New Zealand College of Primary Health Care Nurses NZNO

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

NEW ZEALAND NURSES' ORGANISATION

COLLEGE OF PRIMARY HEALTH CARE NURSES'

DISTRICT NURSING

KNOWLEDGE AND SKILLS PROGRAMME FOR REGISTERED NURSES

Contents

INTRODUCTION

The aging population and a shift to community based care have combined to create a period of rapid growth in demand for home and community based nursing services. Within the broad range of such services available in New Zealand, District nurses provide a comprehensive range of advanced nursing care for:

- People with health care needs that cannot be met by a generalist medical or nursing service alone,
- AND who, without advanced nursing care, are at risk of further health deterioration,
- AND for whom provision of that care in their normal living environment would not further compromise their health status.

District nurses provide rapid response, intensive and short term episodes of care in collaboration with the wider interdisciplinary team. This often includes complex and technologically advanced care within the home, the goals being to:

- Prevent avoidable admission to, or enable early discharge from, hospital
- Minimise the impact of a personal health problem
- Support people with long term or chronic personal health problems or conditions
- Promote self care and independence
- Improve the health of Māori and Pacific people by delivering services that are accessible, fit for purpose and responsive to their needs
- Provide terminal/palliative care in the community

(Specialist Community Nursing Service Specifications, MOH Objectives, 2012)

Although district nurses incorporate a primary health care (PHC) focus into their care, in general, the practice of district nursing does not include first point of contact PHC nursing services. Instead, District nurses provide a unique and vital intermediary care role within the health continuum by linking between acute/specialist services and primary care, between medical and nursing, and between high and low technology care. This is demonstrated in the model below.

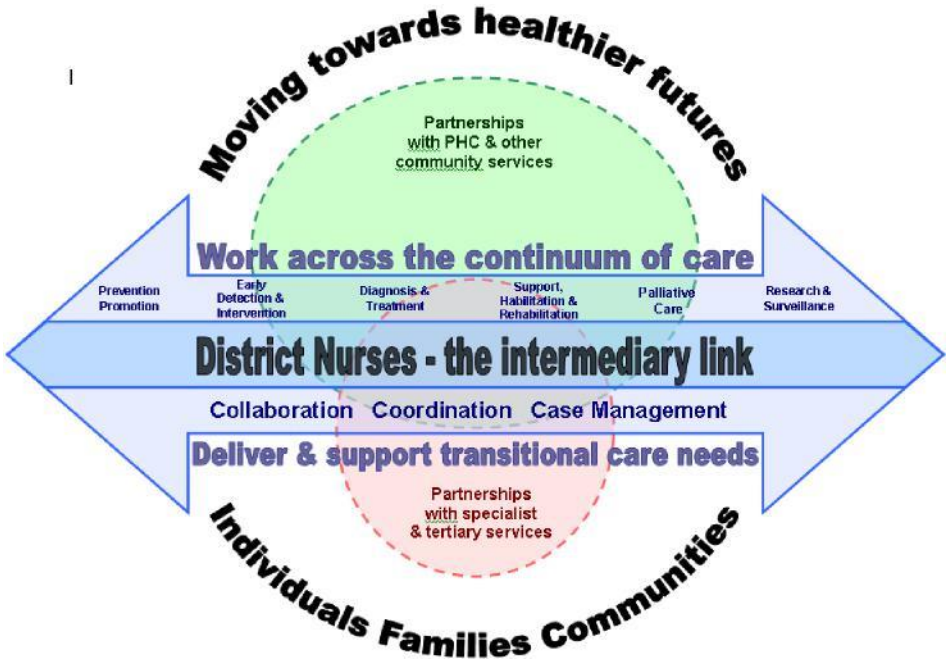

Figure 1 District Nurses - the intermediary link

The intermediary position of district nurses in the care continuum is key to their ability to promote faster recovery from illness by supporting transitional care needs, maximising quality of life and independent living. To do so, district nurses must perform a multitude of activities and roles related to advocacy, information and education, self- management, health promotion, community liaison, clinical skills, navigating and linking with community resources, empowering people, care coordination and case management. District nurses often navigate complex health systems to ensure their patients' needs are met, requiring extensive knowledge of their community and established collaborative networks.

District nursing care is primarily home based, however, some care may be provided in district nurse clinic settings. Practising in the domiciliary setting, district nurses often encounter and are required to manage unpredictable and rapidly changing circumstances in order to ensure health and safety for themselves, their colleagues, patients and family/whānau.

The six guiding principles below describe the practice of district nursing.

DISTRICT NURSES:

- Work in partnership with people across the lifespan, having regard for all cultures and are committed to the partnership, protection and participation principles of Te Tiriti o Waitangi.
- Demonstrate innovative practice applying expert community nursing knowledge, advanced assessment skills and professional judgement in delivering quality nursing care. This care includes the promotion of health and independence, rehabilitation to optimal health and the professional care and support required by some patients at the end of their life.
- Provide episodic care with links between primary health and acute/specialist services to meet specific health needs for patients in their communities. District Nurses have an in-depth knowledge of their communities and the flexibility to practise in a wide range of settings.
- Practise independently and interdependently, as part of interdisciplinary teams and collaborate with other health professionals across the continuum of care.
- Facilitate early discharge and the prevention of avoidable admissions, as well as seamless transitions of patients through District Nursing services, enhancing safe patient outcomes.
- Work to influence local and national health policy development to promote quality District Nursing services to reduce health disparities and improve patient health outcomes.

The content of this Knowledge and Skills Programme is focussed on enabling district nurses to achieve these principles in their practice.

PART ONE: DISTRICT NURSING KNOWLEDGE AND SKILLS PROGRAMME

The District Nursing Knowledge and Skills Programme (DNKSP) has been developed by the New Zealand Nurses' Organisation (NZNO) College of Primary Health Care Nurses' (CPHCN) in partnership with the MidCentral District Health Board Health Care Development Team and District Nursing Service and a wide range of community nurses working in specialty areas. The programme draws on the content from a range of other programmes including the National Diabetes, Respiratory, Pain Management, Youth Health and Nephrology Nursing Knowledge and Skills Frameworks and the NZNO Cancer Nurses' Section competencies as well as aligning with the Nursing Council of New Zealand (NCNZ) competencies. The result is a programme that illustrates the continuum of learning required to develop from a generalist nurse to a level two nurse within the specialty practice area of District Nursing.

The goal of the programme is to facilitate evidence based teaching and learning that is focussed on the development of:

- Prepared, proactive, culturally responsive district nurses
- Interdisciplinary collaboration, communication and quality improvement processes throughout NZ district nursing services
- Collaborative learning environments.

More specifically, the purpose of this DNKSP is to:

- Identify the knowledge and skills that a District Nurse needs
- Support the individual's career development.
- Assist with the development of services as follows: linking what the health sector needs for effective service delivery with the knowledge and skills needed in specific positions and then enabling the people in those positions to develop that knowledge and skills.
- Provide a reference point for planning educational programmes and clinical preparation for district nurses.
- Provide a mechanism for portfolio development for Professional Development Recognition Programmes (PDRP) and NCNZ competency requirements.

PROFESSIONAL NURSING PRACTICE AND DISTRICT NURSING

The NCNZ prescribes scopes of practice and under the Health Practitioners Competence Assurance Act 2003 each nurse must practice within that scope. 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 (Nursing Council of New Zealand Competencies for Registered Nurses, 2012).

District nursing practice is extensive. It incorporates working with patients and their families across the lifespan and within the patient's home to promote wellness, prevent health problems, maintain current health and intervene in acute and chronic illness. District nurses are required to function autonomously and interdependently in assessing needs, monitoring, delivering and evaluating care, utilising generalist and specialist nursing knowledge and skills, as well as knowledge of community resources to complement care. Consequently, education is vital in the development, maintenance and extension of district nursing knowledge and skills.

This programme, set at Level 2 (Competent), identifies the **fundamental knowledge and skills** that district nurses require to care for people in NZ, and reflects the core components of the regulated health workforce professional association standards. When completed, the evidence can be cross referenced to the NCNZ domains for the Registered Nurse Scope of Practice, enabling it to be used to evidence professional development and continuing competence for the issuing of annual practising certificates.

> Competent performers know solutions to common problems and use rules and judgment to deal with the situation. The competent nurse is able to develop a plan based on considerable conscious, abstract, analytical contemplation of the problem. This conscious deliberate planning is characteristic of this skill level. Competent people have a typical 'forgetting curve' regression, forgetting many of the facts they once knew, but as they develop in their competency they subconsciously access these facts to make intuitive decisions. Competency is developed from lots of varied experiences. It takes a lot of real world experience to become competent (Benner, P. (1984) From Novice to Expert: Excellence and power in clinical nursing practice).

The position of the DNKSP within a wider nursing professional development pathway that incorporates the four levels of practice is shown in the model below (Figure 1). This model has been designed by Hawkes Bay, MidCentral and Whanganui District Health Boards (DHBs) as part of a joint project to develop a nurse specialty education framework that will support and enhance nursing practice over the districts now and into the future. Consistent with this model, nurses will need to access ongoing professional development opportunities that enable them to develop the level required to meet the changing needs of the populations they serve and the context of their practice.

Registered Nurse Professional Development and Recognition Career Pathway

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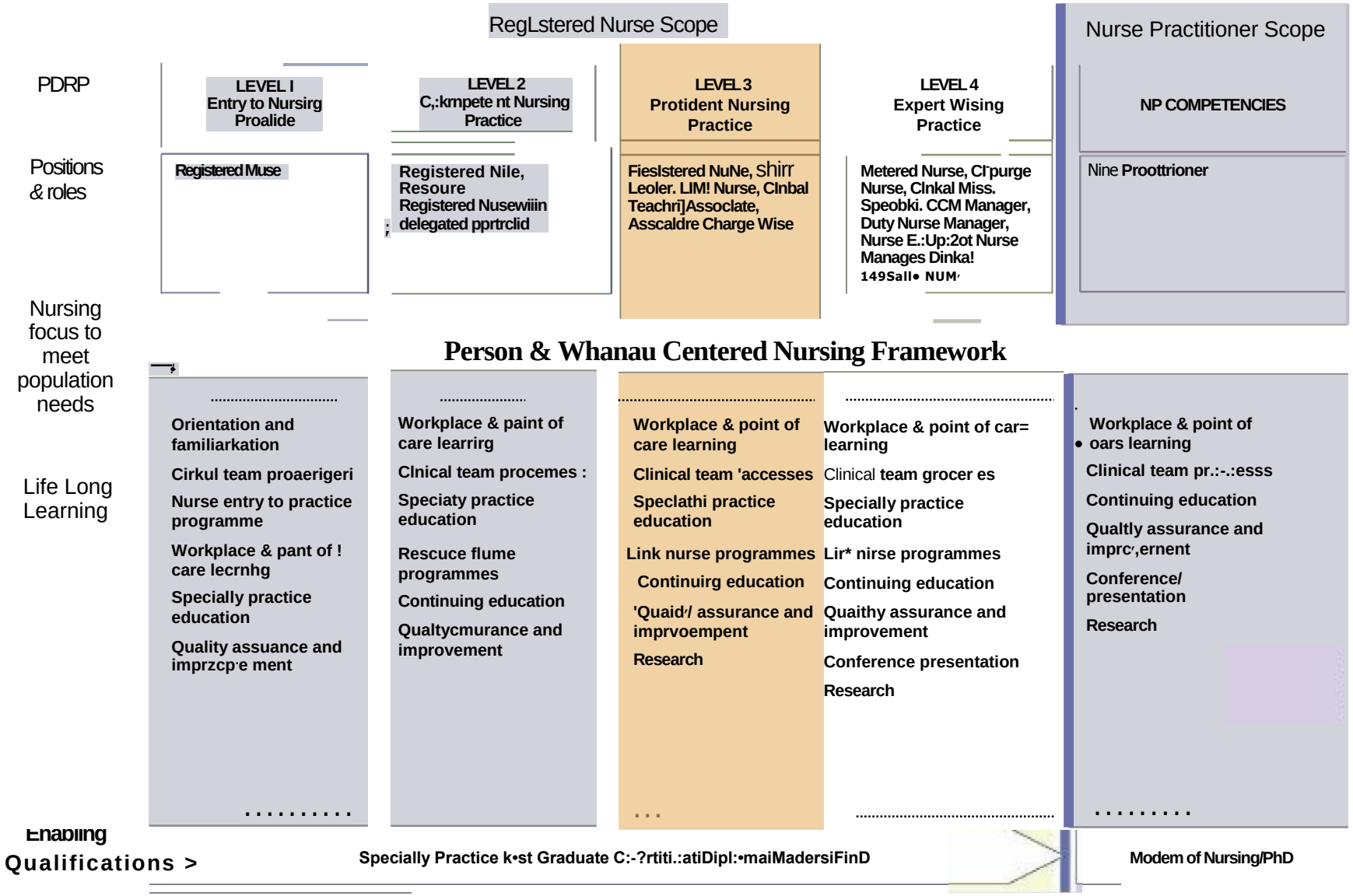


Ufe Long Learning is self directed. self regulated, self motivated and reflective.

STRUCTURE AND USE OF THE DNKSP

The District Nursing Knowledge and Skills Programme (DNKSP) is practice based, requiring participants to work alongside peers to develop and validate knowledge and skills. Adapted from the United Kingdom National Health Service Knowledge and Skills Framework, the DNKSP incorporates five DIMENSIONS: Core; Health and Wellbeing; Clinical-Specific; Information and Knowledge; and Leadership and Management. See Figure 2 below.

