Nurse Executives of New Zealand Inc.
DEVELOPING NEW ZEALAND'S NURSING LEADERS

National Framework and Evidential Requirements

New Zealand Nursing Professional Development & Recognition Programmes for Registered and Enrolled Nurses

PDRP document review project team
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Contents

Executive Summary

The National framework and evidential requirements: New Zealand for nursing professional development and recognition programmes (PDRPs), for registered and enrolled nurses document reflects the unique nature of nursing in Aotearoa/ New Zealand (NZ). It recognises Te Tiriti o Waitangi (the Treaty of Waitangi) as the founding document of NZ and sets expectations about how the nursing profession through its practise, upholds the principles of partnership, participation and protection.

This most recent national review of the framework, builds on the expert work done in the previous versions. This continues to evolve with the nursing profession, the development of PDRPs and technology which surrounds nursing and healthcare. PDRP programmes currently include nurses in the Registered and Enrolled Nurse scopes of practice.

The current document reflects the diversity of organisations involved with PDRP, acknowledging that the framework has to be broad enough to fit across organisations, while aiming to ensure consistent interpretation and application of the PDRP standards. Primarily, this document provides a foundation for all PDRP coordinators in development of programmes.

The current document has combined the two original documents to:

- Address the sections of the documents which require clarification.
- Refresh the documents to reflect current trends and requirements.
- Reflect the change in registered nurse (RN) scope to include RNs who have completed additional experience, education and training to be authorized by the Nursing Council of New Zealand (NCNZ) to prescribe.

Recommendations:

- 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 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.

Chapter 1

PDRP Goals, Principles and Standards.

The PDRP goals, principles and standards provide national guidelines for the consistency between programmes.

Goals

PDRPs aim to:

- Ensure nursing expertise is visible, valued and understood
- Enable differentiation between the different levels of RN and EN practice
- Value and reward clinical practice
- Encourage practice development
- Identify expert nurses/ role models
- Encourage reflection on practice
- Supports the use of evidence based practice
- Provide a structure for ongoing education and training
- Assist nurses to meet the requirements for competence based practising certificates
- Assist in the retention of nurses

Principles

- **Based on and linked to the NCNZ competencies for RN and EN scopes**
- Reward, recognise and respect contemporary nursing practice
- Open to RNs and ENs who are working within an organisation which supports a PDRP
- Developed and managed by the profession for the profession
- Reviewed and updated at least 5 yearly
- Consistent, fair and transparent processes
- Comply with relevant legislation
- Support and facilitate nurses to provide education to their colleagues
- Support and facilitate nurses in their professional development
- Recognise the value of professional development and innovation
- Accept a range of evidence to demonstrate competence
- Use Māori processes to consult with Māori
- Active involvement of Māori nurses and cultural advisors in the introduction, ongoing development and decision making processes of PDRP, including the integration of the principles of Te Tiriti o Waitangi
- Support nurses in designated roles to demonstrate their continuing competence in accordance with NCNZ continuing competence requirements for: research, management, education and policy

Standards

The Health Practitioners Competence Assurance Act (2003) (the Act) provides a framework for the regulation of health practitioners to protect the public where there is risk of harm from professional practice. The Act identifies responsible authorities (e.g. NCNZ) which have the role of ensuring all registered health practitioners, issued with an annual practising certificate (APC), are competent in their scope of practice.

The PDRP standards incorporate and extend the NCNZ Standards for approval of professional recognition programmes to meet continuing competence requirements (NCNZ, 2013). These PDRP standards include other components that are important in the development and review of all PDRPs in New Zealand. These include processes for transportability, transferability and open progression.

The [1]NCNZ standards below have been developed to ensure that nurses participating in an approved PDRP will automatically meet NCNZ continuing competence requirements in addition to specified organisational requirements.

1. **The programme complies with legislated requirements and Nursing Council of New Zealand policies, guidelines and codes.**
   - 1.1. All nurses on the programme have a current annual practising certificate.
   - 1.2. Portfolio requirements encompass the requirements for continuing competence. All nurses on the programme are therefore currently assessed as competent to practise.
   - 1.3. Competence is assessed at least three-yearly. This could be part of the performance appraisal/review process depending on the programme assessment procedures.
   - 1.4. The programme's competencies and processes incorporate the principles of the Treaty of Waitangi.
   - 1.5. The programme's competencies and processes incorporate the principles of cultural safety.
   - 1.6. Programme records (names, registration numbers and assessment dates) must be kept and supplied to the Council on request.
2. **The programme supports the nurse to develop her/his practice.**
   - 2.1. The programme has a structure and competencies that promote and support ongoing professional development to continue learning and maintain competence and to meet the continuing competence requirements.
   - 2.2. For each level of the programme, assessment of the nurse's practice against the Nursing Council competencies can be demonstrated at least three yearly.
   - 2.3. The programme is written and reviewed in consultation with nurses in practice.
   - 2.4. The programme requires practice to be evidence-based.
3. **The programme will have clearly defined assessment processes.**
   - 3.1. The assessment process is valid and reliable.
   - 3.2. Confidentiality requirements for clients, family and employees are met.

[1] Nursing Council of New Zealand. (2013). *Framework for the approval of professional development and recognition programmes to meet the continuing competence requirements for nurses.* Wellington: Author

3.3. The assessment is undertaken by nurses who are prepared in assessment.
3.4. Criteria used for assessment are made available to applicants.
3.5. Applicants have opportunity for self-assessment.
3.6. Applicants receive individual feedback.
3.7. Decisions about assessment are based on evidence and documented.
3.8. Appeal mechanisms are explicit and appeals are resolved.
3.9. Assessment timeframes are identified, appropriate and able to be met.
3.10. Processes are in place for recognising transferability of skills and knowledge.

4. Appropriate resources are available to support the programme.

4.1. Nurses have access to relevant and current literary resources (e.g. journals/texts/internet).
4.2. The coordinator of the programme is a nurse with a current practising certificate.
4.3. Information/education about the programme and assessment processes is made available to all nurses.
4.4. Nurses have opportunities for ongoing professional development activities.

5. Quality improvement processes are integral to the programme.

5.1. There is a statement of programme goals and outcomes.
5.2. The programme is evaluated at least five-yearly. This includes feedback from nurses and participation by nurses in the programme.
5.3. The programme has assessor selection criteria and processes, appraisal and development.
5.4. Assessment is moderated (internal or external as appropriate).
5.5. Issues and appeals are resolved.

Privacy

Privacy[2] [3] extends to all individuals and portfolio development must take into account an individual's right to privacy. There are 3 components to confidentiality and privacy in regard to portfolios including electronic portfolios.

