

# **Implementing a prescribing practicum within a Masters programme in advanced nursing practice**

**A pilot study**

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## **Executive Summary**

This report presents the findings and recommendations derived from a collaborative action research pilot project undertaken alongside the implementation of two nurse prescribing practicum courses in New Zealand.

The students, teachers and supervisors participating in year long Masters' level prescribing practica at Auckland University of Technology (AUT) and Eastern Institute of Technology (EIT) were interviewed about their perceptions, concerns and actions relating to the first time implementation of their respective practicum papers.

Results are presented from three perspectives: students, supervisors and clinical academic staff. Research findings suggest that the practicum implementation has been successful overall. However, there is a need to refine delivery and to review current funding arrangements. Further research is also required as is the dissemination of findings to all stakeholders.

### **Recommendations**

#### **1. Practicum delivery**

- 1.1 Continue implementation of current teaching / learning and preparation processes. These include the following critical elements: selection of supervisors by students and their subsequent ratification by the academic institution; maintaining the minimum specified clinical practice hours, regular site visits by academic staff and collaborative assessment students' clinical performance.
- 1.2 Develop an interactive DVD to provide additional information about practice expectations to supervisors and students prior to commencement of the practicum.
- 1.2 Refine guidelines to clarify the procedure for changing supervisors should this be necessary.
- 1.3 Improve inter-institutional communication about models of practicum delivery

#### **2. Review of funding**

- 2.1 Recompense students, at minimum, for the 250-300 clinical hours required for practicum completion.

- 2.2 Provide the registered practitioners supervising all post entry health professional students with a more realistic remuneration for their time. At \$50.00 per hour for 40 hours this would equate to \$2,000 per practicum student.
- 2.3 Develop a less intensive form of supervisory support following completion of the practicum as graduates transition to their various Nurse Practitioner roles and positions.
- 2.4 Review current billing systems and the implementation of funding streams in Primary Health Care so that patients may be seen either by a GP or an NP.

### 3. Further research

- 3.1 Extend this project to include the remaining Nursing Council accredited tertiary providers.
- 3.2 Extend research to include collection and analysis of data six months beyond completion of the practicum.
- 3.3 Evaluate the impact of the programme on other health professionals and the public. This includes evaluation of client outcomes.

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## Introduction

This report describes the implementation of a pilot project undertaken to monitor and improve the effectiveness of a prescribing practicum within master's programmes in advanced nursing practice. It presents the summative findings of the project and makes recommendations for further development of this curriculum innovation. Undertaken in 2005 following New Zealand legislation granting prescriptive authority to Nurse Practitioners who meet Nursing Council requirements for registration, the project seeks to inform the Ministry of Health's Chief Advisor Nursing, Nursing Council of New Zealand, nurse educators in the tertiary sector and the Nurse Practitioner Advisory Committee (NPAC-NZ). A glossary (see appendix 5.1) is available for those requiring clarification of specific terminology.

### 1.1 Aims of the project

To identify and resolve issues relating to the implementation of a master's level prescribing practicum within nursing

To work collaboratively with another educational institution for the purpose of curriculum development

To publish findings and recommendations to benefit future students and practicum supervisors

To inform future nationwide nursing research

### 1.2 Background

The potential for nursing to contribute more effectively to improve the health needs of New Zealanders has been significantly enhanced through the recent introduction of Nurse Practitioner registration and the inclusion of specialty related prescribing within this role.

Throughout the country a small but increasing number of experienced registered nurses are engaged in completing clinically focused master's degrees. Within these programmes, some are choosing to develop competency as prescribers of interventions, appliances, treatments and authorised medicines within their scope of practice.

Both the Auckland University of Technology and the Eastern Institute of Technology are accredited by the Nursing Council of New Zealand to offer an "advanced nursing programme with prescribing" and their commitment to quality education led to a decision, in 2005, to monitor and report upon the first time implementation of their prescribing practica.

A developmental action research project (Cardno, 2003) was undertaken. Following discussions between Auckland University of Technology, Eastern Institute of Technology and Massey University, a draft proposal was developed and circulated by Dr. Deb Spence at the end of 2004.

Invitations to participate in the pilot project in 2005 were then extended to each of the institutions accredited to prepare nurses in advanced practice programmes for prescribing. Otago Polytechnic was keen to participate but declined involvement because their practicum would not be offered until 2006. Massey University was interested but not ready to commence in 2005 because of an insufficient time lapse following the recent arrival of a new research coordinator and Auckland University declined because they were “running their own research”. Thus it was decided that EIT and AUT, with 4 and 5 students respectively enrolled, would pilot a small collaborative project in 2005.

### **1.3 Research Approach**

Action research is a systematic method of learning from experience. Its purpose is to solve practical problems through the application of scientific method (Gay, 1996). Action research is a cyclical process that enables researchers and practitioners to interact with a system for the dual purpose of finding out about the system and effecting change. Because it allows the participants to assume an active, collaborative role, it is both empowering for the participants and reflective of their practice (Dempsey & Dempsey, 2000). Formative evaluation monitors the effectiveness, or otherwise, of strategies planned and implemented during the course of the research and summative evaluation provides a written review upon conclusion of the activity (Cardno, 2003). The methodology is not highly prescribed. Emphasis is placed on learning through action and method choices depend on the situational context (Streubert & Carpenter, 1995).

#### Ethical considerations

Approval for the research was granted by each of the participating institutions (see appendices 5.2).

All participants were fully informed of the proposed research (see appendix 5.3) and were encouraged to constructively critique the process of implementing the practicum. Participation was voluntary, consent was obtained formally (see appendix 5.4); and data was returned to participants for verification / alteration following each cycle of data collection.

The researchers (progressively collecting, collating and disseminating the data) were not involved in teaching or assessing the students undertaking the prescribing practicum, nor did they interact with the practicum supervisors other than as researchers.

Difficulties associated with ensuring anonymity were discussed at the outset. These related to the small number of participants in the study and the unique nature of each supervision context. Most participants were happy to be named in the final report, however in the interests of those less comfortable with open identification, efforts have been made to maintain anonymity by presenting the findings collectively.



## Action Research Plan

This action research project comprised three phases and three cycles.

*Phase One: Investigation and Analysis*, required that researchers and participants were familiar with documents, policies and practices relating to implementation of the practicum papers. These included Nursing Council requirements, curriculum documents and the recent legislation governing nurse prescribing.

*Phase Two: Planning and Action*, involved devising strategies for implementation of the project. The researchers worked collaboratively to devise an overall project plan with suggested ways of monitoring and providing feedback. These were discussed in turn with and modified by the study participants.

*Phase Three: Evaluation and Reflection*, consisted of focussed group and individual reflections by the participants on the progress of implementation of the practicum during which decisions were made about any required changes.

## Action research process

Cycles of data collection and action contributed reflexively in a spiral fashion. Participants were involved in planning, acting and evaluating. Although the cycles were formalised initially, they needed to be sufficiently flexible to allow adaptation (in the form of mini cycles) throughout the research process. This was essential because decisions about how best to respond at any given point varied according to context.

## Data Collection

Data was collected from five, initially, and then four AUT students and two academic staff in three focus group interviews (April, July, November) which lasted 60-90 minutes each. The researchers were present in discussion groups for purposes of facilitation, note taking and recording only.

