2022 Longitudinal Study Nurse Practitioners New Zealand

334 respondents

Tables created in SPSS where blank/empty cells in the table represent missing data (no response).

How long have you been registered as a NP in NZ?

		Frequency	Percent
	1-2yrs	73	21.9
	2-3yrs	46	13.8
	3-5yrs	80	24.0
	5-8yrs	63	18.9
	8-10yrs	22	6.6
	10-13yrs	25	7.5
	13-15yrs	10	3.0
	15+yrs	15	4.5
	Total	334	100.0

Where geographically in New Zealand do you work? (as listed by NCNZ)

		Frequency	Percent
	Auckland	77	23.1
	Bay of Plenty	37	11.1
	Canterbury	32	9.6
	Hawke's Bay	15	4.5
	Manawatu-Whanagnui	34	10.2
	Nelson Marlborough	15	4.5
	Northland	16	4.8
	Otago	24	7.2
	Southland	12	3.6
	Tairawhiti	5	1.5
	Taranaki	6	1.8
	Waikato	22	6.6
	Wellington	37	11.1
	West Coast	2	.6
	Total	334	100.0

Are you currently working in a clinical NP role?

		Frequency	Percent
		4	1.2
	Not working in clinical role	7	2.1
	Recently retired within last 12mths	1	.3
	Yes [if yes, select then skip to Question 7]	322	96.4
	Total	334	100.0

If you answered no to the previous question, would you work as an NP if you were offered a position?

		Frequency	Percent
		326	97.6
	No longer want to nurse	1	.3
	Not really	1	.3
	Yes, definitely	3	.9
	Yes, dependent on hours and if geographically manageable	2	.6
	Yes, seriously consider it, including moving sites	1	.3
	Total	334	100.0

If you are not currently working as a Clinical NP, why not?

		Frequency	Percent of total
	Doing own research/ further study	0	0
	In management	3	.9
	Teaching	0	0
	On extended leave	2	.6
	Recently retired within last 12 months	1	.3
	Changed field of employment, ie left NP work. If so, what are you doing now? Comment in free text box below	2	.6
	Total	334	100.0

Free text comments:

- After registering as an NP, I could not find a position that suited my experience speciality. It was frustrating as I had been promised an NP role by the DHB and this was why I pursued the NP training. I am dissillusioned with the nursing profession and healthcare system in this country and now choose not to work clinically as an NP, despite me knowing that there are potential opportunities with a highly skilled clinician within my area of expertise.
- Currently on parental leave for 9 months but have permanent employment to return to in an NP role
- have a dual role of NP and management
- Helping on home farm, but do occasional casual NP work
- No opportunity in current workplace
- On Maternity leave but returning february 2023
- Retained one day a week clinical
- Will reconsider options once I feel recovered from burnout

Who are your current employer/s ? select as many as applicable

	Frequency	Percent of total
DHB on individual contract NON MECA	6	1.8
DHB under MECA	144	43.1
PHO on Individual contract NON MECA	54	16.2
PHO under MECA	7	2.1
Independent practice but not self employed	22	6.6
Private Medical Practice	75	22.5
Private Surgical Practice	1	.3
Private Hospital NON MECA	9	2.7
Private Hospital under MECA	0	0
NGO/ Trust	33	9.9
University	17	5.1
Self employed	37	11.1
Total	334	100.0

What is your field of work as an NP? eg PHC/ Aged Care, Emergency, Mental Health, etc

	Frequency	Percent
	31	9.3
2ndry Care based specialty eg Ophthalmology, Oncology, transplant, rare diseases	31	9.3
Aged Care PHC	22	6.6
Emergency / Acute Care	42	12.6
GP Practice PHC	108	32.3
Longterm Conditions PHC	9	2.7
Mental Health Adult	17	5.1
Mental Health Youth	1	.3
Neonatal	8	2.4
Paediatrics	14	4.2
Palliative Care	11	3.3
Perioperative Private	5	1.5
Sexual Health	7	2.1
Urgent Care	17	5.1
Whanau Ora	2	.6
Youth Health	9	2.7
Total	334	100.0

What is your field of work as an NP? eg PHC/ Aged Care, Emergency, Mental Health, etc_'Other' please specify in free text box below (50 characters)

	Frequency	Percent
	255	76.3
public health	1	.3
+ emergency/PRIME	1	.3
+ Urgent Care + Education + MoH	1	.3
Acute care NP in PHC and clinical editor for Health Pathways	1	.3
Addictions and Mental Health Adult	1	.3
Aesthetics	1	.3
also casual in urgent care	1	.3
Also Neonatal	1	.3
and aged care	1	.3
and general practice 50/50	1	.3
And GP PHC	1	.3
And rural	1	.3
and urgent care	1	.3
and Whanau Ora	1	.3
Cardiology	4	1.2
Cardiology - Adult Congenital Heart Disease	1	.3
Cardiology community outreach services	1	.3
Chronic kidney disease	1	.3
Critical Care & flight	1	.3
Dermatology	1	.3
Dhb employed in primary care	1	.3
diabetes	2	.6
dual disability - developmental disabilities (intellectual disabilites and or autism spectrum disorder) and mental health	1	.3
ED/Urgent Care/Prison	1	.3
Gastroenterology/Endoscopy	1	.3
General Surgery/Acute Care	1	.3
Gerontology	1	.3
GP Practice PHC	1	.3
GP Practice PHC as well part-time	1	.3
GP practice with an acute clinic and an aged care facility with dementure unit	1	.3
GP/UC/whānau ora/agecare -needs multiple choice	1	.3
Hospital in the Home - General Medical/LTC	1	.3
Hospital in the Home (sub-acute, interim-care)	1	.3
I also work P/T as a CNS cardiorespiratory but my DHB will not employ me in an NP role	1	.3
I work in both ED and primary care	1	.3
Inclusive of youth health and sexual health	1	.3
Iwi Provider Primary Health Care Community	1	.3

	Life span PHC community based	1	.3
	Locum work i rural areas in rural practices	1	.3
	Medical	1	.3
	Mental health old age	1	.3
	MH across lifespan in 2 GPs practices rural	1	.3
	MH across the lifespan	1	.3
	Older adults	1	.3
	Older Persons Health	1	.3
	Ophthalmology	1	.3
	Orthopaedics	1	.3
	Paediatric oncology	1	.3
	Pain management/rehab	1	.3
	Pain Medicine	1	.3
	Pediatrics and primary care	1	.3
	PHC	1	.3
	Primary care	1	.3
	primary care also	1	.3
	primary health with acute walk in	1	.3
	private cardiology	1	.3
	Professional Teaching Fellow NPTP UOA	1	.3
	Reproductive / women's health	1	.3
	Respiratory	1	.3
	Rheumatology	1	.3
	Rural	1	.3
	Rural acute and GP PHC	1	.3
	Secondary employment GP practice	1	.3
	Sexual and reproductive health	1	.3
	Sexual Assault Forensic Examiner/ Clinician	1	.3
	Shared role with DHB Older persons health and Primary care providing care in ARC	1	.3
	Sleep medicine	1	.3
	surgical. pre, peri, post	1	.3
	urgent care and gp	1	.3
	Urgent care and private orthopaedic practice	1	.3
	Urgent Care/Sexual Health	1	.3
	Vascular	1	.3
	Womens Health	1	.3
	Work primary and secondary care	1	.3
	Work seeing acute presentations as GPs do, also work one day week in community. Also attend remote community clinics	1	.3
	Total	334	100.0

What is your status & frequency of prescribing?

	Frequency	Percent
	1	.3
Do not prescribe	1	.3
Prescribing on a daily basis	293	87.7
Prescribing on a monthly basis	5	1.5
Prescribing on a weekly basis	32	9.6
Prescribing rarely, less than monthly basis	2	.6
Total	334	100.0

Do you sign off on Standing Orders for staff under your direction?

	Frequency	Percent
	3	.9
No	128	38.3
Non Applicable	54	16.2
Yes	149	44.6
Total	334	100.0

How do you document your prescribing? select as many as applicable

	Frequency	Percent of total
Electronic Patient Management System [PMS]	224	67.1
DHB prescription pad	117	35.0
DHB electronic prescribing	99	29.6
DHB medication charts	94	28.1
Non DHB handwritten scripts	39	11.7
Non DHB medication chart e.g. Hospice / Residential care	50	15.0
Total	334	100.0

If you are prescribing electronically please select the system/s that are applicable to your practice

	Frequency	Percent of total
Concerto	57	17.1
Medimap	81	24.3
Medtech32	75	22.5
Medtech Evolution	78	23.4
My Practice	17	5.1
NZ e Prescription	44	13.2
One note	6	1.8
Profile	1	.3
other	82	24.6
Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

	Frequency	Percent
	219	65.6
& evolution	1	.3
1 chart	2	.6
1 Chart	1	.3
1 chart, Indici	1	.3
1-Chart	1	.3
1chart	8	2.4
1Chart	3	.9
Can't remember	1	.3
CDHB MedChart	1	.3
Changed ti Indici in August 2022. Rest homes with our enrolled patients use 1 chart or medimap	1	.3
Clinical portal	1	.3
Clinical Portal	2	.6
Clinical vision	1	.3
DHB	1	.3
DHB prescribing system	1	.3
dr info	1	.3
ECA with DHB	1	.3
Elixir	1	.3
Emeds	1	.3
HCC	4	1.2
HCS	1	.3
health connect	1	.3
Health connect south	2	.6
IChart	1	.3
Indeci	1	.3
indici	3	.9
Indici	41	12.3
INDICI	2	.6
Indici and 1Chart	1	.3
Indici and Rescript	1	.3
Indici E-Prescibing	1	.3
indici e-prescribing	1	.3
Indici e-prescribing (PHS or what was Concerto)	1	.3
indici-e prescribing	1	.3
Indici. 1chart	1	.3
inidici	1	.3
Medchart	2	.6
MedChart	2	.6
Mental Health Electronic system	1	.3
MHprescribe	1	.3
MHPrescribe	1	.3
Mosaiq - oncology software	1	.3

	Nephrology database eprescribing	1	.3
	Not sure, DHB electronic system	1	.3
	one chart	1	.3
	One chart	2	.6
	One Chart	1	.3
	Onechart	1	.3
	OneChart	1	.3
	Palcare	1	.3
	RCP	1	.3
	Regional.clinical pathways e indici	1	.3
	Renal reality system - specific to renal.	1	.3
	Whatever system is used with Health Connect South (perhaps Concerto?)	1	.3
	Total	334	100.0

What is your status & frequency of ordering Laboratory investigations?

		Frequency	Percent
	Not ordering laboratory investigations	5	1.5
	Order on a daily basis	264	79.0
	Order on a fortnightly basis	10	3.0
	Order on a monthly basis or less	16	4.8
	Order on a weekly basis	39	11.7
	Total	334	100.0

How do you order your Laboratory investigations? select as many answers as applicable

		Frequency	Percent
	Electronic PMS printed lab form	119	35.6
	Electronic PMS eLab directly sent to lab	163	48.8
	Private lab forms handwritten	49	14.7
	DHB lab forms handwritten	126	37.7
	DHB eLab sent directly to lab	52	15.6
	Individual 'Point of care' testing	40	12.0
	Total	334	100.0

Which electronic ordering systems do you use to order your lab requests?