1. Patients/ family
   - All patient personal details and any identifiers must be removed from all parts of the portfolio. The nurse must abide by the Privacy Act (1993), so that information collected for the furthering of patient care is used only for that purpose, not for inclusion in a portfolio.
   - 'Identifiers' relates not only to a person's specific information such as birth date or NHI, it can relate to a context or situation whereby if that situation is described, it will identify the person by process of elimination. *"It is very easy to breach privacy and confidentiality inadvertently even if pseudonyms are used. Even a description of an entire context of a situation can result in those involved being identifiable. New Zealand is a small country and contextual descriptions along with the author's location can result in identifying those involved."* NZNO (2016).
   - **Guidelines for how to anonymize and gain consent for a case study or exemplar can be found at** New Zealand Nurses Organisation (2016) Guideline- privacy, confidentiality and consent in the

[2] Privacy Act (1993)
[3] Privacy Commissioner (2008)

use of exemplars of practice, case studies and journaling.

- The Health Practitioners Disciplinary Tribunal have stated in respect of a nurse's argument that she had accessed some of the patient records for PDRP case studies: *"[4]There is no justification for a nurse accessing the records of a former patient without authority for any reason. Once the care of the patient has passed from the nurse, the nurse has no right or authority to any information concerning the patient's condition, no matter how much concern or curiosity there may be. If there is learning to be done from accessing records and structured inquiry, then that should be done with proper authority and after having obtained appropriate consent."*
- Privacy requirements do not preclude the inclusion of exemplars and/ or written reflections on practice, as these are expected within a portfolio. The focus of these pieces of evidence is on the nurse's practice rather than on the patient and therefore can generally be provided without accessing a patient's clinical record. In contrast, in-depth detailed case studies have a strong patient focus and are not recommended within portfolios. However, if they are included, full informed consent must be gained and evidenced within the portfolio.

2. Health professionals/ colleagues
    - Nurses must not reveal names or identifiers of other health professionals or colleagues in portfolios. Generic job titles could be used if required. **Privacy extends to all individuals.**
3. The portfolio contents.
    - Portfolios when not being assessed should be secured in a locked cupboard or room
    - Consent to access portfolios is given only by the nurse who has completed the portfolio
    - Assessors should not discuss what the portfolio contains unless:
        - It is for the direct purpose of assessing the portfolio
        - There are concerns regarding practice found in the portfolio e.g. unsafe practice
        - There are concerns regarding privacy breaches within the portfolio. The inclusion of evidence which breaches privacy in any way should require return of a portfolio and immediate removal of the privacy breach
    - If an assessor does need to discuss concerns it should be with either the nurse, PDRP coordinator, the nurse leader / line manager and/ or the Director of Nursing (or equivalent) of the nurse whose portfolio is being assessed
    - Permission may be sought from a nurse to use their portfolio for internal / external moderation and/or NCNZ recertification purposes.

PDRP providers may need to reinforce that only documents specifically prepared for portfolio submission be included in the portfolio.

Extending the reach of PDRP

A number of organisations allow other organisations or individuals to join or partner with their PDRP, creating the opportunity to uptake a fully developed and NCNZ approved PDRP. To achieve this, the development of a memorandum of understanding (MoU) is recommended, which can be signed by both parties and then sent to the NCNZ.

Contents of MoUs should contain:

[4] *Raju* 712/Nur14/302P p46,47

- Start and end dates (or open ended) for MOU
- Notice required to terminate MOU
- Contact details for PDRP Provider and 'PDRP Extension Organisation'
- Scope of MOU and coverage e.g. RN, EN, Senior Nurse
- Arrangements regarding education and support of applicants
- Assessment and moderation arrangements
- Process for resolving issues or appeals
- Resources to support programme
- NCNZ mid-term reporting arrangements
- PDRP Provider responsibilities may include;
    - administering Advisory/Governance Committee
    - access to policy and programme documentation
    - support and guidance for the programme
    - PDRP review processes
    - training and education
    - maintaining a database of nurses with current portfolios
    - reporting programme data to NCNZ
- PDRP Extension Organisation responsibilities may include;
    - identifying a PDRP contact person within the Extension Organisation
    - providing programme data to PDRP Provider
    - ensuring assessors attend assessor training
    - complying with policy and programme documentation
    - training and education
    - promotion of the programme

Technology

In the last five years, there has been a focus on the use of technology to develop 'electronic' portfolios, or generic 'e-portfolios'. There is currently a proliferation of e-portfolios as organisations wish to give nurses access to their own organisational model of an electronic portfolio and independent companies see the opportunity to link into this growing market.

E-portfolios are either specifically formatted for a particular PDRP or are 'platforms' which can hold any PDRP programme or evidence for a NCNZ recertification audit. Many are based on Mahara software and use a Moodle platform; some are uploaded documents, and some offer different ways to present evidence such as video or podcast. Videos or podcasts have already been used to supply supporting evidence, but nurses may choose to video themselves making their statement against a competency rather than write it down (the content should remain relevant to the competence, time framed and professional at all times).

Organisations should caution the use of video or photographs, and ensure that all the requirements of privacy[5] [6]required of a PDRP are carried into any electronic portfolio system.

[5] Privacy Act (1993)
[6] Privacy Commissioner (2008)

Chapter 2

Competencies and Levels of Practice Definitions.

This chapter provides the framework for PDRPs, to ensure organisations align their PDRP with the characteristics that differentiate the levels of practice for RNs and ENs. The purpose is to provide a broad framework to achieve the goal of national consistency and facilitate transferability and transportability of the nurse's level of practice within and across organisations. It is not the intent of this chapter to prescribe competence expectations to organisations.

EN levels of practice

The Competent EN

- Under the direction of the RN, contributes to assessment, planning, delivery and evaluation of nursing care
- Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe
- Applies knowledge and skills to practice
- Has developed experiential knowledge and incorporates evidence-based nursing
- Is confident in familiar situations
- Is able to manage and prioritise assigned client care/workload appropriately
- Demonstrates increasing efficiency and effectiveness in practice
- Responds appropriately in emergency situations

The Proficient EN

- Utilises broad experiential and evidence-based knowledge to provide care
- Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe
- Has an in-depth understanding of enrolled nurse practice
- Contributes to the education and / or preceptorship of enrolled nurse students, new graduate EN, care givers/healthcare assistants, competent and proficient EN
- Acts as a role model to their peers
- Demonstrates increased knowledge and skills in a specific clinical area
- Is involved in service, professional or organisational activities
- Participates in change

The Accomplished EN

- Demonstrates advancing knowledge and skills in a specific clinical area within the enrolled nurse scope
- Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the clients determine is culturally safe
- Contributes to the management of changing workloads

- Gains support and respect of the health care team through sharing of knowledge and making a demonstrated positive contribution
- Undertakes an additional responsibility within a clinical/quality team, e.g. resource nurse, health and safety representative, etc
- Actively promotes understanding of legal and ethical issues
- Contributes to quality improvements and change in practice initiatives
- Acts as a role model and contributes to leadership activities

