Australian
Private Hospitals
Association

APHA response to ANMAC's review of RN accreditation standards – consultation paper 2

24 July 2018

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Contents

Introduction

The Australian Private Hospitals Association (APHA) is appreciative of the opportunity to make a submission to the Australian Nursing and Midwifery Accreditation Council (ANMAC) in response to the review of registered nurse (RN) accreditation standards (consultation paper 2).

The APHA is broadly supportive of the proposed changes to RN accreditation standards, including the reduction from nine standards to five, and the changes to take into account technological advancements. However, healthcare provider concerns remain over medication administration errors by new graduates, and given the considerable magnitude of the proposed changes the APHA suggests an interim review after the revised standards are rolled out.

Responses to consultation questions

Accreditation Standards Framework – moving to five standards

Question 1
Do the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the new graduate meets the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016)? Please provide an explanation for your answer.

Yes. The reduction in repetition by the move to five streamlined standards down from the nine-standard framework is a great improvement and covers the requirements to ensure contemporary accreditation of education institutions.

Question 2
Are there any additional criteria that should be included?

A criterion to safeguard the standard of professional competence of academics seems to be missing: the head of school is mentioned, along with RNs during professional experience, but there is no criterion against which to audit teaching staff. We would like to see an addition to ensure education providers offer adequate support to facilities accepting placements.

Question 3
Are there any criteria that could be deleted or amalgamated with another criteria?

Criterion 1.2 'Person receiving care gives informed consent to care provided by students' could be amalgamated with criterion 1.5 'Health services providing students with professional experience placements have robust quality and safety policies and processes and meet relevant jurisdictional requirements and standards'.

Question 4
Does the draft structure reduce duplication within the standards? If not, which areas of duplication still exist?

No comment.

Question 5
Please provide any other feedback about the structure and/or content of the draft standards.

Since students should be able to meet requirements prior to graduation (in addition to after graduation), should criteria 2.3 and 3.7 refer to 'students' rather than 'graduates' meeting the RN standards for practice? The draft standards also refer to students in numerous other places.

Prescribing for graduates of an entry-to-practice program

Question 6
Do the draft standards continue to capture the learning outcomes required to enable graduates to safely supply and administer medicines via a protocol and/or standing order (prescribing via a structured prescribing arrangement)?

There is some hesitation from acute care health service providers on the ability of students to gain sufficient exposure and experience within the 800 hours of clinical placements (criterion 3.8) to be deemed adequately competent as novice practitioners to safely supply medicines, when unfortunately, errors in medication administration by new graduates continue to be seen.

The standards should assist to ensure education providers are building in at every opportunity overlearning and repetition of safe medication administration practices, to reduce these errors.

Simulated learning

Question 7
Should the proposed definition of simulation be adopted for the RN Accreditation Standards?

Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner. [12,p.i2]

The definition is largely appropriate, however, the word 'replace' in the definition is ambiguous and could be interpreted to mean simulation can replace clinical placement hours. Given the consultation paper recognises the "limited evidence of equivalence between professional practice experiences and simulation-based learning experiences in Australian nursing programs", the word 'replace' should be 'supplement' instead.

Health informatics and health technology

Question 8
How can the accreditation standards better support the inclusion of health informatics and digital health technologies in entry-to-practice nursing programs?

Digital technologies: The extent of digital technology uptake will vary between healthcare provider workplaces, and will be informed by differing paces of growth and investment in acute / sub-acute / primary services, as well as varying with geographical remoteness and healthcare provider size. The best way to support this wide range of technological inclusion levels across workplaces from a course accreditation standard is to ensure it is explored in the curriculum, however, not necessarily an outcome measured in clinical practice.

Health informatics: There may be some value in embedding regular access to health informatics tools (computers, clinical guidelines, performance scorecards etc.) in day-to-day nursing practices to help improve the overall effectiveness of patient care delivery through presentation and review of high quality relevant data.

Quality professional experience

Question 9
Do the draft standards capture the learning outcomes required to ensure quality professional learning experiences in entry-to-practice nursing programs?

No comment.

Question 10
Are there any other issues that should be considered?

The reduction from nine standards to five constitutes a significant change. Given the magnitude of this change, the APHA suggests there should be an interim review once the revised standards are rolled out, instead of waiting six years as is currently proposed.

Private hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

According to the most recent data available, the private hospital sector treats:

- 4.4 million separations a year.

In 2016–17, it delivered:

- More than a third of chemotherapy
- 60% of all surgery
- 79% of rehabilitation
- 73% of eye procedures
- Almost half of all heart procedures
- 73% of procedures on the brain, spine and nerves.

Australian private hospitals by numbers:

- Half (49%) of Australian hospitals are private
- 657 private hospitals made up of:
    - 300 overnight hospitals
    - 357 day hospitals
- 34,339 beds and chairs
    - 31,029 in overnight hospitals
    - 3,310 in day surgeries
- 69,299 full-time equivalent staff (AIHW 2018, ABS 2018).

The Australian Private Hospitals Association

The APHA is the peak industry body representing the private hospital and day surgery sector. About 70% of overnight hospitals and half of all day surgeries in Australia are APHA members.