		Frequency	Percent
	Concerto	56	16.8
	DHB	62	18.6
	Medtech 32	74	22.2
	Medtech Evolution	76	22.8
	My Practice	20	6.0
	Profile	2	.6
	other	52	15.6
	Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

		Frequency	Percent
		267	79.9
	&evolution	1	.3
	Clinical Portal	1	.3
	Clinical portal/Medlab	1	.3
	Community path lab	1	.3
	eclair	1	.3
	Eclair	3	.9
	eClair (southern labs)	1	.3
	Eclair on Indici	1	.3
	Eclair through INDICI	1	.3
	Elixir	1	.3
	ERMS	1	.3
	form emailed to Labtests	1	.3
	hand written lab forms	1	.3
	Indeci	1	.3
	indici	3	.9
	Indici	35	10.5
	Indicu	1	.3
	medlab eclair	1	.3
	mosaiq	1	.3
	NA	1	.3
	path lab forms handwritten	1	.3
	pathlab	2	.6
	RCP	1	.3
	RCP programme (akin to Concerto)	1	.3
	Regional clinical pathways	1	.3
	sent directly to the Lab	1	.3
	Southland laboratories	1	.3
	Switched to Indici August 2022	1	.3
	Total	334	100.0

What types of laboratory testing do you order? Select as many answers as applicable

	Frequency	Percent of total
Blood Biochemistry, standard & incl TropinT, BNP, Blood gases	320	95.8
Blood Hormone / Endocrine	236	70.7
Blood Immunology; incl HIV, Hep B/C, Quanterferon Gold	234	70.1
Blood 1st /Subsequent Ante Natal	158	47.3
Blood Other ; incl Beta Hcg, HLAB27, PSA,TTG	199	59.6
Blood cultures	115	34.4
Microbiology swabs, incl HPV	242	72.5
Microbiology Covid	165	49.4
Microbiology Urine	293	87.7
Microbiology Faecal	248	74.3
Microbiology Other eg Body fluids / Sputum	219	65.6
Cytology smears	131	39.2
Cytology urine	141	42.2
Histology cellular swab or whole tissue	85	25.4
Covid/ Viral swabs / PCR/ RAT	223	66.8
Other: anything else you routinely do, if there is a test you would like access to do please identify 'would like to do'	27	8.1
Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

	Frequency	Percent
	294	88.0
Amonia, Growth hormone, Karyotype, FISH, (genetic testing), cortisol, Vitamin D, LP	1	.3
Antenatal USS.'would like to do!'	1	.3
CA19-9	1	.3
Certain autoimmune disease related immunology related tests	1	.3
coag screen, urine ACR	1	.3
Cog ag studies / VBG /	1	.3
CSF testing and BMA and trephine testing for oncological diagnoses	1	.3
Drug levels	1	.3
FBC, allergy, aspergillus, ANCA	1	.3
FBC, Coagulation screen	1	.3
fbc, coeliac, immunoglobulins, lft etc	1	.3
Full blood counts	1	.3
Genetics	1	.3
Group and hold	1	.3
Haematology	1	.3
haematology, calcium, B12	1	.3
Hba1c .LFT, renal function electrolytes , TSH, FBC	1	.3

	HbA1c, TFT, LFT, Uric Acid, CRP, FBC, Free chains, various drugs	1	.3
	Histology	1	.3
	immunology, allergy testing, BNP, coeliac serology, helicobacter plory	1	.3
	Joint aspirate, CSF MC&S	1	.3
	Lithium	1	.3
	Micro Skin Scraping	1	.3
	mycology	1	.3
	Newborn metabolic screening, microarray	1	.3
	not sure what standard means in 1st box - FBC, thyroid function, HbA1c,	1	.3
	PCR STI swabs, endometrial samples	1	.3
	Pipelle endometrial samples for histology, anti CCP, joint aspirate	1	.3
	Pregnancy USS	1	.3
	RAST testing, parasite - strongyloides	1	.3
	serum IgE (RASTS) and skin prick tests	1	.3
	Skin prick Tests, RASTs, FBC,	1	.3
	Skin/ nail scraping,	1	.3
	therapeutic drug monitoring- clozapine, lithium, Na Val	1	.3
	Toxicology Urine drug screen	1	.3
	UDS	1	.3
	Urine cytology,	1	.3
	Urine drug analysis	1	.3
	Urine drug screens	1	.3
	whatever is needed for my pt	1	.3
	Total	334	100.0

What is your frequency of ordering Radiology imaging?

		Frequency	Percent
		5	1.5
	Daily	144	43.1
	Fortnightly	19	5.7
	Less than monthly	27	8.1
	Monthly	27	8.1
	Not ordering radiology. Please comment in free txt below if barriers are preventing you	25	7.5
	Weekly	87	26.0
	Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

		Frequency	Percent
		318	95.2
	May be up to 3-4x per week	1	.3
	have not needed to in my role.	1	.3
	have put referrals through in the past which do not get replied to, haven't tried for at least 2 years	1	.3
	MH not allowed to order radiology refer to specialist or gp.	1	.3
	Need for electronic ordering, Not patients primary practitioner	1	.3
	No	1	.3
	No barriers	1	.3
	No barriers but not often necessary in my role	1	.3
	No barriers, just not needed in my speciality	1	.3
	or when required	1	.3
	Ordered by our medical team	1	.3
	Primary teams have usually done this or will do it on advice	1	.3
	See comment below	1	.3
	Unable to order any radiology in current role	1	.3
	usually needed for acute injuries in my line of work and no casting available in my role	1	.3
	Variable week to week	1	.3
	Total	334	100.0

What sort of Imaging do you order? Select as many as applicable to your practice

		Frequency	Percent of total
	ACC through private radiology	171	51.2
	ACC via DHB radiology	130	38.9
	Barium swallow/ Enema	24	7.2
	Bone Scans	71	21.3
	CT head	138	41.3
	CT other; Abdo, pelvis, renal, sinus	129	38.6
	Echocardiogram	110	32.9
	MRI	46	13.8
	Ultrasound Bedside [performed by yourself]	37	11.1
	Ultrasound General incl abdo, blood vessels, Gynae non preg related ,line placements , MSK	235	70.4
	Ultrasound TOP/ pregnancy	112	33.5
	Other ?	35	10.5
	Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

	Frequency	Percent
	257	76.9
angiogram (with cardiologist approval)	1	.3
angios - fistulograms, angiograms,	1	.3
Bone X-rays non ACC through DHB, EEGs, second opinion X-rays through starship	1	.3
Bone. Abdo, Chest XRs	1	.3
Chest & Abdo X-rays.	1	.3
chest x ray	1	.3
Chest X-ray	1	.3
Chest x-ray - DHB	1	.3
Chest X-Rays	1	.3
Chest XR, General XRs e.g. Fractures	1	.3
Chest Xray via DHB and POAC (provate radiology)	1	.3
Chest xray, CT chest, PET scans	1	.3
Chest xrays, Abdo xrays	1	.3
chest/body xrays	1	.3
Community radiology	1	.3
Cranial ultrasound	1	.3
CT Aorta, CT lower limbs, MRI	1	.3
CT KUB	1	.3
CT scans when asked to for further investigation after ED visit	1	.3
CT Sinus & KUB	1	.3
CTCA and stress echo	1	.3
CTPA, CXR- private radiology	1	.3
CXR	2	.6
CXR, Chest/Abdo x-ray, Abdomen series, USS - head (neonatal),	1	.3
Cxray	1	.3
DEXA	1	.3
EEG	1	.3
General non acc x-rays both private and DHB	1	.3
General X-rays - mainly chest and abdomen	1	.3
I dont order any as they are never accepted. I request a consultant colleague to make the request, ofthen they are still declined.	1	.3
I order USS pregnancy but have to put a gp name on the form for it to be funded. I order CT HEAD and sometimes others by writing to a specialist with the clinical case and get approval	1	.3
I work for a consult service - so largely requesting scans through primary teams	1	.3
Interventional radiology e.g. biopsy, nephrostomy insertion	1	.3

	Interventional radiology for Portacath insertions	1	.3
	Most unticked have to be approved by specialist in Waikato	1	.3
	MSK us	1	.3
	Musculoskeletal X-rays	1	.3
	Need to get GP to sign of U/S for Pregnancy or TOP	1	.3
	No funding for TOP/Pregnancy	1	.3
	non acc dhb radiology	1	.3
	Non acc eg Chest Xray	1	.3
	Non Acc eg chest xray	1	.3
	Non ACC via dhb	1	.3
	Non-ACC radiology through DHB	1	.3
	Non-ACC via DHB or private radiology	1	.3
	None	1	.3
	Nuclear medicine scans	1	.3
	PET CT	1	.3
	Plain chest films not in this list?	1	.3
	plain x-ray imaging	1	.3
	Plain xrays mostly CXR	1	.3
	post op jint x rays - sometime CXR's	1	.3
	Pregnancy complications	1	.3
	Pregnancy uss under GP - when will this be resolved?	1	.3
	PSMA	1	.3
	Radiology - postoperative hip and knee joint	1	.3
	Related to health condition and as tests required	1	.3
	Request antenatal Uss through GP colleagues	1	.3
	Should be able to order MRI but ACC do not allow? Could order when I DHB even as Nurse Specialist	1	.3
	Ultrasound not credentialed	1	.3
	USS guided steroid injections	1	.3
	USS Top/USS with GP support as rejected due to section 88	1	.3
	with USS Pregnancy/TOP order under GP name cc to myself so can continue care	1	.3
	X-ray via DHB/public system	1	.3
	X-Ray, Nuclear medicine gastric emptying scan	1	.3
	X-rays in general	1	.3
	XR	1	.3
	xray	1	.3
	Xray - chest	1	.3
	Xray - mainly of feet	1	.3
	Xray abdo, chest via DHB	1	.3

	Xray non ACC	1	.3
	Xray through DHB	1	.3
	Xrays	1	.3
	Xrays - mostly chest and abdo	1	.3
	Xrays, nuclear medicine scans - thyroid, renal	1	.3
	Total	334	100.0

How do you order radiology imaging?

		Frequency	Percent
	Electronic PMS	240	71.9
	DHB radiology forms	102	30.5
	Private Radiology forms	60	18.0
	Nursing notes eg cath lab , in ED or theatre for bedside proceedures	6	1.8
	Total	334	100.0

Which electronic system/s do you use for ordering Radiology investigations? select as many as appropriate for your practice

		Frequency	Percent
	Concerto	86	25.7
	Medtech 32	73	21.9
	Medtech Evolution	77	23.1
	My Practice	23	6.9
	Profile	2	.6
	Other	59	17.7
	Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

		Frequency	Percent
		252	75.4
	Available through Clinical portal	1	.3
	BPAC	1	.3
	BPAC / indici	1	.3
	BPAC referrals	1	.3
	Clinical portal	1	.3
	Clinical Portal	2	.6
	Clinical portal on DHB system	1	.3
	Clinical workstation CWS	1	.3
	CWS, Indici	1	.3
	DHB	2	.6
	DHB clinical workstation CWS	1	.3
	Dhb electronic	1	.3
	DHB electronic request - unsure of name	1	.3
	DHB internal system	1	.3

	DHB intranet	1	.3
	DHB paper forms	1	.3
	DHB specific system	1	.3
	DHB system	1	.3
	don't know, DHB system	1	.3
	eclair (this is embedded in clinical portal which is the new version of concerto)	1	.3
	Eclait	1	.3
	Elixir	1	.3
	Email to Pacific Radiology	1	.3
	Erms	1	.3
	ERMS through Indici	1	.3
	ERMS via medtech	1	.3
	HCS	2	.6
	Health connect south	1	.3
	Health Connect South (Concerto?)	1	.3
	Indeci	1	.3
	indici	6	1.8
	Indici	31	9.3
	INDICI	1	.3
	mosaiq	1	.3
	not clinically indicated for my field of practice	1	.3
	order hand written	1	.3
	PACS	1	.3
	Private form emailed to Radiology provider	1	.3
	RCP	1	.3
	Regional clinical pathways ROERS	1	.3
	Roers	1	.3
	ROERS	1	.3
	Telephone the xray company.	1	.3
	Unclear/no idea sorry!	1	.3
	Total	334	100.0

Which of the following documents are you completing & signing off? Select as many as applicable to your practice

		Frequency	Percent of Total
	ACC; M45s & ARC18s	226	67.7
	Advanced Directive Forms	99	29.6
	Covid documentation	141	42.2
	Death & Cremation Certificates	132	39.5
	Disability Certificates child/ adult	171	51.2
	Disability Parking Forms	150	44.9
	Drivers Licensing	148	44.3
	Drug testing compliance	34	10.2

	Controlled Drug agreements	60	18.0
	Compulsary Treatment forms	14	4.2
	Enduring Power of Aoterny applications	65	19.5
	Hospital admission/ discharges	137	41.0
	Immigration applications	8	2.4
	Insurance Medical applications	103	30.8
	Medical Alarm application forms	139	41.6
	Police Documentation eg Blood alcohol, DSAC	37	11.1
	Work & Income ; Work Capacity , Independent Living Allowance	181	54.2
	Travel Documentation	122	36.5
	other; anything you frequently sign off that is not listed	25	7.5
	Total	334	100.0

If 'Other' please specify in free text box below (50 characters)

		Frequency	Percent
		296	88.6
	Ability to go back to work or medical leave	1	.3
	ACC requests for info. WINZ disability forms for counselling. Once had to do a coroners report. LSV applications and various Medical's eg seamans, outward bound etc	1	.3
	Army medicals, Diving, Fire brigade	1	.3
	Care coordination for funding though DHB for home/community/ARC supports	1	.3
	Competency assessment, EPOA activation, Dementia specialised care sign off	1	.3
	Disability allowance	1	.3
	Donor breast milk consents	1	.3
	Employment medicals	1	.3
	enacting EPA	1	.3
	EPOA activation	1	.3
	Fire brigade medical forms, glider/microlight pilot medicals, seafarers medicals	1	.3
	Housing NZ letters	1	.3
	I am one year post NP graduation so still working through other documents/training.	1	.3
	Immigration do not allow NP to do them	1	.3
	INCAPACITY	1	.3
	Just in case plans	1	.3
	Just In Case Plans	1	.3
	LSV Medical's	1	.3
	MEDA - Medical request to fly	1	.3
	Medical alert applications	1	.3
	Medical certificates	1	.3

	Medical certificates for Northern Health Schools	1	.3
	Medical certificates for school or work	1	.3
	Medical certificates for time off work	1	.3
	Medical/off work certificates	1	.3
	NB: DSAC is now known as MEDSAC	1	.3
	Non ACC work certificates	1	.3
	off work certificate	1	.3
	Off work certificates	1	.3
	Off work certificates, Kiwi saver release forms	1	.3
	Off work medical certificate Support letters for patients eg winz	1	.3
	Oranga Tamariki- fostering medicals	1	.3
	Rehabilitation plans	1	.3
	School High Health Needs Funding	1	.3
	Section 10/11 assessments for MHA - this is new nr NPs since COVID	1	.3
	Sick leave	1	.3
	Volunteer FENZ medicals, armed forces medicals, Certificates of competency	1	.3
	Welfare Guardian and Property Orders Placement in locked units	1	.3
	Total	334	100.0

Are there other NPs or NP interns in your immediate team / workplace/ practice?