RN levels of practice

The Competent RN:

- Effectively applies knowledge and skills to practice
- Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe
- Has consolidated nursing knowledge in their practice setting
- Has developed an holistic overview of the client
- Is confident in familiar situations
- Is able to manage and prioritise assigned client care/workload
- Demonstrates increasing efficiency and effectiveness in practice
- Is able to anticipate a likely outcome for the client with predictable health needs.
- Is able to identify unpredictable situations, act appropriately and make appropriate referrals

The Proficient RN:

- Acts as a role model and a resource person for other nurses and health practitioners
- Participates in changes in the practice setting that recognise and integrate the principles of Te Tiriti o Waitangi and cultural safety
- Has an holistic overview of the client and the practice context
- Demonstrates autonomous and collaborative evidence based practice
- Actively contributes to clinical learning for colleagues
- Supports and guides the health care team in day to day health care delivery
- Participates in quality improvements and changes in the practice setting
- Demonstrates in-depth understanding of the complex factors that contribute to client health outcomes

The Expert RN:

- Is recognised as an expert and role model in her/his area of practice
- Guides others to apply the principles of Te Tiriti o Waitangi and to provide culturally safe care to clients
- Engages in clinical learning for self and provides clinical learning opportunities for colleagues
- Contributes to specialty knowledge and demonstrates innovative practice
- Initiates and guides quality improvement activities and changes in the practice setting

- Delivers quality client care in unpredictable challenging and/ or complex situations
- Demonstrates successful leadership within a nursing team unit/facility
- Advocates for the promotion and integrity of nursing within the health care team
- Is involved in resource decision making/strategic planning
- Influences at a service, professional or organisational level

New graduate RNs and ENs

- Graduates should, in their first year of practice, be gathering evidence for competent level RN or EN portfolio submission at end of the first year of practice.
- It is essential that graduate RNs and ENs have comprehensive orientation, mentoring, support, guidance, coaching, planned professional development opportunities and a safe environment to be able to consolidate competence in the practice setting.

RNs in non-clinical roles

- **RNs in non-clinical roles who are NOT designated senior nurses:** complete a portfolio at the appropriate level of practice (i.e. proficient or expert) using the management, education, policy or research competencies for the self-assessment and peer review or senior nurse assessment.
- RNs in management, education, policy or research (indirect patient care) must still meet NCNZ competencies and continuing competence requirements (standard requirements). These nurses are exempt from those competencies in domain two (management of nursing care) and domain three (interpersonal relationships) that only apply to clinical practice.
- RNs practising in direct care and in management, education, policy and/or research [7]must meet both sets of competencies in domains 2&3. This does not mean submitting 2 portfolios but provision of evidence for the relevant competencies for current practice.
- **RNs in non-clinical roles who are designated senior nurses** refer to page 20

Expanded RN scope

RNs working in [8]expanded practice roles **must meet three competencies which are additional to those that already described in the RN scope of practice**.

- Nurses who are practising in an expanded scope are expected to declare this when they apply for the Annual Practising Certificate(APC) and to demonstrate and document how they meet these competencies. They will be assessed as part of a PDRP or employer's credentialing programme and as part of the NCNZ's recertification audit.

RN prescriber

The assessment against the prescribing competencies is currently separate and requires an annual recertification process which is managed by NCNZ.

[7] Nursing Council (2011) Guidelines for Competence Assessment.

[8] Nursing Council of New Zealand. (2011). Expanded Practice for Registered Nurses.

As this is still a new process for nursing it will be reviewed, at an appropriate timeframe, by NCNZ as the number of RN prescribers increases and assessment/recertification audit requirements become clear (A. Shanks, personal communication, 2nd February, 2017).

Progression

A nurse can progress to proficient, expert or accomplished in a number of ways which includes relevant clinical experience combined with ongoing professional development activities, increasing self-awareness and reflection on practice. Although progression through the levels of practice is generally linear, **portfolio submission does not always have to be.** i.e. a nurse can in some situations, submit an expert portfolio without the need to first submit a proficient portfolio e.g. Time lapse between portfolio submissions; new to PDRP.

Nurses employed in more than one organisation

If a nurse works in more than one organisation and both organisations have PDRPs, only one portfolio should be required. It is recommended that this be for the primary employer, if there is one, but in all cases this should be discussed and agreed with both employers.

Nurse Practitioners (NP)

NPs are not included in PDRP at this stage. NP competencies and continuing NP competence requirements are available through the NCNZ website.

Chapter 3

Portfolio requirements

A portfolio consists of a collection of selected evidence that articulates how in day to day practice the nurse consistently demonstrates achievement of the competencies at the level of practice submitted. This evidence includes, but is not limited to, the nurse's self-assessment, senior nurse/peer feedback and a performance review/appraisal.

It should be noted that for a PDRP to achieve approval by NCNZ, the programme must demonstrate how, through its assessment processes, the NCNZ competencies are assessed. All programmes approved by NCNZ must use the NCNZ Domains of Practice and competencies as the foundation of their programme.

To remain in a NCNZ approved PDRP, nurses are required to submit a new portfolio of evidence every three years. The triennial application process reaffirms the nurse is **consistently** practising at that level of practice. **The only time a nurse submits a portfolio more frequently than three yearly is when the nurse is ready to progress to a higher level of practice**. A new triennial cycle will commence from the time that portfolio is approved by the organization. In some situations, e.g. return from long term leave, the triennial cycle timeframe may be altered to support collection of evidence. PDRP policies should be fair and equitable in managing these situations and timeframes.

The portfolio requirements in this document are:

1. Standard portfolio evidence for all applicants;
2. Level of practice evidence with specific requirements - proficient and accomplished ENs
3. Level of practice evidence with specific requirements - proficient and expert RNs
4. Designated senior RN portfolio.

1. Standard portfolio requirements

The standard requirements apply to all RNs and ENs who prepare a portfolio for assessment through an organisational PDRP portfolio assessment process.

1.1 Components

- **From the last 3 years**:
    1. **Verification of 450 hours of practice over last 3 years**, validated by either a senior nurse (Charge Nurse, Nurse Manager or the nurse to whom the applicant reports) or a letter from the employer indicating the clinical area and number of practice hours over the last 3 years.
    2. **60 hours of professional development over last three years**. This may include organisational mandatory / essential requirements (as per employment agreement). Professional development requirements must:
        - Be validated either by signature or someone who can verify your attendance, or certificate or organisational education record

- Related to the relevant area of practice
- Include either:
  - a statement, for each PD activity (describing the difference the learning has made to your nursing practice), ***or***
  - a short reflection on three key activities attended (note: this is more in-depth than 'a statement').

