EVALUATION REPORT 2013-2019

Te Kāhui Kōkiri Mātanga Professional Development Recognition Programme

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Executive Summary

This evaluation is a summary of the Te Kāhui Kōkiri Mātanga Professional Development Recognition Programme (PDRP) during the period 2013 to 2019. The review comprised an evaluation of the programme components, programme evaluations of key stake holders, and focus group interviews.

The review consulted with nurses involved in PDRP, applicants, assessors, resource nurses and senior nurses, and nurses who had no formal involvement with the PDRP programme. Nurses were invited to attend focus groups from the Canterbury District Health Board (CDHB) and community and primary partnering organisations within Canterbury.

The findings were overall positive in that the nurses who had attained PDRP endorsement, felt it validated and influenced their nursing practice. Most concerns that have been identified during the review timeframe have been addressed or are in the process of improvement.

Recommendations

Focus group participants, and Survey Monkey respondents have requested areas to improve the PDRP process. Many of the issues raised have been reviewed and improved during this review.

It is further recommended that:

- The programme be evaluated in 2025, as required by Nursing Council of New Zealand (2013), to include focus group surveys
- Review communication to stakeholders, for example: establish a 'what's new' section on the PDRP webpage, updated with changes and improvements; or if a regular newsletter would communicate to nurses any assessing issues, or timeliness of assessment process
- Review the PDRP evaluations to enquire how PDRP is influencing nursing practice, and patient/client and whanau health and wellness outcomes
- The Princess Margaret and 'Older Person's Health' data to be included in the 'Specialist Mental Health and Addictions', and 'Burwood Hospital' data sets.
- PDRP Education sessions have a current lesson plan and Kirkpatrick evaluation
- Update PDRP database resource personnel
- Review how PDRP utilise assessors, who do not complete a minimum of eight assessments per annum
- Review the Memorandum of Understanding to reflect practice, regarding Assessors and Resource person roles
- Update the database assessment time parameter to 10 weeks
- The end of year booking system; and assessment timeframes continue to be reviewed to mitigate timeliness of assessment and the return of portfolios
- Review assessment timeframes from both the database *and* applicant perspective
- Review workplace education on enrolled nurse quality initiatives and quality improvements to assist the enrolled nurse PDRP pathway
- Review the 'practice discussion' section within PDRP documentation
- Review Te Kāhui Kōkiri Mātanga website to ensure alignment with documentation (e.g. overall statement of learning) at regular intervals

Introduction

Te Kāhui Kōkiri Mātanga PDRP has undergone an eighteen-month review. This evaluation report identifies the background to Te Kāhui Kōkiri Mātanga PDRP, the methodology undertaken for this review, and the status of the programme for the Canterbury region.

Background

The Health Practitioners Competence Assurance Act (Ministry of Health [MoH], 2003) legislates for the ongoing competence of nurses. The Nursing Council of New Zealand (NCNZ) is responsible for ensuring the competence of registered and enrolled nurses via published guidelines; scopes of practice; competence assessment requirements; and standards and frameworks for undergraduate and post graduate nursing programmes. Compliance of standards is met by NCNZ audit processes.

One method of supporting enrolled and registered nurses to ensure their competence to practice, is for the nurse to engage with a PDRP. The *Framework for the approval of professional development and recognition programmes* (NCNZ, 2013) enables assessment, approval and monitoring of PDRP programmes so that nurses who successfully attain at any level upon the PDRP, will also meet the continuing competence requirements for renewal of their annual practising certificate (NCNZ, 2013).

Five standards outlined by the NCNZ ensure Te Kāhui Kōkiri Mātanga PDRP meets the requirements for NCNZ enrolled and registered nurse competence:

- *The programme complies with legislated requirements and NCNZ policies guidelines, codes*
- *The programme supports the nurse to develop her/his practice*
- *The programme will have clearly defined assessment processes*
- *Appropriate resources are available to support the programme*
- *Quality improvement processes are integral to the programme*

Nursing Council of New Zealand, 2013

PDRP programmes are further supported by multi-employer collective agreements, for example the District Health Boards (DHB) and New Zealand Nurse's Organisation (NZNO) *Nursing and Midwifery Multi-Employer Collective Agreement* [MECA], (2018); St Georges Hospital INC *Nursing, Midwifery and Clinical Support Services Collective Agreement* (2019-2021), Primary Health Care *Multi Employer Collective Agreement* [MECA] (2019). The MECAs identify each employer's nurse entitlements, for example additional leave to complete PDRP; and remuneration for some MECA nurses who successfully complete proficient or accomplished/expert levels on the programme.

Alongside the above *Framework for the approval of professional development and recognition programmes* (NCNZ, 2013) and various the MECA's (NZNO), the *National Framework and Evidential Requirements* (Nurse Executives NZ [NENZ], 2017) recognises the '*unique nature of nursing in Aotearoa/New Zealand*' (2017, p.3) with regards to PDRP for nurses on the enrolled or registered nurse scope of practice. This framework, updated in 2017, reflects the diversity of organisations engaged in a PDRP - a framework to '*fit across organisations*' (NENZ, 2017, p.3). It is a foundation framework for PDRP coordinators to develop and maintain their respective programmes.

The *National Framework and Evidential Requirements* (NENZ, 2017) acknowledges the diversity of organisations who facilitate PDRP for their nurses. This is important for Te Kāhui Kōkiri Mātanga PDRP.

Since its inception in 2006, Te Kāhui Kōkiri Mātanga PDRP has grown significantly and is now utilised by all the Southern Region District Health Boards (Nelson/Marlborough, South Canterbury, Southern and West Coast), some Government Organisations for example the Department of Corrections; and several Non-Government Organisations (NGO) within the South and North Islands, or nationally. This may include each District Health Board area's partnering organisations. The diversity of health care by DBHs and their partner organisations reflects where healthcare is occurring and where nurses are practising, and the collaborative support given by member DHB's to facilitate their partner organisations to undertake PDRP.

This review is concentrating on evaluating the Canterbury DHB and Partner Organisations. The initial Canterbury and West Coast PDRP (now titled Te Kāhui Kōkiri Mātanga PDRP) was developed in collaboration between CDHB, the West Coast DHB and NZNO. The WCDHB has indicated they have undertaken their own data review, sharing the project plan developed for this review.
The CDHB and WCDHB mutual philosophy of collaboration and partnership, and the sharing of knowledge and resources, reflects the intent of both the Canterbury District Health Board (CDHB) and the West Coast District Health Board regions, who collaborate in a trans-alpine partnership. The mutual aim is to support the patient/client and their whānau closest to home with a seamless support for health and wellness. This aim is influenced by a collaboration and sharing of knowledge, education, resources and support for health care personnel across all aspects of healthcare enabling the nursing workforce to be responsive to the health requirements of the community it serves. This intent is best expressed by the Executive Director of Nursing, CDHB:

> '*Canterbury nursing leaders recognise that in order to provide a nursing workforce that is responsive to changing workforce needs and models of care, strategic oversight needs to cover the continuum of the nursing career pathway from undergraduate to senior nurse roles. The generalist nature of the nursing workforce will continue to be a core strength enabling flexible deployment of nurses within and across care settings. Educational support at all stages of the nursing career continuum will allow nurses to work confidently within scope of practice*.'
>
> Mary Gordon, Executive Director of Nursing CDHB, (2015) cited in *Nursing Workforce Education Plan Canterbury Health System, 2015-2018*

A strategic outcome of the CDHB *Nursing Workforce Education Plan 2015-2018* (2015) is to support nurses' life-long learning options with an emphasis on active learning and the relationship to the workplace. To achieve this goal, enrolled and registered nurses are encouraged to participate in Te Kāhui Kōkiri Mātanga PDRP.

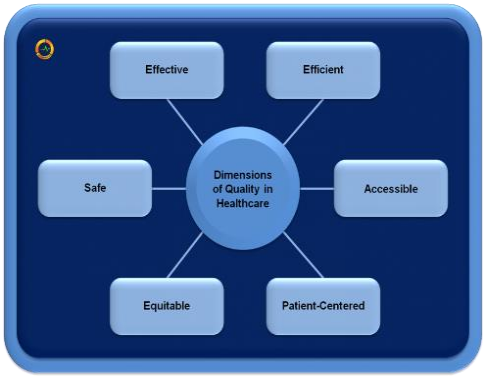
Te Kāhui Kōkiri Mātanga PDRP is a voluntary process for nurses within the CDHB, except for the Nurse Entry to Specialty Practice [Mental Health and Addictions] (NESP), and the Nursing Entry to Practice (NETP) programmes. These two programmes have a mandatory requirement where the beginning registered nurse must complete a PDRP portfolio on completion of their respective programme - for NETP this is specified by Health Workforce Directorate [NETP] (MoH, 2018).

Te Kāhui Kōkiri Mātanga PDRP has been approved by the New Zealand Nursing Council (NCNZ) since 2006. It is a requirement by NCNZ Standard 5.2 that the programme be evaluated five yearly (NCNZ, 2013).

A timeline of historical changes to Te Kāhui Kōkiri Mātanga PDRP, prior to this review timeframe, is attached (Appendix 1).

Methodology

Te Kāhui Kōkiri Mātanga PDRP Quality programme is based on the CDHB Quality and Patient Safety programme (CDHB, 2018). The CDHB Quality and Patient Safety vision is an integrated health system that keeps people well and healthy in their homes. To achieve this a process for improvement includes a commitment to lifelong learning as individuals and as a health system (Quality and Patient Safety, 2018). The dimensions of quality are to be safe, effective, efficient, accessible, person centred and equitable:



CDHB, 2018

In support of this philosophy, a project plan and evaluation process were developed in collaboration with PDRP personnel supported by the PDRP Advisory Committee. Programme evaluation included:

- Data from the PDRP databases
- Audit against the National Evidential Requirements, PDRP policy, and PDRP Advisory group minutes
- Programme evaluation survey data
- Stakeholder feedback via focus group discussion

The evaluation utilised the principles of Appreciative Inquiry (AI), a background methodology already utilised by the CDHB Organisational Development Team.

AI has been developed for organisations as a change methodology (Cooperrider, Whitney, Stravos, 2008). AI is a flexible and a positive approach to search for the best in people, encouraging trust and utilising success to motivate and creative positive interactions within work environments. It places an emphasis on dialogue, collaboration and affirmation. It is a distinctive approach to seek out what is working well within an organisation (Carter, 2006; Cooperrider et al, 2008; Reed, 2007) focusing upon the positive within an evaluation rather than '*what is wrong*' (Reed, 2007, p. 74). AI however, does not overlook the problems within this evaluation but reframes the issues from a positive perspective to enhance and acknowledge change processes and growth within the PDRP (Reed, 2007; Trajkovski et al., 2013).

The aim of utilising an AI approach would positively value and appreciate the stakeholders within the PDRP evaluation, and their current role in healthcare, while gaining information from them regarding the programme and how this applies to people/whanau centred care.

Risk Management

Risk management identified ethical considerations, power imbalance in focus group work; and Te Tiriti O Waitangi and Cultural Safety as key to stakeholder safety in the evaluation process. The NCNZ Code of Conduct, is also significant to this review.

This project is guided by the ethical principles of Beneficence, protection from harm; Justice, the right to fair treatment and privacy; and Respect for Human Dignity, and the right to ensure participants self-determine their participation in the project (NZNO, 2010). This is achieved by ensuring participants attend focus groups in a voluntary capacity and ensuring the participant's data is not used in any way which is harmful to them. The data maintains their anonymity and confidentiality.

Te Tiriti O Waitangi and Cultural Safety Guidelines (NCNZ, 2013) and Code of Conduct principles (NCNZ, 2012) were adhered to during this evaluation, paying importance to acknowledging, valuing and respecting all contributions to the review of Te Kāhui Kōkiri Mātanga PDRP.

Using Appreciative Inquiry as a methodology for this project has also presented a deliberate bias. Appreciative Inquiry seeks to look at Te Kāhui Kōkiri Mātanga PDRP and any issues that may arise within a positivist framework, enabling the project team to do so. Utilising this methodology does not, however, exclude any issues that may arise. It enables these issues to be identified and looked at from a positive perspective to seek change and improvement of Te Kāhui Kōkiri Mātanga PDRP.

Aims of Te Kāhui Kōkiri Mātanga PDRP

Te Kāhui Kōkiri Mātanga PDRP has been developed collaboratively between the Canterbury District Health Board, West Coast District Health Board, and NZNO Representatives to achieve the following purposes:

- *To advance professional development in nursing*
- *To support nurses in demonstrating competency to the NCNZ; and*
- *To fulfil obligations negotiated under the DHB/NZNO Nursing and Midwifery MECA (2018).*

The programme aims to promote and reward nursing expertise and recognise the contribution of nurses in achieving quality person centred health outcomes. The PDRP assessment criteria have been developed to align with the *National Framework and Evidential Requirements* (NENZ, 2017) and integrate the national requirements along varying levels of practice.

Since its inception within Canterbury, the programme has grown significantly in numbers of nurses submitting and gaining recognition through the PDRP process. It has also welcomed local and national partner organisations onto Te Kāhui Kōkiri Mātanga PDRP.

Participating District Health Boards and Partnering Organisations

The following organisations have a Memorandum of Understanding (MOU) with Te Kāhui Kōkiri Mātanga PDRP (or currently in progress of developing a MOU):

- ACCESS Homehealth Limited [National]
- Christchurch Eye Surgery Limited
- Christchurch PHO
- Department of Corrections [National]
- Elmswood Life Care [Christchurch]
- Fendalton Life Care [Christchurch]
- Forte Health [Christchurch]
- HealthCare NZ Limited [National]
- Heritage Life Care [National]
- Homecare Medical (NZ Limited Partnership) [Auckland based; National]
- Intus Limited, Digestive and Colorectal Care
- Kaupapa Maori and Pacific NGO Collective [Canterbury]
- Laura Fergusson Trust (Canterbury) [National]
- Merivale Retirement Village
- Nurse Maude Association [Canterbury]
- Oceania Healthcare (NZ Limited) [South Island]
- Oxford Women's Health [Christchurch]
- Pegasus Health Ltd [Canterbury]
- ProCare (Auckland)
- Radius Residential Care Limited [South Island]
- Rannerdale Ware Veterans Home Limited (Christchurch)
- Ryman Healthcare Limited [National]
- Summerset Holdings Limited [Canterbury]
- St George's Hospital [Christchurch]
- Ultimate Care Group [Canterbury]
- Waipuna Trust [Tauranga]
- Windsorcare [Christchurch]

  This list does not include South Island DHB partner organisations, outside CDHB, who have a MOU with that DHB.

And the South Island DHB's, and who have MOU's with their own Partner Organisations:

- Nelson Marlborough District Health Board
- South Canterbury District Health Board
- Southern District Health Board
- West Coast District Health Board

The four District Health Board's Nelson/Marlborough, South Canterbury, Southern and West Coast facilitate Te Kāhui Kōkiri Mātanga PDRP within their regions and evaluate their regional PDRP.

Nursing Council of New Zealand (NCNZ) Audit

Te Kāhui Kōkiri Mātanga PDRP was audited by NCNZ in 2006, 2011 and 2017. The latest period between audits was extended due to the Canterbury earthquakes.

On the 8th August 2017 NCNZ met with the Canterbury region Director of Nursing group, Nurse Manager Nursing Workforce Development, members of the Nursing Workforce Development team, PDRP applicants, assessors and resource people.
The Canterbury DHB nurse coordinator PDRP position was vacant at that time.
This audit was the first to be fully electronic. A shared electronic file was made available for the NCNZ auditors to access PDRP audit documentation and evidence of compliance.

NCNZ Audit Outcomes (2017)

NCNZ acknowledged the positive aspects of the programme, specifically:

- The strong and positive relationships with and between programme partners
- The supportive process for nurses to develop their portfolios
- Assessors were well prepared and appreciated the collegiality of the annual assessor workshops
- Robust internal and external moderation processes
- The supportive role Coordinators played in assuring the Programme ran smoothly.

NCNZ Audit Recommendations (2017)

NCNZ recommended that the programme:

- Move to using the same documentation to ensure consistency of the Programme across all partners
- Continue to work on timeframes to reduce portfolio assessments to ten weeks
- The portfolio reassessment date be set at three years from the date the 'met letter' was issued to the PDRP applicant (rather than from the submission date, as some submissions took a significant time to assess which resulted in a shorter resubmission period).

National Framework and Evidential Requirements PDRP

The *National Framework and Evidential requirements* (NENZ, 2017) is the national framework for PDRP programmes in New Zealand and was reviewed nationally between 2016 and 2017. A final review was accepted April 2017. The responsibility for this framework is now with Nurse Executives New Zealand, originally being the responsibility of the National Nursing Organisations.
The previous Nurse Coordinator of Te Kāhui Kōkiri Mātanga PDRP Chaired the National Nursing PDRP Committee and was a member of the National PDRP document review project team which updated the framework.
The Nurse Coordinator PDRP Canterbury, and chair of the National Nursing PDPR committee resigned their CDHB position mid-2017.

Changes within the National Evidential Requirements (2017)

- Expert (RN) Level evidential requirements – "*Postgraduate education (Level 8) or equivalence in education and practice*" is no longer a requirement
- Also removed: *"the applicant is required to demonstrate within their portfolio the integration of the nursing knowledge at level 8 into their nursing practice."*
- Previously there was a requirement to set up a postgraduate equivalence process. This has changed to state that an organisation could develop either an *"RN Expert Panel Process"* or that there is an *"RN Expert Support/guidance process"*. Te Kāhui Kōkiri Mātanga PDRP Advisory Group has agreed that a way forward is to have a process to moderate expert level portfolios.

National Evidential Requirements Review Recommendations (2017, p. 3):

- All organisations which host PDRP merge to a single national PDRP over the next 5 years
- A review of the document should be undertaken at least every five years, or earlier if indicated, to keep up with the pace of change in the [nursing] profession
- Clear national leadership on standards and guidelines for development of electronic portfolio platforms is indicated
- All PDRPs are aligned with the changes in the National Framework and Evidential Review document by January 2019

Governance and Leadership of Te Kāhui Kōkiri Mātanga PDRP

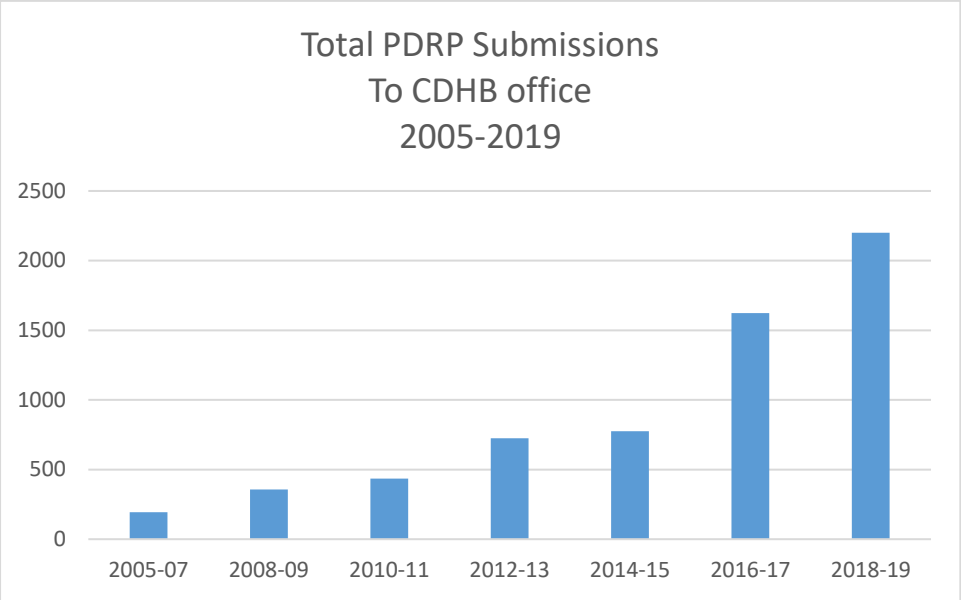
Te Kāhui Kōkiri Mātanga PDRP is directed by an Advisory Committee, sponsored and led by the Executive Director of Nursing, CDHB. Committee attendance includes Directors of Nursing representatives, nursing and PDRP representatives from the CDHB, the South Island DHB's, and partnering organisations. The advisory committee is responsible for the overall development and outcomes of the programme.
This group meets four monthly and is supported by a current Terms of Reference.

