Te Kaunihera Tapuhi o Aotearoa
Nursing Council of New Zealand

Tuhinga Kōrero whakamuri Hangarau
Technical Background document

Review of the Enrolled Nurse Scope of Practice Scope Statement

December 2022

Contents

Kupu Whakataki - Introduction

He karapa ki ō mātou whai tohutohu - Our consultation at a glance

In this consultation, Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand is seeking views on a proposed new scope statement for the Enrolled Nurse Scope of Practice. A scope statement is part of three elements of a Scope of Practice. It describes the nature of the role and sits alongside the nursing competencies that define what makes competent practitioners in that scope, and the education standards for programmes that develop competent practitioners.

Under the Health Practitioners Competence Assurance Act 2003 (the Act), setting scopes is one of the core functions of the Nursing Council.[1] The Council's statutory role under the Act is to protect the health and safety of the public, and the scopes that describe the profession are part of the foundation for that protection.

The current scope statement for Enrolled Nurses was approved by the Nursing Council in 2010 and formally published in 2012. The Council's statutory role is to protect public safety and these proposed changes to the Enrolled Nurse Scope of Practice reflect the Council's desire to modernise the current scope statement by:

- clearly recognising commitment to and the position of Te Tiriti o Waitangi
- reflecting more breadth of practice in the scope statement
- removing specific prescription of tasks and
- better reflecting the appropriate position of Enrolled Nurses with respect to Registered Nurses and other practitioners.

Subsequent sections in this document detail the background to the review, the specific changes we are proposing to the Enrolled Nurse scope of practice, our rationale, and the questions we would like you to consider as you respond to our consultation.

This is a technical background document, which discusses the background and rationale behind the proposed statement. A shorter summary of the statement and key elements where we are looking for feedback is available on the consultation webpage for this Review.

Consultation on the proposed scope statement begins on December 12, 2022 and runs until February 13, 2023. How you can have your say is described at the end of this document, as well as on the consultation webpage.

[1] The other two Scopes of Practice set by the Council are for Registered Nurses and Mātanga Tapuhi Nurse Practitioners.

Proposed Enrolled Nurse Scope of Practice Statement

The practice of Enrolled Nursing in Aotearoa New Zealand reflects concepts, knowledge, and world views of both partners to Te Tiriti o Waitangi. Enrolled Nurses are committed to upholding and enacting Te Tiriti o Waitangi ngā mātāpono – or principles, based within the Kawa Whakaruruhau framework for cultural safety, with respect to equity, inclusion, and diversity.

The Enrolled Nurse works in partnership and collaboration with the health consumer, their whānau, communities, and the wider healthcare team to deliver equitable person/whānau/whakapapa-centred general nursing care, advocacy, and health promotion across the life span in all healthcare settings. Their practice is informed by their level of educational preparation and practice experience, and may include a leadership or coordination role within the healthcare team.

Enrolled Nurses manage the health status of the health consumer through nursing assessments, care planning, implementation, and evaluation of care, and in some settings seeking guidance from a Registered Nurse or other registered health practitioners.* They are accountable and responsible for their nursing practice, ensuring all health services they provide are consistent with their education and assessed competence, legislative requirements, and are supported by appropriate standards.

*A health practitioner is a person who is registered under the Health Practitioners Competence Assurance Act 2003 – for example, a midwife, medical practitioner or occupational therapist.

The current Enrolled Nurse Scope Statement is set out below. A comparison between this and the Registered Nurse Scope Statement can be found in Appendix Two.

Enrolled Nurse Scope of Practice[2]

Enrolled Nurses practise under the direction and delegation of a Registered Nurse or Nurse Practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings.

Enrolled Nurses contribute to nursing assessments, care planning, implementation, and evaluation of care for health consumers and/or families/whānau. The Registered Nurse maintains overall responsibility for the plan of care.

Enrolled Nurses assist health consumers with the activities of daily living, observe changes in health consumers' conditions and report these to the Registered Nurse, administer medicines, and undertake other nursing care responsibilities appropriate to their assessed competence.

In acute settings, Enrolled Nurses must work in a team with a Registered Nurse who is responsible for directing and delegating nursing interventions.

In some settings, Enrolled Nurses may coordinate a team of health care assistants under the direction and delegation of a Registered Nurse.

In some settings, Enrolled Nurses may work under the direction and delegation of a registered health practitioner.* In these situations, the Enrolled Nurse must have registered nurse supervision and must not assume overall responsibility for nursing assessment or care planning.

*A health practitioner is a person who is registered under the Health Practitioners Competence Assurance Act 2003 – for example, a midwife, medical practitioner, or occupational therapist.

[2] https://www.nursingcouncil.org.nz/

Arotakenga o te Hōkaitanga o te Wainga o ngā Tapuhi kua whakauru - Review of the Enrolled Nurse Scope of Practice

The proposed new scope statement has been developed through the Review of the Enrolled Nurse Scope of Practice. This is a collaborative project, that started in mid-2022, and is being undertaken in partnership between the Nursing Council, and the Enrolled Nurse Section of Tōpūtanga Tapuhi Kaitiaki o Aotearoa New Zealand Nurses Organisation (NZNO). We have worked on this review together to undertake a review that respects both the Council's functions, and the integrity and potential of enrolled nursing practice. The Council has also sought guidance from Te Poari o Te Rūnanga o Aotearoa (Te Poari) to ensure that the voice of Māori has been present in the foundation of this review.

This review is examining all three elements of the Scope of Practice: the scope statement; the competencies; and the education standards. We have begun by reviewing the scope statement, as this represents the foundational definition of practice which the competencies and standards will need to reflect.

This review involves three layers of development and consultation. A Design Group has been established to work in collaboration with representatives from the Council, the Enrolled Nurses Section, Te Poari, and educators and employers of Enrolled Nurses. The Group is responsible for developing initial drafts of the statement, competencies, and standards. Members of this group are listed in Appendix One. A Sector Reference Group, with membership varying depending on the topic being considered, provides feedback on the draft results of the Design Group's work. Once the Design Group considers the Reference Group's commentary, material is then released for public consultation and input. The scope statement has reached this third stage.

The feedback and advice we receive during consultation will be considered by the Design Group and the proposed scope statement revised appropriately. It will then be formally proposed to the members of the Nursing Council's Board for their consideration and approval.

Te Tiriti o Waitangi me te Wairua Tōkeke mō te Māori - Te Tiriti o Waitangi and equity for Māori

The Council carries out its functions within the context of its commitments, responsibilities, and obligations under Te Tiriti o Waitangi, and has developed a Te Tiriti o Waitangi statement and framework to guide its work. The statement and framework adopt Te Tiriti principles and some of the goals from Whakamaua: Māori Health Action Plan 2020-2025.

Equity, inclusivity and diversity stand as key pillars in the vision to which the Council is currently working. What the nursing future will look like for Māori depends on whether plans and objectives – across health, education, social, and employment systems – align with Te Tiriti obligations. The Council, through partnership and meaningful engagement and approaches such as the Tukutuku Rau framework that incorporate Te Ao Māori

perspectives, is working to support and enable equitable outcomes for Māori within the regulatory space.

The Council as a Tiriti partner has articulated the ways in which we can uphold Te Tiriti o Waitangi, through our Te Tiriti policy statement and framework. The Tiriti principles we have articulated can be used as a tool to develop not only the work, but our way of working. Key actions we have identified to uphold Te Tiriti through this review include:

- Identifying and building relationships with tangata whenua partners to work alongside us
- Collaborating with Tōpūtanga Tapuhi Kaitiaki o Aotearoa /Te Pōari as a key strategic partner
- Examining the data to understand the current representation of Māori nurses within enrolled nursing, and the workforce as a whole
- Understanding historical tangata whenua connections to enrolled nursing and working in partnership to enact aspirations for the future.

One important way in which we can uphold Te Tiriti in our regulatory work is through ensuring an appropriately prepared and competent Enrolled Nurse workforce, where our definition of competence includes a strong focus on Kawa Whakaruruhau and cultural safety. The Council's statutory role is to protect public safety, and this includes requiring culturally safe practice in the context of Te Tiriti o Waitangi. This is especially important as we work towards equitable health outcomes for tangata whenua.

The Nursing Council acknowledges that there are specific issues around equity for Māori in the context of Enrolled Nursing. The Design Group has heard that, due to systemic and institutionalised racism and bias, many Māori interested in nursing have historically been positioned as 'not good enough' to be successful with Registered Nurse training. This view was expressed In Meek's (2009) study, through personal email correspondence with the National Council of Māori Nurses: "Historically Māori have been directed towards second level nursing because they are so good with their hands. We reject this notion that Māori prefer to do the hands on nursing and leave the intellectual thing to others as a legacy of our education system" (p 31).

Māori nurses are significantly under-represented in the nursing workforce; at 31 March 2022, Māori made up 7.3% of the nursing workforce and 9.2% of Enrolled Nurses. Barton (2022) claims the current system disadvantages Māori in many ways, as illustrated through the ongoing relatively static percentage of the Māori-registered nursing workforce. The reasons for this are many and varied, but inherently rooted in our colonial history (see, for example, Manchester 2018). A sustained effort to increase this workforce is needed to ensure it can meet the demands of a predicted growth in our Māori population and to better reflect their communities. Increasing the Māori health workforce is one way of improving Māori health outcomes and health status. As Nuku (2015) notes, the Human Rights Commission has identified the under-representation of Māori in the health workforce as a form of structural discrimination.

The Enrolled Nurse Scope of Practice must demonstrate an understanding of Te Tiriti o Waitangi and how to honour it through nursing, an understanding of health equity and its contributing factors (including colonisation), and how to provide culturally safe care that is consistent with Te Tiriti. Making these expectations clear is a key way in which we can support our Enrolled Nurses to deliver care that is responsive to the rights and needs of tangata whenua and does not entrench existing health inequities.

However, bias is also systemically and institutionally enabled, and addressing it requires a holistic approach; cultural training alone is not enough. For our health settings to achieve equity, there needs to be consideration of the needs of our diverse communities. A key element within the equity conversation therefore must be the way in which our health settings recruit, support, and treat Enrolled Nurses to ensure a sustainable workforce. The views of Māori Enrolled Nurses need to be acknowledged and implemented as a key factor in this.

Kōrero whakamuri – Background

Horopaki mō tēnei mahi – Context for this work

Aotearoa New Zealand as a whole, and specifically the context for nursing regulation, is currently undergoing considerable change. The system in which nurses practice and are educated are experiencing their most dramatic transformation since the creation of the current regulatory regime. The past two years have seen our society and systems dealing with what is literally a global health emergency with the country coming to grips with how we transition to managing COVID-19 as an ongoing health condition in our communities. At the same time, with the Pae Ora[3] health reforms, we are seeing significant changes to the structure of the health sector, while the restructuring of our vocational education system is affecting institutions responsible for creating many of our next generation of nurses.

The Nursing Council's fundamental role is to protect the safety of the public by ensuring that nurses are competent, safe, and fit practitioners. This is the reason why we set scopes of practice: so that we can clearly describe what nurses do, what it means to do that competently, and the key features of education programmes will create competent and safe practitioners. However, in setting scopes we must take account of the context in which nursing is practised and taught.

While the Council does not have a role in workforce planning, we do need to ensure we develop scopes of practice that can enable a flexible workforce to meet health needs and deliver quality health services. Any scope we set must also have credibility with the profession and other stakeholders. This includes the international nursing community and regulators in other jurisdictions where nurses may wish to work. The Council also recognises that the implications for individual nurses, employers, education, and policy makers of introducing a new scope need to be considered.

Finally, any new scope of practice for Enrolled Nurses needs to consider current and projected health needs of the New Zealand population and the current and projected workforce issues facing the health sector. The Council is also aware that changes to the Enrolled Nurse scope of practice need to acknowledge the composition of the health workforce, particularly the roles of the Registered Nurse and non-regulated workers.

Kōrero Hītori – Historical Background

Since it was first introduced in 1939, Enrolled Nursing in Aotearoa has undergone significant changes to its scope of practice and title. With the introduction of the Nurses Act in (1977), registered Community Nurses were renamed Enrolled Nurses. An amendment to the Act (section 53A) in 1983 introduced the requirement for Enrolled Nurses to practise under the direction and supervision of a Registered Nurse or a medical practitioner. This was viewed as an attempt to reduce role conflict between

[3] https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pae-ora-healthy-futures

Registered and Enrolled Nurses and to control the EN Scope of Practice (MacKenzie, 2020; Dixon, 1996).

The training of Enrolled Nurses ceased in 1993 as training providers and public hospitals considered that the current supply of Enrolled Nurses would meet workforce requirements without the need to provide further training programmes. However, the roll remained open for applicants from overseas. In 2000, the then Minister of Health, Annette King, indicated a desire to reintroduce training for a second-level health worker in New Zealand (NCNZ, 2009). She requested that the Nursing Council examine the related issues from the Council's perspective of programme development, approval, and monitoring. Following consultation, and with the assistance of a working party appointed by the Minister of Health, new Enrolled Nurse programmes based on a new scope of practice and programme standards were introduced. The title Enrolled Nurse was, at this time, required for the graduates of those programmes as the Nurses Act 1977 and subsequent amendments had established a roll for second-level nurses who were not registered nurses.

Although one year long, the new programmes, established initially in Northland and later in Christchurch Polytechnics, differed considerably from the previous hospital-based apprenticeship-type programmes. The certificate programme was set at level 4 on the NZQA framework, with each programme focused on one area of practice: aged medical care (Northland) and long-term care and rehabilitation (Christchurch). Clinical experience was obtained as a student, not as an employee, and was restricted to the area of focus of the programme. The programme areas were driven by the industry workforce needs, not limited by the Nursing Council (NCNZ, 2009).

With the implementation of the Health Practitioners Competence Assurance Act 2003, the Nursing Council consulted on new scopes of practice for nurses including a scope for a new regulated second-level nurse. This led to a further name and role change in 2004, when the Enrolled Nurse title changed to Nurse Assistant and a requirement to work under the 'direction and delegation' of a Registered Nurse was added. The existing title and scope of practice was then closed by the Council, except for those Enrolled Nurses who trained prior to 1993. All second-level nurses registered from September 2004 were registered under the Nurse Assistant Scope of Practice. The competencies for the Enrolled Nurse and the Nurse Assistant remained the same (NCNZ, 2009).

Many Enrolled Nurses were upset and dissatisfied with this change, perceiving it as part of a broader attack on the profession (Meek, 2009). In 2006 the Council was taken to court by a group of students, and in 2008 the New Zealand Nurses Organisation (NZNO) submitted a complaint on behalf of its members to Parliament's Regulations Review Committee (RRC)[4]. The RCC complaint focused on the point that the Council's changes retrospectively affected a group of students in Enrolled Nurse programmes, but the Committee's investigation covered a wider range of issues around the positioning of enrolled nursing (Regulations Review Committee, 2008). ".

