enable the growth of the Māori workforce. It was also noted that the Council's Kawa Whakaruruhau and cultural safety guidelines would support the standards. There was a concern regarding some English terms and Māori terminology that required some amendments.

[1] 1.3: To support co-design, co-delivery, and review of nursing education programmes, nursing education providers have authentic and active partnerships with iwi, hapū, and Māori."

There was a strong view that adequate resources, staff knowledge, and experience were important to support providers to meet this standard. Several respondents questioned the current government's strategy and how this might impact these standards or resources to support education providers to build capacity.

What we heard:

"Agree with the documented criteria and that it meets Te Tiriti o Waitangi partnership."

"It will ensure a foundation for effective alignment with Wai 2575, and as it is implemented there will be opportunity for ongoing development."

"True partnership as emphasised in the Treaty, tino rangatiratanga, can only be achieved if Māori are to be included as part of the system, i.e.. equally employed within it, rather than simply a requirement in the criteria to be consulted as outsiders."

"These are core principles for all professionals whether they are EN or RN and educational standard alignment is logical and appropriate. These criteria demonstrate an active Te Tiriti partnership."

"Increase education of academic staff, ensure there is a requirement on the level of knowledge they must have to be able to teach on an EN/BN programme, to ensure it is both safe for the students, as well as the staff. Not having the knowledge can leave them extremely vulnerable."

"Everyone in NZ can speak English so the requirement to provide education in Māori is not necessary, and it may be unrealistic to expect to find tutors with the skills to meet this criteria."

"I am concerned that many educators require upskilling in this area, especially IQN educators who may not have the depth of knowledge in the Te Tiriti o Waitangi obligations."

"Stop being so specifically intense on the TOW and focus on the fact that New Zealand is multicultural, not just a bicultural nation."

Standard two: safe care for the public

Consultation questions:

Do you agree with standard two and its criteria?

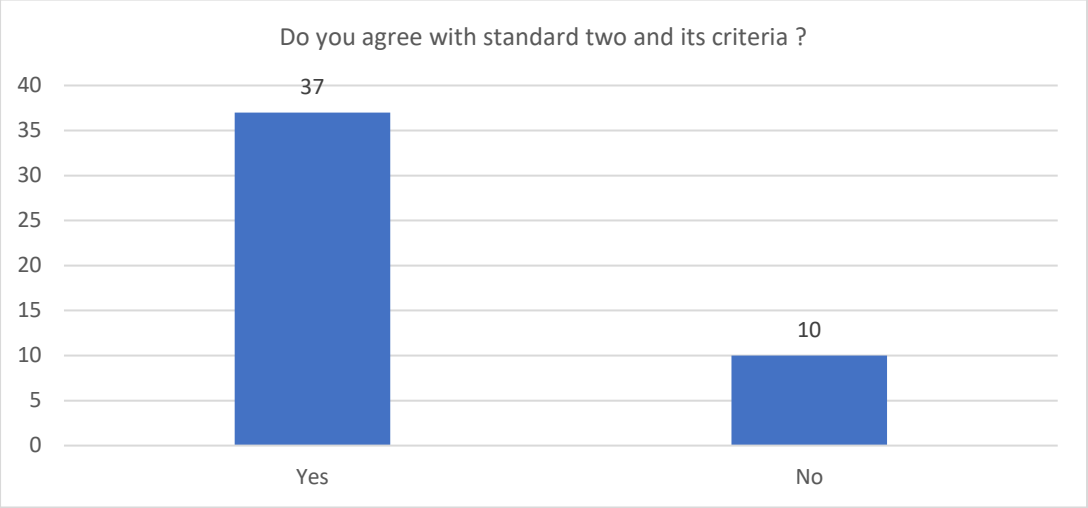
Do you think standard two will ensure education programmes' focus on safe and socially accountable practice?

What changes would you suggest to standard two to make it more meaningful for nursing education programmes?

Survey response

There was general support for standard two and its criteria. Of the 47 responses to this question, 37 (79%) agreed and 10 (21%) disagreed.

Figure 4: Standard two survey response



Overall, respondents agreed the standard was clear regarding safe care for the public. Survey respondents predominately viewed standard two as comprehensive and appropriate for nursing education programmes to focus on safety and socially accountable practice, covering all relevant and appropriate legislation, particularly with strategies to prioritise the Māori and Pacific workforce.

There were concerns raised about students' rights regarding inadequate preparation for clinical practice and their learning needs, and academic staff having adequate access to professional development opportunities. Respondents also commented about service users determining what safe care is, along with students being able to determine what self-care means to them. Clarity was sought on whether rostered and rotating shiftwork applied to all clinical placements or just the transition to the practice period.

There were questions raised about language and naming such as "nurse education provider" and "Te Pūkenga", particularly with a change in government, including consistency of head / lead of nursing terminology.

There was a considerable response to standard 2.2[2] with most survey respondents supporting the proposal, although some recommended that the EN programme is delivered within an institution providing an RN programme. There was some concern that EN students may not get the same access to the level of resources and facilities as Bachelor of Nursing/Masters' students in organisations where only an EN programme is offered.

Clarification was sought with Standard 2.10[3] as to whether consideration was given to students who attend foundation programmes outside of a nurse education provider.

[2] "The educational institution must be accredited by the Council, as per section 12(2)(a) of the HPCA Act (2003), to provide a programme leading to registration as an Enrolled or Registered Nurse. 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. This relationship is demonstrated through mechanisms such as a Memorandum of Understanding."

[3] The nursing education provider has foundation programmes that enable future ākonga/students to meet entry requirements for nursing education programmes.

Further clarity was sought about the rationale for students not being given more than two opportunities to enrol in a clinical learning course, standard 2.16.[4]

Written response

Overall, respondents supported standard 2.2 noting this provided opportunities to articulate from an EN to RN programme. However, further clarification and guidance on a formal relationship or a memorandum of understanding (MOU) was sought. There was a concern raised regarding access to clinical placements if more independent tertiary providers were delivering programmes without collaboration with other education providers.

There was a minority view that did not support standard 2.2, calling for fast-track accreditation of EN programmes and noted the lengthy timeline for completion and implementation of the education standards.

There were requests for more than two opportunities for students to enrol in a clinical learning course under standard 2.16 and to understand the rationale for this number of opportunities. Respondents also noted support for emphasis on diverse learners and a category for alternative admission to nursing education programmes.

There was a view the standard needed to be more explicit on research-informed practice and skills in the curriculum, particularly if level six credits were being introduced.

What we heard:

"The changes and alignment are educationally sound. Core values of the EN or RN and acknowledges scope of practice."

"Standard 2 Public safety 2.4 – include the NZNO code of ethics – important to have the ability to inform decision making – these are the professional nursing ethics statements for nursing in Aotearoa. 2.5 Vaccination requirements are part of their health checks to include the – entry requirements for clinical requirements for study or employment – MMR, Hep B 2.16 – clinical – need to outline the exemption process the NCNZ uses to approve a student to re-engage in the programme if failed twice. Need to find a rationale for the "2" – why is this?"

