	Feedback received - Consultation 3
Standard 1: Safety of the public	
1.1 The program's guiding principle is safety of the public.	• The definition and scope of safety of the public in addition to the interplay of individual accountability might be strengthened.
1.2 The program is delivered in Australia to prepare graduates for safe and ethical practice.	• 1.2 conflicts with 3.2 in that 1.2 implies the entire program is delivered in Australia whereas 3.2 states no more than one semester of the program is completed outside Australia. In addition, when a nurse trained and obtained registration as a nurse overseas he or she was able to complete the 3rd year of a Bachelor of Science (Nursing) program in Australia and, following successful completion, apply for registration in Australia. The standard as written would prevent this pathway from occurring, and requires modification or development of a separate criterion to address this point.
1.3 The education provider ensures that organisations in which students undertake professional experience placement have: a) evidence-based quality and safety policies and processes that meet relevant jurisdictional requirements and standards b) registered nurses who are prepared for the role and are able to supervise and assess students during all professional experience placements c) inter-professional practice settings where teaching and learning can be in collaboration with other relevant registered health practitioners.	• 1.3 a) Make explicit reference to NSCHS Standards • 1.3b) do the mentors/supervisors require Bachelor of Nursing or higher qualifications and their Cert IV TAE? This is a key issue particularly for the Diploma of Nursing courses (due to challenges with ASQA practical assessment requirements in at least four HLTENN units) • 1.3c) an open ended statement – may need further clarification about specific qualifications. A footnote could be added here • 1.3a) What degree of responsibility do the education providers have for this criterion? There are some details in the clinical placement agreements. • 1.3b) This criterion needs to be discussed more fully regarding the degree of responsibility. E.g. programs can be provided and RN can attend but still may not be prepared for the role. • 1.3b) What is meant by prepared for the role? How would this be measured? • 1.3c) What is meant by collaboration? How would this be measured?
1.4 Students are registered with the Nursing and Midwifery Board of Australia (NMBA) before their first professional experience placement[1].	• Change words to 'prior to commencing their first professional experience placement'

[1] Student registration: Nursing and Midwifery Board of Australia, 2017. Available from: https://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Student-Registration/Fact-sheet-education-providers.aspx

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1.5 The education provider undertakes screening and management of students who present with an impairment[2] and reports to the NMBA as required.	• Does the RTO or education provider also have a duty of care to disclose their concerns in these circumstances? • Who will undertake screening and assessment? Update to *the education provider supports students who present with an impairment, in accordance with relevant legislation, and notifies the NMBA as required* • The meaning of the word 'present' is ambiguous. Currently students are required to make a declaration, but it is beyond the capacity of the university to screen all students for 'physical or mental impairment, disability, condition or disorder (including substance abuse or dependence)'. • Comment – suggested review of language in this standard to aline with the mandatory guideline– the provision of inherent requirements as part of the admission requirement is part of 1.6 therefore this is only around the reporting of an impairment that is identified as having putting the public at risk - The education provider has a process in place to make a mandatory report to NMBA of students who have an impairment that in the course of completing clinical training, may place the public at substantial risk of harm. • Suggest re-wording of this statement to improve readability: The education provider undertakes screening of students for impairment and has a documented process for management of identified impairments, including reporting to NMBA as required. • Suggested wording change to standard 1.5 The education providers undertakes the management of students who present with an impairment and reports to the NMBA as required. Rational there is no mechanism for universities to screen all students for an impairment. Self declaration is important • 1.5 The language of 'impairment' is deficit focused. Maybe replace with ...screening and management for inherent requirements...
1.6 Program admission requirements are fair, equitable and transparent. Before accepting an offer of enrolment applicants must: a) meet the program's inherent requirements b) provide evidence of meeting the NMBA's English language skills registration standard[3]	• 1.6b) The words 'before course commencement' should be added to 1.6 under point (b) to provide • further clarity regarding the entry requirements for English language skills. • The order of standard 1 needs to be changed. 1.6 should swap with item 1.3 to provide a more logical order within the standard. • Criterion 1.5 and 1.6: not every university has inherent requirements – might also want to include fitness to practice;