[4] https://www.parliament.nz/resource/en-NZ/48DBSCH_SCR3828_1/6bc2a13c049154f367a0fb4a4c61784153bf42e4

The RRC (2007) found the notice had unauthorised retrospective effect and recommended it be amended to remove this effect. Specifically, the Committee noted that although there had been several retrospective changes to titles in the nursing profession, in this instance the change was unacceptable because, in contrast to other title changes within the profession, it mattered to the affected second-level nurses. To remedy this retrospective effect, clause 4 of the Notice, dealing with the scope of practice of Enrolled Nurses, was subsequently revoked. This has been the subject of two further consultations by the Nursing Council before the title was changed to Enrolled Nurse in late 2008 following a recommendation by the Regulation Review Committee (NCNZ, 2009).

In September 2008, new Minister of Health David Cunliffe announced a motion to reinstate the scopes of practice and qualification of 'Enrolled Nurses' for 137 nurses who began their education or had graduated as Enrolled Nurses between 2000 and 18 September 2004, but whose title had been altered to 'Nurse Assistant' under the Council's changes. He said, "The issue is one where a group of nurses, through no fault of their own, were caught out by a decision which changed their job title and their scope of practice to something different from what they intended when they signed up for a course of study" (Minister of Health, 2008).

Further in 2008, the Minister of Health directed the Ministry of Health (the Ministry) to provide advice on the clinical workforce needed to support services provided by Registered Nurses (MOH, 2009). Consequently, a Ministry of Health Nursing Advisory Committee[5] was established to provide the Director-General of Health with relevant and practical advice on options for the clinical second-tier workforce(s) to support Registered Nurses, including the question of regulation for such workforce(s), and suggested actions to give effect to any recommended changes. This Committee's deliberations resulted in a change to the scope of practice for Enrolled Nurses and Nurse Assistants. The intention was for Enrolled Nurses to have a greater role in assessment, working as part of a team with Registered Nurses and other health professionals in a variety of settings, and to have their nursing skills recognised when working with unregulated health care assistants in aged care settings and the community (NCNZ, 2009).

After receiving the Nursing Advisory Committee report (MOH, 2009), the Minister of Health requested that the Nursing Council work with sector representatives, including those from District Health Boards (DHBs) and professional organisations, to develop a revised scope of Enrolled Nurse practice. The Nursing Council was aware of the complex issues and divergent opinion within the sector surrounding the Enrolled Nurse and Nurse Assistant scopes of practice, and thus undertook significant consultation to capture these perspectives and clearly define issues (NCNZ, 2009).

As a result of this consultation and sector engagement, the scope of practice for Enrolled Nurses and Nurse Assistants changed on 31 May 2010. This defined a broader scope of practice and the reintroduction of the Enrolled Nurse name. From 1st July 2010, the Nurse Assistant scope was disestablished, and all second-level nurses became

[5] https://www.health.govt.nz/publication/clinical-workforce-support-registered-nurses

Enrolled Nurses with an expanded scope of practice. Following this, an 18-month Diploma in Enrolled Nursing (at Level 5 on the New Zealand Qualifications Framework) was developed. Along with this change, considerable communication and information were provided to the sector, highlighting both professional and employer responsibilities, when implementing this new scope of practice due to the broader scope and higher skills required (NCNZ, 2018). However, Enrolled Nursing continued to face ongoing impacts in the health sector with job visibility and security, including ongoing confusion regarding their scope of practice (Meek, 2009; Mackenzie, 2020).

Today, Enrolled Nurses work in a variety of practice areas and settings providing health care and education across home, community, residential and hospital settings. [6] The Ministry of Health has stated that enrolled nursing is an important component of a high-quality health system, and recorded its commitment to enrolled nurses as part of skill mix planning: "All around New Zealand, Enrolled Nurses are demonstrating how much they can improve the quality of health care" (Ministry of Health, 2013).

The Design Group is aware of diverse opinions and commitment within the health and disability support sector regarding the Enrolled Nurse scope of practice. This is not helped by a historical lack of clarity around the position of Enrolled Nurses in discussions of future nursing workforce needs, skill mix, and models of care in various health and disability settings. The introduction of any revised enrolled nursing scope of practice may not be a simple process. However, this dynamic time for health and nursing regulation requires standards and competencies that reflect the nature and requirements for contemporary nursing and to anticipate how these may change in the future.

Ngā take o te wā – Current issues

The scope and expectations of nursing have increased significantly over the last few decades and regulation, practice, and employment arrangements must keep pace with these changes. The issues related to the Enrolled Nurse workforce are complex. If a revised scope for Enrolled Nurses is to be sustainable, it requires a significant commitment from all parts of the health system.

The NZNO Enrolled Nurse Section (2019) surveyed their membership for their views on the Enrolled Nurse Scope of Practice. Enrolled Nurses reported either that they were working to the 'fully enabled' scope, or else that they were very restricted in their practice due to interpretations of the Registered Nurse 'direction and delegation' policy by their employer. More than two-thirds of respondents cited the requirement to practise under direction and delegation as the most restrictive part of the current EN scope.

[6] Examples of the diverse areas in which enrolled nurses practice can be found at https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/enrolled-nurses-new-zealand

There was also concern that the wider nursing profession did not fully understand the Enrolled Nurse Scope of Practice. Only a third of Enrolled Nurses in the survey believed that other regulated health professionals understood the Enrolled Nurse Scope of Practice. There were a wide range of responses regarding access to training for specific tasks or procedures and the ability to provide various procedures (e.g.: immunisations, intravenous cannulation, InterRai assessment etc) depending on the health setting or employer. Respondents also reported that it remains difficult for Enrolled Nurses to move between different areas of health care, with employment options for Enrolled Nurses varying considerably between Te Whatu Ora regions (previously DHBs).

These all point to varied perceptions of enrolled nursing across the health and disability support system, which lead to different permitted practices, employment of Enrolled Nurses, and working arrangements. Many of these differences seem to be based on decisions, attitudes, and interpretations held by individual workplaces.

The Enrolled Nurses Section has also identified numerous barriers that have limited Enrolled Nurses' ability to work to their full scope of practice and to full employment opportunities (NZNO, 2022). Over time, these have been brought to the attention of various agencies such as the Ministry of Health, Nursing Council, Nurse Executives, Directors of Nursing, Health Workforce New Zealand, and other key forums to progress key strategic workforce, scope of practice, and pay equity issues.

Mackenzie (2020) described notable challenges and opportunities faced by Enrolled Nurses in today's nursing workforce, and identified several themes that related to significant historical hurt and modern-day devaluing of the Enrolled Nurse role. Further, Mackenzie refers to confusion over the Enrolled Nurse Scope of Practice, regional and employer differences, and competition for employment and remuneration with other health roles, in particular with the non-regulated health workforce. Role progression and professional development opportunities are also limited in some areas given variable support for the Enrolled Nurse role. However, Mackenzie's research also highlighted positive examples of Enrolled Nurse integration into the health workforce where several Enrolled Nurses and employers are forging new ground through models of care, for example, in primary health care and mental health and addiction services, with opportunities for role expansion to enable Enrolled Nurses to work to the top of their scope.

Many of the issues for the Enrolled Nurse Scope of Practice today are the same as those raised by the sector in 2009, when the Nursing Council consulted on the Enrolled Nurse and Nurse Assistant scopes of practice (NCNZ, 2009). They are multi-faceted and cover a broad range of concerns predominantly relating to marginal employment opportunities and underutilisation, attitudes of individual managers, lack of clarity over the Enrolled Nurse Scope of Practice by health professionals (including other nurses), and competition with other roles for jobs and remuneration.

Ngā Kaupapa Matua mō te Arotakenga – Key Issues for the review

A variety of strategic and system-level barriers exist for the Enrolled Nurse workforce. Although not all of these can or should be directly addressed through the Enrolled Nurse Scope of Practice, they are informing the review.

New Zealand has a significant gap with this workforce

At 31 March 2022, the 2,378 Enrolled Nurses made up under 4% of the regulated workforce. As shown in Figure 1, they are also one of the only major parts of the Aotearoa New Zealand workforce where the number of practising nurses is actually declining. The number of ENs holding practising certificates fell from 3,152 in 2011 to 2,378 in 2022, while the number of Registered Nurses grew from 45,307 to 62,429 over the same period. A large factor in this was the effect of decisions made during the 1990s and early 2000s.

Training for Enrolled Nurses ceased in 1993, and as shown in Figure 2, the programmes reintroduced from 2002 have only recently begun to produce more significant numbers of graduates. As a result, Enrolled Nurses are facing a large demographic 'gap'. While 45% have trained after 2010, 44% of Enrolled Nurses trained pre-1990 and only 11% of ENs trained in the 1990–2010 period.

The Enrolled Nurse workforce is also ageing, with a median age of 57 years; of respondents to the NZNO survey referenced above, almost half of the respondents were aged 55-64 years of age with two-thirds planning to retire within the next 10 years. While an ageing workforce is an issue for the whole nursing profession, the ten-year hiatus in education means that the EN workforce lacks a large number of experienced later-career nurses who will keep nursing as older nurses retire. Therefore, greater investment will be needed if numbers are to increase significantly to replace the Enrolled Nurses who are exiting the profession.

Figure 1: Number of Enrolled Nurses with APCs, Registration Year 2011 to 2022

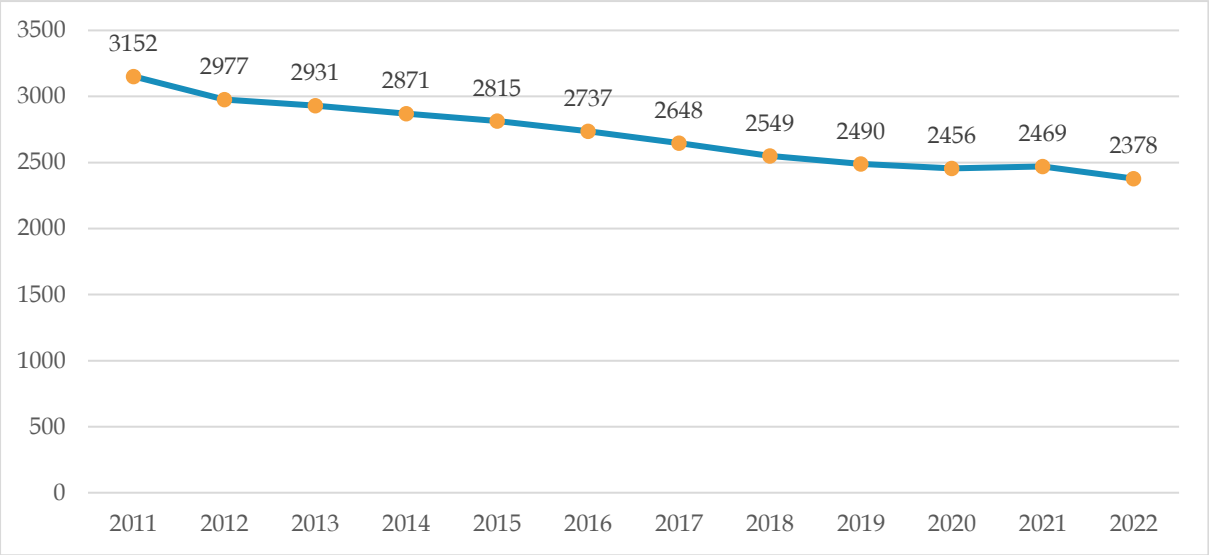
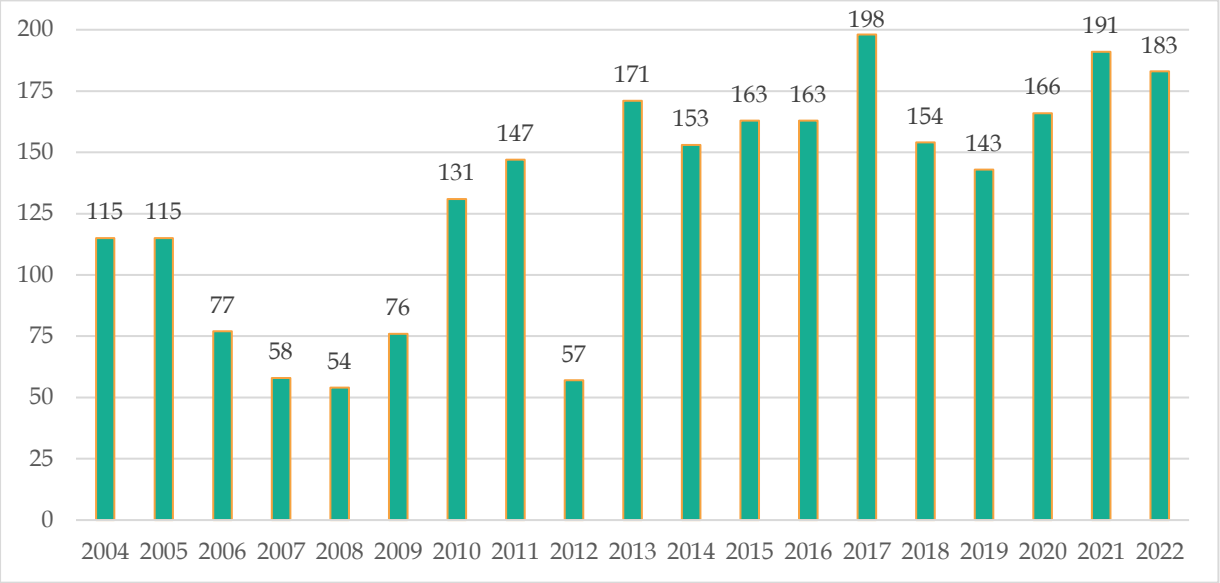


Figure 2: New Enrolled Nurses added to the Register, Registration Year 2004 to 2022[7]



Lack of clarity and consistency with current scope of practice and role

Expectations of Enrolled Nurses, their role, and the level to which they are employed vary between health settings and employers. Feedback and discussions in the Design Group have identified a number of potential reasons for this, but a large factor lies in different interpretations of the current scope. The introduction of a broader and more enabling scope will require strategies to mitigate continued inconsistencies and lack of role clarity. These strategies will need to recognise that current different practises are influenced not only by the Council's formal regulatory settings, but also by expectations of registered nurses, employer policies, and pressures of the clinical environment.

There is a view that a more generic scope is required that would clearly enable Enrolled Nurses to work in any setting commensurate with their skills and knowledge (NCNZ, 2009). This broader scope would enable Enrolled Nurses to work collaboratively with the wider healthcare team without the burden that some current interpretations of the 'direction and delegation' requirement create. It would also better recognise the position of an Enrolled Nurse as an accountable and responsible health professional in their own right.

