Submission on the EN/NA Scope of Practice

October 2009

Submission from:

The College of Nurses (Aotearoa), "the College", is a professional body of New Zealand nurses from all regions and specialities both within and outside of the District Health Board setting. It provides a voice for the nursing profession and professional commentary on issues that affect nurses, and also the health of the whole community.

Submission on the basis of:

The submission is the result of previous policy analysis undertaken by the College, internal consultation on and off line and direct discussions with College members in a range of leadership positions in different parts of the sector. No College member expressed a view significantly at odds with this submission.

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Permission is given to publish the submission

Some relevant literature is appended

1-2 General consultation questions

The document provided a comprehensive view of the issues for the EN and NA scopes of practice. We have tried where possible to use your question format as we know it makes analysis of submissions simpler but we have been unable to consistently do so because of the presumptive nature of the questions in some places. As noted in other fora we believe that the questions posed in the Council's consultation document limited the scope of feedback and provided some sense of foregone conclusion, which was unfortunate.

The College continues to hold the firm view that the re-establishment of the enrolled nurse position and title would be an unfortunate step with prolonged and wide-spread consequences. We are fully supportive of the need for a second level position, which at most should be recognized as a Nurse Assistant. The title describes the role more accurately than the enrolled nurse title, which may have some historical meaning, but is not adequately descriptive. The use of the term 'assistant' is more aligned to other nomenclature, which is appearing in the sector e.g. Health Care Assistant; Physician Assistant. Physician assistants are not referred to as doctors because it is recognized that they have only a partial preparation in medicine. We think the parallel is instructive and the lack of confusion ensures public safety **through limiting the potential for misuse.**

However we caution that the use of nurse assistant itself still limits the potential flexibility of the role.

A further major reason for our lack of support for a second level nurse role is the concern of our Maori caucus that the presence of this option will reactivate the inappropriate direction of Maori students towards such a role rather than to the BN degree. It remains critically important to create supportive BN environments for Maori and Pacifica students rather than create lesser options.

3 Revised scope of practice.

There should be a generic scope for an NA.

4 Exclusions

The issue of exclusions does not arise if the second level worker is not understood to be a nurse. This lies at the very heart of our concern as historically the profession has grappled with the use and abuse of second level nurses and grappled with discussions about where they should and should not work. This concern has been fostered by the endless potential for a second level nurse to be inappropriately employed, inadequately supervised and even in some cases employed to supervise the work of RNs (examples exist in older care settings and in school nurse settings that we know of). This concern

has also been fostered by the clear evidence, which shows increased patient safety when care in acute settings is delivered by registered nurses. This does not mean that a nurse assistant role cannot provide supportive work for the RN but when that second level role is deemed to actually be a nurse then the risk that patients will be allocated to their care under, inadequate, inappropriate or distant supervision immediately arises. This does not align with the professions commitment to patient safety.

In planning for the future, we should retain flexibility and not limit options. Direction and delegation skills need a significant amount of work and this is the most critical tool for teamwork and safe, quality care. There is an ongoing need to ensure both RN's and recipients of delegation understand this thoroughly.

5 The College does not support NA's direct delegating to unregulated workers –

This role should be working as part of a team under the direction of a RN. The primary relationship for the patient should be with an RN and all assessment and delegation should stem from that point. The nature of the relationship is reciprocal and information on care provided and activity needs to go to the RN, not a 2nd level worker for evaluation. Such muddled communication is a recipe for error and adverse events.

6-8 If the role is identified as a NA and regulated then they should work under the direct supervision of an RN only.

We do however see value in a more generic assistive role that has a nationally standardized preparation. The health sector needs a second level worker which has the potential and flexibility to work across all settings - health, mental health, disability, community, primary, secondary and tertiary environments.

9-10 The Councils guidance on direction and delegation is sufficient for the management of NAs. However uptake and utilization of this guidance remains poor. We would consider that many RNs find it extremely difficult to assume the authority and ownership of outcomes which good delegation and supervision require

11-12 We do not support the removal of the phrase "*to implement nursing care for people who have stable and predictable health outcomes in situations that do not call for complex nursing judgment*?"

We do not support removal of this phrase regardless of whether Council decides on an NA role or should the Council determine that the second level worker will be a nurse. We believe this removal would support widespread and inappropriate employment of either NAs or ENs and would directly contravene patient safety in a range of settings.

13-14 Inclusion of assessment as part of the role of a second level nurse Not supported for any category of second level worker

Currently research and anecdotal evidence regularly attest to the poor quality or complete lack of assessment done by registered nurses in many settings. We do not seem to be in safe position to consider supervision and delegation of this critically important work to a second level worker.

15 No comment

16-17 The scope of practice statement provided in the consultation document is inappropriate for a nurse assistant or a second level nurse.

18-20 We do not support an 'endorsed' scope of practice through employer credentialing for this role. Attention to the RN scope and possible credentialing options is the higher priority.

21 Preferred title: Nurse Assistant

Our reasons are clearly outlined in the introductory comments above

Option One: Development of existing programmes into a generic programme

21 Yes

22-24 The educational preparation for this role should remain 1 yr at level 4 of the NZQA.
In principle we support the inclusion of a 12-week clinical placement, but have a number of questions about how the demand for clinical placements will be accommodated by service providers.

