Australian Nursing & Midwifery Accreditation Council

www.anmac.org.au

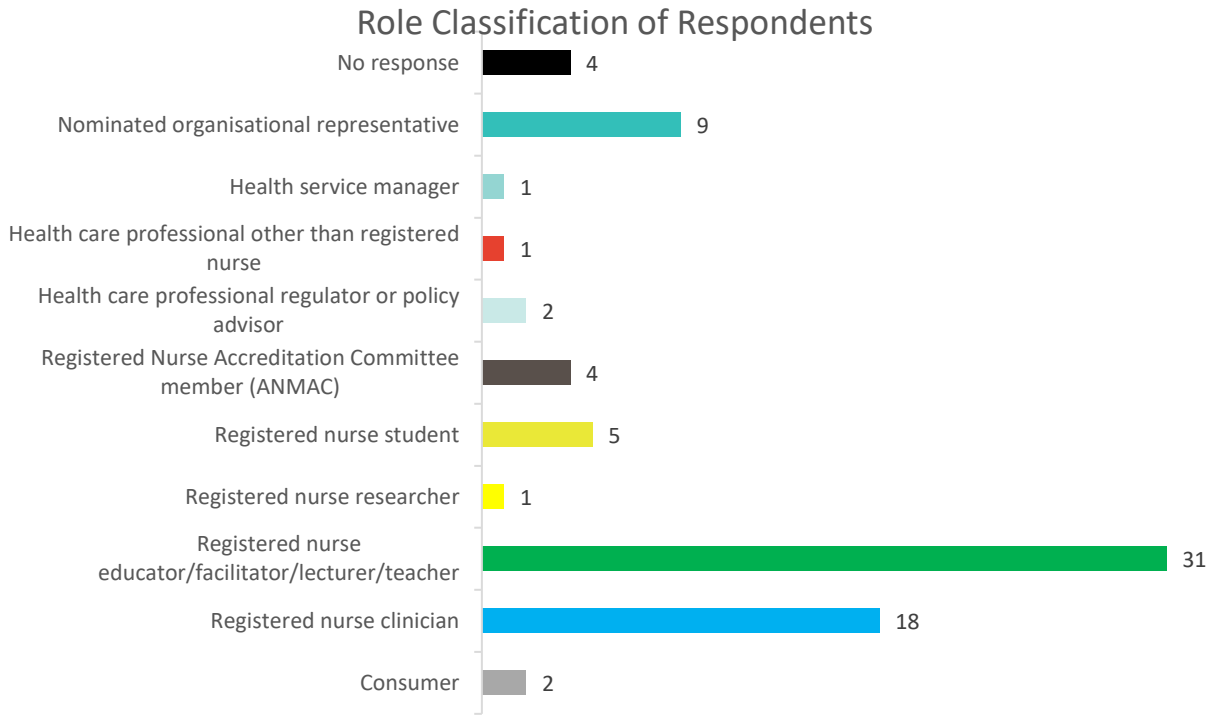
REGISTERED NURSE ACCREDITATION STANDARDS CONSULTATION PAPER 1 – FEEDBACK SYNTHESIS

ANMAC presented a paper for consultation on the review of the Registered Nurse Accreditation Standards. Stakeholders were invited to provide responses by online survey or written submission. This paper provides an synthesis of the responses received.

Demographic Data

There were 77 participants of the online survey of which 74 provided details of their current role. 31 survey respondents classified themselves as registered nurse educator/facilitator/lecturer/teacher where 5 respondents classified themselves as registered nurse student (figure 1).