Limited professional development opportunities

Enrolled Nurses have variable access to professional development opportunities and education that includes a career path in enrolled nursing. Notably, there are concerns that the primary – or only – pathway for Enrolled Nurses to advance their practise is to transition into the Registered Nurse scope. While such a pathway is an important part of ensuring a sustainable nursing workforce, it is also important that enrolled nursing is

[7] Including Nurse Assistants when that title was active. This graph includes both domestic and internationally-qualified nurses. Prior to 2004, and following enrolled nurse education ceasing in the 1990s, the only new enrolled nurses joining the Register were qualified overseas.

treated as a scope with integrity and career options in its own right. Enrolled nursing must not be seen as just a 'stepping stone' to becoming a Registered Nurse.

Access to professional development is influenced by a combination of many things, including employer decisions. However, the Enrolled Nurse scope (and regulation in general) can encourage such access by clearly acknowledging the ability of Enrolled Nurses to undertake work such as leadership roles, and to expand their practice. A key element here will also be engagement with the education sector.[8]

Variability of employment

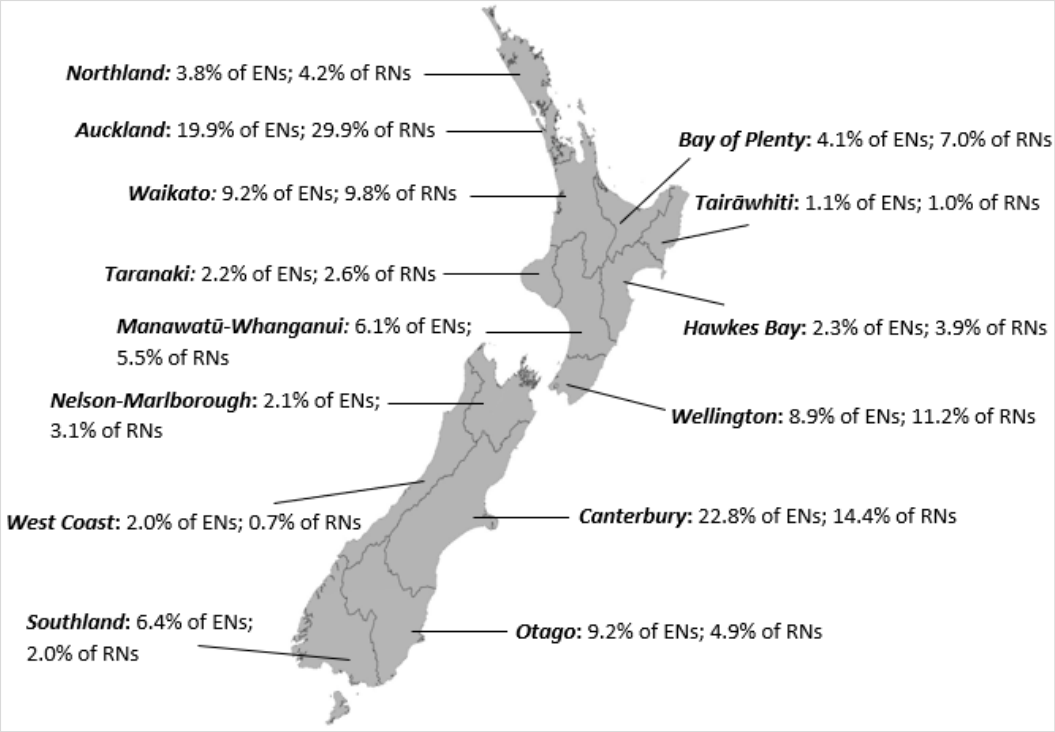
There is variation in the use of Enrolled Nurses across different parts and regions of our health and disability support system. The NZNO Enrolled Nurse survey found that 81% of respondents had difficulty applying for and moving into other areas of health care (with 12% reporting mental health and primary health care as more supportive fields of practice). Respondents stated that there was variable employment of Enrolled Nurses in a wide range of areas throughout DHBs; that was illustrated by the range of comments with 14% of respondents indicating that Enrolled Nurses were employed throughout their DHB, while 7% reported their DHB offered only restricted options for Enrolled Nurses. Nine percent commented that Enrolled Nurses jobs were not available at their employer, or at least not advertised (NZNO, 2019).

Mackenzie's research (2020) found in some regions of the country Enrolled Nurses have been integrated into the regional workforce and their role has flourished as a valued health professional. She claims that in some isolated regional centres, the Enrolled Nurse continues to be the backbone of the nursing workforce. The continued inclusion of the Enrolled Nurse role within the staffing matrix highlights the importance of the role within these regions.

Nursing Council data shows significant variation in the distribution of Enrolled Nurses across the country. For example, Figure 3 shows that the Enrolled Nurse workforce is more concentrated in South Island regions than Registered Nurses; 42% of ENs practise in the South Island, compared to 25% of RNs. There are also significant differences in patterns of employment and practice compared to the Registered Nurse workforce. These differences may stem from a variety of reasons, including the commitment and culture of employers, Senior Managers or connections between education programmes and their local health providers. However, it is important that the Enrolled Nurse scope supports the utilisation of these nurses across our health system.

[8] How the scope can support innovation in education delivery will be explored as part of the education competencies. For example, the University of Auckland is coordinating a model in Te Tai Tokerau that supports the development of the Māori and Pacific Enrolled Nurse workforce in primary and community settings (University of Auckland, 2021).

Figure 3: Regional distribution of Enrolled and Registered Nurse workforces at 31 March 2022[9]



Future workforce and models of care

Projected demand for Enrolled Nurses has not been fully quantified over the years as there has generally been a lack of attention to Enrolled Nurse workforce planning. This lack of information within the sector makes it difficult to make informed decisions and quantify the number of Enrolled Nurses required in our system. Ideally, there needs to be further analysis of models of care and skill mix that incorporate Enrolled Nurses. This issue links with others identified here, including employment variability, the potential for advanced practice, and the position of the non-regulated workforce.

The Te Aka Whai Ora and Te Whatu Ora workforce taskforce (Te Whatu Ora, 2022) has recently confirmed its work programme[10] to be delivered over the next two years. This will include the future vision and aspirations for the health workforce and the overall approach it will take (underpinned by Te Tiriti, Pae Ora, and the strategic direction of the Te Pae Tata Health Plan). The nursing group is already well established through the existing Nursing Pipeline Programme, and we understand this includes a focus on the review of the Enrolled Nursing scope, competency, and education standards to ensure they are fit for purpose.

Non-regulated workforce

The non-regulated kaiāwhina workforce is an important component of the health and disability support workforce. Substantial work has been done through the kaiāwhina

[9] Derived from Nursing Council workforce survey data. Nurses working across multiple regions, overseas, or not stating a region have not been included this analysis.

[10] https://www.tewhatuora.govt.nz/whats-happening/work-underway/taskforces/#workforce-taskforce

taskforce (Kaiāwhina Workforce Taskforce, 2022) to ensure wider integration into the health and disability workforce, including standardisation of training and qualifications.[11] With this extension of practice, however, there are concerns about the relationship between non-regulated health workers and Enrolled Nurses (NZNO, 2019). This is particularly the case as the kaiāwhina workforce increasingly provide more advanced personal care or begin undertaking what are usually viewed as nursing care interventions.

MacKenzie (2020) suggests an increase of non-regulated workers could be attributed to historical changes, as the attempted phasing out of the Enrolled Nurse was associated with other roles being utilised to fill this gap. She argues that Enrolled Nurses have a specific skill set which has been eroded over time with the introduction of non-regulated healthcare workers. While non-regulated staff may be able to carry out tasks and skills, their lack of clinical understanding and decision making potentially poses a risk to health delivery and public safety. Some employers have established clear delineation between regulated and non-regulated staff, reducing the risk of this occurring, where other employers may simply utilise non-regulated staff for these traditional nursing tasks (2020).

The Nursing Council's regulatory functions and responsibilities, by definition, do not extend to the non-regulated health and disability support workforce. However, it is important that the establishment of a new scope statement (and associated nursing competencies) recognises the increased use of healthcare assistants and other support workers within the sector. This includes establishing a distinct sphere of activity for Enrolled Nurses in comparison to kaiāwhina roles and exploring the working relationships between these two groups.

Pēhea nei te āhua o te ohu Tapuhi kua Whakauru? - What does the Enrolled Nurse workforce look like?

The Enrolled Nurse workforce is generally older, more experienced, has a smaller percentage of male nurses, and includes fewer internationally-qualified nurses (IQNs) than the nursing workforce as whole. Due in part to the comparatively small number of IQNs, the workforce contains higher percentages of nurses who identify as Māori, Pacific, and European/ Pākehā.

At 31 March 2022, there were 2,378 Enrolled Nurses with APCs. This represents just under 4% of the nursing workforce. Of these:

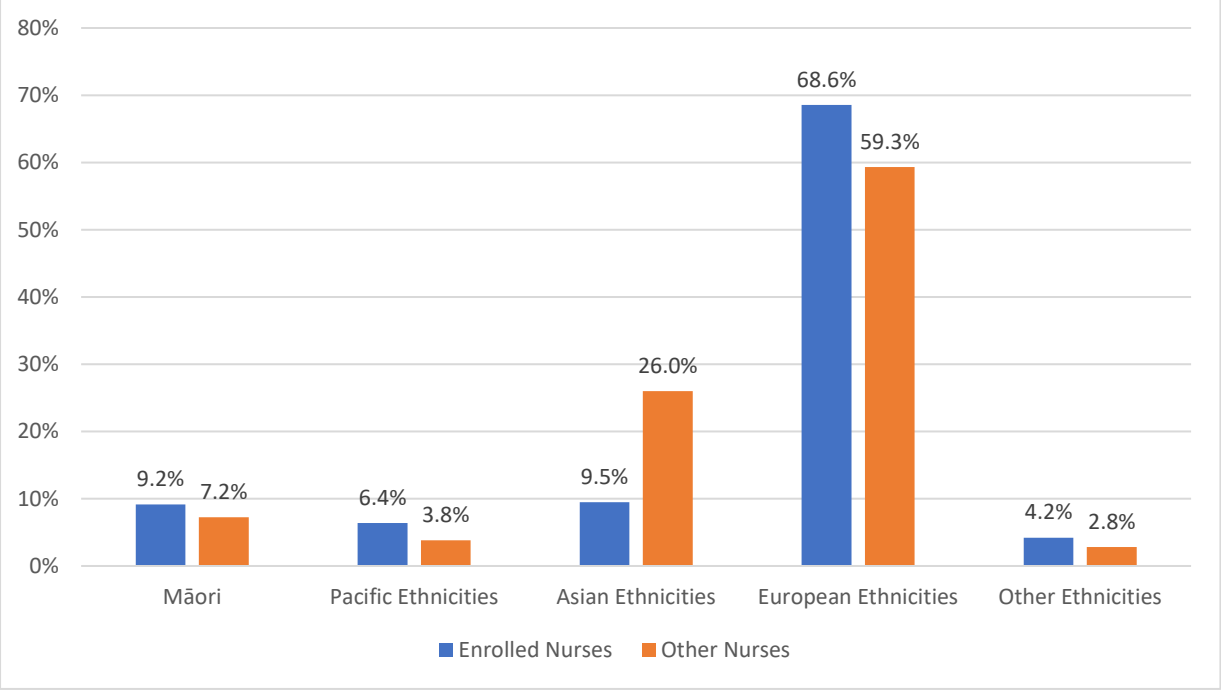
- 92% were women, compared to 87% of Registered Nurses (RNs) and Nurse Practitioners (NPs)
- 62% were aged 50 years or older, compared to 39% of RNs and NPs

[11] https://kaiawhinaplan.org.nz/

- As shown in Figure 4, Enrolled Nurses identifying with Asian ethnic groups made up a significantly smaller percentage of the workforce than in other parts of the profession
- 10% were internationally-qualified nurses, compared to 32% of Registered Nurses and Nurse Practitioners
- 25% worked in aged care and 15% worked in assessment and rehabilitation. Other common practice areas were medical (9%), inpatient mental health (8%), and surgical (8%)
- 46% were employed in (former) District Health Boards, 23% in rest homes and residential care, and 14% in primary health care settings
- 44% had been educated before 1990, while 45% graduated after 2010. In keeping with this, 29% had been on the Register for five years or less, 16% for six to 10 years, 8% for 11 to 20, 2% for 21 to 30, and 46% for more than 30 years.

The age and experience structure of the workforce is a particularly distinctive feature of enrolled nursing. Due to the reduction and subsequent cessation of training from the early 1990s until the early 2000s, no new Enrolled Nurses entered the workforce during that decade. As a result, while the number of non-enrolled nurses with APCs increased by 49% from 2002 to 2022, the number of ENs fell by 56%. Although recent years have seen a notable increase in the Enrolled Nurse pipeline, Enrolled Nurses are significantly older than those in other nursing roles, with a median age of 57 years compared to 43 years for non-EN members of the profession.

Figure 4: Ethnicities of Enrolled Nurses with APCs at 31 March 2022[12]



[12] Respondents have been included in all ethnic groups with which they identify. Percentages are of total nurses, including those who did not state an ethnicity.

Ō Mātou Marohi – Our Proposals

Ō mātou whakaritenga, hātepe hoki –Our current requirements and process

Scope of Practice

The Council must specify scopes of practice. Section 11 of the Health Practitioners Competence Assurance Act 2003 states that we must describe the 'contents' of the profession that we regulate in terms of one or more scopes of practice. The Act is highly enabling in terms of how a regulator can define a scope:

> A scope of practice may be described in any way the authority thinks fit, including without limitation, in any one or more of the following ways:
>
> > [a] by reference to a name or form of words that is commonly understood by persons who work in the health sector
> >
> > [b] by reference to an area of science or learning
> >
> > [c] by reference to tasks commonly performed
> >
> > [d] by reference to illnesses or conditions to be diagnosed, treated or managed
>
> (HPCA, s. 11(2))

Internationally and in research literature, there are a wide variety of approaches to defining scopes of practice. An overview of these with particular reference to scopes of Enrolled Nurse practice can be found later in this document. Generally, however, a scope of practice is a broad description of the role associated with the educational preparation and level of the nurse. It is provided as a foundation for establishing standards of nursing practice, nursing education, nursing roles and responsibilities, and is defined within the legislative and regulatory framework of the country in which the nurse works (ICN, 2013).

Leslie et al (2021) report recent reforms across international jurisdictions emphasise the realities of modern healthcare provision and practice, including a need for mobility and team-based care. As a scope of practice inherently entrenches a narrower range of controlled activities (what is 'in scope' and 'out of scope') for practitioners, determining scopes in this environment can be complex and multifaceted.

