Consolidated list of issues – Submission Nursing and Midwifery Council NSW (NMC)

Improving efficiency

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

Nursing degree costs for accreditation to the education facility can be about $30,000 per degree/course which is paid by the university. However costs vary for different professions. Some courses being subsidised by overseas students and through registration fees/international student fees. The variation may be driven by:

- differing accreditation standards;
- the evidence required to meet the standards; and
- how and by whom the evidence is assessed.

The accreditation process would benefit from more ‘standardised’ approach and, where possible, consistent standards, and processes that are transparent and provide greater efficiency, equity and quality across the professions.

The research has indicated there is significant consistency between the professions for the process of accreditation, including:

- an application for accreditation and self assessment by the education provider
- consideration of the application by the accreditation authority
- site visit by the accreditation team
- development of an accreditation report with a decisions and possible conditions for submission to the National Board
- consideration of the accreditation body decisions (approve, refuse, approve with conditions)
- annual reporting by the education provider to the accreditation body about eg student enrolment, clinical placement information, changes to the curriculum, program outcomes.

There is however also considerable variation in the process of accreditation ie who, what, how and when accreditation occurs, which could be standardised.

There is some concern about the:

1. variation of standards for English language when entering a course due to the importance of communication within health services
2. variation of ATAR scores and entry requirements for courses within each profession between universities and learning institutions. There is data that indicates that an ATAR for nurses of less than 72 is associated with out of pattern completion/ non completion due to students failing subjects
3. the identification and variation in ‘inherent requirements’ for the different professions
4. variation in reasonable adjustments within courses and how this compares to the adjustments that can be made in practice in the clinical context - universities must abide by the anti discrimination and disability laws even when similar adjustments are not possible in the clinical context.

2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

There is an overlap between the standards used by TEQSA/ASQA and the accreditation bodies. It is recommended that the standards for accreditation for all the professions be mapped against each other and against the TEQSA/ASQA to determine the:

- standards that overlap with TEQSA/ASQA
- similarities and differences in accreditation standards and processes between the professions.

This may enable further standardisation of accreditation processes, and minimising overlap where possible, while still acknowledging areas of differences.

TEQSA accredits courses for a 7 year period. TEQSA’s risk assessments do not draw conclusions about compliance with the Threshold Standards or the ESOS Act and National Code 2, but rather identify potential risks of non-compliance. In other words, risk assessments may identify ‘leads’ that warrant closer consideration by TEQSA case managers, but do not confirm that there is necessarily a problem.

The purpose of the Risk Assessment Framework (RAF) is not to identify all institutional risk or to replace or replicate a provider’s own risk management. The RAF focuses on key risks across the sector that can be readily measured on a regular basis.

TEQSA’s assessment processes, such as a renewal of registration, involve a deeper assessment of evidence to determine compliance with the TEQSA Standards. Some of the areas that are examined for risk assessment, student load, experience and outcomes, academic staff profile, financial viability and sustainability, regulatory history and standing

Where TEQSA/ASQA have similar standards to the regulatory standards these should be used and the standards removed from the regulatory standards except where the criteria does not adequately cover regulatory requirements eg clinical practice experience.

3. What are the relative benefits and costs associated with adopting more open-ended and risk managed accreditation cycles?

Using a risk assessment framework to determine when a more thorough review occurs or other action may be beneficial if specified risks are reported on regularly so that they can be identified early and trigger a review in a timely fashion. But they should also be supplemented by routine reviews identifying the maximum time period between reviews. For example, by linking it to the TEQSA or ASQA reviews eg AHNMAC has 5 year reviews

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1 NMC discussion with NSW Council of Deans Nursing and Midwifery
2 http://www.teqsa.gov.au/for-providers/course-accreditation
currently but could move toward 7 year in step with TEQSA reviews. This should be combined with the use of Risk framework and the ability to review if and when risks are identified.

Such a framework may minimise the costs of reviews for increasing the periods between reviews unless identified at risk, and minimising the need to repeat reviews for TEQSA/AQSA and regulatory bodies.