Figure 1: Role classification of survey respondents



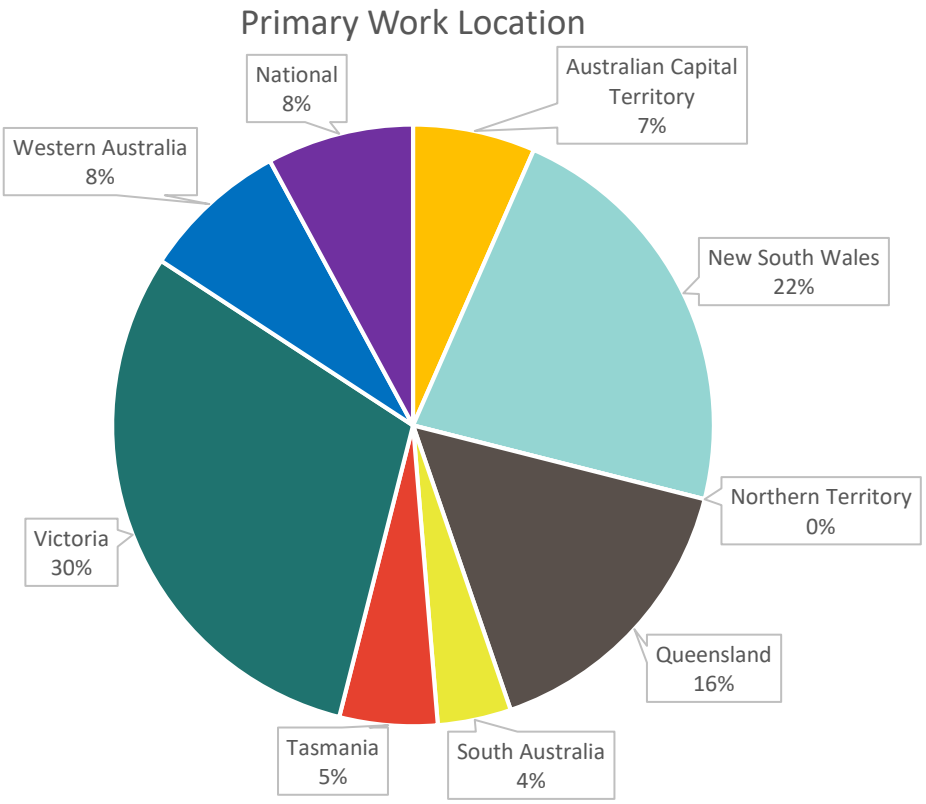
11 respondents provided further information regarding organisations represented:

- Queensland University of Technology
- Nursing Informatics Australia
- Council of Deans of Nursing and Midwifery (Aus. & NZ)
- NSW Nursing & Midwifery Office

- Safer Care Victoria & Victoria Department of Health and Human Services Workforce Branch
- Australian Pharmacy Council
- University of South Australia, School of Nursing and Midwifery
- Organisational representative for Australian Society for Simulation in Healthcare
- Ramsay Health Care
- Enrolled Nurse
- Eastern Health

Respondents also provided data on their primary work location. As seen in figure 2, majority of respondents were from Victoria (30%) and New South Wales (22%), while there were no respondents from the Northern Territory.

Figure 2: Primary location of survey respondents



Written responses were received from 22 organisations, those who provided permission for submission publication are:

- Australian College of Midwives
- Australian College of Nurses
- Australian Commission on Safety and Quality in Health Care
- Australian Nursing and Midwifery Federation
- Australian Technology Network of Universities
- Chief Nursing and Midwifery Officer, Queensland Health

- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Department of Health
- Edith Cowan University
- Migrant and Refugee Women's Health Partnership Secretariat
- Office of the Chief Nurse and Midwife, DHHS Tasmania
- Queensland Nurses and Midwives Union
- South Australian Nursing and Midwifery Office
- Southern Cross University
- T. Levett-Jones, University of Technology Sydney
- University of South Australia
- Universities Australia
- University of Technology Sydney Midwifery

Responses from all written submissions, including those not available for publication are included in this synthesis.

Question 1

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

58 responses were received to this question. The majority of responses mentioned support mechanisms for English language, cultural safety, mentoring and academic support, as well as flexible entry pathways to encourage enrolment and retention of Aboriginal and/or Torres Strait Islander peoples as well as cultural diversity. Academic and literacy and numeracy support were also important in responses. Flexibility and alternative options for study mode and clinical placement were mention as well as scholarships and financial support whilst on clinical placement.