The PDRP operational group meets four monthly and is currently chaired by the PDRP representative from Nelson/Marlborough DHB. Representatives from the CDHB PDRP team, South Island DHB's, and partnering organisations attend. This meeting includes external moderation and operational updates and changes and is supported by a current Terms of Reference. Information and discussion from this group informs the PDRP Advisory Committee.
Both meetings occur on the same day.

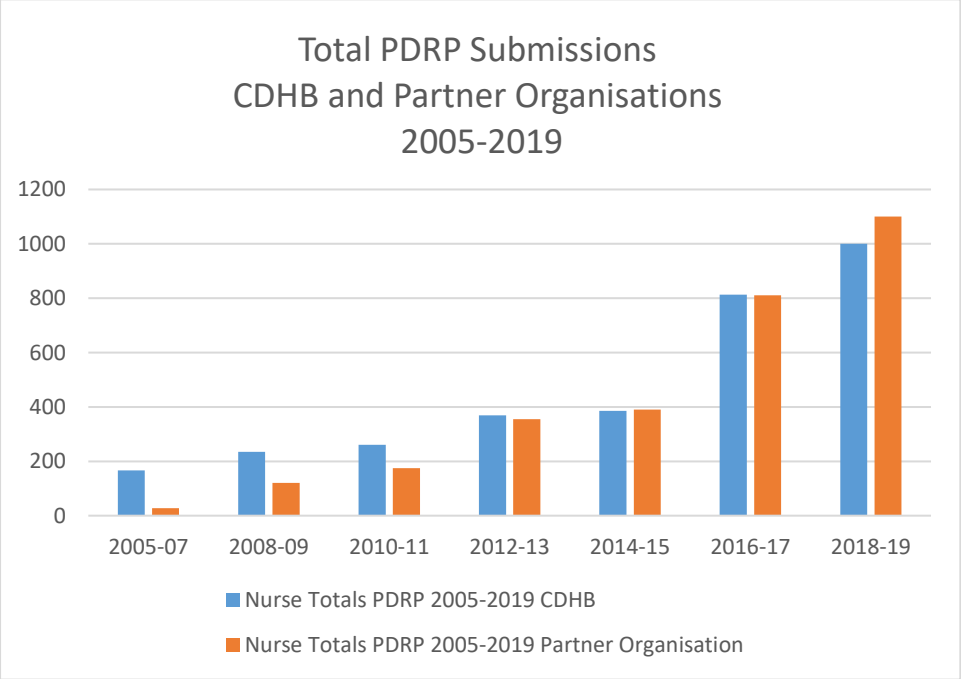
Te Kāhui Kōkiri Mātanga PDRP is managed by the Nurse Manager Nursing Workforce Development team, CDHB, and operationalised by the Nurse Coordinator PDRP and administration personnel, in partnership with participating organisations.
A Canterbury member of Te Kāhui Kōkiri Mātanga PDRP, from Pegasus Health Christchurch, is joint National Chair of the National Nurse PDRP Coordinators (NNPC).

PDRP Database Statistics

The following outlines PDRP programme growth since commencement of PDRP:



Includes submissions; and re-submission for a nurse at another level
Includes CDHB only, Canterbury DHB Partner Organisations, some national partners
Please see page 12 *Findings*: *



Includes submissions; and re-submission for a nurse at another level
Includes CDHB only, Canterbury DHB Partner Organisations, some national partners
Please see page 12 *Findings*: *

Achieved PDRP levels:

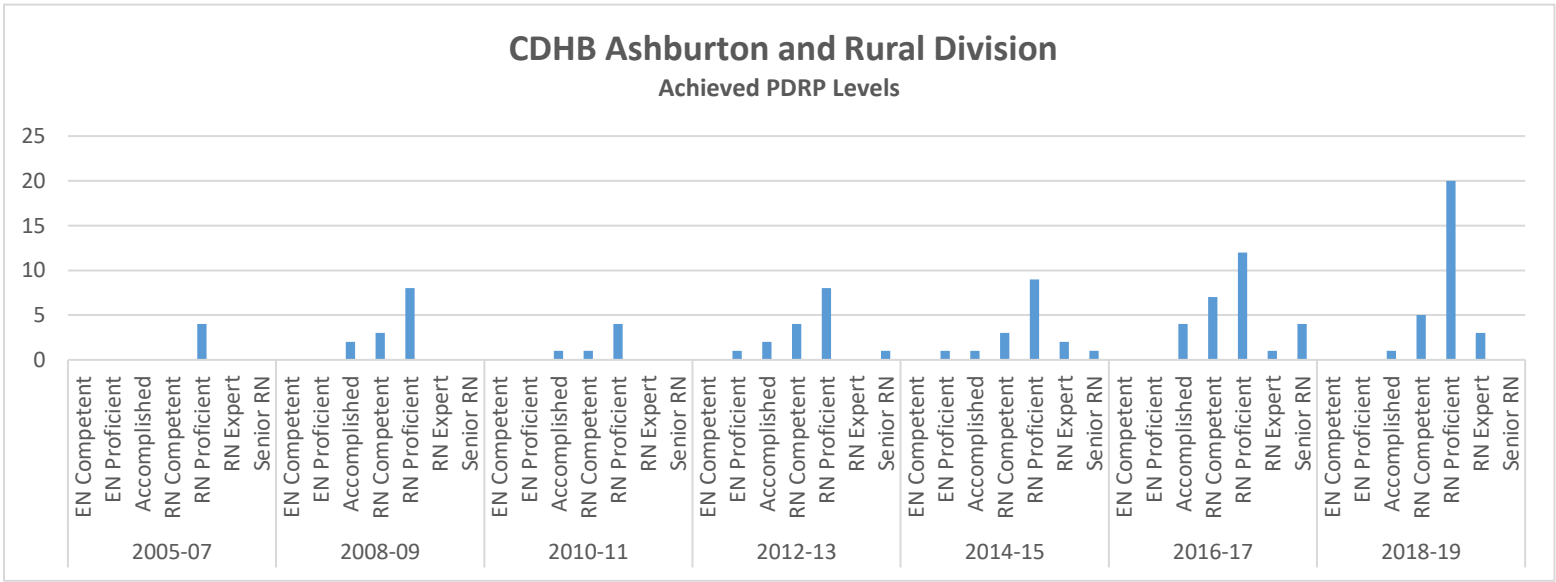
The following data identifies the PDRP levels attained by each CDHB division, and for nurses who are employed across the wider CDHB; and Canterbury partnering organisations.

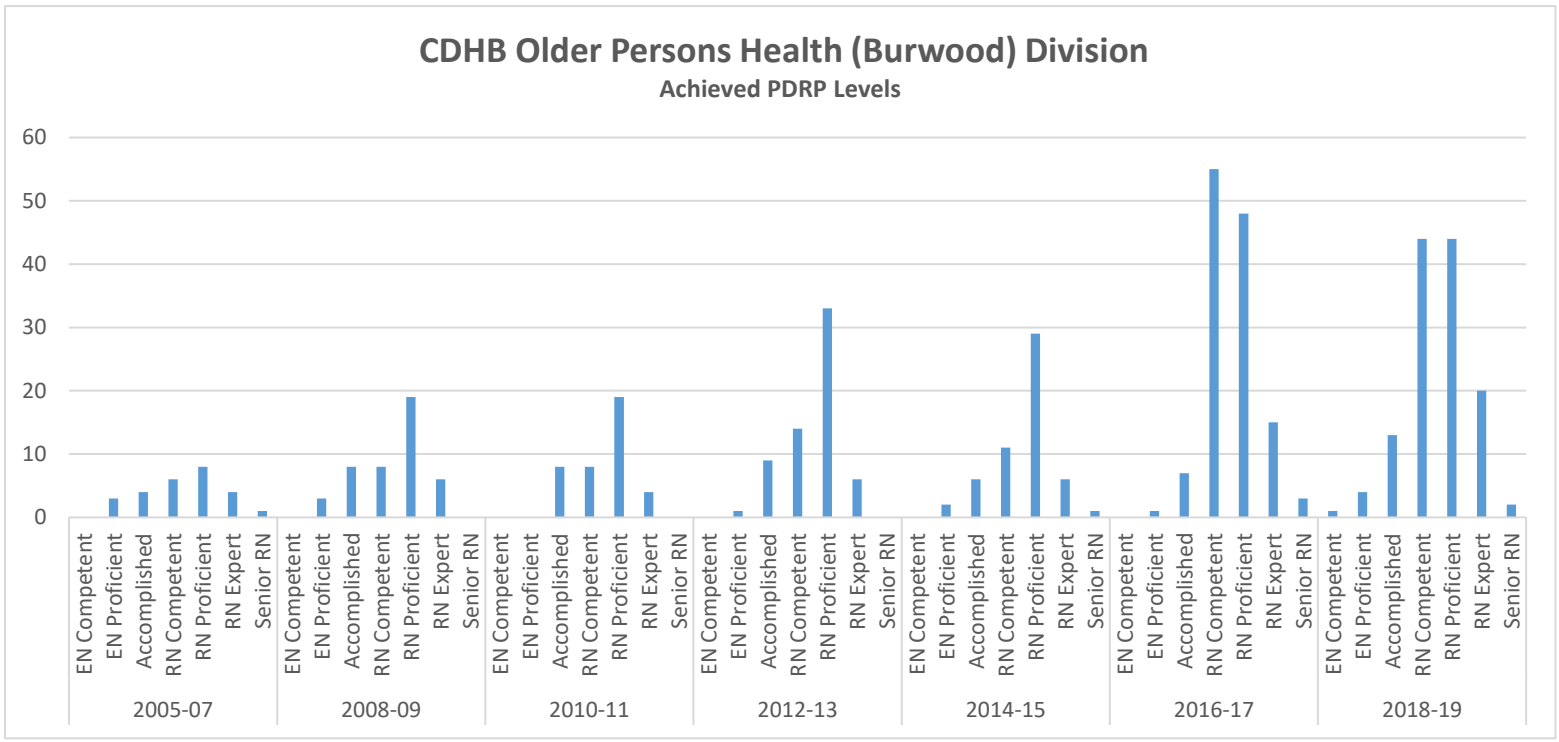
In 2016 Older Person's Health nursing staff transferred from the Princess Margaret Hospital (TPMH) site to Burwood Hospital Site, Burwood Hospital is now titled 'Older Person's Health and Rehabilitation' (OPH&R), although some data continues to be placed under both Burwood and OPH&R on the database. Therefore, TPMH Data up until 2017 includes OPH&R applicant's data, and from 2017 the Burwood Hospital data now includes OPH&R data.
To differentiate between the two sites over following data period, the titles 'The Princess Margaret Hospital' and 'Burwood Hospital' are still used.

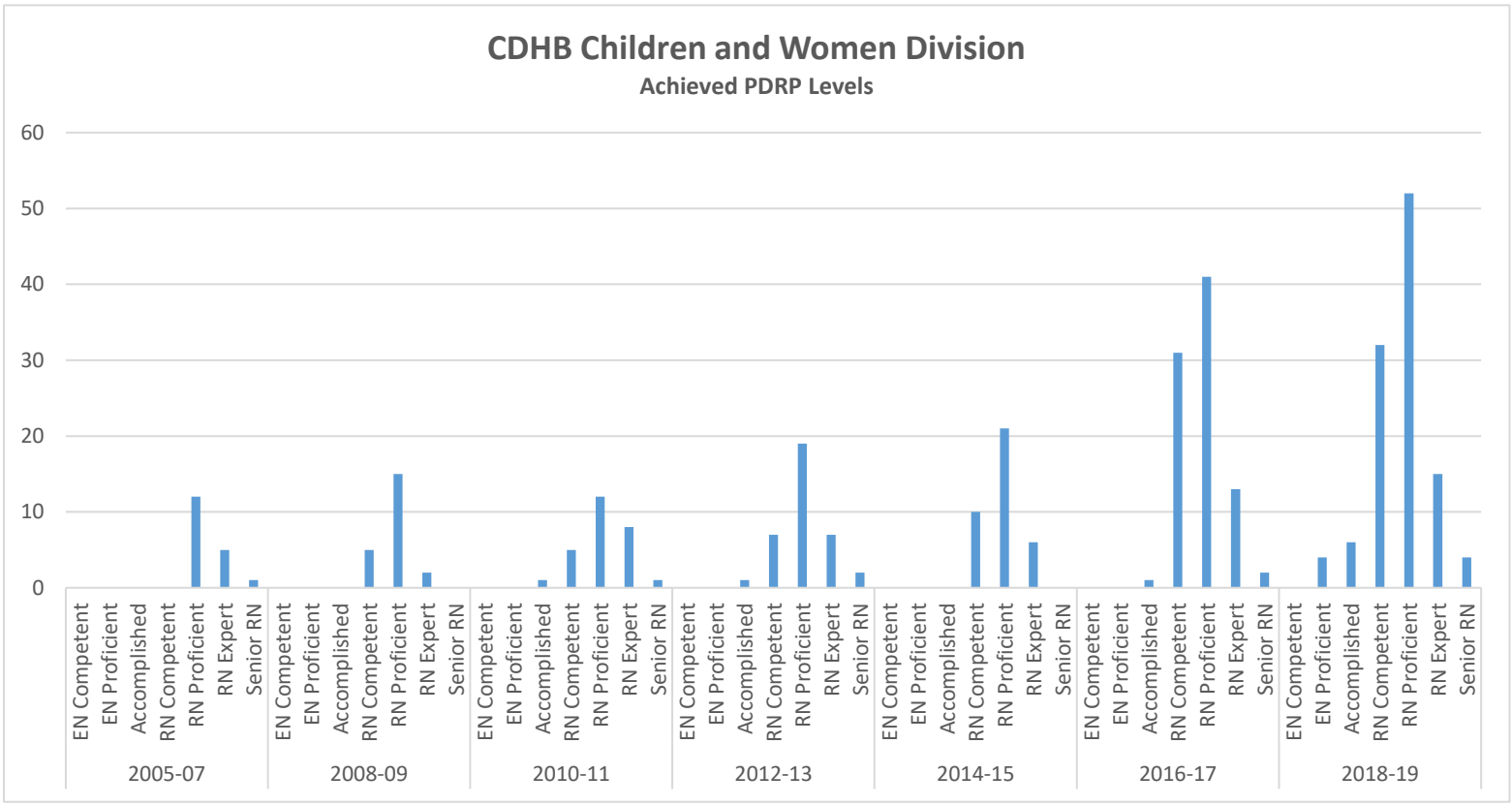
Findings: *
In mid-2017 when commencing collation of data for this review revealed not all competent level PDRP applicants had been registered onto the PDRP database prior to 2017. Until that time, most competent level portfolios were received and assessed by the NETP and NESP programmes within the Canterbury health region. This was rectified and from 2017 all competent level portfolios administration and assessment is managed by the PDRP office.

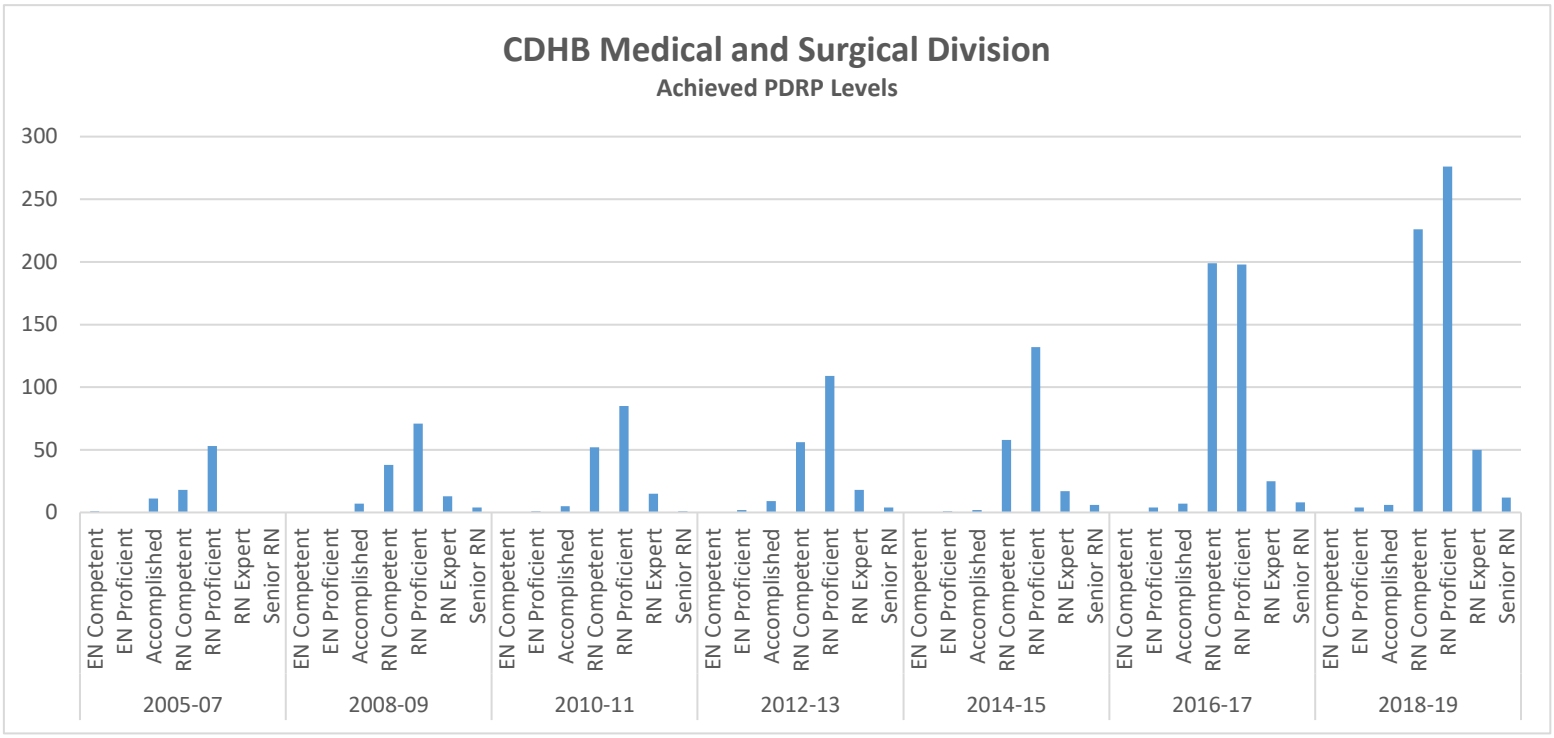
As a result, the previous two data graphs (*page 11*) which identifies 'Total Submissions' has a notable increase within the period 2016-2017 - the data for PDRP *competent level* being inaccurate up until the end of 2016.
The following data at *Competent* level data is accurate from 2017.