- **From the last 12 months**:

3. **Self- assessment against NCNZ competencies:** One piece of evidence for each competency is required. The example is to be from the previous 12 months. It is to describe how day to day practice meets the indicator for the competency and the level of practice applied for. It must be verified by a RN with a current practising certificate.
4. **Peer /senior nurse assessment against NCNZ competencies** describing how the nurse's day to day practice meets the competency (one indicator for the competency is to be used as an example). The information must be from the previous 12 months. This may have been completed as part of the performance review where the NCNZ competencies are the foundation for performance review
   - Peer or senior nurse assessment may comment on the same example used by the nurse in their self-assessment; however, it should be a **validation** of the self-assessment, **providing objective comments from a different viewpoint or focus**.
   - Peer or senior nurse feedback should be from a nurse with a current APC.
5. **Performance appraisal OR nursing development plan/ career plan** must be from previous 12 months.
   a) May include long term and /or short term educational and / or professional goals, with steps to achieving goals.
6. **Printout of current practising certificate** (from NCNZ website) ***or*** a copy of both sides of the current practising certificate ***or*** a link to the NCNZ website in the case of electronic portfolios

2. EN Level of practice evidential requirements

There are specific evidential requirements for competent, proficient and accomplished levels of practice. This evidence may be presented within the standard requirements. These level requirements apply to both progression and maintenance of level of practice.

2.1 Competent EN

Standard portfolio evidential requirements only.

2.2 Proficient EN

- **Standard portfolio** evidential requirements (see 1.1) **PLUS**:
  1. **A copy of CV** providing work and education history
- **From the last 3 years**:
  2**. Level of Practice evidence** to demonstrate;

a) Participation in practice change or quality initiative.
b) Teaching and/or preceptorship.
c) In-depth understanding of patient care and care co-ordination within scope of practice.

- **From the last 12 months**:

3. **Statement that the Charge Nurse, or an equivalent senior nurse with whom the nurse has a professional relationship (when the manager is not a nurse),** supports the level of practice the nurse is applying for. This support must be in writing. The statement must not be unduly withheld.

NB. **If the level of practice evidence (2a, 2b, and 2c) is met within the standard requirements (e.g. self-assessment and senior nurse/ peer review), then no additional evidence is required**. If it is not, then separate evidence should be provided to support this level of practice. For example, a self-assessment should contain evidence from the last 12 months, so if a practice change was completed 2 years ago, this would not be included, as it is over the 12-month self-assessment timeframe, so a separate piece of evidence or statement would be needed.

2.3 Accomplished EN

3. Standard portfolio evidential requirements (see 1.1) **PLUS**:
    1. **A copy of CV** providing work and education history

- **From the last 3 years**:

2. **Level of Practice evidence** to demonstrate;
    a) Contribution to quality improvement and the change process.
    b) Engagement and influence in professional activities.
    c) In-depth understanding of patient care and care co-ordination as within scope of practice, and the ability to identify changes in patient health status and action this appropriately.

- **From the last 12 months**:

3. **Statement that the Charge Nurse, or an equivalent senior nurse with whom the nurse has a professional relationship (when the manager is not a nurse)**, supports the level of practice the nurse is applying for. This support must be in writing. The statement must not be unduly withheld.

NB. **If the level of practice evidence (2a, 2b, and 2c) is met within the standard requirements (e.g. self-assessment and senior nurse/ peer review), then no additional evidence is required**. If it is not, then separate evidence should be provided to support this level of practice. For example, a self-assessment should contain evidence from the last 12 months, so if a practice change was completed 2 years ago, this would not be included, as it is over the 12-month self-assessment timeframe, so a separate piece of evidence or statement would be needed.

	EN Competent	EN Proficient	EN Accomplished
Standard requirements	**Last 3 years** • Validation of 450 hours of practise • 60 hours of Professional development- with reflection **Last 12 months** • Self-assessment (verified by an RN) against all the NCNZ competencies • Peer review / senior nurse feedback against the NCNZ competencies • Performance Appraisal /Nursing Development Plan • Printout of APC	**Last 3 years** • Validation of 450 hours of practise • 60 hours of Professional development- with reflection **Last 12 months** • Self-assessment (verified by an RN) against the NCNZ competencies • Peer review / senior nurse feedback against all the NCNZ competencies • Performance Appraisal /Nursing Development Plan • Printout of APC • Support statement from relevant senior nurse for this level of practice	**Last 3 years** • Validation of 450 hours of practise • 60 hours of Professional development- with reflection **Last 12 months** • Self-assessment (verified by an RN) against all the NCNZ competencies • Peer review / senior nurse feedback against all the NCNZ competencies • Performance Appraisal /Nursing Development Plan • Printout of APC • Support statement from relevant senior nurse for this level of practice
Level of practice specific requirements		**General work history** • CV providing work and education history **Last 3 years** One piece of evidence *(if not evidenced in the above)* demonstrating: • Participation in practice change or quality initiative • Teaching and/or preceptorship • In-depth understanding of patient care and care co-ordination within scope of practice	**General work history** • CV providing work and education history **Last 3 years** One piece of evidence *(if not evidenced in the above)* demonstrating: • Contribution to quality improvement and the change process • Engagement and influence in professional activities. • In-depth understanding of patient care and care co-ordination within scope of practice and the ability to identify changes in patient health status and action this appropriately.

Table 1 EN Evidential requirements

3. RN Level of practice evidential requirements

There are specific evidential requirements for competent, proficient and expert levels of practice. This evidence may be presented within the standard requirements. These level requirements apply to both progression and maintenance of level of practice.

3.1 Competent RN

Standard portfolio evidential requirements only

3.2 Proficient RN

Standard portfolio evidential requirements (see 1.1) **PLUS**:

1. **A copy of CV** providing work and education history.

- **From the last 3 years**
    2. **Level of Practice evidence** to demonstrate:
        a) Participation in practice change or quality initiative.
        b) If a teaching session is used, evidence of organisation and delivery may be included. Preceptorship or supporting skills development should include reflection and feedback from the person preceptored or supported.
        c) Ability to manage and coordinate care processes for patients with complex needs.
- **From the last 12 months**:
    3. **Statement that the Charge Nurse, or an equivalent senior nurse with whom the nurse has a professional relationship (when the manager is not a nurse),** supports the level of practice the nurse is applying for. This support must be in writing. The statement must not be unduly withheld.

NB. **If the level of practice evidence (2a, 2b, and 2c) is met within the standard requirements (e.g. self-assessment and senior nurse/ peer review), then no additional evidence is required**. If it is not, then separate evidence should be provided to support this level of practice. For example, a self-assessment should contain evidence from the last 12 months, so if a practice change was completed 2 years ago, this would not be included, as it is over the 12-month self-assessment timeframe, so a separate piece of evidence or statement would be needed.

