Caroline Homer AO
Distinguished Professor of Midwifery
Centre for Midwifery, Child and Family Health
Faculty of Health
15 Broadway, Ultimo NSW 2007

T: +61 2 9514 4886
M: +61 (0) 418 466 974
Caroline.Homer@uts.edu.au

PO Box 123
Broadway
NSW 2007 Australia
www.uts.edu.au

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Re: REVIEW OF REGISTERED NURSE ACCREDITATION STANDARDS – 2017

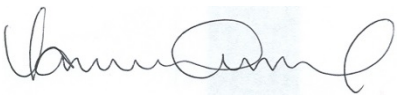
This response is made by Professor Caroline Homer (Professor of Midwifery and Director of Midwifery Studies) and Dr Christine Catling (Senior Lecturer in Midwifery) at the University of Technology Sydney through the **Centre for Midwifery, Child and Family Health.** UTS has educated midwives for more than 25 years – both undergraduate direct-entry and post-graduate after a nursing qualification. We estimate we have educated more than 1000 midwives in this period who work in every state and territory across Australia. We submitted our two curricula to ANMAC for accreditation in 2011 and again in 2016 receiving 5 years of accreditation without conditions on both occasions. We are a team of nine midwifery academics who teach, undertake research and provide academic leadership within the Faculty of Health.

We have made this submission as we teach a midwifery entry-to-practice program (Graduate Diploma of Midwifery) that is predicated on students being a registered nurse. Therefore we are interested in the accreditation standards for registered nurses.

We have addressed your specific questions.

Should you require any further information regarding this submission please feel free to contact me on: (02) 9514 4834 or by email: caroline.homer@uts.edu.au.

Yours sincerely



Professor Caroline Homer AO RM MMedSc(Clin Epi) IBLCE PhD

Professor of Midwifery UTS

REVIEW OF REGISTERED NURSE ACCREDITATION STANDARDS – 2017

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?

Each university has support programs related to the context of their demographic and intake of students. Support mechanisms that are often offered to students from diverse backgrounds entering RN programs include having a student liaison officer for these students who can direct them to supportive programs that they need. Having early constructive feedback from their work is also useful to identify any challenges early on. Access to academic writing workshops and one-on-one help with their writing is also likely to be beneficial.

It is not clear that it is the role of accreditation standards to determine support mechanisms across the country. We would prefer that universities, who are accredited and regulated by external agencies already, are provided with the flexibility and scope to address the need for support in a way that best meets their own requirements.

Question 2

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

Most universities have strategies in place to increase student retention. It is well recognised, as highlighted in the consultation paper, that supporting students through first year is particularly important. UTS, like other universities, has a First Year Experience Project and teaching and learning grants have been awarded over the past 3-4 years in an effort to address this important issue. We have developed a number of initiatives including a mentorship program for 1st year students with 3rd year students. Different universities will have different programs to meet the demographic of their student cohort.

It is not clear that it is the role of accreditation standards to determine the inclusion of strategies to increase student retention. We would prefer that universities, who are accredited and regulated by external agencies already, are provided with the flexibility and scope to address the need to develop their own strategies and initiatives in a way that best meets their own requirements.

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?

We agree that there are significant challenges with the development of language skills through a RN program with the assumption that students (domestic and international) will reach the level required for registration at the end of the program. Students are required to demonstrate English language proficiency during their educational program both within the classroom, online and clinical situations. Universities have systems in place to assess the English language skills on entry and will put processes into place to address deficiencies.

We do not agree that 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. This would disadvantage prospective students – domestic as well as international – and out undue burden on students and institution to meet the requirement. The unintended consequences of such a policy need to be considered (increased cost for prospective students, potential decrease in enrolments due to an inability to meet the level, difficulty in accessing assessment).

Question 4

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

We agree that a dedicated education unit model for students is useful due to its proven benefits. There are a number of strategies that this approach could support including ensuring hospital staff working with students have all completed training to better support students including addressing bullying in the workplace.

However, it is difficult for university programs to dictate to health services the model or approach to clinical education that they should take. Not all hospitals will have the size or resources to enable a DEU to be implemented and it this was a mandated requirement it would reduce the capacity for clinical places and experience for students.