Te Tauāki Hōkaitanga Hou e Whakaarotia ana - The Proposed New Scope Statement

The Design Group has developed the following new Enrolled Nurse scope statement. The proposed changes to the Enrolled Nurse Scope of Practice reflect the Council's desire to modernise the current scope statement by:

- clearly recognising commitment to and the position of Te Tiriti o Waitangi, within the Kawa Whakaruruhau framework for cultural safety
- reflecting greater breadth of practice in the scope statement
- removing specific prescription of tasks and
- better reflecting the appropriate position of Enrolled Nurses with respect to Registered Nurses and other practitioners.

As well as presenting the scope statement for consultation, there are specific focus areas and issues on which we would like dedicated feedback. These are discussed further in this section.

In this section we have also identified a set of key consultation questions that will help the Design Group understand views on the proposed statement. A combined list of these questions can be found in Appendix Three. You may find these helpful if you intend to provide a written submission during this consultation.

Proposed Enrolled Nurse Scope of Practice Statement

The practice of Enrolled Nursing in Aotearoa New Zealand reflects concepts, knowledge, and world views of both partners to Te Tiriti o Waitangi. Enrolled Nurses are committed to upholding and enacting Te Tiriti o Waitangi ngā mātāpono – or principles, based within the Kawa Whakaruruhau framework for cultural safety, with respect to equity, inclusion, and diversity.

The Enrolled Nurse works in partnership and collaboration with the health consumer, their whānau, communities and the wider health care team to deliver equitable person/whānau/whakapapa centred general nursing care, advocacy, and health promotion across the life span in all healthcare settings. Their practice is informed by their level of educational preparation and practice experience, and may include a leadership or coordination role within the healthcare team.

Enrolled Nurses manage the health status of the health consumer through nursing assessments, care planning, implementation, and evaluation of care, and in some settings seeking guidance from a Registered Nurse or other registered health practitioners.* They are accountable and responsible for their nursing practice ensuring all health services they provide are consistent with their education and assessed competence, legislative requirements, and are supported by appropriate standards.

*A health practitioner is a person who is registered under the Health Practitioners Competence Assurance Act 2003 – for example, a midwife, medical practitioner, or occupational therapist.

Key Consultation Questions

1. Overall, do you support the proposed Enrolled Nurse Statement?
2. What are the strengths or potential benefits of the proposed scope statement?
3. What are the weaknesses or potential risks of the proposed scope statement?

Te Tiriti o Waitangi

The new scope statement is intended to ensure the position and importance of Te Tiriti o Waitangi, cultural safety, and kawa whakaruruhau in the practice of enrolled nursing. The current Enrolled Nurse scope does not refer to Te Tiriti o Waitangi, Kawa Whakaruruhau or cultural safety. The Design Group firmly believes the scope must acknowledge this clearly to ensure Enrolled Nurses are supported to deliver care that is culturally safe and responsive to the rights and needs of tangata whenua and does not entrench existing health inequities.

The scope statement is not intended to provide a detailed articulation of how enrolled nursing reflects and addresses Te Tiriti and Kawa Whakaruruhau. It sets out a high-level statement of the relationship between enrolled nursing and these key elements of nursing practice in Aotearoa New Zealand. New Enrolled Nurse competencies and education standards, to be developed in the next phase of the review, will reflect this statement and provide more specific and practice-oriented descriptions of what is required of enrolled nursing in these respects.[13]

Kawa Whakaruruhau Framework for Cultural Safety

Although often used generally to encompass cultural safety in Aotearoa New Zealand, Kawa Whakaruruhau refers to a specific concept or approach.[14] The Design Group acknowledges the mana and wehi of ngā wāhine Māori, especially Dr Irihapeti Ramsden, who led, persisted, and worked tirelessly in the development of Kawa Whakaruruhau in the 1980s and 1990s.

Kawa Whakaruruhau remains one of the most significant pieces produced and published in the Aotearoa New Zealand health sector. It critiques the impact of western

[13] The Scope of Practice content will also be supported by the requirements, expectations, and guidance included in other Council documents, including the Code of Conduct.
[14] "See, for example, Ramsden (1990; 2015), Roberts (2019)."

(or colonial)-centred nursing practices that have dominated the health sector since colonisation in Aotearoa New Zealand.

Cultural safety is a necessary response to the painful experiences of Māori communities. The need to change access to and delivery of equitable health care is based on the premise of 'by Māori for Māori'. Te Tiriti o Waitangi guarantees the protection of Māori intellectual property and cultural integrity as taonga. The principles of cultural safety are broadly based and applied. Thus, the principles are not only limited to those who identify as Māori, but also peoples from all communities.

Kawa means 'protocol' or 'rules', and Whakaruruhau means to be 'sheltered' or 'embraced with protection'. When we acknowledge the meaning behind these terms as possessing their own mauri as 'living' and evolving things, then we can recognise the nature of Kawa Whakaruruhau as an ongoing process. Deriving from a holistic perspective, it is imperative to recognise the relationality of Kawa Whakaruruhau. In western culture hierarchies are common, meaning that society, its systems, and institutions are organised according to a specific ranking system from the 'highest to lowest ranking'.

In contrast, Te Ao Māori challenges this view by seeing things and individuals as being 'in relation to'. Relationships, self-identity, and concepts exist in relation to others, and without this relationality it is difficult to clearly understand the true purpose and meaning of things. The importance of relationality in this context is that as a cultural framework, Kawa Whakaruruhau is to be framed and understood in the same manner. When we understand that Kawa Whakaruruhau must exist and operate not in isolation, but in relation to concepts of diversity, inclusiveness, and equity then we are able to have a greater understanding of how we need to conduct ourselves throughout this journey.

Kawa Whakaruruhau requires a commitment to purposeful collaboration between all individuals and groups involved. Communication and acknowledging the importance of providing each other with the necessary space to voice one's own concerns and ideas are also essential. In doing so, we can take real and practical steps towards re-enhancing the mana of Kawa Whakaruruhau as a taonga that needs to be protected by those who engage with it. We recognise Kawa Whakaruruhau as a taonga which has been gifted to the nursing profession as a tool to add to our own kete of knowledge.

We are proposing that the mana of the Kawa Whakaruruhau framework for cultural safety fundamentally needs to be central to the Enrolled Nurse Scope Statement.

Key Consultation Questions

4. How well does the proposed Scope Statement reflect the appropriate position of Te Tiriti o Waitangi within the practice of enrolled nursing?

5. How well does the proposed Scope Statement support and enable equitable access, experience, and outcomes for Māori?

Te Wehewehe i ngā hōkaitanga o te Wainga Tapuhi - Differentiating Nursing Scopes of Practice

The new scope is intended to describe Enrolled Nursing practice more broadly, reflecting a breadth of practice across the life span while recognising the Enrolled Nurse level of educational preparation and practice experience. There is extensive discussion in the international literature on lack of clarity and confusion with the Enrolled Nurse Scope of Practice, particularly regarding distinction with the Registered Nurse Scope of Practice, as discussed later in this document. However, while there are areas of overlap between nursing scopes, there are differences that are based on entry-level and ongoing nursing knowledge and competencies (RPNAO, 2018).

This proposed change is intended to enable a more optimal scope of practice, recognising the Enrolled Nurse works in partnership and collaboration with the health consumer, their whānau, communities, and the wider healthcare team that may include a leadership or coordination role within the team, taking into account the differences in role expectations.

Roots & Gibson (2016) claim that when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality care and access to health care, this requires elements of collaboration that include respect, trust, shared decision-making, and partnerships. Jacob et al (2017) recommend consideration of the differences in education and experience when allocating patients for nursing care and determining skill mix within the healthcare team. It requires the Enrolled Nurse, Registered Nurse, and all other members of the healthcare team to work in partnership with the person receiving care. Successful collaboration depends on communication, consultation, and joint decision-making within a risk management framework, to enable appropriate referral and to ensure effective, efficient, and safe health care (NMBA, 2007).

Key Consultation Questions

6. How well does the proposed Scope Statement capture the distinctive features of enrolled nursing practice?

7. How well does the proposed Scope Statement appropriately distinguish enrolled nursing from other types of nursing practice?

8. How well does the proposed Scope statement appropriately distinguish enrolled nursing from the practice of other members of the health care team, including both regulated and non-regulated healthcare workers?

Ahunga me te tāpae – Direction and Delegation

The Design Group is proposing to remove language around the Registered Nurse 'directing and delegating' to the Enrolled Nurse. The proposed statement instead focuses on an Enrolled Nurse establishing a relationship with the Registered Nurse and wider healthcare team. The Council recognises that additional guidance on this relationship will likely need to be developed with the sector if there are changes to this requirement.

One of the distinguishing features of the current Enrolled and Registered Nurse scopes of practice and their respective competencies, is that the direction and delegation relationship is a professional competency required by all nurses who are registered with the Nursing Council of New Zealand (NCNZ, 2011).[15]

The direction and delegation terminology in the current Enrolled Nurse Scope Statement has long been a contentious issue. Mackenzie (2020,p.109), proposing a way forward, claims:

> The debate about Enrolled Nurses working 'under the direction and delegation' of a Registered Nurse or other health professional continues. The Enrolled Nurse is a health professional in their own right and makes a valuable contribution to health care delivery and supports the whole health team. Would the term 'in collaboration with the Registered Nurse or other health professionals' provide clarity for the Enrolled Nurse? I assert that if Enrolled Nurses were able to work at the top of their scope of practice consistently, then this confusion would be reduced. (p. 109)

The boxed text overleaf indicates that Nurse regulators from countries with comparable health systems to Aotearoa New Zealand have differing requirements for Registered Nurse responsibility, direction and delegation, or direct supervision. Hughes (2017) states that the term "direction and delegation" is used only in New Zealand. However, literature from Europe, the United States, the Nordic countries, Australia, and Korea notes the tension and barriers associated with delegation interactions. An overview of the context for direction and delegation, focusing on the domestic context, can be found later in this document and in the timeline on the consultation page for this Review.

[15] The Registered Nurse Scope Statement states that RNs "delegate to and direct Enrolled Nurses" (among other groups of health workers), and RN Competency 1.3 refers to "directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others".

International Descriptions of the 'Enrolled' and Registered Nurse relationship

Nursing and Midwifery Board Australia (Enrolled Nurse)

The Enrolled Nurse (EN) works with the Registered Nurse (RN) as part of the healthcare team and demonstrates competence in the provision of person-centred care. Core practice generally requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to patient safety. (Source: Enrolled Nurse standards for practice)

The Nursing and Midwifery Council UK (Nursing Associate)

Health care is becoming increasingly demanding and we know that Registered Nurses often need to focus today on more complex clinical cases. Nursing Associates support Registered Nurses by allowing nurses to focus on such cases. At the same time, Nursing Associates have a standalone role in their own right which provides a progression route into graduate-level nursing. Increasing integration of health and social care services will require Nursing Associates to play a proactive role in multidisciplinary teams. (Source: NMCUK Nursing Associates leaflet)

U.S.A. Nursing Licensure (Practical or Vocational Nurse)

The U.S.A. does not have a single national nursing regulator with each state implementing its own requirements. An individual Practical/Vocational Nurse (LPN/VN) licensed by a state Board of nursing to provide patient care normally works under the supervision of a Registered Nurse, Advanced Practice Registered Nurse or physician. The scope of practice for LPNs varies from state to state, sometimes significantly. In many states, there are non-specific guidelines as to what the LPN can and cannot do, leaving much to the employer's interpretation. The essential difference between the LPN and the RN is not related to task. (Source: https://www.ncsbn.org/index.page)

Canadian Nursing Licensure (Registered or Licensed Practical Nurse)

Canada does not have a single national nursing regulator. Each province and territory of Canada has its nursing regulatory body for Registered Practical Nurse (RPN)/licenced Practical Nurse (LPN). RPNs work collaboratively with other healthcare team members, including RNs, when caring for less stable clients at higher risk for unpredictable health outcomes. Through a combination of further education and experience, LPNs are able to care for clients who have more complex care needs. They work collaboratively with clients, families, groups, communities, and other members of the healthcare team to support safe, competent, and ethical care. LPNs work in hospitals, residential care facilities, home and community care, clinics, schools, occupational/industrial health, correctional facilities, complex care, and palliative care. (Source: https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada)

Singapore Nursing Board (Enrolled Nurse)

The scope of practice of an Enrolled Nurse (EN) is the range of activities and clinical nursing decisions that the EN is educated and competent to perform. The EN is authorised to carry out nursing assignments under delegation, supervision or direction of a Registered Nurse, Advanced Practice Nurse, and/or medical doctor. The scope of practice of the EN is a dependent and directed scope of practice. (Source: https://www.healthprofessionals.gov.sg/snb)

Key Consultation Questions

9. How well would the proposed Scope Statement support an appropriately safe and respectful relationship between the Enrolled Nurse and Registered Nurse (or other health professional) ?

10. Do you believe there are any specific risks in the Design Group's approach to or wording of the appropriate relationships between an Enrolled Nurse and other health practitioners?

11. Do you support the removal of "direction and delegation" terminology from the Enrolled Nurse Scope Statement?

Taitara Tapuhi Whakauru - Enrolled Nurse Title

The Design Group has had an indepth kōrero on the Enrolled Nurse title. The Group acknowledges both the historical trauma for Māori related to the connotations of a second- level scope of nursing, and the hurt and distress for Enrolled Nurses impacted by legislative and structural changes to the scope and title over time. This is discussed more fully later in this document.

Titles are used to inform the public of a health care practitioners 's scope of practice and professional identity. However, these titles vary by country and may vary within the same country. Where the titles are the same, the nurse's role and responsibilities may differ by country or jurisdiction. Commonly, there are four categories of titles for nurses outlined by the World Health Organization: first level or RN, second level or Licensed/Enrolled/Practical Nurse, specialty midwife, and no professional level (RPNAO, 2018).

We are seeking the Profession's view on the Enrolled Nurse title through this consultation. The Nursing Council is not at this point proposing to change the name of the Enrolled Nurse scope. However, we are seeking the profession's views on the appropriateness of the name, and how this part of the nursing profession might be described in the future. This will be shared with the profession to support ongoing discussions about the title and future recommendations to the Council.

Key Consultation Questions

12. Do you have any comments on the title of "Enrolled Nurse"?

13. Given that there are many titles around the world for this form of nursing, do you have any comments on other potential titles?

Kaupapa Atu – Other Issues

The questions outlined above cover some of the key issues that the Design Group has concentrated on in developing the draft scope statement. These focus largely on the effect of a new Scope Statement for enrolled nurses and their practice.