Each dimension has its own ASPECTS OF CARE: Aspects of Care cluster the major clinical functions and activities that occur within and across work teams.

Each aspect of care has an identified knowledge and skill for achievement with associated INDICATORS. Indicators provide the detail of how the knowledge and skills can be evidenced. Achievement of these indicators will evidence successful performance.

DIMENSION 1: CORE KNOWLEDGE AND SKILLS has eight ASPECTS. It is recommended that participants complete all eight.

DIMENSION 2: HEALTH AND WELLBEING has six ASPECTS. These will be relevant to most roles and include health promotion, assessment and care planning, interventions and self-management support.

DIMENSION 3: CLINICAL SPECIFIC has sixteen ASPECTS related to the practice of district nursing.

DIMENSION 4: INFORMATION AND KNOWLEDGE FOR HEALTH has three ASPECTS. It is recommended that participants do Aspect 1. Aspects 2 and 3 are optional. **DIMENSION 5**: LEADERSHIP AND MANAGEMENT has eight ASPECTS. It is recommended that participants select three Aspects.

Core *Each of the 8 Aspect of Care within the Core Dimension is applicable to every position within the Health Care sector.*	**Health and Wellbeing** *The 6 Aspects of Care within this Dimension will be relevant to most roles, and include health promotion, assessment and care planning and self-management support*	**Information and Knowledge** *These 2 Aspects relate to the knowledge and skills required to manage the collection, analysis, security, protection and integrity of information*	**Leadership and Management** *These 8 Aspects are about establishing and maintaining a focus on the goals, values and aspirations of the organisation through planning, managing performance, motivating people and role modelling. Select at least 1).*
Teams Communication Ethics Cultural Responsiveness Health & Safety & Risk Management Service Improvement Quality Improvement Personal Development	Promotion of Health and Well being Assessment and Care Planning Provision of Care to Meet Health Needs Self Management/Self Management Support Health Education and Health Literacy Health and Wellbeing: Lifestyle - Nutrition and weight management - Physical activity - Smoking cessation	Health Informatics Information Risk Management	Managing Self and Personal Skills Providing Direction: Strategic And Operational Planning Leading and managing change Leading and building Interdisciplinary Teams: Working with People Purchasing and Financial Management: Using Resources Performance and Service Improvement Services and Project Management Public Relations and Marketing

Clinical Specific for District Nursing

This Dimension contains Aspects of Care that specifically relate to the clinical practice of district nursing

Skin Integrity (wound management), Pain and Comfort , Continence – Urinary, Continence – Bowels, Enteral Nutrition, Cardiovascular, Respiratory, Diabetes, Chronic Kidney Disease, Cancer Care, Palliative Care, Care of the Older Person, Care of a Child or Young Person, Care of a Person with Mental Health Needs, Care of a Person with Intellectual Disability Needs, General Medication Administration.

Figure 2: DNKSP model

HOW TO USE THE DNKSP

Throughout each DNKSP aspect of care there are indicators which need to be endorsed by peer assessor(s). The lists of indicators have been divided by colors (blue, green and red); a suggested order of completion for nurses entering the practice of district nursing is:

- Blue: completed within 2 – 4 weeks of commencing the programme
- Green: complete within 3 – 6 months of commencing the programme
- Red: complete within 6 – 18 months of commencing the programme

However, as education to complete the DNSKP needs to be set in the context of the individual's practice setting, specialty, local operating policies, the clinical governance team and local expertise, the indicators can be completed in any order and agreed timeframes.

Prior to commencing the DNSKP, the individual and their preceptor/leader meet and confirm which ASPECTS and INDICATORS need to be undertaken and/or evidenced and in what order. As part of this process, it is recommended that the individual completes a self assessment of their current knowledge and skills against the indicators of each agreed ASPECT and records their self assessment score for each in the first column of the template (see example below). From this, the teaching/learning opportunities necessary for completion of each ASPECT can be identified and timeframes agreed.

Recognition of Prior Learning (RPL) can be requested where the individual identifies they have already met required outcomes (RPL Tool kit on CPHCN website).

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can Teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	Identifies what collaboration means and how this applies to their team.				

***NOTE**: The space provided in the DNSKSP tables (see Part Two) is sufficient to list evidence, but not for full descriptions. If participants elect to use descriptions as their main mode of evidence, the use of a ring binder/ring bound book in which to write/collate these descriptions under each aspect of care and listed indicator heading is recommended. Cross referencing, rather than repeating evidence provided in a previous aspect of care is also recommended.

A number of ASPECTS within the DNSKP list pre-requisite knowledge requirements, considered key for completing the DNSKP, but which should have been achieved during Level 1 knowledge and skills development (e.g. through an entry to practice programme or novice and advanced beginner nursing knowledge and skills programme). The pre-requisite sections are not an exhaustive list but act as a prompt during self assessment and should not require peer assessment.

SELF ASSESSMENT AND PEER REVIEW

The greatest emphasis is on self directed learning, self assessment and peer assessment.

Self-assessment involves: practitioners making judgments about their own work. Assessment decisions can be made on the practitioner's own projects, presentations, and/or performance. Self-assessment can be extremely valuable in helping practitioners to critique their own work, and form judgments about its strengths and weaknesses. The individual's self-assessment is required to be endorsed and validated by their preceptor and/or peer assessor(s).

Once the person being assessed believes they have achieved the outlined knowledge and skills, they provide the relevant evidence to their peer assessor for validation. Because we are all individuals, there needs to be some degree of flexibility around how evidence of competence can be presented. However, the method must be appropriate to the particular competence being assessed. A variety of methods can be used to evidence knowledge and skills, for example:

- *Written evidence (see note on page 13)
- Demonstration/practice based assessment/verbal discussion
- Case review/case study presentations
- Education sessions
- Exemplars
- Journaling
- Examination
- Reflection on practice
- Recognition of prior learning

Evidence presented must be:

Authentic: an honest reflection of your practice

Relevant: appropriate to the criteria

Sufficient: enough evidence to satisfy the assessment criteria

Current: relate to current practice and role (i.e. within the last 3 years)

Repeatable: a consistent feature of your practice

Peer assessment has been defined as: "An agreement in which individuals consider the amount, level, value, worth, quality, or success of products or outcomes of learning of peers of similar status" (Topping, 1998). Peer review is considered to be an evaluation of the performance of individuals or groups of clinicians by members of the same profession or team. Formal peer involves peers systematically reviewing aspects of the clinicians work to provide guidance, feedback and a critique of performance. The goal being, a review process that is educational, consistent, timely, balanced, fair, useful and ongoing. The peer review process is not the same as the annual performance review and development procedure – though aspects of the peer review process may contribute to the improvement of healthcare quality, performance, effectiveness and efficiency of patient care by the clinician.

The NCNZ defines a peer assessor as an "experienced registered nurse who has recognised clinical skills in the area of practice. The nurse will either work with the nurse or will have observed his/her practice for the purpose of making an assessment" (Nursing Council of New Zealand, 2011). The peer assessor should be at the same, or higher, level and area of practice as the person being assessed. Ideally, each peer assessor has undergone training in assessment methodology (e.g. NZ Qualifications Association Assessing in the Workplace: Unit Standard 4098, or a locally approved training programme).

Holistic competency assessment involves assessing a group of related competencies at the same time. By doing this the assessment better reflects the real world, saves time, streamlines processes and optimises opportunities. As this type of assessment is being performed the applicant's competence and gaps in knowledge should become apparent (Australian Government Education Department Resource Generator, nd.).

If using questioning to validate competency, Spencer (2006) suggests using the following four broad lines of enquiry:

1. Clarifying experience
2. Exploring routine and planned responses
3. Responding to challenges
4. Promoting health, safety and wellbeing.

For skills demonstration, the Criteria for Clinical Competency Evaluation (Bondy, 1983) is suggested for evaluating performance (see below). The tool uses a five point rating scale to evaluate performance in three major areas. Independent means meeting the criteria identified in each of the 3 areas above. Performance must be observed to be rated independent by someone other than the nurse carrying out the procedure.

> **Effect** refers to achievement of the intended purpose of the behaviour.
>
> **Affect** refers to the manner in which the behaviour is performed.
>
> **Quality of performance** includes the use of time, space, equipment, and expenditure of energy.
>
> **Assistance required**. Cues can be supportive or directive. Cues such as 'that's right' or 'keep going' are supportive/encouraging but do not change or direct what the nurse is doing. Directive cues, which can be verbal or physical, indicate either what to do or say next or correct an ongoing activity. The x (not observed) category indicates when the opportunity to demonstrate a particular competency was not available to the nurse in the setting.

The RPL toolkit on the CPHC Nurses provides more information regarding competency assessment.

CRITERIA FOR CLINICAL COMPETENCY EVALUATION

Scale Label	Professional standards and procedures for behaviour	Quality of performance	Assistance to perform the behaviour
Independent	Safe Accurate Effect } Each time Affect }	Proficient, coordinated, confident. Occasional expenditure of excess energy Within an expedient time frame	Without supporting cues
Supervised	Safe Accurate Effect } Each time Affect }	Efficient, coordinated, confident. Some expenditure of excess energy Within a reasonable time frame	Occasional supportive cues
Assisted	Safe Accurate Effect } Each time Affect }Most of time	Skilful in parts of behaviour. Inefficient and uncoordinated. Expends excess energy Within a delayed time frame	Frequent verbal and occasional physical directive cues in addition to supportive ones
Marginal	Safe but not alone Performs at risk Accurate –not always Effect } occasionally Affect }	Unskilled, inefficient, Considerable expenditure of excess energy Prolonged time frame	Continuous verbal and frequent physical cues
Dependent	Unsafe Unable to demonstrate behaviour	Unable to demonstrate procedure/behaviour. Lacks confidence, coordination, efficiency	Continuous verbal and physical cues
X	Not observed		

PART TWO: THE KNOWLEDGE AND SKILLS PROGRAMME

DIMENSION 1: CORE

This includes

(C1) Health Care Teams

(C2) Communication

(C3) Ethical Health Care

(C4) Treaty of Waitangi, Cultural Safety and Maori Health

(C5) Health and Safety/Risk Management

(C6) Service Improvement

(C7) Quality Improvement

(C8) Personal Development

A KEY is provided in each section for you to self assess against the indicators and for your preceptor/leader to validate your knowledge and skills. Space is provided for you to write a brief summary of evidence. The lists of indicators for each aspect of care have been divided by colours (blue, green and red); a suggested order for nurses entering the practice of district nursing is:

- *Blue: completed within 2 – 4 weeks of commencing the programme*
- *Green: complete within 3 – 6 months of commencing the programme*
- *Red: complete within 6 – 18 months of commencing the programme*

TEAMS (C1)

Description

The Team is a group of individuals with diverse education, training and backgrounds who work together as an identified unit or system. To be effective teams must have a clear purpose, good communication, co-ordination, protocols and procedures and effective mechanisms to resolve conflict when it arises. Effective teams recognise everyone's contribution, promote individual and team development, recognise the benefits of working together for the patient and see accountability as a team responsibility.

Suggested Resources

- The following website provides information and links about Team Development: http://www.humanresources.about.com/od/teambuilding/f/team_stages.htm
- How to be a good team player: http://www.mindtools.com/pages/article/newTMM_53.htm
- Nursing Council: Guideline: Responsibilities for Direction and Delegation of Care to Enrolled Nurses (2011)

Core 1/Level 2: Collaborates with team members, sharing knowledge, skills and expertise to achieve agreed outcomes.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Identifies what collaboration means and how this applies to their team.				
	b) Discusses the principles of direction and delegation, applies them to self and others (e.g. other nurses, students, family/whānau).				
	c) Demonstrates effective prediction, scheduling and allocation of nursing resources to deliver patient care.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	d) Identifies the members of their team, their scopes of practice, and their roles and responsibilities within that team (including own).				
	e) Identifies the role and criteria for service delivery models unique to their team (e.g. HITH, acute demand/rapid response).				
	f) Describes the role of IDT members, multi-professional agencies and community organisations in supporting people with health conditions, including PHC organisations and NGOs. Discuss the appropriate referral process for these.				
	g) Identifies how the team contributes to the current organisational vision, goals and strategies.				
	h) Demonstrates networking with relevant IDTs and other services when planning and delivering care.				

COMMUNICATION (C2)

Description

This aspect relates to effectively communicating the needs and requirements of patients, staff and stakeholders to provide excellent care and service. Effective communication is a two way process. It involves identifying what others are communicating and the development of effective relationships as well as one's own communication skills.

Suggested Resources

- Introduction to Communication Skills: Why Communications Skills Are So Important: http://www.mindtools.com/CommSkll/CommunicationIntro.htm

Core 2/Level 2: Communicates effectively with patients, their family/whānau, and team members including using a variety of effective communication techniques and employing appropriate language for the context.