At EIT, an initial focus group interview with four students and two academic staff took place successfully. However, recording difficulties during the second cycle meant that data was collected on two separate occasions. The first was an interview with the clinical academic staff member by the researcher who took notes and the second was a tape recording of the same staff member conversing with a student.

It had been originally planned that data would be collected from the students' supervisors (medical practitioners who were geographically scattered throughout the North Island), as dictaphone recordings. However, time pressures in clinical practice precluded this and, although academic staff visited supervisors and students to monitor the students' clinical progress, formal recording for the purposes of research did not occur until the final stages of the practicum. Collection of information from supervisors thus comprised early informal comments regarding students' progress and any concerns to academic staff and later, through face to face and telephone interviews by the AUT researcher.

EIT, despite several attempts, did not manage to collect data from the medical staff supervising their students.

All interviews undertaken at AUT were tape recorded, transcribed and summarised. The transcriptions and summaries were circulated electronically to participants for validation, comment and subsequent action. At EIT transcriptions were posted to the participants in hard copy. These were then commented upon by the participants and returned to the researcher.

The three questions guiding data collection were as follows:

- What, in relation to the practicum, is going well?
- What needs attention or is causing concern?
- What are your suggestions for action in relation to the identified issues and / or concerns?

Material such as newspaper clippings, related research, discussion documents relating to nurse prescribing and the New Prescribers' Advisory Committee were also collected and discussed. This is congruent with the recommendation by Winter (1989) that reflexive and dialectical critique are integral components of action research.

### Issues of rigour

Triangulation of data was achieved through using a variety of data collection strategies: informal conversations, note taking, tape recorded interviews from differing perspectives and document analysis. Internal validity was achieved through the sharing and verification of findings by the participants and regular checking that the intentions of the research were being met. Electronic communication was the primary means by which this was facilitated.

### Study Participants

#### AUT

Dr Deb Spence (researcher and project coordinator)

Dr Michal Boyd - USA and NZ registered Nurse Practitioner (NP) and Debbie Bassett-Clarke (clinical pharmacist), academic staff/ practicum teachers.

5 Registered Nurse students enrolled in the practicum paper

Clinical supervisors of above students – all were NZ registered medical practitioners

#### EIT

Maxine Anderson (researcher)

Susan Jacobs (academic staff member)

Mary Jane Gilmer (academic staff member and clinically-practising nurse; USA-registered Nurse Practitioner, with current application to the Nursing Council of New Zealand for New Zealand registration as NP)

4 Registered Nurse students enrolled in practicum paper

### Course related information (see also appendices 5.5)

The practicum paper is one of a number of compulsory courses for practitioners undertaking the prescribing pathway within a Masters degree in advanced nursing

practice. The paper prepares students to competently prescribe interventions within a chosen area of advanced nursing practice. It focuses on the prescription and administration of appliances, treatments and medicines within a framework of current best practice as defined by research evidence, legislation, Codes of Conduct and scopes of professional practice.

The paper continues students' development in terms of advanced assessment, differential diagnosis and the prescribing of interventions in clinical practice. It facilitates the development of autonomous clinical expertise. It also enables nurses practising at an advanced level to gain competence in prescribing under the direct supervision of a clinician with prescriptive authority in New Zealand. Students are required to perform between 250 and 300 hours of supervised clinical practice.

The practicum runs over an academic year. The students in this study were enrolled part time and were also practising outside the requirements of the practicum. Each student selected a supervisor in their practice area who was easily accessible and willing to participate in the clinical education process. The academic institutions then formalised this relationship, checking credentials, outlining roles and responsibilities and providing written information about course requirements and the role played by academic staff.

A summary of roles/responsibilities is provided below:

#### Academic institution

- Initiates signing of the supervision agreement.
- Provides site visits to support student and supervisor during practicum.
- Provides course information, materials and assessment tools.
- Provides lectures/ tutorials assisting the application of theory to practice.
- Completes final assessment of student performance.

#### Supervisor

- Provides a setting in which the student can work with clients with a range of health problems.
- Provides teaching and clinical supervision in the assessment and management of cases.
- Meets periodically with the student to discuss progress and complete feedback forms.

#### Student

- Negotiates and carries out learning activities in the process of providing care at the supervision site.
- Follows policies / procedures established in the clinical site.
- Practices according to the requirements of the Health Practitioners Competency Assurance Act.
- Participates in discussion re progress.

### Assessment of student performance

The students' clinical performance was formally evaluated midway and upon completion of the practicum. Evaluation was undertaken at the clinical practice site by the clinical supervisor and the clinical academic staff member. Students were required to be performing at the competent level (Student Competency Evaluation Instrument adapted from Colorado University) on all clinical competencies. These competencies cross-tabulate with those required by the Nursing Council of New Zealand.

Students were also required to write up and orally present clinical case scenarios providing clear rationale for all decisions made. These became part of their professional practice portfolio.

### Models of clinical supervision

Supervision arrangements for the students differed according to the range of clinical settings in which the nurses were advancing their practice and slight variations in the curricula of the two institutions. Of the 5 students enrolled in the AUT practicum, 4 were practice nurses and one was working in an intensive care setting.

Practicum supervision arrangements for the AUT students commenced as follows:

- a) One student was working full time as a practice nurse in a new setting. Two afternoon sessions and one late night were designated as supervised practicum time. Supervision was provided by the general practitioner (GP) /employer.
- b) Another student was receiving scholarship support for her prescribing practicum for 2 days a week in a familiar practice. Supervision was provided by 2 previous GP employers.
- c) The third student was working full time in a familiar GP practice. Three GPs in the practice had agreed to provide supervision but commitment and time were problematic and this student later became supernumerary for 2 days per week in another practice setting.
- d) The fourth student was self employed and working as a consultant in primary care. Supervision was shared between an NP and a GP.
- e) The fifth student was working full time as a nurse manager in a new ICU /CCU context. However, the only suitable supervisor was someone who was themselves being supervised towards obtaining registration from NZ Medical Council. Difficulties arranging adequate supervision thus forced this student to withdraw from the paper. Rather than completing an advanced practice qualification, the student is completing a Masters in Health Science by dissertation.

The 4 students enrolled at EIT were a nurse case manager, clinical charge nurse, nurse manager and an independent practitioner.

All students had a nurse mentor and a medical practitioner as prescribing supervisor. Supervision arrangements for the EIT students were as follows:

1. One was working full time as cardiac nurse manager, supervised by a cardiologist with a nurse mentor working in the same institution.
2. Another was working full time in ED supervised by a medical registrar and a nurse mentor working in same institution.
3. The third was working full time as nurse case manager (elder care) in the community. Supervision was provided by a GP and a nurse mentor working in another institution.
4. The fourth student was working full time as a collaborative practitioner in a nursing innovations project. This student was supervised by a GP working for a Primary Health Organisation (PHO) and a nurse mentor working within same PHO.