However, changing a scope of practice can have implications for systems, processes, and groups outside of the professionals it is intended to describe. These include effects for other scopes of practice – both inside and outside nursing.

We are also interested to hear the sector's views on how the proposed Scope Statement may intersect with other dimensions of the health and disability support system. We are especially interested in hearing the voice and perspective of those who use that system: patients, consumers, clients, and their advocates.

Key Consultation Questions

14. Are there any other implications of, or issues with, changing the Enrolled Nurse Scope Statement?

Pārongo Ake – Further Information

As noted several times in this document, the practice, description, and strategic positioning enrolled nursing is associated with several complex debates and issues. This section discusses in more depth a selection of these issues that are particularly relevant to consultation on the proposed Scope Statement.

Tautuhi i tētahi Whānuitanga o te Wainga – Defining a Scope of Practice

In discussing scopes of practice, the RPNAO (2014) notes that:

> Although frequently used, the phrase scope of practice is not well understood, with most nurses describing scope of practice in terms of tasks or what they are allowed to do in their practice settings … from a regulatory perspective, scope of practice is a broad description of what the profession is educated in and authorised to do and not just about functions and tasks." (p.26)

The RPNAO (2018) cites the definition from Canada's Health Authorities Health Professions Act Regulations Review Committee: "Scope of practice is defined as health care professionals optimising the full range of their roles, responsibilities, and functions that they are educated, competent and authorised to perform" (p. 24). However, internationally there are many ways that scopes of practice for nurses are defined that include differing levels of contribution to care planning, assessment, implementation, and evaluation. Requirements for delegation and supervision also vary greatly.

Leslie et al (2021) argues determining scope of practice is complex and multifaceted with recent reforms across international jurisdictions emphasising the realities of modern health care provision and practice that requires a need for mobility and team-based care. The way in which the scope of nursing practice is defined, outlines the very parameters and boundaries within which nurses practice. It is vital that the profession is able to clearly articulate its practice parameters in order to ensure that nursing practice can accommodate and respond to the current needs of society, otherwise, there is a risk that practice may become restricted and constrained, thereby leaving needs unmet or care delivery fragmented (ICN, 2010).

Scopes of practice will continue to evolve over time to meet the changing needs of patient populations and the health care system. Increased clarity regarding roles and responsibilities is essential in order to support decision making and the optimal utilisation of nursing resources.

There are two main approaches to describing a scope of practice that are either permissive or restrictive (NNNET, 2005; ICN 2010). Permissive (or client/patient-focused) approaches are where client needs are considered paramount. A restrictive approach describes and impose limitations on aspects of practice, as they define and protect professional boundaries. This approach provides clarity and protection for nurses, employers and the public by defining the boundaries and limitations of practice.

Restrictive approaches frequently list those activities that may only be performed by nurses or which nurses must be credentialed to perform. Such lists of approved activities risk becoming out of touch with contemporary practice very quickly. In addition, this specificity raises the risk that the activities will be viewed as the limit of a nurse's capability and therefore opportunities for expansion of practice are lost. For this reason, nurses often oppose any attempts to define the limits of their work especially in the current climate of rapid change when new needs and situations arise. A permissive approach is less prescriptive and does not define boundaries around scope of practice. This approach transfers the responsibility and accountability for professional practice from the regulatory body to the individual practitioner and the employer, and thus facilitates the evolution of practice (NNNET, 2005).

Seago et al (2004) recognise that practice scopes vary in the way they restrict or expand the role including the amount of detail used to describe them. Some jurisdictions limit the level of autonomy and flexibility as well as provide a different level of specificity to the parameters of the RPN/EN role. Seago et al found that restrictive scopes of practice had a significant negative effect on hospital and long-term-care facility demand for RPN/ENs as they found that hospital employers perceived restrictive scopes of practice as a limiting factor in hiring and using RPN/ENs.

Birks et al (2016), in a literature review exploring the Australian Registered Nurse scope of practice, found 'scope' to be an elusive concept that was contextual, influenced by boundaries and could extend into advanced practice. They considered the professional, legal and ethical significance of scope of practice as well as the legislative and contextual influences on, and challenges to, defining scope of practice at both a professional and individual level. Mackenzie's research (2020) has identified ongoing confusion regarding the understanding of the contribution from Enrolled Nurses within today's health workforce. She argued that Enrolled Nurses understand and can articulate their scope of practice, however even with changes to their scope, there continues to be significant regional and employer variances with their role.

Newsome et al (2006) claim there is continued debate about whether there should be specific lists of tasks and guidelines to direct the use of RPN/ENs. Further, the RPNAO (2014) argues the reduction of scope of practice to a description of tasks or functions is problematic in that it contributes to role confusion due to the significant degree of overlapping patient care-related functions performed by different categories of nurses. More importantly, this reduction of scope of practice unintentionally devalues the depth and breadth of the knowledge required by nurses. They argue the focus should change from tasks to focusing on competencies to reflect the complexity of knowledge, judgement, and critical thinking required of nurses to support clinical decision making.

The use of decision-making frameworks as opposed to lists of skills has evolved as a favoured approach to scope of practice decisions. The WHO (2002, p.16) has stated, "Scope of practice definitions and educational standards should give broad guidance to practitioners and employers through general statements of nursing function." They argue that that broad guidance should be the goal rather than detailed prescription, as guiding principles are much safer than rigid rules (RPNAO, 2018).

Te Wehewehe i ngā Hōkaitanga o te Wainga Tapuhi - Differentiating Nursing Scopes of Practice

Across the world, confusion about the scope of practice and roles of the Registered Practical Nurse (RPN) and Enrolled Nurse (EN) is longstanding. Subedar (2006), suggests, that while the scope of practice for an Enrolled Nurse is restrictive and limiting, in reality Enrolled Nurses are expected to assume responsibilities that are far beyond their scope of practice in most health care settings.

Some of the confusion with the Enrolled Nurse scope of practice relates to a lack of a clear distinction of practice for the different categories of nurses, a lack of clearly stated broad parameters and a lack of definition of the minimum competencies required for the scope of practice for each category of nurses (RPNAO, 2018). Globally, the introduction of new roles and the expansion of existing roles has contributed to the blurring of perceptions of what constitutes a nurse, what different categories of nurses can do, and the effects on patient outcomes. When applied to the confusion regarding the RPN/EN and RN roles, this may result in either underutilisation (e.g., limited or restricted scope of practice) or overutilisation (e.g., inappropriate use beyond authorised scope of practice) of the RPN/EN role. RPN/ENs more focused scope of practice allows them to practice autonomously in the care of less complex patients, and in collaboration with Registered Nurses in the care of patients with more complex needs and less predictable outcomes (RPNAO, 2018).

In Aotearoa New Zealand both the Registered Nurse and the Enrolled Nurse are required to work within their designated Scope of Practice. However, the current direction and delegation terminology in the Enrolled Nurse scope (see below) places additional requirements on the Registered Nurse Enrolled Nurses are required to practice under the direction and delegation of a Registered Nurse or Nurse Practitioner, and in acute settings must work in a team with a Registered Nurse who is responsible for directing and delegating nursing interventions.

This means that while both Registered Nurses and Enrolled Nurses must accept responsibility for their actions and decision making within their scope of practice, Registered Nurses are *also* required to understand the Enrolled Nurse scope of practice, and ensure that the Enrolled Nurse has the knowledge and skills to undertake delegated nursing activities. Enrolled Nurses are only responsible for ensuring they themselves have the knowledge and skills before accepting responsibility delegated to them. This is the case regardless of the experience and seniority of the nurses involved, although the Enrolled Nurse role and level of direction will vary according to the health care setting, context of care and the health status of the health consumer (NCNZ, 2011).

In a review of educational preparation between registered and enrolled programmes in Australia, Jacob et al (2014) identified common areas included teaching and assessment methods, core theoretical units and general nursing skills. They suggest these findings further add to confusion regarding Registered and Enrolled Nurses in Australia for employers and other major stakeholders. These recent changes to educational preparation and resulting scope of practice for Enrolled Nurses have resulted in increased confusion between roles and expectations of the different levels.

In a further study, Jacob et al (2017) argue defining nursing roles can be challenging, with studies from many countries identifying role confusion and overlap as issues with employing two levels of nurse. Recent changes to increase the educational level of Enrolled Nurses have resulted in increasing similarities in skills and knowledge being taught compared to degree-prepared Registered Nurses, causing role ambiguity and confusion between the two levels of nurse. Levett- Jones (2012) suggests it does not require the Enrolled Nurse to demonstrate a theoretical understanding of the formal clinical reasoning cycle rather the use of the nursing process (assess, plan, implement and evaluate), and applying problem solving, and critical thinking and analytical skills as described in the *Standards for practice: Enrolled nurses* (NMBA, 2016), would reflect the expectations of reasoned clinical thinking.

Jacob et al (2017) suggest despite similarities in graduate role expectations, differences remain in the expected level of practice with graduate Registered Nurses expected to be prepared to care for patients of higher acuity and undertake higher levels of responsibility than graduate Enrolled Nurses. They recommend Nurse Managers need to take into account the differences in educational preparation and role expectations when allocating patients for nursing care and determining skill mix for patient care (2017).

The United Kingdom has recently reintroduced a Nursing Associate who is a member of the nursing team who provides care for people who use health and care services. This role is only being used and regulated in England at present. The findings of poor care and increased mortality rates at the Mid Staffordshire NHS Foundation Trust resulted in a large public inquiry that was completed in 2012 with the findings from the UK inquiry providing useful learning for nurses, and the wider health sector in New Zealand (NZNO, 2013). Of note, poor skill mix with a lack of Registered Nurses was highlighted as a concern with the use of inexperienced staff, casual staff and caregivers to replace experienced staff adding to the problem.

The introduction of the Nurse Associate is intended to address a skills gap between health and care assistants and registered nurses. It's also a stand-alone role in its own right, which provides a progression route into graduate level nursing.[16] Nursing Associates are trained to work with people of all ages and in a variety of settings. It's intended that this new role will support Registered Nurses by enabling them to focus on more complex clinical duties. While Nursing Associates contribute to most aspects of care, including delivery and monitoring, Registered Nurses take the lead on assessment, planning and evaluation, including managing and coordinating care with full contribution from the Nursing Associate within the integrated care team. The Nursing and Midwifery Council highlights the main differences between the two roles in the following graphic.[17]

[16] https://www.nmc.org.uk/about-us/our-role/who-we-regulate/nursing-associates/
[17] https://www.nmc.org.uk/news/news-and-updates/blog-whats-a-nursing-associate/

Difference between Nursing Associates and Registered Nurses (Nursing & Midwifery Council – United Kingdom)	
Nursing Associate	**Registered Nurse**
Be an accountable professional	Be an accountable professional
Promoting health and preventing ill health	Promoting health and preventing ill health
Provide and monitor care	Provide and evaluate care
Working in teams	Leading and managing nursing care and working in teams
Improving safety and quality of care	Improving safety and quality of care
Contributing to integrated care	Coordinating care
	Assessing needs and planning care

In Ontario Canada, nursing is described as one profession with two categories; Registered Practical Nurse (RPN) and Registered Nurse (RN) who combine nursing skill, knowledge and judgment and are experts of nursing care at the bedside, however they recognise there are areas of overlap between the two categories, but equally there are differences that are based on entry-level and ongoing nursing knowledge and competencies. The RPN role enables Ontario's nursing leaders across the province to create an optimal staffing skill mix as the RPN's more focused scope of practice allows them to practice autonomously in the care of less complex patients, and in collaboration with RNs in the care of patients with more complex needs and less predictable outcomes (RPNAO, 2014; RPNAO, 2018).

Dumont et al (2008) report that some regions and provinces in Canada, make more use of a mix of skills in their nursing needs than others. For example, the mix of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Registered Psychiatric Nurses, unregulated aides and others who provide nursing services to patients varies by region. Baumann et al (2014) report the effectiveness of Ontario's nursing resource model, where nurses and clinical managers report that high-functioning collaborative nursing teams comprised of RPNs and RNs who trust and respect each other have a strong patient focus and provide excellent clinical care.

Changes to educational preparation and scope of practice, coupled with variations in nursing care delivery models, have resulted in varying degrees of role ambiguity and, in some instances, role conflict. In order to better understand the factors that contribute to role clarity or role confusion, the RPNAO (2014) reviewed the role of the RPN in Ontario's Health Care System. They noted given the significant degree of overlap between the RPN and RN roles, many nurses and nursing leaders are uncomfortable with the resulting ambiguity and would like a list of who can do what to cover all possible scenarios.

The RPNAO (2014) recommended further research and program evaluation studies to increase understanding in areas such as enablers and barriers to optimal scope of practice, the characteristics of high-functioning nursing teams, nursing models of care delivery, and the impact on outcomes at the patient, nurse, organization, profession, and system levels. They also recommended that organisations review their policies and

procedures to assess the impact on the ability of health care professionals to work to their full scope of practice, further adding that the consistent application of policies and procedures that align with regulated scopes of practice and research evidence can lead to role clarity, team cohesion and effective and efficient patient care.

Ahunga me te Tāpaetanga – Direction and Delegation

In 1983, amendments to the Nurses Act 1977 required that Enrolled Nurses were to practise under the direction and supervision of a Registered Nurse or Medical Practitioner. This Act provided for direction and supervision of Enrolled Nurses, Registered Obstetric Nurses and General Nurses regarding obstetric nursing. It did not define or explain delegation or supervision. The 1983 Amendment reaffirmed that Enrolled Nurses were required to work under the "direction and supervision" of a medical doctor or Registered Nurse, except in an emergency. Further, it stated that the failure of the Enrolled Nurse to follow the direction and supervision of registered nursing and medical staff would result in a fine (Hughes, 2017).

The Nurses Act also stated that: (all) nurses were "fully responsible and accountable for their actions" and stipulated that the title "nurse" referred to both Registered and Enrolled Nurses (cited in Hughes, 2017). According to Dixon (1996), even though the law changed, the tensions between registered nurses and enrolled nurses remained unabated. It was believed at the time, that the Nurses Act and amendments had little relevance to nurses in their daily lives until something went wrong; with the Amendment creating new problems for the profession, due to its lack of clarity and definition.

In 2002, a Health and Disability Commissioner report (HDC, 2002) had a substantial impact leading to significant changes to Enrolled Nurse practice. While the findings of care received by a patient in mental health services specifically referenced an Enrolled Nurse and a Registered Nurse, the Ministry of Health and the Nursing Council responded by writing to District Health Boards stating that the concerns were broader than mental health and in the Ministry's view the scope of practice significantly restricts the number of acute settings in which Enrolled Nurses were competent to practice. As a result, Enrolled Nurses ceased to be employed in many acute settings.