[2] Definition available from: https://www.ahpra.gov.au/Registration/Graduate-Applications-for-Registration-FAQs/Registration-Standards-FAQs.aspx#impairment

[3] Registration standard: English language skills. Nursing and Midwifery Board of Australia, 2019. Available from: https://www.nursingmidwiferyboard.gov.au/Registration-Standards/English-language-skills.aspx

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c) be informed of NMBA registration requirements[4].	
1.7 Program progression policies allow student access to professional experience placement where the student is deemed competent to attend.	• The criterion could be reworded. Our interpretation is: if students are not deemed competent in a professional experience placement, they are not able progress. Perhaps it could read 'should only allow students to progress...'
Standard 2: Governance	
2. 1 Academic governance arrangements for the program of study includes: a) current registration by the Tertiary Education Quality and Standards Agency as an Australian university or other higher education provider b) mechanisms to meet relevant national or state regulatory requirements c) listing on the Australian Qualifications Framework National Registry for the award of a Bachelor Degree as a minimum.	• Amend 2.1c as Australian Qualifications Framework Registery is no longer in operation
2.2 The governance structure for the provider and the school conducting the program ensures the: a) academic oversight of the program and promotes high-quality teaching and learning experiences for students to enable graduate competence b) Head of Discipline is a registered nurse with the NMBA, without conditions on their registration relating to conduct, and holds a relevant post-graduate qualification.	• APNA proposes that for nursing education curriculum to have the important primary health care focus that is required for the RNAS to indeed be "contemporary and aligned with emerging research, policy and best practice" as is one of the aims of the review, academic oversight of the program must include representation from a registered nurse who has substantial experience within primary health care, ideally with post graduate qualifications in this area of practice but who also importantly has firsthand knowledge and understanding of the importance of primary health care for the population.

[4] Registration Standards: Nursing and Midwifery Board of Australia. Available from: https://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

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2.3 Relevant input to the design and ongoing management of the program exists from external representatives of the nursing profession, including Aboriginal and/or Torres Strait Islander peoples, consumers, students, carers and other relevant stakeholders.	• The design and ongoing management of the nursing education program must also have input from primary health care practice-based representatives of the nursing profession and engagement with relevant peak bodies.
2.4 All entry pathways for which students receive block credit or advanced standing (other than on an individual basis) are identified and allow graduates to meet the Registered Nurse standards for practice.[5]	• 2.4 All entry pathways for which students receive block credit or advanced standing (other than on an individual basis) are identified, approved by ANMAC and allow graduates to meet the Registered Nurse standards for practice.
2.5 Program quality improvement mechanisms addresses: a) risk assessment of student learning environments b) student evaluations c) internal and external academic and health professional evaluations d) evidence-based developments in health professional education e) evidence-based developments in health and health care.	• 2.5c) What is an internal academic - to the discipline, university? What is an external academic – e.g. Assoc Prof teaching into the program, staff teaching into the program from other disciplines? • e) evidence-based developments in health **and aged care.** • The ANMF also suggests the inclusion of standard 1.9 from the 2017 ANMAC Enrolled Nurse Accreditation Standards be included in this section. This standard states the following: The education provider must provide evidence of governance arrangements between the education provider and health service providers to monitor students' learning and teaching when undertaking professional experience placement including, but not limited to, clinical teaching, supervision and assessment.
Standard 3: Program of study	
3.1 The curriculum document articulates the educational philosophy and how it is practically implemented into the program of study.	• wording of criterion should include how it practically underpins and is implemented as it should not just be implemented but rather should be the underlying structure of the curriculum document;
3.2 Teaching and learning reflects contemporary practices in health and education, and responds to emerging trends based on research, technology and	• As identified in 1.2 above, this statement is in conflict with 'the program is delivered in Australia' and in conflict with 2.4 in that some block pathways may be more than one semester and may include international collaborations and programs.