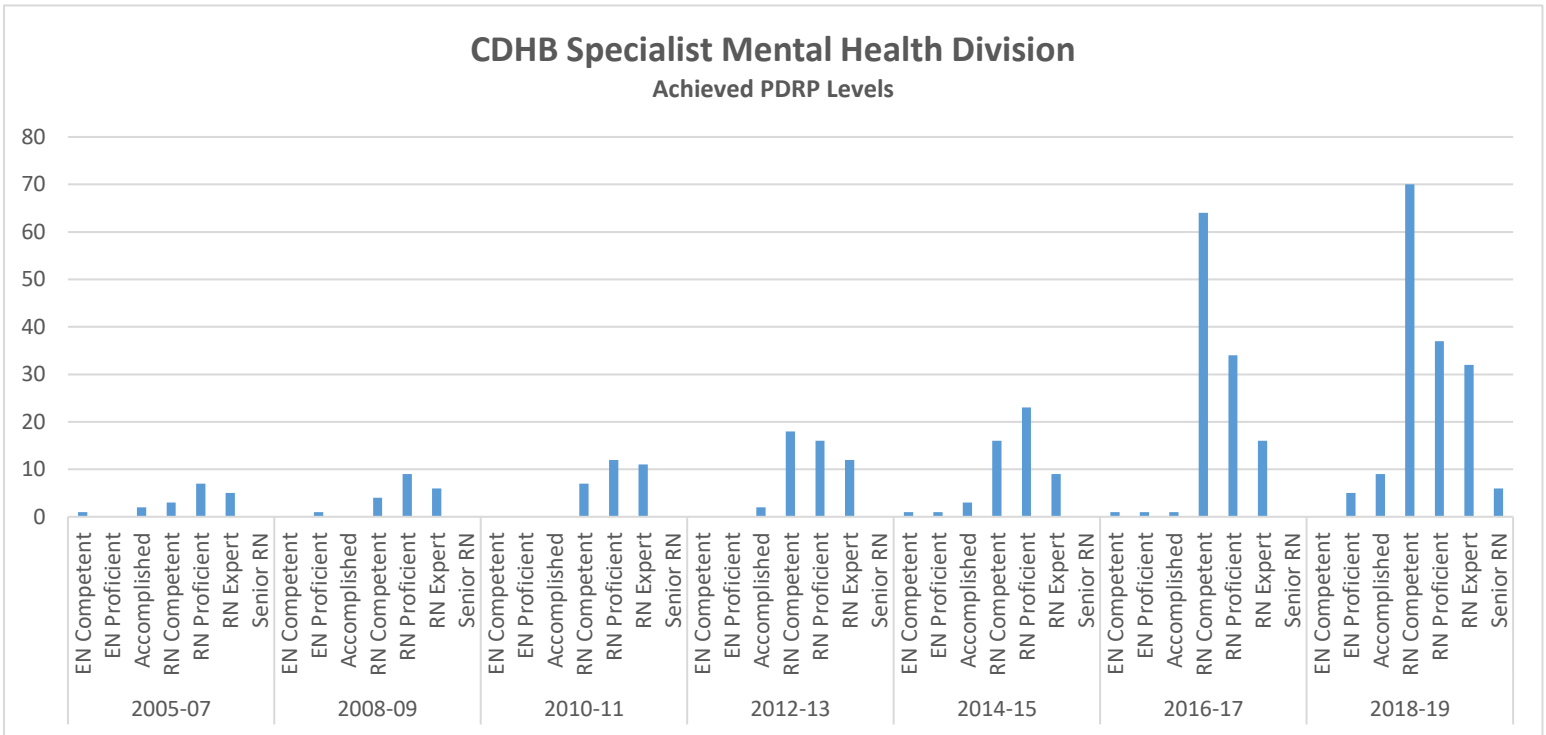
Recommendation:
The 'Princess Margaret' and 'Older Person's Health' data to be included in the 'Specialist Mental Health and Addictions', and 'Burwood Hospital' data sets.

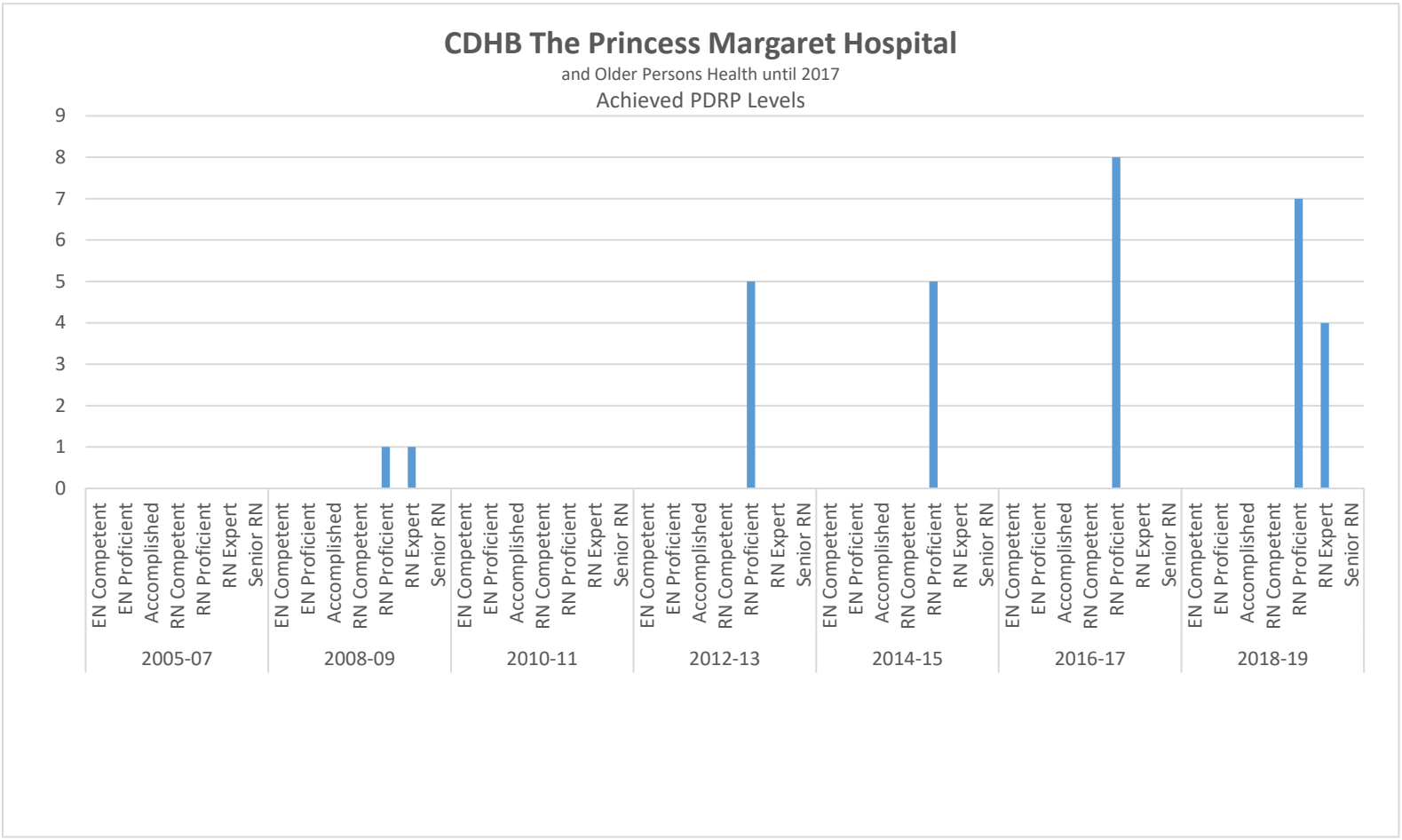


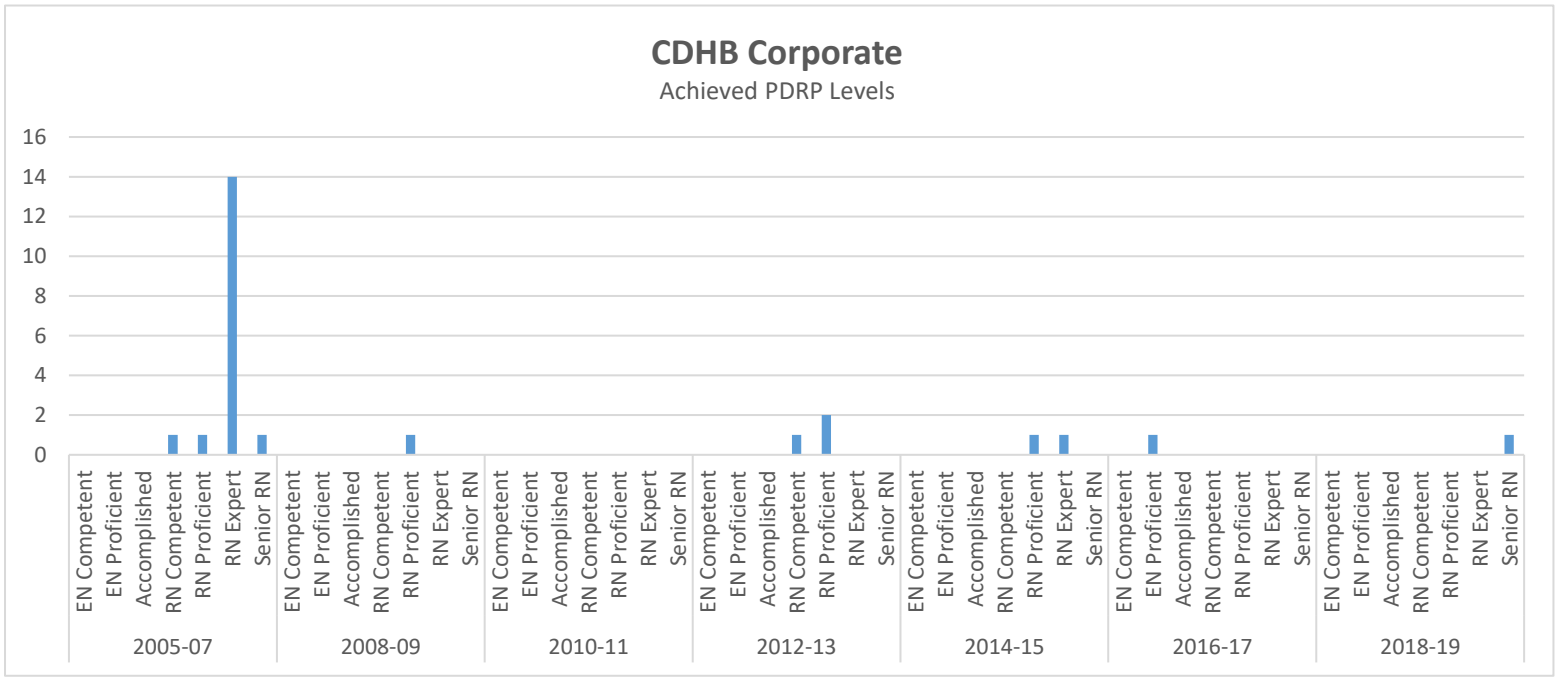

CDHB Older Persons Health (Burwood) Division
Achieved PDRP Levels
60
50
40
30
20
10
0
EN Competent
EN Proficient
Accomplished
RN Competent
RN Proficient
RN Expert
Senior RN
2005-07
2008-09
2010-11
2012-13
2014-15
2016-17
2018-19

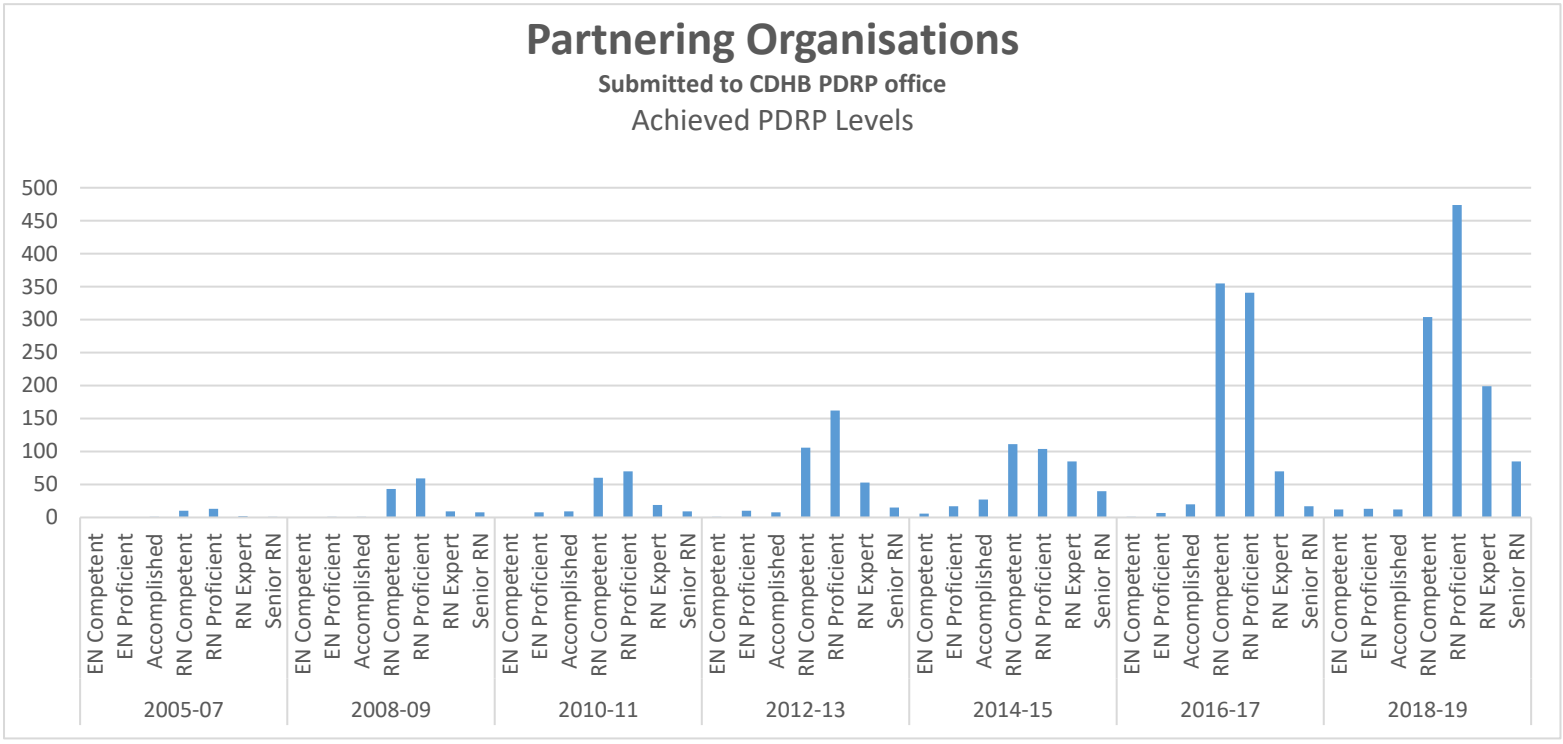

CDHB Children and Women Division
Achieved PDRP Levels
60
50
40
30
20
10
0
EN Competent
EN Proficient
Accomplished
RN Competent
RN Proficient
RN Expert
Senior RN
2005-07
2008-09
2010-11
2012-13
2014-15
2016-17
2018-19


CDHB Medical and Surgical Division
Achieved PDRP Levels
300
250
200
150
100
50
0
EN Competent
EN Proficient
Accomplished
RN Competent
RN Proficient
RN Expert
Senior RN
2005-07
2008-09
2010-11
2012-13
2014-15
2016-17
2018-19

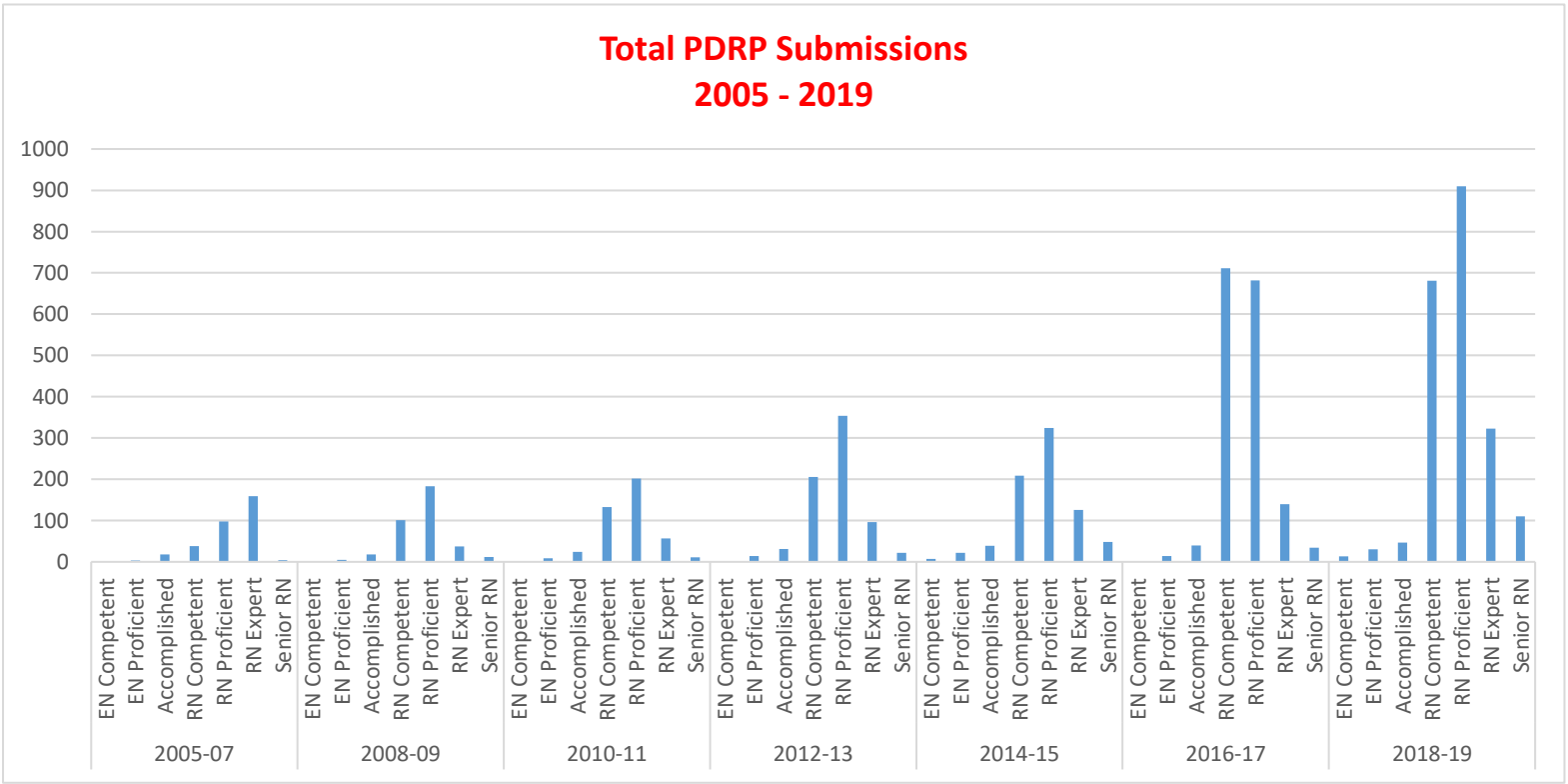

CDHB Specialist Mental Health Division
Achieved PDRP Levels
80
70
60
50
40
30
20
10
0
EN Competent
EN Proficient
Accomplished
RN Competent
RN Proficient
RN Expert
Senior RN
2005-07
2008-09
2010-11
2012-13
2014-15
2016-17
2018-19