There is increasing pressure for universities and other education organisations to maintain reputation, revenue and status. There is also increasing competition both within Australian and internationally for students. Competition for placement in clinical setting is becoming more difficult with increasing numbers of students. The range of clinical experiences of students may also be decreasing. Students are also provided with significant opportunities for appealing failed courses and there have been increased media reports of academic fraud by students (ie submitting work completed by others). There is also a variety of pathways students can take with varying levels of recognition of prior learning. Not all students are accepted into new graduate programs and there are few alternatives for support for new graduates outside the acute clinical and public hospital settings.

Employers typically expect new graduates to be work ready however their clinical experience within courses, ability to deal independently with stressful situations time management and confidence requires development. There is a lack of supervisors. Some research suggests an environment where bullying and harassment can occur because of the work pressure associated with increasing age of patients chronicity and complexity of and acuity of patients in the acute and community sectors. There is increasing concern about the quality of some graduates successfully completing courses and their ability to function safely in such an environment. The Council has receives about 20-30 complaints about new graduates (within the first two years of initial registration) each year of which approximately 2/3 are related to conduct and performance and 1/3 to health issues.

One of the challenges is how to best measure outcomes of courses and the variables associated with risk. A standardised measure for outcomes via a national exam combined with clinical exams conducted by the education facilities during clinical practice or during a new graduate year or internship may at least ensure that graduates meet a common standard. This might be achieved even when the entry requirement and teaching and learning pathways and methods may differ. A national exam would also provide some transparency particularly if the same exam is used to test practitioners who have trained overseas and wish t be registered in Australia. An exam similar to the NCLEX exam would be suitable for nurses. Research into how variation in entry requirements such as ATAR scores, and English level requirements and the personal attributes questionnaire score (PAQ) is associated outcomes is necessary. Consistent collection of data across educations systems an across health professions must occur to examine and describe risks more thoroughly.

**Training and readiness of assessment panels**

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and inter professional collaboration?
There should be:

- consumers
- employers
- professional and inter professional and experts in pedagogy
- Aboriginal and Torres Strait Islander Health stakeholders and
- ex students

on the assessment team and involved with assessment. This is to ensure a broad range of stakeholders can ensure that appropriate education frameworks, content and process are used and critical elements for safety such as Aboriginal and Torres Straight health and cultural safety.

5. **Should the assessment teams include a broader range of stakeholders, such as consumers?**

As above. There should be consumer, professional and inter professional and experts in pedagogy represented and involved with involved in assessment.

**Sources of accreditation authority income**

6. **What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?**

Costs may differ due to the different cost associated with the members of assessment panels. However if the processes of accreditation are more consistent this may minimise differences in the costs between professions. Having an umbrella organisation may increase or decrease costs depending on how its structured and its purpose (e.g. adding additional layer of organisation and whether it provides greater efficiencies or adds further bureaucracy).

Proposed principles:

- Education providers should meet the direct cost of accreditation of the programs
- Funding for the accreditation body should be from registration fees.
- There might be a need for government subsidy for the smallest professions
- Cost efficiency and effectiveness of the accreditation body must be promoted

7. **Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidize accreditation functions for on shore programs?**

Overseas qualified practitioners should not be expected to subsidise accreditation functions. They will pay fees if they become registered.
Relevance and responsiveness

Input and outcome based accreditation standards

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

Both outcome and input accreditation standards are required to:

- maintain teaching and learning standards,
- minimise risks and

on occasions to introduce innovations. But the focus should be on outcomes.

9. Are changes required to current assessment processes to meet outcome-based standards?

The courses must be outcomes focused and use criteria and standards for practice to determine outcomes.

Some input accreditation standards are also required eg total time of clinical practice / simulated practice. Input standards may be required when new risks or evidence are identified. Input standards can be changes easier than output standards.

Content is also another input that is sometimes specified. Content may need to change as practice changes over time and should not be too restrictive or prescriptive as it may restrict innovation.

NMC supports the current recognition of appropriate overseas clinical placements within courses.