Further restrictions in the area of acute mental health occurred in 2007 following an investigation by the Health and Disability Commissioner into a patient's death on an acute medical ward (HDC, 2007) that found an Enrolled Nurse was practising outside their scope. In response, the Nursing Council established a working party to provide clarification on the employment of Nurse Assistants . In June 2008, the Nursing Council updated its advice to Registered Nurses and the sector by publishing *Direction and Delegation Guidelines* that replaced the 1999 *Direction and Supervision* paper (NCNZ, 2009).

Hughes (2017) describes changes to nursing supervision, direction and delegation roles and responsibilities over the years since Registration for nurses was introduced in 1901. Despite changes to its specific name, a supervision relationship has been a requirement for New Zealand nurses, and nursing support personnel throughout nursing history. In

the early 20th century, new categories of nursing personnel were introduced to meet the increasing demand for 'trained' and 'untrained' nurses. With the introduction of obstetric, maternity and district nurses, and nursing aides, community and enrolled nurses, reference to a nursing supervision role emerged. While a supervision relationship is not a new requirement for nurses, different terms have been used to describe it historically, such as "training," "teaching," "charged with", "instructing" and "supervising". Despite changes to its name, the meaning and intent of each of the terms point to some form of supervisory interaction (Hughes et al, 2018).

The Nurses Amendment Act (1983) did not define, describe or explain "direction" or "supervision". Hughes' (2017) exploration of the nursing supervisory role in New Zealand found there were expectations in one way or another that resulted in one group being "charged with" "instructing", or "supervising", and the other group receiving guidance to complete their duties through being taught, supervised or instructed. She argues, it remains unclear how practical guidance needed to support robust delegation should be provided, and how the delegation roles should be carried out.

The Nursing and Midwifery Board of Australia (2007) has identified a range of clinically-focused supervision between direct and indirect. Importantly, however, both parties (the delegator and the person accepting the delegation) must agree to the level of clinically focused supervision that will be provided. Direct supervision is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised. Indirect supervision is when the supervisor works in the same facility or organisation as the supervised person but does not constantly observe their activities but must be available for reasonable access. What is reasonable will depend on the context, the needs of the person receiving care, and the needs of the person who is being supervised.

With the reintroduction of the Enrolled nursing training programme in 2002, and a revised and broadened Enrolled Nurse scope of practice in 2010, new inexperienced Enrolled Nurses, as well as experienced Enrolled Nurses, were required to work under Registered Nurse direction and delegation. Many Registered Nurses had not worked with Enrolled Nurses, as New Zealand attempted to move to a Registered Nursing-only workforce over the years preceding 2010, and some of the Registered Nurses were themselves new and inexperienced (Hughes et al, 2018). Nurses in clinical workplace settings and nursing students knew they were required to direct and delegate, or be directed and delegated to, but struggled to know how to carry out this professional competency. Hughes et al (2018) suggest most Registered Nurses and Enrolled Nurses reported confusion surrounding the different Enrolled Nurses levels and how the resultant restrictions on an Enrolled Nurses scope of practice influenced what they could and could not do. The confusion was amplified because many Registered Nurses were confused about what an Enrolled Nurses could do in any one specific workplace, as this differed from one nursing workplace to another.

Meek (2009) in exploring the requirements for Direction and Delegation, noted the application of direction and supervision varied within different settings with much debate about levels of delegation and supervision, whether it be indirect or direct. Role confusion was identified many times as an issue for Enrolled Nurses. Gibson et al.

(2001) had previously reported that Registered Nurses have difficulty in asserting authority over Enrolled Nurses who are perceived as their colleagues. The development of competencies standards in Australia was the result of a national concern regarding variations in the role throughout Australia.

Hughes (2017) contends the specific term "direction and delegation" is unique to Aotearoa New Zealand, although literature related to nursing delegation from Europe, the United States, the Nordic countries, Australia and Korea identifies many barriers to successful delegation interactions. Hughes' research identified that one of the main barriers to safe and effective delegation interactions is that many Registered Nurses are confused about the Enrolled Nurse Scope of Practice, what Enrolled Nurses could, and could not do, with this impacting on their understanding of their direction and delegation roles and responsibilities. She suggests the implications of this are two-fold; Registered Nurses need access to national guidelines that provide clear information related to how to assess the Enrolled Nurse's skill and ability to either delegate or direct tasks, and in addition to clear national guidelines, Registered Nurses need access to workplace relevant area-specific information about what an Enrolled Nurse can and cannot do in their workplace (2017).

Additionally, Hughes' (2017) research explored nurses' perceptions about their everyday direction and delegation experiences, identifying that both Registered Nurses and Enrolled Nurses acknowledged that good delegation required a sophisticated range of communication strategies, and this way of communicating took time. They voiced a need to "work together," that it was better to work "alongside", not "under" the Registered Nurse, and that delegation was more than giving a set of instructions, it required taking the time needed for sensitive communication, robust assessments skills and leadership. Hughes argues that accountability is not well understood with a lack of understanding about the Enrolled Nurse Scope of Practice and the associated roles and responsibilities that contributes to the confusion about who is accountable, and when.

An increasing shortage of Registered Nurses has also increased the need to employ support staff to provide or assist nursing care, however it also means that there are insufficient registered nurses to direct and delegate to Enrolled Nurses or non-regulated health care workers. The Ministry of Health clinical workforce committee (2009) reported this created major issues in terms of quality and safety. The committee also highlighted the related issue that Registered Nurses may not have sufficient time for direction and delegation of a second level workforce. Some of the committee also questioned whether current Registered Nurses were prepared enough to supervise the second level nurse/care worker. Consideration was given to whether there needed to be a review of Registered Nurse undergraduate and new graduate training in relation to the Registered Nurse's delegation, supervision and leadership responsibilities, however leadership and delegation was also seen as an inherent part of the Registered Nurse role and therefore required no further training (MOH, 2009).

Roots and Gibson (2016) claim that while the Enrolled Nurse is expected to work under direct or indirect supervision by a Registered Nurse there is an integral relationship between them. They work collaboratively to develop and evaluate the plan of care for an individual or group with the Enrolled Nurse implementing this plan of care (within

their scope of practice), while the Registered Nurse maintains overall responsibility for the plan of care. Mackenzie (2020) suggests the Enrolled Nurse as a health professional makes a valuable contribution to health care delivery through supporting the whole health team. She proposes the notion 'in collaboration with the Registered Nurse or other health professionals' would provide more clarity for the Enrolled Nurse. Further, if Enrolled Nurses were able to work at the top of their scope of practice consistently, then this confusion would be reduced.

Ngā Ahunga Ao Whānui - International Approaches

In 2018, the Registered Practical Nurses Association of Ontario completed an international comparison of Registered Practical Nurse (RPN) and Enrolled Nurse (EN) utilisation to identify best practice (RPNAO, 2018). This is the most comprehensive recent review of international approaches to enrolled-type nursing.

This environmental scan identified considerable variability in RPN/EN roles across jurisdictions. For example, while Canada and the United States are neighbouring countries, entry to practice preparation of the RPN in the United States is based on one year of education in comparison to a two-year program in Ontario. Finland provided a contrasting perspective by describing a care model where RPNs are well integrated and comprise much of the nursing workforce. Overall, interviews conducted by the RPNAO across jurisdictions consistently indicated the need for RPN/ENs and the value of their role in the healthcare system. However, they also reported the underutilisation of the role and the restrictions on RPN/ENs' ability to work to their full scope. Even when the RPN/EN was well utilised and accepted as a full member of the nursing and healthcare team, there were inconsistencies in title, education, and scope of practice, making it impossible to generalise research findings from one jurisdiction to another (RPNAO, 2018).

Determining the appropriate scope of practice for Enrolled Nurses has been an ongoing issue in Australia, compounded by the existence of two regulated levels of nurse with overlapping roles and functions. The nursing profession comprises Australia's largest regulated health workforce, yet Birks et al (2016) argue that its practice boundaries are poorly understood and claim the ambiguity surrounding the practice scope of nurses limits the profession's ability to fully respond to Australia's current and emerging health system challenges. Significant changes to the scope of practice for Enrolled Nurses have occurred over the past decade, largely as a consequence of staff shortages and economic pressure, and these have resulted in increased role confusion and overlap between Enrolled and Registered Nurses.

Gibson and Heartfield (2005) explored Australian Enrolled Nurse experiences of practice drawing on findings from national research that examined the role, function, and competencies from a range of settings in all states and territories. Their findings indicated various influences on the Enrolled Nurse role and function, including geographical location, organisational policy, and management practices, including Registered and Enrolled Nurse relationships, and lack of differentiation between the roles. They identify the value of decision-making frameworks in clarifying the scope of Enrolled Nurse practice.

A review of the literature by Jacob et al (2013) found the number of Enrolled Nurses and the roles they perform have changed significantly following the introduction of an enhanced Enrolled Nurse Scope of Practice, however, they question the potential benefits to patient care of advanced Enrolled Nurses roles given the lack of evidence to support this change. Most Australian states and territories in Australia recognise an advanced Enrolled Nurse classification. Cusack (2015) reports this initiative was an opportunity to respond to the changing healthcare scene by providing a more structured enrolled nursing model of care that embraces advanced skills and knowledge within a collaborative nursing framework. They recommend clear role delineation is necessary for the Enrolled Nurse with advanced skills to prevent further role confusion and to be effective in enhancing health care. This also requires advanced Enrolled Nurse competencies to be broad to ensure they remain relevant to diverse practice settings that include leadership, coordination, administration, and management, as well as clinical skills, technical tasks, care delivery, and clinical responsibilities.

The United Kingdom discontinued the second level nurse role in 2000 as nurse training moved into university settings. However, it has recently reintroduced the Nurse Associate role (in England only at this point), with the first graduates registering in 2019 . The cessation of the second level nurse led to a reduction in the size of the nursing workforce with an increase in the use of non-regulated workers thus impacting skill mix. Systemic failings in some areas of care prompted a review of roles, education and training to support high quality nursing and to build the capacity and capability of the workforce heavily affected by staff shortages (Lucas et al, 2001).

An environmental scan by the Nursing Council of the Enrolled Nurse (or International Equivalent) scope of practice and role looked at qualification, length of training, title, and scope internationally that supported the RPNAO findings noted above. The difference in the education of RPN/ENs creates a particular challenge to migration and the value and utilisation of the role. The RPNAO Report (2018) found education of RPN/ENs varies in several ways: the entrance requirements for the programs (age, years of education), the duration of the program (anywhere from six months to three years), the type of educational institution (secondary school, tertiary school, post-secondary school), the accreditation status of the educational institution (accredited or non-accredited), the curriculum, and the split between theoretical and practical training.

The RPNAO's review reported there was a need to ensure that all health care professionals, in particular RPN/ENs, are supported to work to their full scope of practice. They cited, a waste of resources when scopes of practice are restricted, additionally the inconsistent use of professionals was mentioned as one of the main reasons for role confusion. Interviewees consistently stated that regulators, educators, and nursing leaders have had a preoccupation with the role of the Registered Nurse and Advanced Practice Nurses, which has led to a lack of vision for the role of RPN/ENs.

Overall, the RPNAO heard consistent messages about the need for RPN/ENs and about their value in the health system, yet it was also stated that in many jurisdictions RPN/ENs were underused and undervalued. This was consistently related to restrictions on their ability to work to their full scope and the impact of the nursing hierarchy.

However, there were jurisdictions where the RPN/EN was well utilized and accepted as a full member of the nursing and health care team. RPNAO recommend it is critical that this issue be addressed to keep pace with a changing population and the evolution of health systems.

Taitara Tapuhi kua Whakauru - Enrolled Nurse Title

The Design Group acknowledges the existence of two histories related to the Enrolled Nurse title, each of which contains elements of trauma. For Māori, the title carries connotations that cannot be divorced from the broader historical relationship between nursing and Māori, and how Māori nurses have been positioned within the profession. For Enrolled Nurses as a professional group, there is a history of hurt and distress related to changes imposed on these nurses without their consent. Both these histories point to the importance of 'naming' as an aspect of identity and collective positioning.

The origin of enrolled nursing in Aotearoa New Zealand lies with what were termed Community Nurses, a role established in 1939. With the introduction of the Nurses Act 1977, these nurses were renamed Enrolled Nurses. This change occurred largely due to a perception that 'Community Nurse' did not reflect the actual role being performed, particularly given that they primarily worked in hospital settings rather than the community. The new title was believed to be less confusing and as enabling these nurses to be "free to practise and excel within the scope of her practical competence and theoretical knowledge" (O'Connor, 2010, p. 179).

The title of Enrolled Nurse reflected that these practitioners were placed onto their own Roll, rather than the Register where Registered Nurses were recorded (Hughes et al, 2018). With the introduction of the Health Practitioners Competency Assurance Act 2003 (HPCA) in 2003 and repeal of the Nurses Act, however, the Roll which lent its name to the title was abolished. From this point on, both Registered and Enrolled Nurses were registered by the Nursing Council and sat on a single New Zealand Register of Nurses.

One of the tasks for the Nursing Council following the passage of the HPCA was to define scopes of practice for the nursing profession – including the name by which different scopes would be known. This led to extensive discussions about the role of the Enrolled Nurse amongst the profession (Hughes, 2017). At this stage, the Nursing Council consulted with the sector on three points, including the title. In response, 43% of submissions supported retention of the Enrolled Nurse title – this was the highest level of support for any particular name but the Nursing Council at the time stated that there was "no consensus" on a new title and undertook a second round of consultation on the name in which 'Nurse Assistant' and 'Registered Assistant Nurse' were the only options (Regulations Review Committee, 2007).

Following this, in 2004, the Council decided to split the Enrolled Nurse scope into two. Those who had been educated and joined the Register before 2000 would continue to be known as Enrolled Nurses, while those who joined afterwards would be known as

Nurse Assistants.[18] This decision was received poorly by the profession and led to a formal complaint by the New Zealand Nurses Organisation (NZNO) to Parliament's Regulations Review Committee in 2007. After considering representations from both NZNO and the Nursing Council, the Committee found that the Council's decision was unlawful in that it retrospectively affected a particular group – namely, nurses that had enrolled in an education programme after 2000 expecting to gain the title of Enrolled Nurse (Regulations Review Committee, 2007).

In 2008, the New Zealand Government tabled a motion to reinstate the Enrolled Nurse scope for both ENs and Nurse Assistants. As then Minister of Health David Cunliffe stated, "the issue is one where a group of nurses, through no fault of their own, were caught out by a decision which changed their job title and their scope of practice to something different from what they intended when they signed up for a course of study."[11] The Council subsequently reinstated the Enrolled Nurse title for all these nurses and a new scope was developed and implemented in 2011.