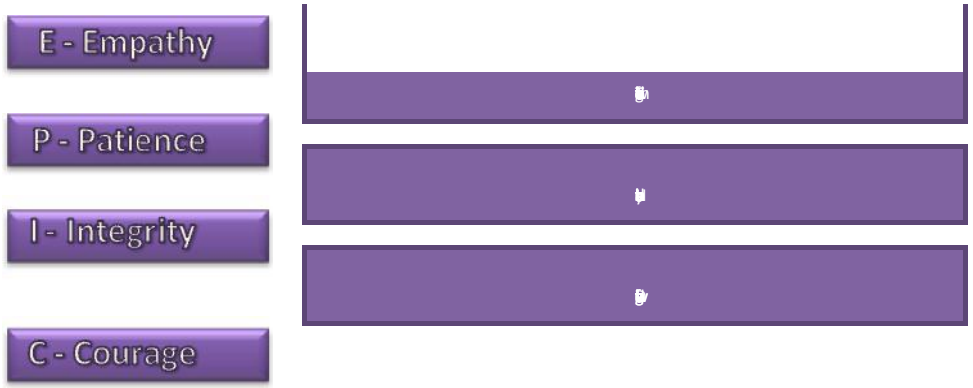
Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Demonstrates communication that is effective, culturally appropriate to individuals, groups and situations, and is consistent with code of conduct, relevant legislation and policies and procedures; uses a range of communication tools (including interpreter services).				
	b) Maintains accurate and complete records, consistent with legislation, policies and procedures.				

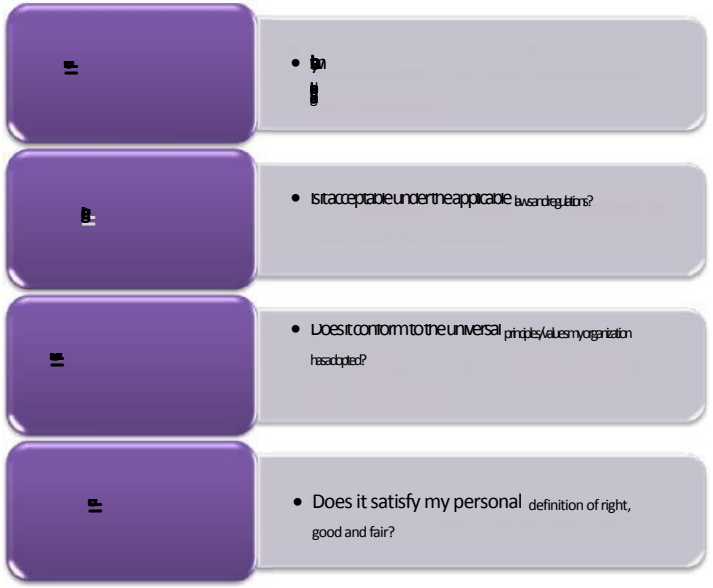
Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	c) Describes key components for the development, maintenance and closure of the therapeutic relationship, including therapeutic use of self.				
	d) Describes potential communication barriers related to illness, age, ethnicity, gender or disability.				
	e) Describes communication strategies that are appropriate for a person/family with aggressive/challenging behaviours, including de-escalation techniques.				
	f) Articulates the ways in which own values, beliefs and attitudes affect interactions with others.				

ETHICS (C3)

Description

This aspect of care relates to ethical principles underpinning health care practice; reflecting on our values and beliefs to ensure equitable and fair service provision and delivery, including respect for the autonomy and choices of individuals and groups. It includes the following universal principles and values:





Suggested Resources

- NZ Health & Disability Ethics Committees http://www.ethicscommittees.health.govt.nz/
- Ethics Resource Centre http://www.ethics.org/
- Code of Health and Disability Consumers' Rights
- Privacy Act/ Health Information Privacy Code
- Nursing Council: Code of Conduct (2012) and Guidelines for Professional Boundaries (2012)

Core 3/Level 2: Complies with ethical principles, legislation, policies and procedures and encourages others to do so.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Demonstrates that own practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.				
	b) Discusses key aspects of community based nursing that need to be considered in maintaining a professional practice environment: i. Privacy/security of patient information ii. Patient advocacy iii. Promoting choice within the context of family care iv. Boundaries/disclosure/dual relationships/gifts/reciprocity v. "Guest" behaviour in the home.				
	c) Identifies, reflects on and addresses ethical issues with the patient/family /whānau /health team members including application of an ethical framework.				

MĀORI CULTURAL RESPONSIVENESS (C4)

Description

Māori as tangata whenua hold a unique place in Aotearoa NZ. Te Tiriti o Waitangi: the Treaty of Waitangi, is widely acknowledged as the founding document for Aotearoa/NZ, signed in 1840 by the Māori people and the British Crown. The principles of partnership, protection and participation enable Iwi/Māori and health care staff to work together from a position of 'good faith' in order to jointly improve the health and wellbeing of Māori whānau. Cultural responsiveness is about the acquisition of skills and knowledge to achieve a better understanding of members of other cultures. Cultural responsiveness is central to improving Māori health, and requires a commitment by health care workers to ensure culturally responsive practices. Cultural responsiveness requires that staff:

- Are aware of the impact of social and cultural factors on health beliefs and behaviours
- Are able to make linkages between cultural responsiveness, quality improvement and elimination of racial and ethnic disparities
- Are equipped with tools and skills to manage these factors appropriately through training and education
- Empower whānau to be actively involved in managing their own health.

(Durie, 1997)

Suggested Resources

- Accident Compensation Corporation Hauora competency standards
- Health Practitioners Competence Assurance Act (2003), Section 118
- He Korowai Oranga: Māori Health Strategy
- Te Puni Kokori Website: http://www.tpk.govt.nz/en/in-focus/whanau-ora/
- The Whanau Ora Tool (Ministry of Health, 2008)
- Ministry of Health Website: http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora
- Maori Cultural Responsiveness in Practice booklet
- Whanau Centred Initiatives
- Regional Maori Health Action Plan, Ka Po Ka Ao Ka Awatea
- Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing education and practice (Nursing Council of NZ, 2011)

Core 4/Level 2: Demonstrates knowledge and application of Māori Health, Te Tiriti o Waitangiand Cultural Safety in own work and encourages others to do so.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Demonstrates application of: I. The principles of the Te Tiriti o Waitangi II. Cultural safety principles in service delivery.				
	b) Describes key Māori values, concepts and beliefs (including Whānau, Hapu and Iwi).				
	c) Applies Māori models of health to practice (including the Te Whare Tapa Wha model and the Whānau Ora framework).				
	d) Identifies local Iwi/Māori networks, providers, and organisations in local geographical area.				

HEALTH & SAFETY/RISK MANAGEMENT (C5)

Description

This aspect of care focuses on maintaining and promoting the health, safety and security of everyone in the organisation or anyone who comes into contact with it. It includes tasks that are undertaken as a routine part of one's work (e.g. moving and handling), as well as managing emotional, mental, physical, social, and spiritual risks.

Suggested Resources

- Code of Conduct
- ACC Health and Safety Guide to Working in Isolation in the Health and Disability Sector
- Managing the Risk of Workplace Violence to Healthcare and Community Service Providers (Ministry of Business, Innovation and Employment, 2009)
- http://www.osh.govt.nz/
- http://www.acc.co.nz/

Core 5/Level 2: Monitors and maintains health and safety of self and others.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Identifies, assesses and documents the potential and actual risks involved in work activities and processes for self and others (e.g. personal risk, physical risk, non physical risk).				
	b) Reports actual or potential hazards/problems that may put health and safety at risk and suggests how they might be addressed (e.g. manual handling, enablers).				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	c) Describes appropriate action to take in an emergency/incident/accident (including recording and reporting).				
	d) Operates vehicle in a manner that promotes occupational health and safety.				
	e) Demonstrates knowledge of and applies legislative requirements and local policy in relation to employer and employee responsibilities for health and safety.				
	f) Discusses education to be provided to patients/carers regarding health and safety (e.g. manual handling, use of equipment, disposal of clinical waste, falls preventions etc) and nursing responsibilities in relation to this.				
	g) Discusses/demonstrates strategies for maintaining Standard Precautions and prevention of cross contamination within and between care settings.				
	h) Describes signs that may indicate that a child, youth or vulnerable adult is at risk of maltreatment, neglect or abuse (physical, emotional or sexual), the nursing responsibilities and reporting process.				
	i) Demonstrates ability to develop a plan to resolve, mitigate or manage risk and document same.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	j) Describes the circumstances/conditions in which transmission based precautions are required, the precautions required and the associated nursing responsibilities.				
	k) Describes nursing responsibilities in relation to management of exposure to blood and body fluid.				
	l) Defines incident/adverse event/near miss and describes nursing responsibilities for same.				
	m) Discusses legislation & local policy in relation to care and protection, family violence, neglect & abuse.				
	n) Discusses indications of substance abuse and appropriate actions to take.				
	o) Discusses the risks associated with working alone or remote from normal services/support: I. Emotional II. Physical III. Professional isolation				

SERVICE IMPROVEMENT (C6)

Description

This aspect is about improving services in the interests of whānau/clients and the community. The services might be services for clients or services that support the smooth running of the organisation. The services might be single or multi-agency and single or multi-disciplinary. Improvements may be small scale, relating to specific aspects of a service or programme, or may be on a larger scale, affecting the whole of an organisation or service. They might arise from:

- formal evaluations (such as audit)
- more informal and ad hoc approaches (such as 'bright ideas')
- outcomes from using Performance and Service Improvement tools such as Process mapping, experience based design
- national policy and targets
- evidence based best practice

NOTE: This aspect is different from Dimension Five: Leadership and Management Aspect 6; Performance and Service Improvement which is about leading and managing services and service improvement.

Suggested Resources

- Bevan H, Ham C, & Plsek P. (2008). The next leg of the journey: How do we make High Quality Care for all a reality?
- Carroll J S, & Edmondson A C. (2002). Leading organisational learning in health care, www.qualityhealthcare.com
- Davies H, Nutley S M, & Mannion R. (2000). Organisational culture and quality of health care, Quality in Health Care, Vol, 9: 111-119
- NHS Institute for Innovation and Improvement (2005). Improvement Leaders Guide: Leading Improvement, http://www.institute.nhs.uk
- Womack, J.P. et al (2005). Going Lean in Health Care. Innovation Series 2005.
- http://www.nursingevidence.org.nz

Core 6/Level 2: Contributes to the improvement of services.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Describes the service's current funding streams and contracts				
	b) Makes suggestions as to how services can be improved for patients and stakeholders.				
	c) Contributes to team based discussions/activities focused on service development, improvement and evaluation.				
	d) Demonstrates knowledge of the potential impact that changes in direction, policies and strategies can have on the above.				

QUALITY IMPROVEMENT (C7)

Description

This aspect relates to maintaining high quality in own individual work and practice, including the important aspect of effective team working. Quality can be supported using a range of different approaches including codes of conduct and practice, evidence-based practice, guidelines, legislation, protocols, procedures, policies, standards and systems. It also supports the governance function in organisations – clinical, corporate, financial, information, staff etc.

Suggested Resources

The Health Quality & Safety Commission was established under the New Zealand Public Health & Disability Amendment Act 2010 to ensure all New Zealanders receive the best health and disability care within our available resources. The programmes focus on specific areas, working with those who provide services and those who use them to reduce avoidable deaths and harm, and make changes for the better. Improving the quality and safety of our health and disability services will lead to greater efficiency and better value http://www.hqsc.govt.nz/

http://www.hqsc.govt.nz/

http://www.hiirc.org.nz/

Core 7/Level 2: Maintains quality in own work and encourage others to do so.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Participates in quality improvement activities to monitor and improve standards of care (e.g. wound audit, case review).				
	b) Describes their organisation's quality plan and goals.				
	c) Monitors the quality of work in own area and alerts others to quality issues e.g. audit schedule and action planning based on audit results.				
	d) Describes and demonstrates processes for initiating practice change based on audit.				
	e) Discusses the roles, responsibilities and activities of their organisation's clinical governance groups.				

PERSONAL DEVELOPMENT (C8)

Description

This aspect of care is about developing oneself using a variety of means and contributing to the development of others during ongoing work activities. This might be through structured approaches (e.g. the development review process, appraisal, mentoring, professional/clinical supervision) and/or informal and ad hoc methods (such as enabling people to solve arising problems).

Suggested resources

- The critical thinking community –nursing and health care http://www.criticalthinking.org/pages/nursing-and-health-care/801
- Performance Development/appraisal processes
- Online professional develoment- eg, http://www.goodfellowclub.org/
- Professional development plans
- Human Resource Personnel
- HWNZ Career Plan Template: http://www.healthworkforce.govt.nz/health-careers/career-planning/career-plan-template

Core 8/Level 2: Develops own knowledge and skills and provides information to others to help their development.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Takes responsibility for own professional development and takes an active part in learning opportunities.				
	b) Seeks feedback from others in relation to how he/she is applying knowledge and skills in relation to the position description.				
	c) Reflects on and evaluates own professional practice and behaviour and its effect on others.				
	d) Participates in the performance review of own work against the position description, identifying areas for learning and development.				
	e) Reflects on and evaluates the effectiveness of learning opportunities and alerts others to benefits.				

DIMENSION 2: HEALTH AND WELLBEING

Complete the 6 Aspects of Care in this section:

(HWB1) Promotion of Health and Wellbeing

(HWB2) Assessment and Care Planning to Meet Health and Wellbeing Needs

(HWB3) Provision of Care to meet Health and Wellbeing Needs

(HWB4) Self Management/Self Management Support

(HWB5) Health Education and Health Literacy

(HWB6) Health and Wellbeing: Lifestyle:

 HWB6/NW Nutrition and Weight Management HWB6/PA Physical Activity
 HWB6/SC Smoking Cessation (HWB6 / SC)

HEALTH AND WELLBEING (HWB1)

Description

This aspect focuses on promoting health and wellbeing. This includes giving information on how to promote the patient's own and others' health using a variety of teaching methods, techniques and approaches. It might include improving resistance to disease and other factors that affect health and wellbeing, limiting exposure to risk and/or reducing the stressors that affect s health and wellbeing. Activities might take place at individual, family/whānau, group, community and/or population level.