A few responses mentioned that this aspect of the standards is the domain of the Tertiary Education Quality and Standards Agency and should not be duplicated in the Accreditation standards. The importance of early feedback to students regarding their performance was also mentioned as a mechanism.

Question 2

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

54 responses were received to this question. Most significantly reported in the responses was quality clinical placement, followed by an improved selection process and academic support. Many responses mentioned supports for pre-entry pathways, cultural safety/support, peer support, simulation, clinical placement evaluation, social supports, health culture policies and increased clinical placements. Further to this, respondents mentioned English language support, counselling/emotional support, clinical placement flexibility, face to face learning, options for study mode full-time/part-time and student input into the program. A number of responses also mentioned mentoring, orientation, early professional placement experience, education providers reporting on retention rates, contemporary teaching and learning, early

feedback to students, a four-year degree, paid placement/ apprenticeship model and active learning methods.

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?

71 responses were received to this question. 52 respondents (73%) supported a change to the English language component of the standards. 15 respondents (21%) do not support a change and 4 respondents (6%) were unsure. Overall, majority of respondents acknowledged the importance of student awareness of the requirements of the registration standards prior to enrolment and acceptance into a program. Also, significantly discussed is the disadvantage to students from culturally and linguistically diverse backgrounds without English proficiency in progressing through programs.

Respondents who do not support a change in the standards, report that universities set their own requirements for entry to programs as supported in the current standards and provide support to students who are identified as needing it. Also identified was decreased enrolments and access to potential students who would like to commence a career in nursing.

Respondents discussed the lack of large, replicable studies in this area particularly related to entrance to undergraduate programs.

Respondents who support the change mentioned:

- the need to be proficient in the English language prior to professional practice experience which often occurs in first semester.
- Fairer for students and facilities and provides clarity
- Avoids disappointment of student completing course and not meeting registration standard
- Greater English comprehension would benefit the student in undertaking studies in English.
- EN standards have been set with a minimum English language requirement and RN standards should match this
- Development of English language skills is not an outcome of a nursing degree.

Question 4

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

52 responses were received to this question. Commonly reported across the responses was the requirement for appropriately trained facilitators, educators and preceptors of students. This was particularly emphasised in relation to staff from health service providers who are supervising or precepting students. Another response mentions that all RNs need foundational knowledge of teaching and learning in a clinical environment. Clinical facilitators should undertake cultural safety training.

Several submissions also identified evidence of collaborative agreements/contract arrangements between education and health service providers which could stipulate principles

for quality clinical placements (guided by ANMAC); should framed in the best interest of students; provision of a culturally safe and respectful environment; include model of clinical services being provided; include ratio of students to clinical educator and a clear process for conflict resolution and/or escalating concerns.

The standards should reflect major health priorities to ensure students are exposed to relevant clinical workplace experiences and encourage universities to seek more opportunities for clinical placements to be undertaken within an Aboriginal health service. Following on from this, providers should be required to have an evaluation framework for clinical placements and show evidence of evaluation of results and how they have been acted upon. This may be possible by the introduction of a single, validated, national competency assessment tool mapped to the Registered Nurse Practice Standards, promoting consistency in assessment of students by clinicians in the workplace and supporting quality improvement in competency assessment. Explicit referencing of the NSQHS standards will promote the alignment of curriculum content on safety and quality and assist to support quality improvements in the clinical learning environment along with the direction proposed in the Draft Report of the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme.

Several responses mention the dedicated education unit model. but acknowledge that this may not be an accessible model for smaller health services providers. A number of responses also mention the current standards (7, 8 & 9) as covering the issues currently experienced by students and providers, however it may be how the standards are implemented that leads to issues with clinical placement.

Question 5

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

58 responses were received to this question. 4 responses considered that the Best Practice Clinical Learning Environment (BPCLE) framework was not useful, 32 responses considered it useful and 22 responses were unsure.

Several responses supporting elements of the BPCLE framework in the standards provide the caveat of difficulty in accessing and influencing all clinical learning environments students access, particularly those of health service providers.