		Frequency	Percent of Total
	NPs only	114	34.1
	NP Interns only	9	2.7
	Both NPs & NP interns	87	26.0
	No, I am the only NP in my setting	125	37.4
	Total	334	100.0

If so, how many of each?

		Frequency	Percent
		215	64.4
	One other and we will have an NP intern next year on a placement	1	.3
	0ne of each	1	.3
	1	15	4.5
	1 (part-time)	1	.3
	1 + 1	1	.3
	1 but intern starting end of 2023	1	.3
	1 NP	1	.3
	1 NP and 1 intern	2	.6
	1 NP and 1 NP intern	1	.3
	1 NP and 1 NP Intern	1	.3
	1 np prim health	1	.3
	1 NP, 1 intern, and 1 pending intern	1	.3

	1 of each	3	.9
	1 other NP	1	.3
	1 other NP and an NP intern (nptp 2023)	1	.3
	10 NP's and 3 NP interns	1	.3
	2	9	2.7
	2 including myself	1	.3
	2 interns, 4 NPs	1	.3
	2 NP , 1 intern	1	.3
	2 NP & 1 intern	1	.3
	2 NP 2 interns (Both just passed Panel)	1	.3
	2 NP; one RN prescriber; 2 cns candidates	1	.3
	2 NPs	2	.6
	2 NPs 1 NP intern	1	.3
	2 nps and 2 interns	1	.3
	2 NPs including myself	1	.3
	2 nps only	1	.3
	2 NPs, 1 intern	1	.3
	2 of us	1	.3
	2 other NP	1	.3
	2 other NPs	1	.3
	2 other NPs, 2 Interns	1	.3
	2 others part time	1	.3
	2 others. 1 x 0.7FTE, 2 x 0.6FTE (total of 1.9FTE)	1	.3
	3	6	1.8
	3 in one practice and 2 in the other practice I work at, we have no regular GPs	1	.3
	3 np 2 intern	1	.3
	3 NP and 2 interns.	1	.3
	3 NP and occasional NP interns as required	1	.3
	3 NP's	1	.3
	3 NP's, 1 NPI	1	.3
	3 NPs	1	.3
	3 NPs + advertising for one more and 1 NP intern due to start,	1	.3
	3 NPs, intermittent supervision of NP intern (from outside workplace)	1	.3
	3 other NPs	1	.3
	3 others	1	.3
	4	3	.9
	4 in total (including myself)	1	.3
	4 total including men	1	.3
	5	1	.3
	5. And 2	1	.3
	6	2	.6
	6 NPs + 1 casual	1	.3
	8 Np 2 np interns	1	.3
	9 NP’s and 3 NP interns	1	.3
	9 NPs, 2 interns	1	.3

	Currently 2 NPs, 5 CNSs	1	.3
	Depends on the practice I am in but at times the only clinician	1	.3
	DHB role 1 other NP and NP intern, GP/urgent care has 2 other NPs, 1 NP intern and another practice am sole NP	1	.3
	DHB setting I am the only one. I work one day a week in a practice, I estimate around 10 NP's and interns there.	1	.3
	However NPs in my secondary placement.	1	.3
	I am one of 4 NPs	1	.3
	I am only one working MH	1	.3
	I provide secondary placements for several NP interns each year0	1	.3
	I work alone at my facility but have another NP working in my role in the Waikato. And 9 of us working in the same role throughout NZ	1	.3
	In ED in hospital I am the first & only NP employed on a casual contract	1	.3
	multiple worksites so varies	1	.3
	myself andone other NP plus GPs/ nurse prescriber intern	1	.3
	NP 4 NPI 2 CNS 5	1	.3
	one	2	.6
	One	2	.6
	One NP intern	1	.3
	One of us is each locality team - two for youth MH	1	.3
	One recently resigned	1	.3
	Potentially - one that has just finished diploma and thinking of going down NP pathway	1	.3
	Team of 11 in urgent care. One NP and one CNS (not yet at NPI stage) in private orthopaedic work	1	.3
	There is only 2 NP in practice	1	.3
	Two NP's and myself	1	.3
	two of us at present	1	.3
	x2 NP's with GP	1	.3
	x2 others	1	.3
	X3 NPs x1 NP Intern (clinical placement only)	1	.3
	Total	334	100.0

If you are working clinically, do you feel you are working to "top of your scope"?

	Frequency	Percent
	2	.6
Definitely not	3	.9
Not really	19	5.7
Yes, absolutely	167	50.0
Yes, mostly	105	31.4
Yes, partially at times	38	11.4
Total	334	100.0

if not why not ? comment free text in box below (50 characters)

	Frequency	Percent
	266	79.6
ACC introducing trial for pHC MRI referrals for shoulder, knee and back injuries. NP invited to do training but not included as trial referers	1	.3
Although this has eroded since a change in medical director - they changed the service model for just me and two part time Drs under the guise of COVID so I no longer can treat and discharge my patients I admit to the ward but can cover Drs and see their patients and discharge them??? It appears my ability to work at the top of my scope if vulnerable depending on who the clinical / medical lead is or if supported by medical colleagues. Hence expanding into private practice.	1	.3
Appointment times are due to business demands shorter than DHB appointments in primary care. Primary care long term condition appointments often cancelled and put on acute care clinic. Essentially businesses demands why can't do my LTC top of scope work.	1	.3
As a beginning practitioner i am slowly extending my practice.	1	.3
Beyond most of the time. I am working in the capacity of a Paediatrician a lot of the time - doing outpatient clinics by myself with very limited support.	1	.3
cannot order dating scans for pregnancies' or CT, MRI and cannot prescribe sec 29 drugs or medicinal cannabis - barriers to treatment	1	.3
clinical notes from old owner not UTD	1	.3
dept model of care, physical layout, staffing resources	1	.3
Developing confidence with practice for babies/ children and clinical skills such as suturing etc	1	.3
Due to health issues can’t work face to face	1	.3
For a first year NP!	1	.3

	Gaps exist with some surgeons not allowing me to see patients I am quite capable of seeing. Not so much of a problem now, but can still occur	1	.3
	Have been utilised in the minors area mainly currently due to staffing issues and not seeing other ED presentations	1	.3
	High demands and short staffing for staff nurses - often get pulled into these roles eg. triage nurse or shift co-ordinator	1	.3
	Huge department pressures, often filling RN roles	1	.3
	I am a new NP in my first year of practice	1	.3
	I am a novice and working within that scope - limitations are self imposed due to lack of experience or skill gaps rather than dictated	1	.3
	I am doing exactly what GPs do in our clinic seeing whom ever walks in the door. although I only see 18 years and over. I am the insulin start practitioner, COPD practitioner and see people who have diabetes and CHF. I also see people who are palliative in their homes	1	.3
	I am not the lead clinician for the patients, large team of clinicians but only a small nursing team which I manage, when we are short staffed I do a mixture of CNS/NP work	1	.3
	I am only new to NP role and still finding my feet.	1	.3
	I feel like I am in urgent care but I would like to know more about long-term conditions etc, this will come with time however.	1	.3
	I provide a consult service and recommend investigations such as lab tests and imaging - so the consultant can take or leave my recommendations. For the most part any recommendations I take are enacted.	1	.3
	I think top of scope in emergency department is seeing all patients. We are not doing that yet	1	.3
	I would like to grow more learning into Imaging and interpretation like echo training for cardiac NP's etc more training package around expanding the practice.	1	.3
	I would like to have more autonomy in general med but dhb wants me to mainly do endoscopy	1	.3
	I'm a relatively new NP - just on 3 years. I am currently working at the upper end of my scope but have a lot my growth in me!!	1	.3
	in ED limited by fact its a teaching hospital and we don't get to work enough in the high acuity areas. Primary health need to upskill in a few areas- have a plan	1	.3
	In my 3rd year of NP practice & steadily getting to the top of my scope of practice..	1	.3

	It’s confidence I need and more acutes	1	.3
	just moved into primary care from acute care and still learning	1	.3
	lack of appropriate education and support	1	.3
	limitations put in place currently by SMO group and the structure of the department	1	.3
	Limited opportunity for ongoing education to bridge gaps in knowledge and experience.	1	.3
	Limited resources and back up to senior clinicians to help support further practice. Next year will work with paeds consultants to help support increase in practice scope in the community.	1	.3
	Most often feel like a 'workhorse' ... doing all the advanced skills in the unit, always being available for teaching RMO/SHO's both skills and clinical practice. SMOs will over-ride decisions made based on diagnosing and treatment, not because the NP is wrong, is just not the way that particular SMO would do it so over-rides your decision.	1	.3
	My role now has a significant management component which means my clinical time is limited, so do not always feel like working to scope due to time restrictions	1	.3
	Need to be able to prescribe S29 meds and S88 Antenatal Ultrasounds independantly	1	.3
	New in role working across two hospitals. Organisation doesn't understand NP role. Staffing shortages- used more to fill gaps	1	.3
	No appetite in service to do things differently - expectation that role looks like a RMO	1	.3
	Not enough nurses in our team, and a large number of NPs, so at times working at a senior nurse level rather than NP…	1	.3
	Novice+ DHB restrictions	1	.3
	Our clinical load is heavy and as we are the 'senior practitioners' and have the 'expert skills' we are often the 'work-horses' of the unit. We teach skills / procedures and clinical practice to our junior docs. Our consultants do appreciate us however, we are often taken advantage of as they do not need to be as present due to our clinical skills.	1	.3
	Our emergency department SMO's would like NP's to stick to minor injuries, unsure if its personal preference or lack of understanding of scope. Often get told complex patients are outside of my scope.	1	.3
	Paediatrics not a priority group. Politics FACEMs and nursing hierarchy limit our role	1	.3

	Pushed out to primary care to deal with the referrals and population that are discharged from secondary and those whom don't meet service criteria or to cater to the population need to avoid requiring secondary services however, primary care demands work in paediatrics, colds, coughs, acute care, gynae it does not value the LTC work and unable to work within this LTC scope.	1	.3
	Redirected during the pandemic - having to adjust to the changing workplace	1	.3
	Reduced numbers in ER during initial COVID meant allocated to more menial stuff, and then 'encouraged' to man an ambulatory care area becoming more de-skilled as time went by... there has been a recent commitment to up-scope the NP's in ED but it is very NP dependant on what they choose to pick up and sometime the path of least resistance is going back to the ambulatory area.	1	.3
	remains still very much a medically lead unit - had more autonomy as a clinical nurse specialist than I do as an NP.	1	.3
	Restricted due to section29 drug prescribing. Limitations around infant care being under named neonatologist	1	.3
	Short staffing restriction ability to progress to higher acuity area of department	1	.3
	SMO's unclear about potential of the role	1	.3
	Some referrals do not require NP to follow up on	1	.3
	Sometimes used to cover vacant RN shifts	1	.3
	Staff shortages require me to cover other CNS roles , admin, manager tasks.	1	.3
	Still a lot of patch protection by GP’s and other Doctors	1	.3
	Still a novice NP, been in the role for 1yr now, continuing to develop and learn	1	.3
	Still developing my practice, confidence growing. Always learning, steep learning curve. No immediate barriers though.	1	.3
	Still learning and expanding my skills and knowledge	1	.3
	Supervised with minor skin and hyena procedures at present and with supervision psychological interventions	1	.3
	There are some areas I need more experience, eg skin lesions	1	.3
	Time constraints; hard to add on new skills safely when already very busy	1	.3

	We are limited by a directive from the Clinical Director that we can not provide dermatology care unless caused by STI related infection.	1	.3
	We work like clinics nurse specialist seeing minor injury mostly, pigeon holed into our role due to the location of our work place and general attitude of the doctors who have overseen the department	1	.3
	work with surgeons and anesthetists and whilst we have 'free range" particularly in the post op period to assess, diagnose and treat - we work in collaboration with surgeon / anesthetists, and they often will "take over'	1	.3
	Working in a GP role at the top of my scope but could be doing more procedures and minor surgery. There is a lot more I could be upskilled to do in PHC.	1	.3
	Working in traditional medical model, slowly changing practice as team aware of my scope and abilities	1	.3
	Working to up skill GP's, so doing a lot of recommendations rather than prescribing	1	.3
	Yes in my primary role. No in my DHB role where I work as a non-prescribing DHB	1	.3
	Total	334	100.0

If you are working in an NP role do you feel your current work environment provides you with the necessary resources and support to practice safely?