## Study Findings

### Summary overview

- 2.1 Students' perceptions, concerns and actions focused on maximising the benefits of the supervisory relationship and developing the clinical expertise required for their future role as a nurse practitioner. A need for some form of supervisory support during the transition from master's student to practice as a registered nurse practitioner was identified.
- 2.2 The perceptions, concerns and actions of the medical staff supervising students focused on balancing the interests of their own practice with the students' needs for learning. Supervisors were pleased with the students' development and well satisfied with the students' levels of clinical expertise. Questions were raised about the adequacy of funding to support 'protected learning time' and a need for greater clarity regarding expected levels of practice during and upon completion of the practicum was identified. Greater clarification differentiating medical practitioner from nurse practitioner roles was also requested.
- 2.3 The academic staff members were cautiously optimistic about implementing the practicum and committed to supporting the students' development. They were encouraged by the students' progress and the support and positive feedback about the students from their medical supervisors. They endorse the students' request for a transition supervision arrangement and for further research to evaluate this transition.

### 2.1 Students' perspective

#### 2.1.1 Establishing and maintaining a good working relationship

Although the students were already experienced registered nurses, many still felt they needed to establish credibility as an advanced practitioner by earning trust and respect for their knowledge so that they felt sufficiently confident to question their supervisors' clinical decisions.

*"I was a bit nervous at first but I question my supervisor now. I use the clinical guidelines. They are evidence based. I know doctors do not always follow the guidelines but at least you know what should be done and it's a good entry point for discussion."*

Cementing an effective relationship in the practicum thus required *"getting to know how your supervisor worked"*, *"the way they run their clinics"* and *"their prescribing preferences"*.

The focus of students during the beginning phase of the practicum also centred on clarifying expectations with their supervisors and working out how their learning could best be incorporated into the working day / week.

*“For me the biggest issue was the response from my medical supervisor, his understanding of his role, related to allocation of ‘teaching/learning’ time. My nursing supervisor was more dedicated and supportive.”*

Concern was often expressed about the limited funding available for “protected learning time”. An honorarium was available to supervisors but the students being supervised by general practitioners were acutely aware that time taken for learning impacted upon the earnings of the practice. This was less of an issue for students in acute care settings but all students were faced regularly with the need to negotiate time to review clinical cases with their supervisor.

Achieving a good working relationship also involved dispelling fears that nurses with advanced practice qualifications may, in future, work in ways that could impact negatively on the medical profession.

*“I think to start with – like when we did have a really good sit down meeting, he found it quite hard to understand where I was going, and basically, as I said to him, because it’s so new and the prescribing is so new, that I would be working in collaboration with the GP and he felt that was okay”.*

One student was forced to change supervisors because a lack of consistent supervision. She had continued working in the General Practice in which she was an employee but her efforts to get adequate supervision were not successful. The busy nature of the practice contributed to this but there was also ambivalence on the part of the practice about the student’s future role in the practice. This student’s learning was further complicated by unforeseen family commitments that disrupted the practicum for 2 months. Arrangements were therefore made by the student, with support from the university, to work (unpaid) alongside another GP in order to achieve the required supervised clinical hours. An extension of time was granted, the transition from one supervisor to the other was smooth and the practicum was completed successfully.

### **2.1.2 Developing in the role of student nurse practitioner**

Four of the five students at AUT and one of the EIT students had selected their supervisor prior to enrolling in the practicum. Thus, for most, establishing the relationship had commenced previously.

*“For my part it was an extension of a previous working relationship... I did not feel I had to prove myself but it was certainly extended in my learning. It was a collegial thing and patients frequently commented positively that they got twice the attention. The discussions about treatments and medication were of great value and the patients would ask if they could see me at the next visit too.”*

Students generally felt very positive about the support they received from academic staff and supervisors. Some were concerned initially about their inexperience assessing clients and developing differential diagnoses when comparing themselves with their more experienced medical colleagues.

One student expressed concern about the adequacy of a treatment plan that she implemented with supervisor approval – checking again with the physician that he had not just agreed with the plan under pressure of time – She needed ‘peace of mind’ and was reassured. Both she and the supervisor recognised this was an essential developmental step in the transition to autonomous practice.

Efforts were expended clearly differentiating their work role from their role as a learner and communicating expectations effectively to others in the work environment. One student expressed concern about how the nurse practitioner role might be perceived by other nurses.

*“I have concern that NP role may be perceived by other nurses as putting myself above other nurses. There is a potential for division especially with salary difference and change in respect gained from other [health] providers.”*

This contrasted with another who viewed the practicum as an opportunity to share knowledge with nursing colleagues getting them onside with this new, expanding role.

Difficulties were also experienced by students whose supervisors were unsure about what was expected of them. Role confusion seemed to be greater for those students pursuing their practicum at their place of employment. It was harder to be ‘at work’ as a student when one was previously, or at other times, at work as an employee. Achieving and maintaining student status was less of an issue for students receiving scholarships.

Issues raised and resolved formatively included the need to clarify legal liability as a student. Students were reminded by academic staff that they were accountable in terms of their scope of practice as a Registered Nurse but that working beyond this required direct supervision. Clarification was sought about what, in AUT terms, constituted a ‘clinically supervised hour’ given that AUT students are required to log 300 such hours during their practicum. Clinically supervised hours are those in which the nurse’s practice is either observed directly or discussed prior to action being taken. Other points of clarification centred on issues of being chaperoned and keeping clients’ anonymity when furthering learning through the presentation of clinical case studies.

A recommendation was made by the student having difficulty arranging appropriate supervision in a new work setting, that more detailed information about the practicum be available prior to enrolment, preferably on the institution’s website.



### 2.1.3 The nature of the students' work

The students in general practice settings worked primarily with clients with chronic illness such as diabetes, cardiovascular conditions and those with complex requirements – the “heart sink” patients – that medical practitioners often find difficult or for whom they have insufficient time.

During the winter students in primary care settings were seeing lots of ‘coughs and colds’. They were also seeing people with acute needs for wound management and other patients requiring follow up. They undertook pre screening for medical practitioners, doing health assessments, checking and interpreting lab results, developing management plans and making suggestions for treatment including the prescription of medicines under direct supervision. One student ran her own appointment list but the patients could also have an appointment with the medical practitioner if necessary.

The students working with GPs were very aware of billing issues – *“I feel guilty taking time [for supervision] out of Drs’ financial day and I actively look for things that can be invoiced eg smears.”*

The issue of practice related costs did not arise in the acute context. The student being supervised by a cardiac consultant stated: *“there were no issues as I wasn’t directly working alongside a GP, although I would communicate with GPs when seeing clients in their home.”*

Preventative education and health promotion featured significantly in the students’ work.

*“I look at when they last had a cholesterol done, talk about smoking and alcohol...”*

*“I am doing the lot. It’s not just prescribing the inhaler, its teaching them how to use and explaining when, encouraging people. It takes a bit longer but they are getting information they do not usually get when they have a Dr’s visit.”*

The students were also developing and presenting case studies referring to clinical guidelines and discussing these with their supervisors. One student (not on a scholarship) struggled to meet requirements for the practicum alongside her dissertation because she needed to continue earning while completing her studies.

### 2.1.4 Looking to the future: the need for some form of transition

Although all students spoke positively about their practicum experiences, each also felt a need for some transition supervision arrangement / support.

*Thinking about the transition to prescribing .... At the moment the buck does not really stop with us. There needs to be another phase ... autonomy but with some supervision. I don’t think that until we take that next step and we are actually writing the prescription and signing it off ...that’s where it would be nice to have someone reviewing what we have done.*

## 2.2 Supervisors' perspectives

### 2.2.1 Perceptions of students' capabilities

The students' supervisors commented positively, right from the outset, about the quality of the students both in terms of knowledge and clinical skill. They felt adequately supported by academic staff and believed in the potential value of nurse practitioners with prescribing credentials. Several had supervised medical students and registrars and used a similar model in their teaching of the practicum students.