CDHB The Princess Margaret Hospital
and Older Persons Health until 2017
Achieved PDRP Levels
9
8
7
6
5
4
3
2
1
0
EN Competent
EN Proficient
Accomplished
RN Competent
RN Proficient
RN Expert
Senior RN
2005-07
2008-09
2010-11
2012-13
2014-15
2016-17
2018-19


CDHB Corporate
Achieved PDRP Levels
16
14
12
10
8
6
4
2
0
EN Competent
EN Proficient
Accomplished
RN Competent
RN Proficient
RN Expert
Senior RN
2005-07
2008-09
2010-11
2012-13
2014-15
2016-17
2018-19



Total PDRP levels for portfolios submitted to Canterbury PDRP office, from CDHB partners, and some national partners



Te Kāhui Kōkiri Mātanga PDRP Programme Totals:

During the 2013-2019 review period 6,350 PDRP applications have been successful in attaining their respective level on Te Kāhui Kōkiri Mātanga PDRP:

Registered Nurse	
Competent	2079
Proficient	2753
Expert	938
Senior Designated	241
Total RN Submissions	6011
Enrolled Nurse	
Competent	25
Proficient	97
Accomplished	217
Total EN Submissions	339
Total Submissions	**6350**

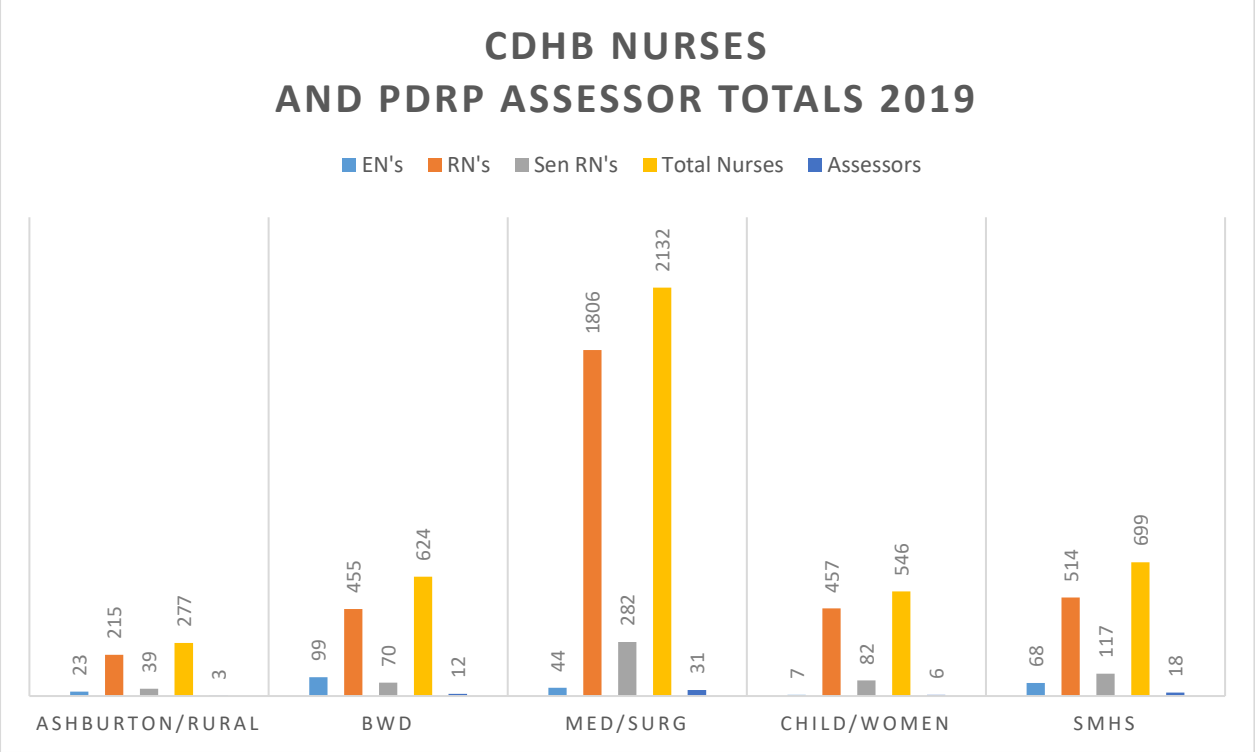
***Note**: This data includes resubmissions of portfolios; CDHB and Partner Organisations And resubmissions at another level for the same applicant*

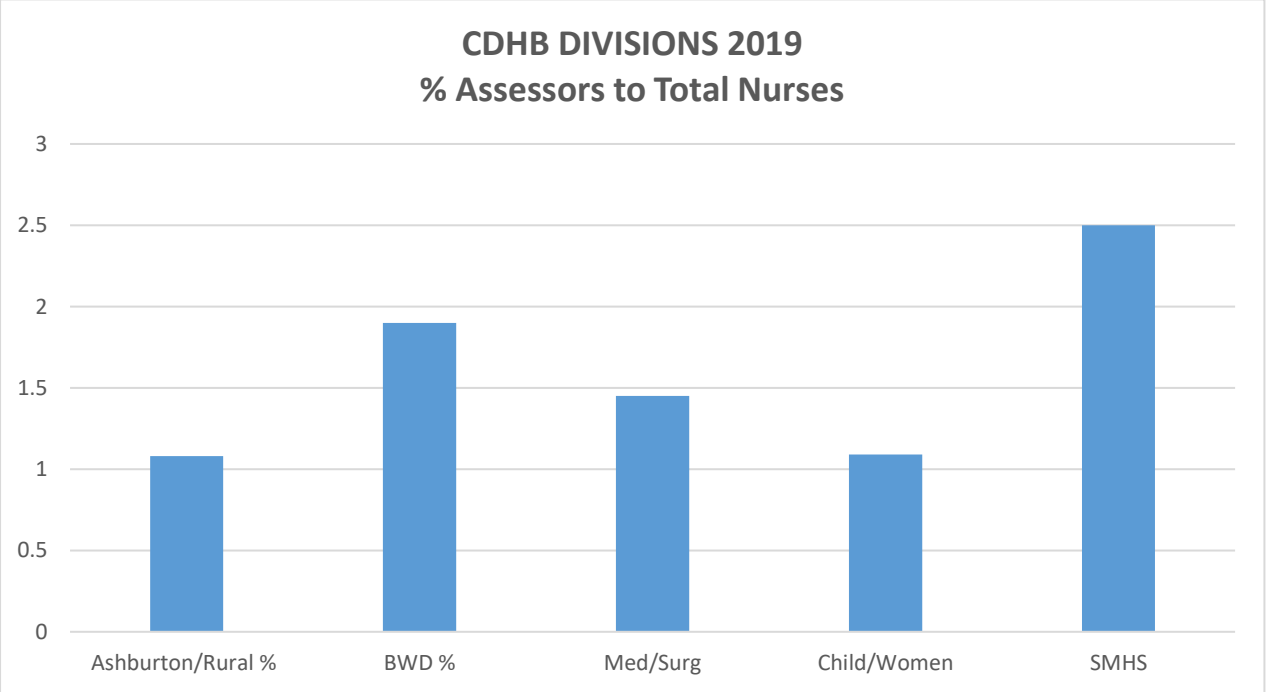
PDRP Assessors:

PDRP assessors are nominated by their line manager and have successfully completed their PDRP portfolio. Assessors attend a two-day initial training to gain a certificate in Assessment, Unit Standard (US) 4098, via a collaboration between the CDHB and the Open Polytechnic of New Zealand. In 2020 Open Polytech will cease to offer face-to-face training and instead will offer US4098 on-line. Some assessors have attained other assessment qualifications and experience other than US4098 and have been recognised for their prior learning to assess portfolios. This is determined on an individual basis by application to the PDRP office.
Assessors are required to attend a regular update study day. CDHB assessors are required to assess a minimum of eight portfolios per annum. The number of portfolios assessed is dependent upon workplace resourcing, acuity, and individual ability to achieve this. Moderation of the assessor, by a second assessor, is undertaken for every tenth portfolio.

Findings:
Not all assessors have attended an assessor study day, after attaining US4098. Upon review of education provided education sessions require a lesson plan, and Kirkpatrick evaluation to align with current CDHB education evaluation processes

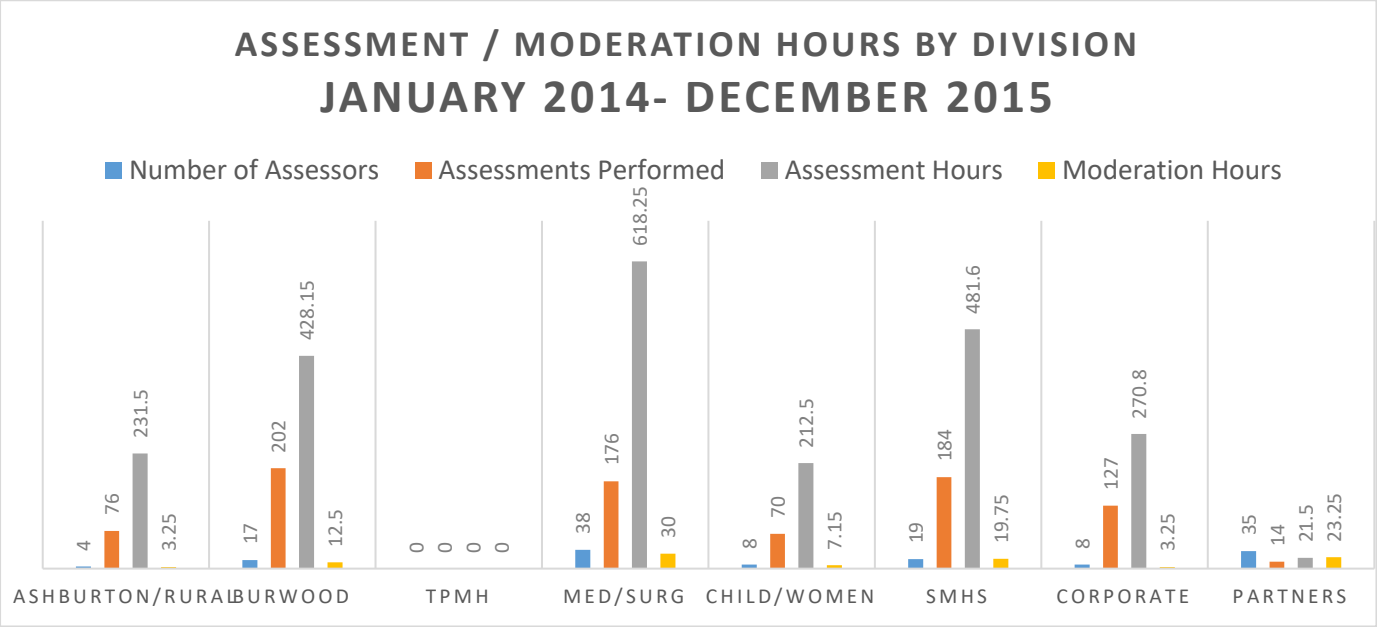
Recommendation:
PDRP Education sessions have a current lesson plan and Kirkpatrick evaluation

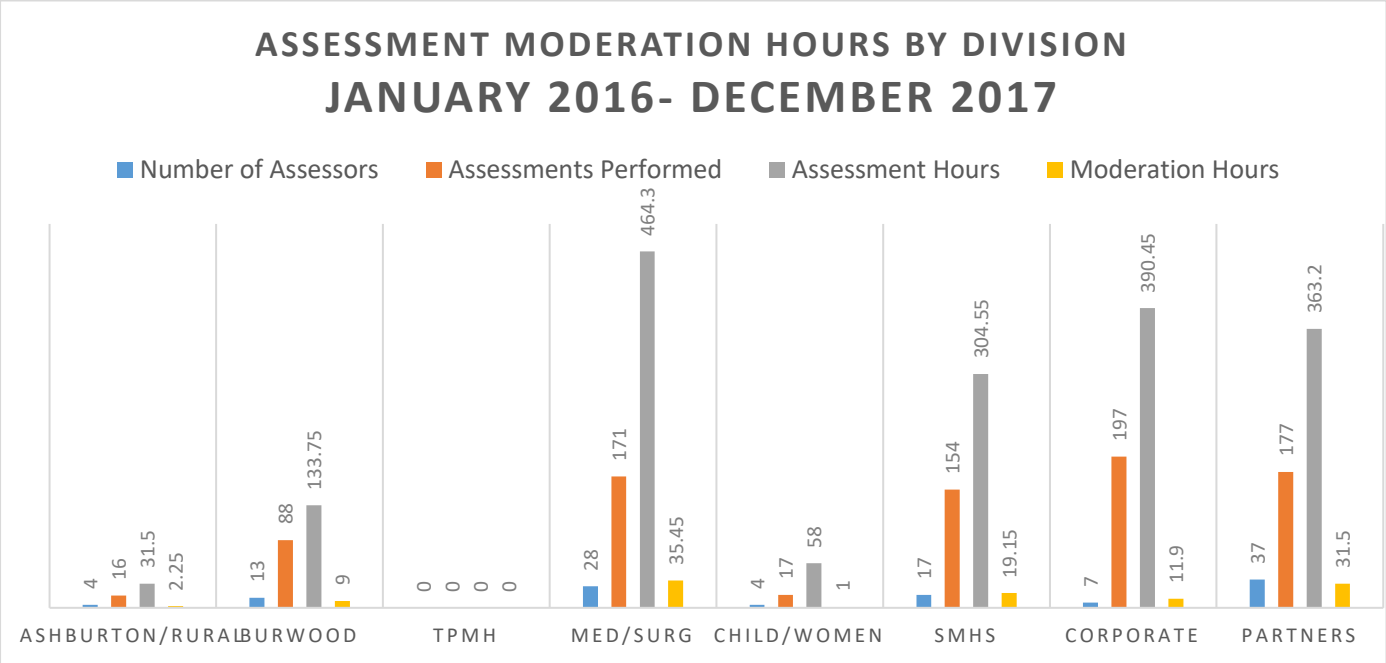

CDHB NURSES
AND PDRP ASSESSOR TOTALS 2019
EN's
RN's
Sen RN's
Total Nurses
Assessors
23
215
39
277
3
99
455
70
624
12
44
1806
282
2132
31
7
457
82
546
6
68
514
117
699
18
ASHBURTON/RURAL
BWD
MED/SURG
CHILD/WOMEN
SMHS

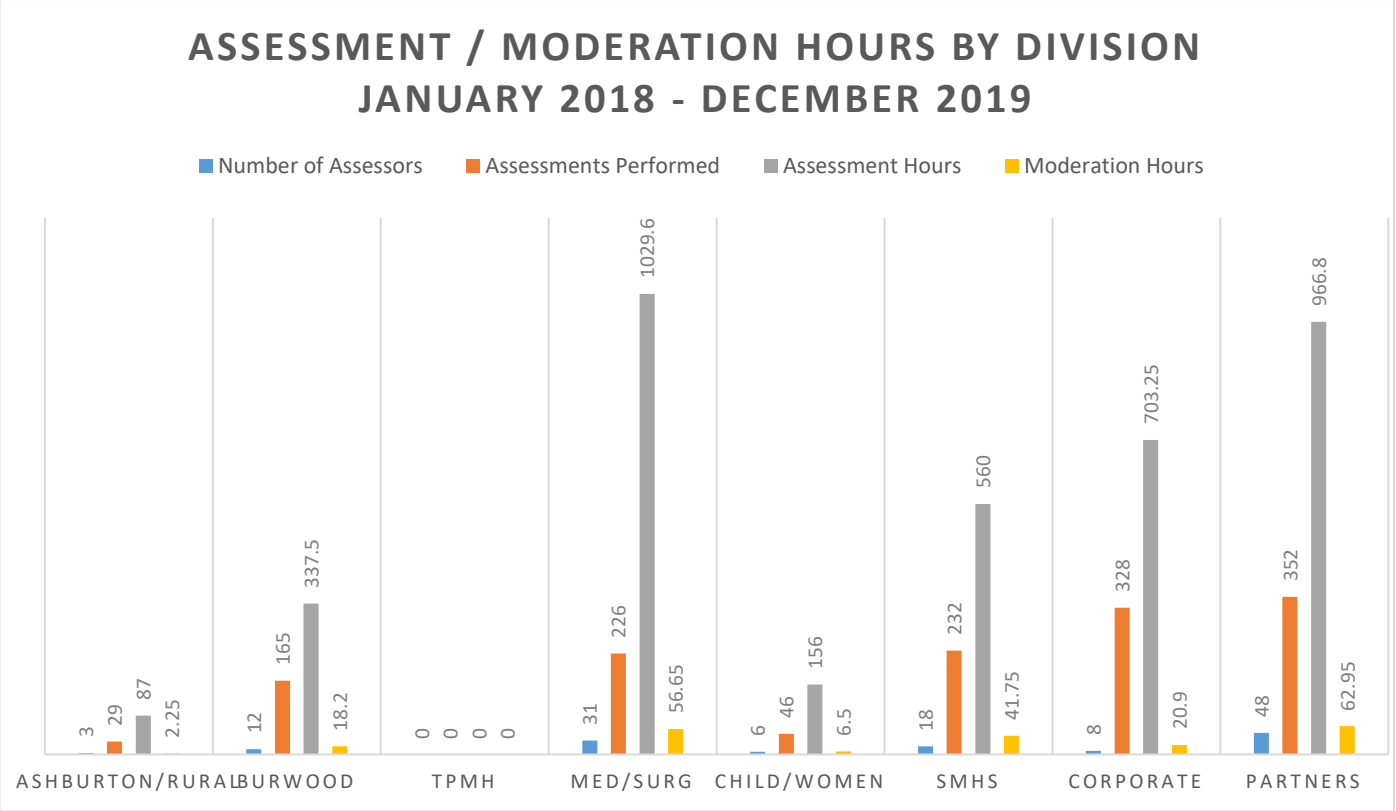

CDHB DIVISIONS 2019
% Assessors to Total Nurses
3
2.5
2
1.5
1
0.5
0
Ashburton/Rural %
BWD %
Med/Surg
Child/Women
SMHS

Assessment and Moderation Hours:

The following data outlines the number of assessment and moderation hours by division and for external partners. It is identified in two yearly timeframes.
The Princess Margaret Hospital has no data entered on the database before and since its merger with the Burwood Hospital site in 2016. A section on the database identified as Older Persons Health also was void of data for some timeframes. Since 2016 Older Persons Health, and TPMH data, is incorporated into the Burwood Hospital and Specialist Mental Health data cohorts respectively, within the PDRP database.







Findings:
The most prolific assessor within the CDHB, has assessed 97 portfolios in 2018 totalling 286.25 hours. The nurse was employed one day per week for portfolio assessment for the PDRP programme when there were issues identified around the timeframes for assessment. The next most prolific assessor assessed 66 portfolios, mainly competent level within the NETP programme, utilising 129.35 hours. A further three assessors assessed 20+ portfolios for the year, two from Specialist Mental Health, and one from the Burwood Hospital.