Partnership is a fundamental aspect of this dimension as it is only through working closely with patients, family/whānau, community and other stakeholders that health and wellbeing can be promoted effectively.

Resources

- Health Promotion Forum: www.hpforum.org.nz
- Public Health Association: www.pha.org.nz
- The Ottawa Charter for Health Promotion (1986) www.who.int/healthpromotion/conferences/previous/ottawa/en/
- Maori Health Models: Te Whare Tapa Wha www.health.govt.nz/our-work/populations/maori-health/maori-health-models
- Pacific Health Promotion Model: Fonofale www.hauora.co.nz/resources/Fonofalemodel.pdf

HWB1/Level 2: Plans, develops and implements approaches to promote health and wellbeing.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Demonstrates practice that reflects patient and their family/whānau centred care, recognises and builds on strengths, fosters hope and enhances resilience to promote recovery and wellbeing. b) Discusses the impact an illness and or life limiting condition has on the individual patient and their family/whānau across the lifespan, including the normal responses to grief and loss, and discusses nursing responsibilities in relation to this. c) Demonstrates knowledge of the role of supportive care, both physical and psychosocial, and refers to such services appropriately.				

ASSESSMENT & CARE PLANNING TO MEET HEALTH & WELLBEING NEEDS (HWB2)

Description

This aspect relates to assessing the health and wellbeing needs of individuals and groups, including families/whānau. The assessment focuses on the patient in the context of their community, family/whānau, lifestyle and environment. It includes assessing physiological and/or psychological functioning, history taking and examination, tests and investigations. An assessment may take place in any setting and involves interactions using a variety of communication methods with patients/family/whānau. In undertaking this work, staff will need to be aware of their legal obligations and responsibilities, the rights of the different people involved, and the diversity of the people they are working with.

HWB2 /Level 2: Uses the five steps of the nursing process (ADPIE) to assess health and wellbeing, and to develop, deliver, and evaluate plans to meet specific needs.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	A: ASSESSMENT				
	a) Reviews referral information to plan for first visit and initial assessment including: I. The urgency with which visit and assessments are needed II. Appropriate assessment approaches/framework (e.g. Marjory Gordon's Functional Health Patterns, 2002), methods, techniques and equipment III. Any potential risks to be managed IV. The specific activities to be undertaken.				

Indicators
b) Demonstrates the ability to undertake a health history utilising appropriate frameworks to gather comprehensive health assessment data including: I. Roles and relationships (including home situation) II. Cognitive perceptual (including pain & comfort) III. Self perception/self concept IV. Coping/stress/ tolerance V. Health perception and health management (including infection control status) VI. Values and beliefs VII. Activity-exercise (including cardiac & respiratory) VIII. Sleep/rest IX. Nutrition/metabolic (including skin, wound and diabetes) X. Elimination XI. Sexuality-reproductive patterns. c) Identifies the involvement of other people/agencies in the patient's care. d) Verifies assessment data with the patient and other sources where appropriate e.g. family, patient records, other health professionals.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Evidence**	**Peer Assessor Signature**	**Date**
	D: NURSING DIAGNOSIS				
	e) Analyses assessment data into meaningful groupings through consideration of: I. Psychological parameters II. Health strengths III. Health concerns IV. Risk factors V. Expectations of care VI. Discharge needs VII. Educational needs.				
	f) Collaborates with the patient to identify concerns about their health and wellbeing, formulates nursing diagnoses/clinical problems in relation to these.				
	P: PLANNING				
	g) Shares assessment findings with the wider HCT and involves them in planning where appropriate in order to meet patient's health and wellbeing needs and to manage risk.				
	h) Formulates desired outcomes based on the nursing diagnoses in partnership with the patient, family/whānau and other HCT members.				
	i) Develops and records an individualised plan of care that is culturally appropriate and SMART (Specific, Measurable, Achievable, Realistic and Time framed).				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Evidence**	**Peer Assessor Signature**	**Date**
Indicators				

j) Selects nursing actions, based on acceptable principles of practice, to achieve the desired outcome(s).

k) Incorporates the care prescribed by other members of the HCT into the plan.

PROVISION OF CARE TO MEET HEALTH AND WELLBEING NEEDS (HWB3)

Description

This aspect relates specifically to working with patients who are dependent on others for meeting some or all of their health and wellbeing needs, and with their family/whānau whose own needs might affect what happens to those patients. This dependence might be short-term, long term, or intermittent, depending on the support structures available.

HWB3 /Level 2: Delivers and evaluates care to meet people's health and wellbeing needs.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	I: IMPLEMENTATION				
	a) Prepares for, undertakes and records care activities as planned and delegated, consistent with legislation, policies and procedures and the management of risk.				
	b) Implements, co-ordinates and documents interventions to deliver the plan in partnership with the patient, family/whānau and wider HCT.				
	E: EVALUATION				
	c) Evaluates and systematically records progress toward desired outcomes in collaboration with the patient, family/whānau and wider HCT and revises the plan of care as necessary.				

SELF MANAGEMENT/SELF MANAGEMENT SUPPORT (HWB4)

Description

This aspect is about enabling and empowering individuals, families and groups to address their own health and wellbeing needs. This would include such areas as:

- Helping people to develop their knowledge and skills
- Helping people manage their health conditions
- Providing advice and information
- Supporting people to live independently
- Supporting people during life events.

Long-term conditions absorb 70% of all health care spending and lead to 80% of all deaths in New Zealand. The rising rates of respiratory and cardiovascular diseases and diabetes combine with increasing health disparities and costs to cause a major burden on our health care system. In order to manage and lower this burden some major changes are required. Research identifies self management as being a key element to improve outcomes for long term conditions, reduce demand, support behavioural changes and reduce disease risk factors. Self Management is also one pillar of the Wagner Chronic Care Model. This widely recognised and utilised model provides a framework for re-orienting health systems by focusing on the following six components: the community, delivery system design, decision support, clinical information systems, system organisation and self management support. Evaluation of the use of this model rather than conventional care demonstrates vastly improved outcomes for people with long term conditions and that it can be used within diverse populations and settings.

Resources

- Bycroft, J. and Tracey, J. (2006). Self Management Support: A win-win solution for the 21st century. NZFP, 44, 3
- National Health Committee. (2007). Meeting the needs of people with Chronic Conditions. Hapai te whānau mo ake ake tonu. Wellington: National Health Committee
- Effecting behaviour change in long term conditions (Ministry of Health, 2012) http://www.health.govt.nz/publication/effective-behaviour-change-long-term-conditions

HWB4/Level 2: Enables people to meet ongoing health and wellbeing needs.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Identifies the differences between health education and self-management.				
	b) Discusses the concepts of self-management/self-management support.				
	c) Discusses how developmental stage and development issues impact on self management of a health condition.				
	d) Identifies capability and readiness to change.				
	e) Plans and implements suitable interventions to support change in collaboration with the patient, family/whānau and wider HCT.				
	f) Supports and monitors the patient throughout, enabling them to address their own health and wellbeing as far as it is possible for them to do so.				

HEALTH EDUCATION AND HEALTH LITERACY (HWB5)

Description

This aspect is about the provision of health education, encompassing health literacy.

Effective health education may contribute to the protection of patient safety, improved health outcomes, and the empowerment of patients and whānau to increase control over their health and wellbeing through increasing health literacy levels.

As indicated in Rauemi Atawhai (A Guide to Developing Health Education Resources in New Zealand), a person with a good level of health literacy is able to find, understand and evaluate health information and services easily in order to make effective health decisions. All New Zealanders have the right to receive 'effective communication in a form, language, and manner that enables the consumer to understand the information provided' (Right 5) and 'to be fully informed' (Right 6) under the Code of Health and Disability Services Consumers Rights Regulation 1996. The health literacy demands of the health sector continue to increase because:

- People are living longer and managing a wider range of health issues
- People are expected to manage their own health, stay informed about health matters and be responsible for their health decisions
- The health system is continually changing
- New technologies are being introduced to the health sector
- More health information is available than ever before.

Health professionals and health providers must ensure health information is communicated in a way that enables patients to make informed decisions, and take appropriate actions to protect and promote their health. Research indicates that health literacy is a stronger predictor of health status than education level, ethnicity, gender, or socioeconomic status.

Resources

- http://www.healthliteracy.org.nz
- http://www.healthnavigator.org.nz/centre-for-clinical-excellence/health-literacy/
- Waipuna Statement 2011 http://www.hpforum.co.nz
- MoH (2012). Rauemi Atawhai: A Guide to Developing Health Education Resources in New Zealand
- MoH (2010) Kōrero Mārama: Health Literacy

HWB5/Level 2: Provides health education to individual and groups.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Demonstrates ability to assess: I. Self-care actions II. Self-awareness III. Patients knowledge about their condition IV. Treatment options V. Health literacy VI. Learning styles.				
	b) Provides ongoing education in relation to the changing need/condition of the patient.				
	c) Maximises opportunities to promote learning.				
	d) Incorporates adult teaching and learning principles in all health education.				
	e) Provides and/or guides the patient / family/whānau to appropriate resources and information that will facilitate informed decision making and the management of their own health needs.				
	f) Plans and implements suitable interventions to support change in collaboration with the patient, family/whānau and wider HCT.				

HEALTH AND WELLBEING: LIFESTYLE (HWB6)

Description

Long-term conditions are a group of diseases that share similar risk factors because of exposure to unhealthy diets, smoking, lack of exercise, and possibly stress. The major risk factors are high blood pressure, tobacco addiction, high blood cholesterol, diabetes and obesity. These result in various long-term disease processes, culminating in high mortality rates attributable to stroke, heart attack, tobacco- and nutrition-induced cancers, chronic bronchitis, emphysema, renal failure, and many others. Internationally, these diseases are also known as 'non-communicable diseases' (NCDs), 'degenerative diseases' or chronic diseases of lifestyle (CDL) (World Health Organisation (2005). *Preventing Chronic Diseases: a vital investment*).

"There is abundant evidence to support the argument that a large percentage of long-term conditions are preventable by changing modifiable and intermediate risk factors. Poor diet and physical inactivity directly account for 4.8 million deaths each year. Furthermore, poor diet and physical inactivity significantly influence intermediate risk factors that contribute to over 14 million deaths a year. This provides an imperative to develop evidence-based policies and supportive programmes to target these risk factors."(World Health Organisation (2008). *Interventions on diet and physical activity. What works?*).

Resources

- New Zealand Guidelines Group http://www.health.govt.nz/about-ministry/ministry-health-websites/new-zealand-guidelines-group
- National Guidelines Clearinghouse http://guideline.gov/index.aspx
- National Institute for Health and Clinical Excellence http://www.nice.org.uk/
- Action on smoking habits http://www.ash.org.nz
- Ministry of Health (2009) Clinical guidelines for Weight Management in New Zealand Adults
- NZ smoking cessation guidelines: NZMJ 20 June 2008, Vol 121 No 1276; ISSN 1175 8716 URL: http://www.nzma.org.nz/journal/121-1276/3114/
- http://www.health.govt.nz/yourhealth-topics/physical-activity

HEALTH & WELLBEING: LIFE STYLE - NUTRITION & WEIGHT MANAGEMENT (HWB6/NW)

HWB6/NW/Level 2: Plans, develops and implements approaches to meet nutritional needs

Pre-requisite:

Knowledge of the relationship between poor eating habits and long term conditions such as heart disease, obesity, cancer, diabetes, hypertension, and osteoporosis.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Identifies barriers to healthy eating including social, financial, physical and provides options to overcome these.				
	b) Supports people to make healthy food choices, increasing awareness of safe alcohol levels, healthy alternatives to popular fast food, healthy cooking methods and cultural and ethnic considerations in healthy nutrition.				

HEALTH AND WELLBEING: LIFE STYLE - PHYSICAL ACTIVITY (HWB6/PA)

HWB6/PA /Level 2: Plans, develops and implements approaches to assist the person to improve their physical functioning.

Pre-requisite:

Knowledge of the impact of exercise and regular physical activity on modifiable health risk factors.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Identifies factors to consider prior to advising on exercise i.e. previous exercise routines, limitations, capacity, cultural needs, social circumstances.				
	b) Helps people set achievable goals for everyday activities.				

HEALTH AND WELLBEING: LIFE STYLE - SMOKING CESSATION (HWB6/SC)

HWB6/SC/Level 2: Gives brief advice for smoking cessation based on national guidelines and standards of practice.

Pre-requisite:

Knowledge of tobacco dependence as a chronic relapsing condition.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Asks all people about their smoking status at each admission to the service and gives brief advice for smoking cessation based on the MOH Smoking Cessation Guidelines.				