*"X is exceptional .... Her knowledge base and her skills are far superior to any other nurse that I have worked with, far superior."*

*"Y is so good ... we are working with really good material.... I get very positive comments from the patients .... I am confident that the full process behind her decision-making is sound."*

*"We might be losing a little bit but the benefit of having someone like Z working in the practice outweighs that.... I have been delighted with how things have progressed. Now she is saving me a lot of time and it is a real help."*

*"Diabetes in particular ... she has been very good... points things out ...makes recommendations ... more of a holistic approach, the diet, the exercise, the foot care...it is reflecting in our diabetics being more stable now too."*

Several supervisors also commented favourably that the role of supervisor had stimulated and sharpened their own clinical practice.

*"It's been very useful ...I have often had to turn around and check my own terms of reference.... So it is a two way process."*

*"I am impressed by what X picks up and I find myself thinking: I hope I would have picked that up too."*

### 2.2.2 Balancing professional interests

Primary concerns related to achieving a balance between the interests of the practice and those of the students' learning. Time is money in general practice and the GP supervisors estimated that their role with the student cost them approximately an hour per day. Although they recognised that the nurses would become quicker and more independent and that clients were clearly benefiting from the more holistic approach taken by the nurses, they were concerned about the commercial viability of their practice and the desirability of achieving time efficient appointments.

*"We know that in general practice we can only allocate 15 minutes per patient and if we allocate more than that, then the practice is not commercially viable."*

The supervisors recognised that opportunities for teaching varied according to client demands, the presence or otherwise of registrars and the nurses' previous experience.

Ensuring adequate 'protected time' for student learning was an ongoing challenge. They also expected the nurses to be "*more forward*" and "*assertive*" in their prescriptive recommendations. They perceived that nurses were initially less confident and "*less willing to take risks*" than medical students and registrars.

One of the GP supervisors talked about needing to take care to reduce the risk of professional rivalry developing with other nurses in the practice. Gaining acceptance and support from their general practice partners was an additional challenge for several of the GP supervisors. The fact that many medical practitioners are not well informed about the Nurse Practitioner programme was acknowledged.

### **2.2.3 The need for adequate funding**

All of the GP supervisors supported current primary health care initiatives including the nurse practitioner role. The potential for advanced nurse practitioners to contribute to improved client outcomes was recognised in a number of areas but the means by which this would be funded remained unclear. One suggestion was that this could be achieved through the Public Health Organisation.

The need to secure funding to ensure quality supervision experiences was also recognised by the supervisors. The time frame of a year for the practicum was supported but the possibility of having more than one supervisor was raised because this could facilitate greater exposure to differing perspectives and approaches to client management. A potential disadvantage of shared supervision related to recognition that establishing an effective working relationship takes time and that this would be more difficult when more than one supervisor was involved.

### **2.2.3 The need for role clarification**

Each of the GP supervisors supported the notion of nurse prescribing but they remained uncertain about how future nurse practitioners would define their scope of practice.

In relation to their role as a supervisor of practicum students, they welcomed the idea of series of video clips exemplifying expectations relating to the progressive development of students' clinical decision-making and prescribing capacity. Role plays of beginning, mid and end point scenarios could assist to clarify expectations for both the supervisor and the student.

#### **2.2.4 Looking to the future: roles for nurse practitioners**

The supervisors recognised the potential for nurses to effectively manage clients with chronic conditions. The GPs could envisage nurse practitioners managing clinics for people with asthma, COPD, hypertension and diabetes as well as dealing with acute cases – minor injuries, coughs, colds and children with sore ears. Taking on care coordination roles was also recognised as something that nurses working between hospitals and the community could achieve. The potential for nurses with advanced skills to lead outreach clinics and assess patients at home was also recognised.

*“So there are plenty of roles. I just wish we had more nurses like Y”.*

### **2.3 Perspectives of academic staff**

#### **2.3.1 Orientation of the students’ supervisors**

The academic staff members were generally satisfied with the first implementation of their courses. AUT staff had met with the clinical supervisors in their respective work settings prior to the beginning of the practicum to provide orientation. Yet a need to supplement this was recognised. This was discussed with the students and the idea of making an orientation DVD for clinical supervisors was mooted.

EIT had invited the students’ medical supervisors to an orientation meeting but none were able to attend and an information package was posted to them instead. Plans for on-site visits are now being made for implementation of the next practicum at EIT.

#### **2.3.2 The ‘ideal’ practicum setting**

Michal and Mary-Jane, the US-educated nurse practitioner / academic staff members were curious to know, from the students, about the pros and cons of undertaking a practicum in a new, as opposed to a previously known, workplace. They recognised the potential for role confusion for students who were working as paid employees while doing the practicum because of the limited financial support available for them to do otherwise. However, in many of the more remote regions in New Zealand where the need for nurse practitioners is often greater, the range of options available for practicum experience is often limited. Moreover, where good working relationships have already been established and where there is shared vision for the implementation of new health initiatives, the successful undertaking the practicum in one’s place of work can be achieved. Clinical academic staff appreciated the need for medical staff to supervise students’ prescribing practices yet also recognised the difficulties this presents in terms of the differing philosophies of nursing and medicine. They looked forward to a future in which supervision of students would be shared between registered medical practitioners and nurse practitioners with prescribing privileges.

### 2.3.3 Recognising developing expertise and changing attitudes

Teaching staff were pleased with the students' clinical decision-making progress including prescribing. They recognised that experiences such as *"waking at night and worrying – Did I get it right?"* were an important part of the developmental process towards autonomous practice.

Clarification was provided to students and supervisors about practicum assessment processes and achievement of the required clinical competencies. Further explanation and a reminder about the time needed for house surgeons' to achieve safe levels of practice helped to allay concerns.

Clinical academic staff also noticed a change in the attitudes of the supervising medical staff and gained insight into how better to prepare them in future:

*"I'm encouraged. At first talking to a GP felt like talking to a brick wall. It was as if I was a Martian. It was such a new concept. They have come a long way... I was amazed at how receptive they were. 'We just want to know what to do, so tell us how this works, what I should be doing as a supervisor.... So what I learned was that I could do a much better orientation ... but they're busy, they not going to come to class and sending them stuff – they not going to have time to read it.... I have been surprised at how well the visits have gone and how open the supervisors are. I have seen a huge amount of movement."*

In relation to prescribing practice, the pharmacist was fully aware of the anomalies, 'fine lines' and 'grey' areas of prescribing and was pleased with the levels of understanding and practice safety achieved by the practicum students. The extensive nature of their previous clinical experience, their commitment to learning and their capacity for recognising their strengths and limitations were the reasons behind this judgement. A concern that some students in earlier stages of the advanced practice programme seem less committed to deepening their knowledge of pharmacology has prompted her to reiterate the importance of rigorous selection of students who progress to the practicum level. In the AUT programme, the applied pharmacotherapeutics and clinical decision making papers (see appendix 5.5) serve as ideal places for this to occur. Experiences at the postgraduate level have also prompted recommendations for changes in the undergraduate preparation of nurses.