Therefore, the accreditation standards need to be flexible enough to enable programs to work effectively with the clinical learning environment in a way that best suits the individual context.

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 appears useful in determining quality. Elements 3, 4 and 5 are particularly appropriate. If these could be encouraged and enabled that would be useful.

However, it will be challenging for accreditation processes to be able to assess this environment given the considerable number of clinical learning environments each RN program may access. At UTS, we would access XX clinical settings, each of these having a number of wards or individual units. Assessing the Clinical Learning Environment in each would be impossible.

Question 6

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

Simulated learning has been found to be important for clinical learning and this has been embraced in many RN programs. There are a number of excellent examples of how simulation has contributed to learning across the country. However, the most effective use of simulation is likely to be inconsistent across the country with differences related to staff expertise, access to facilities and equipment, commitment by the institution and design of the curriculum.

Clear guidance in the accreditation standards as to the way simulation is used would be useful. This could include guidance about the most effective models of simulation and the different approaches. Consideration however needs to be given to smaller programs who may lack access to high fidelity simulation facilities and so would be disadvantaged if the standards were too prescriptive.

Question 7

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

While simulation is important and is ideal to prepare students for the clinical setting and for real-life interaction with patients, care needs to be taken with ensuring that this clinical time is still available.

We do not feel that simulated hours can replace the majority of practice hours as the style of learning is different. It would be important that if simulated learning hours are included, then there needs to be a cap on how many hours this is, perhaps 20% would be reasonable. The risk is if the proportion of simulation hours is greater than 20% this may have significant impacts on learning and in building confidence and competence in the real world situations.

Question 8

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

There is no doubt that interprofessional learning is important and has benefits. Historically, this has been challenging in many universities although in reality students in practice are experiencing interprofessional learning every day.

It would be useful if the standards were flexible in the types of interprofessional learning that were supported and included clinical practice times as well as collaboration with other disciplines such as design, communication, law, science and the media. Experiencing interprofessional learning with non-health disciplines is likely to be very important for the future generation of nurses who will be working in a different environment over the next 10-20 years.

Question 9

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

The RN standards have developed and become clearer over the past 5-8 years.

Question 10

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

Addressing each of the sections can be challenging as there is duplication – both with the standards and also with the university accreditation processes - Tertiary Education Quality and Standards Agency (TEQSA).

Addressing the 9 standards in the development of the accreditation document and curriculum is a huge burden on institutions. In our experience this has taken at least 12 months of development and usually a full-time staff member dedicated to the process. This is a considerable cost and means that it is a disincentive for some institutions to offer nursing (and midwifery) programs.

Question 11

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

To avoid the repetition within the standards, it seems sensible to move towards the 5-standards structure, similar to other registered health professionals.

Question 12

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

The standards are reasonably clear but the amount of material required to demonstrate compliance is significant and at time, inconsistent.

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)?

While the evidence guides for the RN standards have improved there is still scope to ensure that duplication is avoided and there are no inconstancies between the standard and the guidance. There also needs to be consistency across assessors as we have experienced different approaches to assessment which means inconsistencies in the depth and nature of the evidence required. A minimal approach is recommended and one that avoids duplication with other processes.

Question 14

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

Yes, there should continue to be an input-based standard prescribing the minimum number of clinical practice hours for RNs. Once clinical skills are mastered, this allows for development of mastery and many other elements that create competency in nursing.

Question 15

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

Many changes are likely in health care in the next 5-10 years and these standards need to be flexible and agile enough to accommodate changes in the health care system but also in the generation of graduates (the so-called millennials will make up the bulk of the workforce.

The changes that will affect the role of the RN include:

- A move from hospital to home-based care
- More care at a primary care level with community-based services
- An ageing population and health workforce
- Increased use of genomic information and gene-based therapies
- Greater flexibility and innovation with health providers including delegations, task shifting, team-based working
- Greater use of technologies within the workplace especially in hospitals
- Information technology changes – electronic medical records, better data linkage and data sharing

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?

The standards need to be aspirational and build capacity in graduates for the future. Aspects such as leadership, innovation, creative intelligence and emotional intelligence need to be built into RN programs and this needs to come from the standards.

Question 17

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

No other issues.