Te Hītori Tuatahi: Tapuhi Whakauru me te Māori – The First History: Enrolled Nursing and Māori

Kia whakatōmuri te haere whakamua: 'I walk backwards into the future with my eyes fixed on my past'.

The framing of the Enrolled Nursing title for Māori is inextricably linked with the broader relationship between Māori and the nursing profession. Acknowledging the trauma and mamae Māori have experienced historically allows us to adopt a forward-thinking approach which focuses on what we can do in the present to address this legacy, and reimagine and reshape the futures of Māori nurses.

This can be expressed through the whakatauki above. Rameka (2016) describes this as speaking to Māori perspectives of time, where the past, present, and future are intertwined. In the specific context of nursing in Aotearoa the lived experiences of Māori bear direct influence on future Rangatira (leaders). As a collective, we share the responsibility to acknowledge and understand the history of Māori, and the significance this plays in shaping where we are today, and where we wish to head in the future.

Māori have a history of exclusion from nursing in Aotearoa New Zealand. At the turn of the 20th century, Hāmiora Hei led the establishment of a Māori Health Nursing Scheme based on developing Māori nurses to work with Māori communities. However, this vision of a 'by Māori for Māori' nursing service faced resistance from existing health and nursing structures and ultimately produced only a few nurses before it became a Pākehā-led service (McKegg, 1992; Holdaway, 1993). One of those who did go through the scheme was Hamiora's sister, Ākenehi Hei (Te Whakatōhea, Ngāti Pūkeko, Ngāi Tai, Tūhoe, Te Arawa, Ngāi Tawarere, Te Whānau-a-Manu), who was the first Māori nurse to register under her own name rather than an English transliteration.[19] In her work at the

[18] There were also some differences between the two scopes, notably that nurse assistants could only work in a defined area of practice, while enrolled nurses continued to be able to work across a broad range of areas. (Regulations Review Committee, 2007)

[19] The very first Māori Registered Nurse was Mereana Tangata, registered in 1896, but she did so as Marion Hattaway.

forefront of a typhoid epidemic ravaging the communities she worked with, Ākenehi was forced to deal with cultural resistance, institutional racism, colonial power, lack of government support, and reconciling Western nursing models with Te Ao Māori (NZNO, n.d.; Sargison, 1996).

This exclusion continues today. The need to increase participation by Māori in the nursing workforce – and health workforce more broadly – has been a major recurrent theme in official strategies for at least the past two decades.[20] Yet despite this, there has been little progress and racism – in both structural and individual forms – continues to be a well-recognised barrier to increasing Māori presence in the profession (Wilson, Barton, and Tipa, 2022).

With respect to enrolled nursing, a particular expression of this lies in the direction of prospective Māori nurses into this part of the profession. Hylton (2005) refers to a history of Māori being channelled into enrolled nursing on the basis that they were not capable of being Registered Nurses. The Design Group has heard personal accounts of Māori being told that they were not 'good enough' to be a Registered Nurse and so needed to become an Enrolled Nurse instead.[21]

As a result, the title can have resonance with broader issues of structural racism within the health workforce, the health and disability support system, and education structures. From this perspective, for Māori, it is difficult to escape the historical association of 'Enrolled Nurse' as a lesser alternative to 'Registered Nurse', and the framing that is all that Māori should aspire to be. An alternative title may provide an opportunity to shed these connotations and establish a scope that is truly empowering for not just Māori but for enrolled nursing as a whole.

Ngā tau 2000, te Taitara me te Ngaiotanga -The 2000s, the Title and the Profession

> Yes, many registered nurses – including myself and probably most of us here – had our title changed through this process. The difference for enrolled nurses was that the change in title mattered for them; it didn't matter for us, because it wasn't a kind of diminished perception.
>
> (NZNO CE Geoff Annals, in Regulation Reviews Committee, 2007: 43)

As noted earlier, the Council's decision to change the Enrolled Nurse title was poorly received by the profession. A particular focus for this – and the formal basis for NZNO's complaint to the Regulations Review Committee – was the position of students in Enrolled Nurse programmes who would no longer be able to call themselves Enrolled Nurses. However, the underlying hurt and anger around the title change was based on deeper foundations than the specific situation of these learners.

A notable element of testimony before the Committee was the status associated with the new name for these nurses. Committee members highlighted the point that to a

[20] For early examples see Ministerial Taskforce on Nursing (1998), Health Workforce Advisory Committee (2003)
[21] Such language also reflects the disparity of esteem and lack of respect enrolled nursing often faces – that the scope is a 'second chance' option for people who can't be Registered Nurses.

layperson's ears the Nurse Assistant title had less prestige and connection to nursing than that of the Enrolled Nurse. As Hon Marion Hobbs stated:

> I think that the nurses, NZNO, or some of the people there, feel that the change from "enrolled nurse" to "nurse assistant" is somehow a lesser status. It's not a different status; it's a lesser status … I've been trained all my life and I've always been an assistant teacher. There is no teacher assistant. We are assistant teachers.
>
> (Regulation Review Committee, 2007: 41-42)

Hobbs' quote above also highlights another element of the new title that caused concern; its emphasis on the term 'Assistant' rather than 'Nurse'. Grammatically, the new title framed the (former) ENs as types of assistants rather than nurses. The union argued that, far from clarifying the status of Enrolled Nurses as the Council intended, this would lead to ongoing confusion between the position of ENs and that of (unregulated) health assistants (NZNO, 2007). This represented a challenge to the identity of Enrolled Nurses, who felt that this was part of a broader trend towards devaluing the work of enrolled nurses and positioning them as closer in stature to the unregulated workforce than part of the nursing profession – or even a stepping stone to removing the role altogether (NZNO, 2008; Meek, 2009)

Especially relevant for the purposes of this Review, however, was how the name change was undertaken. Not only was the new title itself problematic, but the way in which the Council had gone about renaming was criticised. Enrolled Nurses felt excluded from the process, especially given that individual submissions had demonstrated strong and significant support for retaining the title. Moreover, when the Council undertook additional consultation, it omitted Enrolled Nurse from the list of possible titles.

Combined with what was perceived to be a broader environment that was hostile to the future of enrolled nursing (Meek, 2009), the removal of the title thus gained critical symbolic importance for Enrolled Nurses. The act of naming is an act of power, and part of the process by which something is given meaning (Harré 1998). The renaming of these nurses without their consent was perceived to be an exercise of power by nursing leaders enacted not simply for achieve pragmatic ends (such as reflecting the removal of the separate Roll), but in order to lower the status of enrolled nurses and potentially even set the scene for their removal. As NZNO remarked in its 2009 submission to the Nursing Council's later consultation: "Regulated Enrolled Nurses and Nurse Assistants and unregulated health care assistants are often jointly referred to as if they are the same, which they are not. This perception needs to change if we are to move forward."

The Council subsequently acknowledged its failings during this time. In July 2010, the then Chief Executive, Carolyn Reed, apologised to Enrolled Nurses at their national conference for the "hurt and distress" the Council had caused Enrolled Nurses over the years. She issued the apology, acknowledging the place of Enrolled Nurses in the health team, and thanked them for their patience while making a personal commitment to

their work.[22] The current Review is being undertaken with an eye to learning from the mistakes of the past and ensuring that changes are made 'with' rather than 'to' Enrolled Nurses.

For many Enrolled Nurses, the 2004 change of title was not well received. This was particularly the case for nurses educated after 2000, who had studied, graduated, and in some cases begun practising, on the understanding that they were to be able to use the Enrolled Nurse title. These nurses now had to relinquish their title and accept that they would now be required to practise as a Nurse Assistant.

In 2007, the New Zealand Nurses Organisation submitted a complaint on behalf of its members under, "Notice of Scopes of Practice and Related Qualifications Prescribed by the Nursing Council of New Zealand", that found the notice split the title of second-level nurses so that those who qualified before 2000 would retain the title of "Enrolled Nurse" whereas those qualifying after this time would have the title of "Nurse Assistant". People enrolled in second-level nursing programmes after 2000 but prior to the notice becoming effective in September 2004, were informed by the polytechnics that their graduation would result in their recognition by the Nursing Council as "Enrolled Nurses". People enrolled as "Enrolled Nurses" during this period subsequently had their title changed to "Nurse Assistant".

The Regulations Review Committee (2007) found the notice had unauthorised retrospective effect and recommended it be amended to remove this effect. Specifically, the Committee noted that although there had been several retrospective changes to titles in the nursing profession, in this instance the change was unacceptable because, in contrast to other title changes within the profession, it mattered to the affected second-level nurses. To remedy this retrospective effect, clause 4 of the Notice, dealing with the scope of practice of Enrolled Nurses, was subsequently revoked.[23] This has been the subject of two further consultations by the Nursing Council before the title was changed to Enrolled Nurse in late 2008 following a recommendation by the Regulation Review Committee (NCNZ, 2009).

In 2008, the New Zealand Government tabled a motion to reinstate the scope of practice and qualification of Enrolled Nurse for 137 nurses in 2008. As stated by the Minister of Health at the time, David Cunliffe, "the issue is one where a group of nurses, through no fault of their own, were caught out by a decision which changed their job title and their scope of practice to something different from what they intended when they signed up for a course of study"[11]

In July 2010, the then Chief Executive of the Nursing Council, Carolyn Reed, apologised to Enrolled Nurses at their national Enrolled Nurse conference, for the "hurt and distress" the Council had caused Enrolled Nurses over the years. She issued the apology, acknowledging the place of Enrolled Nurses in the health team, and thanked them for their patience, making a personal commitment to their work.[24] The, then Chair

[22] Nursing council apologises to ENs (2010) https://www.thefreelibrary.com/Nursing+council+apologises+to+ENs.-a0233291238

[23] https://www.parliament.nz/resource/en-NZ/48DBSCH_SCR3828_1/6bc2a13c049154f367a0fb4a4c61784153bf42e4

[24] Nursing council apologises to ENs (2010) https://www.thefreelibrary.com/Nursing+council+apologises+to+ENs.-a0233291238

of NZNO's National Enrolled Nurses committee, Robyn Hewlett, said the apology would go some way to ameliorating the pain caused by previous Nursing Council decisions on the scope of practice and title of Enrolled Nurses.

Me Pēhea Te Whakatakoto Tāpaetanga – Have Your Say

The Design Group has developed this new scope statement with the goal of supporting Enrolled Nurses to be fully enabled to practise to the top of their scope of practice, while providing safe, effective nursing care to the population of Aotearoa New Zealand. This is an important time to consider how nursing, including enrolled nursing, is positioned to meet current and projected health needs of the New Zealand population and workforce issues facing the health and disability support sector. It is also an opportunity to ensure that the Nursing Council's regulation of Enrolled Nurses is fair and appropriate for the purposes of protecting public safety, including how we attend to Kawa Whakaruruhau, cultural safety, and Te Tiriti o Waitangi.

We now want to hear your views on this draft statement and how it describes the practice of enrolled nursing in Aotearoa New Zealand.

Consultation on the proposed new scope statement is being conducted from December 12, 2022 to February 13, 2023. In addition to our electronic consultation, we will be undertaking additional meetings with stakeholders and forums in early 2023.

We have developed a short consultation questionnaire to help you provide us with feedback. This can be accessed through our consultation webpage.

We will also accept written submissions. We have developed a template to help with this which you can find on our consultation webpage. If you would like to send us a submission or have any questions about this consultation, please email us at enreview@nursingcouncil.org.nz

The material from this consultation will be analysed by the Review Team and then provided to the Design Group for their consideration. This analysis may be published so if you are making a submission please indicate if you would like us to ensure your comments remain confidential.

Ngā tohutoro – References

Barton, P. (2022). Fund out training – it's time for the government to seriously invest in the domestic nursing workforce. *Kaitiaki* https://kaitiaki.org.nz/article/fund-our-training-its-time-for-the-government-to-seriously-invest-in-the-domestic-nursing-workforce/

Birks, M.& Davis J, Smithson, J & Cant, R. (2016) *Registered Nurse Scope of Practice in Australia: an integrative review of the literature*. Contemporary Nurse, 52:5, 522-543, DOI: Available at 10.1080/10376178.2016.1238773

Baumann, Blythe, Crea-Aresnio, & Norman, (2014). *High Functioning Nurse Teams: Collaborative Decisions for Quality Patient Care*. Available at: https://fhs.mcmaster.ca/nhsru/documents / High-Functioning-Nurse-Teams-Report-2014-01E.pdf

Cusack, L. Smith, M. Cummins, B. Kennewell, L. Dennett, L. & Pratt, D. (2015). *Advanced skills for Enrolled Nurses: A developing classification*. Australian Journal of Advanced Nursing. 32. 40-46. Available at https://www.researchgate.net/publication/283129390_Advanced_skills_for_enrolled_nurses_A_developing_classification

Dixon, A. (1996). *Critical case studies as voice: The difference in practice between Enrolled and Registered Nurses*. Unpublished Doctoral dissertation, Flinders University of South Australia, Australia.

Dumont, J.-C., Zurn, P., Church, J., & LeThi, C. (2008) *International mobility of health professionals and health workforce management in Canada: Myths and realities*. (OECD Health Working Papers, No. 40). Available at https://doi.org/10.1787/228478636331

Gibson, T., Heartfield, M., & Cheek, J. (2001). *Final report to the Australian Nursing Council Inc: An examination of the role and function of the Enrolled Nurse and revision of competency standards*. Centre for Research into Nursing and Health Care, University of South Australia.

Gibson, T. & Marie Heartfield. M. (2005) *Australian Enrolled Nurses have their say – Part 2: Scope of Practice.* Contemporary Nurse, 19:1-2, 126-136, DOI: 10.5172/conu.19.1-2.126

Harré, R. (1998). The Singular Self: *An Introduction to the Psychology of Personhood*. London: Sage Publications.

Health and Disability Commissioner. (2002). *Southland District Health Board Mental Health Service: February-March 2001. A report by the Health and Disability Commissioner*. Auckland: Health and Disability Commissioner. Retrieved from http://www.hdc.org.nz/files/hdc/publications/other-southlandreport.pdf

Health and Disability Commissioner. (2007). *Capital and Coast District Health Board. A report by the Health and Disability Commissioner (Case 05HDC11908).* Health and disability Commissioner. Available at https://www.hdc.org.nz/decisions/search-decisions/2007/05hdc11908/

Holdaway, M. (1993). *Where are the Maori Nurses who were to become those "Efficient Preachers of the Gospel of Health?*". Nursing Praxis in New Zealand, 8(1), 25-34

Hughes, M, E. (2017). *Nurses storied experiences of direction and delegation*. A thesis submitted in total fulfilment of the requirements for the Degree of Doctor of Philosophy, University of Canterbury, Christchurch

Hughes, M., Kirk, R., & Dixon, A. (2017). *How and why nurses' direction and delegation skills should be improved*, Kai Tiaki Nursing New Zealand. 23 (9)

Hughes, M., Kirk, R., & Dixon, A. (2018). *Supervision, direction and delegation – what do the terms mean?* Kai Tiaki Nursing New Zealand. 24 (3).