### 2.3.4 Supporting the need for transition arrangements

Like the students, the NP / clinical academic staff recognised an interim requirement for some form of ongoing supervision.

*"The problem in the practicum is that you are almost too supervised... the next step is to be really seeing your patients, not as a student and not a total employee. There needs to be something in the middle...a sort of informal chat at the end of the day....  
"I just want to run these by you, just to make sure, but you don't have to see the patient."*

*“In the US we are really pushed to position ourselves with either a well established nurse practitioner or a physician mentor for a while. I was with a physician for 8 years as part of the practice. So I was never independent - on my own. Even though I practiced autonomously and maybe I didn’t even talk to him all week long, he was there. ...In NZ I think this is a little different ... more autonomy where you might not necessarily have a tandem practice, so it is hard to take that leap from okay, one day you’re a student and the next day you’re out there by yourself. That’s pretty scary. So I can see why a lot of the nurses are retracted over it ... shrinking.”*

Looking towards the future, concern also centred on the additional stress and expectations that is being placed upon new and pioneering nurse practitioners in NZ. The demands of maintaining an advanced clinical role alongside that of teaching / supervising students and undertaking much needed research in relation to clinical outcomes can easily become overwhelming and detrimental to both practitioners and clients. Learning to set limits and the need for succession planning were identified in relation to this.

Negative views such as those published without substantial evidence by the NZ Medical Association (eg. Moller & Begg, 2005) and in the media (Davis, 2005) can also adversely impact not only on nurse practitioners but also on the development of collaborative and more seamless models of health service delivery. Moller and Begg argued that only medical practitioners can diagnose and therefore prescribe, that the preparation of nurse practitioners is inadequate and that NPs will undermine the teamwork essential to effective medical care. Ross Boswell, the chairman of the New Zealand Medical Association, voiced similar concerns (Davis, 2005) yet research internationally (Mundinger, Kane, Lenz et al. 2000; Venning, Durie, Roland et al. 2000; Horrocks et al., 2002) has demonstrated the safety and effectiveness of nurse practitioners. Although some New Zealand medical staff working (often those who have experienced working with NPs overseas) actively support the development of advanced nursing practice with prescribing in New Zealand, it is recognised that those at the forefront of new developments will always encounter resistance.

*“It takes courage. What we are doing is difficult... but the rewards are there.”*

## Discussion and Recommendations

The first time implementation of the practicum for nurse prescribing at EIT and AUT has been successful in that all students who completed these papers met the course requirements. Formative evaluation of the effectiveness or otherwise of the strategies planned and implemented during each practicum facilitated this outcome well. The focus group discussions provided regular opportunities for problem identification and problem solving. The progressive dissemination of findings to all participants encouraged collaborative action and consultation in relation to the summative evaluation has further clarified understanding of the significant issues. Raw data exemplars will be used to support the discussion and related recommendations.

### Practicum delivery

The successful delivery of a practicum paper is significantly enhanced by the selection of a supervisor, by the student, prior to commencement of the practicum. An already established working relationship significantly reduces the amount effort required for students to establish their clinical credibility and thus to gain their supervisor's confidence. Regular site visits by clinical academic staff are also essential. Students need individualised input from academic staff because of the different ways in which their working contexts influence their scopes of practice. Moreover, when supervised by medical practitioners, students also need to be supported and challenged to maintain a nursing rather than medical focus to assessment and clinical decision-making.

The tension inherent in meeting the educational needs of nurse prescribers through supervision by medical staff is evident in the following raw data excerpt from one of the clinical academic staff during a visit to a student on practicum placement.

*There was obviously a huge miscommunication even though what had been written sounded very clear to me.... They [physician and student] weren't getting that. And so after she was done assessing the patient, the student said, 'well what would you want me to do now?' and so I said, 'well why don't you get Dr X to come in here?'*

*So he did. He looked at me and here I am in their practice. He said, 'Well what would you like me to do?' So here I was, a foreign person on their turf, and I said 'why don't you listen to Y's [the student's] presentation of the patient and you can satisfy yourself if you need to look, read her notes and offer suggestions as a mentor?'*

*Which they did, but I still wasn't really getting a good feeling that Dr X had got it yet. It took me saying, "just as you would oversee a medical student", before the light bulb went on. And he said "Oh". So, at that point he became very interactive with Y, asking her questions, challenging her, making her explain, asking for the notes, reading the notes, offering suggestions on the notes.*

*So the whole process happened in just two words "medical student". Even though we [as nurses] kind of shiver at saying 'medical model', I think that its necessary in order to give the message initially – as long as we're using physician mentors, that that's the way its going to have to be".*

In addition to highlighting the need for orientation of supervisors to their role, this story reveals that, despite differences in the foci of their professional practice, the processes by which medical and nursing students learn are similar. The implementation of nurse prescribing in New Zealand is a new and challenging experience for all those involved. In the USA, postgraduate nursing students are supervised by registered nurse prescribers but it will be some time before this is possible in New Zealand. It is essential that the medical and nursing practitioners pioneering these developments have clear information about what is expected of them. This includes understanding of the similarities and differences between medical and advanced nurse practitioner roles.

Thorough orientation to the supervisor role is vital. The written material provided by educational institutions prior to commencement of the practicum and visits by clinical academic staff need to be supplemented with audiovisual material that provides examples of the supervision process and the clinical progress expected of students during and upon completion of the practicum. The School of Nursing at AUT is in the throes of producing an interactive DVD for this purpose.

Regular feedback about students' performance is also essential to the students' progress and success. Time available in the clinical setting is often pressured and supervisors are not always sufficiently forthcoming when discussing progress with students. Half way in to the practicum, a story from one student participating in the research provides an example of the need for regular appraisal, clear communication and flexibility.

*The supervision was not consistent. It was not too bad initially. It was the circumstances of the practice and trying to do work and supervision in the normal working day. So I decided to leave and talked to M about someone I knew who had experience with medical students and was a keen promoter of education. We decided that I would approach her and that the university would follow up formally. The transition was quite smooth actually. Taking the clinical supervisory situation out of my employment setting really changed the dynamics. It made the experience more positive for me. I was supernumerary in the practice I went to and felt more comfortable and less pressured.*

Early identification and response to supervision that is unsupportive and/or inconsistent is very important. Although opportunities were available for students and supervisors to communicate their concerns to academic staff, the development of specific guidelines to assist this process is recommended.

## **Review of funding**

King (2001) has argued that nurses are crucial to the successful implementation of the Primary Health Care Strategy yet the funding and employment structures enabling nursing to respond to this challenge have not been fully realised. Additional funding is required to more adequately support student learning and to maximise the benefit from nurse-led innovations.



### Support of student learning

Being a practicum student requires relinquishing, to some extent, one's previous expert nursing role and taking on the role of learner. As intimated in the previous exemplar, this is easier for those who are supported financially than for those who must continue to earn a living. Although the Ministry of Health scholarships introduced in 2003 and 2004 have facilitated supernumerary status for some primary health and rural nurses, many nurses are struggling to complete the courses required to achieve the masters' degrees that will prepare them for future advanced practice roles. This is compounded by the fact that money is not available to reimburse supervisors of nursing students undertaking practicum placements. It is interesting to note that current funding for medical registrar training (not dissimilar to NP training) through the Clinical Training Agency ranges between \$35,500 and \$55,000 per student depending on the year of their study, yet Ministry of Education funding for Category B 3 is currently \$10,190 per taught postgraduate EFT and there is no additional TEC funding similar to that provided to medical students. All post entry health professional students require support from the Ministries of Health and Education. Yet disparity in the level and availability of such funding is clearly evident.

