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**Review of Registered Nurse Accreditation Standards**

**Consultation paper 2**

**Review Prepared by Council of Deans of Nursing and Midwifery.**

**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.*

The draft standards cover the required knowledge, skills and attitudes, although there is some criterion that need clarification or amendment as follows:

* 1.2 Person receiving care gives informed consent to care provided by students.

Guidance that verbal consent will be accepted is necessary to avoid ambiguity in this criterion.

* 1.11 Any multiple entry pathways for which students receive block credit or advanced standing (other than on an individual basis) meet Registered Nurse Accreditation Standards: Where block credit or advanced standing is given it is following a process where the program (EN) or curriculum is mapped against the accredited RN course units to assess equivalence. The accredited course is approved as having met the standards though the curriculum and course design. Guidance is needed that this mapping would be accepted as appropriate evidence.
* 2.5 There is relevant input to the design and management of the program from external representatives of the nursing profession including Aboriginal and Torres Strait Islander peoples and other relevant stakeholders: Guidance is required on external representatives. For example, would utilising the curriculum developed by CATSIN&M to inform the design of the curriculum be sufficient. ‘Representative bodies or individuals” may be better wording.
* 3.3 … content related to mental health integrated throughout the program: Why is this content specified when other equally important content such as physical health, management of disease etc not? While mental health is a national priority, we believe there should be reference to the other national priorities such as aged care.
* 3.5 Cultural safety is integrated within the program and clearly articulated as required disciplinary learning outcomes: Consider inclusion of cultural competence as well as safety in this standard.
* 3.11 All staff teaching into the program, including clinical supervisors, are suitably qualified, registered and experienced to deliver the units that they teach: Clinical supervisors are not teaching into the program but rather supervising clinical practicums. Clinical supervisors need to be a separate criterion and removed from 3.11 to avoid any confusion between the TEQSA requirements for academics teaching into a program and professional practicum supervision.
* Some repetition remains
* We welcome the reduction in the number of standards from 9 to 5 (could be 4).
* Support the use of the evidence guide as well as a template which will assist education providers in their applications.
* Support the inclusion of a minimum 800 practice hours. We feel this must be stated.
* To avoid duplication with TEQSA - standard 4 is not reflective of the standards for RN, could easily refer to an engineering student etc suggests this should be for TEQSA or be specific for nursing.
* Inclusion of the Code of Conduct and Code of Ethics.

**Question 2**

*Are there any additional criteria that should be included?*

* We suggest that there is a separate criterion in relation to Standard 5 (student assessment) related to education providers using a national validated clinical assessment tool.
* The current proposed 5.3 could be related to theory courses/units/subjects and add 5.4 regarding a validated national CAT and reorder the other criteria.
* Include volume of learning statement.
* The only mention of the law was in relation to consent and there is little reference to the Code of Ethics and Code of Conduct.

**Question 3**

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

* We suggest that Standard 4 (student experience) are generic criteria that could apply to any higher education students’ journey through the program.
* Many of the standards are related to governance or the program of study.  Therefore, suggest remove Standard 4 and incorporate proposed:

4.1 to Standard 3

4.2 to Standard 2

4.3 to Standard 3

4.4 to Standard 2

4.5 to Standard 2

4.6 to Standard 2

4.7 to Standard 3

This would reduce the burden of duplication and ensure a leaner approach to the accreditation documentation.

**Question 4**

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

Yes, it reduces duplication.

**Question 5**

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

* Standard 1.9 (stem) is about marketing to prospective students and should be included in Standard 2 (governance).
* Criterion 1.9 a) and b) are poorly written and need to be redrafted in a precise way to lessen the ambiguity regarding the English language requirement on entry to a program for prospective students under the NMBA condition.
* Terminology (e.g. Clinical Supervisor) where there are any differences across jurisdictions we suggest that these are included in a glossary.
* Criterion 2.3, 2.2 poorly written, consider revision for clarity.

**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)?*

* Yes, however, the term ‘prescribing’ was a concern.  Suggest that the evidence guide clearly articulate what is meant by ‘structured prescribing arrangement’ and that prescribing under endorsement is at postgrad level preparation.
* 5.4 needs revision – suggest, Assessments include knowledge and application of pharmacokinetics and pharmacodynamics, the quality use of medicines and assessment of the competence in the administration of medications within the scope of practice of the Registered Nurse.

**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 substantial aspects of the real world in a fully interactive manner.
* 3.7 does not capture that simulation should be meaningfully scaffolded throughout the program, and staff in these environments have sufficient knowledge skills and education to support student learning in this environment.
* We believe that the definition of simulation needs to be expanded from: ‘Any educational method or experience evoking or replicating aspects of the real world in an interactive manner’ to ‘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’.
* Gaba, D. (2004). The future vision of simulation in healthcare. Quality and Safety in Healthcare. 13(Supp 1), i2-i10
* Additionally, there should be some reference in the standards to the need for simulation experiences to align with the evidence-based quality indicators and International Nursing Association for Clinical Simulation and Learning (INACSL) standards.  For example,
  + Arthur, C. Kable, A. & Levett-Jones, T. (2013). Quality indicators for the design and implementation of simulation experiences: A Delphi study. *Nurse Education Today,*33(11), 1357-13 61doi:10.1016/j.nedt.2012.07.012<https://www.newcastle.edu.au/__data/assets/pdf_file/0008/107486/quality-indicators.pdf>
  + International Nursing Association for Clinical Simulation and Learning. (2016). *Standards for best practice: Simulation*.  https://www.inacsl.org/i4a/pages/index.cfm?pageid=3407

**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?*

* The statement against 3.2 is adequate. The addition of standards to specific emerging trends takes time away from teaching the ‘fundamentals of nursing’. The focus should be more about responsive curricular that can incorporate trends into content appropriately.
* Clarity around the theoretical preparation in health informatics and digital health technologies and placement experiences (which can be variable across sectors).  Need to also have an emphasis on math literacy – which supports digital health technologies and quality use of medicines.

**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?*

* There is no reference to what is expected to be ‘known’ by a graduate on completion of their course. Is it that they will be able to nurse people across the lifespan who present to health care services with compromised wellbeing that ranges in severity, and contributes to illness prevention or harm minimization as part of fundamental nursing care?
* What is the expectation of Australian nurse graduates in relation to beginning practitioner competence?
* Standards 3.2 and 3.3 seem to leave it up to the individual course to decide, but we would argue there is minimum expectation of what a graduate RN is equipped for. For example, in midwifery, for example, it is evident in the accreditation standards that graduates must be able to safely and competently (including culturally competently) assess women’s and foetus’ health status, plan care (including consulting and referring with other HCPs), implement and evaluate care for childbearing women of all obstetric risk profiles (in an interdisciplinary team if necessary) until 6 weeks postpartum, and for the neonate from birth to 6 weeks – it’s very specific.
* Criteria under each standard need to be reviewed for emphasis on learning outcomes.  While it is appreciated that the Standards are broad by necessity – the evidence guides will need to provide clarity and specificity around demonstrated outcomes.

**Question 10**

Are there any other issues that should be considered?

* Could consider a minimum volume of learning under AQF (3 years) with opportunity for providers to have a 4-year degree – similar to a minimum 800 hours with opportunity for 1000 – 1200hrs.