Hylton, J. A. (2005). *Relearning how to learn: Enrolled nurse transition to degree at a New Zealand rural satellite campus*. Nurse Education Today, 25(7), 519–526.

International Council of Nurses. (2010). *Scope of Nursing Practice and Decision- Making Framework TOOLKIT* - ICN Regulation Series

International Council of Nurses. (2013). *Scope of nursing practice* (pp. 2). Geneva, Switzerland: International Council of Nurses.

Jacob E, Sellick K, & McKenna L. (2012). *International Journal of Nursing Practice* 2012; **18**: 303–307

Jacob, E, Barnett, A., Sellick, K., & Mckenna, M. (2013) *Scope of practice for Australian Enrolled Nurses: Evolution and practice issues*. Contemporary Nurse, 45:2, 155-163, DOI: 10.5172/conu.2013.45.2.155

Jacob, E, Barnett., Mckenna, M., & D'Amore, A. (2014) *Similarities and differences in educational preparation of Registered and Enrolled Nurses in Australia: An examination of curricula content*. Contemporary Nurse, 48:2, 199-211, DOI: 10.1080/10376178.2014.11081942

Jacob, E, Barnett., Mckenna, M., & D'Amore, A. (2017*) Role expectations of different levels of nurses on graduation: A mixed methods approach*. Collegian, Journal of the Royal College of Nursing Australia.

Kaiāwhina Plan (2002). *Kaiawhina workforce plan*. https://kaiawhinaplan.org.nz/

Leslie, K., Moore, J., Robertson, C. et al. Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia, and the UK. Hum Resour Health **19**, 15 (2021). https://doi.org/10.1186/s12960-020-00550-3

Levett- Jones, T. (2012). Clinical Reasoning: Learning to think like a nurse. Sydney: Pearson Australia.

Lucas G, Brook J, Thomas T, Daniel D, Ahmet L, Salmon D. (2021). Healthcare professionals' views of a new second-level nursing associate role: A qualitative study

exploring early implementation in an acute setting. J Clin Nurs;30:1312–1324. https://doi.org/10.1111/jocn.15675

Manchester, A. (2018). Growing the Māori nursing workforce. *Kaitiaki Nursing New Zealand*, (24) 4.

MacKenzie, M. (2020). *The Development of the Enrolled Nurse role in the Waikato, Tainui region, Aotearoa New Zealand*, Masters dissertation thesis, Wintec. http://researcharchive.wintec.ac.nz/7834

McKegg, A. H. (1992). The Maori health nursing scheme: an experiment in autonomous health care. New Zealand Journal of History, 26(2), 145–160.

Meek, G. (2009). *Second level nurses: A critical examination of their evolving role in New Zealand healthcare*. (Master's dissertation thesis, Wintec). Research Archive. http://researcharchive.wintec.ac.nz/962/1/Repository_entry_HLNU902.pdf

Ministry of Health. (2008). *Enrolled Nurses reinstated.* Beehive.govt.nz. https://www.beehive.govt.nz/release/enrolled-nurses-reinstated

Ministry of Health (2009*). Clinical Workforce to Support Registered Nurses Nursing Advisory Committee*. https://www.health.govt.nz/publication/clinical-workforce-support-registered-nurses

Ministry of Health. (2013). *Enrolled nurses in New Zealand*. https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/enrolled-nurses-new-zealand

National Council of State Boards of Nursing (2005). *Working with Others: A Position Paper*. Available at www.ncsbn.org/Working_with_Others.pdfMOH, (2008).

National Nursing & Nurse Education Taskforce (2005). *Scope of Practice Commentary Paper.* Australian Health Ministers' Advisory Council, National Nursing & Nurse Education Taskforce, Melbourne, Victoria.

NZNO. (2008). *Feedback to the Nursing Advisory Committee on the Clinical Workforce to Support Registered Nurses*. Available at https://www.nzno.org.nz/Portals/0/Files/Documents/Activities/Submissions/2008-07%20FEEDBACK%20TO%20ADVISORY%20COMMITTEE%20ON%20CLINICAL%20WORKFORCE%20TO%20SUPPORT%20RNs.pdf

NZNO. (2013). *Analysis of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. United Kingdom.

NZNO. (2019). *Enrolled Nurses – Scope of Practice Survey*.

NZNO. Enrolled Nurses Section. (2022). *Barriers for Enrolled Nurses.*

NZNO. (n.d.). Whaea Tipuna - Akenehi Hei. Available at https://www.nzno.org.nz/groups/te_runanga/rangatiratanga/whaea_tipuna_-_akenehi_hei

Newsome, P., Black, A., McCance, A., Worrall-Carter, L., Ostaszkiewicz, J., Valentine, T., Wilson, C., & Bowtell, A. (2006). *Implementing and evaluating the extended scope of practice for division 2 Registered Nurses in medication administration*. Melbourne, Australia: Eastern Health/ Deakin University.

Nuku, K. (2015). *Building the Māori nursing workforce*. *Kaitiaki Nursing New Zealand*, 21 (1).

Nursing Council of New Zealand. (2009). Consultation on the Enrolled Nurse and Nurse Assistant scopes of practice under the Health Practitioners Competence Assurance Act (2003). Wellington

Nursing Council of New Zealand. (2011). Guideline: responsibilities for direction and delegation of care to Enrolled Nurses. Wellington

Nursing Council of New Zealand. (2022). Strategic Plan, Mahere Rautaki 2022-2024 (2022). Wellington

NCNZ. (2018). The New Zealand nursing workforce. Wellington. Available at https://online.flippingbook.com/view/407289207/

Nursing and Midwifery Board of Australia (2007). *A national framework for the development of decision-making tools for nursing and midwifery practice*. Melbourne: NMBA

Nursing and Midwifery Board of Australia (2016). *Standards for practice: Enrolled Nurse*. Melbourne: NMBA.

O'Connor, M. (2010). Fr*eed to care proud to nurse: 100 years of the New Zealand nurse's organisation*. Wellington, New Zealand: Steele Robert.

Ramsden, I. (1990). *Kawa Whakaruruhau: Cultural safety in nursing education in Aotearoa*. Wellington: Department of Education.

Ramsden, I. (2015). *Towards Cultural Safety*. In D. Wepa (ed.), Cultural Safety in Aotearoa New Zealand (pp 5-25). Second Edition. Melbourne: Cambridge University Press.

Rameka, L. (2016). *Kia whakatōmuri te haere whakamua: 'I walk backwards into the future with my eyes fixed on my past*.' Contemporary Issues in Early Childhood, 17(4), 387–398. Available at https://doi.org/10.1177/1463949116677923

Registered Practical Nurses Association of Ontario (RPNAO) Report. (2018). *Practically Speaking: International Comparision of Registered Practical Nurse Utilisation to identify best practice.*

Registered Practical Nurses Association of Ontario (RPNAO) Report. (2014). *It's All About Synergies*.

Regulations Review Committee. (2007). Report of the Regulations Review Committee "*Complaint regarding Notice of Scopes of Practice and Related Qualifications Prescribed by the Nursing Council of New Zealand".* Available at https://www.parliament.nz/resource/en-NZ/48DBSCH_SCR3828_1/6bc2a13c049154f367a0fb4a4c61784153bf42e4

Registered Practical Nurses Association of Ontario (2018). Practically Speaking: International Comparision of Registered Practical Nurse Utilisation to identify best practice.

Roberts, J. (2019). *Kawa Whakaruruhau – has its intent been lost?* Kai Tiaki Nursing New Zealand, 25(11), 14-15.

Roots, A. & Gibson, P. (2016). *Confidential Reports: Assessment Framework for Entry-Level Enrolled Nurses in Australia*. This document is the sole property of Health Management and Planning Solutions.

Sargison, P.A. (1996). *Hei, Ākenehi*. Dictionary of New Zealand Biography. Availabe at https://teara.govt.nz/en/39821/akenehi-hei

Seago, J., Spetz, J., Chapman, S., Dyer, W., & Grumbach, K. (2004). *Supply, demand, and use of licensed Practical Nurses*. Available at supply1.cdr (ucsf.edu)

Subedar, H. (2006). *The nursing profession production of nurses and proposed scope of practice*. South African Nursing Council.

Te Whatu Ora, Health New Zealand. (2022). Workforce Taskforce. https://www.tewhatuora.govt.nz/whats-happening/work-underway/taskforces/#workforce-taskforce

University of Auckland. (2021). *Earn as you learn model. EN Apprenticeship fact sheet*. Faculty of Medical and Health Sciences. School of Nursing.

Wilson, D., Barton, P., Tipa, Z. (2022). *Rhetoric, Racism, and the Reality for the Indigenous Māori Nursing Workforce in Aotearoa New Zealand*. OJIN: The Online Journal of Issues in Nursing, 27(1).

Waitangi Tribunal. 2019. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Wellington. Waitangi Tribunal. pp. 163–164

World Health Organization. (2002). *Nursing and midwifery: A guide to professional regulation*. Available at http://apps.who.int/iris/bitstream/10665/119665/1/dsa189.pdf

Tāpiritanga 1 - Appendix 1 - Design Group- Enrolled Nurse Scope Review Membership

Group Convenors	Robyn Hewlett Catherine Byrne
Membership	• Robyn Hewlett, NZNO EN Section Lead • Michelle Prattley, Chairperson NZNO EN Section • Suzanne Rolls, Professional Nurse Adviser, NZNO • Mairi Lucas, Nursing & Professional Services Manager, NZNO • Kerri Nuku, Kaiwhakahaere, Te Rūnanga, Tōpūtanga Tapuhi Kaitiaki o Aotearoa, NZNO • Catherine Byrne, Chief Executive, NCNZ • Brittany Jenkins, Director Professional Standards, NCNZ • Carolyn McCullough, Nursing Director CDHB • Sue Hayward, DON Waikato DHB • Margaret Pearce, Manager Ross Home and Hospital, Dunedin • Coral Wiapo, Te Tai Tokerau Regional Coordinator, NP & EN Workforce Development Programme, Auckland University • Dr Lorna Davies, Ara Institute of Canterbury Ltd • Johanna Rhodes, Head of School of Nursing, SIT
Nursing Council Project Team	• Dr Nyk Huntington, Director Policy, Research and Performance, (Project Sponsor) • Jane MacGeorge, Projects Leader • Waikura Kamo, Kaitohutohu Nēhi Māori / Nurse Advisor

Tāpiritanga 2 - Appendix 2 Current Registered and Enrolled Nurse Scopes of Practice

Tapuhi Kua Rēhitatia **Registered Nurse** Scope of Practice	**Tapuhi Kua Whakauru** **Enrolled Nurse** Scope of Practice
Registered Nurses use nursing knowledge and *complex nursing judgement* to assess health needs and provide care, and to advise and support people to manage their health. They *practise independently* and in collaboration with other health professionals, perform general nursing functions, and *delegate to and direct* Enrolled Nurses, healthcare assistants, and others. They *provide comprehensive assessments* to develop, implement, and evaluate an integrated plan of health care, and *provide interventions* that require substantial scientific and professional knowledge, skills, and clinical decision making. This *occurs in a range of settings* in partnership with individuals, families, whānau, and communities. Registered Nurses *may practise in a variety of clinical contexts* depending on their educational preparation and practice experience. Registered Nurses may also use this *expertise to manage, teach, evaluate, and research nursing practice*. Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements, and are supported by appropriate standards. There will be conditions placed in the scope of practice of some Registered Nurses according to their qualifications or experience limiting them to a specific area of practice. Some nurses who have completed the required additional experience, education, and training will be authorised by the Council to *prescribe some medicines* within their competence and area of practice.	Enrolled Nurses *practise under the direction and delegation* of a Registered Nurse or Nurse Practitioner to deliver nursing care and health education *across the life span* to health consumers in community, residential or hospital settings. Enrolled Nurses contribute to nursing assessments, care planning, implementation, and evaluation of care for health consumers and/or families/whānau. *The Registered Nurse maintains overall responsibility for the plan of care.* Enrolled Nurses *assist* health consumers with the activities of daily living, *observe* changes in health consumers' conditions and *report* these to the Registered Nurse, administer medicines, and undertake other nursing care responsibilities appropriate to their assessed competence. In *acute settings, Enrolled Nurses must work in a team with a Registered Nurse* who is responsible for directing and delegating nursing interventions. In some settings, Enrolled Nurses may *coordinate a team* of healthcare assistants under the direction and delegation of a Registered Nurse. In some settings, Enrolled Nurses may work under the direction and delegation of a registered health practitioner.* In these situations, the Enrolled Nurse must have *Registered Nurse supervision* and *must not assume overall responsibility* for nursing assessment or care planning. Enrolled Nurses are accountable for their nursing actions and practise competently in

	accordance with legislation, to their level of knowledge and experience. They work in partnership with health consumers, families/ whānau, and multidisciplinary teams. *A health practitioner is a person who is registered under the Health Practitioners Competence Assurance Act 2003 – for example, a midwife, medical practitioner or occupational therapist.

Tāpiritanga 3 - Appendix 3: Our Key Consultation Questions

1. Overall, do you support the proposed Enrolled Nurse Statement?

2. What are the strengths or potential benefits of the proposed scope statement?

3. What are the weaknesses or potential risks of the proposed scope statement?

4. How well does the proposed Scope Statement reflect the appropriate position of Te Tiriti o Waitangi within the practice of enrolled nursing?

5. How well does the proposed Scope Statement support and enable equitable access, experience, and outcomes for Māori?

6. How well does the proposed Scope Statement capture the distinctive features of enrolled nursing practice?

7. How well does the proposed Scope Statement appropriately distinguish enrolled nursing from other types of nursing practice?

8. How well does the proposed Scope statement appropriately distinguish enrolled nursing from the practice of other members of the health care team, including both regulated and non-regulated healthcare workers?

9. How well would the proposed Scope Statement support an appropriately safe and respectful relationship between the Enrolled Nurse and Registered Nurse (or other health professional) ?

10. Do you believe there are any specific risks in the Design Group's approach to or wording of the appropriate relationships between an Enrolled Nurse and other health practitioners?

11. Do you support the removal of "direction and delegation" terminology from the Enrolled Nurse Scope Statement?

12. Do you have any comments on the title of "Enrolled Nurse"?

13. Given that there are many titles around the world for this form of nursing, do you have any comments on other potential titles?

14. Are there any other implications of, or issues with, changing the Enrolled Nurse Scope Statement?