[5] https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx

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other forms of evidence. No more than one semester of the program is completed outside Australia.	It is fully recognised that the program must 'prepare graduates for safe and ethical practice' however consideration needs to be given to how this is achieved. Providers of programs that lead to registration must by standard 2.1 be registered with TEQSA and as such are self-accrediting bodies in term of block credits or advanced standing as recognised in standard 2.4 • Query why the term semester has been chosen rather than a percentage of the program. A full time student may study twice the units of a part time student. • 3.2 Suggest adding innovation to reflect the contemporary teaching and learning environment and link to research and technology.
3.3 Program content and unit learning outcomes ensures: a) achievement of the Registered Nurse Standards for Practice[1] b) recognition of regional, national and global health priorities c) recognition of safety and quality standards as they relate to healthcare d) integrated knowledge of care across the lifespan, including aged care, primary health care and digital health.	• 3.3c) make explicit reference to NSQHS Standards • APNA recommends the addition of some further related sub-criterion to specifically highlight important aspects of primary health care that should be core to an undergraduate nurse education. We acknowledge primary health care is mentioned in sub-criterion d) but this is not enough in the context of current health system reforms towards a strong future focus on primary health care. Further related sub-criterion should include: e) recognition of the central role of primary health care in the health and well-being of the population, incorporating education regarding the social determinants of health and health equity and how these affect the individual's health literacy and corresponding ability to respond to the advice and treatment recommendations of health care professionals Given a key role of nurses is care planning and education, across all settings, there should be a criteria to emphasise this: f) recognition of the importance of taking a person-centred approach to care, how to go about facilitating care and decision making so that people are more empowered to move towards being able to develop self-care skills and manage their own health needs Nurses also need to understand the issue of sustainable use of health care: g) knowledge of how health care is funded across different sectors and states of Australia h) knowledge of assessment, triage and referral across different sectors of the health care system i) knowledge of the structure of the Australian health care system and the challenges with continuity of care • 3.3d) Digital health to be a separate category. Digital health includes hardware, middleware and software that encompasses health information systems, health technology and personalised software/apps for health promotion, monitoring and diagnosis. It also includes the capability for storage and retrieval of anonymised large data-sets or individual health information, such as a patient's electronic health record. •
3.4 Program content and subject learning outcomes embeds principles of interprofessional and intra-professional learning and practice.	• This criterion needs to highlight that these principles are important in all of primary, secondary and tertiary settings. Further, it is not just inter and intra professional learning and practice that is required, but also multi disciplinary care.

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3.5 Program content and subject learning outcomes integrates cultural diversity and cultural safety.	• Content and subject learning outcomes must also include practical aspects as to how to implement care with culturally diverse groups within the population. • 3.5 Perhaps include the language of inclusion in addition to cultural diversity and safety. Perhaps integrate the WHO social determinants of health here?
3.6 Program content and subject learning outcomes supports the development of research skills that include searching and reviewing research and other evidence for translation into practice.	
3.7 Program content and subject learning outcomes prepares students to supply under a structured prescribing arrangement.	• Further clarification of the word 'supply' • Suggest rewprding to: *Program content and subject learning outcomes prepares students to supply and administer under a structured prescribing arrangement. It is acknowledged that it could be argued that, in its entirety, the undergraduate program of study prepares a registered nurse to administer under protocol. Despite this, "supply and administer" is the term used in the majority of papers and documents addressing this pat of the registered nurse's role.* *Supplying and administering under a structured prescribing arrangement (or under protocol_ by a registered nurse is seen as withing scope by the profession, however, it may be a concept to many outside the profession. Inclusion of "and administer' will make explicit to all stakeholders that this is a role that undergradate education adequately preparesregistered nurses for.* • As yet, there is no understanding of the amount of content required to address this criterion and whether it can be accommodated in current programs. • ACN would like to suggest the amendment of the wording in Standard 3.7. In the context of the RN scope of practice, ACN considers "administer medication(s)" to be a more appropriate term than "supply". • Amending element 3.7 to Program content and subject learning outcomes prepares students to supply and administer under a structured prescribing arrangement will provide crucial support for the creation of authorisations for registered nurses to supply and administer under protocol under Queensland legislation. • Standard 3: Program of study. Item 3.7 concerns supply under a structured prescribing arrangement. While this pre-empts any changes to registered nurse prescribing, does this item limit nurse prescribing to one particular model? • more detail on what is specifically meant by 'supply under a structured prescribing arrangement' The terminology and phrase could be interpreted in a few different ways, e.g. standing orders, prescribing-in-partnership or other. Currently under the Poisons Act 1971 (TAS), s 3 Interpretation: supply, in relation to a substance, includes – a) administer a substance, whether orally, subcutaneously, or by any other means;