Nineteen CDHB nurses have assessed over the required 8 portfolios per year for 2018. One CDHB assessor did not complete a portfolio assessment.

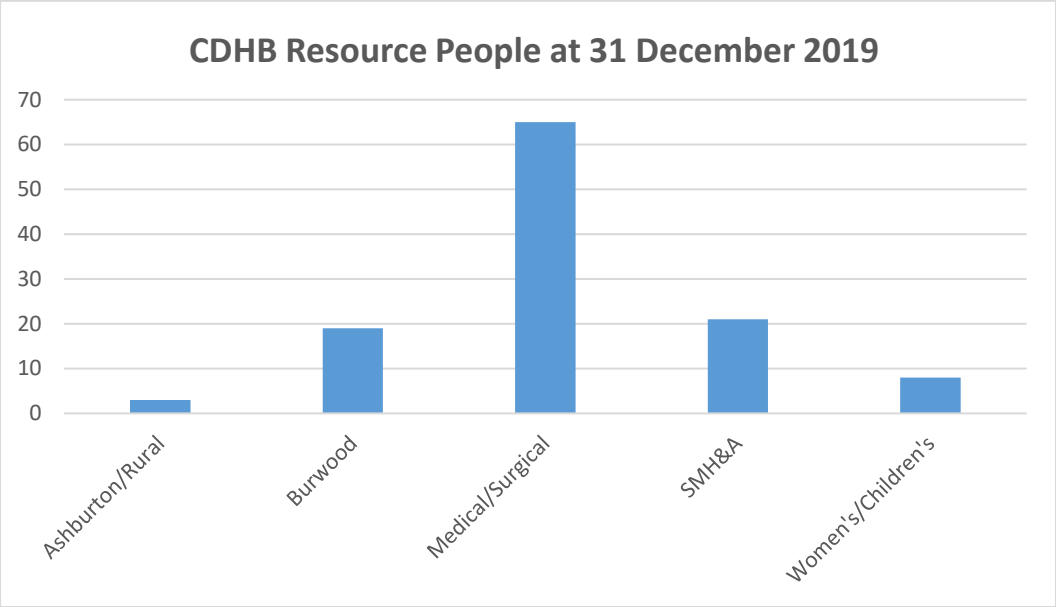
The assessment records for partner organisations collects data for only some organisation portfolios which have been submitted into the Canterbury PDRP office. Some organisations, for example the Southern Region DHB's, record their own assessment/moderation data. Therefore, the partner organisation data is not accurate within the data tables.

A further break down of assessor data, for divisional Directors of Nursing, is available upon request to PDRP@cdhb.health.nz

Recommendation:
Review utilising assessors, who do not complete a minimum of eight assessments per annum

Resource People:

Resource people provide support and advice to PDRP applicants. The resource person role is pivotal to successful completion of a portfolio and attainment on the PDRP. They are nominated by their line managers and have successfully completed their PDRP portfolio. Resource people are required to attend a 3-hour yearly update which is facilitated by the PDRP team.



Findings:
In some workplaces resource people are also assessors, although it is identified in the Memorandum of Understanding (MOU) that assessors cannot be a resource person.
The current Nurse Coordinator PDRP is reinforcing the importance of the resource person role to applicants, to mitigate portfolio issues prior to submission of a portfolio and to augment assessment within the current ten-week assessment timeframe.

Resource people data on the PDRP ACCESS database needs updating for accuracy.

Recommendations:
Review the MOU to reflect practice regarding Assessors and Resource person role(s)
Update PDRP database re: resource personnel

Desk Audit

A desk audit against the revised *National Framework and Evidential Requirements (2017),* the *Framework for the approval of professional development and recognition programmes* (NCNZ, 2013), *Te Kāhui Kōkiri Mātanga PDRP Policy* (CDHB, 2018) and Quality Plan (2017), and the PDRP Advisory Committee and Operational Committee minute(s) was undertaken.
Review of the above documents commenced in 2017 prior to the commencement of the current PDRP Coordinator. The following findings and concurrent improvements have been implemented over the timeframe of this review:

Findings and Concurrent Improvements

National Framework and Evidential Requirements	▪ Te Kāhui Kōkiri Mātanga PDRP changes aligned to National Framework, prior to January 2019 **Completed** ▪ 'Levels of Practice' Definitions renamed, previously called 'National Indicators'. Changed in Te Kāhui Kōkiri Mātanga PDRP documentation **Completed**
PDRP Documents: - Guidelines - Forms - Templates	▪ All documentation updated to include a PDRP logo, file pathway and date of review **Completed** ▪ Guidelines format redesigned for ease of reading and understanding **Completed** ▪ New updated guidelines, forms and templates are now the accepted documentation only, from 1 January 2019 This is after a six-month transition period when both previous and new documentation was accepted by the PDRP office **Completed** ▪ A Document Review Panel has been established to review Te Kāhui Kōkiri Mātanga PDRP documents two yearly **Ongoing** ▪ Consent Form: previously a 'standalone document' this is now included in applicant's PDRP guidelines **Completed** ▪ Role Overview: not a NCNZ nor PDRP requirement. Can now be incorporated in applicant's Curriculum Vitae if the applicant wishes **Completed** ▪ Code of Conduct: no longer required by NCNZ audit of individual nurses, therefore not required in PDRP portfolios **Completed** ▪ Individually written evidence (other than the performance appraisal), e.g. reflections, do not require applicant's signature. **Completed** ▪ Guidelines: section on performance appraisal/peer review: requires review and rewording to alleviate confusion within the DHB's and for partner organisations. Some organisation's applicant's do not have a nursing line manager and undertake peer reviews. **For review**
Website: -Te Kāhui Kōkiri Mātanga	▪ Realignment of the Expert PDRP guidelines, checklists and practice discussion information changed on website

PDRP	**Completed** ▪ Updated guidelines, forms and templates uploaded **Completed** ▪ Development/re-alignment of Website to be more streamlined for each level of application, with assistance from CDHB Communications Team. Initial changes completed. Discussion is ongoing re: a PDRP 'What's New' section on website to centralise programme changes and updates for nurses **Ongoing** ▪ Interim Performance Appraisal Hyperlink placed on PDRP website. **Completed**
Expert Level changes:	▪ Realignment of the Expert RN workbooks, checklists and practice discussion information for stakeholders to align with National Framework and Evidential requirements (level 8 education changes) ▪ Practice level discussion now optional for applicants **Ongoing**
Levels of Practice Evidence	▪ No additional evidence is required in a portfolio for a specific level, if it is identified within the standard requirements (e.g. PA, Peer review). **Completed**
Policy: -Expert Level update: -Management of performance issues, prior to and during PDRP application:	▪ Te Kāhui Kōkiri Mātanga PDRP policy updated to include the Expert level changes **Completed** ▪ Performance Management section rewritten in the PDRP policy to align with National Framework and Evidential requirements section on performance issues [also Advisory Group recommendation, November 2017, for PDRP policy change] **Completed**
Memorandum of Understanding (MOU)	▪ Te Kāhui Kōkiri Mātanga PDRP Memorandum of Understanding between Host DHB and their partner organisations reviewed and updated. New MOU's being developed with new partners during time of review **Ongoing**
External Moderation	▪ External Moderation process reviewed and changed, to reflect each 'Host' District Health Board within Te Kāhui Kōkiri Mātanga PDRP is responsible for moderation of their partner organisations' portfolios **Completed**
Portfolio Timeframes	▪ Regular meetings within the Canterbury PDRP team commenced to review portfolio timeframes, and actions to progress lengthy assessments **Ongoing**
Ethnicity of PDRP applicants	▪ Ethnicity data is now obtained on PDRP application at all levels. This is voluntary for applicants **Completed**
Annual Practising Certificates (APC)	▪ APC information now obtained on PDRP database **Completed**
Terms of Reference (TOR)	▪ Operational Group TOR developed and accepted **Completed**
National PDRP Programme	▪ PDRP Coordinator Canterbury, working towards national PDRP documentation with National PDRP committee, 'Aotearoa Collective Group'. This is nearing completion and is currently out for national review **Ongoing**
Communication	▪ Letters of successful completion updated regarding wording; and competent level wording regarding 'success on NETP' removed

	Completed ▪ Workplaces informed of new documentation on website, and to remove any copies of previous documents that may be held in workplaces **Ongoing** ▪ Applicants emailed confirming receipt of portfolio into PDRP office **Ongoing** ▪ Stakeholders emailed more frequently when changes occur **Ongoing** ▪ Applicants to be emailed when assessment delayed **Ongoing**
Education	▪ Assessors to be encouraged to attend assessor study day ▪ Education sessions require lesson plans and Kirkpatrick evaluation ▪ Resource education to be reviewed: time/content **Ongoing**
healthLearn: e-learning platform e-portfolio	▪ Education resources are to be developed for healthLearn, for example: Resource Role, Assessor and Applicant education on-line learning. **To be developed** ▪ Development of e-portfolio on healthLearn utilising the Mahara ePortfolio platform; and in collaboration with Christchurch Hospital Professional Development Unit nurse educator, CDHB healthLearn team, and PDRP consultation nationally **Commenced**
Maternity Leave -PDRP payments during	▪ Reviewed following a query from applicant **Status quo remains**
Assessment Timeframes	▪ *See page 24*
PDRP name change	▪ May 2017 Advisory Minutes: name change from CDHB PDRP to Te Kāhui Kōkiri Mātanga in consultation with Executive Director of Maori and Pacific Health, CDHB. Reflecting the diversity and growth of the programme outside Canterbury and the South Island.
Traumatic events: -extensions requested by applicants	▪ NCNZ approved PDRP portfolio extensions for individual 'applications for extension' that may be received by the PDRP office. This was specifically requested following the 2011 Canterbury and 2016 Kaikoura earthquakes and the 2019 March 15 incident
Te Tiriti O Waitangi	▪ *See page 27*
Quality and Patient Safety Programme -Te Kāhui Kōkiri Mātanga	▪ Further Quality programme development and auditing required to close the gaps regarding improvements indicated in this review **Ongoing**

Assessment Timeframes: Standard 3.9 (NCNZ, 2013)

In late 2016 feedback was received by the PDRP office of the extended time periods that some portfolios were taking for assessment, and their subsequent delayed return to the applicant. A quality audit of the timeframes of the portfolios that were being assessed by the Canterbury office was undertaken. At that time assessment was expected within an eight-week timeframe. This changed to 10 weeks in 2016.

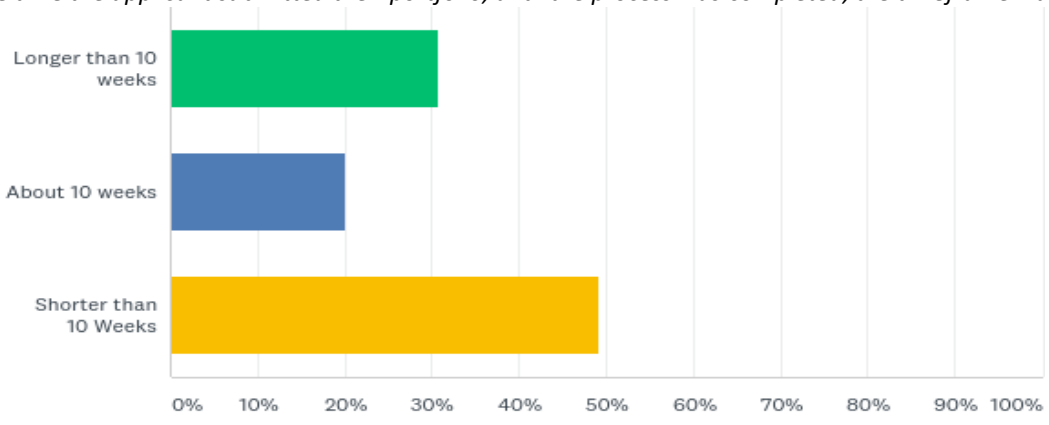
Finding:
The PDRP database still captures assessment time data over an 8-week period. In 2016 the assessment time was lengthened to 10 weeks.

Further finding:
From 4th February 2014 – 20th December 2016 there were 241 portfolios from 2,985 submissions which exceeded the ten-week assessment period (8.1%). One portfolio was unable to be retrieved for over 12 months, from an earthquake damaged house. The then backlog of portfolios >10-week period, was remedied at that time, and all portfolios completed assessment.
In January 2017, after a four-week closure of the PDRP office over the Christmas period, fortnightly 'spreadsheet meetings' were initiated to review applications currently under assessment. This identified applications who were nearing the maximum assessment period, reviewed the progress and any rationale for those applications who had exceeded the ten-week submission/assessment period.

At 1st February 2017, there were 320 portfolio current submissions, of which only 20 exceeded the 10-week assessment period (6.25%). Due to the Christmas/summer holiday time lag, assessors commenced assessing later in January/February which had contributed to some delayed assessments.
For the majority of the 20 assessments exceeding the 10-week period, the reason for the delayed outcome was the assessor awaiting further evidence from the clinical leader or applicant. In addition to this, three of the 20 required a second assessment, and four of the 20 were submitted either without a performance appraisal, or with the wrong appraisal (e.g. interim) included, so further evidence was required. These issues are mostly outside the realm of control of the PDRP office and ongoing communication with the line manager and applicant occur to manage the timeliness of evidence.
Assessment timeframes continue to be monitored with fortnightly 'spreadsheet meetings' between the PDRP coordinator and administrators.

The following data was obtained from an on-line survey: surveyed January 2018-June 2019:

'From the time the applicant submitted their portfolio, until the process was completed, the timeframe was:



The above data informs us 30.7% of applicants' portfolios were received by the applicant after a 10-week assessment period. The timeframe is *upon receipt* of the portfolio by the applicant, *as indicted by the applicant*. Previous assessment time data provided in earlier PDRP evaluations on this issue, calculated the timeframe from when the portfolio information was loaded onto the PDRP database until the date of achievement on the PDRP, as *indicated by the PDRP office* - and not receipt back of the portfolio by the applicant.

Within the 18-month timeframe of the above Survey Monkey audit, the PDRP office (Canterbury) were actively seeking to reduce assessment times from submission to final return of portfolios. However, at the time of the 30.7% Survey Monkey respondents who indicated the portfolio process was still taking longer than 10 weeks to be completed, it also revealed some portfolio assessments had taken 5-6 months duration. When this was realised towards the mid audit period, the PDRP cupboard storing portfolios was rearranged to improve portfolio process flow, and to mitigate long assessment timeframes. In 2017 a senior nurse was employed on a casual basis one day a week to assess portfolios, alleviating the back log and to decrease assessment timeframes.

During focus group discussion on this issue, the respondents within the focus groups requested an email from the PDRP office to inform them of any delay in assessment, to alleviate their concerns. Other respondents commented there were reasons for the delay from their own perspective – for example they were on annual leave or it was the Christmas/New Year break and staff were away or workplaces closed. Some focus group respondents found the process short at 4-6 weeks.

Further finding:
From the applicant's perspective, the 'booking in' process for some portfolios during the year, (dependent upon the time of year the portfolio is received into the office) has an impact upon assessment timeframes.
Portfolios that are received from a new applicant, who is submitting at the end of the year, are 'booked in' for Sept/Oct advertised dates. If the portfolio arrives some weeks early, or not booked in, the portfolio is 'held over' until the booked-in date for assessing, or until January the following year - extending the process timeframe. This booking system was implemented in 2016 due to the large number of NETP and NESP portfolios arriving into the office in November/December.
There are issues identified with this process:

- The end-of-year booking system impacts upon future resubmission dates in three years' time, when large numbers of portfolios are resubmitted in masse in October/November or January, also the time of the NETP/NESP portfolio submissions, (an additional +/- 100 competent level portfolios). Whilst this is the reason the booking system was introduced, it continues to have an impact on end-of-year and beginning-of-year portfolio assessment times and the processing of portfolios in a timely way.
- Being less flexible with the 'booked in' date of the portfolio, resulted in the portfolio not being processed or put into circulation for assessing until it reached its booked date. Therefore, even if there were no other portfolios to be assessed in the office, the 'booked' portfolio was not released for assessing until it's 'booking' date - even if assessors were available to assess portfolios.
- Thirdly, applicants were not informed their portfolios were being held until their booked date or held over to the following January. They believed their portfolios were being assessed. The process was longer from their perspective, yet on the database the dates were shorter (having not being 'entered' on the PDRP database until the 'booked date').

This 'booking-in' system is currently under review.

Further finding:
When investigating assessment timeframes early in this review, 2017, it was found many portfolios were arriving with inadequate evidence or incorrect paperwork/signatory. Applicants were not

always aware of updated guidelines or PDRP documentation, and some workplaces had photocopies of out-dated documents which were being used.
Applicants have since been encouraged to access information from the PDRP website, and a resource nurse for advice and mentorship, prior to submitting their portfolio.

Further finding:
In negotiation with the PDRP office, some applicants awaiting their line manager to complete their performance appraisal (PA), have forwarded portfolios without the completed PA to ensure they meet their resubmission timeframes. Some applicants are waiting for completion of their PA by the senior nurse for extended weeks and months but are also required to re-submit their portfolio within the month their submission is due. This extends timeframes as the office waits for the outstanding PA, and in some cases, this takes several attempts by the PDRP office to source the outstanding PA from the senior nurse.
When there are lengthy delays the relevant Director of Nursing is contacted to enlist their support to resolve the issue.

Recommendations:
Update the database assessment time parameter to 10 weeks
The end of year booking system; and assessment timeframes continue to be reviewed to mitigate timeliness of assessment and the return of portfolios
Continue to review assessment timeframes from both the database *and* applicant perspective.

Te Tiriti O Waitangi (competency 1.2/1.3) and Cultural Safety (competency 1.5)

Since the 2011 NCNZ Audit, there has been a focus on teaching and understanding Te Tiriti O Waitangi and Cultural safety, how this is applied to practice; and how to articulate practice and evidence within competencies 1.2 (RN), 1.3 (EN) and 1.5 (RN/EN).
The confusion between these competencies has been discussed at PDRP assessor update days, new applicant workshops, and resource nurse study days from 2011 until 2018.
After discussion with Ara Institute of Canterbury (formally CPIT) regarding a similar confusion issue in NETP education delivery, a level 7 Maori Health paper was developed at Ara Institute of Canterbury, with both CDHB and Ara staff teaching on the paper. In 2015 Phil Patira commenced his research study on how Maori Health and Te Tiriti O Waitangi is articulated within PDRP portfolios. At the unexpected passing of Phil in 2017, this research was discontinued.

At the focus group sessions for this review, PDRP assessors were invited to comment upon the evidence now articulated in competencies 1.2/1.3 and 1.5. When discussing these competencies with the applicants', their responses were varied in the focus groups. One applicant commented they provided the '*same evidence every time'*. Others stated they struggled to find evidence for 1.2 as there was not the opportunity to care for Maori patients in their service. Hillmorton Hospital nurses provided an in-depth discussion on these competencies, particularly on Te Tiriti O Waitangi, believing Maori Health and cultural safety has a strong background and awareness in mental health services. They find it easy to articulate and speak of 'Treaty in action', linking this directly to practice with comments, for example '*…looking at Maori patients and seeing what you can do to reduce their length of stay and improve their journey through the service. This includes ensuring comprehensive discharge planning involving whanau in this process…*' and '*…reducing barriers for example sorting childcare and making sure the Whanau is ok on the outside* [of Mental Health Services] …

Findings:
Each focus group discussed utilising Maori health services or workers in their practice.
Assessors commented that articulation of the competencies is improving, however they believed there continues to be variations in performance appraisals with the applicant's evidence being 'often stronger' than the Charge Nurse Manager's/senior nurse's evidence in the appraisal.
Evidence via reflection to meet these competencies, was well articulated in portfolios and it was felt applicants now have an overall better understanding about competencies 1.2/1.3 and 1.5.
However, some assessors felt applicants were continuing to mention the 'three P's' but not actually explaining how this is practised in patient/client/whanau care.
Overall, it was believed that the evidence provided for competencies 1.2/1.3 or 1.5 was evidenced mainly at proficient level, even within competent portfolios. Respondents believed these competencies were particularly well written by nurses working within mental health practice.