"Standard 2.5: We support the comment on rostering and rotating – would be nice to have this clarified if it is for all clinical placements or just the final 6-week placement."

"I do not agree with Criteria 2.2 in Standard 2 in that educational institutions not offering a BN programme should be allowed to offer an EN programme. The focus should be on workforce development for nursing and health as a whole and there is a real risk that PTEs and other providers will want to offer EN and be driven to do so from a fiscal as opposed to a workforce development imperative."

"Yes, it is worded to ensure accountability to be sound and safe for EN/RN."

[4] The nursing education provider ensures ākonga/students are not given more than two opportunities to enroll in a clinical learning course. Exemptions are made on a case-by-case basis approved by the Nursing Council.

"My only concern is around 2.6 and 2.9. Whilst every effort must be made to encourage priority learners, public safety must not be compromised."

"There needs to be some specific consideration given to different learning styles as well as neurodiversity within the criteria and the education provision for nursing."

Standard three: academic governance, leadership, and partnership

General questions:

Do you agree with standard three and its criteria?

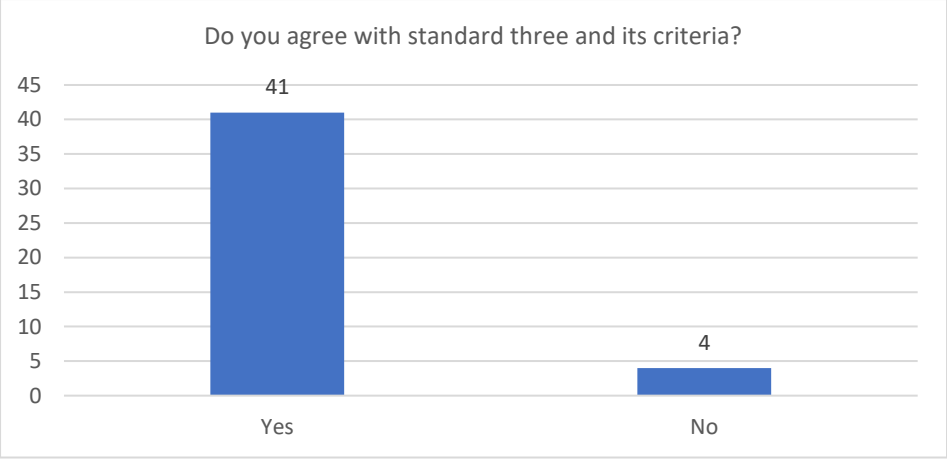
Do you think standard three will ensure education programmes focus on safe and socially accountable practice?

What changes would you suggest to standard three to make it more meaningful for nursing education programmes?

Survey response

Overall, there was general support for standard three and its criteria. Of the 45 responses to this question, 41 (91%) agreed and four (9%) disagreed.

Figure 5. Standard three survey response



Respondents commented about the clarity this standard provides by setting expectations for academic and clinical staff. There was a view that academic staff need to have broader experience, such as mental health and community nursing, if teaching in a specific field of nursing with a focus on application of knowledge to practice. This included employing Māori lecturers and cultural advisers to support a te ao Māori view in nursing education. There was concern raised over the lack of access to EN post-graduate education that would be an issue if they are required to have a post-registration qualification as clinical teaching staff.

Respondents also commented about the proposed education changes and future of Te Pūkenga and impacts this may have on future implementation of the education standards.

Further clarification was sought about clearly defining what qualifies as a quality outcome.

Written response

Respondents commented that this standard provided a strong framework to assist education providers deliver high-quality education with strong professional leadership. Several respondents commented that there needed to be recognition that heads of nursing are often required to be integrated across the institution with other accountabilities.

Further clarity was sought about how leaders of education programmes would be knowledgeable in te ao Māori and tikanga to ensure consistency with the principles of Te Tiriti o Waitangi, and have strategic and functioning partnerships with iwi, hapū, and Māori.

There was a positive response to a requirement for professional development opportunities for te ao Māori development, with a call for funding of cultural supervision for all staff.

There was some concern expressed about what appeared, to some respondents, to be a dumbing down of qualifications for academic staff with a recommendation that a significant proportion of academic staff hold a master's degree or higher.

Overall, there was support for ENs as part of clinical teaching staff and the ability to have a career pathway. However, there was some concern voiced whether ENs teaching or preceptoring and providing clinical oversight to EN students, would get access to professional development opportunities. More clarity was sought on post-registration education requirements.

What we heard:

"Yes, it is worded to ensure academic governance is robust and practicable across the programmes for EN/RN."

"Although in some TEPs where there are multiple sites, the Head of School can have less than desirable oversight of programmes being delivered on smaller sites. This can lead to inequitable opportunities for students and staff."

"I believe you need to incorporate a requirement within the nursing education provider to employ Māori Kaimahi as part of the paid academic staff, in order to reflect the tino rangatiratanga component of Te Tiriti. Having a requirement to engage with Māori outside of the programme is not sufficient to meet this much neglected commitment of the Treaty, and does not address the decolonisation process which needs to happen, including rebalancing the power and autonomy between Māori and their treaty partner."

"I appreciate the clarity of the expectations of academic staff and clinical teaching staff."

"Clinical teaching staff – it is important the enrolled nurses continue to be involved in the leadership role."

"If no importance is placed in mental health nursing at the training level then no undergrads will choose MH as a viable career option. Not good enough."

"Would like to see that clinical teaching staff actually received some education around teaching/assessing in the workplace, such as having US4098."

"Suggest there is a need to ensure that there is clear defining of what qualifies as a quality outcome."

"Standard three (3.10) states that the clinical teaching staff can be either an EN or RN and have to hold a post-registration qualification in nursing or related discipline. However, there isn't post graduate qualification for ENs so how will this work?"

Do you think criteria 3.1 reflects the positioning of the head or lead of nursing to enable quality outcomes from the nursing education programme?

Of the 43 responses to this question, 33 (77%) agreed and 10 (23%) disagreed.

Respondents commented about the skills and experience required of the head of nursing, particularly academic and professional leadership, and how support is provided to reflect the Tino Rangatiratanga component of Te Tiriti o Waitangi and authentic engagement with Māori.

There was concern raised about the ability to provide oversight of programmes across multiple programme delivery sites which can lead to inequitable opportunities for students and staff but also be a challenge for a head of school.

What we heard:

"Providing the clinical experience, attitude, and aptitude of the leader is reflected in the successful education of nursing students and the practical clinical experience is provided & assessed."

"As head of school, the expectation would be that they display professional and academic leadership as they will be 'guiding' the school and the processes within it."

"To put all of this responsibility on one person is unrealistic. It needs to be a team-led responsibility and accountability, with ongoing input and feedback from all stakeholders including students incorporated within the measuring of quality outcomes within nursing education."

Standard four: programme of study

Consultation questions:

Do you agree with standard four and its criteria?

Do you think standard four will ensure nursing education providers and programmes enable graduates to achieve safe and competent practice?