		Frequency	Percent
		3	.9
	Absolutely not	2	.6
	Not really	13	3.9
	Yes , absolutely	123	36.8
	Yes, mostly	156	46.7
	Yes, partially at times	37	11.1
	Total	334	100.0

if not why not ? Please specify in free text box below (50 characters)

		Frequency	Percent
		285	85.3
	.imited opportunity for protected mentoring, collegial interface wi5h tertiary clinicians.	1	.3
	Access to DHB records from across the country is limited	1	.3

	Appointment time demands are for shorter times and now Auckland Uni has released documents for NP new graduate program with aim of 20min appointments this is expected. 20 min appointments however included a concurrent script template whereby nurses place repeats scripts on a list for completion every appointment slot time. Admin and paper work often done in own time. Need to set up work life balance to practice safely as current business hours do not support safe practice and often doing work beyond what is expected professionally in own time. Understand as a professional need to do some work outside business hours for patient safety but this has got more and more and encroaching on burnout levels and difficult to maintain balance at this pace and speed. Need more protected admin and protected script renewal time.	1	.3
	Business need requires more than that which trained within.	1	.3
	capacity to see the number of patients is limited by my knowledge and skills - pressure to see patients and make $	1	.3
	Clinical Nurse Managers exclude from discussion of nursing issues as would prefer to speak to Drs! I do not report to her so professional jealousy	1	.3
	Electronic prescribing and radiology testing would be beneficial for audit.	1	.3
	Everywhere is short staffed	1	.3
	Hospital yes, urgent care no	1	.3
	I am an acute care NP, recently moved to PHC from ED. I do not have LTC specific experience and find I end up with LTC in my book. at times difficult to access GP/NP review of cases at the time if outside my scope	1	.3
	I have been working in a challenging work situation with sadly breakdown of relationships between clinicians - this has led to a need for increased vigilance and safety on my part - the employer has been supportive of me in this process	1	.3
	I now have no formal Clinical Surpervision since my GP clinical supervisor left Nov 2021	1	.3
	I think my scope, my limitations of knowledge and my practice are kept safe with knowing boundries and never going it alone on complex issues. I'm still learning and feel part of the team	1	.3

	I would like more support. This has been brought up numerous times but nothing formal is organised, it is left to me to do but I dont have time to do it.	1	.3
	insufficient funding for CNE	1	.3
	It systems don't work for my setup	1	.3
	Lack of equipment that a GP would have access to	1	.3
	Lots of locum SMO Drs whom, so don't trust our skills or knowledge. Find it impossible to hand over patients at end of shift to medical colleagues.	1	.3
	Lots of work and time spent on getting the much needed support which is granted to Medical colleagues without any need to negotiate. Expected to do lots of admin in own time	1	.3
	Making some progress in gaining momentum and support with education	1	.3
	More CME would be good	1	.3
	Need more clinical support	1	.3
	Newly established NP model of care. Some lack of support re education/skills when starting	1	.3
	No orientation, no support	1	.3
	No peer review case review. No oversight of prescribing decisions esp in first year out	1	.3
	No Test safe access test results provided by facility	1	.3
	Non DHB so not on dame electronic system. Unable to share or access data easily creating risk	1	.3
	not enough time for each consult/pts multiple issues when they come	1	.3
	Not given support when performing outpatient clinics in comparison to medical colleagues who are given support	1	.3
	Often have to work without the support of an RN. Which means doing both RN and NP roles.	1	.3
	old clinical notes not up to date new practice owners	1	.3
	Poor understanding or NP role from leadership	1	.3
	Prefer to decline to answer. Need more than 50 characters to explain my experience.	1	.3
	Short staffed, working through breaks - great expectation from doctors that as a team we will do more and more - however don't have the staff to do all they ask which puts us in unsafe environments at times.	1	.3
	Sometimes feel unsafe when I can't contact my supervisor for advise	1	.3

	Sometimes I am the only practitioner in the clinic for the day. However, I am aware of my support network so know who to contact if needed	1	.3
	Sometimes the patient load exceeds capacity and the volume and pressure concern me that I might miss a red flag as it can be overwhelming at times.	1	.3
	Staff shortages = clinics risk, highly stress work environment	1	.3
	Time constraints of general practice 15min apts and endless paperwork and no space for additional paperwork for walk in acutes	1	.3
	Time pressure, duration of appointment 15min/patient, limited time for administration/paperwork and scripts, taking work home to complete	1	.3
	time restraints for other clinicians	1	.3
	Time!	1	.3
	Too much pressure to work faster	1	.3
	We are always the first to loose a nurse when short staffed, often our area is not serviced as it's deemed not as important	1	.3
	We are very short staffed and need more clinicians.	1	.3
	work different days to other NP's, all part time so limited peer contact, although Drs very supportive- Np's not included in their peer group meetings, division between Dr's and NP's. Is rural practice within DHB environment	1	.3
	would be nice to be provided more education by the SMOs	1	.3
	Would like ACC training to order MRIs	1	.3
	Would like more mentorship but busy practice so totally understandable	1	.3
	Total	334	100.0

What things do you do to promote NP roles? select as many as appropriate

		Frequency	Percent of Total
		37	11.1
	Teaching/ Education in own scope/ region	297	88.9
	Mentoring budding NPs	270	80.8
	Writing academic papers	38	11.4
	Presenting at conference	107	32.0
	Leading NP regional support	39	11.7
	NP representative on regional bodies	65	19.5
	NP representative on national bodies	62	18.6
	Other	27	8.1
	Total	334	100.0

if 'Other' Please specify in free txt box below (50 characters)

	Frequency	Percent
	285	85.3
A while since conference presentations	1	.3
Actively working in own time with medical college to help with access to ongoing training.	1	.3
At present I have had to reduce hours of work due to terminal family illness, no time to participate in any of above apart from NP peer meetings	1	.3
Attend Maori NP hui in the BOP region, discuss how we can support upcoming Maori NPs	1	.3
Chairperson of DHB support network	1	.3
Clinical Lead of Clinical Reference Group (Allergy) for PSNZ	1	.3
co ordinate NP peer meetings locally	1	.3
Completed Doctor of Health Science thesis- study about NPs in NZ	1	.3
continually educating patients re role, SOS	1	.3
developed a NP led specialist primary MH service, although I am finding it difficult to attract funding or contracts	1	.3
developing pathways in DHB/providers, am not often the "NP" rep on national meetings but am in national meetings where I push the NP model of care and development	1	.3
Discussing the role and study pathway with potential candidates	1	.3
Employing other nose and Nurse prescribers working towards NP	1	.3
Govt lobbying	1	.3
head office support of nps	1	.3
I have requested an NPI for 2023 through Massey University. I am also on Jane Keys nurse prescribing group that meet 2 monthly for nurse prescribers.	1	.3
I think we overlook the daily examples with patient engagement and other intrinsic and extrinsic team relationships- interactions with pharmacists, physics, patients themselves and every opportunity to share knowledge and encouragement with othe GPS and nurses. I no longer participate in formal activities but don’t underestimate the value added with each encounter, each and everyday	1	.3
Lead role. Governance including supporting all on prescribing pathway	1	.3
Limited opportunity within workload and current structure	1	.3
Making sure clinicians know it is a possibility	1	.3
Mark Pharmacology books for NGO for Nurses as part of Nurse Prescribing	1	.3

	Meeting with senior medical/management to promote our case	1	.3
	Member of special interest groups	1	.3
	Mentoring nurse prescribing	1	.3
	National PRIME Commitee and Review Group for rural health /funding	1	.3
	new to PHC, previously in ED did a lot more	1	.3
	Nil	1	.3
	Nothing specific at present but have been involved in education/mentoring/nzno college member	1	.3
	NP panel member NCNZ	1	.3
	NP participation in interdepartmental clinics (e.g. combined radiation oncology clinics)	1	.3
	NP rep in organisational committees; leading organisational NP group	1	.3
	NP rep on international bodies	1	.3
	NP rep on workplace governance committee	1	.3
	NP representation on local and primary care bodies and initiatives within MH	1	.3
	NP representative advocating at DHB level	1	.3
	NP representative on international bodies	1	.3
	Organise our local NP Peer review group	1	.3
	Peer support group	1	.3
	Professional supervision for nps and interns	1	.3
	Professional supervision to nps outside my workplace	1	.3
	promoting the role among nursing colleagues	1	.3
	Retired from broader involvement	1	.3
	Supervising community prescribing for RN's	1	.3
	Supporting NP imtern candidates in Child and Adolescent MH nationally.	1	.3
	Teaching and education of NP students	1	.3
	Was on the executive for NPNZ	1	.3
	word of mouth between patients, family and friends, Neighbours	1	.3
	Working groups within our multidisciplinary team	1	.3
	Writing stories for NZ Dr, teaching Doctors and Nurses about the NP role at national conferences, challenging the status quo at any opportunity, supporting rural PHC to create NP roles.	1	.3
	Total	334	100.0

Are you financially supported by your employer to maintain your competencies to meet the 3 yearly audit requirement by Nursing Council New Zealand for renewal to practice as an NP?

	Frequency	Percent
	2	.6
N/A as self employed	20	6.0
Not at all & not self employed	23	6.9
Yes fully	174	52.1
Yes partially	115	34.4
Total	334	100.0

If yes, what does your employer fund towards your meeting of the competencies? Select as many as are appropriate

	Frequency	Percent
Professional development	258	77.2
Research initiavies	16	4.8
Quality improvement audits	59	17.7
Scholarship for further study	22	6.6
Travel	138	41.3
Conference registration fees	220	65.9
Accommodation	171	51.2
Specific Clinical Supervision	75	22.5
Annual $$ PD budget [appreciate answers here to lobby for equity of PD $$ nationally] Please enter $$amount in comments box below	147	44.0
Total	334	100.0

If yes, what does your employer fund towards your meeting of the competencies? Select as many as are appropriate_NZ$

	Frequency	Percent
	145	43.4
$ 4500.00	1	.3
$ 5,000	1	.3
$1000	2	.6
$1500	1	.3
$2000.00	1	.3
$300.00	1	.3
$3000	3	.9
$3000 annually	1	.3
$3500.00	1	.3
$4000	1	.3
$4000, I think but to use more would not be a problem if needed	1	.3
$5,000	2	.6
$5,000 (have only just received it this year - nothing before then)	1	.3

	$5,000 pro rata	1	.3
	$500	1	.3
	$5000	6	1.8
	$5000 a year saved for up to 2 years	1	.3
	$5000 PA	1	.3
	$5000 per annum	1	.3
	$5000 per annum - accrual 3 years max	1	.3
	$5000 per year	1	.3
	$5000 to a max 3 years	1	.3
	$5000 which roles over for 2 years	1	.3
	$5k annually	1	.3
	$6.000 annually and able to accumulate x 2 years	1	.3
	$6000	1	.3
	$6000 annually able to accumulate for 3 years	1	.3
	$6000 per year	1	.3
	10,000	1	.3
	1000	1	.3
	1000 a year towards professional development	1	.3
	1000.00 (just started this year)	1	.3
	10000	1	.3
	1500	1	.3
	15000 over 3 years.	1	.3
	2,500	1	.3
	2000	7	2.1
	2000 per annum approx	1	.3
	2500	2	.6
	3.5k	1	.3
	3000	9	2.7
	3000 annually, pro rata	1	.3
	3500	2	.6
	4,000	1	.3
	40 hrs of professional development and 30 mins weekly of clinical supervision from GP	1	.3
	4000	6	1.8
	4000 pa (pro rata)	1	.3
	4000 pa and accruable up to three years	1	.3
	4000 per year, accumulating up to three years	1	.3
	4000 prorated to FTE	1	.3
	5 professional development days at new employer	1	.3
	5,000	5	1.5
	5,000 pa	1	.3
	5,000 PA over two years.	1	.3
	500.00 approx - still waiting on agreed amount	1	.3
	5000	23	6.9
	5000 - as per MECA	1	.3
	5000 + private job supports to whatever needed	1	.3
	5000 for PD in CMDHB	1	.3
	5000 in MECA annually	1	.3

	5000 PA	1	.3
	5000 PA as per DHB MECA	1	.3
	5000 per annum	1	.3
	5000 per annum can roll up for 3 years- as per MECA	1	.3
	5000 per year pro rata, accumulated up to 3 consecutive years	1	.3
	5000 pro rata	2	.6
	5000. Rolled over for 3 years	1	.3
	5000.00 per annum	1	.3
	5000/annum	1	.3
	5000/year	1	.3
	5000/year as per DHB MECA	1	.3
	5000/year in DHB	1	.3
	5000/yr	1	.3
	5k	1	.3
	5k apparently	1	.3
	6,000	3	.9
	6,000.00	1	.3
	6,000pa + $500pa for professional affiliation (not for Union fees)	1	.3
	6000	4	1.2
	6000 pro rata	2	.6
	6k	1	.3
	6K	1	.3
	6k pro rata	1	.3
	7,000	1	.3
	700	1	.3
	7000	1	.3
	750	1	.3
	800	1	.3
	according to MECA	1	.3
	approx 4k per year	1	.3
	Approx 5000 but can be more with negotiation	1	.3
	As per DHB MECCA	1	.3
	as per MECA	1	.3
	As per meca	1	.3
	As per MECA… but can accrue for 3 years	1	.3
	Considered on case by case basis-no set amount, although trying to get this!	1	.3
	Depending on budget	1	.3
	DHB $5000 pa, other employers have no set PD budget	1	.3
	I have to apply to Nurse Trust Find prior to applying for full payement of conference leave	1	.3
	i need to check this, sorry!! u can email me re this, and i can provide/share	1	.3
	I think $5000 as per MECA for BOPDHB.	1	.3
	I think it's 5k as per meca, not sure	1	.3