3.3 Expert RN

Standard portfolio evidential requirements (see 1.1) **PLUS**:

1. **A copy of CV** providing work and education history

- **From the last 3 years**:
    2. **Level of Practice evidence** to demonstrate:
        a) The integration of the acquired nursing knowledge into nursing practice demonstrated throughout the portfolio.
        b) Expert knowledge and application of expert practice in the care of the complex patients and clinical leadership in care coordination. May include, but not limited to e.g. reflection of: a complex patient, or family situation, clinical leadership role or situation.

c) Contribution to specialty knowledge or innovation in practice and the change process in quality improvement activities. May include, but not limited to: e.g. quality project, practice improvement.

d) Active engagement and influence in wider service, professional or organisational activities. Advocacy for nursing needs to be shown (this could be an attestation). May include, but not limited to e.g. contributing member of committee, multi-disciplinary or nursing group.

e) Responsibility for learning and/or development of colleagues. May include, but not limited to, evidence that education has been developed and delivered.

- **From the last 12 months**:

3. **Statement that the Charge Nurse, Nurse Manager or an equivalent senior nurse with whom the nurse has a professional relationship (when the manager is not a nurse),** supports the level of practice the nurse is applying for. This support must be in writing. The statement must not be unduly withheld.

NB. **If the level of practice evidence (2a, 2b, 2c, 2d, 2e) is met within the standard requirements (e.g. self-assessment and senior nurse/ peer review), then no additional evidence is required**. If it is not, then separate evidence should be provided to support this level of practice. For example, a self-assessment should contain evidence from the last 12 months, so if a practice change was completed 2 years ago, this would not be included, as it is over the 12-month self-assessment timeframe, so a separate piece of evidence or statement would be needed.

Expert RN Pre-submission process

- Organisations may choose to have a pre-submission process for Expert RN portfolios that best suits their processes and organisational requirements.
- This may range from a formal panel process to a more informal support/ guidance process as outlined below.

RN expert panel process	RN expert support/ guidance process
• The RN applicant meets with the PDRP coordinator or PDRP support person who will assist the RN to complete the attached template (Appendix 5). • The completed template (*not the portfolio*) is given to a panel for review to ensure the evidence within the portfolio will meet the standards required. • The panel will endorse / not endorse for the portfolio submission. • If endorsed the portfolio will be assessed for expert level.	• The RN applicant may meet with the PDRP coordinator or PDRP support person who will assist the nurse to understand the level of evidence required. • The portfolio will be submitted for assessment at expert level.

Table 2 Expert RN pre-submission processes continuum

	RN Competent	RN Proficient	RN Expert
Standard requirements	**Last 3 years** • Validation of 450 hours of practise • 60 hours of Professional development- with reflection **Last 12 months** • Self-assessment (verified by an RN) against all the NCNZ competencies • Peer review / senior nurse feedback against all the NCNZ competencies • Performance Appraisal /Nursing Development Plan • Printout of APC	**Last 3 years** • Validation of 450 hours of practise • 60 hours of Professional development- with reflection **Last 12 months** • Self-assessment (verified by an RN) against all the NCNZ competencies • Peer review / senior nurse feedback against all the NCNZ competencies • Performance Appraisal /Nursing Development Plan • Printout of APC • Support statement from relevant senior nurse for this level of practice	**Last 3 years** • Validation of 450 hours of practise • 60 hours of Professional development- with reflection **Last 12 months** • Self-assessment (verified by an RN) against all the NCNZ competencies • Peer review / senior nurse feedback against all the NCNZ competencies • Performance Appraisal /Nursing Development Plan • Printout of APC • Support statement from relevant senior nurse for this level of practice
Level of practice specific requirements		**General work history** • CV providing work and education history **Last 3 years** One piece of evidence *(if not evidenced in the above)* demonstrating: • Participation in practice change or quality initiative • Teaching or preceptoring or supporting skills development of colleagues • Illustrating ability to manage and coordinate care processes for patients with complex needs	**General work history** • CV providing work and education history **Last 3 years** One piece of evidence *(if not evidenced in the above)* demonstrating: • Expert knowledge and application of expert practice to care of the complex patient and clinical leadership in care co-ordination • Contribution to specialty knowledge or innovation in practice and the change process in quality improvement activities • Engagement and influence in wider service, professional or organisational activities. • Describing and reflecting on responsibility for learning and/or development of colleagues

Table 3 RN Evidential requirements

3.4 Designated Senior Nurse(DSN)

- **Designated position:** [9]*An appointed nursing position that requires specific clinical expertise and/or responsibility for coordination, management, education, practice development or research.*
- *Some organisations may choose not to include the DSN portfolio evidential requirements in their PDRP but continue to use the RN levels of practice (i.e. proficient or expert) using the appropriate NCNZ competencies for the specific role.*
- DSNs in management, education, policy or research (indirect patient care) must still meet NCNZ competencies and continuing competence requirements (standard requirements). These nurses are exempt from those competencies in domain two (management of nursing care) and domain three (interpersonal relationships) that only apply to clinical practice. They are to use the competencies from Domains 2 and 3 that best align with their specific role.
- [10]DSN practising in direct care and in management, education, policy and/or research must meet both sets of competencies in domains 2&3. This does not mean submitting 2 portfolios but provision of evidence for the relevant competencies for current practice.
- The following table provides guidance as to the appropriate NCNZ competencies to be used by DSN.

Note: these are only suggestions; each RN must select the competencies appropriate to their role.

Competencies	Role examples:
Clinical/[11]Clinical management *(direct patient care)*	Clinical Nurse Specialist, Clinical Nurse Educator Charge Nurse, Clinical Nurse Manager
Management *(non-clinical/ indirect patient care)*	Nurse Manager, Unit Manager, Director of Nursing
Research *(non-clinical/ indirect patient care)*	Practice Research Nurse, Academic Research Nurse
Education *(non-clinical/ indirect patient care)*	Academic Educator, Non-Clinical Educator
Policy *(non-clinical/ indirect patient care)*	Nurse Consultant, Nurse Advisor

Table 4 Examples of competencies and Designated Senior Nurse roles

- **Standard portfolio** evidential requirements (see 1.1) using the **appropriate NCNZ competencies** e.g. clinical, management, policy, research or education) **PLUS**:
    1. **A copy of CV** providing work and education history.

From the last 3 years:

2. **Evidence to demonstrate**:
    a) Leadership in practice innovation and quality improvement.
    b) Education and development of others.
    c) Active participation in wider service, organisation or professional activities/groups.
    d) Leadership in management, education, policy or research.

