Review of Registered Nurse Accreditation Standards

Consultation paper 1

For Stakeholders

September 2017

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For further information, contact:

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Executive summary

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for nursing and midwifery programs of study with responsibility for maintaining and facilitating the development of accreditation standards leading to registration as a nurse and/or a midwife. To ensure standards remain current, contemporary and effective, ANMAC follows a five-year cyclical review. The current registered nurse accreditation standards were approved in 2012 and are now due to be revised.

This paper contributes to Stage 1 of the consultation undertaken by ANMAC to gather feedback from stakeholders to ensure the standards meet future nursing workforce challenges. A literature review identified several issues including:

- entry criteria and undergraduate nursing courses
- attrition rates
- English language requirement for entry to registered nursing programs
- quality of clinical placements:
- simulation and student learning outcomes
- inter-professional learning for practice
- accreditation standards framework.

Each of these issues is briefly outlined below and further expanded upon later in the paper.

Increasing the diversity of students entering undergraduate nursing programs is a priority for the profession. ANMAC seeks comment on how useful the current accreditation standards are in supporting students from diverse backgrounds. Additionally, students who speak English as a second language may have difficulty communicating with patients and colleagues in the practice setting potentially compromising patient safety. ANMAC seeks feedback regarding whether students who would be required by the Nursing and Midwifery Board of Australia (NMBA) to provide a formal English language skills test result for registration should be required to demonstrate achievement of that level of English language skills before starting a registered nurse program.

Clinical placements offer nursing students the opportunity to apply theoretical knowledge, develop practice skills and become socialised into the nursing profession. Research has highlighted that a quality environment is crucial for this learning. Indicators of quality have been identified in the research literature and ANMAC seeks feedback on changes and/or additions to the current standards to better support quality improvement in the clinical learning environment.

Research into simulated learning highlights that these activities also provide opportunities to apply theoretical knowledge, develop practice skills, refine critical thinking abilities and make appropriate clinical decisions. Simulated learning activities are generally used as an adjunct to clinical practice. Evidence exploring the effectiveness of simulated learning activities as a substitute for time in the clinical setting is presented in this paper. ANMAC seeks comment; first, on how the revised standards could better support the use of simulated learning; and second, whether minimum practice hours should be inclusive of simulated learning hours.

The healthcare system is described as operating in silos with boundaries between health professionals resulting in poor coordination of patient care. Teamwork is crucial for quality care and teamwork depends on communication, collaboration and respect across multidisciplinary teams. Preparing pre-registration students to work effectively and collaboratively in inter-professional teams is crucial for their practice and the quality of patient care and safety. ANMAC seeks input into how the accreditation standards can better support inter-professional learning.

Finally, considering the current regulatory environment and scope of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (2017), ANMAC needs to explore further opportunities to create consistency and collaboration across health professions for the accreditation of education programs. Recently, the five-standard accreditation framework used in the Australian Dental Council/Dental Council (New Zealand) (DC(NZ)) Accreditation Standards for Dental Practitioner Programs (December 2014) was adopted by other professional groups including the Optometry Council of Australia and New Zealand and the Australian Physiotherapy Council.

Revision of the current nursing standards provides an opportunity to improve effectiveness while reducing the repetition of evidence required in the current framework of nine standards. Moving to a more streamlined structure is also congruent with other nursing accreditation authorities, with the United Kingdom Nursing and Midwifery Council presently consulting on a move to a five-standard accreditation framework. Therefore, ANMAC seeks stakeholder's views on a proposed move to a five-standard accreditation framework.

The questions posed this consultation paper are reproduced in an online survey. Stakeholders can provide feedback by completing the survey and/or providing a written submission to ANMAC. Further information on how to respond is outlined on page 9.

Consultation questions

Entry criteria in undergraduate nursing courses

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What support mechanisms should be offered to students from diverse backgrounds entering registered nurse programs to ensure they receive the appropriate levels of support?

Question 2

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English language requirement for entry to Bachelor of Nursing programs

Question 3

Should students who are required by the Nursing and Midwifery Board of Australia (NMBA) to provide a formal English language skills test result for registration, also be required to demonstrate achievement of the NMBA specified level of English language skills before starting a registered nurse program?

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Introduction

In 2010, the Australian Nursing and Midwifery Accreditation Council (ANMAC) became the independent accrediting authority for nursing and midwifery programs of study.

ANMAC performs the following accreditation functions as defined in section 42 of the *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law):

a. developing accreditations standards for approval by a National Board

b. assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards

The NMBA approved the current registered nurse accreditation standards (the standards) in 2012. They are due to be revised and updated. Revised or new standards—once approved by the Nursing and Midwifery Board of Australia (NMBA)—are the standards used by ANMAC to assess and accredit programs that lead to registration, enrolment or endorsement of nurses and midwives in Australia.

The previous work in developing these standards is recognised and valued. This review seeks to refine and improve them through constructive and respectful engagement with stakeholders so they continue to meet this National Law objective:

> *… to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered*

Aim of the review

The aim of this review is to develop a revised set of standards that are:

• contemporary and aligned with emerging research, policy and relevant industry guidance

• able to ensure registered nurses are suitably educated and qualified to practice in a competent and ethical manner to the required NMBA standards for practice

• acceptable to the profession and relevant stakeholders

• able to support continuous development of a flexible, responsive and sustainable Australian health workforce

• supportive of innovation in the education of health practitioners

• acceptable to the community in supporting safe, accessible, quality care.