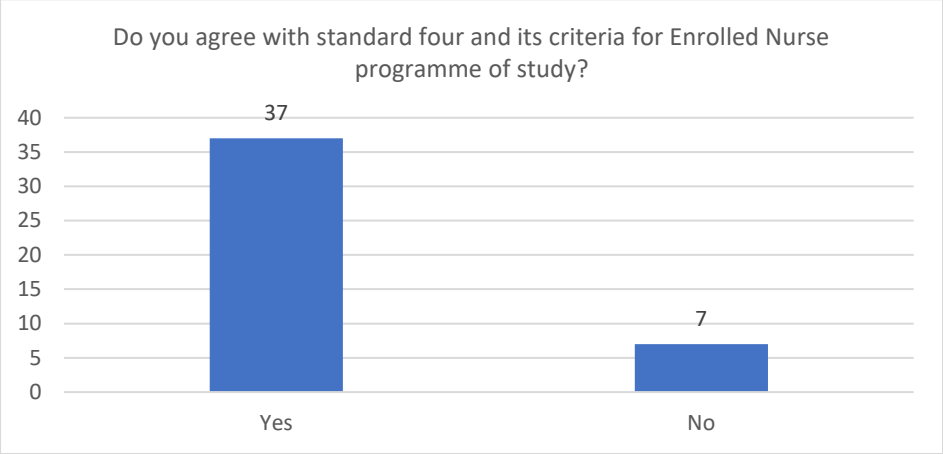
What changes would you suggest to standard four to make it more meaningful for nursing education providers and programmes?

Enrolled nurse programme of study

Survey response

Overall, there was general support for standard four, the EN schedule, and its criteria.. Of the 44 responses to this question, 37 (84%) agreed and seven (16%) disagreed.

Figure 6. Standard four survey response



Respondents commented about the curriculum content and the need for communication and listening skills, specific areas of practice such as primary care and mental health knowledge, and mastery of additional skills (e.g. intravenous therapy) to prepare ENs for practice. There was a call for paid clinical placements, particularly for Māori, to keep students in the programme.

Overall, the introduction of level six credits and 240 hours of transition placement in the last semester was received positively, however, there was a request to see the rationale for introducing level six credits into the EN programme as this could be challenging for students. It was also seen as unnecessarily complex having three NZNA levels across a diploma. There was a call for the EN diploma exiting at NZNA level six with healthcare assistants now undertaking certificates at NZQA level 5.

Written response

Respondents noted that opportunities for articulation between EN and RN programmes would be enhanced and the requirement for recognition of prior learning (RPL) strengthened by introducing consistent pathways across education providers. There was also a recommendation for ENs and RNs supporting students to have completed a nationally recognised preceptor course.

There was a call for further clarification and the rationale behind introducing 30 credits at level six, particularly the implications for the current level 5 diploma and curriculum. Further clarification was also sought regarding entry criteria if level six credits were introduced and whether the EN diploma would shift to a level six diploma. There was concern about the impact of ENs working in Australia under the Trans-Tasman Mutual Recognition Act 1997 (TTMR).

It was also noted that 50% of curriculum hours with a nursing focus was too low with a recommendation to increase this to allow ākonga adequate learning time.

Respondents commented positively that the broader overview of the programme content and learning outcomes in standard four were flexible and not prescriptive, however, it was noted that learning outcomes were not explicit on anatomy and physiology, pathophysiology or communication.

Overall, there was positive support for the 240-hour transition placement in the final semester with a request for more information about how this would work in practice and what impact this may have on other clinical placements across the programme. Some respondents commented on the need for a standard on "clinical placements," specifically describing what they are, what is delivered across parties, and how they are monitored and evaluated to ensure quality placements. There was also reference to Te Whatu Ora's project to design a new system for clinical placements.

What we heard:

"Yes, agree with this standard and criteria. Definitely need individual schedules for EN and RN."

"Why only 50% of programme has a defined nursing focus? It seems very low."

"Specific communication and listening skills need to be taught as part of the curriculum, as they are the key to a nurse being able to understand, empathise, evaluate, and provide effective person-centred care."

"I do agree with the inclusion of 30 credits at level 6, as the mixture of level 4 and 5 credits in the previous standards did not ensure adequate acquisition of knowledge for an EN student. The inclusion of a 240-hour transition placement for EN students is a great addition."

"I am concerned that the inclusion of 30 credits at level 6 (i.e. BN Year 2) will be challenging for students. There is no clear rationale provided for this change from current 90 points at level 4 and 90 points at Level 5. Having three different NZQA levels across 180 points seems unnecessarily complex .and unusual for Level 5 diplomas."

"Currently ENs in Australia complete a minimum 18-month diploma of nursing (level 5) and ENs in New Zealand must successfully complete the 18-month diploma of enrolled nursing (level 5 on the New Zealand Qualification Authority framework). The proposed change would see the qualification as a level 5 diploma on the New Zealand Qualifications Framework, comprised of 180 credits, of which 30 credits must be at level 6, recommending diploma of enrolled nursing programmes include one paper at level 6 (30 credits) in the final semester. Has a gap analysis of the new EN scope of practice and mapping of the existing nursing curriculum informed this proposed change to the nursing education programme standards leading to registration as an enrolled nurse (EN)?"

"I think there is a challenge for the Nursing Council when considering the achievement of safe and competent care. On the one hand, there is a desire to be broad and flexible - and to be future-focused in the education of nurses and, on the other, wanting to be specifically supporting the delivery of safe, quality care. The higher and less specific the scope (parameters of practice not clearly described) the more difficult it is to articulate what safe, quality care is."

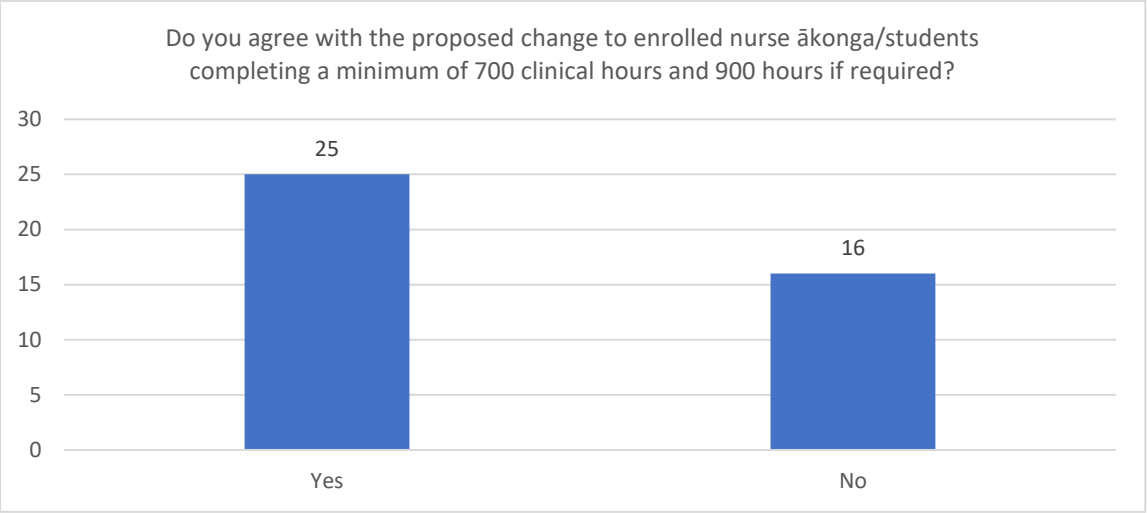
"I believe consideration needs to be given in future to paid earn-as-you-work student placements, following an adequate training period, to address equity amongst low socio-economic Māori students and those unable to afford the financial costs of nursing education

easily. It could also address the learning needs for Māori students and others who learn best with on-the-job training as opposed to the classroom setting."

