What influenced changes to Enrolled Nursing in New Zealand

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Lucy Prinsloo

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ABSTRACT

Background

Enrolled nurses and enrolled nursing practise in New Zealand today originated from the introduction in 1939 of registered nursing aids. Numerous changes have occurred, including different titles and roles within the health care environment, as well as the nature of enrolled nursing practice. Various events and influences from nursing groups as well as Government policies and legislative amendments have contributed to this historical journey.

Aim of the research

The aim of this research was to explore what influenced changes to enrolled nursing in New Zealand. The links between social and political changes that influenced the nursing profession have been identified as major contributing factors affecting enrolled nursing. This research identifies discourses associated with the need for a different occupational category of nurse, Critical analysis of this data identifies how politics is positioned within these discourses.

Research design and methodology

This research utilised Critical Discourse Analysis (CDA). This is a type of analytical research that primarily studies how issues of social power, abuse, dominance and inequality are enacted and resisted in the social and political context. It aims to offer a different aspect on theorising and analysing these issues (Van Dijk, 2013).

Findings and Conclusions

There have been three main discourses around enrolled nursing identified in this thesis which have been discussed. The first is social discourse, where individual events have been judged and the outcome shaped by society. The second is safety discourse, where the language around second level or “lesser ability” is identified as shaping history. Lastly is a justice discourse where it is identified that NZNO have supported the EN’s through legal processes around title change and scope of practice and professional status within the health workforce of New Zealand.
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Chapter One: Overview of this thesis

Introduction

Enrolled nursing practice has changed through the years along with its legal title. The subsequent changes in responsibilities have potentially been confusing to the nursing profession, members of the public, as well as members of the wider health care team in relation to what enrolled nurses (ENs) are allowed to do in their nursing practice. It raises a significant issue in terms of why organisations should spend money and time employing and orientating enrolled nurses into their workforce, when further changes might happen.

This research thesis has developed from an initial idea into an amazing journey through the ever changing historical landscape of New Zealand and how that has influenced changes to enrolled nursing within this country. This thesis will outline when changes to enrolled nursing took place and discuss specific factors that influenced these changes at that time. Some of these changes are of a socio-political nature and others as a direct result of requirements within nursing practice.

Positioning myself in this thesis

To say that enrolled nursing is a passion of mine would really be an understatement. I commenced my nursing training in 1990, in South Africa, completing a hospital based two year Diploma in Enrolled Nursing program. Being an enrolled nurse was a position to be proud of, as you were looked upon as the practical nurse that had sound clinical skills and competence and was an integral part of the health care team. I grew in this role for ten years before deciding to “transition” to becoming a registered nurse through a “bridging course” which equated to a further two years of full time work and study. My experience as an enrolled nurse was critical in the registered nurse role that I was to take on. I was immersed in a certain expectation of how I should act within this role, as I now had a new title and different coloured epaulettes. However, I was to become a nurse who not only had clinical experience, knowledge and practical, hands-on nursing values, but could now be a critical thinker and decision maker within the ward. Yes, this new role that I had undertaken gave me autonomy and the qualification that I thought was most important to me, however, took away from why I had become an enrolled nurse in the first place, and that was to spend maximum hands-on nursing and patient care, with the comfort in knowing that not only did I have responsibility for my patient load, but always had the comfort of knowing that a registered nurse would have
overall decision making responsibility for staff and patients. I realised then that this was the reason enrolled nursing appealed to so many, it was hands on, practical nursing, with the comfort of completing delegated tasks and having continuous direction took away the stress load that so many registered nurses complained of. It was then that I realised the true value of the enrolled nurse and flexibility of their role.

Transitioning was not an easy decision for me, as I had developed wonderful collegial relationships with both the nurses and doctors at the hospital where I was employed; however, I wanted to do more and broadening my nursing practice through the transition process would allow this.