	Left community work as NO funding or support for PD at all in 4 years. Now working in DHB told can't have any more education as budget blown, but I have only used approx $800 of my $5,000 in the MECA	1	.3
	Meant to be $4000PA accured for 3yrs.... but it is still not showing up on employee connect so I have no idea how much I have	1	.3
	MECA agreed $5000. still to see any allocation of funds	1	.3
	Negotiable depending on need	1	.3
	no annual PD Money, I have to apply to directors, they have supported cervical screening training so support things that make a difference to the practice	1	.3
	No clear specified amount; considered on case by case basis	1	.3
	no idea, haven't asked	1	.3
	No set budget just need to apply	1	.3
	No set PD budget in my contract	1	.3
	No specific budget	1	.3
	No specific budget, but have been supported financially by workplace with paid study leave 3 days and also utilised RAPHS PHO Nurse education fund ($500 a year) for NPNZ Conference.	1	.3
	Not specified. Was a scholarship fund for all nurses but then excluded nPs	1	.3
	Not sure amount! Only in urgent care	1	.3
	now have access to DHB MECA PD funding, nil prior	1	.3
	Since the MECA change DHB allows $5000 per year to use as needed for professional development activities. In addition, manager happy to cover off 'non conference' meetings/accommodation out of departmental budget	1	.3
	Standard MECA PD allowance pays for all of the above	1	.3
	Unable to access annual $ budget allocated	1	.3
	Unknown	1	.3
	Unknown, collective pool	1	.3
	Unsure	1	.3
	Up to $1000 plus 4 days paid study	1	.3
	Up to $7k	1	.3
	We still do not have final sign off on PD - has been in negotiations for 3+ years	1	.3
	X1 8hr PD day annually. Paid for NP conference attendance $450	1	.3
	Total	334	100.0

In your NP role are you funded or allocated Non-clinical time from your employer to teach others

	Frequency	Percent
	16	4.8
No, Please state how many hours /mth on average	184	55.1
Yes, Please state how many hours / mth on average	134	40.1
Total	334	100.0

Please specify average hours / mth in free text box below (50 characters)

	Frequency	Percent
	166	49.7
+/- 10 supervising NP intern	1	.3
<2hours monthly	1	.3
0	3	.9
0.1 FTE per week	1	.3
0.1 of a 1.0 FTE - therefore one 8 hour shift a fortnight	1	.3
1	3	.9
1 hour per week teaching, 30 mins per week with my gp supervisor	1	.3
1-2	2	.6
1.5 hours per week	1	.3
10	3	.9
10 - 16 hours a week	1	.3
10 hours per month	1	.3
10hrs/month	2	.6
12	1	.3
12 hours	2	.6
15	2	.6
16	6	1.8
16 hours	2	.6
16 hours admin	1	.3
16 hours per month	1	.3
16 hoursr via auckland uni NP transition	1	.3
16 hrs - not specifically for teaching - project work audit etc	1	.3
16hrs	1	.3
1hr/month	1	.3
2	2	.6
2 hours 2 days per week	1	.3
2 hours a week but I re organise my work to enable me to do this. have never been questioned.	1	.3
2 hours approx	1	.3
2-6 PRN	1	.3

	2/month - also for management component	1	.3
	20	2	.6
	20 hours approx or more	1	.3
	20 hrs per month non-clinical time for combination of clinical contact prep, own ongoing education, and educating others. How i use this time is up to me.	1	.3
	20 pro rata	1	.3
	20-40 - one day a week, I work full time	1	.3
	20+	1	.3
	20hr/month pro rata	1	.3
	20hrs	1	.3
	24	2	.6
	24 - once 8hr shift per week	1	.3
	24 hours every 6 weeks.	1	.3
	24 hours in six week roster	1	.3
	2hrs/month	1	.3
	3	1	.3
	30 hours a month on quality activities including coaching, project work, preparing presentations, writing papers	1	.3
	32 hors / month	1	.3
	4	4	1.2
	4 - 5 hours per month	1	.3
	4 hours/month	1	.3
	4 hrs	1	.3
	4-6 hours	1	.3
	40	2	.6
	40 hours	1	.3
	4hrs non contact time per week (a day a fortnight)	1	.3
	5	1	.3
	6	1	.3
	6 hours a month	1	.3
	6hours a fortnight	1	.3
	8	3	.9
	8 hour non-clinical day/month to do whatever is needed	1	.3
	8 hours a fortnight	1	.3
	8 hours a fortnight rostered non - clinical time utilised however i want to	1	.3
	8 hr/wk	1	.3
	8 hrs per ftnt	1	.3
	8-16	1	.3
	8-16 hours per year	1	.3
	8/month	1	.3

	9 shifts in 13 weeks for non clinical work including teaching personal education and quality improvements etc	1	.3
	Allocated non-clinical time (18hrs/4 weeks) but not specifically to teach others.	1	.3
	Approx 10 hours/month	1	.3
	Approx 2 hrs funded	1	.3
	approx 3	1	.3
	approx 5 hrs / month	1	.3
	Aprox 3 - 5 hrs monthly	1	.3
	As many as required. I would teach about 4 to 8 hour/month on average	1	.3
	As needed- too variable to say	1	.3
	But I am supervising final year TIs who are at the practice on 6 week placements throughout the year.	1	.3
	BUT.... I have been challenged on this and have a meeting soon. My colleagues have around 20% - it would be good to see what the average is so I can use it as a benchmark	1	.3
	Currently 8 hours a fortnight, aiming to extend to one day a week	1	.3
	Currently working as a locum in rural general practice, any teaching on site	1	.3
	Do a/hrs outside work	1	.3
	ED pays me an RN wage to do SIM and NIXR teaching	1	.3
	expectation is to provide education to others within usual clinical hours	1	.3
	Expected as part of role, but no time/funding allocated	1	.3
	for NP intern 5	1	.3
	free to build this time into my working day - approx 4-8hrs/month	1	.3
	Happens within clinic setting and opportunistcally.	1	.3
	Have 4hrs admin time/month - for clincal notes/results. Not for teaching. Have done cns teaching at auckland on own time	1	.3
	I am supposed to have 0.2FTE but currently on contract at medical centre and no ability to have any PD time	1	.3
	I do alot of teaching and mentoring that is done within my existing hours	1	.3
	I get 20% non clinical time	1	.3
	I have at least 8 hours week if not more sometimes for my prof development, projects and teaching etc.	1	.3

	I usually block off my template when needed to teach others or use allocated time for administration	1	.3
	Informally - depends on the situation at the time	1	.3
	intermittently have NP interns come to service	1	.3
	it varies and my employer is flexible to meet the need	1	.3
	mora adhoc on floor, orientation of new CNS's	1	.3
	N/A	1	.3
	N/A as self-employed	1	.3
	N/A self employed	1	.3
	no formal time, just casually if needed for the practice nurses	1	.3
	no set allocation - employer is quite flexible - would't be more than about 2/ month	1	.3
	non clinical time 8 - 16 hrs month, teaching included in use of this time	1	.3
	None	2	.6
	Not as yet	1	.3
	Not enough about 2 days every 6 weeks	1	.3
	not funded but expected in FTE	1	.3
	not monthly every 4 months	1	.3
	Not specific time but part of my role	1	.3
	Not specifically but I can factor this into my workload. Not currently providing regular teaching	1	.3
	Not specifically but then I have never requested this	1	.3
	not sure varies aver 4 hours month	1	.3
	not yet but I hope to	1	.3
	one day per week if full time	1	.3
	One to Two hours per month as needs required.	1	.3
	One-two	1	.3
	only as needed -	1	.3
	Probably 4 hrs/month. Non-clinical regular hrs keep getting declined but will pay extra on case-by-case (eg cpr instruction)	1	.3
	random	1	.3
	random depends on trainee NP nursing/Med student placements with us	1	.3
	Recently officially reduced to 16 hrs/monthy	1	.3
	secondary employment 12 hours per week	1	.3
	Supported to work this into my clinical role as needed	1	.3
	Take from non patient contact. 4 per month	1	.3

	Teach on the job. Average 8 hrs per month	1	.3
	Teaching is during clinical hours, not separate	1	.3
	teaching is within clinical hours	1	.3
	Theoretically have 20% non clinical time - teaching + mentioning occurs in this time along with many other administration tasks eg rostering	1	.3
	Total 8 hours fortnight for teaching, education, supervision	1	.3
	University pays DHB to administer and teach a course 176 hours each year	1	.3
	Unlimited. Varying from month to month. This month has been about 20 hours	1	.3
	Up to 8 hours per week if I include, formal team teaching, mentoring, and every ad hoc teaching moment	1	.3
	varies	1	.3
	Varies wildly month to month dependent on need	1	.3
	Varies. Dependent on need. I'm not restricted	1	.3
	We get 30 hours non-clinical pro rata for teaching, quality, committees etc	1	.3
	Whatever is required	1	.3
	When I have intern i would spend 2 hours a week	1	.3
	When mentoring 4 hours a week	1	.3
	work teaching arround clinical time approx 10 hrs month	1	.3
	would be nice/totally approp	1	.3
	Yes x1 eight hour day a week	1	.3
	Total	334	100.0

When requested by your employer to speak at conference or teach others, is this included in your own professional development time?

	Frequency	Percent
	31	9.3
No	163	48.8
Yes	140	41.9
Total	334	100.0

If you work in an RN / NP role are you expected to maintain two separate portfolios, one for each role?

	Frequency	Percent of Total
Yes	4	1.2
No	42	12.6
Not applicable to me	284	85.0
Total	334	100.0

Is your NP role a pilot role?

		Frequency	Percent
		7	2.1
	No	292	87.4
	Yes	35	10.5
	Total	334	100.0

Has your employer retained an NP position in the instance of an NP leaving?

		Frequency	Percent
		3	.9
	No	45	13.5
	Not applicable	169	50.6
	Yes	117	35.0
	Total	334	100.0

Is there any succession planning in place for your role?

		Frequency	Percent
		4	1.2
	No	203	60.8
	Yes	127	38.0
	Total	334	100.0

Have you changed or extended your specified area of NP practice since registering as an NP?

		Frequency	Percent of Total
	Yes	78	23.4
	If yes, What did you change to? comment in free txt box	42	12.6
	No, and not planning to	192	57.5
	No, but planning to change / extend	43	12.9
	Total	334	100.0

Please specify what you have changed in free text box below (50 characters)

		Frequency	Percent
		216	64.7
	1	1	.3
	across the life span instead of just adult	1	.3
	Acute care in private surgical setting to Urgent Care in Primary Health setting	1	.3
	Added aged and urgent care	1	.3
	Added Mental Health as excluded due to hospital training.	1	.3
	Added mental health to NP scope of practice, as was RGON when initially registered	1	.3
	Adult and Older Adults	1	.3

	Aesthetic Medicine	1	.3
	Already at the top of scope	1	.3
	Am working in both ED and Primary now. Worked for a year in Australia in rural/remote	1	.3
	And was declined (acute care- adult older adult) am about to try again	1	.3
	bgr5	1	.3
	Cardiac care to generic	1	.3
	cardiology to general adult then across lifespan	1	.3
	Change of role planned January 2023 to long term conditions from respiratory	1	.3
	change of scope to include mental health- was hospital trained with mental health excluded from RGON qualification	1	.3
	Change to no restrictions from adult	1	.3
	Changed from CNS to NP within the same department	1	.3
	Changed from Ed to urgent/acite phc	1	.3
	Changed from paediatric cardiology to primary health care - GP	1	.3
	changed from paeds cardiology to Primary health care, massive change	1	.3
	Child and youth removed	1	.3
	Child and youth to primary care.	1	.3
	Chronic Disease from general practice.	1	.3
	Contracted out to a sport event doctor business and being a "race doctor" in endurance sporting events	1	.3
	Copd and asthma	1	.3
	currently primary health care/lifespan registered so no imminent need to	1	.3
	Currently working in oncall RN role with Medsac team with plan to transition into forensic examiner role as NP after next year	1	.3
	developing skills in managing women health, family planning, LARC alongside of general practicing	1	.3
	Didn’t register with a specified scope. Initially working in palliative care now moved to aged care	1	.3
	dropped diabetes part	1	.3
	Dropped scope of practice to broaden to NP	1	.3
	ED acute NP across the lifespan until July22. working as acute NP in primary care setting since Aug. Seeing a real mix of acute and LTC end up in my book due to lack of NP/GP LTC appts avail	1	.3

	expanded ED skills - along side Reg teaching/skills. ongoing supported skill development encouraged to see all patients in the dept including trauma.	1	.3
	Expanded my role from Mental Health of Older People to Older Adults generally	1	.3
	Expanded scope	1	.3
	Extend to add mental health and recertification next year	1	.3
	Extended from older adults to adults	1	.3
	Extended to care of adults in acutes/ed. I was previously child/youth but have been given education and mentorship to extend.	1	.3
	Extending in aged care.	1	.3
	Extending to LTC model and more like transition and community clinics as per need	1	.3
	Forensic medicine	1	.3
	from acute care to primary care	1	.3
	From hild and youth to lifespan	1	.3
	From long term conditions primary health care to acute rural primary health care	1	.3
	From Older adult to Adult	1	.3
	From paediatrics only to urgent care with full scope of practice	1	.3
	From specialist pain management to aged care	1	.3
	From Youth health PHC to general practice PHC, I now work in both spaces	1	.3
	Have also started working in crisis response team and in recent months done eight nights psychiatrist on call cover gif whole region. Am going to stop doing this. Paid $8 per hour before tax. So 16 hrs total of $128 then a third taken off so approximately $80 per night.	1	.3
	have increased to include sexual health/womens health clinic NP	1	.3
	Have moved to primary health care/ aged residential care	1	.3
	I added mental health to original scope	1	.3
	I changed from CAMHS NP to MH NP - able to work with children, young people and adults nwow.	1	.3
	I changed from child and youth to age span	1	.3
	I changed from older adult to Lifespan	1	.3
	I do outreach clinics nationally.	1	.3
	I have been doing some primary care general health visits	1	.3

