Queensland Office of the Chief Nursing and Midwifery Officer

ANMAC – Review of Registered Nurse Accreditation Standards

Consultation Questions

Entry criteria in undergraduate nursing courses

Question 1

What support mechanisms should be offered to students from diverse backgrounds entering registered nurse programs to ensure they receive the appropriate levels of support?

If the aim of the ANMAC Registered Nurse Accreditation Standards ('the Standards') is to '… to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered,…' then they must include mechanisms to attract, recognise, support and retain students from diverse backgrounds. Students from diverse backgrounds bring a wealth of experience and understanding of different cultures, customs, languages and perspectives that have the potential to not only enrich their own lives and the lives of those around them, but also the lives of health professionals, patients and the broader community.

The Australian health system needs people from diverse backgrounds for the simple reason that our patients are from diverse backgrounds. Over 25 per cent of Australians were born overseas, and over 50 per cent of Australians have one or two parents born overseas. That is not to mention the diversity of cultures, beliefs and languages amongst Australia's first people.

In order to realise the benefits that students from diverse backgrounds may bring to our health system, their unique learning needs should be considered and addressed. The circumstances in which they have lived, and in which they may continue to live, need to be understood. Some of these students come from areas of political and military instability. They may have fled war, famine, torture or disease. They may

have lost loved ones and experienced imaginable hardship. They may have experienced physical and mental health injuries, or may have lived in communities with high rates of physical and mental health injuries. While they may speak many languages, English may not be their first. Despite being intelligent and experienced, they may not have had the formal education that most Australians enjoy.

Education providers have a duty of care to their students' well-being, and the Standards should reinforce this duty. They should provide programs that take into account the unique needs of students from diverse backgrounds and support them to succeed. This duty should be present right through the student's educational journey, from their first enquiry to graduation.

At a minimum the Standards should provide for:

- Ethical recruitment of people from diverse backgrounds, including ensuring they understand the NMBA Registration Standards and any implications the NMBA Registrations Standards may have for them personally;
- Flexible entry pathways that enable people from diverse backgrounds to access tertiary education nursing programs;
- Early identification of educational deficits, such as language proficiency
    - Individual assessments (as opposed to group work) to enable educational deficits to be identified and addressed;
- Adjacent educational programs to address any educational deficits;
- Opportunities to showcase unique cultural, language or other skills.

Question 2

How can the accreditation standards support inclusion of strategies to increase student retention?

The Standards should be used as a mechanism to encourage people from diverse backgrounds to access tertiary nursing education, including RN Bachelor programs.

The Standards should allow education providers the flexibility to develop programs that meet the needs of students from diverse backgrounds.

The Standards should be informed by credible evidence. In particular the Standards should not impose more stringent entry requirements for people from diverse backgrounds, in the absence of strong evidence that students with lower language levels do not adequately progress over the period of their Bachelor studies. More stringent entry requirements may become a permanent and unnecessary barrier to students from diverse backgrounds accessing nursing tertiary education.

The Standards should require educational providers to demonstrate they have appropriately informed students of NMBA registration Standards, and build into their courses a requirement that meeting these is critical to course success and completion. For example, attainment of standards such as of English Proficiency could be included as an essential component of the educational program, similar to the requirement to undertake clinical placements. This would have the benefit of raising the level of English Proficiency of all students, not only those from diverse backgrounds.

English language requirement for entry to Bachelor of Nursing programs

Question 3

Should students who are required by the Nursing and Midwifery Board of Australia (NMBA) to provide a formal English language skills test result for registration, also be required to demonstrate achievement of the NMBA specified level of English language skills before starting a registered nurse program?

As outlined in the consultation paper, there is limited evidence that students from non-English speaking backgrounds do not achieve the requisite level of language required over their period of study. That said, if this was accepted as fact there is no evidence about why that may be the case. It is arguable that while universities have increased the number of students from non-English speaking backgrounds, they have paid very little attention to their needs, with some students claiming they were

never made aware of the NMBA Registration Standards. It is also perplexing that universities continue to award students with Bachelor degrees in nursing and yet the students do not meet all the NMBA Registration Standards.

While patient safety is paramount, it is important that the protections in place are fair and that they do not themselves do more harm than good. Especially in this case, where nurses from diverse backgrounds are so desperately needed by a system that is struggling to understand and provide services to people from culturally and linguistically diverse backgrounds.

Rather than to lock students from non-English speaking backgrounds out of nursing education, which is likely to be the case if the level of language proficiency is raised in this manner, it would be better to focus on promoting improved language proficiency as a core element of the Standards.

It is questioned that if a student produced proof of language proficiency at the start of their studies, would that be sufficient for NMBA registration, given the 'time limited' nature of current testing? What if a student was not able to maintain the level of proficiency? Would they still be registered, or would a second test be required closer to the time of registration?