NB. **If the practice evidence is met within the standard requirements (e.g. self-assessment and senior nurse/ peer review), then no additional evidence is required.** If it is not, then separate statements

[9] National Professional Development & Recognition Programmes Working Party. (2004*). p.23*

[10] As per 'Nurses in management, education, policy and research' http://www.nursingcouncil.org.nz/Nurses/Recertification-audits

[11] Nursing Council of New Zealand. (2011). *Competence Assessment form for Registered Nurses in Clinical Management.* Retrieved from: http://www.nursingcouncil.org.nz/Nurses/Continuing-competence/Competence-assessment

should be provided to support this portfolio. For example, if a practice change was completed 2 years ago, this would not be included in the self-assessment, as it is over the 12-month self-assessment timeframe, so a separate statement would be needed.

Chapter 4

Additional requirements

Performance Appraisal and competence assessment

Competence assessment is about assuring the public/profession/NCNZ that a nurse is safe and competent. A performance appraisal is about meeting the requirements of the role as described in a position description. Organisations may have;

- NCNZ competencies included in performance appraisal documents, including both self-assessment and peer review on all NCNZ competencies. These meet PDRP self-assessment and peer review/ senior nurse requirements provided the comments reflect the level of practice for which the nurse has applied.
- Separate performance appraisal and NCNZ competence assessment documents. If this is the case, the organisation should ensure nurses are assessed against the NCNZ competencies using an appropriate template (templates available on the NCNZ website).

Competency Indicators

Nurses are assessed against competencies and all the competencies must be addressed within a portfolio. The **wording of the NCNZ competencies must not change** however, the indicators are a guide and may be modified by an organisation to reflect the higher PDRP levels, as long as the intent of the indicator is not dramatically altered. The indicators are a guide to help nurses interpret the competencies and to provide the right type and level of evidence for each competency.

Transferability

It is acknowledged that nurses' knowledge, skills and attributes are portable and transferable and it is strongly recommended that every organisation has a process for transferability and continuity of levels of practice between areas of practice and between organisations.

These processes must be aligned to terms that may be specified in an organisation's employment agreement. For District Health Board (DHB) nurses, the DHBNZ/ NZNO MECA, (August 2015-August 2017), 27.9 (p.52) states; *e.g. When transferring either internally or externally, continuity of levels should occur with provision for the staff member to meet the competencies for the level in the new area within a negotiated period.*

It is recommended that the negotiated period be up to 12 months from the date of commencement. This applies **even if the area of practice or role has changed**. The date of certification is taken from the original certification date from a PDRP accredited programme. Each organisation should ensure a process is in place for the management of this, including a process should a nurse not maintain their level of practice by 12 months. The organisational process should specify that the Level of Practice allowance will be reduced/cease if the nurse has not met the competencies in the new clinical area for the level of practice, following a 12-month review (12 months from the date of the transfer not 12 months from the date of certificate).

Organisations which do not have the same DHBNZ/NZNO MECA terms, conditions and clauses relating to PDRPs included within their employment agreements, are not required to comply with this clause but it is encouraged. Each organisation should abide by the terms specified in the employment contract and their organisation's PDRP processes. Any difficulties with this process should be referred to organisational processes e.g. HR, PDRP appeals process.

Endorsement of level of practice

The Charge Nurse/Manager needs to have confidence in the nurse's level of practice, professional development and delivery of investment through the employment agreement. All portfolio applications should be discussed with the relevant Charge Nurse/Manager, or relevant senior colleague, to allow the opportunity to support, or not support, application for any level of practice above competent i.e. proficient, accomplished, expert. This may be done at the time of performance appraisal and individual organisations should utilise their own processes to manage this, ideally before the portfolio is completed.

Documentation that this discussion has occurred should be part of the portfolio's application process, but should be only one consideration point in the portfolio assessment process and the portfolio evidence should 'stand by itself' as it contains peer and senior nurse review. Where nurses report to a [12]manager who is not a nurse, a peer or senior nurse assessment will be required. Any difficulties with this process should be referred to organisational processes e.g. HR, PDRP appeals process.

Maintenance of portfolio and enrolment in PDRP

Whilst it is a nurse's responsibility to have a current portfolio, every organisation must have a process for nurses to maintain the currency of their portfolio and therefore their enrolment in the PDRP. It is recommended that each PDRP has a robust process to notify nurses of their portfolio expiry date well in advance to ensure they have adequate time to renew their portfolio. This time frame needs to be cognizant of the organisation's assessment timeframe and any other processes which may delay the renewal process. It is strongly recommended that this process also include notification to the nurse of any ramifications of not completing the requirements by the expiry date, which may include (but not limited to):

- Being subject to NCNZ recertification audit.
- Possible removal or alteration of additional conditions linked to their employment contract e.g. remuneration.

Appeals process

NCNZ approval of PDRP programmes includes the appeals process review. Every organisation must have a documented and time-framed appeals process which can be applied as required, to any aspect of the PDRP e.g. PDRP process or outcome. The process should be timely, fair and transparent for all parties.

[12] Nursing Council of New Zealand. (2011). *Guidelines for Competence Assessment.*

Appendices

1. Background to Professional Development and Recognition Programmes

[13]Clinical Career Pathways (CCPs) were introduced to nursing in North America in the 1970s at a time of nursing shortage. Prior to their inception, nurses wishing to develop their careers had to move to administration, management or education. CCP programmes[2] recognised and rewarded expertise in clinical practice through levels of practice as described by Benner (1984). Since the 1980s, CCPs have been introduced to nursing in much of the western world. The application of Benner's work (1984) to underpin the structure of CCP programmes meant that their focus was on clinical practice and in particular the staff nurse and enrolled nurse roles.

In Aotearoa/New Zealand (NZ), CCP programmes were introduced in the late 1980s as a mechanism to openly recognise the clinical expertise of nurses and to retain professional autonomy and development. However, because recognition, valuing and rewarding exists within designated roles through the responsibilities of the role and remuneration process (in 2005 scoping) these roles have not traditionally been included in CCPs – the Levels of Practice component. Benner's (1984) levels of novice to expert were adapted as the Levels of Practice Framework for most programmes. NZ nurses and others have actively worked towards achieving a national clinical framework since the late 1980s. This has been demonstrated through participation with the State Services Commission joint working party on nurses' terms and conditions and career options (1990) which formulated recommendations on a clinical career structure; the development of A Proposal for a Clinical Path for Nurses (NZNA, 1989); NZNO Fact Sheet: clinical career pathways – points for inclusion in contract negotiations, (1995); An NZNO Proposed Generic Nursing Workforce Structure (1996); the collaborative work between CCP Co-ordinators; participation in four NZNO National Clinical Career Pathway Seminars (1994, 1995, 1998, 2001) and NZNO's Certification process for Nurse Clinicians and Nurse Consultants.

Ongoing work has progressively adapted programmes to the New Zealand context so that they include Te Tiriti o Waitangi and cultural safety. During this time, a distinction has been made between a Clinical Career Pathway (CCP) and a Professional Development Programme (PDP). The term Professional Development and Recognition Programme (PDRP) is now considered to more accurately describe these programmes and is therefore used in this document.