After relocating and continuing my nursing practice in New Zealand I was intrigued to learn that the role of the enrolled nurse in New Zealand healthcare has seen constant change and uncertainty since its conception in 1939. Coming in to the nursing education field I learnt that hospital based training programmes were disestablished in the early 1990s, but later reintroduced in 2002. Subsequent title changes and scopes of practice had caused changes in the New Zealand nursing workforce and I was interested in what forces had been in play during these times.

Research Question

The research question “What influenced changes to enrolled nursing in New Zealand?” emerged as an important research question, as there is no critical historical analysis in New Zealand that addresses this question. A concern about whether history is repeating itself and enrolled nurses will be subjected to further title changes and further caveats placed on their practice is at the forefront of discussion. This was most recently a highly debated topic at the 2014 New Zealand Nurses Organisation (NZNO) Enrolled Nurse Section Conference.

The focus of this thesis in determining an answer to this question is an exploration of specific events in New Zealand’s history, especially in relation to events surrounding changes that have influenced enrolled nursing. The positions of the Nursing Council of New Zealand, the College of Nurses (Aotearoa) New Zealand, and the NZNO in particular are important factors explored in this thesis, as they can be viewed as both collaborative and competing discourses.

Changing Titles

The terms enrolled nurse and enrolled nursing are used to position the topic when discussing changes to the various titles associated with, or previously ascribed to, enrolled nurses.
Registered nursing aids were introduced into the health care environment in 1939 as a direct response to staffing shortages in ‘Chronic Hospitals’ which housed patients recuperating from chronic illness such as tuberculosis (Lambie, 1951). Training consisted of a hospital based two year course, with the first six months of the course largely devoted to domestic science and thereafter, domestic and elementary nursing duties, of a practical nature. In addition to doctors’ lectures, tuition in nursing technique, nutrition and domestic duties were given throughout the course of training by fully qualified Tutor Sisters and Dieticians (Cook, 1939).

The title registered community nurse resulted from amendments to legislation in 1971, namely the enactment of the Nurses Act 1971. All individuals previously registered as nursing aids, were now entered into a new register and become registered community nurses (Nurses Act 1971, Section 16 (5)). The period of training was reduced from two years to 18 months and was provided within a hospital school of nursing.

The Nurses Act 1977 changed the title of registered community nurse to enrolled nurse, and the training programme was reduced to one year. The education of enrolled nurses would continue to be delivered by hospital schools of nursing. After the 1983 Nurses Amendment Act, the requirement for direction and supervision from either a registered nurse or medical practitioner further changed how enrolled nurses were to practise.

With the introduction of the Health Practitioners Competence Assurance Act in 2003, a further scope of practice was added in 2004, - that of nurse assistant. Nurse assistants worked under the direction and delegation of a Registered Nurse (Nursing Council of New Zealand, 2014), limited to stable and predictable environments, and specialising in rehabilitation and long term care. According to the Nursing Council of New Zealand, nurse assistants were able to contribute to the care of patients by undertaking assessments, recording their findings and reporting any changes or abnormalities that they have interpreted to the registered nurse (Nursing Council of New Zealand, 2004). This scope of practice was legally challenged by the New Zealand Nurses Organisation during 2006 and 2007.

In 2014 the title is once again enrolled nurse, who must practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings (Nursing Council of New Zealand, 2014).

This brief overview shows that over a relatively short period of time, enrolled nursing changed several times to reach the present state. These changes will be discussed further in a later chapter.
Overview of this thesis

This first chapter has provided a background and introduction to the research, outlining the research question. It provides a brief summary of second level nursing titles and an overview of the thesis structure.

Chapter two addresses literature reviewed, and provides a brief historical overview of enrolled nursing in New Zealand, as well as nursing generally, nursing registration and the regulation of nursing in New Zealand. Professional nursing organisations are introduced and nursing education in New Zealand is explained. The trending ageing workforce is discussed and enrolled nursing in New Zealand is defined.