Amending the Standards to require a higher level of language proficiency places an unfair burden on people from non-English backgrounds, and no additional responsibility on educational providers to ensure they graduate competent nurses who have the requisite skills for practice, including English proficiency.

Quality of clinical placements

Question 4

What changes and/or additions to the standards are necessary to support quality improvement in the clinical learning environment?

There is no doubt that the transition of registered nurses from hospital to university education has been difficult and that there is ongoing debate about whether nurses are appropriately prepared. While the focus could be on individual models of clinical placement, the better issue to explore is how these models could be funded. Currently financial pressures on industry make it difficult to open up additional clinical placements, and arguably nursing schools faces similar pressures, with many being seen as a way for universities to generate profits.

Without doubt the Standards should require students to be placed in environments that are safe, supportive and where education is valued. But unless there is adequate funding allocated to provide clinical placements, and a focus on providing more than the bare minimum, the situation is unlikely to change. That said, the current Standard 7 covers these exact issues, suggesting that it may be more an issue of implementation than the actual standards.

Question 5

Are elements of the Best Practice Clinical Learning Environment framework useful in developing outcome-based standards for accreditation? If so, which ones?

The Best Practice Clinical Learning Environment framework could be used to develop outcomes based standards, as it provides a comprehensive view of the elements that impact on the students' clinical placement experience. What is unclear is whether all of these elements are necessary or whether some are more important than others.

Simulation and student learning outcomes

Question 6

How can the accreditation standards better support the use of simulated learning?

The important role that simulated learning plays in modern education cannot be underestimated, and without doubt with advancement in technology this will

continue to be the case. The requirement for minimum numbers of simulated learning hours / activities, in addition to clinical placement, would be highly beneficial and ensure that all students benefit from advances in technology and emerging educational opportunities.

Question 7

Should minimum practice hours be inclusive of simulated learning hours? If so, should a maximum percentage of simulated learning hours be stipulated?

Given the ongoing debate about the lack of 'work readiness' of new nurses it is not recommended that simulated hours be substituted for clinical placement hours. To do so may see further erosion of the direct clinical experience, which in tangible and intangible ways is critical to the preparation of the new nurse. While simulation provides learning opportunities, it is actual clinical practice that supports socialisation to the profession, contextualisation of nursing into practice, and role modelling from other nurses and clinicians.

Simulation should be encouraged and even be a separate minimum hours set, but they should remain separate. As such, simulation would be a mechanism to bridge the existing 'work readiness' gap. If simulation hours were to be included in the existing practice hours, there is unlikely to be any net benefit, and would be more likely to result in a net deficit in preparation. To have them included in the existing hours there would need to be credible evidence that simulation was not only as effective as clinical placement, but superior, as there is an existing deficit that needs to be bridged. At this stage there is nothing to suggest this is the case. Simulation hours should be encouraged, but not included in the current minimum practice hours required.

Inter-professional learning for collaborative practice

Question 8

How can the accreditation standards better support inter-professional learning?

While the importance of interprofessional learning is not to be understated, the current Standards include significant requirements for interprofessional learning, including that the program provider demonstrates:

- *'Teaching and learning approaches that incorporate an understanding of, and engagement with, intraprofessional and interprofessional learning for collaborative practice.* Standard 2.4 (j)
- *'Opportunities for student interaction with other health professions to support understanding of the multi-professional health care environment and facilitate interprofessional learning for collaborative practice.'* Standard 3.5
- *'Each student is provided with a variety of workplace experiences reflecting the major health priorities and broad landscape of nursing practice. Opportunities are provided for intraprofessional and interprofessional learning and the development of knowledge, skills and behaviours for collaborative practice.'* Standard 8.4

While it is considered this is already addressed in the Standards some additional areas of consideration are:

- Ensuring classroom, clinical laboratory and online learning groups are interprofessional when undertaking core foundation subjects;
- Use of simulation to support inter-professional learning is to be encouraged, but not to be substituted for real life opportunities for interprofessional learning;
- Increasing the minimum clinical practice hours would support contextualisation and role modelling with exposure to other professions.

Accreditation standards framework

Question 9

What are the strengths of the style and structure of the current registered nurse accreditation standards?

The strength of the current framework is that it has been informed and developed by nurses to meet the needs of nursing students and the nursing profession. It is detailed and nuanced, clearly articulating key governance and structural requirements under the nine domains:

1. Governance
2. Curriculum conceptual framework
3. Program development and structure
4. Program content
5. Student assessment
6. Students
7. Resources
8. Management of workplace experience
9. Quality improvement and risk management.

It is also well known and understood by nurses and educational providers.

Question 10

What are the limitations of the style and structure of the current RN accreditation standards?

Nil identified.

Question 11

Should the RN standards move to a five - standards structure in line with accreditation standards of other registered health professions?

While it is argued that alignment to the five standards structure would be easier for educational providers, it must be remembered that nursing makes up the bulk of all health professionals and students. It is unlikely that adhering to these standards places any unfair burden on universities, who already profit significantly through their nursing programs.