We also consider that the sector (both practice and education) are under extreme stress and we should not create the need for energy consuming consultation and development of a new program and processes.

25-26 There is no need for an entry to practice programme for a nurse assistant

This type of programme shifts the cost to the employer who is already providing the clinical placement. Who will pay for this? In addition DHBs are currently expressing difficulties in employing graduate registered nurses. Why would we potentially compound that problem?

Option 2 *Develop a work based programme that requires a partnership between an education provider and an employer*

27-32 No comment nor interest was expressed in this option therefore we do not have a view.

Option 3 *Develop a "seamless" programme which allows students to exit at either the certificate or diploma level*

Not supported; Not entirely clear what is meant by the certificate or diploma level but if this is proposing that we have certificated, diploma and degree based nurses then we are totally opposed

33-34 We do not support any overlap of the Nurse Assistant training with the RN education. The BN degree is already far too tight and we believe that students coming in for RPL would create significant difficulties in delivering the BN degree. If nurse assistants choose to advance their career and undertake further study then that is a good pathway, but it is separate from the employment relationship and should not displace existing undergraduate RN programmes or enrolment numbers.

Option 4 *Cease providing nurse assistant programmes*

35-36 Many College submitters were strongly in favour of a generic flexible health care assistant role, regulated if need be and able to assist in a variety of settings. Of critical importance was the need for national clarity and consistency. So on this basis there is support for ceasing the NA program but NOT in favour of an EN programme.

37-38 Support development of national requirements for an unregulated role that assists registered nurses?

We partially support this as outlined in many comments throughout this submission.

What is important is a robust – nationally consistent – training that installs values and attributes and clarity around function and scope. This in turn should be supported by position descriptions, which are not ambiguous. It is likely this role will remain low-income, so preventing the burden of certification/ enrolment fees would be of use.
The best flexibility is investing in the existing care assistant/ health care assistant role rather than expending energies in an enrolled structure. That title should include the words 'care assistant'. The use of a preceding word could be useful in reflecting the practice domain e.g. primary care assistant, community care assistant, health care assistant. There is a clear need for an assistive role in the primary health care setting.

Some submitters see value in regulation of the role. We appreciate the ownership and implementations issues created by such a position. We also recognize the need to move beyond the current very ad hoc and variable nature of second level or assistive positions. Perhaps as nursing provides the “glue” which underpins and holds together a wide range of health service settings and it is nursing most likely to utilize and supervise this role, then we need to “own” the implementation of the role. We have the broad grasp of sector need to prepare such a role but without limiting the flexibility of such a role.

Appendix one

Relevant literature to this submission.

The substitution of registered nurses with support workers may lead to inferior inputs, a reduction in quality, and may increase costs (Bostick et al., 2003; Dorr et al., 2005).

It has been well reported in the United States that having a high ratio of second level nurses to registered nurses can adversely affect the quality of care. Bostick (2004) demonstrated that with higher second level nurses and second level nurse HPRD, some adverse outcomes actually increase. With all other facility characteristics being equal, and holding all other factors constant, a six-minute increase in second level nurse hours was reported to be associated with a three per cent greater chance (OR = 1.03) of one resident developing a pressure ulcer. Other researchers provide further evidence that higher second level nurse HPRD may not have been in the best interest of residents, with increases in adverse outcomes such as pressure ulcers and related costs being reported (Dellefield, 2000; Hendrix & Foreman, 2001; Zhang et al., 2006). Conversely, Horn (2005) was able to show that more second level nurse time was significantly associated with less likelihood of developing pressure ulcers. Some researchers have recommended increasing registered nurse and support worker HPRD and reducing or eliminating second level nurse inputs (Hendrix & Foreman, 2001).

Whereas for RNs
Horn (2005) reported that registered nurse direct care time of 30 to 40 minutes per day was among the most significant predicators of better outcomes. This view was supported by Bostick (2005) who found, that with all other facility characteristics being equal, and holding all other factors constant, a six-minute increase in registered nurse minutes per resident per day appeared to be associated with a three per cent reduction in the chance of one resident developing a pressure ulcer (Bostick, 2004). Caution was needed when making comparisons as data from different periods of time and different clinical processes may have been in use; for example, the type of pressure reducing surfaces used. Still, these results signal the importance of the role of the registered nurse whose functions of completing comprehensive assessments, care planning, follow-through, and evaluations are significant in preventing the development of pressure ulcers, and are very important at the private hospital care level.

Horn (2005), reported a reduction in pressure ulcers from 32.1 per cent when less than 10 minutes per resident per day of registered nurse direct care time was provided, to 9.4 per cent when 30 to 40 minutes per resident per day of registered nurse direct care time was provided ($p=<0.001$). This verified the findings of a 1997 study (Dorr et al., 2005). When Horn's (2005) results are compared graphically to the 57 minutes per resident per day of registered nurse and to the 1.2 per cent pressure ulcer rate found in private hospitals (Whitehead, 2007), the trend identified by Horn (2005) continued downward.