	I have included a separate new tumour stream of patients now managing Gastrointestinal tract cancers and melanoma	1	.3
	I have moved from DHB ED to private urgent care and general practice. I moved due to terrible short staffing at DHB.	1	.3
	I have switched from secondary care as no funded position to primary care	1	.3
	I just recently passed my panel and became registered today	1	.3
	I plan to move to a Rural hospital and hopefully establish the NP role there. This would be beneficial for many babies born who require transport to a major L3 center. I am currently joining the outpatient clinics here, to extend my experience and expertise moving forward.	1	.3
	I see more FSA patients Developed PTNS service	1	.3
	I started in NICU as a neonatal nurse practitioner and then moved to pediatric and congenital cardiac services (PCCS)	1	.3
	i want to remove my scope condition	1	.3
	I work in aged care but trained mainly in acute care	1	.3
	Icu outreach to aged care	1	.3
	Initally adult PHC/palliative, now broadened to include children for PHC, as well as sub-acute care	1	.3
	Initially registered as primary care but specialised in paediatrics inclusive of other roles that sees me keeping up to date with youth health and sexual health	1	.3
	Just to specify answer 32 the position was unable to be filled by NP and so a CNS was employed to fill it	1	.3
	mental health [basic] and Primary Health Care	1	.3
	More complexity, acute and chronic patients across the lifespan	1	.3
	More confidence with prescribing. Now working in palliative care (hospice) -was not employed by DHB initially when registered.	1	.3
	Moved from a nurse role with limited clinical support at the pho to general practice	1	.3
	Moved from an ED with primarily adult focus. Now lifespan urgent care	1	.3
	Moved from youth to across the lifespan	1	.3
	Need a nurse Educator role, currently campaigning for establishment.	1	.3

	No role in DHB so had to get work in primary care.	1	.3
	Not specifically, but was Primary/Palliative Care, now closer to General Medical	1	.3
	Now also travel to West Coast to see Patients	1	.3
	Original role in renal, then acquired more hours as Primary NP, in rural health	1	.3
	Paediatric to no restrictions	1	.3
	Plan to broaden skills with clinical supervision and cme such as bedside ultrasound but area of practice remains same	1	.3
	Population group I see- extending it to child and adolescents	1	.3
	Primary care and then switched back to emergency/urgent care	1	.3
	Primary care outreach	1	.3
	Primary health care Mental heat	1	.3
	Private practice hospital - surgical	1	.3
	registered in acute care, had that removed as I have taken on more primary care and work rurally	1	.3
	Removal of area of Practice as solely being NP PHC lifespan to NP across the boarf	1	.3
	Removal of scope limitations	1	.3
	Removed acute care nurse practitioner endorsement	1	.3
	Removed area of practice and expanded	1	.3
	Removed renal restriction from initial registration	1	.3
	removed specific area of practice	1	.3
	Rest home care Minor operations / IUD trainginh	1	.3
	Scope broadened beyond initially registered specialist role	1	.3
	Scope lifted	1	.3
	Service development is currently in planning phase	1	.3
	Specialist palliative care input is lacking in Canterbury for cardiac patients. My intention is to extend to this.	1	.3
	Taken also the clinical lead role on	1	.3
	The initial condition specific focus has been removed	1	.3
	To arc. Extending to children/maternal health	1	.3
	To extend to lifespan and include older adults >65	1	.3
	Transitioned from LTC to acute care and general practice presentations	1	.3

	treating Hep c patients and running POC testing at the needle exchange.	1	.3
	Trying hard but politics	1	.3
	Want to become a specialist NP	1	.3
	Was rural PHC, changed to urgent care urban 6 months ago	1	.3
	We have added a np led minor injury illness are in new build ED. Currently working on new model of care for NP's to also cover general ED and acute assessment unit with admitting role for all specialties	1	.3
	Well supported by department SMOs to extend	1	.3
	Worked for 6 years as NP with no backfill for previous CNS role including being team leader across 2 sites. Qualified in specialist area and extended to NP (not just disease specific.	1	.3
	Working in primary care	1	.3
	Working with RNs as clinical support	1	.3
	Would like to go into primary care	1	.3
	Youth health then extended to include sexual health and now primary health care	1	.3
	Youth mh	1	.3
	Total	334	100.0

If there was one thing you could change about being an NP, what would it be?

		Frequency	Percent
		83	24.9
	$$$ compensation	1	.3
	1)The clinic often receives pts wantign to confirm pregnancy, hyperemesis - unable to see these pts re funding 2) sect29 meds growing - unable to do prescriptions for pts presenting for scripts as visitors from out of town, etc	1	.3
	30minute appointments in primary care minimum.	1	.3
	A better understanding amongst the health workforce of what an NP is	1	.3
	A more defined/clear succession plan	1	.3
	Ability to provide maternity care i.e. order dating and confirmation ultrasounds	1	.3
	Able to order antenatal scans and S29 meds in my own name	1	.3
	Academic teaching role recognised as a competencies to see more workforce development	1	.3
	acceptance by nurses and pts	1	.3
	access to CT scans and USS from PHC	1	.3
	Access to maternity U/S and funding	1	.3

	Access to professional development support particularly for those of us that work outside the DHB setting	1	.3
	Acknowledging NP's are safe prescribers & Remove the "Medical Practitioner" terminology. move forward to "Authorized Prescriber" in all the laws.	1	.3
	Adding PhD or research or DNP (like USA) at the end of NPTP, this could have been great decision since doctors finish their MD with research tail as well as Dr title, we do a similar or a better role and we shouldn't be inferior to no one in practice or societal standards.	1	.3
	Allocated mentor in first year of practice	1	.3
	As a begining practitoner and the first NP in the practice I work at, I find there is a lot of explaining what I can do for the person. I would like some more informative advertising to the public that explains what a NP is and what we can do. I would like to be able to Rx section 29 medications as i find this is a barrier at times.	1	.3
	Awareness of the difference between NP and RN in an advanced role like clinical nurse specialist. A lot of medical and nursing colleagues don't know the difference, so how are the general public/politicians/decision makers supposed to know.	1	.3
	Barriers such as s29 and acc 554 forms.	1	.3
	Be respected and addressed correctly by secondary care colleagues And prescribe section 29 drugs!	1	.3
	Become a Dr	1	.3
	Being able to be called doctor as those with medical degrees are	1	.3
	Being able to claim pregnancy ultrasound under section 88 funding and being able to script section 29 meds	1	.3
	being able to go through gp college training be able to submit immigration medicaid under own name	1	.3
	Being able to order CT scans without needing SMO endorsement.	1	.3
	Being able to provide funded ante natal care including ordering funded scans. Also being included in the PHC MECA	1	.3
	Being able to Rx Section 29 meds - ongoing barrier to practice.	1	.3
	Being able to work in the community	1	.3
	Being able to work more independantly to the top pof my scope without Control drug restrictions in prescribing for ADHD.	1	.3

	Being given enough non clinical time to actually fulfil KPIs and expectations/innovative thinking/audits/teaching/equity provisions etc and not worry that there won't be enough when it comes to the 3 yearly NP audit requirements.	1	.3
	Being more supported and valued	1	.3
	better exposure of NP's in the public hospital setting, it can get tedious being asked if a doctor has assessed a patient you're trying to hand over.	1	.3
	better NP Training in primary care - kinda like GPEP, we need better post qualification back up	1	.3
	better pay	1	.3
	Better pay	1	.3
	Better PR for NP role and importance	1	.3
	Better public (and colleagues actually) understanding of the NP role	1	.3
	Better public understanding of the role and skill of NPs	1	.3
	better recognition and support for role	1	.3
	Better recognition from professional colleagues and the public about what we can do	1	.3
	Better support for clinical and recognition of pay equity	1	.3
	Better support in practice	1	.3
	Better understanding and support from the wider DHB to enable to work at full scope	1	.3
	Can't prescribe section 29 drugs!	1	.3
	Change in medicines we cant prescribe section 29	1	.3
	Clearer NP role for the Emergency Department nationally. All NPs should be able to do A. Then some NPs should do A&B, few NPs should A&B&C. Closer tie in to ACEM but without losing our Autonomy	1	.3
	Consistency of support/model of care to be able to work to my top of scope.	1	.3
	Dedicated peer supervision time. As I only have 2 other NP's working in the BOP MHS it is difficult to achieve adequate peer group supervision, much like our medical colleagues. I would suggest NP's are incorporated into their supervision forums?	1	.3
	Dedicated supervision time with GP colleagues	1	.3
	Easier access to supervision time	1	.3
	equal pay and opportunities to GP as well as removing barriers such as sec 29	1	.3
	equity in pay scales & PDP budgets	1	.3
	Equity with GPs and what we sigh, section 29 especially	1	.3
	Expectation to work in the same way as medical staff.	1	.3

	Fight harder to have a scope of practice that reflected my belief of what I was clinically capable off (and by virtue of this open the gates for other to follow .. .. now I am very part time, near the end of my career and less engaged that I would have liked to have been	1	.3
	First year out needs better supervision.	1	.3
	Fix issue re access to USS for pregnant women	1	.3
	for the DHB to respect our chosen area of practice as per our practice statements and stop trying to use us to plug staff shortages in clinical areas where we are not as experienced.	1	.3
	For the medical staff to understand and embrace thew benefits of a nurse practitioner on the team	1	.3
	For the medical staff to understand what the role entails	1	.3
	Formalised non clinical time	1	.3
	funding for other/more NP'S	1	.3
	Greater financial access to professional resources, conferences, journals etc - we still struggle relative to our medical colleagues	1	.3
	greater public understanding of the role	1	.3
	Greater recognition of doing the same as Doctors. Paid parity across NP sector	1	.3
	Greater recognition of the difference between np and gp, and how each role can compliment the other	1	.3
	greater understanding from our medical peers	1	.3
	Greater understanding of the role with our medical colleagues. More aligned teaching for ED specific skills/procedures in NZ	1	.3
	have more NP's	1	.3
	Have the ability to order CT	1	.3
	Having access to pregnancy USS	1	.3
	Having it recognised by outside workforces and not having to battle to be able to sign off forms. Maternity care needs to be included for funding purposes for one.	1	.3
	Having more allocated non-clinical time to extend current knowledge	1	.3
	Having more clinicians to work with	1	.3
	having more clinicians to work with so it is not so crazy busy and I don't feel like I am burning out	1	.3
	Having someone to cover me as work in my field alone	1	.3

	Having title automatically changed and not still being called CNS 5 yrs later. Being told my use of a clinic room was low value when a reg could be using it. Being told I had to pass my case load and clinic space over to a new registar, and function as his clinic nurse instead, and the implication that I was out of line when I protested.	1	.3
	Having to constantly explain what the role is and what it is not! Being called a cheap Dr!	1	.3
	Having to explain what we are...21 yrs and counting..	1	.3
	Health care is understaffed and overworked	1	.3
	I am too new to want to change anything, am loving it all	1	.3
	I dont know	1	.3
	I have a list, but to choose on SECTION 29!	1	.3
	I love being an NP - however, having to explain what I do all the time is a bit tiresome!!	1	.3
	I love my mani it’s a orivledge. I would like to see more access to professional development and collaboration with GPNZ. - which have excellent online trading for GP’s that Primary care NP’s would also greatly benefit from. Would be good to see more inclusive language if practitioners used consistently by government.	1	.3
	I really wish there was a structured post grad development programme to support new NPs.	1	.3
	I think there is little autonomy as an NP working in a DHB. I think medical teams need to be given a greater understanding of what an NP is - we are still treated as the poor cousin to the doctor.	1	.3
	I wish I'd studied medicine instead, I feel like i constantly have to explain my role and that it just isn't as respected as being a doctor	1	.3
	I wish that the role was better understood by other health professionals and the health care consumers	1	.3
	I would have included a part of my role or FTE to go towards leadership development	1	.3
	I would like to be recognized as an advanced nurse practitioner in the NZNO contract. All of the same rules are applicable to the NP as they are to the junior nurse, and everyone inbetween. There is a very wide scope of difference in these roles but we are not recognised for it.	1	.3
	I would not have bothered doing the training knowing the DHB would then tell me there was no NP position for me	1	.3