Chapter three outlines and discusses the theoretical framework and methodology used and critical discourse analysis is introduced and linked to this thesis. Ethical considerations and data collection and analysis are discussed, as well as credibility and trustworthiness of the data and its interpretation.

Chapter four has a focus on the history of nursing and enrolled nursing in New Zealand, highlighting specific dates and elaborates on the corresponding changes that occurred.

Chapter five introduces and analyses socio-political discourses, focussing on specific influences on change, and discusses the Strategic Plan for Enrolled Nurses developed by the NZNO.

Chapter six summarises and concludes key points addressed in the thesis enabling a conclusion to be made. Limitations around the methodology used for the purpose of this research are identified and suggestions for future research and implications for nursing practice are outlined.

For the purposes of this thesis, the terms enrolled nurse and enrolled nursing are used, except where the variety of other titles are under discussion and analysis.
Chapter Two: Review of Literature

Introduction

This chapter offers an overview of literature and other documents that have influenced the development of what is now referred to as enrolled nursing in New Zealand. As enrolled nurses are part of the nursing profession, it is important that a wider view of the historical development of nursing is addressed.

Nurses represent the largest group of health professionals within the health care sector, and are employed throughout the wider health care system. The Ministry of Health (MOH) (1998) suggests that nursing is a combination of many elements: knowledge, styles and models of care, professional codes, clinical styles and attitudes. Within the sociological study of nursing, there are a range of concepts that are of interest, including gender relations, patriarchy, organisations and management, labour, knowledge and skills and professionalism (Wall, 2010).

It could be expected that there would be an abundance of written material and research that relates to enrolled nursing, both historically and current. There is, however, little literature about enrolled nursing in this context.

Search strategy

It is important to note that the literature is the data for this thesis. The literature includes New Zealand legislation pertaining to the various iterations of enrolled nurses, reports and policies, and corporate publications and written textbooks.

Literature was obtained through an extensive search of online clinical databases PubMed, Ebsco A-Z, CINAHL, and EBSCOHost, multiple internet searches through Google Scholar. A variety of literature from pre 1930s to current literature was identified and reviewed to determine its appropriateness in relation to historical and contemporary perspectives of nursing and enrolled nursing.

Although there is literature available from Australia and the United Kingdom about enrolled nursing, a decision was made with supervisor guidance that the focus would be on the New Zealand literature. While this might be viewed as a limitation, the uniqueness of enrolled nursing and associated legislation which has defined enrolled nursing in New Zealand was considered to be the most appropriate data.

In terms of the New Zealand literature, most of what has been researched or written specifically about enrolled nursing can be found as a thesis topic (Brownie, 1993; Adamson,
Dixon’s (1996) seminal research involved extensive interviews with five registered nurses who had commenced their nursing career as enrolled nurses. A number of issues identified in this research are referred to in discussion and analysis. Other literature, in textbooks, while addressing nursing in a broader context, also includes enrolled nursing (Burgess, 1984; Papps, 1997; Papps & Kilpatrick, 2002).

**Nursing and the medical profession**

Nurses work in collaboration with medical doctors and other health professions as part of health-care teams, and they also offer services and skills that complement these other professions (Burgess, 1984; The Ministry of Health, 1998). The health care system in New Zealand has evolved into a complex matrix of services provided by public, private and voluntary sectors (Burgess, 1984). Therefore the number of nurses directly employed in health services totals more than all other health professions and technical groups combined. For medical doctors, the achievement of professionalisation has followed a different route from that experienced by nurses. Doctors have seen themselves as having the authority to control other health professions, including nursing. Hence, it is appropriate to briefly examine the professional development of the medical profession as this provides insight into delegation, direction and supervision of other health professions within health care providers (Burgess, 1984).