DIMENSION 3: CLINICAL SPECIFIC

Complete all Aspects of Care in this section relevant to your service

(CS1) Skin Integrity (Wound Management)
(CS2) Pain and Comfort
(CS3) Continence – Urinary
(CS4) Continence – Bowels
(CS5) Enteral Nutrition
(CS6) Cancer care
(CS7) Palliative Care
(CS8) Cardiovascular
(CS9) Respiratory
(CS10) Diabetes
(CS11) Chronic Kidney Disease
(CS12) Caring for the older person
(CS13) Caring for a child or young person
(CS14) Caring for a person with a mental health condition
(CS15) Caring for a person with an intellectual disability
(CS16) General Medication Administration

For resources to assist with completing the following aspects of care - see the NZCPHCN Education Standing Committee resource list of websites with content of educational value to PHC nurses for clinical specific resources. Available at http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/resources

SKIN AND TISSUE INTEGRITY (CS1)

CS1/Level 2: Applies evidence based practice principles to prevent skin breakdown, and to enable early recognition and effective management when caring for people with altered skin integrity.

Pre-requisites:

Knowledge of the anatomy and physiology of the skin and underlying

structures Knowledge of the pathophysiology of:

- peripheral arterial disease
- venous disease
- lymphoedema
- diabetes including sensory, autonomic and motor neuropathy.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses factors that impact on skin integrity I. Age and developmental stage II. Extrinsic: moisture, sheer and friction III. Intrinsic: nutrition, skin temperature, oxygen delivery, illness, BMI IV. Impaired activity/mobility V. Other.				
	b) Identifies and discusses the stages and principles of wound healing including Tissue, Infection/Inflammation, Moisture Balance and Edge of Wound (TIME).				
	c) Performs and documents an assessment using a recognised wound assessment				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	tool/framework.				
	d) Recognises and discusses factors that impact on wound healing and action to take in relation to the following: I. Colonisation, critical colonisation, infection II. Smoking III. Malignancy/illness IV. Diabetes V. Other factors.				
	e) Describes different types of pain associated with a wound - before, during and after a dressing change - and discusses appropriate management in relation to the following: I. Background forces e.g. ischaemia, infection, neuropathy II. Mechanical forces e.g. trauma, tight bandaging III. Chemical forces e.g. contact allergies, wound exudate IV. Thermal stimuli e.g. temperature of wound cleansing V. Wound desiccation e.g. product selection.				
	f) Determines the nursing diagnoses for a person with each of the following categories of wounds and develops a nursing care plan for each category:				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	I. Acute wound e.g. burn, skin tear, surgical wound II. Chronic wound e.g. arterial or venous leg ulcer, pressure injury, diabetic foot wound III. Malignant wound.				
	g) Discusses the impact of wounds, and appropriate action to take, in relation to: I. Body image/appearance II. Self-esteem / social isolation / relationships / emotions / culture.				
	h) Identifies the range of nutritional elements required to promote optimal wound healing and discuss strategies for addressing deficits.				
	i) Discusses the purpose, action, rationale for use, and possible side effects of wound care products for the following types of wounds:				
	I. Moist II. Wet III. Dehydrated IV. Sloughy/necrotic V. Malodorous VI. Painful/sensitive VII. Critically colonised/infected				
	VIII. Wounds requiring drainage systems Pre-vacuumed drain (e.g. Medinorm) Drainage tube (e.g. Penrose drain)				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	□ Concertina drain (e.g. Haemovac)				
	The actions and reasons for use of: IX. Rapid capillary action dressings X. Sodium chloride impregnated dressings XI. Topical negative pressure therapy XII. Enzymatic debriding.				
	j) Demonstrates evidence based practice in the following:				
	I. Skin preparation and protection II. Removal of dressings III. Cleansing of wounds IV. Removal of sutures/clips V. Dressing preparation and application, including packing of wounds VI. Use of equipment related to wound care e.g. scissors, probes, forceps VII. Infection control practices VIII. Wound swabbing IX. Debridement of wounds				
	X. Topical negative pressure therapy.				
	k) Performs and documents a pressure risk assessment using a recognised assessment tool/framework e.g. Braden.				
	l) Discusses the difference in appearance between pressure injuries caused by: I. Pressure II. Friction III. Shear.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	m) Identifies the six stages of pressure injuries as described in the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury and discuss the nursing interventions required for each, including pressure redistribution and reporting.				
	n) Discusses the range and function of pressure redistribution devices, how to access these and other nursing responsibilities in relation to their use.				
	o) Describes the factors that contribute to reduced wound healing in people with diabetes e.g. hyperglycaemia, advanced glycation end product (AGE).				
	p) Demonstrates assessment, diagnosis and nursing management of a person with diabetes in relation to: I. Screening an "at risk" foot, including Charcot Foot II. Self-management strategies to reduce risk of ulceration III. Treatment of ulcerated areas IV. Treatment of necrotic area (dry & moist) V. Signs of infection and management VI. Glycaemic control.				
	q) Discusses nursing management of the following in relation to best practice				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	guidelines and local policy and procedure: I. Skin tears II. Burns III. Lymphoedema IV. Radiation therapy skin reactions V. Skin grafts VI. Donor sites VII. Pin sites.				
	r) Discusses signs, symptoms and contributing factors, recommended management protocols and nursing responsibilities in relation to the following conditions: I. Fungal and or bacterial infections II. Infestations III. Allergies IV. Eczema V. Psoriasis VI. Gout VII. Osteomyelitis.				
	s) Discusses patient education and self management to prevent skin tears/breakdown and manage recently healed wounds.				
	t) Demonstrates assessment, diagnosis and nursing management of a venous leg ulcer as outlined by the Australian & NZ Clinical Practice Guideline for Prevention and Management of Venous Leg Ulcers.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	u) Demonstrates evidence based compression therapy practice.				
	v) Demonstrates evidence based Doppler assessment (or appropriate response to ABPI and lower limb assessment data).				
	w) Identifies arterial, neuropathic or atypical characteristics of a leg ulcer and discusses appropriate nursing management.				
	x) Discusses services available to assist with wound management e.g. podiatrist, wound specialist, surgical services, OT, lymphoedema specialist.				
	y) Identifies subjective and objective parameters that indicate that a person with a wound requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				

PAIN AND COMFORT (CS2)

CS2/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people experiencing pain.

Pre-requisite:

Knowledge of the pathophysiology of pain and differences between:

- Nociceptive pain
- Neuropathic pain
- Acute pain
- Persistent pain
- Palliative pain.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Describes the components of comprehensive pain assessment and discusses signs, symptoms, characteristics and impact of pain including physical, social and psychological factors.				
	b) Discusses acute clinical presentation, recommended management protocols and nursing responsibilities in relation to abnormal, persistent, recurring, or deteriorating symptoms of pain.				
	c) Demonstrates the use of an appropriate pain assessment tool for the following				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	groups and develops a plan of care: I. Adult II. Older person III. Person with a cognitive impairment (e.g. Abbey tool) IV. Child.				
	d) Describes the steps of the analgesic ladder, medication classes, actions, interactions, potential side effects and nursing responsibilities.				
	e) Identifies strategies for improving comfort and educates the patient/family/whānau; includes the use of: I. Analgesia II. Non-pharmacological interventions III. Complementary therapies.				
	f) Discusses factors to be considered when evaluating the effectiveness of pharmacological and non-pharmacological analgesic interventions (including timeframes).				
	g) Describes the role of antidepressant and anticonvulsant adjuvant medications for people with neuropathic pain.				
	h) Discusses addiction, tolerance and dependence in relation to analgesia, including signs and management of each.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	i) Discusses the clinical presentation and nursing care/management protocols of a person with Complex Regional Pain Syndrome.				
	j) Discusses resources and other services available to assist with pain management e.g. NZ Pain Society.				
	k) Identifies subjective and objective parameters that indicate that a person with pain requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				

CONTINENCE – URINARY (CS3)

CS3/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for experiencing alterations in urinary continence.

Pre-requisite:

Knowledge of the structure of the pelvic floor, detrusor muscle and normal bladder function.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Knows signs and symptoms and criteria for suspecting a urinary tract infection and treatment options for a person: I. Without an indwelling urinary catheter II. With an indwelling urinary catheter.				
	b) Discusses the nursing responsibilities, management and patient education, including physical, social, sexual and psychological factors, required when caring for a person with altered urinary elimination, and develops a care plan for one (may be person with catheter, nephrostomy, urostomy or ileal conduit).				
	c) Demonstrates knowledge of a range of continence products and catheters, including basis for selection, size and properties.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	d) Describes indications, rationale, management, limitations and contraindications for the following: I. Indwelling Catheter II. Suprapubic Catheter III. Intermittent Self-Catheterisation IV. External Catheter (Uridome) V. Bladder Irrigation VI. Catheter Valve VII. Catheter specimen VIII. Nephrostomy. e) Describes the nursing responsibilities, management and patient education and demonstrates knowledge and skill in relation to the following: I. Insertion of an indwelling catheter (male and female) II. Change of indwelling and suprapubic catheter III. Trial removal of catheter (TROC) IV. Irrigation of bladder. f) Demonstrates patient education for the following: I. Intermittent self-catheterisation, including use and care of catheter II. Catheter valve and cautions for use III. Post TURP IV. Catheter bag V. Uridome VI. Adequate hydration				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	VII. Prevention of infection, trauma (bladder, penile & urethral), obstruction. g) Discusses potential causes, nursing responsibilities and management of the following problems: I. Leaking catheter II. Blocked catheter III. Detrusor muscle spasm IV. Haematuria V. Trauma (bladder, penile and urethral) VI. Blocked nephrostomy tube h) Outlines the pathophysiology of autonomic dysreflexia, the signs and symptoms, causes and management.				
	i) Describes the following types of urinary incontinence, their causes, signs, symptoms and management: I. Stress II. Urge III. Neuropathic IV. Overflow V. Functional VI. Transient VII. Overactive bladder syndrome (detrusor instability). j) Describes the components of a comprehensive urinary continence assessment including abdominal palpation				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	and bladder scan (if available) using appropriate tool(s) and diagnostics to complete; identifies the type of incontinence and develops a nursing care plan.				
	k) Demonstrates effective nursing education and support in relation to pelvic floor exercises and bladder retraining.				
	l) Describes the role of the following medications (include indications for use, actions, side effects, interactions and nursing responsibilities): I. Anti-cholinergics II. Oestrogen III. Tricyclic antidepressant IV. Vasopressin				
	m) Discusses resources and other services available to assist with continence management e.g. Urology Service, Continence Association.				
	n) Identifies subjective and objective parameters that indicate when a person with altered urinary elimination requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				

CONTINENCE – BOWELS (CS4)

CS4/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people experiencing alterations in bowel function.

Pre-requisite:

Knowledge of bowel muscle types and function, and bowel section types and function.

Knowledge of requirements for the maintenance of a healthy bowel – nutrition, hydration, activity.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses signs and symptoms of impaired bowel function/bowel obstruction and action to take, including common causes of constipation and diarrhea.				
	b) Describes the components of a comprehensive bowel assessment and demonstrates the use of an appropriate bowel function assessment tool. Include: I. Bristol stool chart II. Auscultation of bowel sounds III. Rectal examination if appropriate.				
	c) Identifies the type of impaired bowel function and develops a nursing care plan.				
	d) Discusses the role of the following medications (oral/suppository/enema) used in the management of constipation and diarrhoea including names, actions, side effects, interactions and nursing				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	responsibilities (including correct insertion technique): I. Osmotic agents II. Stool softeners III. Stimulants IV. Lubricant V. Sodium Citrate VI. Bulking agents VII. Anti-diarrhoeal agents. e) Describes the management of suspected constipation: I. 1st line treatment (days 1-3) II. 2nd line treatment (day 4) III. 3rd line treatment (day 5). f) Describes the management of diarrhoea: I. Days 1-2 II. Day 3- 4 III. Day 5. g) Discusses the nursing responsibilities, management and patient education required following the formation of a colostomy or ileostomy; include: I. Physical factors such as, stool consistency and frequency, skin care, pouch location, application, odour control, nutrition and hydration II. Social and psychological factors including return to usual lifestyle Develop a plan of care.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	h) Discusses potential causes, recommended management protocols and nursing responsibilities when caring for a person with a stoma that has: I. Retracted II. Prolapsed III. Painful IV. Producing altered motions or change in output V. Broken skin surrounding stoma.				
	i) Describes the components of a comprehensive bowel continence assessment including abdominal palpation using appropriate tool(s) and diagnostics to complete; identifies the type of continence problem and develops a nursing care plan for these.				
	j) Describes indications, rationale, nursing management and patient education for use of a Chait Tube in the management of chronic constipation.				
	k) Discusses available resources and other services available to assist with bowel management e.g. Stomal Therapy Service.				
	l) Identifies subjective and objective parameters that indicate a person with impaired bowel function requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				

ENTERAL NUTRITION (CS5)

CS5/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people having enteral nutrition.

Pre-requisite: Knowledge of normal anatomy and physiology of the alimentary canal and surrounding structures.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses reasons for a person to have a Percutaneous Endoscopic Gastrostomy/Jejunostomy (PEG/PEJ) /Nasogastric (NG) tube inserted for the purpose of providing nutrition.				
	b) Discusses the nursing responsibilities, assessment, nursing diagnoses (including physical, social and psychological factors), interventions and patient education required when caring for a person with a PEG/PEJ or NG. Develops a care plan.				
	c) Demonstrates: I. Routine care of site II. Flushing technique and regime III. Medication administration IV. Feed via bolus to PEG/PEJ or N/G V. Setting up of pump including correct position of patient VI. Monitoring nutritional status.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	d) Describes the education and equipment required to enable the patient/family /whānau to manage the PEG/PEJ or NG independently.				
	e) Discusses the likely cause and management of the following: I. Blocked or clogged tube II. Leakage around the tube III. Diarrhoea IV. Constipation V. Stomach discomfort VI. Over-granulation/impaired skin integrity around stoma VII. Wound infection VIII. Aspiration IX. Accidental removal.				
	f) Demonstrates knowledge and skills to replace PEG/PEJ or NG if appropriate to area of practice.				
	g) Discusses available resources and other services available to assist with enteral feeding e.g. dietitian, company representatives for feeding devices.				
	h) Identifies subjective and objective parameters that indicate that a person with a PEG/PEJ or NG requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				

CANCER CARE (CS6)

CS6/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people with cancer.