Further to this, the Resource nurses have been having discussion(s) with applicants on theses competencies, and usually begin their discussion/review with the applicant, on these competencies first. Resource nurses are aware these competencies often require re-work in PDRP applicant's understanding and articulation of evidence in some portfolios. A healthLearn module will also be developed in the future to help provide further education and resources for nurses.

Competencies 1.2/1.3 and 1.5 continue to be a focus of attention during PDRP education delivery, within NETP education and with individual nurses.

Stakeholder Evaluations: on-line Programme Evaluation: Survey Monkey

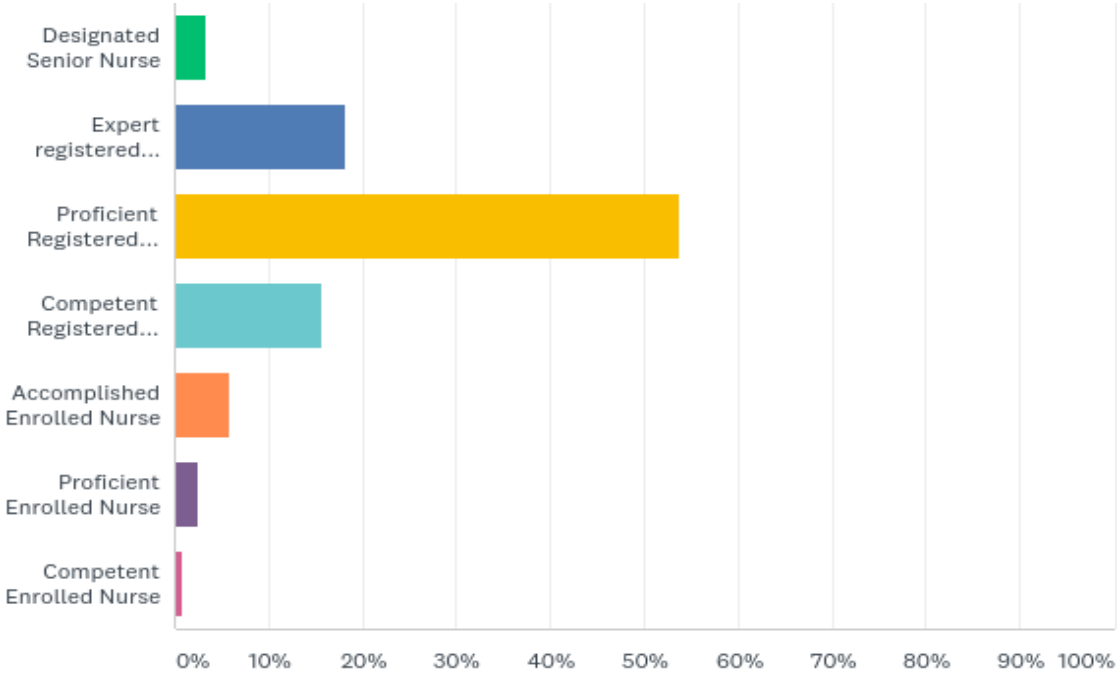
PDRP applicants, resource nurses and assessors are consistently invited to respond to surveys via the online evaluation tool 'Survey Monkey'.
This mode of evaluation commenced January 2018 to replace paper-based evaluations.
The following data includes responses from nurses nationally, who have attained PDRP via CDHB partnering organisations, including the Southern Region District Health Boards, and partners.
The data is unable to be extrapolated further from the Survey Monkey data, for the Canterbury programme evaluation.

PDRP Applicants: Survey Monkey

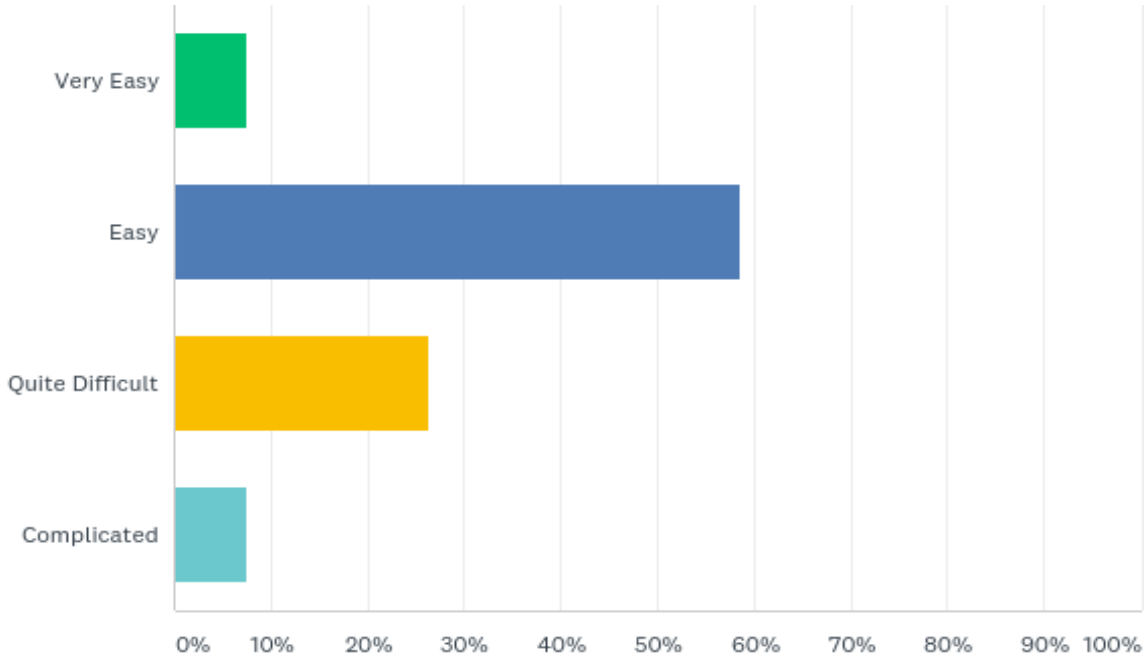
Nurses who successfully attained a level on Te Kāhui Kōkiri Mātanga PDRP were invited to complete a survey upon return of their portfolio. During January 2018 – June 2019, 122 nurses responded.

- 112 CDHB employees
- 10 partnering organisation nurses

Survey Monkey Respondents: level on PDRP



Applicants found the PDRP Process:

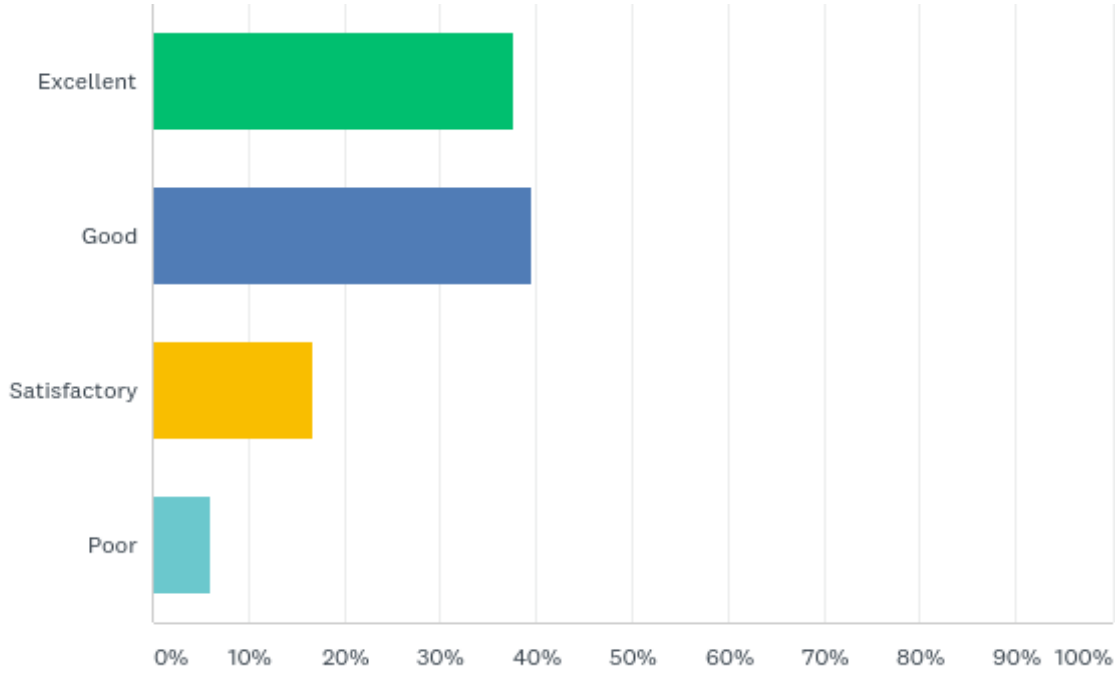


Findings:
Of the applicants who responded 66.1% found the PDRP process 'easy or very easy', with 33.9% finding it 'difficult or complicated'.
In a further question regarding the applicant's use of the PDRP guidelines, 80.9% found these easy to follow and 19.1% found these difficult.

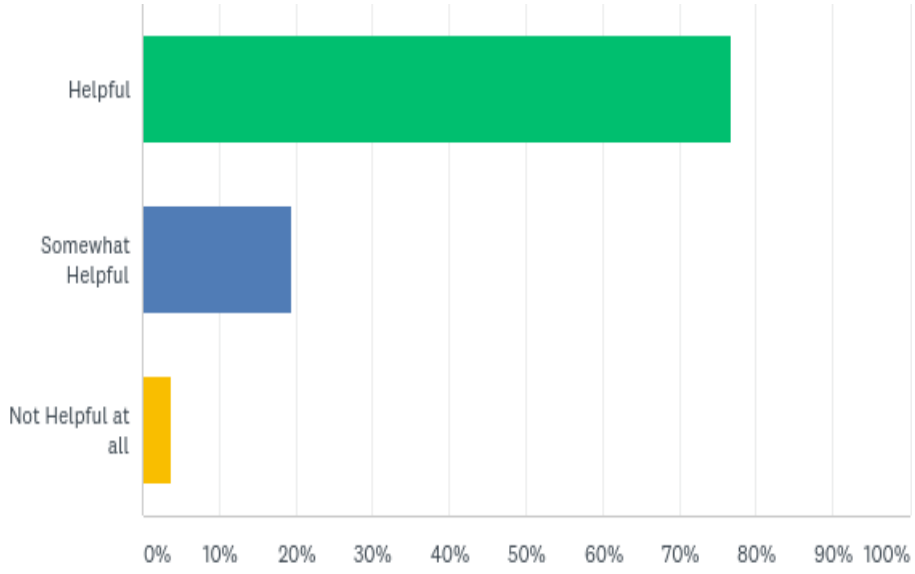
When questioned regarding their attendance at a PDRP workshop prior to submitting a portfolio, 25% had attended and 75% had not. When questioned if the workshop gave the applicants an understanding of the concept and process of PDRP, 88 responded to this question, with 55% responding in the affirmative.

The applicants were further asked if they sought assistance from a resource person before submitting their portfolio. Of the 119 applicants who responded to this question, 89.9% had been assisted by a resource person, and 10.9% did not seek assistance.
A further question asked applicants about the support they had received from the PDRP office regarding the submission process. Seven respondents replied they received poor support from the PDRP office and the remaining had satisfactory-good-excellent support.

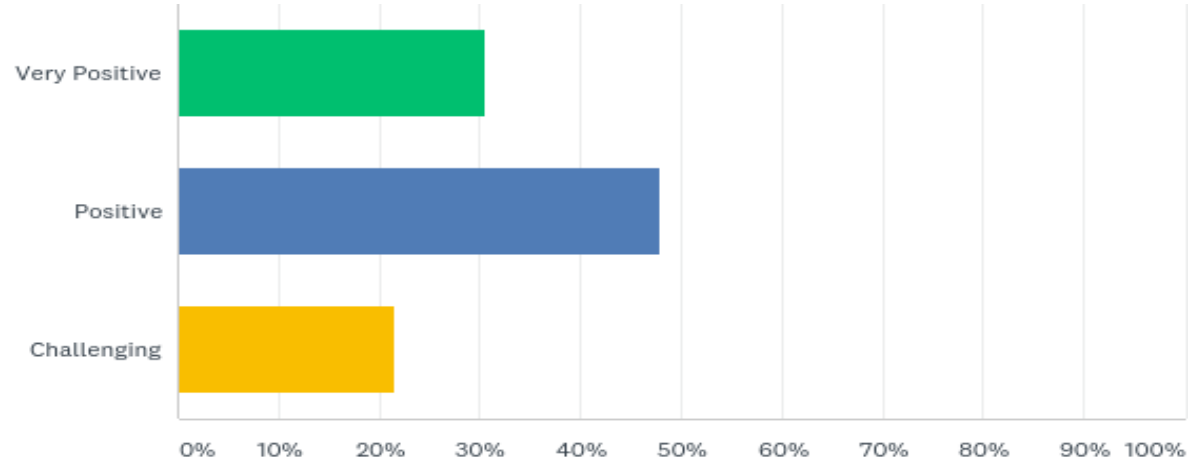
Applicant Support from PDRP team, Resource People, Colleagues:



Applicant(s) found the assessor comments and feedback received about their portfolio was:



Applicant(s) overall experience of collating, submitting and having their portfolio assessed:



Findings:
Overall, respondents felt that the evidence required for Proficient, Expert or Accomplished level is appropriate and realistic. Many felt the performance appraisal (PA) with examples meant there was a lot less evidence required to submit overall within a portfolio. Having '*a good PA is a very good start'* (PDRP applicant, p 1414/ (sic), Survey Monkey).

Applicants offered suggestions via Survey Monkey to further improve the PDRP submission process. Those that had re-submitted portfolios found the process easier. One respondent requested the emphasis to be placed on the performance appraisal statements as it reflects more accurately the current practice of the nurse. There were issues around the submission documents or their format changing during a portfolio submission, although when using the new system of documentation nurses felt it easier to navigate.
Nurses were pleased to have 'unnecessary paperwork' removed from the process. There were requests for regular updates to be communicated regarding any changes to process requirements and documentation.
Some respondents felt confused with the 'inconsistent advice' they received from nurse colleagues and then from their Nurse Educators/PDRP resource people.
One respondent requested the resubmission of portfolios every five years and not three-yearly.

The majority felt the revised PDRP intranet site easy to navigate, although a small number of respondents found this difficult. During the period of the Survey Monkey evaluations, the website underwent change to ease navigation issues for applicants. Equally applicants found the guidelines easy or difficult to navigate.

On-line survey questions and answers did not indicate how PDRP applicants applied their attainment of PDRP to patient outcomes.

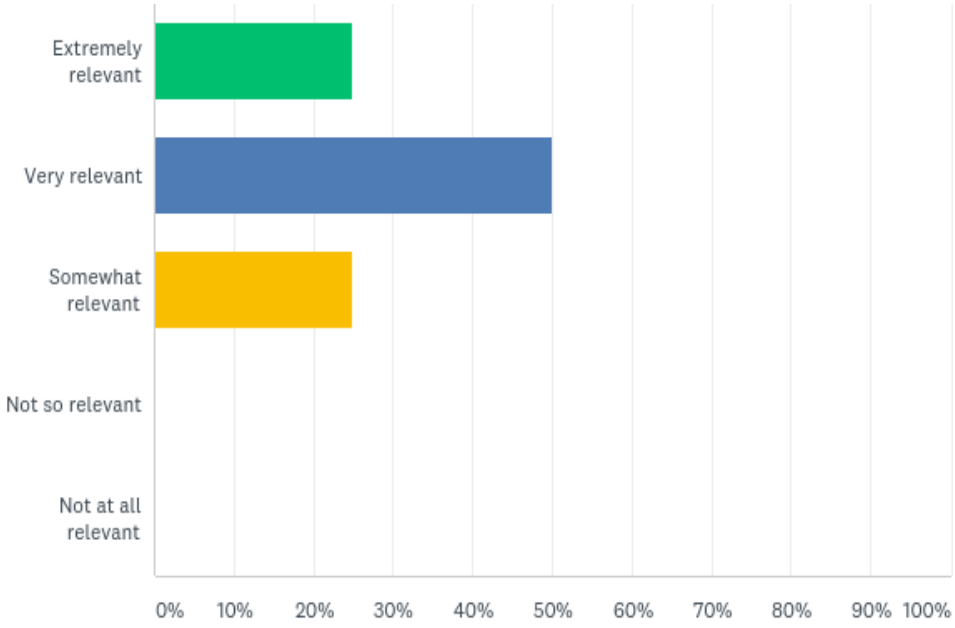
The guidelines have since been reviewed to reflect changes indicated earlier in this evaluation and refined to alleviate any confusion.

PDRP Applicant Workshop Evaluation: Survey Monkey

Thirteen nurses completed the online survey monkey evaluation following a CDHB workshop which introduced them to the PDRP process. Support was offered to complete a PDRP portfolio submission.

Findings:

All respondents felt the study day was of value to them, and three found the PDRP website information only 'somewhat relevant' to completing their portfolio, as indicated here:

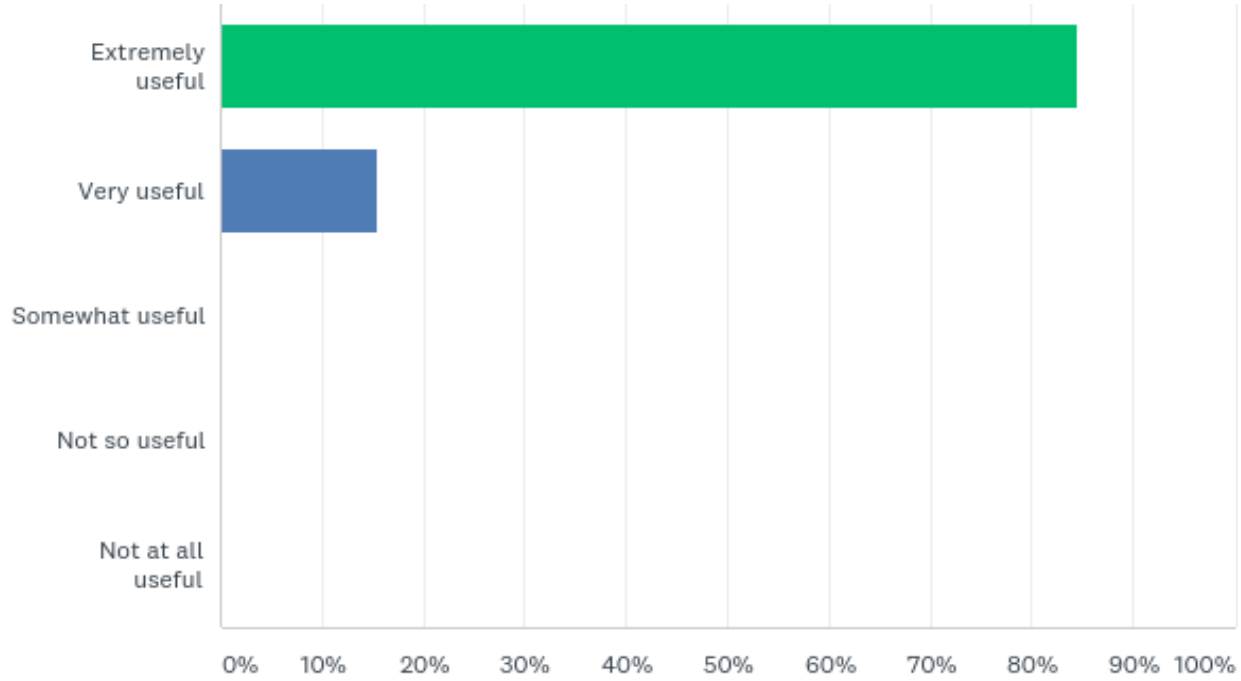


An education session delivered by the Executive Director of Maori and Pacific Health, CDHB, about competencies 1.2 (Te Tiriti O Waitangi) and 1.5 (Cultural Safety), was well received by the nurses attending the workshop for new PDRP applicants.