In 1875, the first medical school in New Zealand was established at the University of Otago. In 1887 the Otago Medical Association merged with similar organisations in other parts of New Zealand to form the New Zealand branch of the British Medical Association (Finlayson, 1996). According to Hay (1989) and Finlayson (1996), the Association assumed responsibility for the standardisation of medical practice and for the control of economic activity within medicine. Finlayson (1996) concludes that the development of the medical school and their own professional association, the status and power of the medical profession became institutionalised, and that “doctors were able to exercise control over the numbers and quality of the candidates entering the medical school and the curriculum that they were taught” (Finlayson, 1996, p.74). Accordingly, the key indicators of professionalisation for doctors are able to be observed in New Zealand from this point forward. With the development of professionalisation, doctors were able to successfully eliminate competition and create a medical monopoly (Finlayson, 1996). Medicine became an exclusive and clearly demarcated profession.
The iconic nature of Florence Nightingale is historically important as the overarching or dominant figure in the development of nursing (Mortimer, 2005). Allen (2001) observes that after the end of the nineteenth century, “nursing was tightly linked to particular hospitals and the knowledge nurses gained was not readily transferable to other types of patient or institutional context” (p.2). Finlayson (1996) notes that in the 1880s, British trained nurses began arriving in New Zealand. Dr Grabham had sent for these British nurses as he was keen to improve the standard of hospital services in New Zealand. He had knowledge of Nightingale’s work and believed that Nightingale trained nurses could be effective in bringing about an improvement (Brown, Masters, & Smith, 1994; O’Connor, 2010; Papps & Kilpatrick, 2002). Consequently, as Webber (2003) observes, the British Nightingale system of ‘lady nurses’ was introduced and formal nurse training commenced in New Zealand main centres.

**Registration and regulation of nursing**

Nurses in New Zealand are currently regulated by the Health Practitioners Competence Assurance (HPCA) Act (2003). This Act, in essence, provides the legal framework for registration and issuing of practising certificates for health practitioners. The HPCA Act 2003 underpins standards of competence, assessment of fitness to practice, and quality assurance for health care practitioners in New Zealand. This Act brought all registered health professions in New Zealand, which had previously been regulated under their own separate statutes, under one consistent regulatory framework (Ministry of Health, 2009). It also provides the legal framework that authorises the Nursing Council of New Zealand to provide registration for nurses (Ministry of Health, 2009; 2010). In order to understand the development of registration and regulation of nursing in New Zealand, it is appropriate to examine the legislative developments that have occurred since 1901.

The Nurses Registration Act 1901 was the first Act of Parliament in New Zealand to provide for the registration of nurses (Brown, Masters & Smith, 1994; Burgess, 1984; French, 2001; Lambie, 1951; Maclean 1932; O’Connor, 2010). New Zealand was the first country in the world to achieve formal nursing registration with a specific statute; a fact of which we are proud of to this day, according to French (2001) and O’Connor (2010). According to Lambie (1951), the inception of the regulated training of nurses came at a time during which there was the development of a consciousness that the State must safeguard the social welfare of the community. The creation of a register for nurses was a natural extension of that consciousness.
Burgess (1984) states that the Nurses Registration Act 1901 came about as a result of the concern expressed by the Inspector General of Hospitals, Dr Grabham, and his assistant Mrs Grace Neill, about nursing standards and the need to safeguard the public from nurses with little or no training. Once the Nurses Registration Act became law, registration demanded certain requirements of persons before they were entitled to have their names recorded on the Register of Nurses. There were strict pre-requisites to becoming a nurse; nurses had to be a minimum of 23 years old and have had three years’ training as a nurse in a hospital, including instruction in theory and practice. Thus, in New Zealand the Act formalised the hospital-based nature of nursing training and its continuation in the manner of an apprenticeship (Brown, Masters & Smith, 1994; Burgess, 1984). An amendment to the Act in 1939 provided for the registration and training of nursing aids, and made provision for public psychiatric hospitals to be approved as training schools for nurses. The Act was completely revised in 1945 and all the amendments passed in the preceding twenty years were incorporated into a new Nurses and Midwives Act (Burgess, 1984).