Health program development and timeliness of assessment

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

There should be a common approach to the development of competency frameworks at a high level however the criteria and cues may differ according to professions. For example,

1. professional and therapeutic relationships
2. analysis and critical thinking
3. scope of practice and maintaining capability
4. assessment and diagnosis
5. planning
6. safe Implementation – procedures and treatment
7. evaluation.

A broad range of stakeholders consumers and employers, academics, students professional bodies, other professions etc should be included in the development of standards.

11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlaid with profession-specific requirements?

Advantages

- common language and understanding between professions, within profession and for the public
- assist universities where they have multiple professional programs which require accreditation
• encourage interprofessional learning and education to promote interprofessional practice
• improve the ability to get recognition of prior learning
• additional efficiencies for accreditation assessors
• consistency of assessment of accreditation across courses for different professions.

Disadvantages
• need to ensure that the standards are sufficiently relevant to each profession
• there may be some professional specific standard also required.

12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

Established process and communication of concerns by employers or regulators about the performance or conduct and health of new graduates to the relevant accreditation body if it occurs within first three years of practice.

Three years duration because some graduates do not get employment immediately after completing course or move employment between employers. Health because education facilities also have a responsibility to ensure resilient practitioners.

We support the exploration of risk based reporting and assessment - consultation and research evidence must be examined to determine the relevant risks to report on.

Outcomes of courses should be examined in terms of eg pass rates assessed against entry pathways, extended time to complete and the nature and reasons for that, student complaints.

Self-reporting of changes in resources, staffing, facilities, changes to program.

Support a maximum of seven year cycle in line with TEQSA and ASQUA with increased frequency of risks identified.

Interprofessional education, learning and practice
13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

There needs to become an’ input’ standard across all the health professions requiring interprofessional learning and teamwork development.

Interprofessional relationships should be identified as an output standard for all professions and examined during clinical placement.
Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?
Have, as an input standard, that ‘health care priorities’ must be embedded in the accreditations standards. These priorities may change but the educators who are engaged with health should be aware of this and update and teach the relevant priorities

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience? Education provides must provide evidence of the embedding of simulation and professional practice that achieves work ready graduates. Including employers in the accreditation assessment process may assist.
There should be some input criteria about skill development and clinical practice which should not be too prescriptive to allow for technical innovations that will become available for simulated experiences as IT develops. There should however be opportunity to practice and be assessed in a clinical setting particularly in the later years of courses. Clinical practice and simulation should provide for both rare emergency situations as well as the complexities in of practicing in busy settings with other health professionals where unexpected events occur and problem solving and time management is required.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?
The NMC can only comment on nursing and midwifery.

In the first year practice there has to be a program of supervised practice for all new graduates. How this happens may vary. These program should be accredited. There should be a consistency with work place and educator providers. Universities may explore with workplaces the establishment of collaborative programs that provide group clinical supervision to nurses and midwives that extend past the acute services; eg clinical supervision for mental health nurses, palliative care nurses etc.

17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?
National examinations
The Council recommends the implementation of a national examination for nursing and midwifery students. This will provide national consistency of graduation standards. The Standards for Practice should be upheld throughout the assessment of nursing and midwifery students in their university education programs. The national examination should be informed by consultation with workplaces regarding their requirements of work readiness.

New graduate programs should be accredited ensuring that induction, supervision and education are active elements of these programs, acknowledging that there is diversity within new graduate programs (size, scope of practice, resources). CPD requirements for registration must be clearly defined, accessible and audited.
To date this has been a significant issue for the nursing and midwifery disciplines. Whilst it is desirable for graduates of nursing and midwifery programs to undertake a transition program in their first year of practice, there are insufficient positions in NSW for all graduates. There is also inconsistency in the structure and support offered in these programs.

**National Examinations**

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

A national assessment process allows for national consistency, national data and clear outcome measures for education providers. The presence of a national assessment process will also allow education providers to actively differentiate specific characteristic/elements of their programs eg; mental health majors, palliative care electives, etc.