"For NetP graduates, they select the place of preference. In my place of work, there is a set program for the new grad, the educator, preceptor, & staff. Everyone has a role to make the transition from new grad, to RN achievable and rewarding. Even though we are stressed as everywhere is, it is the team who creates 'calm'."

Do you agree with the proposed change to enrolled nurse ākonga/students completing a minimum of 700 clinical hours and 900 hours if required?

Figure 7: Proposed EN clinical hours



Survey response

There were 41 responses to this question, 25 (61%) agreed and 16 (39%) disagreed.

Respondents who supported the proposal noted this was not really a change as ākonga complete 700 hours in the existing programme with a range of experiences for the length of programme now. This was viewed as sufficient and could be increased if required.

Some respondents considered that with the changes to the EN scope and additional responsibilities, including the introduction of level 6 credits, clinical learning hours should be between 800 to 900 hours to prepare students sufficiently for the practice context.

Written response

Of the written organisation responses, those who supported the proposal also supported the importance of the additional 200 hours if required for learner success. There was acknowledgement that some education providers already provide 700 hours of clinical learning with an additional 200 hours of simulation as a blended learning approach.

The place of simulation was recognised, however, several respondents recommended more standardisation and national consistency for simulation hours. There were questions about the evidence to support replacing quality clinical learning with

simulation, including the use of simulation with assessment of clinical and cultural practice.

Several respondents commented about having already provided feedback to this question in earlier conversations and questioned why this was being consulted on again. It was recognised that clinical learning hours was a well-debated topic with little evidence either way. There was a recommendation to benchmark using the Australian nursing standards assessment tool.

There was concern as to whether a minimum of 700 hours of clinical learning would meet additional requirements with the changes to the EN scope of practice. However, it was also questioned whether a focus should be on clinical competence rather than hours, where evidence-based teaching, learning, and assessment methods were applied to reflect robust learning outcomes. There was also a view that the primary purpose of clinical learning hours should be preparation of students rather than increasing student placements.

There was acknowledgement of the importance of clinical learning placements and quality preceptorship. More clarification was sought about how the Council would evaluate clinical learning experiences if hours were reduced, where additional support for education and clinical settings to achieve learning outcomes may be required. It was noted that EN ākonga are mainly kinesthetic learners where the application of theory to practice was applied through clinical learning hours, including socialisation into the profession.

There was also a call for paid clinical placements or a student training allowance to take the financial pressure off students and support more access to clinical learning placements.

What we heard:

"Feel this is a sufficient minimum and hours can be increased if required."

"This is not really a change as ākonga have completed 700 clinical hours within existing programmes and given the length of the programme it provides a range of experiences."

"The EN programme is an applied programme, I support a range that focuses on achieving competence; and also supports the additional responsibilities in the revised EN scope and the level 6 credits. I would propose 800 - 1000 hours."

"Simulation has its place – need references and statements to underpin the argument to keep simulation in the nursing programmes and these education standards so institutions have the resources to do high-fidelity simulation. Practicing observations, doing a round, listening, and literacy of health education."

"Concerned that reduced hours will lead to reduced competence and graduates will be under-prepared for the complex healthcare environment."

"Support the hours to be maintained at 900 for enrolled nurses. EN students need as much clinical experience as possible during their programmes to prepare them for their future in nursing, cutting back on clinical hours will not prepare them sufficiently."

"Reducing clinical hours is never the answer. The rationale for reducing clinical hours in previous years has been about not having enough clinical placements available. Now the rationale has

changed to it being about it being a barrier to students, mainly financial. There are always going to be challenges to clinical placements, but reducing the hours is not a solution. This becomes a slippery slope, and hours may continue to be reduced in the future."

"Providing students with as much exposure to the reality of nursing will enable them to have a greater understanding on what they're getting into when graduation occurs. Limiting clinical hours won't promote this. More practice clinically, the better our students will be."

"There is strong concern that again they are trying to shorten clinical hours. Suggest clear guidelines to the statement 'if required' means and who determines that? How would the use of OSCE or simulation to augment clinical practice if hours not available due to pandemic or in rural areas. Is Te Pukenga committed to supporting dedicated education units for students in general practices? This will reflect an equitable exposure and learning experience for all students."

If the number of clinical hours is reduced, what measures would the Nursing Council use to evaluate enrolled nurse ākonga/students' quality learning experiences?

Respondents commented generally about the quality of clinical learning placements and evaluating the outcome of knowledge and skills acquired from the learning experience. There was a view that EN graduates were further supported through Enrolled Nurse Support Into Practice Programme (ENSIPP) and transition to practice placements.

What we heard:

"It's not about evaluating the quality of their learning experiences, it's about the Nursing Council needing to evaluate whether the students have acquired enough knowledge and skill from those learning experiences. Too much emphasis is put on the perceived quality of the experience, rather than determining whether they are getting out of the placement what they need."

"ENSIPP and transitioning placements."

"Make sure when they have completed diploma that they complete a full year of a new entry into practice of some sort."

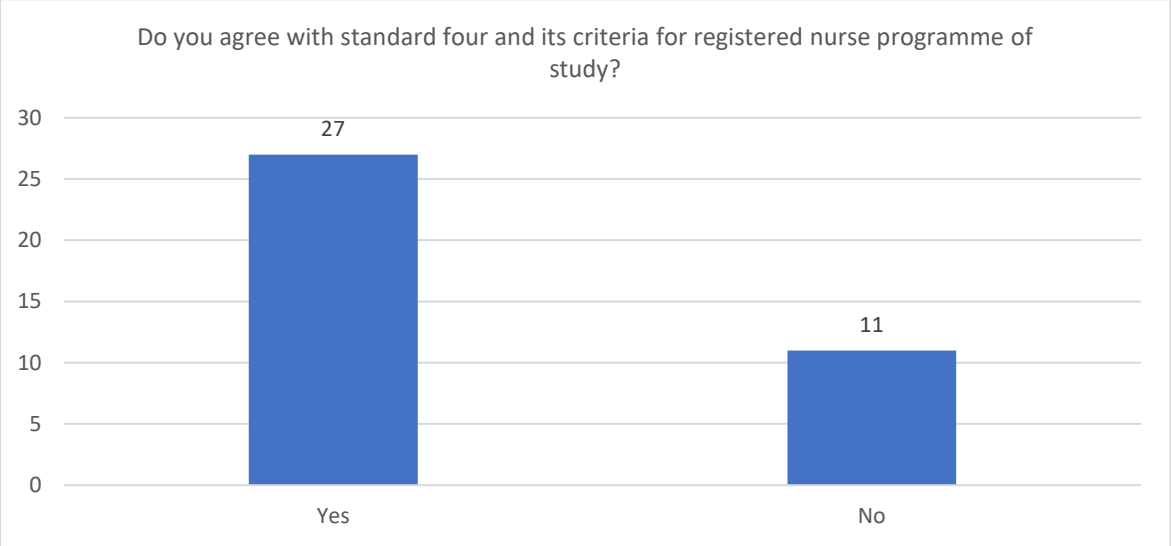
"I have concerns regarding how this could be measured if clinical hours reduced that if the preceptors or tutors are the relevant accessors and the students do not meet learning competencies, then the pressure this might put on the students."