When the Nurses and Midwives Act 1925 underwent major revision, the number of registration categories had again increased according to Burgess (1984) and French (2001). Under the Nurses Act 1971, the Nursing Council of New Zealand was established, a new autonomous organisation. The Council was to elect its own chairperson, and it was to be financially independent (Burgess, 1984).

The HPCA Act 2003 aimed to balance the demands of public safety with allowing practitioners sufficient involvement in the regulation of their respective professions. The HPCA Act’s approach is largely based on certification of title, and each responsible authority must describe its professions in terms of one or more scopes of practice, and prescribe qualifications for every scope of practice. Further, health practitioners must work within their scope of practice when performing a health service that is part of their profession. The Nursing Council of New Zealand, under the HPCA Act, can accredit and monitor nursing education providers and set the state nursing examination.

**Professional organisations**

Grace Neill, a Scottish nurse with experience of nursing in Australia, was an assistant inspector of hospitals and asylums in New Zealand, and the only woman official in Wellington’s government buildings at the time (O’Connor, 2010). It has been said that she orchestrated the registration of nurses through a parliamentary process which was achieved in 1901, under the veil of hospital boards. New Zealand was the first country to have this specific legislation
(O’Connor, 2010). Nursing leaders across New Zealand soon realised the importance of having a unanimous voice as the nursing organisation, which was to become a member of the International Council of Nurses.

The New Zealand Trained Nurses’ Association (NZTNA) was formed in 1908 as a trade union for nurses within both the public and private sector and later became the New Zealand Nurses Association (NZNA). The New Zealand Nurses Union (NZNU) acted as a subsidiary of the New Zealand Nurses Association between 1973 and 1993, when they amalgamated to become one body, the New Zealand Nurses Organisation (NZNO). The newly elected National Government in 1990 set out to de-regulate the labour market in New Zealand, which impacted greatly on the New Zealand Nurses Union. The private hospital nurses’ award, which covered aged care was the largest NZNU award, (O’Connor, 2010). The National Government passed the Employment Contracts Act 1991 which allowed for individual employment contracts to be created, which tightened employment conditions, including industrial action. O’Connor (2010) highlighted that the NZNO had to be more aware of its members’ employment contracts, in order to address employment issues that may arise.

**Nursing Education**

Nursing education in New Zealand has undergone substantial change, particularly with the transfer of nursing education into the tertiary education sector, according to (Burgess, 1984) and (O’Connor, 2010)

A review of nursing education in New Zealand was commissioned by the Minister of Education in 1971. Dr Helen Carpenter, who was a director of a school of nursing in Canada and a consultant for the World Health Organisation, published her report after she had undertaken this review. The report included the clear recommendation that nursing education should move away from hospital based training and into technical institutes. The hospital boards defended their hospital based schools of nursing and were opposed to losing student nurses from the workforce. Individual doctors were also against this shift as they showed concern that nurses would become ‘over educated’ (Carpenter, 1971).

Nursing education moved away from hospital apprenticeship type training to mainstream education, which began in the early 1970s. Trainee nurses gained the title of student as education became more theorists driven, as opposed to hospital based, task driven training (Burgess, 1984; Department of Health, 1988; Jacobs, 2005; New Zealand Public Service Association, 1974). Comprehensive nursing education courses were considered experimental.
as there was no established legislation based around this course of study; rather the legislation referred to nursing programmes (Papps & Kilpatrick, 2002). Nursing courses were made official through the enactment of the Nurses Act 1977 (French, 2001; Papps & Kilpatrick, 2002). This Act recognised nursing to have its own body of knowledge, despite working in collaboration with other health disciplines, which ultimately re-iterated that nurses were responsible and accountable for their own actions (Ministry of Health, 1998).

Nursing workforce demographics and models of care
According to Liu (2011) the New Zealand workforce is ‘greying’. Older workers, it is claimed, will have a profound effect on the labour market as ageing will affect the size, characteristics and possibly the productivity of the workforce. Clinical nurses and nurse educators alike have challenges associated with the ageing of the workforce. The recognition that the shortage of nurses in New Zealand is heading for crisis levels, due to an ageing workforce, and new graduates heading overseas, has created concern in nursing education. Providers of nursing education became aware of the pressing need to educate and train more nursing students to be clinical nurses.