	I wouldn't change anything about my work but I would make some changes to the process of becoming an NP. Having trained in the USA, it was really difficult to get my registration recognised in NZ.	1	.3
	Improved educational opportunities	1	.3
	Improved mentoring support, time fir clinical case reviews	1	.3
	Improved on-going regular education.	1	.3
	Improved recognition by the public	1	.3
	increase in pay	1	.3
	Increased understanding of the NP scope of practice by health leaders and the public	1	.3
	Inequity with medical staff regarding pay/conditions e.g. RMOs paid incentive payments to work extra shifts, NPs are not, RMOs have paid meal breaks + food provided, NPs do not, RMOs have medical insurance reimbursed, NPs do not despite the fact we do the same job as many of our ED RMO colleagues.	1	.3
	its not the NP role, is the funding for the role thats the problem	1	.3
	Less micro managing from nursing management, (Many of whom are less qualified than the NP's) and allow us to work independently within the medical team, whom we work closest with.	1	.3
	Lifting restrictions on 1st antenatal scans and section 29 drugs	1	.3
	Longer appointments (at least 30 min/patient) to allow application of nursing (non-medical) model of care with more holistic approach	1	.3
	Longer appointments with patients	1	.3
	longer appt times, less stress, increased public knowledge/promotion of role	1	.3
	make it more acceptable and known	1	.3
	Make sure there are enough RNs to fill the roster so I can actually work as an NP full time!	1	.3
	Maternity claiming for NPs. I have to complete USS under GP and for claiming as well.	1	.3
	More admin protected time. 30 min appointments at least for patient within primary care.	1	.3
	More autonomy and more direct patient contact	1	.3
	More awareness and education around the abilities of Nurse Practitioners and to educate the medical profession	1	.3
	More clerical/admin support	1	.3
	more clinical mentoring- time for GPs to spend mentoring	1	.3
	more clinical supervision	1	.3

	More clinical support in first 2 years similar to new GPs. More time with patients initially . More professional development costs covered	1	.3
	More education/non clinical time and better supervision	1	.3
	More hours in the day!	1	.3
	More intensive training eg like medical house officer in public hospital	1	.3
	More mentoring	1	.3
	More money	1	.3
	More money to reflect the advanced responsibility.	1	.3
	More money!	1	.3
	more of us	1	.3
	More of us and a greater understanding of what our role is among all health professionals- to be honest I find it harder getting buy in from RNs than medical colleagues!	1	.3
	More on the job training/ mentor support	1	.3
	More pay equity across PHC NPs	1	.3
	More professional development time and access	1	.3
	More promotion about the role	1	.3
	More public knowledge about the role	1	.3
	More recognition and understanding of the NP roles. Equity across NP funding and prof development.	1	.3
	More respect and acknowledgement of role better remuneration	1	.3
	More structured education program	1	.3
	More support at the begging mentoring that should be paid. Working with other NPs	1	.3
	More support from some employers to provide $ for PD. One of my employers provides none.	1	.3
	More support when starting in role to help with setting up ordering radiology, lab sign off etc.	1	.3
	more teaching from the SMOs. I would love if they felt the same responsibility to teach us as they do the fellows. They would have gotten more out of the NPs in the service - probably wouldn't have had 1/2 of them quit and also we would be happier and more useful. Its so short sighted of them as we are the staff who have been around for 20 plus years	1	.3
	More time for appointments I currently have a mix 15/20 mins but prefer20 mins	1	.3
	More time for extra learning. Mentoring	1	.3
	More time to reflect with colleagues	1	.3
	More time with my mentor especially in the first year after qualifying	1	.3
	More training when you change scope - ie muscular skeletal, Neurology etc	1	.3

	more understanding of role from other professionals, patients- therefore less barriers	1	.3
	More understanding of roll especially from DHB colleagues.	1	.3
	my pay is far behind my colleagues - due to NGO funding constraints	1	.3
	nil	1	.3
	Nil	1	.3
	No	1	.3
	No 3 yearly audits.	1	.3
	Not allow no interns pass at council who are really not ready t do or understand the role	1	.3
	Not be expected to see as many patients as doctors. I am not paid as much so should have more time	1	.3
	Not being expected to work like and /or harder than the GPs in my practice Eg GPs have 20min appts I have 15 I currently see more patients than the Gp Recognition that some patients are more suited to seeing the GP	1	.3
	Not having Section 29 limitations - it is extremely irritating	1	.3
	Not having to battle politics to advance role. Having supportive nurse leadership. Having professional leadership being valued.	1	.3
	Not having to explain what the scope involves I.e. if this was better understood within our communities	1	.3
	Not having to fight to have systems recognise me as an NP and not a nurse or GP.	1	.3
	Not sure	1	.3
	Nothing	1	.3
	Nothing - in my AOP/workplace I am well supported and valued	1	.3
	Nothing at this stage	1	.3
	Nothing currently.. I'm busy and fulfilled and well supported by my nursing and medical colleagues	1	.3
	Nothing I can think of.	1	.3
	Nothing love it	1	.3
	Nothing springs to mind. But generally continuing with education about what the role of NP con contribute	1	.3
	NP collaboration	1	.3
	NP education support group within the hospital.....trying to establish this	1	.3
	NPs being able to write prescriptions for Sect 29 medications and being able to apply for special authority for certain medications	1	.3
	On going support/training networks.	1	.3

	Other nurse's attitudes towards NPs. This is a huge problem. I would change the Problem radiologists have with us ordering tests. They don't understand, have put a person's life at risk due to delays in carrying out the test because it was an NP would requested it. Doctor's attitudes to NPs.	1	.3
	Others understanding of the role	1	.3
	Our name. I find doctors and some patients take a default position of looking down on us, in spite of our expertise and Masters degree	1	.3
	Patients judgements, I'm not seeing her she's not a doctor	1	.3
	Pay	4	1.2
	Pay & PD equity as medical colleagues.	1	.3
	Pay parity with medical colleagues	1	.3
	Pay reflective of responsibility, but aware I am currently trading being on a MECA for having increased team support (compared to my previous role - more money but less support)	1	.3
	Pay reflects the role	1	.3
	Pay scales!	1	.3
	People understanding what we do and not being upset I'm.not a DR	1	.3
	Professional recognition from doctors	1	.3
	Properly funded professional development	1	.3
	Protected ongoing education time and funding. Thought I would get this working in a DHB so a little shocked I am still missing out.	1	.3
	Provide education to drs about what NP role is	1	.3
	public attitude on our scope and other health professionals understanding sometimes nursing is the worse	1	.3
	Public understanding of the role & to be compensated for the complexity of clinical decision making	1	.3
	Recognition from medical colleagues.	1	.3
	Recognition of role	1	.3
	Regular support with education, conferences and support from NZNC with legislation changes and teaching	1	.3
	removal of barriers in prescribing, eg section 29	1	.3
	removal of section 29 and ability to complete lump sum acc forms.	1	.3
	Remuneration to equal dhb or other practice colleagues plus more clinical development	1	.3
	S29 rx	1	.3
	Salary	2	.6
	Scope for ANC allowed	1	.3
	Section 29	1	.3

	Section 29 !	1	.3
	Section 29 drugs and the ability to prescribe these, causes frustration for myself, patients, and medical practitioners	1	.3
	Section 29 extended to NP in prescribing	1	.3
	Section 29!!!!	1	.3
	Societies understanding of what we do	1	.3
	Some designated non-clinical time	1	.3
	Still under changes, it is hard to say at present	1	.3
	Structure in place where a clinician is supported and respected with all resources irrespective. It feels like professional orphans as all the time trying to get support and explaining the role	1	.3
	Stupid government policy and stupid DHB ignorance	1	.3
	Succession planning	1	.3
	Succession planning and collegial support	1	.3
	That colleagues understand what our scope is.	1	.3
	that its a fight to keep role development going eg scrape to get FTE, have to take it off SMP/nursing budget "no new money etc" The fight thats been happening in NZ i see the roles as being mutually beneficial with different skills	1	.3
	That others would understand your role and not needing to explain what the role is. Inclusive of work colleagues, families and patients	1	.3
	That the public understand and that we are seen as valuable members of the health care team.	1	.3
	That there would be some consistency in supporting the development of NPs across DHBs. I miss the NP group and the advanced nursing group from my previous DHB - this was useful for practice updates, networking and support	1	.3
	The ability to have access to relevant patient notes from GP/NP, imaging from DHB (not just reports of imaging), and electronic imaging requesting - all relate to the sharing of information for best outcome for patient	1	.3
	The being in limbo and the name Nurse Practitioner- it is confusing to everyone not fully part of the nursing team, not fully part of the medical team, who knows what we can actually do. Plus the what seems like weird restrictions made on us for certain prescribing/investigation ordering.	1	.3
	The name of the role. Advanced Practitioner would be better and more inclusive.	1	.3

	The name. Nurse Practitioner is very much like Practice Nurse and I am challenged almost daily on my role and have to explain it. Very frustrating. There should be more education to the public on what we are/do and the training etc required. Also we are undervalued financially. We need a better pay rate.	1	.3
	The NP role strongly integrated into hospital systems and led by nursing and not just to suit medical colleagues	1	.3
	The paperwork load!	1	.3
	The pay	1	.3
	The pay! A better understanding of our role in the eyes of the public	1	.3
	The perception of NPs not only by the public and other healthcare providers, but also from nursing. The role is still greatly misunderstood. We are not substitute doctors which often NP's are referred to	1	.3
	The same Salary as a Medical Officer. I train Medical officers year in and year out and get paid about 30% less without other benefits MO's receive	1	.3
	The title. The word "nurse" in the title creates confusion for patients	1	.3
	The understanding of others about the role!	1	.3
	There would be structured education offered towards hours	1	.3
	They way 30yrs on we are still having to justify our roles and explain the scope of practice.	1	.3
	This is not specific to being an NP. Would like other practitioners (particularly medical) to have a greater understanding and positive view of the NP role and the benefits to patients these roles can bring. Many practitioners are very supportive but certainly not all.	1	.3
	This sounds terrible but the name. In acute care patients will ask after I've assessed, diagnosed, provided treatment/plan, and explained everything if they are now going to see the Dr because I'm a nurse. Sometimes I don't get that far on occasion a person will decline to be seen by a NP as they have already seen a nurse (triage nurse) and they are paying to see a Dr and want to see a Dr not a NP. It's quiet deflating really when this happens.	1	.3
	To be honest I'm not sure if I would do it over again. The responsibility vs renumeration is not worth it. A friend works the same FTE as me on a ward (granted she does shift work) and gets paid roughly the same as me. When I consider our different levels of responsibility, that is crazy. However I do like that I am able to provide complete care for my patients.	1	.3

	To be recognised for who we are and what we do and what we can do.	1	.3
	To be respected by my employer as a senior clinician and given the resources I need to do my job	1	.3
	To give more support to those entering into NP journey, very difficult to find clinical hours	1	.3
	To have a CME type funding as part of employment contract and also to have professional development non clinical hours set out on employment contract or part of MECCA	1	.3
	To have more support around me, I feel I do not fit in with the drs or the other nurses in my clinics.	1	.3
	To not always have to explain yourself, your role and your scope. Pay parity with GPs if doing the same role.	1	.3
	Too early to answer	1	.3
	Two things, more access to CME and better understanding of role from medical colleagues	1	.3
	Two things.. section 88 and how we demonstrate continuing competence. The current system is substandard in my opinion and should be on line and involve evidence of pharmacological development, prescribing and clinical audits	1	.3
	Unity between executive, managerial and clinical nursing leadership. Often NPs influence from the sidelines instead of a united front, with operational and clinical nurses side by side.	1	.3
	Unsure	1	.3
	unversal recognition of what NP is - by health professionals as well as public	1	.3
	Used like a GP by management but Treated like a nurse!	1	.3
	Wage equity with DHB NP's	1	.3
	We be seen as colleagues with highly effective skills and equally valued as our medical colleagues, and to have more clout to change the legislation that restricts NPs from practicing at the top of the scope - ACC (mental injury), S.29 medicines, health insurance, special authorities etc... (I know I have two things sorry :))	1	.3
	Wider recognition between senior nursing roles and NP in MECA/pay negotiation	1	.3
	Work more toward the theory of NP practice	1	.3
	Work part time in primary care & PT in current role, need to maintain generalist NP practice gained in internship	1	.3
	would like it to be more widely recognised and accepted within the health system by health professionals and the public	1	.3

	would like to do more skillbased care "hands on" suturing /biopsy etc - limited availability currently - more time to learn safely	1	.3
	Total	334	100.0