A number of responses support the use of the BPCLE framework as a scaffold for the development of outcome-based standards, with clear expectations stipulated for how education providers can demonstrate application of the framework due to a number of adjectives used to describe outcomes, such as well prepared, highly competent and appropriate ratios. Another response suggested there need to be clear indicators to ensure consistency and enable assessment teams to easily identify that the elements of the framework are in place and effective. Several responses mention specific elements of the framework as particularly useful, most commonly mentioned is element 3 (a positive learning environment), then 4 (an effective health service – education provider relationship), 5 (effective communication processes) and 6 (appropriate resources and facilities).

Unsure and negative responses discussed the health service focus of the BPCLE framework and that education providers would be unable to control several of the elements; the framework needs to be strengthened to assert that clinical learning must be provided in a culturally safe manner. This framework is not freely available to health services outside of Victoria and the

development of a National BPCLE requires further consideration. In considering a national BPCLE framework, key issues to be considered are:

- Placement funding models
- Models of WIL supervision
- Availability of placements
- RN program requirements
- How all stakeholders would partner in a collaborative approach to implement and evaluate the framework

Question 6

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

Fifty-three responses were received to this question. Only two respondents considered that no change to the present standards as necessary. Overall, respondents considered that a clear definition of simulation was the crucial starting point with one respondent proposing the development of a nationally agreed set of standards for simulated learning which could be used as the benchmark. Potential best practice standards for simulation include those proposed by the International Nursing Association for Clinical Simulation in Nursing (https://www.inacsl.org/i4a/pages/index.cfm?pageid=3407) or those proposed by Arthur, Kable and Levett-Jones (2013).

Respondents believed that, once a clear definition was adopted, then the standard/s, the criteria and the evidence necessary to demonstrate achievement of the standard/s would follow. Some respondents considered that guidance on the way simulation could be used, the most effective models, the different approaches, together with examples of innovative ways to facilitate simulated education would be useful.

Respondents supported evidence based, high quality approaches to simulated learning in nursing and indicated a preference for a structured approach to the included criteria. Possible evidence for inclusion in standard/s incorporated the following:

- the type/s of simulation
- access to physical resources
- the experience and qualification of the educators designing and delivering simulated learning experiences
- the process of developing, adapting and validating clinically authentic scenarios
- how simulation articulates with the clinical practice hours to ensure students achieve a range of experiences
- a mandated ratio of staff to students for the learning experience
- the structure of the experience (briefing, debriefing, assessment & evaluation)

One respondent advocated use of the term ‘simulation-based education’ (SBE) to replace the term ‘simulated learning’ and two respondents recommended adoption of Gaba’s (2004) definition of health care simulation.

> ‘Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner’.

This definition was proposed because it:

- specifies simulation as a technique not a technology
- implies that simulation experiences should be authentic, scenario-based, holistic and person-centred
- distinguishes between immersive simulations and more traditional skill-based training.

Three respondents considered a clear distinction needed to be made between simulation-based learning and clinical skills rehearsal. This distinction was important in the context of concerns of the adequacy of the current stipulated clinical placement hours. Several respondents highlighted the need for further research to provide better direction for the questions of what, when and how much in relation to issue of simulated learning in the accreditation standards. ANMAC was encouraged to collaborate with research partners to undertake this research.

Question 7

a) Should minimum practice hours be inclusive of simulated learning hours?

Fifty-seven responses were received to the question. Five respondents considered that there was currently not sufficient evidence, or they would require stronger evidence, on which to make a robust decision whether or not to replace clinical practice hours with simulation. Twenty-three respondents agreed that minimum practice hours should include simulated learning hours. Twenty-nine respondents did not agree that the current minimum practice hours should include simulated learning hours.

b) If so, should a maximum percentage of simulated learning hours be stipulated?

A majority of respondents agreed that the maximum percentage of simulated learning hours should be stipulated. The amount of simulation that should be stipulated ranged from 10-20% (n=5) to 50% (n=1).

Given the lack of evidence in relation to proportional replacement of clinical practice hours with simulation hours, two respondents proposed options (outlined below) for consideration.