"Case-based OSCEs with direct feedback. Scaffolded competence assessments throughout the programme. Stakeholder feedback including clinical practice areas and workforce teams within industry."

Registered nurse programme of study

Overall, there was general support for the standard four registered nurse schedule and its criteria. Of the 38 responses to this question, 27 (71%) agreed and 11(29%) disagreed.

Figure 8: Standard four survey response



Survey response

Respondents commented about the alignment between the EN and RN standards, but several noted there were not many changes overall for the RN programme of study, with little difference between programme learning outcomes.

There was a call for making learning environments safe and motivating for learners to support a positive experience.

The place of simulation was noted with a call for more evidence about the application of simulation in programmes, and the variable capability and resourcing across education providers to use this as a teaching method.

Some respondents recommended paid clinical placements to address inequity amongst students who were struggling financially and to support learners who learn best with on-the-job training as opposed to a classroom setting.

Written response

Mostly respondents commented about the EN schedule only, but several wanted to be able to see the difference between EN and RN programmes, particularly in mental health, with a focus on RNs needing integrated knowledge while ENs need knowledge of safety and quality.

There was a call to see articulation between the EN and RN programmes enhanced and an ability for nursing students to move between qualifications.

What we heard:

"I like the alignment between the EN and BN standards providing the application of knowledge to practice is required and demonstrated."

"4.6: Except for the learning outcome 'clinical assessment and clinical decision making' everything is the same for the revised RN standard. Where is the point of difference between the EN and RN learning outcomes? Also, no mention of differential diagnosis for RNs."

"Add a new criterion for standard 4 regarding paid clinical placements – to ensure new models of payments are included – why do we want this – benefits – keep students in learning, disadvantaged with the costs associated with clinical placement – accommodation, childcare, provision of accommodation. Need look at the NSU student survey. should not be the survival of the fit and the wealthy to complete a nursing programme."

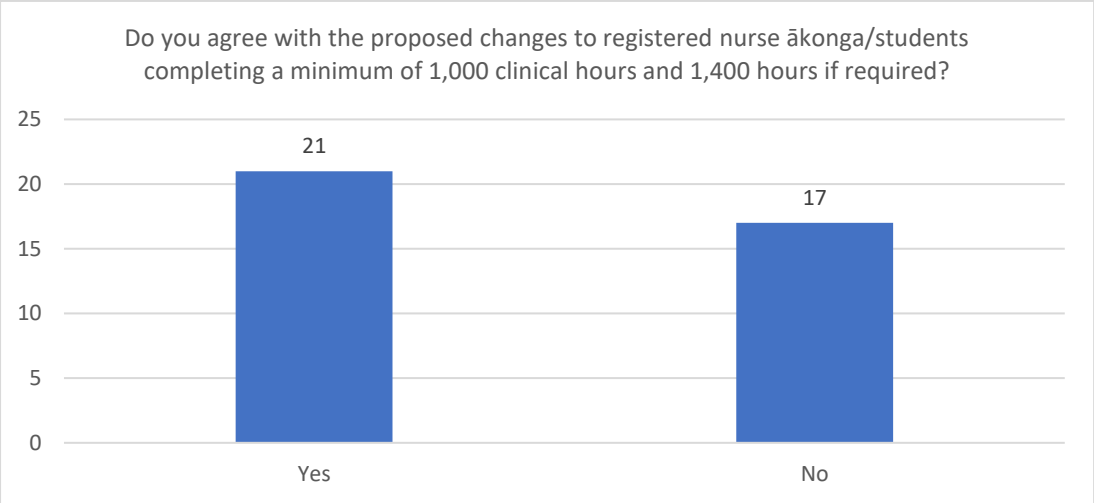
"As long as students are supported sufficiently within the program, with flexibility in the achievement of their learning outcomes as required on an individual basis. I believe consideration needs to be given in future to paid earn-as-you-work student placements, following an adequate training period, to address equity amongst low socio-economic Māori students and those unable to afford the financial costs of nursing education easily. It could also address the learning needs for Māori students and others who learn best with on-the-job training."

"At present undergrads are being discouraged from careers in mental health by educational providers. MH content and placements appear to be something to endure rather than understood."

"Simulation has its place – need references and statements to underpin the argument to keep simulation in the nursing programmes and these education standards so institutions have the resources to do high-fidelity simulation."

Do you agree with the proposed changes to registered nurse ākonga/students completing a minimum of 1,000 clinical hours and 1,400 hours if required?

Figure 9: Proposed RN clinical hours



Survey response

Of the 38 responses to this question, 21 (55%) agreed and 17 (45%) disagreed.

Many respondents voiced opposition to reducing the RN clinical hours, questioning why the Council was consulting on this again. It was noted that reducing clinical hours was not a solution to student barriers or managing the demand on clinical placements. Several respondents commented that RN students need as much clinical experience as possible to prepare them for practice, and any reduction in clinical learning hours would lead to reduced competence and under preparation for the complex health environment. Some respondents suggested more clinical hours than the current 1,100, and that included increasing to a four-year programme.

It was noted that most countries provide more than 1,100 hours, except Australia.[5] A concern was also voiced that the 360-hour transition placement only left 640 hours to learn about clinical nursing. Less than half the minimum number of hours were provided in the first two years and that was insufficient for students early in their education. Furthermore, it was noted that the proposed reduction in hours is only 100 more than the suggested maximum number of hours for the EN programme.

Respondents who supported a reduction in RN clinical hours did so on the proviso that the hours were sufficient to provide opportunities for the student to learn core requirements. There was also a call for clear guidelines on additional hours to provide national consistency.

Written response

Of the written organisation responses, there was a strong response to not reducing the clinical learning hours in the BN programme. It was recognised that clinical learning hours was a well debated topic with little evidence either way. There was a call to provide RNs with as much clinical experience as possible to prepare them sufficiently for practice. There was a recommendation to benchmark using the Australian nursing standards assessment tool.

The place of simulation was recognised, however, several respondents recommended more standardisation and national consistency for simulation hours and questioned the evidence to support replacing quality clinical learning, including assessment of clinical and cultural practice.

There was a view that if clinical hours were reduced, how would the Council evaluate learning experiences? There would need to be appropriate support for education providers and clinical settings to achieve learning outcomes.

What we heard:

"Strongly opposed to reducing clinical placement hours, 1,000 –1,400 hours of practice, no mention of simulation hours."