Review process

ANMAC, as an independent accrediting authority, must comply with the National Law when reviewing and developing accreditation standards. This law states that:

> *In developing an accreditation standard for a health profession, an accreditation authority must undertake wide-ranging consultation about the content for the standard.*

ANMAC's review process ensures stakeholder feedback, expert opinion, relevant national or international benchmarks, and that the best available evidence is used in developing standard content. The iterative process for stakeholder consultation provides ANMAC with an opportunity to:

- validate whether revised accreditation standards are accurate and relevant for a contemporary Australian health care system and education environment
- evaluate whether the expectations upon education providers to meet revised standards are reasonable in terms of benefits and burdens.

Stakeholder-identified benefits and burdens are considered by the Office of Best Practice Regulation, Department of the Prime Minister and Cabinet, during the preliminary assessment of the regulatory impact of the revised standards.

A robust review process is essential if ANMAC is to assure the NMBA and community that a graduate of an accredited registered nurse program is eligible for registration and can practice in a safe and competent manner.

Purpose of the consultation paper

This consultation paper identifies how the National Law underpins the aim of this review. It describes the consultation process, including how feedback is to be provided and offers context to promote stakeholder understanding of key issues relating to and engagement with the review process. This paper presents the key issues identified and explored in the literature search relevant to the review and development of the standards. It also evaluates the current accreditation standard framework and transcribes online survey questions for stakeholder comment.

For the review to achieve its aim, it is important that organisations and individuals with an interest in registered nurse practice education provide critical input. This paper has been distributed to such organisations and individuals, inviting them to write a submission or answer the online survey.

Literature search

ANMAC conducted a literature search for relevant policy, standards or discussion documents on Australian Government and other websites relating to registered nurse practice, standard development, education, policy and regulation. Through database searches and a search of reference lists of selected articles, ANMAC identified published research on a range of issues. Professional networks provided further literature.

The literature search identified and explored these issues:

- entry criteria and undergraduate nursing courses
- attrition rates
- English language requirement for entry to registered nursing programs
- quality of clinical placements:
  - clinical learning environment
  - supervision of professional practice experiences
  - practice readiness

- simulation and student learning outcomes
- inter-professional learning for practice
- accreditation standards framework.

Consultation process

ANMAC's Chief Executive Officer (CEO) convened a Professional Reference Group to work with the Director of Accreditation Services and guide the review. Membership comprised key stakeholders and nursing professionals who could share insights into regulation, education and health policy. Members were selected after the CEO reviewed expressions of interest. The Professional Reference Group reports and provides advice to the CEO.

Members are:

- Professor Amanda Henderson, School of Nursing and Midwifery, Griffith Health, Griffith University
- Professor Melanie Birks, Head of School of Nursing, Midwifery and Nutrition, College of Healthcare Science, James Cook University
- Ms Lynne Stuart, Senior Lecturer in Nursing, School of Nursing and Midwifery, Faculty of Science, Health, Education and Engineering, University of Sunshine Coast
- Ms Kathryn Riddell, Executive Director, Learning and Teaching, Nursing and Midwifery, Eastern Health
- Adjunct Associate Professor Kim Ryan, Chief Executive officer, Australian College of Mental Health Nurses
- Ms Ann Maree Keenan, Chief Nurse and Midwifery officer, Department of Health and Human Services, Victoria
- Ms Bronwyn Clark, Chief Executive Officer, Australian Pharmacy Council
- Ms Julie Reeves, Federal Professional Officer, Australian Nursing and Midwifery Federation
- Ms Donna Waters, Dean, Faculty of Nursing and Midwifery, Sydney Nursing School
- Mr Ethan Althofer, Senior Project Coordinator, Campus development, University of Canberra
- Professor Phillip Della, Head of School, School of Nursing, Midwifery and Paramedicine, Curtin University
- Petrina Halloran, Policy Manager, Strategy and Policy, NMBA, Australian Health Practitioner Regulation Agency (AHPRA)
- Dr Wendy Penney, ANMAC, Associate Director of Professional Programs
- Dr Margaret Gatling, ANMAC, Director of Accreditation Services

How stakeholders can participate

In stage 1 of consultation, stakeholders can provide feedback by:

1. Completing an online survey.
   The questions in this consultation paper are reproduced in the online survey, which is accessible via SurveyMonkey

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2. Preparing a written submission
Written submissions must include the stakeholder's name and contact details (phone number, email, address). They can be emailed to ANMAC:
standardsreview@anmac.org.au

Or posted to:

Standards review

Australian Nursing and Midwifery
Accreditation Council
GPO Box 400
Canberra City ACT 2601

In the interest of transparency, all written submissions will be published on ANMAC's website, unless the stakeholder has asked for their submission to remain confidential.

Material supplied in confidence, should be clearly marked 'In confidence' and be provided as a separate attachment to non-confidential material. Information that is confidential or submitted in confidence will be treated as such, if the stakeholder explains why such treatment is necessary.

You may be asked to provide a non-confidential summary of confidential material or explain why such a summary cannot be provided.

ANMAC will publish a summary of survey results on its website.

The Professional Reference Group will respond to feedback collected. Responses will be published on ANMAC's website and emailed to stakeholders.

> **Survey responses or written submissions are requested by Sunday, 22October 2017**

ANMAC's website will be updated to reflect each review stage. Stage 2 of consultation is planned for December 2017.

ANMAC expects to release the revised registered nurse accreditation standards mid-2018, subject to NMBA approval.

Background

Workforce characteristics

On 31 March 2017, 280 000 registered nurses were practicing in Australia with an additional 7000 holding both enrolled and registered nurse registration. Of this group, approximately 60 per cent are aged 40 years or over [1]. The potential loss of experienced nurses, due to retirement, will exacerbate nursing shortages. Workforce planning projections estimate a shortage of 80 000 registered nurses by 2025 [2]. As nurses make up more than half the health care workforce it is essential to ensure the profession's sustainability.