- Option A: include an additional 80 (10%) simulation hours in the clinical practice hours
- Option B: replace 10% (80 hours) of the 800 clinical practice hours with simulation hours

These proposed options were subject to the education provider demonstrating that the simulation experience was implemented in line with best practice guidelines. A further four respondents also suggested that a stipulation of maximum simulation hours could be included but should be additional to the current 800 hours of clinical practice (e.g. 880 hours).

Question 8

How can the accredited standards better support inter-professional learning?

Fifty-two respondents answered this question. Overall, the responses indicated strong support for inter-professional education (IPE). Six respondents considered that the current standards satisfactorily address inter-professional learning. A number of respondents believed that IPE was most appropriately undertaken in the clinical setting where some of the most effective IPE experiences for nursing students occur opportunistically (attending team meetings and grand rounds, working collaboratively with physiotherapists to mobilise a patient, spending time with a pain team, accompanying a pharmacist on discharge rounds.

Other strategies to better support inter-professional education in nursing accreditation standards included the following:

- include an agreed definition
- specify learning outcomes
- provide evidence of how IPE experiences map across the curriculum to address the specified learning outcomes
- include multiple modes and channels of communication between health professionals (e.g. EMR)
- provide formal and informal opportunities in on-campus (e.g. simulation, classroom) and/or clinical placement
- mandate hours devoted to IPE/no of experiences (n=8)
- enable education and practice supervision to be delivered by other accredited health professionals where relevant (n=5)
- include other disciplines (design, communication, law, science, media)
- encourage mentors to foster collaboration across universities/institutions

Respondents also cautioned that over regulation may disadvantage rural and/or smaller institutions. Simulation can be utilised for IPE, but it should not be substituted for real life opportunities for inter-professional learning. An increase in the requirement for IPE would require an increase in the current minimum clinical practice hours.

Question 9

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

Thirty-seven respondents addressed this question. Overall, respondents considered the standards were:

- comprehensive, rigorous, well established
- informed by nurses and developed to meet the needs of the profession
- well known and understood by the nursing profession and education providers
- consistent across other categories of registration (Enrolled Nurse, Midwife & Nurse Practitioner)
- sufficiently flexible to support innovation
- focused on student support and safe practice

One respondent noted the recommendation for a standardised process by the *Independent Review of National Registration and Accreditation Scheme for health professionals* but went on to state,

> 'It is essential that the nursing and midwifery professions maintain their professional identity and established expertise in relation to accreditation standards...'

citing loss of the distinctive contribution of nurses and midwives to the health care system, impacting on the workforce and compromising care delivery.

Other respondents noted and supported retention of a distinctive nursing perspective in the revision of the standards arguing that, while there was always for improvement, the considerable corporate expertise developed by ANMAC over the years of refining the standards should not be underestimated.

Question 10

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

Thirty-five respondents replied to this question. Overall, the feedback indicated that respondents considered the standards were repetitive, contained elements of duplication within the standards themselves and also with university processes (TEQSA), and were open to interpretation.

Other respondents concluded the standards were:

- burdensome
  - separate sets of documents for single and double degrees
  - costly in time and staffing dedicated to the task of addressing the criteria
  - column format was cumbersome
- lacking templates and guides leading to assessment panels requiring differences in the way evidence is presented
- lacking the required emphasis on public safety
- overly prescriptive, process driven and input focussed

In contrast with the respondents arguing for the retention of a distinctive nursing perspective to revising the standards, one respondent considered that the current standards may limit room for multi-professional rigor, potentially contributing to nursing or midwifery silos.

Question 11

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

Fifty responses addressed this question. Twenty-four respondents agreed that the registered nurse standards could move to a five-standard structure, two respondents did not agree, and 24 respondents provided were unsure or provided conditional support.