"We disagree with the Nursing Council reducing the number of hours for registered nurses and we strongly advocate for the hours to be maintained at 1,100. RN students need as much clinical

[5] NCNZ paper (2021), Clinical hours in Nurse Education (link)

experience as possible during their programmes to prepare them for their future in nursing, cutting back on clinical hours will not prepare them sufficiently."

"I just wanted to give my support to reducing the number of clinical hours for RN education and support the other changes proposed for RN education."

"There is a need to clearly identify what a clinical learning experience hour is. Currently there is variation amongst education providers e.g. one education provider counts a day on placement as 9 hours as this is giving the ākonga time to prepare for their placement, however, this hour is not time spent in a clinical learning environment. Clinical learning experience/placement hours should be actual hours spent in the clinical area. It should also not include clinical debrief days undertaken within a classroom."

"There would need to be clear guidelines as to where someone needs further hours so all students across the motu are being assessed equally."

"Concerned that reduced hours will lead to reduced competence and graduates will be under prepared for the complex healthcare environment."

"Providing those clinical hours provide the opportunity for the student to learn how to communicate, evaluate, and demonstrate nursing care procedures."

"There is a need to increase the clinical hours, and the nursing course to four years instead, to ensure clinical competency within the changing and increasingly complex nursing environment. It is additionally vital to have more opportunities for learning within actual clinical environments, with supervision provided for students, rather than relying more on simulation within classrooms. These could include a variety of placements including primary and secondary inpatient outpatient settings."

"The attachment to this consultation, "Clinical Hours in Nurse Education" which provides an overview of international literature would suggest that the majority of countries (with the exception of Australia) provide more than 1,100 hours. New Zealand has a highly respected international reputation for quality graduates, please do not dilute the number of clinical hours, just to increase the number of graduates - quality has to override quantity. With the 360-hour transition placement, this only leaves 640 hours to learn about clinical nursing. In addition to the final 360 hours of clinical learning, a further 150 hours clinical learning is to take place in the final year of study. This means that less than half the minimum number of hours will occur in the first two years of education. I am also surprised that 1,000 hours is only 100 more than the suggested maximum for EN training. There does not seem to be a suggested maximum number of hours to be offered."

"To define really clearly what is meant by quality clinical learning experiences and to audit and monitor how clinical learning experiences are evaluated."

Standard five: ākonga/student experience

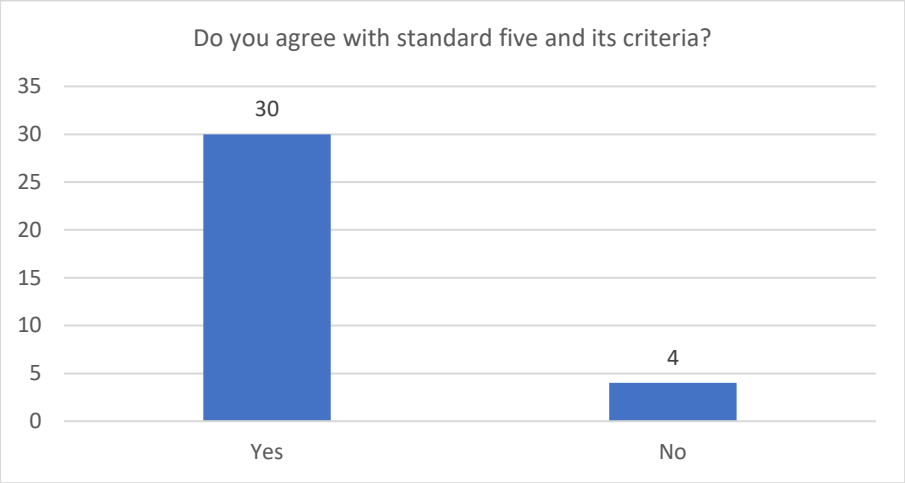
Consultation questions:

Do you agree with standard five and its criteria?

Do you think standard five will ensure students are appropriately supported?

What changes would you suggest to standard five to make it more meaningful for nursing education providers, programmes, and students?

Figure 10: Standard five survey response



Survey response

There was general support for standard five and its criteria. Of the 34 responses to this question, 33 (88%) agreed and four (12%) disagreed.

Respondents noted their current policies and procedures do reflect this standard, however, they voiced the importance of these being implemented or applied appropriately due to a lack of consistency across the country.

Clarification was sought about standard 5.4,[6] and how this would be applied in practice.

Several respondents advocated for more support from mentors/supervisors to ensure positive learning experiences and student wellbeing. Also, there were calls for academic and clinical teaching staff, including preceptors, having the right skills and experience to meet student learning needs, including te ao Māori knowledge and experience.

Respondents commented about requirements for students to uphold professional behaviour and standards, particularly when undertaking clinical placements. Concerns regarding use of social media and privacy were also raised.

[6] 5.4: Nursing education providers have processes and procedures to ensure ākonga/students can raise and report any issues in relation to clinical learning experiences.

There were comments related to recognition of prior learning (RPL) and reducing the barriers to transfer between education providers nationally, but also when transferring from Australian programmes. There were calls for pathways to bridge from EN to RN programmes with more recognition of EN practice experience and workplace learning.

Written response

Overall, respondents agreed with this standard and many noted their current programmes deliver these criteria already.

There was general concern that each education provider could determine a nurse's RPL and that there was a lack of national consistency of how RPL is applied. There was a call for reducing barriers for nurses wanting to transition to the BN programme including support to transfer to another provider. There was a view that ENs should be accredited for the first year of the BN programme in recognition of prior knowledge and skills.

Standards 5.2[7] and 5.3[8] were seen as aspirational but there was a general commitment from respondents to support a culturally safe and appropriate environment and development opportunities for ākonga.

While there was support for standard 5.4[9], further clarification was requested about how to enable this through processes and procedures in practice.

What we heard:

"Current policies and processes reflect this."

"Standard 5.4: need further clarification with regards to students' concerns around clinical placements."

"Standard 5.4: clinical placement providers or preceptors teaching students activities that are not in their scope of practice – this is a public safety risk."

"I have some concerns about the professionalism of some ākonga and their understanding of what it means to be a registered nurse and to be a health professional, and uphold the professional roles and responsibilities within and for the profession."

"Standard 5.9: recognition of prior learning requires the ability to transfer institutions without barriers. Need Nursing Council to expand on the RPL standards and to include the ability to transfer institutions without barriers. No recognition of previous nursing experience issues or years of practice and workplace learning. No recognition of ENs who are trained in Australia into RN programme."

"Tertiary hospitals are used to having students of all levels, so the transition is smooth. Unfortunately, personalities do clash, but that is easily solved."

"I think more support the better."

[7] 5.2: Ākonga/student academic learning needs are identified and supported by the nursing education programme. Academic learning needs for Māori and Pacific peoples' ākonga/students are identified and targeted support is provided.
[8] Nursing education providers have processes to ensure cultural safety for all ākonga/students, including culturally appropriate support, engagement, and processes for Māori and Pacific peoples' ākonga/students to enable success.
[9] Nursing education providers have processes and procedures to ensure ākonga/students can raise and report any issues in relation to clinical learning experiences.