The Nursing Council of New Zealand (NCNZ) (2013) concluded its ‘Future nursing workforce supply projections’ document by stating that there will continue to be constraints on nursing student numbers due to limited clinical learning environments, which will inevitably result in nurse shortages. It is suggested that these shortages could be filled by internationally qualified nurses (IQNs), however bearing in mind that these IQNs must be assessed as competent to practise through competency assessment programmes (CAP), to meet registration requirements. The document also suggests an ‘evolution of the models of care’, moving away from primary patient care to a more collaborative approach, using a varied skill mix of nurses such as registered nurse, enrolled nurse, and health care assistant to care for a larger group of health consumers. This model of nursing care would suit the enrolled nurse as they are New Zealand trained (as opposed to IQNs who will require further training and education as part of their CAP) and due to their shorter 18 month course of study, are able to be part of the workforce sooner.

Defining Enrolled Nursing
The NCNZ has a clear definition of enrolled nursing and what the responsibilities of enrolled nurses are. According to the NCNZ (2014) ENs may practice under the direction and delegation of a registered nurse or nurse practitioner to deliver care and health education across the lifespan of the health consumer. Their responsibilities include assisting health consumers with their activities of daily living, as well as observing for any changes that might occur and to
report these to the registered nurse or registered health practitioner. A registered health practitioner may include, but not limited to a doctor, physiotherapist or occupational therapist. Depending on competence, they may also administer medication and any other nursing responsibilities that may arise.

Enrolled nurses may contribute to patient care, including assessment of health status, developing nursing care plans, implementing those plans of care and evaluating the health outcomes derived from those plans of care. Enrolled nurses working within acute care environments must do so within a team nursing approach, where a registered nurse will take overall responsibility for the health outcomes of the patients, including health assessment and care planning. Enrolled nurses may in some instances, coordinate a team of health care assistants, under the direction and delegation of a registered nurse; however enrolled nurses must accept accountability for their own practice and nursing actions, all within their scope of practice and according to legislation. The competencies for enrolled nurses comprise four domains of practice, including professional responsibility, provision of nursing care, interpersonal relationships and interprofessional health care and quality improvement. An exact breakdown of each domain for enrolled nurse practice is provided in Appendix One.

**Chapter summary**

It has been established in the literature that New Zealand has been recognised as being world leaders in introducing nursing legislation and aspects of nursing education and training, and in doing so has developed a strong culture of nursing professionalism. Events in history have highlighted a shift from the perception of nursing being for working class women to that of a more middle class profession. The nursing care delivered to patients had become increasingly intensive which necessitated a shift from nursing in the community to hospitals. The legislation governing nurses was to suit the changing roles and scopes of practice required to provide a nursing workforce best suited to the needs of the country.

The potential impact of the ageing workforce has been briefly highlighted as this has implications on current programmes of delivery and the attempt to train nursing students efficiently through a shorter course of study (that being an eighteen month diploma as opposed to a three year degree).

The next chapter presents the methodology utilised for this thesis.
Chapter Three: Methodology

Introduction
In this chapter the methodology and theoretical positioning for this thesis is outlined and explained. As the research sought to answer the question of what influenced changes to enrolled nursing in New Zealand, the most appropriate methodology to do this was explored. While several methodological approaches may have been utilised, for example a survey, focus groups or interviews of key informants may have revealed what perceptions were of what influenced changes. However, the issue in both these approaches was who the key informants might be, and accessing an appropriate population may have been ethically complex and time consuming. In exploring these matters, it became apparent that a number of positions and views about enrolled nurses and enrolled nurses exist. Discourse analysis was identified as the most appropriate method to address the research question.