Arguments supporting a change to a five-standard structure included:

- reduces repetition
- simplifies the accreditation process for education providers with multiple accredited programs
- accords with the recommendation for a standardised process by the Independent Review of National Registration and Accreditation Scheme for health professionals
- better supports inter-professional learning for collaborative practice by referencing common core set of competencies

Arguments against moving to a five-standard structure cited:

- the limited evidence for the change

- the unclear benefits
- that public safety is central to the national law regulating the health professions and should not be a reflected as a stand-alone domain but integrated within all the accreditation domains
- the potential 'blurring' of nursing standards
- a structure developed for the Allied professions is not sufficiently rigorous for the nursing profession

Arguments providing conditional support for the move included:

- condensing the nursing standards to 5 in a similar way to those of Pharmacy may reduce duplication that exists in the 2012 RN standards
- creating similarities in expectations may improve communication and inter-professional practice between profession

Respondents cautioned that:

- moving to a five-standard structure should only be undertaken if the benefits were clear
- core nursing knowledge and skills should not be compromised
- more information, clarity and further consultation is needed

Question 12

To what extent are the accreditation standards clear in their expectations of the evidence required of education providers to demonstrate compliance?

Forty-six responses (55%) out of the total number of respondents (n=83) provided direct feedback to this question. Twenty respondents considered the accreditation standards were clear, 11 indicated they were not clear with a further 15 respondents highlighting that they considered the standards were somewhat clear/somewhat unclear and would benefit or required clarification and a consistent approach and interpretation from assessors.

A number of respondents commented on this last issue highlighting that assessment teams apply differing perspectives on what does, or does not constitute, sufficient/appropriate evidence to demonstrate compliance with a standard. One respondent considered that orientation to the role (education and preparation of assessors) would provide better consistency among teams and ensure the process was more time efficient.

Question 13

What is the best way to provide guidance to the standards and criteria (for example, to ensure consistent interpretation on important concepts?

A majority of respondents considered that an evidence guide would enhance/clarify the evidence required to demonstrate compliance. Additionally, examples (de-identified) to demonstrate the key concepts that must be addressed in each standard would be useful.

One respondent wrote

> 'The standards need to include clearer expectations and the supporting evidence required of education providers to demonstrate compliance with regard to the teaching of Aboriginal health history and culture within a culturally safe teaching environment. This could be done through an explanatory note to guide and assist the university sector'.

Another respondent stated

> 'it would be essential that if an evidence guide was to be re-instated, the guide be publicly consulted on, with the same rigour as the accreditation standards '.

One respondent commented on the language used in the standards and highlighted that some words (quality, adequate, sufficient) are vague, open to interpretation and it is unclear how they might be measured.

Other suggestions to improve clarity included:

- the provision of a FAQ fact sheet
- a video of people discussing the issues that occur, why they are of concern and how to address them
- a list of 50 discrete psychomotor skills that an RN should competently perform
- the inclusion of minimum data requirements for each criterion together with the required evidence
- an expanded glossary with clear definitions
- templates if a particular format is required to present evidence
- the inclusion of KPI's

Question 14

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

A total of 49 responses addressed this question. A majority of respondents agreed that there should continue to be an input-based standard prescribing the minimum number of clinical practice hours required to be completed in the registered nurse education program. Public safety was cited as a rationale for continuing to retain a minimum number of clinical practice hours. One respondent considered that the standard would be strengthened by the development of a contemporary list of clinical skills expected of a competent beginning practitioner. They argued that there are core nursing skills which are not necessarily covered by an outcome statement.

Two respondents did not agree that there should continue to be an input-based standard prescribing the minimum number of clinical practice hours. They argued that outcome-based standards demand a competency-based approach.

Five respondents were unsure about the need to stipulate clinical practice hours. They commented that there was a lack of robust evidence to support the current number of hours. One respondent commented

> 'An input or process-based element should only be utilised when there is robust evidence that is essential to the overarching quality assurance process….'

However, they went on to argue that without a stipulated number of hours' pressure could be brought to bear on nursing programs to reduce clinical practice hours to reduce costs. Alternatively, it was thought that utilising outcome –based standards could encourage the use of innovative technological and pedagogical advances such as simulation-based education and training.

Another respondent argued that the requirement for nursing students to demonstrate completion of a stipulated number of clinical practice hours irrespective of competency achievement was problematic and the focus should be on assessment and the evidence of robust assessment processes.

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 future health care requirements of individual and communities?

Forty-five responses (54%) out of the total number of respondents (n=83) provided feedback to questions 15 & 16.