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	b) dispense a substance on prescription; and c) offer or agree to supply a substance; Further, it is noted that each State and Territory have differing governing legislations and Drugs and Poisons Act which will need to be considered when developing curricula. As such more clarity around this standard and the sub sets would be appreciated. Notation of importance of deprescribing should be included as would consideration for medication reconciliation and clinical perspectives of prescribing under structured arrangements rather than the foci being pharmacological perspectives. • In point 3.7 'medicines' needs to be added: 3.7 Program content and subject learning outcomes prepares students to supply medicines under a structured prescribing arrangement.
3.8 The program includes: a)Aboriginal and Torres Strait Islander peoples' history, culture and health taught from an Indigenous perspective as a discrete unit of study and based on the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework[6] b) content relevant to health outcomes of Aboriginal and Torres Strait Islander peoples embedded throughout the program.	• Insert the word 'nursing' to make it read … Indigenous nursing perspective…
3.9 The program includes: a) a discrete unit addressing mental health taught by a registered nurse with a formal qualification in mental health b) mental health content embedded throughout the program.	• 3.9 is deeply insufficient to address the needs of the emerging mental health workforce and the mental health consumer cohrt that is reliant upon them for care, safety and intervention. • The Higher Education Standards 3.2 clearly articulate requirements for academic staff teaching into a program as follows: *Staff with responsibilities for academic oversight and those with teaching and supervisory roles in courses or units of study are equipped for their roles, including having:* *a. knowledge of contemporary developments in the discipline or field, which is informed by continuing scholarship or research or advances in practice* *b. skills in contemporary teaching, learning and assessment principles relevant to the discipline, their role, modes of delivery and the needs of particular student cohorts, and* *c. a qualification in a relevant discipline at least one level higher than is awarded for the course of study, or equivalent relevant academic or professional or practice- based experience and expertise, except for staff supervising doctoral degrees having a doctoral degree or equivalent research experience.*

[6] Available from: https://www.linmen.org.au/project/nursing-and-midwifery-aboriginal-and-torres-strait-islander-health-curriculum-framework/

