Response to District Health Boards NZ Professional Development Programme Project

Prepared by College of Nurses Aotearoa (NZ) Inc. on behalf of member submissions

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Background

District Health Boards NZ has sought consultation on Professional development and recognition programme (PDRP) project work that it is currently undertaking.

College of Nurses Aotearoa (NZ) Inc. members have been consulted during a three week period and their contributions are summarized. Submissions were received from our members and are representative of non government organizations (NGO), Primary Health Organisations (PHO), palliative care and Nurse Practitioner settings.

College of Nurses Aotearoa (NZ) recognizes the legal requirements under the Health Practitioners Competency Assurance Act (2003) to ensure the ongoing competence of Registered Nurses in New Zealand. Currently Nursing Council (NZ) approves professional development and recognition programmes as recertification under section 41 of the act. Typically these programmes have been developed in hospital settings as well as a number of other organizations who have sought approved programmes with Nursing Council NZ.

PDRP assists building partnerships and shared understandings of nurses' contribution to health care. Agreeing a national PDRP framework will ensure the portability of both knowledge and skills for Registered Nurses as and when they choose to move between areas of practice.

The College of Nurses Aotearoa (NZ) is pleased to see that the DHB's are considering extending their PDRP's to non government organizations and agencies outside of DHB. Non government organizations, PHOs and Hauora Providers are commonly contracted by District Health Boards to provide care to their district's population. It is only appropriate therefore that DHB's assist these organisations to ensure they have a competent and safe nursing workforce. Projects such as this will contribute to a more consistent workforce in terms of competence review and lead to greater transferability of skills across clinical settings.

Some NGO's and PHOs have developed their own PDRP's. Often these are not Nursing Council (NZ) approved. This means that there is increased likelihood of these individual nurses being called by the Nursing Council for audit. Support for these nurses during the audit process from within their organisations is variable. A nursing workforce that is supported by a Nursing Council approved PDRP will ensure regular performance appraisal, a current job description that accurately reflects their role within the organisation and support to participate in the professional development activities required to meet the standards set by the Nursing Council.

Summary of submissions

NGO

Submissions received from nurses working in a current PDRP approved programmes confirmed that the process applied was easy to use. The location for providing PDRP education is considered important ; This comment was clarified by the suggestion that Hauora providers, Plunket, Practice and aged care nurses can often feel uncomfortable in combined training sessions, particularly where there is a perception by some of these nurses that their experiences are lesser than those in hospital settings. The suggestion is that education settings are considered and delivery options varied to mitigate this risk.

Question was raised regarding the scoping activity available for those NGOs that have PDRP programmes in place already and how might these be incorporated into existing DHB programmes?

Hospice Sector

Hospices throughout New Zealand vary in terms of their service delivery, population size and nursing workforce. Hospices provide specialist palliative care to patients within their district. Many provide both community and inpatient care in partnership with generalist providers such as district nurses, general practitioners and hospital staff.

Some hospices have developed their own PDRP; it is unclear how many (if any) have been accredited with Nursing Council. Some hospices have developed partnerships with their DHB's to use their PDRP whilst others have no PDRP at all. NZNO recently developed a hospice PDRP as part of the recent Hospice Multi Employer Collective Agreement (MECA) negotiations. To date 14 hospices are part of this MECA.

Hospices vary in their commitment to having a designated senior nursing role responsible for the development of their nursing workforce. Many are charged with this on top of their clinical workload. They have similar issues to residential aged care sector in terms of their lack of knowledge of how a PDRP works or how it will assist them to ensure they have a competent nursing workforce.

Private Residential Aged Care Sector

A significant amount of palliative care is provided in the private residential aged care setting and with the predicted changes in older people's health in the next decade this is going to increase significantly. Many nurses working in private aged residential care settings are overseas trained and English is their second language. They are poorly paid in comparison to their DHB colleagues. Together with this they are under resourced in terms of having organisational support to engage in professional development activities. As a result many attend in their own time. We have personally witnessed nurses attending study days after working a night shift for example. Organisations need to be held accountable to provide their staff with opportunities to engage in professional development activities including the facilitation of work based activities such as journal clubs, quality initiatives, or in house teaching programmes. They may need guidance and direction from DHB's to do this.