In order to be able to achieve the required levels of clinical competency, practicum students need to be financially recompensed, at minimum, for the 300 clinical hours required for practicum completion. The registered practitioners supervising these students should also receive more realistic remuneration for their contribution. The medical practitioners in this study estimated that they spent approximately an hour per day on student supervision. The educational institutions participating in this study recognise that the honorariums offered to the clinical mentors/supervisors are a token gesture and quite inadequate, particularly for doctors working in general practice.

### Support for nurse-led innovations

Some funding is also required support the transition from practice as a master's student to practice as a registered nurse practitioner. The nurses in this study, both students and their clinical academic staff, believe that access to interim support while they establish themselves as nurse practitioners with prescriptive authority will maximise their effectiveness in this new role. Collegial support is currently available through NPAC-NZ, the College of Nurses Aotearoa and the New Zealand Nurses' Organisation but these are mentoring rather than supervisory in nature.

Concern was also expressed about ongoing employment and the adequacy of current funding models to achieve improved client outcomes. This is exemplified in the following dialogue about the current model of health service delivery via the general practice.

### Academic / NP

*The hardest problem is that their [GPs] business is their money. They are not an educational institution and have no desire to be. They haven't used NPs before. They don't understand how it's going to help them. There is not a way that nurses can bill patients. So it's hard to argue 'I'm going to be a boon to your business'. How is that going to work?*

Student

*They [GPs] are starting to think about it. Nurses charging patients.*

Academic / NP

*Yes, but it's not only that, the other thing is that bulk funding is not a reality.*

*It[general practice] is the culture of small business.*

The current billing system in many general practices (and indeed district and Plunket nursing) comes down to 'time' – 15 minute appointments. Capitation and other funding streams into general practice remain linked to enrolled service users through general practitioners and as such do not foster the expansion of nursing services. Because present service delivery models do little to foster holistic practice, the hoped for improvements in population health may be difficult to achieve, as is evident in the next excerpt:

*The risk for nurses running hypertension or other clinics, for example, is that you become more indoctrinated into the medical model especially when you have to stick to short appointments. We will have to wait and see what happens....*

*We are very short of doctors.*

*I think nursing can come up with some innovative ways of dealing with this. But there's a conundrum. You need to learn diagnosis and treatment but the doctor sees dollars in every nook and cranny. When it comes to time, they see dollars. It's difficult to know how to get around that.*

The nurses who participated in this study are concerned that nursing innovations may suffer either through lack of funding or through billing systems that are profession based rather than being population or client outcome based. Moreover, although some medical practitioners (Way, Jones, Baskerville & Busing, 2001; Kamien, 2002; Feek, 2005) recognise that nurses with advanced practice skills can effectively ease some of the escalating demands on health services, there are tensions inherent in how this might be achieved. Research evidence suggests that nurse practitioners provide a more holistic approach to care (eg. Reverley, 1998; Shuler & Huebscher, 1998; Beal, 2000) and this is particularly important for the increasing number of clients with chronic illnesses and multiple co-morbidities. There is also evidence that those with more autonomous control of their practice engage more effectively in consultation and that professional autonomy and collaborative practice are not mutually exclusive (Brown & Draye, 2003). New Zealand nurses practising at an advanced level are well suited to such work but they are determined to practice from a nursing and population health philosophy and want to ensure they do not become 'cheap doctors'.

## **Glimpses of future possibilities**

The most rewarding aspect of this research, from the perspectives of all those participating, was the insights into future possibilities gleaned through the students' clinical development. Through commitment and hard work the students, with the assistance of their teachers and supervisors, are developing new ways of working.

There is clear evidence of the potential for nurse practitioners to work with 'complex' clients and, as seen in the next exemplar, those deemed 'complex' by medical staff, may not be so complex from a nursing perspective.

*The Dr that I work with gives me his 'heart sink' patients.*

*'Heart sink' patients are those people who are complex, people with chronic health conditions. He gets me to see them first to find out what the problems are. I do that in my Care Plus role so I am quite comfortable talking with these people, educating them and supporting them and I enjoy providing that nursing input. You can give them information that they do not get when they have a visit with the doctor.*

*I get time to sit down and explain things, especially with things like heart failure. A lot of people do not understand what heart failure is. So I bring out the Heart Foundation booklet and I show them, saying 'Well you may have been told you have got an enlarged heart, but have you ever been talked to about heart failure?' No. ... Often they have just been told that their heart is not working... I explain what heart failure is and that it doesn't mean that your heart is about to fail, it just means that it is not pumping as strongly. I show them the picture which shows why, and we go onto the symptoms and I show them pictures of what is wrong with their heart and why the symptoms are still happening. It's just explaining things a bit better and talking about what their medications are for. That is another example. A lot of people are put on medication and you say to them 'what are you taking that for?' 'I don't know, the doctor gave it to me'. Or 'I listen to Radio Pacific and they told me Lipex is bad for you, so I stopped it'. Yes. A lot of these people do not know what their medications are for, but in a nursing role I am able to teach people about their health condition and some of the things that they can do to help themselves. I do a health assessment to find out how they live their life and then I talk about what they can do to help. In this environment I have the time frame to be able to do that. When the doctors try to tell some of these 'heart sink' patients everything in a ten minute appointment it just doesn't work. That is probably why the patients like talking to me. I can give them more information and I take more time taking them through that.*

The emphasis on client education and assessment of individuals in the context of their everyday lives has long been a focus for nursing. Yet many practice nurses have been unable to fully realise their potential because they have also been required to function as receptionists or secretaries and have not been able to work beyond the confines of the clinic. In the next exemplar, a student describes her enhanced capacity to meet a wider range of needs.

*Getting out of the general practice is different and really good. For example I had an older lady whom I visited at home. She was in her mid 70s and her children were really worried that her cognitive function was declining. So I went out and did a full assessment. I figured out that it was probably her depression and that she wasn't getting treated properly. The GP said, 'wow you did a really good assessment, I didn't even do a mini mental, and yes, you have done the right thing and we do need to increase the medication and refer her on'.*

*That was a really good experience for me. In the general practice it is all very rushed. It is not the optimum. So yes, I am enjoying, that ability to make decisions and then follow them up.*

*It also raises questions for me about trying to meet population health needs through clinics. That has been one of my frustrations. I mean I totally agree that working with GPs within the general practice is good when you are a student because you get the notes and you get all that follow up, but I think being able to go out to clients' homes has huge advantages. I can work with the rehab unit at the hospital and also the case managers. Those relationships will build and they will think of me when they send a patient out from the hospital. So there's another opportunity to bridge that primary/secondary gap. It's looking really positive.*

An opportunity to work differently during the practicum has provided this nurse with insight into a possible future role that is congruent with the Ministry's Primary Health Care Strategy. New nursing roles are emerging with the emphasis on population health and a wider range of services (MOH, 2005) and a number of exciting initiatives have been described recently in a MOH publication entitled: "Evolving Models of Primary Health Care Nursing Practice". The glimpse provided by this student is another example of nursing being poised to more effectively contribute to improved patient outcomes.