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	The requirement for a discrete unit addressing mental health to be only taught by 'a registered nurse with a formal qualification in mental health' is overly prescriptive and is at risk of excluding appropriately qualified academic staff utilising the higher education standards as the benchmark. It should also be recognised that nurses in Australia have been prepared to work in both a mental health and generalist setting for many years and that academics could hold a Masters and/or PhD with a research interest in mental health but not hold a formal qualification in mental health. The broader criteria in 3.12 is more appropriate and the requirement to hold a formal qualification in mental health should be removed. • Inclusing of the words '*also addressing problematic alcohol and other drugs across a wide variety of health care settings'* • The ACMHN requests this be reworded as: a) A discrete unit addressing mental health nursing taught by a registered nurse with a formal qualification and expertise in mental health nursing. • what are the implications of this for other areas of practice and for integrated curricula (I know same question has been asked re Aboriginal and Torres Strait Islander content and a separate unit does not preclude including this content elsewhere) why not also have a discrete unit re chronic care, aged care and qualified staff etc are we moving to separate unit on each priority area • 3.5 Perhaps include the language of inclusion in addition to cultural diversity and safety. Perhaps integrate the WHO social determinants of health here?
3.10 The program includes: a) a minimum of 800 hours of professional experience placement, exclusive of simulation and not exceeding 130 hours (one-sixth) undertaken outside Australia b) professional experience placements underpinned by contractual arrangements between education providers and placement providers.	• A minimum of 400 hours of professional experience placement for Diploma of Nursing programs. • As identified in 1.2 when a nurse trained and obtained registration as a nurse overseas, he or she was able to complete the 3rd year of a Bachelor of Science (Nursing) program and following successful completion apply for registration in Australia. 3.10 would preclude internationally qualified registered nurses from completing this pathway. The development of a separate criterion to address internationally qualified registered nurses from other countries entering Australian programs of study needs to be addressed within these standards. • 3.10a) Clarification is required whether the placement of 130 hours outside Australia needs to be under the supervision of an Australian Registered Nurse. • Undergraduates should be required to complete at least 40 hours of practice within the primary care setting, in addition to a placement for another specialty which may also be in the primary health care setting e.g. a mental health placement. We also highlight here that the timing of this placement should not occur until undergraduates have completed education so that they are sufficiently trained to be able to actively participate and take advantage of skills development opportunities in the primary health care e.g. medication administration including of injections and importantly immunisations. • As outlined previously in this submission, the ANMF suggests that the minimum professional experience placement hours should be increased to 900 hours. Further, considering the current concerns with professional experience placement, the ANMF recommend that these 900 hours

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	are only completed within the Australian context. The new 3.10 (a) should state the following: 3.10 The program includes: a) a minimum of 800 900 hours of professional experience placement, exclusive of simulation, and within the Australian context. and not exceeding 130 hours (one sixth) undertaken outside Australia In regard to 3.10 item (b), the ANMF suggests that it is not enough to only state contractual arrangements, further detail needs to be included in this item to provide clearer expectations of the arrangement for both the education provider and the health service. Item 3.10 (b) should state the following: b) professional experience placements that are underpinned by contractual arrangements between education providers and placement providers. The contract outlines the model of support used, such as the Best Practice Clinical Learning Environment Framework that will be used to facilitate student learning and provide clear expectations for both the education provider and health service. • wording should be adjusted for programs which include clinical practicum hours in excess of 800… exclusive of simulation and not exceeding 130hrs (one-sixth) should be adjusted to state no less than 630hrs of practicum to be completed in Australia.
3.11 Program resources are sufficient to facilitate support student achievement of the Registered Nurse Standards for Practice, with attention to human, physical and financial resources supporting all teaching and learning environments, including simulated practice and professional experience placements.	• 3.11 Program resources are sufficient to facilitate ~~support~~ student achievement of the Registered Nurse Standards for Practice, with attention to human, physical and financial resources supporting all teaching and learning environments, including simulated practice and professional experience placements. Note probable typographical error. • Support needs to be deleted from point 3.11.
3.12 Staff teaching into the program: a) are qualified and experienced to deliver the units they teach b) are registered nurses when the subject relates to nursing practice c) hold one qualification higher than the program of study being taught.	• 3.12c) may need to be more explicit e.g. taking into consideration the hospital trained RNs versus Bachelor of Nursing RNs • Equivalent also needs to be considered. TEQSA states '…or have equivalent relevant academic, professional or practice-based experience and expertise, except for staff who are supervising doctoral degrees, who must have a doctoral degree or equivalent research experience'. • I have concerns regarding the removal of "identified experience" (or language similar to TESQA) – the reasoning of this is that the important of our clinical facilitators working in clinical placement is their clinical relevance/currency. I completely support c) for academic positions – however there needs to be flexibility of this criteria to ensure we focus on currency for facilitators. • The ANMF suggests the following additional item is added as item 3.12: Theory taught outside of the Australian context cannot exceed the equivalent of a total of three months of the total program and must be equivalent in terms of subject and objectives, learning outcomes and assessment.