Education programs and education providers still require a robust accreditation process, with a particular focus on input and process standards. The national assessment process will allow for objective outcome data.

**Producing the future health workforce**

**Independence of accreditation and registration**

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?

National Boards are currently constituted appropriately to determine accreditation standards. However, there must be strong consultative networks to facilitate regular dialogue between accreditation bodies, workplaces/employers/ professional regulation bodies/ consumer representation organisations and student representative organisations.

20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

Interdependence is the goal here – through the consultative networks identified in 19.

**Governance of accreditation authorities**

21. Is there adequate community representation in key accreditation decisions?

The engagement of education providers with community representation organisations/stakeholders must be involved with accreditation input and process standards for education programs.
22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

In principle; professional expertise should be sourced outside of the programs to be accredited.

23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

Conflicts of interests must be reported and transparent processes used.

**Role of accreditation authorities**

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS? What other governance models might be considered?

No Comment

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

The latter alternative provides independence.

A single accreditation entity could, with a combination of common interdisciplinariany standards as well as the discipline specific standards provide accreditation services. This would allow for the alignment of education standards across all health programs and allow for discipline specific and interprofessional standards specific standards. The alignment with teaching and learning standards of TESQA and ASQA standards could also occur.

Such an approach may assist education providers who deliver multiple discipline programs as there are alignment of education standards that goes across the programs, rather than each discipline having its own specific standards. It may also prevent duplication in accreditation systems that education providers undertake.

26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

The establishment of core interprofessional competencies must lead this process. This would enable the assessment and recognition of cross-professional competencies. Education providers have a key role in establishing these core competencies and facilitating interprofessional learning, assessment and recognition.

The Council agrees that the current accreditation system fails to easily foster the development of new cross-professional competencies and roles. Having a single accreditation authority may
assist in the development of cross-professional competencies and the development of new innovative health discipline roles.

**Accountability and performance monitoring**

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance? Setting health workforce reform priorities

Performance measures should include: timeliness, adherence to required processes, responsiveness (effective communication), integrity (competence of assessors/assessment tools and processes), feedback from education providers, governance, cost effectiveness.

NRAS are the reporters against these measures.

**Setting health workforce reform priorities**

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

Scrutiny, consultation with key stakeholders such as health services and education providers to ensure fit for purpose with States and territories and nationally

The Ministerial Council may not be best placed to determine the design and reform for specific health disciplines. However, the Ministerial Council could influence workforce reform in line with new models of health delivery.

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

The recruitment and supply of health practitioners must be balanced with the production of health practitioners that are safe to practice, and must be balanced with the need for health care reforms and changing health practices.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

Recommend using consultation workshops and discussion papers.
Specific governance matters
The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

In principle. Boards, specialist colleges and postgraduate medical (and other) councils should have:

- processes for declaration of conflicts of interests,
- membership that includes consumer, stakeholder and interprofessional engagement
- clearly stated mission, values and remit, and
- accessible complaint processes.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

No

33. Is there a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

Accreditation bodies are assigned the responsibility for accrediting programs and not individuals for registration. Registration should remain the National Boards responsibility through AHPRA. The accrediting body could accredit education and or assessment programs for registration purposes in Australia.

The standards and assessment process for overseas applicants must be consistent o the assessment process required of internal Australian educated applicants

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

Yes

There must be some consistency in the assessment pathways and approaches taken for overseas trained practitioners. However these approaches would need to be fully funded, either through registration fees or direct fees to the applicant.

Overseas trained practitioners should be assessed against the practice standards of the discipline. This could be achieved through theory examinations and simulated performance assessments.
35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

Supervised practice becomes a requirement when assessment processes identify the need for workplace-based supervision, in the interests of public safety and standards for practice. This requirement and process cannot be achieved by any alternative means.

A period of supervision may be required to provide orientation to the health system which can be very different from the country of origin.

**Grievances and appeals**

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

No; an external grievance/appeal mechanism is an essential requirement for accountability, disclosure, and conflict resolution.

37. If an external grievance appeal process is to be considered:

- Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
  
  Yes

- Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

  Yes