"If a mentor/supervisor/advisor was available to students, and effective communication skills used, then their health, wellbeing, understanding of roles, confidence, and competence could be better assured."

"Ensure that the Te Pūkenga policy for RPL aligns with those for nurse education."

"Ensure that some proportion of Kaimahi within academic nursing staff/lecturers/preceptors are Māori, and not simply non-Māori teaching Māori content."

"Blended approach. More simulation labs."

Standard six: ākonga/student assessment

Consultation questions:

Do you agree with standard six and its criteria?

Do you think standard six will ensure assessments are robust and effectively demonstrate graduates meet the competencies?

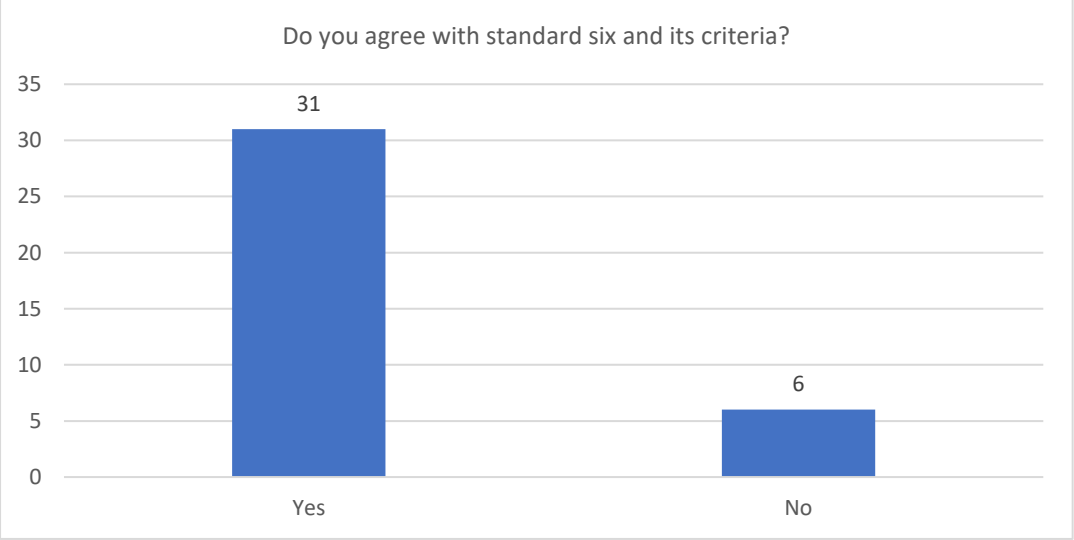
What changes would you suggest to standard six to make it more meaningful for nursing education providers and programmes?

Survey response

There was general support for standard six and its criteria. Of the 37 responses to this question, 31 (84%) agreed and six (16%) disagreed.

There were comments that some of these standards were currently in place (e.g. 6.4[10]).

Figure 11: Standard six survey response



Overall, respondents were positive about formative and summative assessments being signed off by an EN or RN, however, it was noted there should be wording to the effect of joint sign-off between the academic and clinical staff supporting the student. Some

[10] Providers of nursing education must provide opportunities for Māori ākonga to undertake clinical learning experiences in te ao Māori settings, and, where possible, be preceptored by a Māori enrolled or registered nurse.

respondents were reluctant to provide feedback without seeing the reviewed competencies or understanding nursing education providers' assessment strategies.

There was also concern raised about students being assessed by staff without a background in specific practice areas. There was a call for education standards for nurses teaching and assessing students, and some level of credentialling to undertake these roles.

There were several comments related to the reluctance of tutors to fail students and a call for an additional standard to address this. It was also noted that preceptors need to have mechanisms to raise concerns about student's clinical competency, particularly around unsafe practice or interpersonal communication.

Written response

Overall, respondents agreed with this standard and some commented that the current assessment processes are robust.

It was recognised that preceptors need to have training or meet the requirements set out in standard three and be involved in the assessment process to ensure consistency across programmes. There was a call for more assessment around medication management and drug calculations.

Standard 6.4[11] was seen as aspirational and there was some concern about how this would be resourced and implemented. This was viewed as a challenge in practice as there is often limited access to Māori and Pacific preceptors. There was a request to review how this is worded considering the cultural complexities that exist for students and staff.

There was also a call for an additional standard where tutors or preceptors could raise concerns about the competency of a student prior to a clinical placement.

What we heard:

"I would recommend inclusion of the wording reflecting final sign-off jointly between the academic and clinical staff supporting the student."

"Standard 6.4: - processes currently in place."

"Yes, assessment should be able to be signed off from ENs or RNs."

"I do in principle, but my response is compromised knowing that the competencies of ENs and RNs have yet to be reviewed. Review of competencies should follow the review of scope. Standards of education should logically follow these two processes."

"Students are being assessed by academic staff who do not have background in the area they are assessing."

[11] Providers of nursing education providers must have processes to enable Māori ākonga to undertake assessments in te ao Māori, and where possible be preceptored by an enrolled or registered Māori nurse when undertaking clinical learning experiences.

"It would be great to have an enrolled nurse teach in the classroom to deliver the practice component. What will the EN teach? The 'basic's' washing a patient, making a bed properly, observation, every day working environment on the floor."

"Does there need to be some reference to the use of artificial intelligence in assessments? The use of AI is growing, and we need to ensure all ākonga are able to use AI where and when appropriately."

"Standard 6: provide an additional standard, tutors do not like failing students – comments from practice. Preceptors need to able to raise significant concerns about the competency of the students –unsafe practices, unsupervised medications, unable to write clinical notes, not speaking with patients and whānau – how they speak with patients or not. Taking on tasks that are not appropriate for the environment."

"Standard 6.5: assessment for EN can be signed by EN or RN. Suggest minimum of two years post- registration experience of either RN or EN to be qualified to sign-off formative and summative assessments along with recommendation of completion of preceptorship learning."

"There has to be a level of safety mechanism to raise and report any issues in relation to clinical competency of students."

"Assessments are so subjective within clinical learning experiences. I would like to see better education for nurses to teach and assess students. In the UK, a nurse educator is registered with the Council following a Council-approved training programme and therefore takes accountability."

Standard seven: emergency events

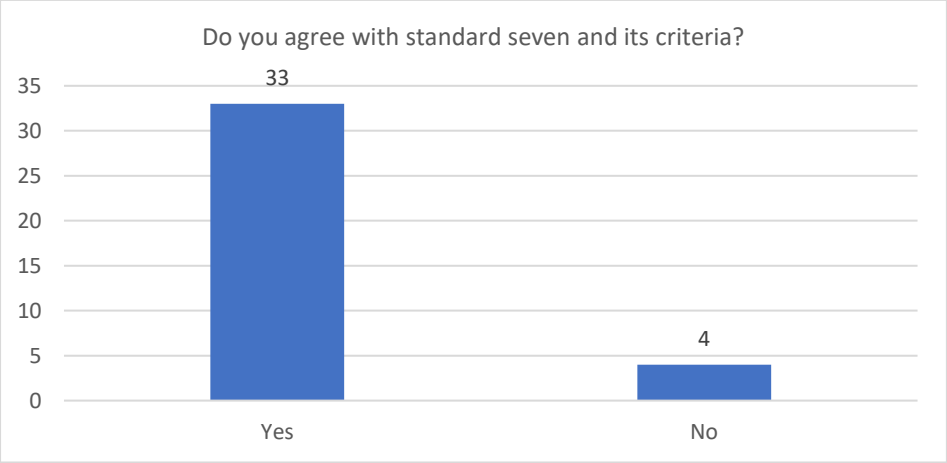
Consultation questions:

Do you agree with standard seven and its criteria?