This five standard framework was developed by Allied Health, and moving to it could potentially see nursing standards blurred into 'generic' health professional ones. This is not to suggest that interprofessional learning is not important, but to ensure that nursing education continues to be governed by the nursing profession and according to the standards of the profession.

While arguably the existing standards could be mapped to the new framework, what would be achieved by doing this, other than merely conforming nursing to a framework developed by the Allied Health Profession?

Guidance on the use of evidence

Question 12

To what extent are accreditation standards clear in their expectations of the evidence required of education providers to demonstrate compliance?

There is always a balance between a concise and readable document and the level of detail presented. The current Standards are clearly written and expectations are well articulated. As such it is considered that they strike an appropriate balance between the two.

Question 13

What is the best way to provide guidance to the standards and criteria (for example, to ensure consistent interpretation of those concepts in the current environment and/or elaborate on important concepts)?

Standards will always be open to interpretation, but that is why they must be effectively implemented and audited. This must be done in a nuanced way, and not by providers merely 'ticking off boxes' despite questionable quality outcomes. Similarly to the argument progressed in the consultation paper about quality clinical placement environments: universities that produce the best nurses should logically be seen as the best learning environments, with their interpretations of these standards studied and promoted. As outlined above, all universities should be

expected to provide access to and 'shoulder the load' of supporting students from diverse backgrounds.

Benchmarking of the Standards should also be encouraged and promoted, as currently universities are overly judged by student entrance scores, which are based on 'popularity' rather than any real measure of educational quality.

Best practice standards

Question 14

Should there continue to be an input-based standard prescribing the minimum number of clinical practice hours to be completed?

While general support is given to a predominantly outcome based standards approach, there is concern that without independent assessment of students this could easily be compromised. Already universities are graduating students with Bachelor and Masters level education that do not have the requisite level of English proficiency to enable them to be registered by the NMBA.

Already students have to carry an unfair level of burden for deficits in the educational systems and structures, some of which undoubtedly result in them leaving the profession prematurely. As such there must be some degree of minimum 'input-based standards prescribing the minimum number of clinical practice hours' to provide students protection from providers who will seek to put profits before students.

Furthermore, given the ongoing debate about student readiness and concerns about inadequate clinical placements, this is not the time to consider removing these requirements. Unless current deficits are able to be addressed through changes to the models or simulation, the minimum number of clinical practice hours may need to be increased.

Consideration should be given to prescribing the minimum number of clinical practice hours for mental health.

Future directions

Question 15

What changes are likely to occur in the role of the registered nurse in next five years?

With increased rates of non-communicable diseases there will undoubtedly be a greater need for nurses to obtain authorities for scheduled medicines. It is already argued that the undergraduate registered nurse course adequately prepares nurses to 'supply and administer' under protocol. This issue needs to be reinforced in this review, while ensuring that nurses are adequately prepared to undertake collaborative prescribing arrangements.

There will also be increased need to deal with the effects of climate change, including being able to provide are for large numbers of environmental refugees from the Western Pacific Region. This will involve greater understanding of chronic disease and mental health issues.

There will also be greater identification as being Aboriginal and Torres Strait Islander (ATSI) and greater expectation that inequalities in care are addressed. As such nurses need to become more culturally competent, and have a stronger understanding of the social determinants of disease.

Rising financial pressures on governments and greater rates of chronic disease will necessitate greater provision of care through Primary Health Care models. Currently there is a view that graduates are not adequately prepared for the complexities of Primary Health Care. This needs to change and students need to become competent in these models as much as they do the tertiary health care models. This review of the Standards should specifically explore ways in which nurses can lead the Primary Health Care models. Failure to do so could see nursing become irrelevant to future healthcare models of care, in favour of allied health professionals and / or unregulated healthcare workers.

The future will be a more agile working environment, with the use of digital equipment and interfaces, increased participation in inter-professional care delivery in integrated teams. Roles will work outside of the traditional hospital practice setting, and increased autonomy will be required. There will also need to be more cross boundary collaboration via digital or electronic communication. As such nurses will need to be better prepared to undertake informatics roles.

Question 16

How can the accreditation standards support the development of the role of the registered nurse to meet the future health care requirements of individuals and communities?

Accreditation standards need to specify that students have:

- The skills to 'supply and administer' under protocol as well as undertake 'collaborative prescribing';
- A high level of cultural competency to support with delivery of care to ATSI and refugee / migrant populations;
- A high degree of understanding of the social determinants of disease and the importance of working interprofessional, intersectorially and strategically to influence address ingrained inequalities;
- The ability to be able to work in Primary Health Care models of care;
- The ability and skill to work with consumers.

Question 17

Are there any other issues you would like consider that have not been discussed in this consultation paper?

- Exposure to critical mental health experience;
- Reinforce the 'essentials of care':
    - Dignity;
    - Privacy;
    - Empathy;

- Understanding;
- Advocacy;
- Speaking up for safety.