The Health Practitioners Competence Assurance Act (2003) requires the Nursing Council of New Zealand (NCNZ) to ensure the continuing competence of all nurses in their scope of practice. Nurses are required to maintain evidence of their competence and usually do this through a professional portfolio.

Organisations with PDRPs may apply to NCNZ for approval of their PDRP which will ensure nurses engaged in these programmes meet NCNZ competence requirements to obtain an annual practising certificate.

[13] **This section is original text from**: National Professional Development & Recognition Programmes Working Party. (2004*). National framework for nursing professional development & recognition programmes & designated role titles (reviewed and updated December 2005).*

Background to the Working Party

[14]The College of Nurses Aotearoa (CNA) is a national, professional organisation for Registered Nurses in NZ. At a Nurse Practitioners Forum (CNA, 2003) held by the CNA in Palmerston North in February 2003, the need for a national framework and guidelines for PDRPs was identified as a priority for the profession. The National Nursing Organisations (NNO) representing all key nursing organisations decided that this work could be undertaken by a small working party. The work was to reference and integrate work undertaken by NCNZ and implement the intent of earlier work led by a small group arising out of the 2001 New Zealand Nurses Organisation (NZNO) CCP Forum.

This action was agreed at the meeting on 7 March 2003 and subsequently each member of the group appointed a representative to the working party. PDRP Coordinators were invited to attend. Those who attended the first meeting agreed to communicate with the others.

The College of Midwives that represents midwives on NNO made the decision at the first PDRP working group meeting that midwives not be included in this framework. A separate framework has been developed in 2005 by The Midwifery Council of New Zealand and the New Zealand College of Midwives.

Background PDRP Evidential Requirements Working Party

[15]Nurse Executives of New Zealand (In February, 2009, Mark Jones, chief nurse, Ministry of Health invited representatives from national nursing organisations to discuss a range of matters relating to nursing, including challenges associated with the registered nurse (RN) scope of practice and the credentialing of nurses or activities of nursing practice.

PDRPs are an established tool that is currently used to assess both continuing competence and where applicable, level of practice. Nationally many programmes have been approved by the NCNZ, thus meeting a minimum set of standards. Nurses most frequently stated the reasons for non-participation in a PDRP are

- a lack of national consistency between programmes; and
- excessive evidential requirements for completion of portfolios

According to the national PDRP coordinators' figures participation nationally is 43.7% of nurses as at 31 December 2008. It was suggested as a first step that every effort should be made to increase participation of nurses in PDRPs rather than introduce a separate process to credential standard nursing practice.

Increasing participation in PDRPs is timely in view of the

- Ministry of Health's credentialing working party;
- Nursing Council of New Zealand's review of the RN scope of practice;
- the forthcoming DHBNZ / NZNO MECA negotiations

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[14] **This section is original text from**: National Professional Development & Recognition Programmes Working Party. (2004*). National framework for nursing professional development & recognition programmes & designated role titles (reviewed and updated December 2005).*

[15] **This section is original text from:** PDRP Evidential Requirements Working Party. (2009). *PDRP evidential requirements working party report.*

Moreover, the refinement of evidential requirements will improve transferability between organisations, reduce assessment time and increase uptake as the perceived barrier of excessive evidence is reduced.

NENZ) and New Zealand Nurses' Organisation (NZNO) agreed to jointly sponsor this project. A timeline and process was developed which was developed and approved by the wider group of national nursing organisation representatives on 27 April 2009.

The working party representatives were asked to participate in developing recommendations for the sector with regards to evidential requirements for PDRPs, i.e. to look at what evidence was required to support a nurse's application to the programme and to reduce that volume of evidence.

It is intended that the examination and review of evidential requirements will produce a high degree of national consistency across PDRPs and increase participation by nurses.

Addendum 2017

In 2015, the NCNZ [16]reported that: *"At the end of March 2015, just over 26% of nurses with current APCs, that is 13,773 nurses, were reported to be taking part in these programmes. This is an increase of 246 nurses from the 2013-2014 year."*

In mid-2016, NENZ identified the need to review the two underpinning documents for PDRP. The aims of the review;

- To address the sections of the documents which require clarification.
- To refresh the documents to reflect current trends and requirements.
- To reflect the change in RN scope to encompass the legislative change to allow RN prescribing.

The project team (below) reflect sector engagement with PDRP and consultation with a wide stakeholder group will ensured broad feedback.

Project Sponsor	Denise Kivell	National Nurses Organisations (NNO) Nurse Executives NZ Chairperson
Project co-lead/ Chairperson	Karyn Sangster	Nurse Executives NZ (NENZ) District Health Board Directors of Nursing
Project co-lead/ Chairperson	Carey Campbell	Nurse Executives NZ Private Hospitals/ non DHB providers
Project Manager	Liz Manning	Project Manager; Kynance Consulting Ltd College of Nurses (NZ) Inc
Team members	Maureen Kelly	Nursing Council NZ
	Angela Clark	NZ Nurses Organisation (NZNO)
	Suzanne Johnson	National Nursing PDRP Coordinators (NNPC)
	Hemaima Hughes	Te Kaunihera o Nga Neehi Māori o Aotearoa- National Council of Māori Nurses (NCMN)

[16] Nursing Council of New Zealand. (2015). *Annual Report.*

2. Scopes

EN scope

Enrolled nurses practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings.

Enrolled nurses contribute to nursing assessments, care planning, implementation and evaluation of care for health consumers and/or families/whanau. The registered nurse maintains overall responsibility for the plan of care.

Enrolled nurses assist health consumers with the activities of daily living, observe changes in health consumers' conditions and report these to the registered nurse, administer medicines and undertake other nursing care responsibilities appropriate to their assessed competence.

In acute settings, enrolled nurses must work in a team with a registered nurse who is responsible for directing and delegating nursing interventions.

In some settings, enrolled nurses may coordinate a team of health care assistants under the direction and delegation of a registered nurse. In some settings, enrolled nurses may work under the direction and delegation of a registered health practitioner[17].

In these situations, the enrolled nurse must have registered nurse supervision and must not assume overall responsibility for nursing assessment or care planning. Enrolled nurses are accountable for their nursing actions and practise competently in accordance with legislation, to their level of knowledge and experience. They work in partnership with health consumers, families/whanau and multidisciplinary teams.

RN scope

Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions, and delegate to and direct enrolled nurses, health care assistants and others. They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings in partnership with individuals, families, whānau and communities.

Registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered nurses may also use this expertise to manage, teach, evaluate and research nursing practice. Registered nurses are accountable for ensuring all health services they provide

[17] *A person who is registered under the Health Practitioners Competence Assurance Act e.g. midwife, medical practitioner, occupational therapist.*

are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards.