Nurses found the education was applicable to practice and it clarified how to evidence practice within the portfolio. Their comments were positive and reflected the individual education needs of individual attendees at the study day.

Comments included '[*I will] continue to apply three P's in practice and to put actual example while preparing PA*'; [*this] 'session was really really* (sic) *valuable to me'…'awareness of disparities in health especially with all the young people in the Maori population'…'loved the message and background to the Treaty'…'[I will] integrate partnership, protection, participation with caring and sincerity*…' (Applicants, Survey Monkey, 2018).

Was the education useful to completing competencies 1.2 and 1.5

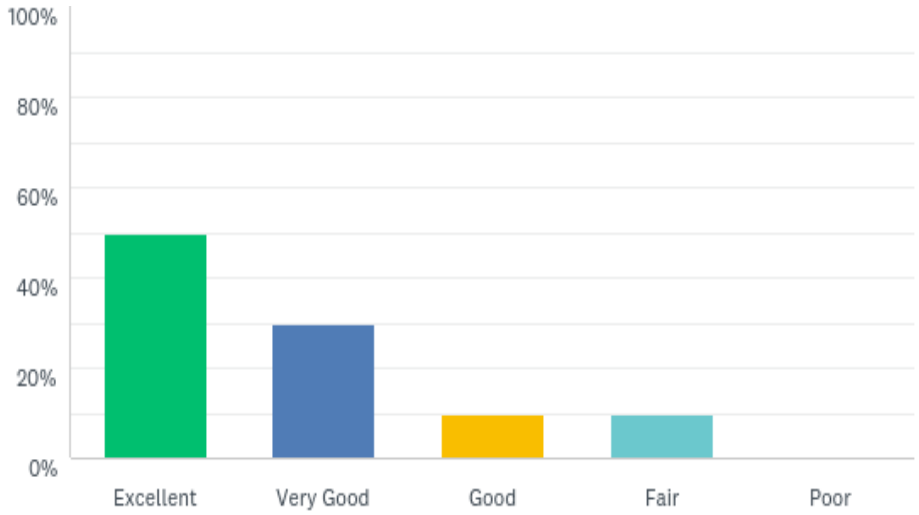


Current Assessor Update Day: Survey Monkey

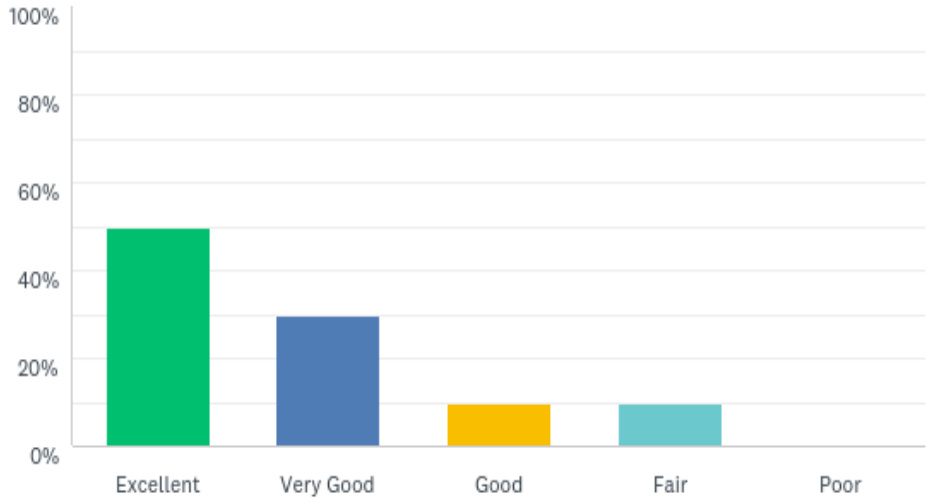
Current PDRP Assessors who attended an update day in 2018 and/or 2019 were encouraged to evaluate via Survey Monkey. This day was the first review via Survey Monkey, with 11 attendees responding.

Findings:
The results indicated all attendees found the day '*very good*' or '*excellent*'. They found the speakers were experienced, knowledgeable and the information was relevant to their role as an assessor. Focus groups were held during the study days held in 2018 to supply the data for this evaluation. One assessor responded to the 'activities' about feedback processes and assessment, as not meeting their needs as an assessor.

Assessment Activity: Competencies and Indicators: Education Session



PDRP Feedback Processes for Assessors: Education Session:



New assessors found value in attending the assessors update day, particularly the moments of discussion with the more experienced assessors.
Programme changes and competencies were discussed, and the applicants commented upon the value of this discussion. The study day attendees requested further education, particularly about assessing senior nurse comments [evidence] within performance appraisals regarding meeting the competencies.
The Nurse Coordinator PDRP provided guidance at this forum about seeking further evidence from applicants and from senior nurses, to meet competency and indicator evidence at the different PDRP levels.

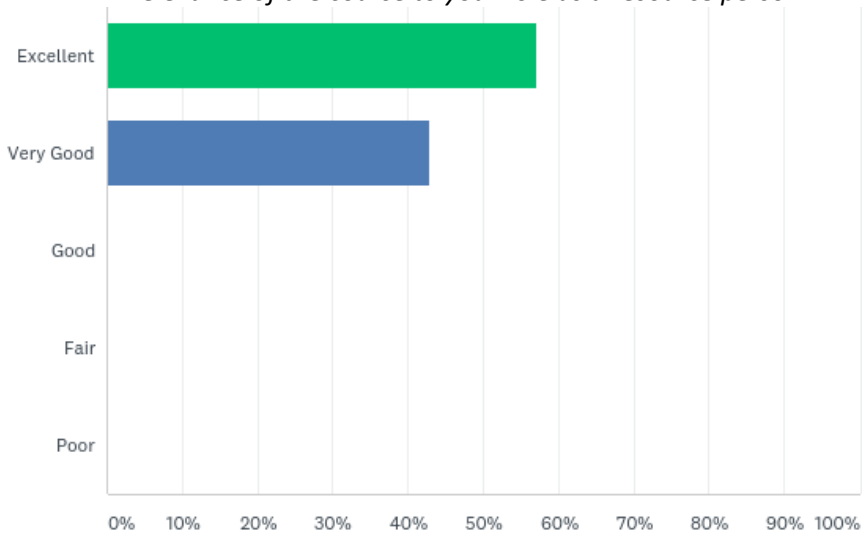
Resource Person Training: Survey Monkey

Of the 56 CDHB nurses who identify as a Resource nurse for the PDRP, eight attended education and evaluated resource training which was held in 2018.
Some assessors also assist their colleague's with portfolio development within the clinical environment.

Findings:

Some resource people who have attended the PDRP Assessor Update days are not 'registered' as a resource person on the PDRP database.
Of the respondents who attended the resource training, 100% indicated '*good, very good or excellent*' to the overall value of the course.
The attendees valued having discussion time to highlight issues, and to share stories and experiences when supporting PDRP applicants.
One attendee found it invaluable to engage with colleagues because of their '*professional isolation*' in a '*satellite hospital*' (applicant, Survey Monkey, 2018).

Relevance of the course to your role as a resource person:



Focus Group Survey

Focus group surveys (Appendices 2-5) were held between September 2017 and December 2018. 125+ registered and enrolled nurses attended focus groups held within the Canterbury region. An attendance list at one focus group was not taken, in error.

Some focus groups were undertaken during PDRP study days, with the option to opt-out if the attendees wished. This medium captured the maximum number of assessors and applicants over a period of one year at the PDRP study days.

Attendance was invited and there was no coercion to participate at any focus group. Although focus groups were held at the Ashburton, Burwood, Christchurch and Hillmorton Hospital sites, nurses were invited to attend from across the CDHB and the partnering organisations, and non-government organisations within Canterbury to attend any group. Five nurses unable to attend focus groups emailed with their comments.

PDRP level	Focus Group Attendees
EN Competent	0
EN Proficient	11
EN Accomplished	10
RN Competent	0
RN Proficient	41
RN Expert	32
Designated Senior RN	18
Expired PDRP	2
Not engaged in PDRP	11
Email responses	5
Attendance not identified#	Unknown (+/- 20)
TOTAL ATTENDANCE	*125+

 # One focus group attendance was not recorded
Includes 52+ assessors and six+ resource nurses.

PDRP Applicants: Focus Group Survey

To meet the philosophy of the methodology of this review all focus group attendees were asked what aspect of the PDRP process they most enjoyed.

Findings discussion:
The nurses had an overwhelming response to factors that influenced them personally in attaining their PDRP. How they felt successful and validated by being at their level of practice on PDRP. Without prompting, each focus group discussed the personal benefits they experienced. The initial response was to discuss the financial remuneration tied to proficient, expert/accomplished levels on the PDRP. Equally they discussed the need for the registered nurse to successfully complete PDRP to access funding for post graduate papers, a requirement of the Canterbury region post graduate funding process. They understood the equivalency process - which was still a current requirement by the nurses at the time of the focus groups - and talked of their feelings of success, when they achieved this prior to their RN Expert application.

Nurses articulated how their practice was validated by participating in PDRP. Engagement with the programme influenced their thinking about nursing as a professional person and influenced their thinking on their individual practice. It reaffirmed where their practice was positioned, '*Yes. I do actually work at proficient or expert level*' (applicant 6 September 2017). Some nurses believed it was more beneficial to undertake competence assessment by their peers via the PDRP process than being audited by NCNZ.

Participation in PDRP fostered nurses to reflect upon their practice more, raising their self-awareness of clinical practice. Developing a portfolio made nursing visible for them, which influenced their feelings of being positive about practice and what they were doing in practice was of personal value. Their self-awareness as a nurse increased, and influenced, or '*promoted*', their professional growth. Engagement in PDRP clarified their future development or pathway in nursing.
The nurses articulated the relationship between PDRP and their nursing practice commenting upon the value of reflection as influencing their practice. They had continued to reflect upon their practice and how reflection enabled them to link to their scope of practice and the NCNZ competencies. They commented about this enabling them to articulate practice and how it supported their writing the evidence within the competencies.

The nurses saw the value of learning about, and updating themselves, on the changes to the PDRP application process - gaining a further understanding of the evidence required for PDRP. It enhanced their thinking about PDRP, '*it takes us off autopilot and makes us realise what we are doing*' (RN, 18 January 2018).
They overwhelmingly talked of enjoying sharing their knowledge with colleagues and enjoyed being able to succinctly and professionally articulate practice to others. They particularly enjoyed sharing their knowledge with new colleagues and graduate nurses.

Some nurses within partnering organisations discussed how PDRP was compulsory in their organisations. One CDHB nurse stated that it was a requirement in their clinical area to participate in PDRP, which then enabled them to practice at an advanced level of practice in their clinical area. Upon further prompting they acknowledged that this was not the process for other CDHB clinical workplaces and felt slightly disadvantaged that they did not have a choice in being able to undertake the PDRP.

Nurses were consistently aware of the evidence that was required for their [next] portfolio submission when they were in clinical practice. They sought out activities to continue fulfilling their PDRP level requirements and searched for the next audit or teaching session, for their next portfolio and opportunities to share their knowledge with colleagues.

Further to this, achieving at a certain level clarified the differences between the levels for applicants. This was particularly evident for nurses scaffolding from proficient to expert RN status. However, one nurse explained how they had failed to see any evidence within their own practice at expert level, but their colleagues had recognised this in them, talked to them about it, which then enabled them to clarify their practice and see it at this level. They then went onto submit a portfolio at expert level with the support of colleagues. These workplace discussions influenced their decision to apply to PDRP at that level.

The nurses valued the support and friendliness of the staff in the PDRP office, and from their resource people and senior colleagues. They discussed the feedback received from the PDRP process/assessment, which encouraged further their professional goal setting. They believed this support encouraged them in their role and influenced their role-modelling of nursing practice to others.

Gaining PDRP made them feel they could '*show them* [Nursing Council] *you are working at proficient/expert level*' (RN, December 2018). Some talked of enjoying talking with their nurse manager in the performance appraisal meeting and gaining feedback on their practice.

Gaining PDRP also encouraged nurse accountability, giving them a greater understanding of certain competencies (e.g. competency 1.5 Cultural Safety) which in turn influenced their changing understanding about their own cultural background, and therefore influenced further application of cultural safety to their own practice.

The nurses whom had not yet engaged in the PDRP process saw the benefits within their colleagues and the changes which resulted in nursing practice. They saw changes in the team, and new knowledge and education being shared. They felt supported in practice even when they were not applying for the PDRP process. These focus group respondents noted how their colleagues who had attained success on the PDRP, also appeared to influence another colleagues' practice from their viewpoint. They saw a change in the overall practice in some clinical areas as their PDRP nurse colleagues, and non-PDRP nurse colleagues, took more responsibility for quality activities and oversight and education of colleagues.

Influencing nursing practice: Applicant's Focus Group Survey

Focus group respondents understood how they influenced nursing practice in their workplaces with attainment of PDRP. The respondents believed that they had an increased awareness of how they were nursing and therefore they utilised broader profession-related documents (e.g. NCNZ guidelines). Further, they felt they were engaging more fully with other health programmes within the workplace, for example *Releasing Time to Care*. Some respondent's felt they had a greater recognition of '*what is Quality*'.

They therefore encouraged other nurses to apply for PDRP, particularly nurses applying for expert level. One nurse was surprised at being encouraged by a colleague to apply at expert level, and felt positively that 'at *expert level, others expect more from you*' (applicant 29 January 2018).
Since achieving on PDRP they felt they were now able to speak the '*language of nursing'* and utilised this more in practice. Most nurses agreed they provided an increased professional and clinical support to colleagues in practice, the '*snowball effect*' as one applicant stated.

Respondents commented upon the benefit of being recognised in the workplace at the PDRP level they were successful at. Gaining recognition on the PDRP gave the nurses more confidence to help others, increased their awareness of the competencies in the workplace when working, and when assisting others. Achievement on PDRP increased their awareness of responsibilities as an individual nurse, and within their team. It influenced their willingness to help other applicants in their own PDRP process, and although not formally recognised as a 'PDRP resource nurse', successful applicants undertook this role in support of their colleagues. PDRP reinforced their achievements professionally at a '*higher level'* than they at first thought possible.

Two applicants believed gaining PDRP did not benefit practice at all, with one making the statement, on behalf of others at their workplace that '*enrolled nurses did not feel PDRP was beneficial'.* One nurse believed that the '*senior nurses are out of touch…and are helped by younger nurses coming through*' (applicant 6 September 2017).

Influencing Patient Outcomes: Applicant's Focus Group Survey

Applicants were asked how achieving on the PDRP influenced patient health outcomes. Most nurses linked PDRP to their overall nursing practice rather than direct person-centred care, and stated they were more likely to share their knowledge around their peer group and therefore '*everybody's practice improved'*. They reflected more on their nursing practice rather than commented about the individual patient/client. Discussion then all moved onto influences on wider nursing practice, for example the nurses had an improved awareness of quality improvement, felt they led by example, and role modelled practice to their colleagues and students.

The focus group respondents had an increased commitment to educating colleagues who weren't on PDRP, influencing them to become involved in improving practice and to submit a portfolio.

One nurse commented that patient care improved if '*resources were good'* within the workplace.

Linking success on the PDRP to health outcomes is not collected in programme evaluation surveys, and is an opportunity for future quality initiatives in the programme

Issues for PDRP Applicants: Applicant's Focus Group Survey

During focus group discussion applicants voluntarily spoke of the most common issues that arose for them within the PDRP process.
Most prevalent was the different views or standards of examples and evidence, which were given by their resource nurse and the assessor of their portfolio. Applicants felt there was a lack of consistency of information between resource nurses and assessors.

One focus group of assessors discussed applicants submitting an '*unrealistic portfolio*', for the PDRP level they had applied for, and which then required a large amount of further evidence to be supplied for the assessment at that level. The discussion centred on the '*requests for further evidence'* - and how this could be discouraging colleagues/future applicants to attain on PDRP (6th September 2017). One nurse stated the '*Charge Nurse Manager is the best measure of your competency*' (11 December 2017), articulating how the Charge Nurse Manager has more oversight and understanding of nurses' practice than PDRP assessors.

Nurses found the quality component (PDRP Domain Four) difficult to meet in the workplace at proficient, expert and accomplished levels. This is an issue for enrolled nurses who stated they did not always undertake or lead a quality audit.
In some workplaces both enrolled and registered nurses are asking to facilitate an audit and their requests are being declined by the line manager. For the EN proficient level the nurse has the choice of a practice change or a quality initiative; and for the EN Accomplished level, they provide a change process activity and a quality improvement.
After this discussion within an early focus group further discussion on quality initiatives were held during remaining focus groups, particularly during the focus groups on study days, as it appeared there may have been a difference of understanding on quality initiatives/activities between the nurses.
Some nurses believed quality was purely working with the Corporate Quality team, or auditing, and were not aware that their attendance and contribution within meetings to improve patient care was a quality activity. This discussion was utilised as an education opportunity within the PDRP assessor and resource nurse study days during 2017-2018.

Many applicants commented upon the paperwork required for submission, and felt the paperwork onerous, 'proficient *level is too hard to attain as there is a lot of information - some don't know where to start, as the paperwork can be overwhelming'* (applicant, 11 December 2017). One felt PDRP was not unified nationally and harder to attain in Canterbury than in Wellington.

The Website is difficult to navigate for many applicants, '*not user friendly and very confusing, it takes ages to find something that you know is there, as you have seen it before, but you just can't find it*' (applicant 29 January 2018). There was a consensus from the group that this is possibly the reason older PDRP templates were occasionally being used in portfolios, and the reason for photocopy's of PDRP documents existing in some workplaces.
Nurses appeared to know that this was occurring, with some focus group attendees admitting to the clinical areas having photocopies for colleagues to use yet knowing these copies may not be the most recent version.

Assessment timeframes were commented upon as an issue. An applicant gave the example of being contacted for further evidence more than six months after submitting their portfolio. Another, speaking on behalf of a Charge Nurse Manager (CNM), believed that there was '*poor communication from the assessor to what further evidence was required*', and it '*wasn't requested in a timely manner*' (29 January 2018). One nurse disputed the extended time frames for assessment as an issue, as they had their portfolio assessed and returned within 3-4 weeks.
There were differing timeframes between colleague's submissions from one workplace. One portfolio was assessed within a few weeks, and their colleagues was assessed some months later,

when both portfolios had been sent to the PDRP office on the same courier. Both had not required any further evidence for successful assessment.