What is your current total FTE situation? eg FTE 1.0 = 40hrs per week

	Frequency	Percent
	3	.9
Variable 20-25 hrs	1	.3
.2 = 8 hours a week	1	.3
.6 + overtime or extra shifts	1	.3
.6 FTE	1	.3
.6FTE	1	.3
.8 in 'DHB' plus oncall with SAAT and police bloods	1	.3
.9 but my days off often entail me remoting in to my work computer to do my inbox	1	.3
.9fte	1	.3
0	1	.3
0.2	1	.3
0.2 per wek	1	.3
0.25	1	.3
0.4	3	.9
0.4 FTE NP 0.4 FTE CNS	1	.3
0.4 permanent + casual	1	.3
0.4FTE in clinical NP role 0.5FTE in an academic role	1	.3
0.5	2	.6
0.5 - 6	1	.3
0.5 clinical NP 0.5 professional teaching fellow	1	.3
0.5 minimum clinical. The rest of week is taken up with leadership/ admin/ practice improvement and with my sexual assault work (mostly on call) plus my Role as Lead Clinician for region's sexual assault service	1	.3
0.5FTE	1	.3
0.6	12	3.6
0.6 - FT variable	1	.3
0.6 + 19hrs week on call	1	.3
0.6 approx but varies depending on need	1	.3
0.6 DHB 0.2 self employed	1	.3
0.6 for DHB 0.6 for NGO	1	.3
0.6 NP , 0.3 clinical advisor	1	.3
0.6 renal FTE Temp 0.2 Primary rural health	1	.3
0.6-0.8	1	.3
0.69	1	.3
0.6FTE	2	.6

	0.6FTE /24hrs wk- acute care NP in primary setting ($70/hr) 0.2-04FTE/8-16 wk - clinical editor health pathways Te Whatu ora ($57/h)	1	.3
	0.7	5	1.5
	0.7 FTE	2	.6
	0.7 per fortbight	1	.3
	0.7 plus oncalls	1	.3
	0.75	3	.9
	0.75 - 30 hours/week	1	.3
	0.75FTE	1	.3
	0.8	32	9.6
	0.8 - 1.0	1	.3
	0.8 (32-34) per week.	1	.3
	0.8 32 p/w	1	.3
	0.8 but usually work 1.0 FTE	1	.3
	0.8 DTE	1	.3
	0.8 fte	2	.6
	0.8 FTE	8	2.4
	0.8 FTE - 32 hrs per week	1	.3
	0.8 FTE = 32 hrs/ week	1	.3
	0.8 to 1.0fte	1	.3
	0.8 total .4 clinical rest is as clinical director	1	.3
	0.8. but the hours i actually work (unpaid overtime) are more like 0.9, these hours are factored into my hourly rate	1	.3
	0.85	1	.3
	0.875	1	.3
	0.88 (70hrs/fortnight)	1	.3
	0.8FTE	3	.9
	0.9	9	2.7
	0.9 fte	1	.3
	0.9 FTE	6	1.8
	0.95 FTE across several organisations Clinical director .4 NGO and Māori provider Clinical .5 primary care (includes 2 youth clinics and a coexisting clinic in residential rehab and a main stream practice)	1	.3
	0.9FTE	3	.9
	0.9FTR	1	.3
	1	70	21.0
	1 fte	1	.3
	1 FTE	1	.3
	1.0 - 40 hrs per week	1	.3
	1.0 - rostered and rotating shifts / days, nights, weekends	1	.3
	1.0 - work 4 x 10 hour shifts per week on the RMO roster	1	.3

	1.0 but work rostered and rotating - 12 week roster combined with 12 and 8 hr shifts, days, nights and weekends.	1	.3
	1.0 FTE	7	2.1
	1.0 FTE clinical lead/NP	1	.3
	1.0 pre parental leave, planning on returning at 0.6 FTE (and hoping that that spare 0.4 FTE will go towards training another NP)	1	.3
	1.0 split equally between NP role in paediatric ED and senior research role at University	1	.3
	1.0, plus some overtime	1	.3
	1.0FTe	1	.3
	1.0FTE	1	.3
	15hrs per week at university teaching, 15 to 23hrs clinical depending on the week	1	.3
	19.5 hrs a week. 3x 6.5 hr shifts	1	.3
	1FTE	1	.3
	20hr per week 0.5 FTE	1	.3
	21 hours per week	1	.3
	24	1	.3
	24hrs + on-call	1	.3
	24hrs a week	1	.3
	28 hours	1	.3
	28 hours per week	1	.3
	30	1	.3
	30 hrs per week	1	.3
	32	2	.6
	32 hours	1	.3
	32 hours per week	3	.9
	32 hours pr week and also week of call for SAATs	1	.3
	32 hrs per week	1	.3
	32 until I recently retire	1	.3
	32hrs	1	.3
	32hrs per week paid but would do at least 4hrs a week unpaid admin as I'm told I am on a salary but on $80 per hour or $133,000 per yer and get time and a half for Saturday morning acute rural clinic where I am the clinical lead with one nurse and one receptionist	1	.3
	33 hours per week - always do more approx 0.5 FTE	1	.3
	34 hours a week	1	.3
	35hrs/week	1	.3
	35hrs/wk	1	.3
	36hrs per week	1	.3

	37	1	.3
	37.5 hours a week	1	.3
	38 hours per week	1	.3
	40	10	3.0
	40 +	1	.3
	40 hour plus bout 8 hours/week on call	1	.3
	40 hrs per week	1	.3
	40 hrs pw	1	.3
	40 hrs wk	1	.3
	40.5	1	.3
	40/ week	1	.3
	40hrs per week	1	.3
	40hrs perweek	1	.3
	40hrs plus	1	.3
	40hrs/week	1	.3
	60	1	.3
	63 hours a fortnight	1	.3
	70 hrs/ fortnight	1	.3
	70hrs/fortnight.	1	.3
	as an NP .10 but even though in a non clinical role the rest of the time i am an advisor for the 2 NP's working.	1	.3
	at present 0.6FTE since August 2022 & previously 0.9 FTE. Plan to go back to 0.9FTE after caring for terminal family member.	1	.3
	Changing from 08FTE ED + 0.2FTE PH to 0.425 FTE ED & .425FTE PH	1	.3
	DHB 0.6fte - recently reduced from 1.0. Private 0.2fte - hope to do more	1	.3
	Employed at 0.6 but often work 0.7 or 0.8	1	.3
	FTE 0.6 in one role, FTE 0.4 in another	1	.3
	FTE 0.6=24hrs/week	1	.3
	FTE 0.8	2	.6
	FTE 0.8 32 hrs week	1	.3
	FTE 0.9	1	.3
	Fte 1.0	1	.3
	FTE 1.0	14	4.2
	FTE 1.0 = 40 hours a week	1	.3
	FTE 1.0 40hrs per week	1	.3
	FTE. 1.0 and also clinic lead within this role	1	.3
	FTE0.6	1	.3
	full time	1	.3
	Full time	1	.3
	Full time between both roles	1	.3
	full time FTE 40 hrs	1	.3
	I work 50/50 clinical and academic. 2 fte total.	1	.3

	Locuming…. To meet minimum requirement of 40 days/ yr	1	.3
	o.8	1	.3
	O.8	1	.3
	o.8FTE	1	.3
	o.9 FTE - but clinically 0.3	1	.3
	Paid for 0.8 FTE, always work above and beyond these hours.	1	.3
	Technically .9 but realistically more than 1 FTE	1	.3
	Two 10 hour shifts per week	1	.3
	When not on maternity leave was FTE 1.0 (will return as FTE 0.4-0.6)	1	.3
	Working as a locum, up to 32 hours per week	1	.3
	Total	334	100.0

To gauge the equity of salaries nationally, what is your annual salary range (before tax) Please note your answer remains annoymous

		Frequency	Percent
		5	1.5
	$100 - 110,000 eg $48.08 to $52.88/hr	18	5.4
	$110 - 120,000 eg $52.88 to $57.69/hr	46	13.8
	$120 - 125,000 eg $57.69 to $60.09/hr	37	11.1
	$125 - 130,000 eg $60.09 to $62.50/hr	34	10.2
	$130 - 140,000 eg $62.50 to $67.30/hr	94	28.1
	$140, 000 + eg more than $67.30 /hr	99	29.6
	$85-90,000 eg $40.89 to $43.26/hr	1	.3
	Total	334	100.0

Do you you attract overtime or shift penalties on top of your base salary?

		Frequency	Percent
		1	.3
	No	198	59.3
	Yes, by time in lieu only	22	6.6
	Yes, shift rate increase	113	33.8
	Total	334	100.0

Do you belong to NPNZ? If not, why not? Please comment in free text box below

		Frequency	Percent
		1	.3
	No	47	14.1
	Yes	286	85.6
	Total	334	100.0

Please let us know why you choose not to be a member of NPNZ

		Frequency	Percent
		291	87.1
	?	1	.3
	Already NZNO member, paying two membership and a mortgage and high living costs at present is not possible. Would like to otherwise	1	.3
	Am a member of the College. I feel like part of a wider group in NPNZ - really appreciate all the updates that are sent out to keep current with latest info.	1	.3
	Apathy on my part - may consider associate membership rather than full membership due to cost	1	.3
	Because I struggled to find the information to join!	1	.3
	Belong to College of Nurses Aotearoa	1	.3
	belong to nzno as they cover union	1	.3
	Can afford it.	1	.3
	Cost	3	.9
	Cost. I'd rather spend my money on MPS membership.	1	.3
	Costs	1	.3
	find it not user friendly. Don't really know what it does and why it's important	1	.3
	Good support and organised information directed at NP	1	.3
	Have not got around to it	1	.3
	Have not gotten around to it, to be honest.	1	.3
	Have only registered recently and haven't managed to do it yet.	1	.3
	have't gotten around to it yet!	1	.3
	Haven't got round to it and unsure what the benefits are	1	.3
	Haven't got around to completing membership form (terrible!!)	1	.3
	Haven't got around to it	1	.3
	I am looking at changing to MPS - my GP mentor has advised they do online support for documentation/how to keep ourselves safe/how to respond to patient complaints/HDC issues.	1	.3
	I am planning to register this week as I just became registered NP	1	.3
	I have been meaning to join	1	.3
	I keep meaning to join but never get around to it!	1	.3
	I need to apply. I will do this asap.	1	.3
	I need to do this!	1	.3
	Just havent got around to it	1	.3
	Like to be part of the NP network	1	.3
	my membership has lapsed	1	.3
	No insurance so belong to another body which provides it	1	.3
	Not really crossed my mind but will look into	1	.3

	Not sure what I'd benefit from joining	1	.3
	Not working clinically	1	.3
	Not yet! Had trouble finding the registration forms (have them now though)	1	.3
	Only qualified two weeks ago need my registration number first	1	.3
	Professional support	1	.3
	thank you for all that you guys do :)	1	.3
	There doesn't appear to be much benefit in belonging for cost associated. CENNZ costs $25 and is similar sidearm of NZNO	1	.3
	Too expensive	1	.3
	Took me 5 years to attain an NP position - plan on rejoining NPNZ in 2023.	1	.3
	Used to be but belonged to two professional groups and cost came into play	1	.3
	Total	334	100.0

Have you faced any disciplinary action from NCNZ or HDC?

		Frequency	Percent
		1	.3
	No	324	97.0
	Yes, current investigation	6	1.8
	Yes, historic & resolved.	3	.9
	Total	334	100.0

Please provide a brief nature of investigation in free text box below (50 characters) ie medication error, duty of care, negligence

		Frequency	Percent
		324	97.0
	An antimandate patient	1	.3
	Conflict of interest	1	.3
	family dispute over client being placed under mental helth act	1	.3
	HDC complaint as part of a larger complaint against a facility I work for.	1	.3
	Historic case while still practicing as RN re duty of care. One of several clinicians involved in current investigation regarding a delayed diagnosis.	1	.3
	I am involved in a complaint but not directly - the complaint is against the practice for a delayed referral	1	.3
	Prefer not to say ongoing.	1	.3
	Related to covid and wearing a mask	1	.3
	Still waiting resolution from 3years ago	1	.3
	unsure, as I was asked to respond to current investigation as part of many people involved	1	.3
	Total	334	100.0

Are you planning your retirement in the next 2 to 5yrs?

		Frequency	Percent
		1	.3
	Non applicable	52	15.6
	Not likely	223	66.8
	Yes	58	17.4
	Total	334	100.0

Were you deployed to Covid pandemic work?

		Frequency	Percent of Total
	Not at all	228	68.3
	Yes, full time	14	4.2
	Yes, partially	76	22.8
	Yes, however no longer involved in pandemic work	20	6.0
	Total	334	100.0

To what degree have you felt burnout since the start of Covid19 pandemic

		Frequency	Percent
		2	.6
	Burnt out	25	7.5
	Definitely, though managing	151	45.2
	Have taken stress leave	10	3.0
	Not at all	28	8.4
	Noting moderate effects, not managing at times	54	16.2
	Somewhat slightly	64	19.2
	Total	334	100.0