Influences on practice

Globally, health care is changing. An ageing population, a significant increase in chronic disease and co-morbidities, and the diverse needs of multicultural Australians all influence nursing practice. At the same time, health and information technologies are creating flexible options for care provision. Registered nurses play a role in the provision of healthcare, and contemporary accreditation standards are key to ensuring that education programs reflect

contemporary workforce requirements. Critical appraisal of the standards is required to support the next generation of registered nurses to be well equipped to provide health care and meet future workforce challenges.

Key areas for consideration

Entry criteria in undergraduate nursing courses

Recent years has seen a push to facilitate access to Bachelor of Nursing programs for students from diverse backgrounds and with varying abilities. In 2015, the Australian Tertiary Admission Rank (ATAR) for entry to a three-year Bachelor of Nursing program in Australia ranged from 50.35 to mid-80.0s (Table 1).

Table 1: Comparison of selected health profession ATAR 2015 with Queensland Equivalent Overall Position (OP)

Program	ATAR	OP
3-year Bachelor of Nursing	50.35 – 80.0	19-10
3-year Bachelor of Psychology	52.30 – 99	19-1
4-year Bachelor of Pharmacy	74-92.15	13-5
4-year Bachelor of Physiotherapy	80->95	10-4

(Source: https://www.myhealthcareer.com.au/nursing/atar-for-nursing)

Entry rankings are linked to the likelihood of a student completing their course [3, 4.] Basing admission requirements on a higher rank protects program entry standards given the complexity of professional nursing practice [5]. However, ATAR rankings are a poor measure of school performance and, therefore, of the potential of applicants to achieve success in future study. Basing entry on results from secondary education may exclude potential applicants from diverse backgrounds who can positively contribute to the profession. Alternative admission pathways allow potential applicants entry to tertiary study who would otherwise not meet admission criteria based on entry ranking. These pathways include Technical and Further Education courses, recognition of prior employment and experience, pre-tertiary study courses and facilitated entry for students from low socioeconomic status backgrounds and/or are living in rural Australia [5]. The Australian Government recognises alternative entry pathways as one way of addressing workforce shortage. This relies on increasing the number of students enrolling in undergraduate nursing programs [6].

Students from alternate entry pathways can succeed in undergraduate nursing programs. One study investigated the link between an alternative entry pathway, selected student attributes and the success of students (n=126) enrolled in an undergraduate nursing program at one Australian university. Students with an entry score between 50 and 70 received extra help with writing and study skills. No significant difference was found between student success, entry pathway and entry score in their first year of study. Students with entry scores < 70 and > 70 achieved similar above average results. These results suggest that a positive learning environment, a keen interest in nursing and motivation can be the platform for success in students from diverse backgrounds [5].

Student attrition rates are another measure used to determine the success of increasing student numbers in pre-registration nursing programs. Attrition is measured by taking the number of students enrolling and starting in a course in one year minus the number of

students enrolled who started in the program that year but did not complete the year or re-enrol the following year, expressed as a percentage [7].

Attrition rates have been a significant issue for workforce retention. Before nursing education moved into the tertiary sector, attrition from hospital-based nursing courses was reported to be as high as 50% in some states and territories [8]. Since that time, the attrition rate of nursing students has continued to vary across sectors and been reported to be an average of 34% (18% to 54%) [2]. This rate contrasts with the reported attrition rate of 14.79% for domestic students enrolled in all undergraduate programs in Australian universities [9].

Issues related to attrition in the literature include, but are not limited to:

- wrong career choice

- academic failure

- poor quality clinical placements

- pressure from other commitments outside study (demands of full-time and part-time employment, carer commitments) [6, 7, 10].

Evidence from the literature identifies that developing supportive strategies to engage learners early in the first year, which facilitates their sense of fitting in, is a key retention strategy [6]. Students who experienced early academic success (submitting and passing their first assessment item), who were engaged with their learning (attending orientation and early semester tutorials) and who had less outside commitments (hours of employment and carer responsibilities) were more likely to progress to the second year of study [6, 11, 12]. Experiencing a supportive clinical placement can positively influence retention [13]. Also, students who experienced a positive learning environment, who had a keen interest in the discipline and were motivated to study were more likely to succeed [5]. While some factors are not modifiable, it is timely to consider how to better engage learners in their first year of study.

In summary, the more diverse the nursing student population becomes, the more diverse their educational needs. Embedding strategies shown to facilitate student success in nursing curricula is crucial.

Question 1

> What support mechanisms should be offered to students from diverse backgrounds entering registered nurse programs to ensure they receive the appropriate level of support?

Question 2

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

English language requirement for entry to Bachelor of Nursing programs

Australia is a culturally diverse country with 26% of the population being born overseas and more than 21% speaking a language other than English at home [14]. To meet the health care needs of a multicultural society, the health system requires health care professionals from different linguistic and cultural backgrounds to provide culturally safe care [15]. Consequently, the nursing workforce is striving to better reflect the diversity of the population it serves.

In response to the demands for a culturally diverse nursing profession, Australian universities have increased admissions from international and domestic students from many backgrounds. In 2011, 27% of students enrolled in Australian universities came from backgrounds where English was a second language with this figure expected to be reflected in the nursing student population [16]. Increasing the numbers of students entering undergraduate nursing programs from diverse backgrounds is an investment in achieving the multicultural nursing workforce much needed in Australia. However, nursing students from English as a second language backgrounds have had difficulty with aspects of English, including reading, writing, and understanding and mastering the technical language associated with nursing care [17, 18]. Being competent in English in the clinical setting is crucial for public protection. Without an appropriate level of proficiency, patient safety could be compromised.