## **Recommendations**

The following is recommended in relation to:

### **1. Practicum delivery**

- 1.1 Continued implementation of current teaching / learning and preparation processes. These include the selection of supervisors by students and their subsequent ratification by the academic institution; maintaining the minimum specified clinical practice hours, regular site visits by academic staff and collaborative assessment students' clinical performance.
- 1.2 The development of electronic audiovisual means of communicating information about practice expectations to supervisors and students prior to commencement of the practicum.
- 1.3 The development of guidelines, in the form of a flow chart, to clarify the procedure for changing supervisors should this be necessary during practicum implementation.

- 1.4 There is an ongoing need to document and communicate the various permutations / models of practicum delivery within the tertiary education and more broadly to disseminate information to all stakeholders about nurse practitioner development. This will help inspire would-be nurse practitioners and allay some of the prescribing-related anxieties currently felt by nurses and other health professionals.

## 2. Review of funding

- 2.1 Students must be financially recompensed, at minimum, for the 250-300 clinical hours required for practicum completion.
- 2.2 The registered practitioners providing supervision for post entry health professional students must receive more realistic remuneration for their time. At \$50.00 per hour for 40 hours this would equate to \$2,000 per practicum student. It would seem appropriate that such funding be made available through the Clinical Training Agency.
- 2.3 Less intensive supervisory support is required following completion of the practicum as graduates transition to their various Nurse Practitioner roles or positions. The Nursing Entry to Practice programme, being launched this year, could provide a model for such transition support.
- 2.4 Review of current billing systems and the implementation of funding streams in Primary Health Care that permit patients to be seen either by a GP or by an NP. This will support health services that are population based rather than profession based.

## 3. Further research

Research based information about the issues faced and resolved during all facets of the implementation of nurse prescribing will enhance the contribution by nursing to New Zealand's health service.

- 3.1 Extension of this research to include the remaining Nursing Council accredited tertiary providers is indicated.
- 3.2 In addition to extending the current research project nationally, the collection and analysis of data six months into nurses' first appointments as registered nurse practitioners is strongly recommended.
- 3.3 The perspectives of other health professionals and the public are also important. Research that examines client outcomes is essential.

## **Conclusion**

Maximising the potential for nursing to contribute to improved health outcomes depends on the sustained commitment of educators, clinicians, nursing organisations and policy makers. Rigorously undertaken research in the area of nurse prescribing will provide information to better inform the teachers, students and supervisors participating in programmes that prepare for nurse practitioner registration. The findings of this study suggest that the process being implemented in two of New Zealand's tertiary institutions is progressing well. Improvement and continued success is, however, dependent on a revision of funding that more equitably supports all post entry health professional students.

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## APPENDICES

### 5.1 Glossary of Terms

**Prescribing Practicum:** A course (paper), within a clinically-focused master's degree at a tertiary institution which has been approved by the Nursing Council of New Zealand as meeting its *Standards for Advanced Nursing Practice Programmes with Nurse Prescribing*. The course facilitates the development of competence to prescribe, which will include “assessing, prescribing and monitoring processes” within a framework of current best practice as defined by research evidence, legislation, Codes of Conduct and scopes of professional nursing practice. Completion of the approved master's programme is one of the requirements for registration as a nurse practitioner.

**Nurse practitioner:** As defined by the Nursing Council of New Zealand as one of the scopes of nursing practice.

Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practice both independently and on collaboration with other health professionals to promote health, prevent disease and to diagnose, assess and manage people's health needs. They provide a range of assessment and treatment interventions, including differential diagnosis, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse practitioners may choose to prescribe medicines within their specific area of practice. Nurse practitioners also demonstrate leadership as consultants, educators, managers and researchers and actively participate in professional activities, and in local and national policy development.

The Nursing Council competencies for nurse practitioners describe the skills, knowledge and activities of nurse practitioners.

**Competencies for nurse practitioners:** As articulated by the Nursing Council of New Zealand (2001).

1. Articulates scope of nursing practice and its advancement.
2. Shows expert practice working collaboratively across settings and within interdisciplinary environments.
3. Shows effective nursing leadership and consultancy
4. Develops and influences health/socio-economic policies and nursing practice at a local and national level.
5. Shows scholarly research inquiry into nursing practice.
6. Prescribes interventions, appliances, treatments and authorised medicines with scope of practice.

**Nurse Practitioner Specialty Areas of Practice:** An area of nursing practice delineating specialty and sub-specialty areas providing service to an identified population. Defined by each nurse practitioner and sanctioned by the Nursing Council of New Zealand.

**Nurse prescribing:** Refers to the prescribing of interventions, appliances, treatments and authorised medicines within an identified area of practice as above.

**Nurse mentor:** An experienced nurse, with advanced qualifications, who provides clinical support to and assessment of a nursing student aspiring to advance her/his practice.

**Practicum supervisor:** A New Zealand registered medical or nurse practitioner with prescribing rights who assists and monitors the clinical development of a nurse aspiring to advance her/his practice as nurse practitioner.

## 5.2 Ethical Approval



# MEMORANDUM

## Academic Services

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To: Deb Spence  
From: **Madeline Banda**  
Date: 21 February 2005  
Subject: **05/06 Implementing a prescribing practicum within a nursing master's programme**

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Dear Deb

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 17 January 2005 and that the Committee approved the revised application at their meeting of 14 February 2005. Your ethics application is now approved for a period of two years until 21 February 2007.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2 which is available online at [http://www.aut.ac.nz/research\\_showcase/pdf/appendix\\_g.doc](http://www.aut.ac.nz/research_showcase/pdf/appendix_g.doc), including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3 which is available online at [http://www.aut.ac.nz/research\\_showcase/pdf/appendix\\_h.doc](http://www.aut.ac.nz/research_showcase/pdf/appendix_h.doc). This report is to be submitted either when the approval expires on 21 February 2007 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you

have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at [charles.grinter@aut.ac.nz](mailto:charles.grinter@aut.ac.nz) or by telephone on 917 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M. Banda', with a stylized flourish at the end.

Madeline Banda

**Executive Secretary**

**Auckland University of Technology Ethics Committee**



EIT

HAWKE'S BAY

*Te Whare Takiura o Kaitiaki*

27 February 2005

Maxine Anderson  
Faculty of Health & Sport  
EIT Hawke's Bay  
TARADALE

Dear Maxine

The Research Committee evaluated your research project on "Implementing a prescribing practicum within a Masters programme in advanced nursing practice: an action research project" for human ethics on Friday 25 February 2005. The Committee noted that this project is conducted in collaboration with the Auckland University of Technology, and a copy of AUT's approval is filed.

The Research Committee approves the project for human ethics for a period of one year with effect from the date on this letter. Should you decide to change anything in the project that may affect ethics, then it is incumbent on you to keep the Committee informed, and seek its further approval as appropriate.

The Committee commends you in undertaking this project and it hopes the finding of the project will help to improve the nexus between teaching and research.