Question 17

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

Stakeholder Response

Overall, 25 respondents provided feedback to these questions. There was considerable overlap between the responses to questions 15, 16 & 17, therefore themes identified in the individual questions were combined to provide an overall picture. The following common themes were identified.

Theme 1: Education for the future

1.1 Curriculum Content

In this theme respondents highlighted where nursing curricula needed to be strengthened as well as nominating additional subject matter considered essential for the RN of the future.

The knowledge and skills to lead, to manage change, and to innovate are crucial and must be included in the curriculum. Working with consumers and others in a multidisciplinary approach to providing care will continue to be essential. Curricula must demonstrate how graduates are prepared with transferable knowledge, skills and attitudes to transition into future advanced practice roles following PG education.

Global issues in health should be considered. Several respondents highlighted that climate change, health issues associated with environmental changes as well as disaster preparedness all require additional knowledge and skills. There also needs to be more emphasis on migrant and refugee health with a focus on women.

One respondent highlighted the need for nursing informatics competencies and directed the PRG's attention to useful documents including ANMF Nursing Informatics Competencies (2015), and ACN, HISA, NIA Nursing Informatics Position Statement (2017).

While expansion of roles is expected, respondents highlighted that 'the essentials of care (dignity, privacy, empathy, understanding, advocacy & speaking up for safety' must not be neglected.

Ensuring nurses were appropriately prepared to fulfil the expanded role of prescribing under protocol by consolidating and expanding knowledge and skills in relation to pharmacotherapeutics was highlighted as crucial.

One respondent considered the current curriculum was heavily competency based and should be more flexible.

1.2 Aboriginal and Torres Strait Islander Issues

Several responses explored issues in relation to Aboriginal and/or Torres Strait Islander people.

The need for action to embed cultural safety training (students, teachers & clinical preceptors) in all aspects of nursing and midwifery education and practice was emphasised. Recommended uptake of the Nursing and Midwifery Aboriginal and Torres Strait Health Curriculum Framework (2017) by all Schools of Nursing and Midwifery was recommended. It was considered that there was a need to develop a national benchmark for high quality cultural safety training, together with an assessment process by suitably qualified people.

Ensuring that clinical placements were culturally safe was a priority. Evidence was presented that Aboriginal and Torres Strait nursing students and educators experience unacceptable levels of racist comments and behaviours from fellow students and some staff.

One respondent considered that

> 'universities should have a choice as to whether or not indigenous health is stand-alone subject/unit/course or spread across the degree'

1.3 Entry to practice

The prospect of a 4-year degree was raised. Several responses highlighted that role changes, role additions (nurse sedationists, care leaders/co-ordinators, nurse proceduralists, nurse prescribers), technological change, new models of care, expanded scope of practice, leadership and delegation skills, as well as enhanced research skills necessitate a change to a 4-year degree for entry to practice nursing education. Two respondents advocated consideration of a master's level (AQF 9) entry to practice with Commonwealth supported places.

1.4 Changing roles

Role change, role expansion, new and emerging roles not envisaged at this time and the need to prepare nurses for a future that is rapidly changing as a constant thread in the responses. One respondent posed the question

> 'how can registered nurses be prepared to respond to whatever environment or context they may be required to practice within and the changing nature of the multidisciplinary team which may include professionals outside the traditional team e.g. data analysts or business information specialists'.

Some responses represented polarised views in relation to the future skilling of nurses.

> 'Nurses need to be skilled in caring for people who are acutely ill' and 'experience in non-acute area is not appropriate

versus

> 'Nurses need to be more broadly skilled in primary health care, mental health, community health'.

Other respondents also highlighted the need for nurses to have exposure to experience in mental health, particularly as 'four out of every five people living with mental illness have co-existing physical disease compared to the general population.'

The future need for nurses to prescribe under protocol was identified consistently in the responses.