Nurses in these settings have become acutely aware of the need to "collect" professional development hours. We have seen an increase in the number of nurses from private residential care settings attending education forums (albeit in their own time) with no clear direction from their organisation in term of learning outcomes and how this might contribute to their ongoing competence. There is a feeling of "attendance for attendance

sake" which may result in ad hoc, ineffective exposure to education initiatives. Aged care settings are managed and directed by multi national companies who provide a manual of education to be delivered within the organisation often with no practical resource or infrastructure.

It is anticipated that introduction of a DHB wide PDRP in these organisations will help to coordinate the competence and development of this work force. However it is important that DHB's understand the environment these nurses work in and the impact this has on their ability to engage in a PDRP. Who is going to ensure that the organisation meets its obligation under the proposed Memorandum of Understanding process?

Primary Health Organisations (PHO)

General Practice

A large number of nurses within primary health care will be practice nurses. There are a large number of employment situations and skill base. Consequently transposing into the DHB model will present challenges for this area of practice.

Although there are generic competencies and portfolio requirements for practice nurses, there is no foundation or national "bottom line" to use as a model. There is currently no clinical 'supervision' or determined competencies for practice nurses. Practice nurses frequently work in isolation and if there are other practice nurses in the practice there are no established criteria to base their interpretation of necessary skills for oversight and peer review. There are potential challenges where competence issues need to be dealt with within a performance management process by the employer. Often the performance management process is undertaken by the employer who is (in some cases) the Medical Practitioner or owner of the practice and who may not be a Registered Nurse. In this instance therefore performance management is based on the GP or owner assessment of 'competence' rather than by a Registered Nurse peer or senior nurse assessment.

In addition, the capitation system of funding does not require general practices to employ Registered Nurses. A number of Enrolled Nurses work in general practice, frequently without the constant supervisory presence of a Registered Nurse. Given this, together with the part time nature of the Practice Nurse Workforce this creates uncertainty as to

portfolio appropriateness for NCNZ competencies approval and sign off in general practice settings.

The number of general practices and varying levels of employment arrangements that exist will present problems for achieving “buy in” to any nationally applied PDRP process. It would be worthwhile to consider NZNO MECA (primary health care) to include a clause on PDRP? However, many nurses may not be members or apply to this process. An alternative way could be to include it with PHO Performance Management System through agreed performance indicators. Achievement of the indicator could provide a funding means for assessors to be trained and paid through PHOs. If this model was applied it may mean there is no need to look at how the programme pays for release time as this could be accommodated through PHO retained performance management programme funds (that is if PHOs retain a portion of these funds-some may operate different payment models and pay all PMP funds out to their providers).

The College of Nurses (NZ) Inc. supports the suggested 1:5 moderation process and recognizes that consideration will need to be made in terms of how resourcing is intended within the primary health care context.

A recent Nursing Council report identifies that competency related issues are over represented in primary health care, specifically aged care (Nursing Council New Zealand, 2008). Systems which support ongoing competency are to be encouraged. Examples of this may include PHO held registers of APC expiry, and provision of competency based assessment education forums, regional list of approved assessors on DHB/PHO websites, and included on inside cover of PDRP folders when distributed to nurses.

PDRP assessment is potentially time consuming. Undertaking the process in general practice and rural settings may provide challenges as payment for back fill of nursing hours may be required where there is a need for deputizing services. As well as this, there is not always the workforce available to provide that back fill.

NCNZ requirements for competency are workable in some community and secondary care settings where supervision is ongoing and where frameworks exist to support clinical supervision. For nurses working in general practice no such frameworks exist so there are not always processes to establish unsafe practice making it challenging to track and trace where it does exist. It may well be considered that competency requirements are embedded into general practice settings already; however there has

been no recognized general practice framework implemented to ensure those nurses undertaking competency reviews are qualified to do so.

Clinical supervision by other nurses for some clinical roles e.g. immunisations, (but only by someone who has a vaccinator's certificate which is not yet a national mandatory requirement for PNs) some wound care, writing protocols and developing position descriptions etc are assistive. But other significant areas relating specifically to primary health care nursing e.g. chronic condition management and lifestyle interventions require robust training and assessment of competency based on a nationally accepted training. At this point in time such training is not considered core requirement, instead competencies work off the premise that if practice nurses have an interest in diabetes and obesity this is sufficient to provide evidence of competency through self assessment. Although self assessment assistance is valuable and essential, practice nurses have no yardstick to base their competency on and neither do other nurses who come from outside the general practice structure unless they have a specialty nursing focus in that particular are of practice.