Pre-requisite: Knowledge of the pathophysiology of the cancer conditions managed within own service.

Knowledge of the structure and function of the haematologic system

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses the components of a comprehensive assessment, identifies potential nursing diagnoses for a person with cancer. Develops a nursing care plan.				
	b) Explains the principles and application of commonly used treatment modalities including potential treatment side effects and toxicities, their management and nursing responsibilities in relation to this. Includes: I. Oral/intravenous chemotherapy II. Radiotherapy III. Surgery.				
	c) Demonstrates the knowledge and skills required to effectively manage disease and treatment related symptoms through appropriate nursing interventions, including the provision of supportive care:				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	I. <u>Treatment related:</u> including fatigue, nausea, vomiting, reduced appetite, constipation, hair loss, impaired skin and mucosal integrity, reduced immune status, anaemia, altered haemostasis II. <u>Disease related:</u> including pain, impaired skin integrity, ascites, hypercalcaemia, gastro-intestinal effects, altered biochemistry.				
	d) Discusses how a cancer diagnosis affects the person and their family/whānau, and how this changes through the course of the disease from diagnosis to active treatment, to survivorship or palliative and end-of-life care.				
	e) Discusses the nursing responsibilities, management and patient education, including physical, social and psychological factors, required when caring for a person with cancer including abnormal, persistent, recurring, or deteriorating symptoms.				
	f) Identifies subjective and objective parameters that indicate that a person with cancer requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	g) Describes and/or demonstrates safe and effective administration of cancer treatments (relevant to the specific practice context), for example, by: I. Administering cytotoxic medicines and other therapies safely (e.g., biological therapies and immuno-therapy) II. Practising principles of health and safety, including radiation protection, cytotoxic disposal, infection control and essential emergency procedures III. Promoting patients' self-awareness of potential treatment effects by providing education and information. h) Discusses available resources and other services available to assist with caring for the person with cancer. i) Discusses when palliative care would be considered for a person with cancer, how to implement this and who would be involved.				

PALLIATIVE CARE (CS7)

CS7/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people in the palliative phase of their illness.

Pre-requisite: Knowledge of the causes of signs, symptoms and syndromes that commonly occur in palliative patients.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Defines palliative care and describe the role of team members involved in the care of the person with a palliative condition.				
	b) Describes the components of a comprehensive nursing assessment and potential nursing diagnoses for a person with a palliative condition and develops a nursing care plan.				
	c) Describes the role of the following medication groups used in palliative care – names, actions, side effects, interactions, mode and nursing responsibilities I. Analgesics (one from each step of the analgesic ladder) II. Aperients III. Anti-emetics IV. Anti-cholinergics.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	d) Demonstrates syringe driver competency including: *I. Procurement and use of equipment* *II. Site access and management* *III. Procurement and preparation of medications (including drug interactions and incompatibilities)* *IV. Patient/family/whānau/carer education* *e) Demonstrates the knowledge and skills required to effectively manage disease and palliative treatment related symptoms through appropriate nursing interventions, including the provision of supportive care:* *I. Pain* *II. Gastro-Intestinal (nausea and vomiting, appetite, constipation, nasogastric tube to manage obstruction)* *III. Respiratory (breathlessness, secretions)* *IV. Agitation* *V. Ascites* *VI. Hypercalcaemia.* *f) Discusses the nursing responsibilities, management and patient education required when caring for a person with a palliative condition, including physical, social and psychological factors; includes the needs and wishes of the palliative*				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	patient and family/whānau and considers cultural and religious practices around death and dying.				
	g) Discusses nursing responsibilities for abnormal, persistent, recurring, or deteriorating symptoms when caring for a patient with a palliative condition.				
	h) Recognises potential palliative care emergencies and initiates a plan of care that anticipates problems and limits distress for those with a life-threatening illness and their families/whānau				
	i) Describes signs and symptoms of patient deterioration in the last 48 hours and the consequent changes to their care (as per the Liverpool Care of the Dying Pathway).				
	j) Identifies key aspects of family/whānau education/support in the last 48 hours including communication that focuses on recognition that the patient is imminently dying, immediate after death care and bereavement follow up.				
	k) Identifies subjective and objective parameters that indicate a patient with a palliative condition requires consultation with specialist services, medical advice or referral to other services and discusses nursing responsibilities.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	l) Discusses strategies to manage complex ethical issues such as patient and/or family/whānau preference in relation to withdrawing/withholding treatment.				
	m) Discusses available resources and other services available to assist with palliative care management e.g. Hospice Service, Cancer Society, and when to seek medical advice.				

CARDIOVASCULAR (CS8)

CS8/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people with cardiovascular disease.

Pre-requisite:

Knowledge of cardiac anatomy, physiology and biochemistry

- Structure and function of the heart
- Structure and function of the central and peripheral vessels
- Haemodynamics
- Control of blood pressure and other regulatory features of the cardiovascular system.

Knowledge of the six main risk factors for cardiovascular

disease. Knowledge of the pathophysiology and causes of:

- Angina
- Atrial fibrillation
- Myocardial infarction
- Cerebrovascular accident (CVA)
- Heart failure.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Describes the assessment (including FAST criteria for CVA), signs and symptoms and nursing diagnoses for the above pre-requisite conditions and develop a nursing care plan for one of them.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	b) Demonstrates physical cardiac assessment - heart, breath and vascular sounds, inspection, auscultation and palpation techniques.				
	c) Describes the role of the following medications including actions, side effects, interactions and nursing/health professional responsibilities and monitoring requirements: I. Aspirin II. Beta blockers III. Statins IV. Ace-inhibitors V. Diuretics VI. Anticoagulants VII. Oxygen therapy.				
	d) Recognises abnormal objective measurements and reflects on possible potential causes including equipment usage, patient variables, and/or poor technique.				
	e) Recognises and assesses deteriorating cardiac function for patients including: I. Vital signs including pain II. Colour III. Oedema IV. Fatigue, faintness, level of consciousness/alertness V. Capillary refill				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	VI. Respiratory changes.				
	f) Discusses acute presentation, recommended management protocols and nursing responsibilities in relation to the following conditions: I. Angina II. Atrial fibrillation III. Myocardial infarction IV. Cerebrovascular accident (CVA) V. Heart failure.				
	g) Identifies subjective and objective parameters that indicate that a person with a cardiac condition requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				
	h) Describes the principles of cardiac rehabilitation. Develops a nursing care plan for same.				
	i) Discusses the rationale for a person to have a pace maker inserted and the nursing responsibilities in relation to this, including patient /carer education.				
	j) Discusses resources and other services available to assist with cardiovascular management e.g. Heart Foundation.				
	k) Discusses when palliative care would be considered for a person with end stage				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	cardiovascular disease, how this would be implemented and who would be involved.				

RESPIRATORY (CS9)

CS9/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people with respiratory disease.

Pre-requisite:

Knowledge of normal pulmonary anatomy, physiology and biochemistry of:

- Upper respiratory tract
- Pulmonary tree
- Alveolar sacs
- Normal respiratory breathing cycle.

Knowledge of the six main risk factors for respiratory

disease. Knowledge of the pathophysiology and causes of:

- Bronchitis
- Pneumonia
- Bronchiectasis
- Emphysema
- Asthma
- Cystic Fibrosis
- Tuberculosis
- Sleep apnoea.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Describes assessment (including measurement of pulmonary function), signs and symptoms and nursing diagnoses for the above pre-requisite conditions and develop a nursing care plan for one.				
	b) Demonstrates physical respiratory assessment - heart, breath and vascular sounds, inspection, auscultation and palpation techniques.				
	c) Describes the following respiratory medications (include names, indications for use, actions, side effects, interactions and nursing responsibilities): I. Short acting beta agonist II. Long acting beta agonist III. Short acting anticholinergic IV. Long acting anticholinergic V. Inhaled corticosteroid VI. Oral steroids VII. Combination inhaled therapy VIII. Nebuliser medications IX. Oxygen.				
	d) Describes the purpose and use of: spacer devices for inhaled medication, peak flow monitor. Assesses the person's ability to demonstrate appropriate technique, record keeping, response as per individualised action plan.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	e) Recognises abnormal objective measurements and reflects on possible potential causes including equipment usage, patient variables, and/or poor technique.				
	f) Recognises and assesses respiratory distress for people including I. Breathing patterns II. Respiratory rate III. Heart rate IV. Use of accessory muscles V. Peak flow VI. Breath sounds, percussion, and inspection.				
	g) Discusses acute clinical presentation, recommended management protocols and nursing responsibilities in relation to the following conditions: I. Bronchitis II. Pneumonia III. Bronchiectasis IV. Emphysema V. Asthma VI. Cystic Fibrosis VII. Tuberculosis.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	h) Identifies subjective and objective parameters that indicate that a person with a respiratory condition requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				
	i) Discusses the rationale for a person to be commenced on home oxygen therapy and the nursing responsibilities in relation to this, including patient /carer education, equipment supply.				
	j) Discusses the nursing responsibilities for care of a person with a tracheostomy, including patient /carer education and equipment supply.				
	k) Discusses resources and other services available to assist with respiratory management e.g. Asthma and Respiratory Foundation.				
	l) Discusses when palliative care would be considered for a person with end stage respiratory disease, how to implement this and who would be involved.				

DIABETES (CS10)

CS10/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people with diabetes.

Pre-requisite:

Knowledge of the normal pathophysiology including:

- The production of insulin and its role in glucose, lipid and protein metabolism
- Normal blood glucose and HbA1c levels
- The influence of diet and exercise on blood glucose levels
- The production and storage of glucagon and its role in metabolism
- Other hormones produced in the Islets of Langerhans and their role in metabolism.

Knowledge of the six main risk factors for developing

diabetes. Knowledge of the pathophysiology and causes of:

- Type 1 diabetes mellitus
- Type 2 diabetes mellitus
- Diabetes insipidus
- Gestational diabetes.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Describes the assessment, signs and symptoms and nursing diagnoses for a person with Type 1 or Type 2 diabetes mellitus and develops a nursing care plan for them.				
	b) Describes the role of the following medications (include names, indications for use, actions, side effects, interactions and nursing responsibilities): I. Oral hypoglycaemics • Sulphonylurea • Biguanides • Alpha-glucosidase inhibitors II. Insulin • Short acting • Intermediate • Long acting • Combination. c) Demonstrates and teaches the following in relation to insulin: I. Storage, preparation and administration II. Preferred sites and rotation and prevention of liperhypertrophy III. Obtaining, storage and disposal of equipment. d) Discusses the use of blood glucose meters and assesses the person's ability to				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	demonstrate appropriate frequency of testing, technique, record keeping, maintenance of equipment and response as per individualised action plan.				
	e) Recognises abnormal objective measurements (e.g. blood glucose levels, ketonuria, monofilament test results, microalbuminuria screening) and reflects on possible potential causes including equipment usage, patient variables, and/or poor technique.				
	f) Recognises and assesses signs and symptoms of hypoglycaemia including: I. Neuroglycopenic effects II. Autonomic Nervous System effects.				
	g) Recognises and assesses signs and symptoms of hyperglycaemia including: I. Neurological effects II. Autonomic Nervous System effects III. Non-specific effects.				
	h) Describes immediate and ongoing nursing action for the treatment of a person with hypoglycaemia and hyperglycaemia.				
	i) Discusses the following complications in relation to diabetes: I. Hypertension II. Cardiovascular disease III. Peripheral vascular disease IV. Retinopathy				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	V. Neuropathy VI. Nephropathy. j) Discusses the acute clinical presentation, recommended management protocols and nursing responsibilities in relation to the following conditions: I. Hyperosmolar Hyperglycaemia Non-Ketosis (HHNK) II. Ketoacidosis III. Sick day (e.g. nausea, vomiting, diarrhoea, loss of appetite) IV. Concurrent illness (e.g. inflammatory illness /undergoing treatment that causes blood sugars to elevate) V. Diabetic neuropathy. k) Identifies subjective and objective parameters that indicate a person with diabetes requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities. l) Discusses available resources and other services available to assist with diabetes management e.g. Diabetes NZ.				

CHRONIC KIDNEY DISEASE (CS11)

CS11/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for people with chronic kidney disease.

Pre-

requisite:

Knowledge of:

- Normal anatomy and physiology of the kidney
- Difference between acute kidney injury and chronic kidney disease (CKD)
- Main risk factors for developing CKD
- The physiological changes in the kidney and other body systems that occur in CKD.