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	• 3.12 Include in 3.12c wording re equivalent relevant academic or practice based experience as per AQF Framework • part c which states that staff teaching into the program must have a qualification one higher than the program of study being taught. What happens with Masters programs which lead to registration to practice? Are we expecting all staff to hold a PhD?
Standard 4: Student experience	
4.1 Program information provided to students is relevant, timely, transparent and accessible.	
4.2 The education provider identifies and supports the academic learning needs of students.	
4.3 Students are informed of, and have access to, effective grievance and appeals processes.	
4.4 Students are informed of, and have access to, pastoral and/or personal support services provided by qualified personnel.	• the identification of qualified personal should be removed. This is a university specific requirement. The importance is that the school has processes in place to ensure the information and services are transparent and
4.5 Students are represented on program advisory and decision-making committees.	
4.6 Principles of equity and diversity are evident in student and/or staff interactions and teaching and learning materials.	• 4.6 Consider replacing draft criterion with; Equity and diversity principles are observed and promoted in the student experience. The specific nature of the requirements inherent in the draft criterion detract from the intent.
4.7 Student experiences across all teaching and learning environments are monitored and evaluated regularly with outcomes informing program quality improvement.	• The minimum accepted frequency of monitoring/evaluation and quality improvement needs to be articulated, for example, at least annually for each year level of a nursing course.
Standard 5: Student assessment	
5.1 Program learning outcomes and assessment strategies are aligned.	

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5.2 Unit learning outcomes, with associated unit assessments, are clearly mapped to the Registered Nurse Standards for Practice.	
5.3 Validated assessment tools, modes of assessment, sampling and moderation are used to ensure integrity in theoretical and clinical assessments.	• The tools and modes of assessment, sampling and moderation that are used to ensure integrity in theoretical and clinical assessments, will need to be tailored to the primary health context, be relevant to the area being studied.
5.4 Assessments include the appraisal of competence in pharmacokinetics, pharmacodynamics and the quality use of medicines.	• 5.4 Consider broadening this criterion to include words re embedding and scaffolding this content over the duration of the course of study and address this criterion re therapeutics in a broader sense.
5.5 Formative and summative assessments are used across the program to enhance learning and inform student progression.	• 5.5 Include clear definitions/expectations re formative and summative assessment that are commensurate with the pedagogy of the curriculum.
5.6 The education provider is ultimately accountable for ensuring students are supervised and assessed by a registered nurse while on professional experience placement.	• This may preclude valuable interdisciplinary placements with an oral hygienist, dietician etc.

Other/Generic feedback:

- No longer a standard related to the nursing philosophy to guide the program, this a retrograde step. Philosophical positioning must be surely viewed as essential to unifying a curriculum and shaping the worldview of nursing students.
- **Standard 3 –** Program of Study: The old standards articulated a list of teaching and learning approaches which covered off some crucial program content, which should be included, along with the addition of content about resilience, selfcare and being part of the learning and teaching culture. In developing the evidence guidance, it is recommended these aspects be included as key evidence in any program of study.
- The recently announced Commonwealth Independent Review of Nursing Education may have implications for the Registered Nurse Accreditation Standards. It is recommended that this be acknowledged in the final version of these standards, including that the findings of the review may require an earlier revision of the standards.
- Standard 5 Assessment - Suggest including timely and responsive feedback to assessment to support, enhance and engage with learning.