On initial registration, all nursing graduates—whether English is their first or second language—must meet the NMBA's English language skills registration standard to demonstrate they can speak and communicate in English sufficiently to practice safely. Registered nurse graduates meeting the requirements of the NMBA's standard require evidence that they have:

a. achieved at a specified level in an English language test[1] or

b. completed five years, or fulltime equivalent of, a combination of vocational, secondary and/or tertiary education taught and assessed in English in a recognised country (including Australia, Canada, New Zealand, Republic of Ireland, South Africa, the United Kingdom and the United States) or

c. completed at least a one-year, full-time equivalent pre-registration program of study approved by a recognised nursing and/or midwifery regulatory body in a recognised country, as well as evidence that the relevant professional qualification was taught and assessed solely in English in a recognised country (including Australia, Canada, New Zealand, Republic of Ireland, South Africa, the United Kingdom and the United States).

To date students undertaking registered nurse programs of study have not needed to demonstrate a similar level of English language skills even though, in such programs, they complete a minimum of 800 hours of professional experience placement. In the clinical setting students may be directly or indirectly supervised, which means times when they interact with patients, their families and other health care professionals on a one-to-one basis.

Literature exploring the experiences of nursing students with English as a second language in the clinical setting found that students:

• had difficulty understanding directions given by nurses and were reticent about seeking clarification

• struggled with understanding medical and non-medical jargon, which they described as a burden of learning an additional language of nursing

• had difficulty introducing themselves, making small talk and understanding patient requests when interacting with assigned patients

• were fearful of making a patient-related error due to lack of language skills

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[1] A number of English language tests are used. Equivalence in English language test scores is detailed in the NMBA English language skills registration standard. The International English Language Testing System (IELTS), as a well-known English language test, is referred to throughout this paper so the reader has a reference point from which they can compare other English language test results, as needed. The NMBA requires a minimum IELTS academic module score of seven in each of the four components of listening, reading, writing and speaking.

- had difficulty communicating with colleagues, patients and their families

- had problems with pronunciation, telephone communication and comprehending colloquial expressions [16, 18].

The English requirements in Australian universities for entry to the Bachelor of Nursing generally range from an IELTS Band score of 6.5 to 7.0 (or equivalent). It has been expected that, following several years of study in English, students entering a nursing program with a score of 6.5 could achieve an IELTS Band score of 7 (or the equivalent) in all bands.

Relevant research, although limited and focused only on higher education, has demonstrated minimal IELTS gains between entry and exit scores for international students completing degrees, over extended enrolment periods [19]. One study analysed the English language proficiency development of 40 international and domestic students with English as a second language enrolled in undergraduate studies in three faculties at one Australian university. The study compared two IELTS tests, one taken before university studies in Australia and the other at the end of undergraduate degrees. While most students improved English proficiency, only a small number achieved an overall score of 7.0 (with 7.0 in all bands). The findings caution against assuming a student who achieves a score of 6.5 in an IELTS test when entering university will likely achieve a score of 7.0 after several years of study in English [20].

One Australian university studied changes in language proficiency among international undergraduate students (n=51) requiring English language support. One facet investigated changes in IELTS scores in the first semester of study. The findings indicate a relationship between language proficiency test scores and academic achievement measured by grade point average (GPA). Listening and reading scores were strongly correlated with GPA while speaking and writing skills were not strongly correlated with this. While the need to replicate this study in a larger sample size is required, the research suggests the need to place greater emphasis on an applicant's minimum entry scores for listening and reading [20, 21].

From the start of studies, it is essential that nursing students have sufficient English language skills to understand and synthesise complex program content. For public protection and to mitigate risk, stakeholders are asked to consider what standard of English language proficiency should be required of students on entry to a registered nurse program of study. As the only nationally accepted and evidenced-based benchmark stipulating a minimum level of English language skills for safe nursing and midwifery practice, ANMAC proposes that the NMBA English language skills registration standard be used to establish an equivalent English language skills standards for students entering a registered nurse program of study.

> **Question 3**
>
> Should students who are required by the Nursing and Midwifery Board of Australia (NMBA) to provide a formal English language skills test result for registration, also be required to demonstrate achievement of the NMBA specified level of English language skills before starting a registered nurse program?

Quality of clinical placements

As more students enter universities seeking nursing qualifications, the demand for clinical places has risen [22, 23]. Experience in the clinical setting is an integral component of undergraduate nursing curricula involving placement, for a set period, in clinical settings across health facilities. During this period, students apply theoretical knowledge in the health care setting, develop practice skills and become socialised into the nursing profession. Research has

highlighted that a quality environment is crucial for this learning, but what is such a learning environment? How can it be defined? What factors are associated with quality? These types of questions are considered next.

Clinical learning environment

Quality is difficult to quantify when discussing clinical learning environments. The quality of student placements has generally been defined in terms of learning outcomes [23]. A circular argument of excellence in achievement of learning outcomes being equated with an excellent clinical learning environment. Factors purported to be related with quality include, but are not limited to, a safe and supportive environment, excellent communication, effective supervision, and diverse and appropriate learning opportunities [13, 23–25]. However, few published instruments measure these factors [23] so how can the essence of quality be captured in clinical placements?

The Best Practice Clinical Learning Environments (BPCLE) framework [26] (Figure 1) comprises six key elements that indicate a high-quality learning environment. Element three's features of a positive learning environment include:

- welcoming environment
- culture of learning
- safe environment
- appropriate learning opportunities
- clarity of objectives
- high-quality clinical education staff
- well-prepared learners
- appropriate ratio of learners to educators
- appropriate ratio of learners to clients
- continuity of learning experiences
- structured learning programs and assessment

This key element of the BPCLE framework could further refine outcome-based accreditation standards for high-quality clinical learning environments.