Knowledge of investigations, and interpretation of the following to assess kidney function:

- Blood
- Urine
- Radiographic
- Ultrasound.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses stages, signs, symptoms of CKD.				
	b) Identifies subjective and objective parameters that indicate a patient with a renal condition requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				
	c) Describes management of the following to delay progression/complications of CKD: I. Blood pressure II. Blood glucose III. Lipids IV. Diet V. Smoking VI. Anaemia. VII. Fluid, hormones and electrolyte balance				
	d) Describes the recall/follow up/referral processes that should occur for people with CKD.				
	e) Discusses resources and other services available to assist with renal management.				
	f) Discusses when palliative care would be considered for a person with end stage CKD, how to implement this and who would be involved.				

CARE OF THE OLDER PERSON (CS12)

CS12/Level 2: Applies evidence based practice principles including prevention, early recognition and symptom management, when caring for older people.

Pre-requisite:

Knowledge of the pathophysiological changes that occur with advancing age including:

- All body systems
- The effect on memory, cognition, learning and decision making
- Sensory perception
- The ability to recover after ill health/hospitalisation and resume activities of daily living
- How the normal ageing process affect pharmacokinetics:
    - Absorption
    - Distribution
    - Metabolism
    - Elimination.

Knowledge of Executive Cognitive Function (ECF) and the impact that impaired ECF has on the behaviour & judgement of affected people. Knowledge of:

- The six most significant risks and exacerbating factors for developing delirium
- The clinical features and progression of delirium
- The clinical features and progression of dementia.
- The six most significant risks and exacerbating factors for developing depression in older people.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	Promoting wellness and 'aging in place'				
	a) Identifies risk factors for older people and nursing/legal responsibilities in relation to the following: I. Risk to self from diminished capacity II. Risk to others III. Risk from others (elder abuse and/or neglect) IV. Risk of suicide.				
	b) Describes risk factors that contribute to falls in older people: I. Environmental II. Person centred III. Medications.				
	c) Demonstrates appropriate assessment and elimination/mitigation/management of falls risk in the home.				
	d) Demonstrates/discusses assessment of the knowledge the patient and carer/family/whānau have of the patient's medication and concordance with same.				
	e) Discusses signs and symptoms that could indicate drug toxicity/interactions/adverse effects and nursing responsibilities in relation to same.				
	f) Discusses factors that would indicate that an older person may have any of the following conditions and identifies the				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	nursing responsibilities regarding each: I. Shingles II. Polymyalgia Rheumatica III. Osteoarthritis IV. Nutritional deficit V. Dehydration.				
	g) Discusses how to approach teaching and support for an older person to be independent with their activities of daily living or equipment, taking into account the following: I. Memory II. Cognition III. Learning IV. Decision making V. Functional ability.				
	h) Identifies factors that would prompt a referral to Needs Assessment and Service Co-ordination and your nursing responsibilities in relation to this.				
	i) Discusses principles of restorative care in relation to building physical and functional capacity and capability for older people to support 'aging in place'. Develops a nursing care plan to support this.				
	j) Demonstrates knowledge of grief and loss. Describes how this might manifest through psychological or physical signs and symptoms.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	k) Describes Enduring Power of Attorney (EPOA) in particular I. EPOA personal care and welfare II. EPOA property III. Limitations to EPOA.				
	l) Describes the process for Advanced Care Planning (ACP) with particular reference to CPR status.				
	m) Demonstrates knowledge of the support services and systems available in the region for the older person and the referral process.				
	Delirium				
	n) Discusses factors that would indicate that an older person may have delirium and identifies the nursing responsibilities regarding this.				
	o) Demonstrates/discusses the assessment tools/nursing investigations used to assess for potential delirium.				
	p) Demonstrates/discusses the nursing assessment and nursing diagnoses for a person with confirmed delirium.				
	q) Demonstrates the knowledge and skills required to effectively manage the care of a person with delirium in relation to the following: I. Fundamental needs II. Environmental approaches				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	III. Orientation IV. Safety V. Psychosocial VI. Support and education of family/significant others/carers VII. Monitor for return to previous level of function. Develops a nursing care plan for these.				
	Dementia				
	r) Discusses factors that would indicate that an older person may have dementia and identifies nursing responsibilities regarding this.				
	s) Discusses the assessment tools/nursing investigations used to assess for potential dementia.				
	t) Demonstrates/discusses the nursing assessment and nursing diagnoses for a person with confirmed dementia.				
	u) Demonstrates the knowledge and skills required to effectively manage the care of a person with dementia in relation to the following: I. Fundamental needs II. Environmental approaches – including management of risk behaviour III. Orientation IV. Communication strategies V. Safety VI. Psychosocial				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	VII. Enhancing function VIII. Support and education of family/significant others/carers IX. Monitoring for disease progression. Develops a nursing care plan for these.				
	Depression				
	v) Discusses factors that would indicate that an older person may have depression and or anxiety and identifies the nursing responsibilities regarding this.				
	w) Discusses assessment tools/nursing investigations used to assess for potential depression (e.g. Geriatric Depression Scale, Cornell Scale for Depression in Dementia).				
	x) Demonstrates/discusses the nursing assessment and nursing diagnoses for a person with confirmed depression.				
	y) Demonstrates the knowledge and skills required to effectively incorporate interventions related to the management of depression into the nursing care plan e.g. I. Physical needs II. Social activity III. Cognitive activity IV. Psychological support V. Building self esteem VI. Education. Develops a nursing care plan for these				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	z) Identifies commonly used antidepressant medication groups including usual dosage regimes and common adverse effects from the antidepressants: I. Selective Serotonin Reuptake-Inhibitors (SSRIs) II. Tricyclics III. Reversible inhibitors of Monoamine Oxidase Type A (RIMAs).				

CARING FOR A CHILD OR YOUNG PERSON (CS13)

CS13/Level 2: Applies evidence based practice principles when caring for children and/or young people.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses the Rights of the Child/Young Person and application of these to practice, including informed consent and privacy.				
	b) Demonstrates/discusses systematic assessment of a child/young person including the recognition of normal and abnormal parameters and identifies when a child or young person requires consultation with specialist services, medical advice or referral to other services and discusses related nursing responsibilities.				
	c) Demonstrates/discusses effective communication with the family and child/ young person using techniques that are appropriate for age and developmental stage.				
	d) Demonstrates/discusses safe and appropriate management of a child having a procedure commonly done in the area of practice including how to minimise				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	distress and promote a sense of control (e.g. play therapy).				
	e) Discusses the treatment and monitoring of a child/young person diagnosed with rheumatic fever and nursing responsibilities in relation to this.				
	f) Discusses factors that influence engagement and impact on child and youth health and the barriers children and young people face in accessing health care.				
	g) Discusses key aspects of supporting a child/young person with cancer or a life limiting condition and their family/whānau including: I. Assessment and consideration of developmental stage II. Symptom, medication and lifestyle management III. Psychological support IV. Patient/ family/whānau education				
	h) Discusses key aspects of supporting a child/young person with a palliative condition and their family/whānau including the aspects listed above.				
	i) Discusses resources and other services available to assist with care of a child/young person.				

CARING FOR A PERSON WITH A MENTAL HEALTH CONDITION (CS14)

CS14/Level 2: Applies evidence based practice principles when providing district nursing care for people who also have a mental health condition.

NOTE: The indicators are to support generalist district nursing practice rather than specialty mental health nursing skills within district nursing.

Pre-requisite:

Knowledge of the interconnected relationship between mental health, physical health and general wellbeing.

Recognises and responds appropriately to changes in a person's mental health state, mood and affect.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses signs and symptoms that may suggest changes in mental health, mood, affect and perception and your nursing responsibilities in relation to these.				
	b) Discusses signs and symptoms that may suggest self harm and your nursing responsibilities in relation to these.				
	c) Demonstrates knowledge/use of assessment tools to identify suicidality, depression and anxiety.				
	d) Ascertains that the patient can describe and recognise their own triggers for distress, can discuss their coping strategies and, where appropriate, their Community Mental Health Safety Plan.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	Indicators	Evidence	Validation Key: P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	Peer Assessor Signature	Date
	e) Describes the role of the following medications including names, indications for use, actions, side effects, interactions and nursing responsibilities including those related to depot injections (e.g. long acting anti-psychotic): I. Anti-psychotics II. Anxiolytics III. Mood stabilizers IV. Anti-depressants.				
	f) Discusses resources and other services available to assist with caring for a person with a mental health condition.				

CARING FOR A PERSON WITH AN INTELLECTUAL DISABILITY (CS15)

CS15/Level 2: Applies evidence based practice principles when providing district nursing care for people who also have an intellectual disability.

NOTE: The indicators are to support generalist district nursing practice rather than specialty intellectual disability nursing skills within district nursing.

Pre-requisite:

Knowledge of physical health complications commonly associated with Down Syndrome.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses the rights of adults with intellectual disabilities and how these apply in practice when there is no Welfare Guardian or EPOA.				
	b) Discusses the importance of ascertaining each person's level of intellectual disability (mild, moderate, severe, profound) and the impact this will have on their developmental age and functioning.				
	c) Uses appropriate language, selects outcomes and interventions, provides care and education at a pace and level that is appropriate to the person's developmental age and functioning.				
	d) Discusses the link between level of fear, anxiety and apprehension and the occurrence of challenging behaviour and				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	discusses appropriate use of verbal and non-verbal communication strategies to reduce same eg pictures, charts, voice, play therapy and body language.				
	e) Discusses resources and other services available to assist with caring for a person with an intellectual disability.				

GENERAL MEDICATION ADMINISTRATION (CS16)

CS16/Level 2: Applies evidence based practice principles to the administration of medications.

Pre-requisite:

 Knowledge of anaphylaxis, including signs and symptoms, management and nursing responsibilities
 Knowledge of legislative requirements for medication prescribing, and administration
 Knowledge of pathophysiology of condition(s) being treated, including signs and symptoms to monitor in relation to the condition and nursing responsibilities. Knowledge of the consequences of missed or late doses of prescribed medication and appropriate action to take in such circumstances.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses local policies and procedures in relation to medication prescribing and administration (including standing orders).				
	b) Discusses/demonstrates administration of medications including subcutaneous, intramuscular and intravascular routes, as per local policy and procedure				
	c) Demonstrates ability to care for people with a peripheral cannula and/or Central Venous Access Device.				
	d) Ascertains the suitability of the prescribed drug regimen and mode of delivery for the person; including current condition, home environment, ability to participate in self care, family/carer support and safety of home environment.				

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	e) Discusses rationale for the medication being administered, mechanism of action, therapeutic ranges, adverse effects and nursing responsibilities including patient education (e.g. antibiotics, anticoagulant, vitamin B12, haemopoetic agent, granulocytic colony stimulating factor, calcium homeostasis regulator, IV fluid therapy, anti-emetics, corticosteroid).				
	f) Describes the importance of assessment of concurrent over-the-counter (OTC) medication use i.e. cough suppressants, herbal remedies.				
	g) Describes nursing responsibilities in relation to prevention and management of needle-stick injury.				
	h) Discusses resources and other services available to assist with medication administration in the home.				

DIMENSION 4: INFORMATION AND KNOWLEDGE FOR HEALTH

Description

This aspect relates to Information Management Practices: Knowledge and skills required to systematically manage information. It includes Operational Processes; Gathering, Organising, Analysing and Evaluating Data and/or Processes; Managing Tools and Resources; Knowledge Transfer and ICT Policy Development and Implementation.

Complete all Aspects from this section that are relevant to your service.

IK1: Health Informatics

IK3: Information Risk Management

HEALTH INFORMATICS (IK1)

Description

The most commonly used definition of Health Informatics is: "the knowledge, skills and tools which enable information to be collected, managed, used and shared to support the delivery of healthcare and promote health." Making Information Count: A Human Resources Strategy for Health Informatics Professionals Department of Health (October 2002).

IK1/Level 2: Gathers, records, maintains and presents data and information including use of electronic tools.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses what data is to be collected and why.				
	b) Uses appropriate methods and sources for obtaining data and information including electronic formats.				
	c) Records/inputs, updates and stores data accurately and according to legislation, policies and procedures and contracts				
	d) Collates, structures and presents data as requested.				
	e) Uses electronic decision support tools in accessing evidence to support practice				

INFORMATION RISK MANAGEMENT (IK2)

Description

This aspect relates to Risk Management: Knowledge and skills necessary to proactively mitigate and manage the potential for damage or loss of records and information. It includes Disaster Recovery: the ability to support, develop, implement and evaluate disaster recovery plans as they relate to the management of information; Maintain, Protect and Preserve - the maintenance, protection and preservation of information by compliance with relevant legislation and policies; Risk Assessment/Audit - the ability to implement established audit and quality controls, as well as the ability to define, assess, analyse, recommend, implement, evaluate and monitor these controls.

IK2/Level 2: Maintains, protects and preserves information by compliance with relevant legislation and policies

Pre-requisite: Knowledge of the ethical, legislative, and regulatory requirements related to the collection, recording, use, amendment, transport and storage of health information, including electronic health information.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses and applies policies and procedures for access to, transportation, storage and disclosure of information.				

DIMENSION 5: LEADERSHIP AND MANAGEMENT

Complete all 6 Aspects of Care in this section that are relevant to your service.

(LM1) Managing Self and Personal Skills

(LM2) Providing Direction: Strategic and Operational Planning

(LM3) Leading and Managing Change

(LM4) Leading and building Interdisciplinary Teams: Working with People

(LM5) Purchasing and Financial Management: Using Resources

(LM6) Performance and Service Improvement

(LM7) Services and Project Management

(LM8) Public Relations and Marketing

Description

Regardless of their role title, all nurses are leaders and managers, both of care and aspects of service delivery. The key purpose of management and leadership is to provide direction, gain commitment, facilitate change and achieve results through the efficient, creative and responsible deployment of people and other resources. This includes managing self and personal skills, providing direction, facilitating change, working with people, using resources and achieving results.