Theme 2: Technological Capacity

Technological change and the need for nurses to be prepared to use digital technology in the provision of care was a constant theme. One submission highlighted the need for *'accreditation standards to address the fundamental requirement of all programs to address digital technology in the delivery of care'.* Clear objectives for the health workforce (to be achieved by 2022) are outlined in The National Digital Health Strategy. Feedback from a survey regarding the readiness of nurses to engage with digital health, currently being undertaken in Qld, will be available for the PRG to review when completed.

One respondent highlighted the need for nursing informatics competencies and directed the PRG's attention to useful documents including ANMF Nursing Informatics Competencies (2015), and ACN, HISA, NIA Nursing Informatics Position Statement (2017).

Theme 3: Workforce Implications

3.1 Role changes

Role expansion, new roles, increasing autonomy and changes to the RN scope of practice were consistent across a number of responses.

3.2 Models of Care

Two responses presented differing views of the nurse's role into the future; that of the nurse as a direct caregiver as opposed to the nurse who directs care by others and the need for associated skills in delegating and managing ENs and unregulated health workers.

One respondent advocated for increased capacity to grow nurse-led models of care in primary and community health context. Team based nursing was also highlighted as a useful model of care for which nurses need to be prepared.

3.3 Quality of Clinical Placements/Clinical Issues

The need for clinical experiences in a variety of settings (acute, mental health, primary care settings) was a constant thread in the responses. Additionally, it was felt that international clinical placement hours should also be included as a component of the required number of clinical hours.

Another respondent argued

> 'Quality simulation needs to be considered as a replacement for clinical hours considering the increasing number of students and limited quality placement opportunities. '

Theme 4: Standards

Respondents considered that standards should be aspirational, flexible enough to build capacity while at the same time true to their purpose to protect the health and safety of the Australian community. Individual responses are outlined below.

The standards need to build capacity in graduates for the future. Leadership, innovation, creative intelligence and emotional intelligence need to be built into registered nurse programs and this needs to come from the standards.

Standards need to be Integrated with NMBA professional practice standards, the code of ethics, and the code of conduct.

The registered nurse accreditation standards 'should make explicit reference to the National Safety and Quality Health Service (NSQHS) Standards. Explicit referencing of the standards will promote alignment of the curriculum content on safety and quality with the requirements Australian health services. Alignment will assist to support quality improvement in the clinical learning environment'.

> 'the absence of a clearly articulated set of patient safety competency statements for nursing students has been a challenge to curriculum development, teaching and student assessment.' The level of detail required for curriculum development or student assessment is limited. Proposed use of the Patient Safety Competency Framework which has been mapped to the NSQHS and NMBA RN Standards for practice.'

> '(It is) essential for curricula and accreditation standards to align in an outcome-based approach. Assessment procedures for students must also align with outcome-based approaches adopted in curricula and in the accreditation standards to ensure the expectations for student nurse performance are effectively met.'

> 'Necessary to ensure standards adequately cover pharmacotherapeutics to support RN's utilising standing orders, protocol prescribing arrangements and nurse-initiated medicines.'

One respondent cautioned against setting entry standards for nursing education programs (ATAR scores & personal attributes tests) on the basis that

> 'strict entry scores are not a good indicator of which students will be successful nurses. They argued that 'universities should be able to set their own entry standards as the accreditation process will ensure that they demonstrate they produce safe, efficient, effective nursing graduates.'

One respondent considered that the designers of the standards needed to be more involved with industry and seek feedback for validity.

Theme 5: ANMAC Processes

Some respondents commented on ANMAC processes. The comments included:

Reference to unrealistic timelines for Education Providers to provide information to ANMAC following request for further information/clarification.

The need for formal inclusion of teach-out/teach-in arrangements in accreditation approval.

One respondent stated

> 'There is a need to drive greater consistency between education providers in relation to assessment, reporting methods, performance appraisals educational tools. Greater consistency would better support continual improvement, quality clinical placements and health service engagement. Greater consistency would enable prospective students to better compare courses and higher education

providers, reduce confusion in the management of students from different institutions on clinical placement and assist graduate employment by allowing health services to more easily compare applications from graduates of different institutions.'

Other

Two respondents raised the issue of Inherent Requirements (fitness to practice) and the difficulties associated with accommodating students who may not meet these requirements.