- APNA notes that Standards 3.8 and 3.9 explicitly and importantly prescribe what the program of study must include regarding Aboriginal and Torres Strait Islanders and mental health. We advocate that primary health care nursing deserves the same level of commitment, for reasons we have already highlighted with respect to criteria 3.3.
  There must be a further stand alone criterion within section 3, which states:
  The program includes:
  a) a discrete unit addressing primary health care, the social determinants of health and health equity, health promotion and preventive health taught by a registered nurse with a formal qualification in primary health care
  b) primary health care content embedded throughout the program.
- 3.5 Program content and subject learning outcomes integrates cultural diversity and cultural safety.
  and
  3.8 The program includes:
  a)Aboriginal and Torres Strait Islander peoples' history, culture and health taught from an Indigenous perspective as a discrete unit of study and based on the Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework6
  b) content relevant to health outcomes of Aboriginal and Torres Strait Islander peoples embedded throughout the program.
  These two elements have overlap and could be integrated into a single element to reduce duplication
- Standard 1: Safety of the public. While I agree about the intent of this standard, I am uncertain as to the evidence that will be required to prove compliance with item 1.1 and 1.2. How will an education provider prove a guiding principle?
  1.2 contains two premises that is, the program is delivered in Australia and that graduates are prepared for safe and ethical practice. Should this item be separated into 2 separate items? Furthermore, how will an education provider prove that their program is both safe and ethical or that their graduates practice safety and ethically?
- I was concerned to hear comments that did not support Mental Health theory and clinical practice hours for undergraduate nursing students. More so that people could not identify what constituted a MH Nurse and suggested that a Psychologist or Addictions Nurse could deliver the material. These are different scopes of practice. MH Nurses are identified by the credentialing process established by the ACMHN. I do think it is time to provide leadership here and indicate a minimum of one core theory subject must be committed to MH Nursing and be delivered by a staff member who could demonstrate education at Postgraduate Diploma Level (or equivalent) with recent if practice or demonstrated contribution to MH Nursing. That clinical practice hours must be included in MH with access to supervision and assessment by a MH Nurse. I think if we can't achieve this then the comprehensive degree will continue to be challenged.
- The idea was a need to prescribe a % of hours that can be given credit for a Diploma of Nursing. Diploma students complete 400 hours. BN students are required to complete a minimum of 800. I would suggest that no more than 25% of the BN clinical hours could be credited - or 200 hours maximum for an Approved Diploma graduate
- would it be useful to list all the evidence and then say which standards it relates to in order to identify where there is replication and where there is overlap -eg is the qi plan and evidence of meetings in standard 2.3 2.5 any different to standard 4.5 and 4.7?
- 3.8 – 3.10 The program includes:
  Aboriginal and Torres Strait Islander peoples' health

Mental Health
Professional experience placement
Comment: in additional Standards 3.8 -3.10, there should be included a similar Standard that addresses dementia.
The rationale being that:
Dementia is the second leading cause of death in Australia for people over the age of 75 years (AIHW 2018) and is the leading cause of death in women (AIHW, 2018).
Dementia has been named as a National Health priority and in 2017 the World Health Organisation released the Global Action Plan, focusing on dementia (WHO 2017).
Existing research (Eccleston et al., 2015) has found that nursing students in Australia had poor knowledge of dementia but with curriculum that supported knowledge development this could be significantly improved.

- Criteria 3.9 is an essential criterion in the current Registered Nurse Accreditation Standards and it needs to be included in the next version of the standards. It states the following: The program provider demonstrates extended professional practice experience towards the end of the program to consolidate the acquisition of competence and facilitate transition to practice. A summative assessment is made at this time against the Registered nurse standards for practice in the clinical setting. This criterion must be retained and added as point 4.8.
- The following changes need to be made to the definition of simulated learning: Simulated learning – refers to a variety of activities using patient simulators, including devices, trained persons, lifelike virtual environments, and role-playing. Simulated learning SBE experiences strengthen or mimic or replace real-life clinical situations. Simulated learning SBE aims to enable students to reason through a clinical problem and make decisions, without compromising patient wellbeing.
- A s a general comment, I see that there is a definition of competence in the glossary of the draft document re Consultation Paper 3. I would contribute to this wording in relation to replacing 'competency' with a more nuanced statement re capability. Capability is the ability to deliver an outcome, and results from a combination and competence, that is, assessment against a standard. I think that the conversation in the broader profession about graduates being ready to practice and future proofing the role of the Registered Nurse requires an enhanced view of the integration of educational preparation, professional preparation and performance of professional standards for capability.
- I know this was documented but we need a glossary inclusion of formative assessment as I think you are actually looking for early low stakes assessments AND/OR formative feedback in tutorials (which is not an assessment item). The common definition for formative assessment is assessment which does not contribute to the subject grade and formulates knowledge rather than is a low stakes contribution.
- English Australia submission