Best Practice Clinical Learning Environment Framework

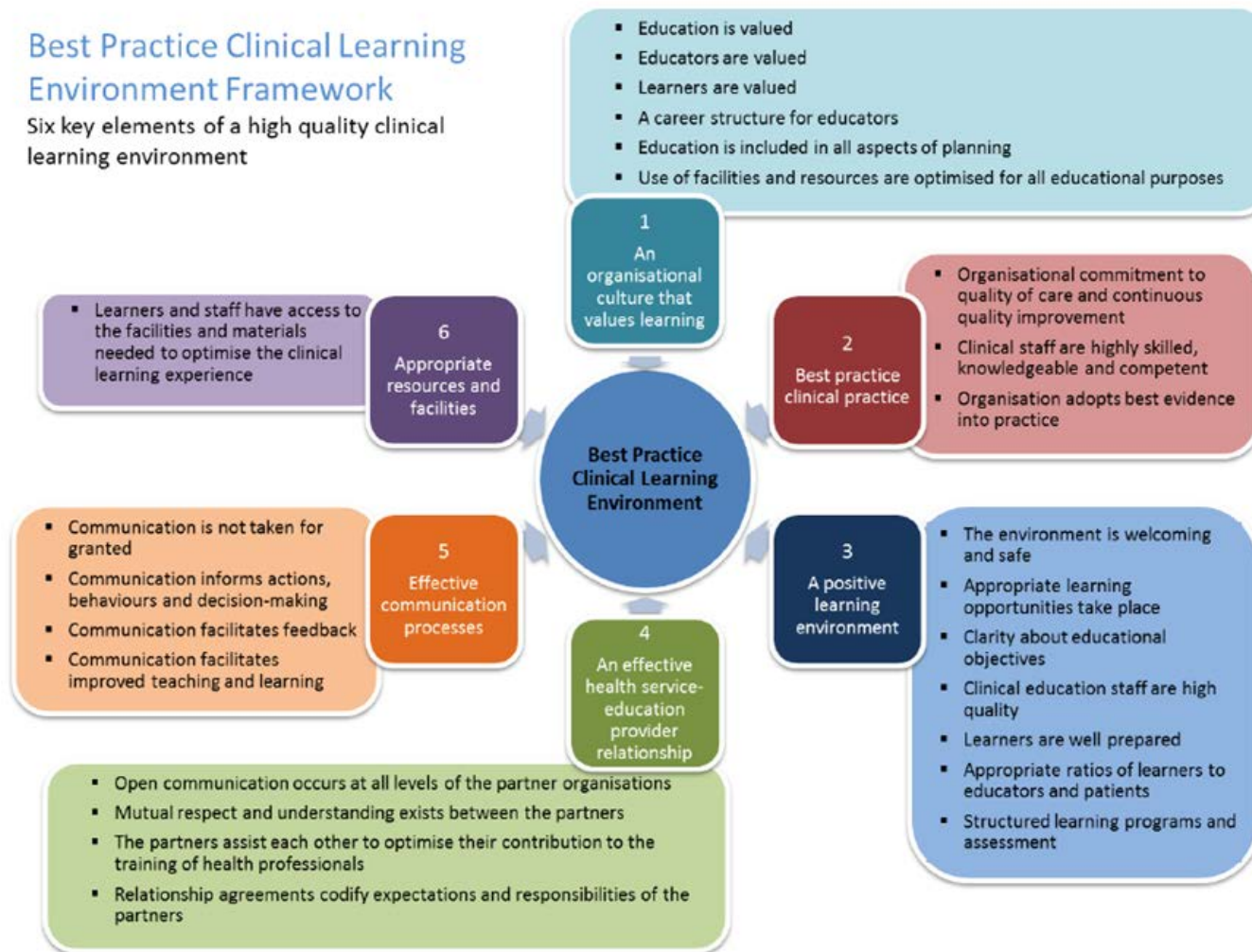Six key elements of a high quality clinical learning environment

1
An organisational culture that values learning

- Education is valued
- Educators are valued
- Learners are valued
- A career structure for educators
- Education is included in all aspects of planning
- Use of facilities and resources are optimised for all educational purposes

2
Best practice clinical practice

- Organisational commitment to quality of care and continuous quality improvement
- Clinical staff are highly skilled, knowledgeable and competent
- Organisation adopts best evidence into practice

3
A positive learning environment

- The environment is welcoming and safe
- Appropriate learning opportunities take place
- Clarity about educational objectives
- Clinical education staff are high quality
- Learners are well prepared
- Appropriate ratios of learners to educators and patients
- Structured learning programs and assessment

4
An effective health service-education provider relationship

- Open communication occurs at all levels of the partner organisations
- Mutual respect and understanding exists between the partners
- The partners assist each other to optimise their contribution to the training of health professionals
- Relationship agreements codify expectations and responsibilities of the partners

5
Effective communication processes

- Communication is not taken for granted
- Communication informs actions, behaviours and decision-making
- Communication facilitates feedback
- Communication facilitates improved teaching and learning

6
Appropriate resources and facilities

- Learners and staff have access to the facilities and materials needed to optimise the clinical learning experience

Best Practice Clinical Learning Environment

Figure 1: Best Practice Clinical Learning Environment Framework
Source : https://bpcletool.net.au/media/medialibrary/2016/09/BPCLE_Framework_Aug_2016.pdf

Supervision of professional practice experiences

The choice of a supervision model for professional practice experiences is key to delivering quality clinical education. The five most commonly used models in Australia are preceptor, facilitation/supervision, facilitation/preceptor, dedicated education unit, and mentor [22] (Table 2). A review of these argued that the dedicated education unit model (DEU) was best suited to provide high-quality professional practice experiences supervision for undergraduate nursing students [27]. Originating in Australia, this model has been adopted in New Zealand, the United Kingdom and the United States. It fosters a supportive clinical learning environment for students, preceptors/facilitators, educators and health facility staff. When compared to traditional models, the DEU model:

- promotes critical thinking and evidence appraisal

- increases a sense of belonging [28]

- provides more opportunities to learn communication, teamwork and time management [29]

- increases self-efficacy [30]

- facilitates stronger academic-clinical partnerships [28, 31]

- provides opportunities to increase the student placement capacity of health services

In summary, the DEU model facilitates a positive learning environment which, in turn, produces critically thinking competent graduates [27].