Do you think standard seven will enable nursing ākonga/students to contribute during such emergencies to support communities?

What changes would you suggest to standard seven?

Figure 12: Standard seven survey response



Survey response

There was general support for standard seven and its criteria. Of the 37 responses to this question, 33 (89%) agreed and four (11%) disagreed.

Overall, respondents were positive about this standard recognising increasing disruption and impact of emergency events. There were suggestions for describing extreme weather events and removing 'Covid-19' and replacing with 'pandemic'. There was also a call for this standard to be widened to include other civil emergency and local impacts on students completing clinical learning hours and theoretical requirements (e.g. road closures, local civil emergencies, infectious disease outbreaks etc).

There was a concern raised about replacing clinical hours with simulation hours due to lack of preparation for the reality of the practice environment and finding alternative ways to complete clinical learning hours later in the programme. Inclusion of online learning was also suggested to support students during an emergency event.

Respondents requested that students understood what was required of them in an emergency situation and had the ability to decline a placement if they felt inadequately prepared for what was being asked of them.

Written response

Respondents generally commented about the need for a definition on 'clinical learning' as quality clinical learning was vague, and to be more explicit with how this relates to direct patient contact and provision of care.

There was a comment regarding the rigour of standard seven and how this may inform paid clinical placements across the programme standards.

What we heard:

"Great to see this, important to consider such incidences in the evolving healthcare environment."

"Emergency events need to be added, in extreme weather events that prevent travel and temporary closure of facilities e.g. outbreaks of infectious diseases."

"Does COVID-19 still need to be mentioned as in 7.1? Suggest use of word "pandemic" as opposed to this."

"It is not just health emergencies that impact upon the ability for students to complete required clinical placement hours and studies (institution). Need this standard to widen to all events that could impact upon the ability of the student to complete the clinical learning hours. Eg – general weather events, earthquakes, lack of roading, flooding, communications – power, internet, transportation – closure of public transport links, closures of certain areas. – AOS police interventions etc. Fire emergencies, strikes (of healthcare workers that prevents the students attending the area for clinical learning)."

"Sensible and practical components added to ensure education can move forward in global pandemics is essential and would be short-sighted if not included. The hours are minimal in some ways. Please consider if they should be allocated to a year but saying that if a third-year

needs hours and pandemic hits, need to find a reasonable pathway forward that is safe for them."

"Yes, as long as they had had some education on what was expected of them as students to contribute to an emergency situation. This would also be dependent on how far through their training they were."

"Don't agree with changing clinical hours to simulation hours as no matter the situation students should continue to do clinical placement as they will work in those conditions once registered."

"Some inclusion of online learning."

Additional comments

Consultation question:

Do you have any additional comments you would like to make regarding this consultation?

Survey response

Respondents acknowledged the opportunity to contribute to this consultation and comment about the proposed education standards. There were several comments urging the Council to look at EN pathways to transition to an RN programme and registration, and a call to support workforce development strategies.

There were comments that the review of the EN scope was well overdue, however, work was required to ensure the knowledge and skills of ENs were valued and remunerated appropriately, especially in some speciality areas where ENs and RNs can do similar work.

A concern was raised about nurses' lack of preparation for online or virtual assessments which was highlighted during the pandemic, and a recommendation for more online education. There was also a strong urge for more undergraduate mental health preparation and clinical placements to encourage more graduates into this area.

Respondents also called for 'earn as you learn' models and paid clinical placements to attract and retain students into nursing.

Written response

Overall, there was appreciation for the opportunity to be able to respond to this consultation and acknowledgement of the significant work that has been undertaken. There was a call to recognise the challenges of the student learner.

Respondents acknowledged that the commitment to Te Tiriti was reflected in the standards including a requirement for active partnerships. Respondents also voiced that the standards need to be in the context of the complexity and strategic context of education and health sectors, particularly with potential changes to Te Pūkenga.

There was a clear view that the standards need to take into consideration the TTMR implications for pathways to registration.

There was a call for digital health being firmly integrated into all nursing care delivery and reflected across all programme standards.

The value of the EN was recognised but there was a call for caution within the aged care sector over changes to the EN scope where there is a limited multi-disciplinary team. The education standards need to support ENs in decision-making, delegation, and seeking appropriate guidance.

There was a strong view that there was no evidence for reducing clinical hours and consideration needed to be given to ensuring the rights of healthcare consumers, and that health and disability services were protected.

Several respondents requested a timeline and implementation plan for the education standards, concerned that there would be a delay in EN programme accreditation.

What we heard:

"Everything we do should be about increasing NZQA AND ENABLING staircases from EN to RN and not reducing any clinical hours but supporting students to get the most out of every clinical placement."

"I am an overseas trained nurse. I have worked in NZ for +20 years. I am very concerned about the future of mental health nursing in NZ. Educational providers are not getting this right. This is evidenced by the acute shortages in the clinical areas and the fact that new graduate nursing places in MH remain unfilled. Apologies for being blunt, but if organisations cannot fill new grad places then there is an issue with the training the students receive. New Zealand is not training comprehensive nurses. It is training nurses to work in physical health settings only. I would like to see mental health course content nationally consistent and mandatory. Current RN training is not good enough."

"Make it easier for enrolled nurses to transition to registered nurses. Currently, it's very, very difficult despite our scope being improved, the pay does NOT reflect the work we do. We work just as hard as registered nurses and get very little recognition for the work we do."

"Thanks for reviewing the EN scope of practice. It's well overdue but I also think there should be an easier pathway for EN to transition to RN programme. It's important to upskill nurses as part of professional development and this should be one too. Sometimes, it takes one to realise their potential and passion for nursing as a career."

"Transition placement is perfect and continuous for final assessment is good 240 hours and again supernumerary."

"The development of the EN and RN workforces needs to be strongly focused on and embedded within principles of workforce development. The education of these workforces needs to be well resourced and supported by robust systems and processes."

"I appreciate the opportunity to submit this consultation. I note in the forward a reference to increased use of technology and reduced F2F contact. As an experienced nurse educator, I spent two and a half years in primary care during the covid pandemic; what was blatantly clear was nurses lack of preparation for conducting assessments/triage over the phone - I hope that this gets covered in the new programmes. As it's very topical at the moment - any further consideration of earn as you learn? Embracing more online education."

"Find a way to pay ākonga during their last transition placement will really encourage more students."