Ami Sundar EdD  
RESEARCH CONVENER

cc Bob Marshall

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## 5.3 Participant information



# Participant Information Sheet

**Date Information Sheet produced** 4<sup>th</sup> February 2005

**Project Title** Implementing a prescribing practicum within a Masters programme in advanced nursing practice: an action research project

### **Invitation**

Nurses enrolled in a Masters level prescribing practicum and their academic supervisors are invited to participate in the above action research project. Should you prefer not to participate in the project while enrolled in the practicum, the contributions you make to the related discussions will be deleted from the interview transcriptions.

### **What is the purpose of the study?**

To identify and resolve issues relating to the implementation of a prescribing practicum  
To publish findings and recommendations that will benefit future students and their supervisors

### **How are people chosen to be asked to be part of the study?**

If you are participating in the practicum offered by the respective institutions during 2005, you will be approached by the researcher leading the study in your region.

### **What happens in the study?**

Discussion of the issues, problems and potential solutions relating to implementation of the practicum will be tape recorded, analysed and fed back to you progressively throughout the duration of the practicum (one year). You will also be able to contribute to evaluation of the practicum upon its conclusion and have input into recommendations made.

### **What are the discomforts and risks?**

None are anticipated, although some degree of stress is likely in any new endeavour.

### **How will these discomforts and risks be alleviated?**

Through progressive cycles of reflection, discussion, collective decisions re resolution of problems and their subsequent evaluation



Should you decide against participating, a student and or staff advocate (as appropriate) will support you through this process. The fact that you are not participating will not be divulged by the researcher to others in the group.

**What are the benefits ?**

Collegial support, quality education, informed recommendations for future prescribing programmes.

**How will my privacy be protected?**

Pseudonyms will protect individuals from identification. Discussion re disclosure of participating institutions will be jointly decided by the groups participating.

**How do I join the study?**

Please inform either practicum coordinator or lead researcher from relevant educational institution of your willingness to participate.

**What are the costs of participating in the project? (including time)**

None additional to participation in practicum

**Opportunity to receive feedback on results of research**

The nature of the action research cycles means that you will be actively involved in identifying issues and solutions. You will also be able to contribute to the final report prior to its publication.

**Participant Concerns**

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, [madeline.banda@aut.ac.nz](mailto:madeline.banda@aut.ac.nz) , 917 9999 ext 8044.

**Researcher Contact Details:**

Dr Deb Spence, 917 9999 extn 7844 or email [deb.spence@aut.ac.nz](mailto:deb.spence@aut.ac.nz)

**Approved by the Auckland University of Technology Ethics Committee  
on 21 February 2005**

**AUTECH Reference number 05/06**

## 5.4 Consent Form



### Consent to Participation in Research

Title of Project: Implementing a prescribing practicum: an action research project

Researcher: **Dr Deb Spence**

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- I have read and understood the information provided about this research project (Information Sheet dated February 4<sup>th</sup> 2005)
- I have had an opportunity to ask questions and to have them answered.
- I understand that discussions will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one: Yes ☐ No ☐

Participant signature: .....

Participant name: .....

Participant Contact Details (if appropriate):

.....  
.....  
.....  
.....

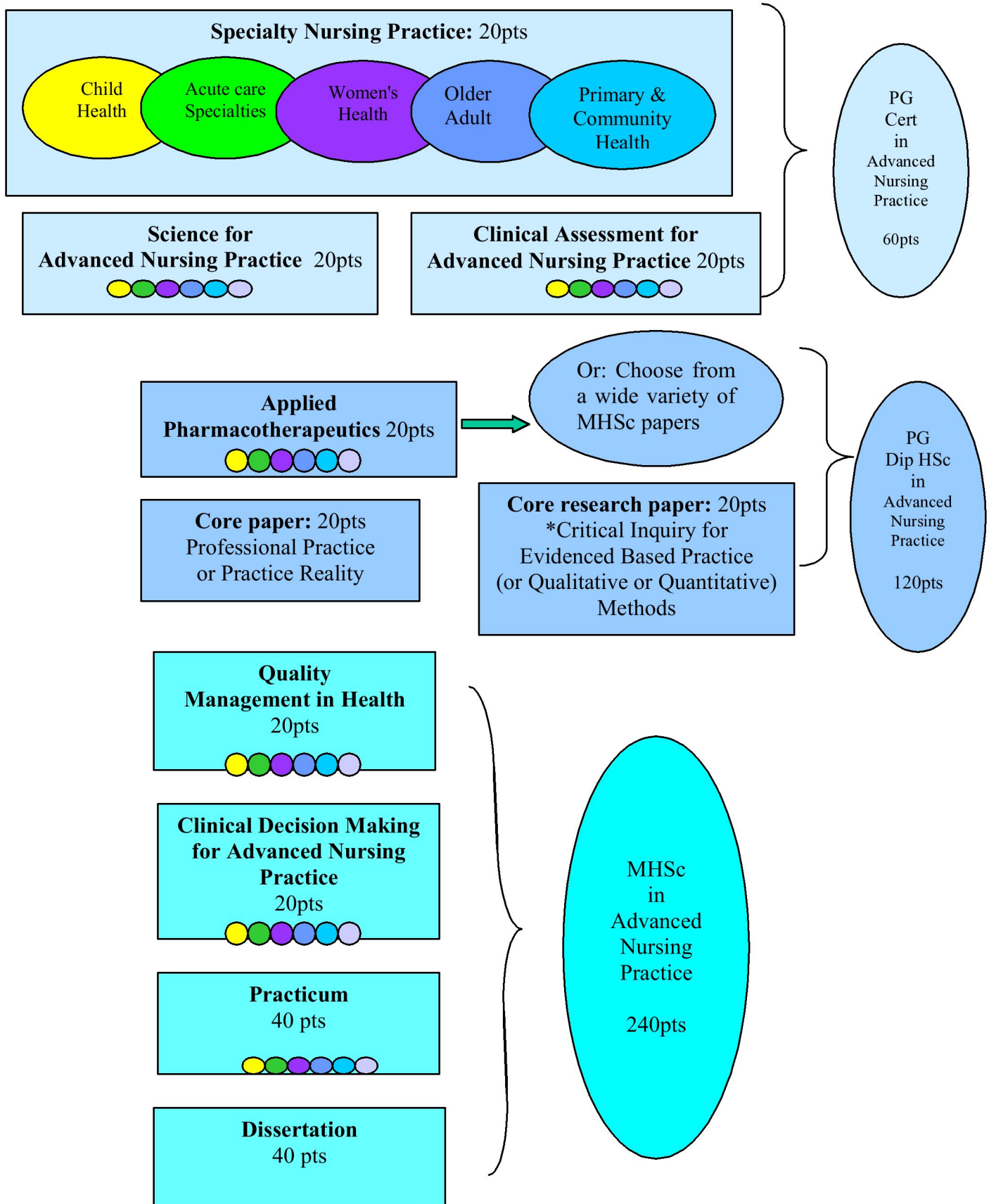
Date:

**Approved by the Auckland University of Technology Ethics Committee  
on 21 Feb 2005 AUTEK Reference number 05/06**

Note: The Participant should retain a copy of this form.



## 5.5 Master of Health Science in Advanced Nursing Practice



# **NURSING COUNCIL COMPETENCIES FOR ADVANCED NURSING PRACTICE SPECIFIC TO PRESCRIBING, EMBEDDED IN EIT MASTER OF NURSING PROGRAMME**