Table 2: Health Workforce Australia supervision of professional practice experience models

Model	Components of model
Preceptor	The 1:1 model—the most commonly used with clinical supervision—is where a student is assigned to a registered nurse known as the 'preceptor'. The student works alongside the preceptor daily for direct and indirect supervision and undertakes formative and summative assessments.
Facilitation/supervision	A 1:6 or 1:8 model is where a registered nurse directly and indirectly supervises a group of students. Facilitators are university employed or hospital employed staff and undertake summative and formative assessments.
Facilitation/preceptor	A combination of the preceptor and facilitation/supervision models where a student is allocated ('buddied') to a registered nurse for preceptoring and the facilitator undertakes group supervision of 1:8 or more.
Dedicated education unit	A combination of the preceptor and facilitator models with the added component that there is a partnership between the health service and university and a Clinical Liaison Nurse (more commonly called 'Nurse Educator') who provides the link to the university.
Mentor	A model similar to the preceptor model but is less commonly used in undergraduate clinical education as the clinical supervision is more often than not, indirect. The mentor model involves a longer-term relationship between the student and registered nurse.

Practice readiness

Research highlights an observed difference between what is expected of a nurse on graduation (sometimes referred to as 'practice readiness') and the perceived outcomes of entry–to-practice nursing programs [32]. The concept of practice readiness is complex and highly contested [33]. Since nursing education moved into the tertiary sector in the mid-1980s, the practice readiness of newly registered nurses has been debated between industry and education providers. Rather than delineating between the requirements and responsibilities of stakeholders, it is argued that nurse education is a joint enterprise and that authorities, health and education providers share responsibility for producing quality graduates [34,35]. Practice experiences are an essential component of education for practice–based professions. It is timely to consider how accreditation standards can contribute to ensuring quality professional practice experiences for undergraduate nursing programs.

Question 4

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

Question 5

> Are elements of the Best Practice Clinical Learning Environment framework useful in developing outcome-based standards for accreditation? If so, which ones?

Simulation and student learning outcomes

Clinical placements, where students are sent to different health facilities for a set period, aim to help students integrate knowledge and skills from the classroom into clinical practice. Providing quality clinical experiences is an ongoing challenge in nursing education because of increasing student numbers. This creates more competition among higher education providers for limited clinical places. This challenge has led to exploring alternative strategies for achieving similar learning outcomes. Increasingly, simulation is the strategy of choice [36].

Simulation is defined as learning experiences that strengthen, mimic or replace real-life clinical situations [37]. It aims to enable students to reason through a clinical problem and make decisions, without compromising patient wellbeing.

Simulation has advantages over didactic approaches to learning with low and high-fidelity approaches considered to be equally useful. High fidelity does not necessarily involve high technology as simulated patient scenarios are relevant for situated learning without this [38].

Research evidence highlights that simulated learning benefits student knowledge and practice [36, 38, 39]. Simulation activities are thought to be an adjunct to clinical practice; however, could they be used as a substitute for hours spent in the practice setting? Can simulation activities prepare students to practice skills, think critically and make clinical decisions when used as a substitute?

The best available evidence comes from a randomised controlled longitudinal multi-site trial conducted in the United States. Cohorts of students (n=666) enrolled in undergraduate nursing programs (n=10) were randomised to receive varying amounts of high-fidelity simulation (10%, 25%, 50%) as a substitute for traditional clinical practice. Findings provide evidence that using high-fidelity simulation as a substitute for traditional clinical hours resulted in no differences in nursing knowledge, clinical competence or overall readiness for practice at graduation, and at

follow-up points following graduation (6, 12 and 24 weeks) [40]. Subsequently, conditions essential for reproducing these outcomes were outlined [41].

Conditions included:

- sufficient numbers of adequately prepared and committed faculty

- dedicated simulation lab with appropriate resources

- realistic, appropriately designed vignettes

- debriefing based on a theoretical model.

Guidelines for regulation authorities assessing the ability of education providers to adopt simulation into their curriculum were also outlined [41].

While this study demonstrates that, under certain conditions, simulation promotes outcomes similar to traditional clinical experiences, its applicability in the Australian context is unclear in the absence of replication studies. Nevertheless, it is timely to consider other questions.

Question 6

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

Question 7

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

Inter-professional learning for collaborative practice

Contemporary health care practice is increasingly complex with health professionals needing to deal with more complex health challenges and disease processes facing individuals and communities. Australia's healthcare system has been described as operating in silos and boundaries between health professionals can result in poor coordination of patient care [42]. Teamwork is crucial for quality care. This depends on communication, collaboration and respect across multidisciplinary teams. Preparing pre-registration students to work effectively and collaboratively in inter-professional teams is crucial for their practice and the quality of patient care and safety.

Inter-professional education (IPE) is defined as 'education [that] occurs when two or more professions learn about, from and with each other to enable effective communication' [43]. Previous research has identified barriers and facilitators to implementing IPE in undergraduate education in health. Barriers include funding by institutions, difficulties with scheduling activities across discipline groups, unclear expectations and over-crowded curriculums. Facilitators include positive staff attitudes, support for developing faculty expertise, shared inter-professional vision and equal status among professional groups engaged in an activity [44].