Currently in primary health care there is significant progress toward organisation quality management systems. These include but may not be limited to Healthcare Aotearoa Te Wana and Royal New Zealand College General Practice Cornerstone accreditation. There are elements of clinical quality including clinical record review activity and ongoing professional development requirements as components of these accreditation systems. It would be useful to consider how PDRP processes may be linked to this aspect of these programmes.

To help frame this feedback we have used some of the "frequently asked questions" as a guide to our comments.

What strategies can be employed to promote the expanded programme to ensure maximum uptake of programme?

The suggested strategies are appropriate. Achieving well developed networks with non government organizations and Primary health organisations relies not only on the DHB Director's of Nursing but also nursing leaders of those organizations outside DHB to actively engage with DHB. For many such organisations this may be a new approach and there is variability around the country in their ability or commitment to actively engage with their Directors of Nursing. Historically NGO's particularly have been "left alone" to do their core business and many do not have a relationship with their DHB and lack knowledge of how to pursue this.

Communication from the DHBNZ project teams via umbrella organisations such Hospice NZ, Health Care Providers NZ, PHONZ and IPAC General Practice Nurse Alliance may be useful to encourage this process.

The suggestion to facilitate regular communication via computers may be difficult for those smaller organisations that do not have ready access to computers. This may need to be supplemented with hard copies by mail.

How do you ensure the sector understands the purpose of a PDRP and how it measures competence?

Many nurses in non government organisations and Primary health organisations do not understand the purpose of a PDRP in that it is designed to measure the competence of a Registered Nurse as outlined by the Nursing Council. It is not designed to measure the skills and knowledge required to work in a specialist setting such as aged care or palliative care. This misunderstanding often leads nurses to believe they need to produce a portfolio that is far beyond what is required.

The strategies suggested by the project team will help to allay fears and concerns regarding this. Communication of information regarding the PDRP from within the partner organisations to nurses working in the clinical interface is paramount for the successful uptake of the PDRP and they will need DHB support to do this. This will also rely on effective and strong nursing leadership within the non government organisations which is variable.

Wherever possible, using existing DHB and NGO forums and services will ensure the success of expanding the PDRP to the primary health care sector. For example, where there are a number of DHB employed senior nurses that engage with either, aged care, palliative care, Maori provider or general practice sector to contribute to improving patient care. This might be a useful vehicle to communicate the relevance of a PDRP to the nursing staff.

We note here that the College of Nurses has provided excellent workshops on portfolio preparation to a wide variety of nurses in the sector, members and non members.

How could co-ordination of the PDRP occur if it is expanded?

It is appropriate to offer the competent level PDRP only initially until expansion of the programme is imbedded across the sector. Beyond this it may be appropriate to incorporate nationally developed competency frameworks that reflect the specialist settings of aged care and palliative care making the PDRP more relevant to nurses working in these settings. It is important that nurses understand that the competent level of practice is not necessarily a measure of their current performance which may be much higher than this.

How will the costs of portfolio assessments be met?

For this project to be successful there needs to initially be no barrier for non government organisations, Primary health organisations and iwi provider organisations to adopt the PDRP particularly in terms of additional cost to them. The college of Nurses recommend that the programme if provided freely to NGO's, PHOs and Iwi provider organisations with access to the existing DHB infrastructure in terms of portfolio assessors for no extra cost in the short term. This would be with an understanding that in time the organisation will put forward appropriate nurses to train as assessors via the portfolio training course offered by the DHB. These nurses would then be added to the pool of DHB assessors assessing portfolios across the district. This approach would also help to strengthen the partnership between NGO's, PHO, Hauora Providers and DHB's.

Our concerns are that if the DHB places restrictions in extending the PDRP out to non government organisations in terms of cost, this project will fail. Many NGO's do not yet appreciate the benefits of participating in a PDRP and a period of time is required to demonstrate the benefits of this programme whilst embedding down the processes

before attempts to recover costs are made. A memorandum of understanding could include an expectation that in time the partner organisation will contribute to the pool of portfolio assessors at their cost as they are able to do so.

How will we ensure there are enough assessors to undertake portfolio assessments?

To insist that sector groups provide a ratio of assessors per staffing levels will be a disincentive for many and will risk the success of this project. We need to reduce as many barriers as possible (including cost to the NGO's) to ensure maximum uptake of this project.

Regular assessor training and updates should be coordinated by the DHB.

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References

Nursing Council New Zealand (2008). *News Update*. Nursing Council New Zealand. Wellington.