Leaders are aware of and can articulate the vision with clarity, keep the focus on change and inspire others to be positive in their support of service improvement. Leadership includes:

- Gaining the support of others by ensuring that they understand the reasons behind the change
- Sharing leadership – with the team and others in the organisation
- Encouraging others, to find new ways of delivering and developing services and to take the lead in implementation of change
- Demonstrating a highly visible, transformational leadership style which is underpinned by strongly held values around equality, diversity and openness
- Taking a collaborative or facilitative approach in working in partnership with diverse groups
- Enabling teams, within the organisation and across the health community, to work effectively together
- Helping to unblock obstacles, identifying and securing resources, taking care of teams and the individuals within them.

MANAGING SELF AND PERSONAL SKILLS (LM1)

LM1/Level 2: Manages and organizes self while taking account of the needs and priorities of others.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Recognises and discusses own values and principles, and how these may differ from those of other individuals and groups.				
	b) Examines and discusses the fit between personal values and organisational values.				
	c) Identifies own strengths and limitations, outlines the plan for meeting own development needs, and works towards achievement of this.				
	d) Identifies the impact of own behaviour on others, and the effect of stress on own behaviour.				

PROVIDING DIRECTION: STRATEGIC AND OPERATIONAL PLANNING (LM2)

Description

Strategic planning is the process of devising a plan of action intended to maintain and build strategic and organisational innovation. It aims to keep the organisation aimed in the right direction, through developing strategic goals and operational actions to achieve organisational outcomes.

Operational planning is a subset of a strategic work plan. It describes short-term ways of achieving milestones and explains how, or what portion of, a strategic plan will be put into operation during a given period. Operational plans link the strategic plan with the activities the organisation will deliver and the resources required to deliver them. An operational plan describes the organisations vision and goals, objectives and activities.

LM2/Level 2: Knowledge of the organisation's vision, goals and operational plans and their contribution to achieving these.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Works towards achieving organisational vision and goals.				
	b) Prioritises and plans work to make best use of time and resources.				
	c) Promotes the organisation positively to others.				

LEADING AND MANAGING CHANGE (LM3)

Description

Facilitating change includes encouraging innovation, leading, planning and implementing change. It involves communicating the vision and rationale for change and service improvement, and engaging and facilitating others to work collaboratively to achieve real change.

LM3/Level 2: Identifies the steps in the change process and supports change in processes and work practices.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Describes the benefits of change and innovation to the team, the overall organisation and patients.				
	b) Responds appropriately to ideas identified by team members, providing constructive feedback.				
	c) Assists others in adapting to a changing work environment, supporting transition.				

LEADING & BUILDING INTERDISCIPLINARY TEAMS-(LM4)

Description

This aspect is about the management of individuals and teams. It covers activities such as recruitment, work planning, allocation and delegation, and reviewing performance, placing emphasis throughout on getting the best from people, treating them fairly and involving them in decisions about their work. Collaborative working is critical to this, as it promotes the sharing of information and appropriate prioritisation of limited resources. It also supports 'joined up' provision of integrated care. The quality of dialogue in collaborative working is critical so that problems can be identified and common solutions agreed. Partners or 'stakeholders' include clients, carers, health service staff and people working in other agencies. Culture change through leadership inspires other to deliver high quality services. Leadership is evidenced by working with others in teams and networks to deliver and improve services.

LM4/Level 2: Identifies the steps in the change process and supports change in processes and work practices.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Confirms the work required in area of responsibility with manager, seeks clarification where necessary.				
	b) Plans how work will be undertaken, seeking views from those in area of responsibility, prioritises and makes best use of the available resources.				
	c) Ensures work is allocated to individuals/teams on a fair basis taking account of skills, knowledge and understanding, experience and workloads and the opportunity for development…				
	d) Ensures individuals/teams are briefed on allocated work and the standard or level of expected performance.				

PURCHASING AND FINANCIAL MANAGEMENT: USING RESOURCES (LM5)

Description

This aspect is about business and financial management, and includes activities such as ensuring efficient and effective use of financial resources. Financial resources include money and finance as well as the financial value of other resources such as people, equipment, materials etc.

LM5/Level 2: Coordinates and monitors the use of resources, and assists in purchasing, sourcing and monitoring goods and/or services.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses/demonstrates fiscally responsible supply/equipment selection and ordering.				
	b) Monitors the ordering and delivery of supplies/equipment.				
	c) Identifies actual or potential deviations from appropriate resource use and takes corrective action.				

PERFORMANCE AND SERVICE IMPROVEMENT (LM6)

Description

Improvement is about continually working together to improve the experience and outcomes for clients and looking for other ways to provide health care that continuously improves the way it meets the needs of those who depend on it and the working lives of staff who provide it. To make improvements we must all work together to:

- develop ways to involve clients and understand their needs
- develop approaches to measuring outcomes that are meaningful to clients
- design safe processes of care to connect these needs and outcomes
- create working environments within which staff teams are provided with opportunities to jointly reflect on, learn and design improvements to the care they provide

A lot of improvement is about changing mindsets. It is about having the tools, techniques and confidence to work with your colleagues to try something that is different. It is about understanding the possibilities of thinking differently and aiming to make practical improvements for clients and a better working environment for yourself.

LM6/Level 2: Actively contributes to continuous service improvement

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**

a) Works with team to identify how services can be improved	
b) Contributes leadership in relation to: service improvement planning, implementation, and evaluation	

SERVICES AND PROJECT MANAGEMENT (LM7)

Description

This aspect is about the management of services and/or projects, and activities within those services and/or projects. It covers a wide range of activities such as: the administration and organisation of individual parts of services and projects; agreeing overall and specific aims and objectives for services and projects; the coordination of multiple activities within services and projects; and the management of contingencies. It may involve the use of technology to assist in the management and coordination of services and projects.

LM5/level 2: Contributes to specific services and/or projects.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**

a) Obtains full, relevant information on specific aspects of services and projects in which they are involved.

b) Undertakes activities to support the efficient project implementation.

c) Monitors the outcomes of projects and alerts manager to any issues.

PUBLIC RELATIONS AND MARKETING (LM8)

Description

This aspect is about marketing and managing public relations for organisations, services or parts of organisations/services. It covers a wide range of activities including: designing and managing campaigns; press and media contacts and management; ad hoc responses to queries; promoting the service/organisation through good news stories; the preparation of reports and marketing information; community engagement and consultation.

Suggested Resources

- Nursing Council Code of Conduct (2012) and Professional Practice Boundaries (2011)

LM6/level 2: Contributes to positive public relations and marketing activities.

Self Assessment 1. No previous experience 2. Experienced but need review 3. Experienced 4. Can teach & help others learn	**Indicators**	**Evidence**	**Validation Key:** P= Peer PDAR = Performance Development & Review RPL = Recognition of Prior Learning E = Exemption request	**Peer Assessor Signature**	**Date**
	a) Discusses/ demonstrates appropriate behaviour in public whilst in uniform (both during and outside working hours).				
	b) Discusses /demonstrates promoting the organisation in a positive way when speaking to patients and general public.				
	c) Discusses relevant public relations and marketing programmes (e.g. healthy homes campaign, being prepared for a civil emergency), including I. their purpose and focus II. the audience and undertakes any aspects of public relations and marketing that are their responsibility.				
	d) Contributes to team discussions and planning for improving public relations and marketing overall.				

SUMMARY OF COMPLETION & NURSE MANAGER SIGN OFF

Name: Date started programme:

Knowledge and Skills	Date completed	Date signed by assessor
Dimension 1 - Core Health Care Teams Communication Ethical Health Care Treaty of Waitangi, Cultural Safety & Maori Health Health & Safety/Risk Management Service Improvement Quality Improvement Personal Development		
Dimension 2 – Health & Wellbeing: Promotion of Health & Wellbeing Assessment & Care Planning to Meet Health & Wellbeing Needs Provision of care to Meet Health & Wellbeing Needs Self Management/Self-Management Support Health Education/Health Literacy Lifestyle		

Knowledge and Skills	Date completed	Date signed by assessor
Dimension 3 – Clinical Specific:		
Skin and Tissue Integrity		
Pain & Comfort		
Continence-Urinary		
Continence - Bowels		
Enteral Nutrition		
Cancer Care		
Palliative Care		
Cardiovascular Management		
Respiratory Management		
Diabetes		
Chronic Kidney Disease		
Caring for the older person		
Caring for a child or young person		
Caring for a person with a mental health condition		
Caring for a person with an intellectual disability		
General medication administration		

Knowledge and Skills	Date completed	Date signed by assessor
Dimension 4 – Information & Knowledge For		
Health Health Informatics		
Information Risk Management		
Dimension 5 – Transformational Leadership and Management -		
Managing Self and Personal Skills		
Providing Direction: Strategic and Operational Planning		
Leading and Managing Change		
Leading & Building Interdisciplinary Teams: working with people		
Purchasing & Financial Management-Using Resources		
Performance & Service Improvement		
Services and Project Management		
Public Relations & Marketing		

Nurse Manager

Name:

Signature

Date

ADDITIONAL LEARNING RESOURCES

The NZCPHCN has developed a list of websites with content of educational value to PHC nurses. This resource, available at http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/resources is intended to assist with the completion of this DNKSP. Speciality nurses, including Nurse Practitioners and Clinical Nurse Specialists, Community Pharmacists, General Practice Teams, Non Government Organisations (NGOs) and other health professionals within your DHB region are also sources of information and support.

An RPR toolkit is also available on the NZCPHCN website

The MoH Learn on Line Site (http://learnonline.health.nz/) is a vocational training resource hub for NZ's health workforce, providing a collaborative approach to educational resources for the health sector. Courses include:

- Power to protect – shaken baby prevention
- Lean thinking
- Hepatitis C learning programme
- Cardiovascular risk assessment and management
- Smoking cessation training
- Infection prevention and control
- Weight management
- ECG learning centre online

Other online courses include:

- Code of conduct for RNs (http://nursingcouncil.org.nz/Nurses/Code-of-Conduct). Online Education is available from CDHB. Use the following link: http://health.synapsyshub.co.nz/login/index.php. Then Login as a guest; Complete the training and the test; Print off the certificate; Retain a copy for your records
- Direction and delegation for RNs (http://nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses)
- Foundation course in cultural competency online (http://www.mauriora.co.nz/)
- Diabetes e-learning platform for PHC nurses (http://www.healthmentoronline.com)
- Nurse led clinics online resources: an information and education website for Nurses and Nurse Practitioners setting up and running their own clinics. It offers video and skills workshops made by healthcare professionals; literature abstracts; news and information. (http://www.nurseledclinics.com/)
- Advanced care planning (http://www.advancecareplanning.org.nz/)
- Cardiovascular System Terminology Quiz: http://www.learningnurse.org/tests/terms/cardiovascular/quiz.html
- Cardiovascular quiz: http://www.phschool.com/science/biology_place/biocoach/cardio1/quiz.html
- Respiratory Terminology Quiz: http://www.learningnurse.org/tests/terms/respiratory/quiz.html
- Respiratory System Anatomy: http://www.free-anatomy-quiz.com/RespiratoryQs3.html?questnum=15&cor=224
    - http://www.medicinenet.com/copd_chronic_obstructive_pulmonary_disease_quiz/quiz.htm
    - http://www.medicinenet.com/asthma_quiz/quiz.htm
    - http://www.medicinenet.com/bronchitis_quiz/quiz.htm

This programme complements other CPHCN documents including:

- CPHCN Education Policy, Standards and Career Development
- District Nursing Standards of Practice
- Framework For A Quality District Nursing Service in New Zealand (full document and summary document)

These can be found at http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/resources

The NZCPHCN PDRP and endorsement process outlines any additional requirements necessary to present this folder as a competent level PDRP (http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses/pdrp). Alternatively contact your local DHB PRDP co-ordinator to ascertain if any additional evidence is required. Successful endorsement exempts you from NCNZ audit for three years.

As district nursing continues to meet the challenges of changing health policy and need, this DNKSP will be reviewed and developed further. An initial review will occur two years after adoption and then will occur every three years.

If you have any enquiries, comments or concerns regarding this DNKSP, please contact us at http://www.nzno.org.nz/groups/colleges/college_of_primary_health_care_nurses

LIST OF ABREVIATIONS

ADPIE	Assessment, nursing diagnosis, planning, interventions and evaluation (the nursing process)
APC	Annual Practising Certificate
CCCE	Criteria for Clinical Competency Evaluation
DHB	District Health Board
DNKSP	District Nursing Knowledge and Skills Programme
HCT	Health Care Team
HITH	Hospital in the Home
HPCAA	Health Practitioners Competence Assurance Act
IDT	Interdisciplinary Team
NCNZ	Nursing Council of New Zealand
NZNO	New Zealand Nurses' Organisation
NGO	Non-Government Organisation
NZQA	New Zealand Qualifications Authority
NZCPHCN	New Zealand College of Primary Health Care Nurses
MOH	Ministry of Health
PDRP	Professional Development Recognition Programme
PHC	Primary Health Care
RPL	Recognition of Prior Learning

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Mission statement
NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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