The inter-professional education workshop—Collaborating for Patient Care-Inter-professional Learning for Inter-professional Practice (2015) [42] explored issues related to IPE with contributors from different professional groups. Participants considered that accreditation standards could be a motivator of IPE by signalling support for IPE and practice. They considered outcome-based standards to be more conducive to supporting education providers scope to innovate when addressing IPE. Participants thought it crucial to develop standards that apply to various practice settings and are achievable for education providers in

geographically diverse areas. They also highlighted the importance of ensuring that standards allow for cross-professional supervision where appropriate.

Workshop participants also explored the usefulness of simulation as a strategy for IPE activities. They argued that high-quality simulation can provide experiential learning opportunities that are superior to traditional clinical placements and complement learning opportunities. The participants considered eight draft competencies outlining graduate outcomes for IPE (listed below) [45]. Six of the eight were behavioural, rather than discipline specific. They could therefore easily be evaluated by assessors from differing professions.

On completion of their study, graduates of any professional entry level health care degree should be able to:

- explain inter-professional practice to patients, clients, families and other professionals
- describe areas of practice of other health professions
- express professional opinions competently, confidently and respectfully without using discipline specific language
- plan patient and client care goals and priorities by involving other health professionals
- recognise and resolve disagreements over patient care arising from different disciplinary perspectives
- critically evaluate protocols and practices in relation to inter-professional practice
- give timely, sensitive and instructive feedback to colleagues from other professions, and respond respectfully to feedback from these colleagues [45].

The current *Registered Nurse Accreditation Standards 2012* require education providers to include opportunities for nurses to engage in activities that facilitate inter-professional learning for collaborative practice (2.4, 3.5 and 8.4). It is timely to consider how revising the standards can support education providers to innovate and strengthen IPE in their curricula.

> **Question 8**
>
> How can the accreditation standards better support inter-professional learning?

Accreditation standards framework

The *Registered Nurse Accreditation Standards 2012* introduced a new ANMAC accreditation standards framework. This framework is structured around nine domains each with a standard statement, expressed in one or two sentences, addressing these broad areas:

1. governance
2. curriculum conceptual framework
3. program development and structure
4. program content
5. student assessment
6. students
7. resources
8. management of workplace experience

9. quality improvement and risk management.

Each standard statement is underpinned by a set of individual criteria, varying from six to 13. The education provider must address the nine standards in the accreditation application for a Bachelor of Nursing program.

The recommendations from the *Independent Review of the National Registration and Accreditation Scheme for health professions* (December 2014) discuss the importance of accreditation authorities standardising accreditation processes and avoiding duplication for education providers with existing education accreditation processes.

Considering the current regulatory environment and scope of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (2017), ANMAC needs to explore further opportunities to create consistency and collaboration across health professions for the accreditation of education programs for health professions. The current registered nurse standards have served their purpose. It is time to improve them and shape the role of the registered nurse, especially in view of feedback from education providers on the repetition of evidence required in the standards. Moving to a more streamlined structure is also congruent with other nursing accreditation authorities with the United Kingdom Nursing and Midwifery Council consulting on a move to a five-standard accreditation framework [46].

An example of standardising accreditation processes between health professions accreditation councils is the adoption of the accreditation standard framework used in the *Australian Dental Council/Dental Council (New Zealand) (DC(NZ)) Accreditation Standards for Dental Practitioner Programs* (December 2014) by the:

• Optometry Council of Australia and New Zealand

• Australian Physiotherapy Council

• Council on Chiropractic Education Australasia

• Australian Psychology Accreditation Council (under review).

These accreditation standards are characterised by five domains, each with a short standard statement (Table 3).

Table 3: Accreditation standards for dental practitioner programs

Number	Domain	Standard Statement
1.	Public safety	Public safety is assured.
2.	Academic governance and quality assurance	Academic governance and quality assurance processes are effective.
3.	Program of study	Program design, delivery and resourcing enable students to achieve the required professional attributes and competencies.
4.	The student experience	Students are provided with equitable and timely access to information and support
5.	Assessment	Assessment is fair, valid and reliable.

Each standard statement is underpinned by criteria, varying from four to 11. The education provider must address 36 criteria in their accreditation application

The Australian Dental Council's accreditation standards emphasise public safety. Standard 1, for example, is wholly dedicated to public safety, which aligns with these aims of the National Registration and Accreditation Scheme:

- protect the public by ensuring that only suitably trained and qualified practitioners are registered

- facilitate workforce mobility across Australia to enable the continuous development of a flexible, responsive and sustainable Australian health workforce.

Other key differences between the Dental Framework and ANMAC's framework include:

- domains of governance and quality assurance, which are merged

- evidence guidelines document supporting accreditation standards by explaining and setting out the accreditation process, as well as outlining the documentary evidence education providers must provide as part of the accreditation process

- assessment of dentistry programs has regard for whether each criteria is met and takes an on-balance view of whether evidence presented by an education provider demonstrates that a standard statement is met.

Question 9

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

Question 10

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

Question 11

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

Guidance on the use of evidence

The review and development of the registered nurse accreditation standards presents an opportunity to introduce evidence guides to support the accreditation standards. These would be designed to support education providers by providing contemporary and useful guidance on the evidence they need to include in their accreditation application.

Evidence Guides support the Accreditation Standards of the following Accreditation Councils:

- Australian Dental Council*

- Australian Physiotherapy Council*

- Australian Pharmacy Council

- Optometry Council of Australia and New Zealand*

- Australian and New Zealand Podiatry Accreditation Council

- Australia Psychology Accreditation Council (proposed to include with the Standards under review). *

Accreditation standards based on the ADC/DC(NZ) framework (*) have developed evidence guides as separate documents. This provides a level of flexibility to review updates and respond to changes in the regulatory, education and health policy environment.

> **Question 12**
>
> To what extent are accreditation standards clear in their expectations of the evidence required of education providers to demonstrate compliance?
>
> **Question 13**
>
> What is the best way to provide guidance to the standards and criteria (for example, to ensure consistent interpretation of those concepts in the current environment and/or elaborate on important concepts)?