Two nurses from one clinical area felt the PDRP process was a barrier in itself, commenting upon the enormity of the work and time involved, the computer literacy required, the Performance Appraisal '*not been attained in a timely manner and not done properly*' (applicant 29 January, 2018), feeling they needed a step-by-step guide, not getting study leave for portfolio development, and asking what to do when there is a conflict between the CNM and the applicant. They felt it was an unfair process for older nurses but did not elaborate further on this other than to discuss computer literacy. Both applicants had successfully attained a level on the PDRP and are colleagues within the same clinical area.

Enrolled nurses felt they had missed out on the [then current] MECA pay rise, and as a result more enrolled nurses were looking at submitting their portfolio. '*Payment is an incentive to carry on*' (applicant, 11 December 2017).
Some focus group respondents felt being audited by the NCNZ was '*more straight forward*' than the PDRP process.

The following requests for programme improvement were received from applicants:

Templates/documents:

- *The PDRP guidelines need to be condensed*
- *CV should be taken out of the portfolio*
- *There's duplication in the portfolio, the Annual Practising Certificate is checked by the Charge Nurse Manager and then checked again in the portfolio*

Website:

- *Access to the website can be difficult, with some having trouble finding the information*
- *Overall statement of learning needs review on the website.*
- *Website to be updated more frequently,*
- *intranet and internet pages need to be easier to follow*

Communication:

- *Communication regarding delays to assessment – applicants wish to be informed if their portfolio had been accepted or even arrived at the PDRP office, or where the assessment was at*
- *Assessors and applicants requested information on changes to PDRP, no matter how small*
- *Emails should be sent if changes made, or on receipt of portfolio into office*
- *Communication is best via email*
- *More resource days are needed*
- *Newsletters to be more frequent on where changes are at, or on the website, making announcements for example, 'Portfolios submitted in July are currently being assessed, September is still waiting assessment'*

Other:

- *Clarification of the Resource role*
- *The practise discussion at expert level 'is meaningless' and ticking the box does not explain what this means.* (This is no longer a requirement for PDRP)
- *Discontinue resubmitting every three years if still working in the same area, resubmit if you change areas*

Recommendations:
Review workplace education on EN quality initiatives and quality improvements to assist the EN PDRP pathway
Review the 'practice discussion' section within PDRP documentation
Review website to ensure alignment with documentation (e.g. overall statement of learning) at regular intervals
Review if a regular newsletter would communicate to nurses any assessing issues, or timeliness of assessment process

Resource Nurse Feedback: Resource Nurse Focus Group Survey

Six resource nurses provided feedback via focus groups. They were asked what they most enjoyed about their role:

Findings discussion:
Resource nurses enjoyed being able to provide information and working alongside colleagues to help them achieve on the PDRP. They believed they promoted growth and professional development of nurses. It validated their own practice by using their own knowledge to support others.

Their most common issue was the applicant seeking resourcing of a portfolio on the day it was to be submitted for assessment. The resource nurses felt applicants were simply '*looking for a sign off, and not help to do it*' (resource nurse, September 6, 2017).

Secondly, PDRP applicants were hesitant to make changes within their portfolio after receiving advice from the resource nurse. Some resource nurses felt this undervalued their role and the PDRP process. Portfolios were thus being submitted without the recommended changes, and then when assessed they required further evidence or corrections sought by the assessor, lengthening the assessment timeframe. Resource nurses were aware this was happening, but knew it was up to the applicant to follow through on advice.

The resource people felt they needed a greater pool of resource nurses and more training time. They felt they required more ongoing education, due to the difficulty being released for a three-hour training session, as currently occurs.

Assessor Feedback: Assessor Focus Group Survey

Assessors were asked what they most enjoyed about their PDRP role when assessing competence via a portfolio of evidence.

Findings discussion:
Overwhelmingly, the assessors enjoyed reading about another nurse's practice. It validated how they were practising themselves and '*bench marked*' their practice.

The main issue for assessors was the response time to requests for further evidence; or waiting for the performance appraisal from a charge nurse manager or team leader to be completed. Currently

some portfolios are submitted without a completed performance appraisal to meet individual time frames, at the discretion of the PDRP office.
Other issues are the Charge Nurse Manager/team leader '*copying and pasting*' comments with obvious differences in language, style and size of font in documents. Assessors commented upon the wrong name, or gender title (his/her) being used by the CNM in their evidence within the performance appraisal. Some assessors discussed the issues of trying to contact CNM's and team leaders, due to their availability, or a change of roles/clinical areas of either the applicants or CNM's.

Assessors discussed the PDRP paperwork retrieved from the website had not changed to keep pace with the programme changes, for example the performance appraisal form, assessor feedback forms, role overview form. The website performance appraisal documents also required further formatting when downloaded and used by assessors; and there were issues with downloading the iPerform performance appraisal when completed, for the portfolios. It was also discovered at one focus group that one division within the CDHB was using iPerform only, for all nurse performance appraisals, yet these were not routinely used by the remaining divisions within the CDHB.

The assessors all agreed that moving to a three-year appraisal process for all nurses (PDRP and non PDRP) would make the workloads easier on senior nurses undertaking appraisals for staff.
Assessors also struggled at times to match the evidence of the level applied for, to the level's competence indicators. In these situations, the applicants were writing to the competency and not to the indicator.

Core components/competencies for external organisations, or any organisation other than the assessors own, created problems during portfolio assessment. Where the CDHB required Cardio Pulmonary Resuscitation and Fire training as a core component which is assessed as being completed, there is an expectation this is the case for all organisations during assessment – these are not always provided as evidence in a portfolio from another organisation. Since the focus groups, this has been reviewed and including core competencies in a portfolio is no longer a requirement, becoming a workplace obligation to meet workplace competencies.
The abbreviation EPT (Emergency Procedure Training) within the CDHB, posed problems for assessors outside the CDHB, who did not know that this included Fire Training.
These were issues at the time of the focus groups and have since been resolved.

Assessors struggled to find the time to assess portfolios in their current role or practice area and were then assessing during personal time at home. This is an issue particularly in primary General Practice areas, who agreed that they would rarely find time in clinical hours to assess. They reaffirmed this by discussing the '*business model'* they work under in General Practice. After the focus groups this was discussed further with some partner organisation PDRP lead nurses who identified that paid time is available for PDRP assessing.
Some CDHB assessors stated their workplace rostered them days away from clinical to assess, which alleviated this issue, although many CDHB assessors opted to complete portfolios at home in their personal time, because of the distractions within the clinical area.

One assessor felt that practising in isolation within a community organisation was an issue for her and appreciated coming to assessor update days for collegial support and problem solving.

Predominant finding:
Nurses from all the focus groups particularly enjoyed reading about other nurses' practice in their various PDRP roles – as an assessor, resource nurse, or as an applicant being shown a portfolio by their colleague. This was an overwhelming theme throughout the focus groups - the desire to read and learn about others' practice encouraged them to continue as PDRP assessors, or to continue with their own application process.
The impact of reading about their colleagues practice further encouraged them to continue to write about their own nursing after attaining success on PDRP. Some nurses spoke of this influencing them to amass evidence over the three-year period between portfolio submissions, in preparation for their next portfolio. They were continually looking for ways to link their practice to how they provided this as evidence in their portfolio.

Senior Nurse Feedback: Senior nurse Focus group survey

Senior Nurses were asked, during a focus group held at the Nursing Entry of Practice assessment centres, what they saw as the positive aspects of PDRP. Of the respondents in this focus group, two senior nurses had attained success on the PDRP.

Findings discussion:
There was a positive response with the senior nurses seeing changes in individual nurse practice in their clinical area, and role modelling practice in the workplace. Education attendance had improved in the workplace, and nurses were seeking quality activities. Nurses were offering to support colleagues in non-clinical activities. They were seeing new nurses, or '*junior*' nurses '*stepping up*' in non-clinical practice, e.g. quality audits, or offering to review a document.
The senior Nurses involvement or role in PDRP was assisting applicants to write performance appraisals or writing the senior nurse assessment of the appraisal. '*I find most staff who are embarking on PDRP process struggle to get their head around the best way to write appraisals, how to include specific non-identifying examples, to demonstrate level of competence*' (email, Senior RN, 2017).
And further '*Nurses who do their PDRP hold their heads high as they feel they really showcase their role and professional development*'.
All the senior nurses nodded in acknowledgement, and agreed with, a comment that time is a factor in writing performance appraisals. When having an appraisal meeting, having the time to write the appraisal and completing the process to sign off, was identified as an issue for the CNM group. There were variations on how the senior nurses completed this, some delegating this to other nurses in their departments, and others completing 40+ appraisals per year.

Further feedback involved dissatisfaction with the repetition in the PDRP documentation, and requesting the webpages be reviewed and reorganised.

One senior nurse requested that the appraisal system could tick 'achieved' for each competency, rather than having to complete a full performance appraisal for each nurse.
Senior nurses were asked what would improve the programme from their senior RN perspective.
Most of the discussion revolved around reviewing the PDRP templates/documents, the website, and improving communication to and from senior nurses on changes.

Summary

Nurses from all levels of nursing within the Canterbury District Health Board and Canterbury partners were invited to participate in this evaluation via focus group survey. Data was also collected from the PDRP database, participant and stakeholder evaluations, and communication with PDRP operational group members.
Participants of the focus groups identified an in-depth understanding of the PDRP process and portfolio development. Discussions were robust, insightful and invaluable in providing evidence to the PDRP operational team regarding what works well within the programme and what can be improved.

During this review process recommendations have been made regarding documentation, the PDRP process and website, and to improve communication with stakeholders. Recommendations regarding these areas have been identified and implemented concurrently during the review. Improvements have been implemented with the support and input from the PDRP operational and advisory groups enabling a programme that supports the nurses applying for PDRP, the resource nurses and assessors.

During this review period the PDRP team has undergone significant change within its personnel, with the resignation and appointment of the PDRP coordinator, long term leave of two administrations assistants, and the resignation and subsequent appointment of administration assistants. The PDRP office moved from the Princess Margaret Hospital into the CDHB Corporate building in 2016, and further moved into the Health Education and Research facility 'Manawa' in 2018.
During this time the PDRP office has provided support to nurses undertaking the PDRP process, and supporting assessors and resource nurses, and senior nurses in practice, while undertaking the concurrent changes noted in this review.

Recommendations

Focus group participants, and Survey Monkey respondents have requested areas to improve the PDRP process. Many of the issues raised have been reviewed and improved during this review.

It is further recommended that:

- The programme be evaluated in 2025, as required by Nursing Council of New Zealand (2013), to include focus group surveys
- Review communication to stakeholders, for example: establish a 'what's new' section on the PDRP webpage, updated with changes and improvements; or if a regular newsletter would communicate to nurses any assessing issues, or timeliness of assessment process
- Review the PDRP evaluations to enquire how PDRP is influencing nursing practice, and patient/client and whanau health and wellness outcomes
- The Princess Margaret and 'Older Person's Health' data to be included in the 'Specialist Mental Health and Addictions', and 'Burwood Hospital' data sets.
- PDRP Education sessions have a current lesson plan and Kirkpatrick evaluation
- Update PDRP database resource personnel
- Review how PDRP utilise assessors, who do not complete a minimum of eight assessments per annum

- Review the Memorandum of Understanding to reflect practice, regarding Assessors and Resource person roles
- Update the database assessment time parameter to 10 weeks
- The end of year booking system; and assessment timeframes continue to be reviewed to mitigate timeliness of assessment and the return of portfolios
- Review assessment timeframes from both the database *and* applicant perspective
- Review workplace education on enrolled nurse quality initiatives and quality improvements to assist the enrolled nurse PDRP pathway
- Review the 'practice discussion' section within PDRP documentation
- Review Te Kāhui Kōkiri Mātanga website to ensure alignment with documentation (e.g. overall statement of learning) at regular intervals

Acknowledgements

The PDRP team wishes to thank members of the PDRP operational group, PDRP advisory group, Canterbury region health personnel, including resource nurses, assessors and the PDRP applicants for their understanding during the last five years of changes within the PDRP team, and the programme.

We also want to acknowledge the support, collaboration and partnership of the wider Te Kāhui Kōkiri Mātanga PDRP group who provide ongoing commitment and dedication to this valuable programme.

The support and guidance of the PDRP Advisory group for the oversight of Te Kāhui Kōkiri Mātanga PDRP is gratefully appreciated and received by the PDRP operational team.

Thank you to the PDRP applicants and focus group participants of this review.

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Nursing Workforce Development

Canterbury District Health Board
March 2020

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Appendices

Appendix 1: Historical changes to CDHB PDRP

Changes since PDRP commencement:

2005:
The PDRP programme was implemented using the 2001 eleven Nursing Council of New Zealand (NCNZ) competencies. NCNZ (2005) Registered and Enrolled Nurse Competencies were introduced following the audit visit by Council. There was extensive consultation on the indicators under each competency for both scopes and these were successfully implemented in 2006.

2009:
In November 2009 the National Evidential Requirements for PDRP came into effect and were appended into the National Professional Development & Recognition Programmes Working Party (2005).

Programmes were given two years from January 2010 to align their PDRP evidential requirements to the National requirements. The Regional PDRP worked on a rollout timeline and after consultation with nurses in practice integrated these change requirements into documents by June 2010.

2010:
A PDRP Regional Website was established to ensure ease of access for all nursing staff and a point of reference for all regional partners. This has been a significant improvement for nurses, increasing accessibility to the PDRP

In February 2010 an evaluation project plan for the Regional programme was presented to the PDRP Regional Advisory Committee and was approved. The evaluation plan included key stakeholder focus groups, including applicants; nurses not currently engaged with PDRP; senior nursing staff including line managers; resource staff and assessors.

A Postgraduate Educational Equivalency process was established as an option for registered nurses who are applying at expert level, and who have not had access to postgraduate level 8 education but have achieved the equivalent knowledge, skills and attributes through other pathways. Equivalency applications are assessed quarterly by the Postgraduate Equivalency committee.

Canterbury District Health Board. (2013). *Professional Development Recognition Programme Evaluation Report, 2005-2012*. Author

Appendix 2: Focus Group Survey Applicants

Focus Group: PDRP Applicant Group

Date:
Venue: Burwood Hospital, CDHB
Lead Interviewer: Jo Greenlees-Rae
Scribes: Aoife Sweeney, Louise Hoban-Watson

Introduction:
Thank You:
Attendance:

Focus Group Questions:

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1 How many in this group are **currently** on the PDRP?
Competent:
Proficient:
Accomplished/Expert:

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2 What aspects of the PDRP process do you enjoy and why?

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3 As a PDRP Applicant, what are the most common issues that arise when you are applying for PDRP?
Prompt: Performance Appraisals: CNM, timeliness

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4 How does achievement on the PDRP influence your nursing practice?

5 How does achievement on the PDRP influence others in your workplace?
Prompt: what does success look like with regards to individual nurse's practice?

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6 How does achievement on the PDRP link to patient outcomes in your workplace?
Prompt: what does success look like with regards to patient care?

_____

7 What changes to the programme would improve the PDRP programme?
Prompt: Think about the issues that arise when assessing

_____

7 You will be aware that there has been a focus on competencies 1.2 (Te Tiriti O Waitangi) and 1.5 (Cultural Safety), tell me about the evidence you are providing for these competencies now.

_____

8 What further support do you require to continue being on the PDRP programme?

_____

9.
For those nurses here who are not actively engaged in PDRP can you talk about the reasons?

_____

10 Is there anything further you wish to comment upon?

_____

Thank you
PDRP Team

Appendix 3: Focus Group Survey: Resource Nurses

Focus Group: PDRP Resource Group

Date:
Venue: Corporate, CDHB
Lead Interviewer: Jo Greenlees-Rae
Scribes: Aoife Sweeney, Louise Hoban-Watson

Focus Group Questions:

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2 How many nurses within this group are currently on the PDRP?
Competent:
Proficient:
Accomplished/Expert:

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9 What aspects of the Resource role do you enjoy and why?

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10 As a PDRP Resource person, what are the most common issues that arise when you are assessing a portfolio?
Prompt: Performance Appraisals: CNM, timeliness

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11 How does achievement on the PDRP influence nursing practice of those individuals in your workplace?
Prompt: what does success look like with regards to individual nurse's practice?

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12 How does achievement on the PDRP link to patient outcomes in your workplace?
Prompt: what does success look like with regards to patient care?

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_____

13 What changes to the programme would improve the PDRP programme?
Prompt: Think about the issues that arise when assessing

_____

14 You will be aware that there has been a focus on competencies 1.2 (Treaty of Waitangi) And 1.5 (Cultural Safety), tell me about the evidence you are seeing in these competencies now.

_____

15 What further support do you require to continue being a Resource person?

_____

16 Is there anything further you wish to comment upon?

_____

Thank you
PDRP Team

Appendix 4: Focus Group Survey: Assessors

Focus Group: PDRP Assessor Group

Date: 31 July 2018
Venue: Burwood Hospital, CDHB
Lead Interviewer: Jo Greenlees-Rae
Scribes: Adriana Humphries, Jackie Nepia

Focus Group Questions:

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3 How many in this group are currently on the PDRP?
Competent:
Proficient:
Accomplished/Expert:

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17 What aspects of the Assessor role do you enjoy and why?

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18 As a PDRP Assessor, what are the most common issues that arise when you are assessing a portfolio?
Prompt: Performance Appraisals: CNM, timeliness

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19 How does achievement on the PDRP influence nursing practice of those individuals in your workplace?
Prompt: what does success look like with regards to individual nurse's practice?

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20 How does achievement on the PDRP link to patient outcomes in your workplace?

Prompt: what does success look like with regards to patient care?

_____

21 What changes to the programme would improve the PDRP programme?
Prompt: Think about the issues that arise when assessing

_____

7 You will be aware that there has been a focus on competencies 1.2 (Treaty of Waitangi) and 3.5 (Cultural Safety), tell me about the evidence you are seeing in these competencies now.

_____

8 What further support do you require to continue being a PDRP Assessor?

_____

9 Is there anything further you wish to comment upon?

_____

Thank you
PDRP Team

Appendix 5: Focus Group Survey: Senior RN

Focus Group: PDRP CNM/Senior RN Group

Date: 25 October 2017
Venue: The Design Lab, Print Place, Christchurch
Lead Interviewer: Jo Greenlees-Rae
Scribes: Aoife Sweeney, Louise Hoban-Watson

Focus Group Questions:

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4 How many in this group are currently on the PDRP?
Competent:
Proficient:
Accomplished/Expert:

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22 What are the most common issues that arise for you regarding the PDRP?
Prompt: Performance Appraisals: CNM, timeliness

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23 How does achievement on the PDRP influence nursing practice of those individuals in your workplace?
Prompt: what does success look like with regards to individual nurse's practice?

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24 How does achievement on the PDRP link to patient outcomes in your workplace?
Prompt: what does success look like with regards to patient care?

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25 What changes to the programme would improve the PDRP programme?
Prompt: PA's, release time

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7 You will be aware that there has been a focus on competencies 1.2 (Treaty of Waitangi) and 4.5 (Cultural Safety), tell me about the evidence you are seeing in these competencies now.

_____

8 What further support do you require for nursing staff and PDRP

_____

10 Is there anything further you wish to comment upon?

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Thank you
PDRP Team

-END-