There will be conditions placed in the scope of practice of some registered nurses according to their qualifications or experience limiting them to a specific area of practice. Some nurses who have completed the required additional experience, education and training will be authorised by the Council to prescribe some medicines within their competence and area of practice

3. Cultural Safety Principles

The following [18]principles underpin cultural safety education.

PRINCIPLE ONE

Cultural safety aims to improve the health status of New Zealanders and applies to all relationships through:

1.1 an emphasis on health gains and positive health outcomes

1.2 nurses acknowledging the beliefs and practices of those who differ from them. For example, this may be by:

- age or generation
- gender
- sexual orientation
- occupation and socioeconomic status
- ethnic origin or migrant experience
- religious or spiritual belief
- disability.

PRINCIPLE TWO

Cultural safety aims to enhance the delivery of health and disability services through a culturally safe nursing workforce by:

2.1 identifying the power relationship between the service provider and the people who use the service. The nurse accepts and works alongside others after undergoing a careful process of institutional and personal analysis of power relationships

2.2 empowering the users of the service. People should be able to express degrees of perceived risk or safety. For example, someone who feels unsafe may not be able to take full advantage of a primary health care service offered and may subsequently require expensive and possibly dramatic secondary or tertiary intervention

2.3 preparing nurses to understand the diversity within their own cultural reality and the impact of that on any person who differs in any way from themselves

2.4 applying social science concepts that underpin the art of nursing practice. Nursing practice is more than carrying out tasks. It is about relating and responding effectively to people with diverse needs in a way that the people who use the service can define as safe.

PRINCIPLE THREE

Cultural safety is broad in its application:

3.1 recognising inequalities within health care interactions that represent the microcosm of inequalities in health that have prevailed throughout history and within our nation more generally

[18] Nursing Council of New Zealand. (2011). *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice.*

3.2 addressing the cause and effect relationship of history, political, social, and employment status, housing, education, gender and personal experience upon people who use nursing services
3.3 accepting the legitimacy of difference and diversity in human behaviour and social structure
3.4 accepting that the attitudes and beliefs, policies and practices of health and disability service providers can act as barriers to service access
3.5 concerning quality improvement in service delivery and consumer rights.

PRINCIPLE FOUR
Cultural safety has a close focus on:
4.1 understanding the impact of the nurse as a bearer of his/her own culture, history, attitudes and life experiences and the response other people make to these factors
4.2 challenging nurses to examine their practice carefully, recognising the power relationship in nursing is biased toward the provider of the health and disability service
4.3 balancing the power relationships in the practice of nursing so that every consumer receives an effective service
4.4 preparing nurses to resolve any tension between the cultures of nursing and the people using the services
4.5 understanding that such power imbalances can be examined, negotiated and changed to provide equitable, effective, efficient and acceptable service delivery, which minimises risk to people who might otherwise be alienated from the service.

An understanding of self, the rights of others and legitimacy of difference should provide the nurse with the skills to work with all people who are different from them.

4. Principles of Te Tiriti o Waitangi

The [19]principles of Te Tiriti o Waitangi form the basis of interactions between nurses and Māori consumers of the services they provide.

PRINCIPLE ONE

Tino rangatiratanga enables Māori self-determination over health, recognises the right to manage Māori interests, and affirms the right to development, by:

1.1 enabling Māori autonomy and authority over health

1.2 accepting Māori ownership and control over knowledge, language and customs, and recognising these as taonga

1.3 facilitating Māori to define knowledge and worldviews and transmit these in their own ways

1.4 facilitating Māori independence over thoughts and action, policy and delivery, and content and outcome as essential activities for self-management and self-control.

PRINCIPLE TWO

Partnership involves nurses working together with Māori with the mutual aim of improving health outcomes for Māori by:

2.1 acting in good faith as Treaty of Waitangi partners

2.2 working together with an agreed common purpose, interest and cooperation to achieve positive health outcomes

2.3 not acting in isolation or unilaterally in the assessment, decision making and planning of services and service delivery

2.4 ensuring that the integrity and wellbeing of both partners is preserved.

PRINCIPLE THREE

The nursing workforce recognises that health is a taonga and acts to protect it by:

3.1 recognising that Māori health is worthy of protection in order to achieve positive health outcomes and improvement in health status

3.2 ensuring that health services and delivery are appropriate and acceptable to individuals and their families and are under pinned by the recognition that Māori are a diverse population

3.3 facilitating wellbeing by acknowledging beliefs and practices held by Māori

3.4 promoting a responsive and supportive environment.

PRINCIPLE FOUR

The nursing workforce recognises the citizen rights of Māori and the rights to equitable access and participation in health services and delivery at all levels through:

4.1 facilitating the same access and opportunities for Māori as there are for non-Māori

4.2 pursuing equality in health outcomes

[19] Nursing Council of New Zealand. (2011). *Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice.*

5. Expert RN pre-submission application guide: Example template

Name	**Designation**
Work area	**Contact information**
[20]Descriptor 1: Knowledge *(1) Advanced technical and/ or theoretical knowledge in a discipline or practice involving a critical understanding of the underpinning key principles* Discuss the integration of the acquired nursing knowledge into nursing practice is **demonstrated throughout the portfolio**	
RN comments:	
Supporting evidence ***(page numbers)***	**Outcomes**
Descriptor 2: Skills *(1) Analyse, generate solutions to complex and sometimes unpredictable problems* Show expert knowledge and application of expert practice to care of the complex patient and clinical leadership in care coordination May include, but not limited to e.g. reflection of: a complex patient, or family situation, clinical leadership role or situation. *(2) Evaluate and apply a range of processes relevant to the field of work or study* Demonstrate contribution to specialty knowledge or innovation in practice and the change process in quality improvement activities. May include, but not limited to: e.g. quality project, practice improvement.	
RN comments:	
Supporting evidence ***(page numbers)***	**Outcomes**
Descriptor 3: Application	

[20] Descriptors based on NZQA (2016).

(3) Developing identification with a profession and/ or discipline though application of advanced generic skills and/ or specialist knowledge and skills. Show active engagement and influence in wider service, professional or organisational activities. Advocacy for nursing needs to be shown (this could be an attestation) May include, but not limited to e.g. active member of committee, member on multi-disciplinary or nursing group. *(5) Some responsibility for integrity of profession or discipline.* Describe and reflect on responsibility or learning and/or development of colleagues May include evidence that education has been developed and delivered.
RN comments:

Supporting evidence *(page numbers)*	**Outcomes**
Provide an example of your expert practice including how you critically analyse and consistently reflect on your nursing practice	
RN comments:	
Nurse line manager/ professional leader statement of support *Include name and designation.*	

Table 5 RN expert submission: template example

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