Best practice standards

Increasingly, best practice in standard development makes use of outcome-based standards. A recent survey of ANMAC stakeholders (n=133) demonstrated that most (53%) preferred a move to outcome-based standards. These differ from process-based standards which focus on inputs and processes (tasks and activities). Outcome-based standards specify what graduates should demonstrate on completion of their education program (knowledge, skills and attributes). Using only outcome-based standards, however, may lead to superficial student learning. As the goal of professional performance contains more than learning outcome based competencies, a comprehensive approach is warranted. Combining process and outcome-based standards allows ANMAC to consider components not easily measured. ANMAC therefore aims for an approach that combines both types of standards, which is necessary for quality improvement [47].

The Registered Nurse Accreditation Standards 2012 are predominantly outcome-based with some process-orientated elements. ANMAC considers that, in combination with outcome-based standards, some prescriptive elements are required. An example is determining competence within the current registered nurse standards where minimum practice hours are mandated. In outcome standards, it could be argued that a student who demonstrated competence at one point in the program before completing the minimum practice hours need not complete the remaining hours. However, practice hours are not only about competence, they are about overall clinical experience which goes beyond knowledge and skills assessed. Practice provides the opportunity of experiential learning, application of theoretical knowledge and growing familiarity and comfort with the workplace environment and requirements such as shift work. Many of these elements are not easily measured or assessed through competency assessments. It should be noted that these are the elements that positively contribute to readiness to practice.

> **Question 14**
>
> Should there continue to be an input-based standard prescribing the minimum number of clinical practice hours to be completed?

Future directions

The following questions seek to explore how the standards could support the next generation of registered nurses to be well equipped to provide health care and meet future workforce

challenges as well as providing an opportunity for identification of issues not covered in the present consultation paper.

Question 15

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

Question 16

> How can the accreditation standards support the development of the role of the registered nurse to meet the future health care requirements of individuals and communities?

Question 17

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

Summary

This consultation paper presents the current evidence on issues relevant to revising the registered nurse accreditation standards. While some issues raised are not new, it is crucial to respond to the challenges of developing accreditation standards for innovative and future directed registered nursing programs.

Glossary

Australian Tertiary Admission Rank (ATAR) – primary criterion for entry into a majority of undergraduate-entry university programs in Australia

Attrition – is measured by taking the number of students enrolling and starting in a course in one year minus the number of students enrolled who started in the program that year but did not complete the year or re-enrol the following year, expressed as a percentage [7].

Criteria – rules or tests on which a judgement or decision in relation to compliance with the Accreditation Standards can be based.

Competence – the combination of skills, knowledge, attitudes, values and abilities underpinning effective and /or superior performance in a profession or occupational area.

Education provider/program provider – university, or other higher education provider, responsible for a program of study leading to the award of a Bachelor Degree in nursing as a minimum.

English language proficiency – ability of students to use the English language to make and communicate meaning in spoken and written contexts while completing their program of study.

Governance – framework, systems and processes supporting and guiding the organisation towards achieving its goals and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements.

Grade point average (GPA) - a number representing the average value of the accumulated final grades earned in courses over time. A student's GPA is calculated by adding up all accumulated final grades and dividing that figure by the number of grades awarded.

Health Practitioner Regulation National Law Act 2009 (the National Law) – legislation contained in the schedule to the Act, which provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010. It covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health performance arrangements and privacy and information – sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner.

Health service providers – health facilities or other appropriate service providers, where students undertake supervised workplace experience as part of a nursing or midwifery program of study.

Health Workforce Australia (HWA) – initiative of the COAG and established to meet the challenges of providing a health workforce that responds to the needs of the Australian community.

High fidelity simulation –involves one or more of the following modalities: partial-task trainers, standardised patients (SPs), full-body task trainers, and high-fidelity mannequins[38].

International English Language Testing System (IELTS) – used to test English language proficiency. The IELTS test is designed to assess the language ability of non-native speakers of English who intend to study or work where English is the language of communication.

Input/process based standards – specifies the tasks and activities which to be undertaken or completed. Focus is on what must be taught [47].

Inter-professional learning (IPL) – when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

Inter-professional education (IPE) – defined as education [that] occurs when two or more professions learn about, from and with each other to enable effective communication [43].

Registered nurse (RN) – a person with appropriate educational preparation and competence for practice, who is registered by the NMBA to practise nursing in Australia.

Simulated learning experiences (SLE) – defined as learning experiences that strengthen, mimic or replace real-life clinical situations [37]. SLE aims to enable students to reason through a clinical problem and make decisions, without compromising patient wellbeing.

Standard – level of quality or attainment.

Student – any person enrolled in a program from which graduates are eligible to apply for registration to practice as a registered nurse.

Supervision – can be direct or indirect:

- Direct supervision is when the supervisor is present and personally observes, works with, guides and directs the person being supervised.

- Indirect supervision is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, needs of the person receiving care and the needs of the person being supervised.

Professional practice experiences – involves placement, for a set period, in clinical settings across health facilities. During this period, students apply theoretical knowledge in the health care setting, develop practice skills and become socialised into the nursing profession.

Program or program of study – full program of study and experiences that must be completed before a qualification recognised under the AQF, such Bachelor or Master of Nursing, can be awarded.

Outcome based standards – specify what graduates should demonstrate on completion of their education program (knowledge, skills and attributes). Focus is on learning [47].

Overall Position (OP) – tertiary entrance rank used in the Australian state of Queensland for selection into universities.

Quality assurance – assures quality by ensuring that practices are compliant with quality standards. Quality assurance in health care is about ensuring adherence to quality standards as mandated by regulatory bodies.

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