Research methodology
Discourse analysis is a broad and complex interdisciplinary field that includes diverse theoretical and methodological approaches from linguistics, anthropology, and sociology and psychology (Stevenson, 2004). As suggested by Fairclough (1995), discourse is the use of language as a form of social practice, and discourse analysis is an analysis of how texts work within sociocultural practice. Discourse influences how we practise as nurses and how those for whom we provide care experience that practice.


Fairclough (1995, p.187) suggests that

“...there are complex relationships that exist between the structures and strategies of discourse at a local, global, social political and historical context, and that both text and context need explicit and systematic analysis and that the analysis must be based on appropriate methods and theories”.

Powers (2001) suggests that discourse analysis was developed by social constructionists. Social constructionism theorises that human interaction is generated through language and meaning. Within a social context, individuals are viewed as responding to and holding others to responsibility. According to Fairclough’s theory of social constructionism (1995), a nurse’s
identity is always under construction and is subject to power struggles and discourse. This theoretical approach is appropriate for analysing the changes to enrolled nursing in New Zealand, as it surmises that events and ideas only come about from other events; ideas or activities. That is, changes to enrolled nursing have come about by actual events, activities or ideas throughout history.

The research for this thesis is situated in a critical paradigm, and was informed by the methodology of Critical Discourse Analysis (CDA). The main focus of CDA is the study of social power abuse, dominance and inequality, and the interaction of these on society, or any research subject. This research has focussed on the discourses surrounding enrolled nursing in New Zealand, and identifies specific indicators which could have contributed to changes in the enrolled nurses’ titles and roles within the health care team. CDA suggests an explicit role within society, arguing that science is influenced in part by social structure and social interaction (van Dijk, 2001).

Van Dijk (2001) also suggests that the forming of a theory, and description and explanation of that theory, are situated within a socio-political context. CDA is not viewed as a “typical” research method, and because of this, it is often required to be “better” than other research within the same field and it focuses on social problems and political issues, rather than current paradigms and fashions (van Dijk, 2001).

The main facets of CDA are summarised by Fairclough & Wodak (1997, pp 271 – 280), who note that “CDA addresses social problems suggest that society and culture is made up of discourse”. They also believe that discourse is historical in nature and that there is a link between text and society, and that discourse analysis is both explanatory and a form of social action.

**Ethical considerations**

The data for this research has not been obtained from any participants; rather the data has been collected from publications and literature that is already within the public domain. This research was approved by the EIT Research and Ethics Approval Committee (refer to Appendix Two).

In respect of the Treaty of Waitangi obligations, researchers must consider how the research will include benefits for Maori and non-Maori equally. Article Two of the Treaty of Waitangi also stipulates that Maori will retain control over all of their resources including its people and that we must recognise that iwi have authority over their people's involvement in research.
(Tolich, 2002). Maori have an expectation and a right to expect equivalent states of health and an equitable share of all benefits of health funding (including research funding).

The research is not Kaupapa Maori research in essence, nor does it fit within a Maori-centred research paradigm, however Maori nurses’ point of view may be sampled from literature used during data collection. As this research is reflective of historical New Zealand nursing facts, recommendations made may help to improve the retention and employment of ENs, including Maori nurses, which will have a positive influence on the Maori health workforce development.

Polit and Tatano-Beck, (2006) state that critical analysis, such as CDA, is an approach to research, considered to be subjective, as it reflects the writer’s own opinion. In order to achieve an unbiased view, it is the writer’s responsibility to ensure that both critical reading and writing has been undertaken in order to achieve this, including careful monitoring by both supervisors within various thesis drafts. This also served to address issues of credibility and trustworthiness of the data and how data were analysed.

**Data Collection**

As described in Chapter Two, the collection of data for analysis was achieved by sourcing material from online clinical databases PubMed, Ebsco A-Z, CIHNL, and Ebsco Host, multiple Internet searches through Google Scholar, corporate publications and written textbooks. A variety of literature from pre 1930s to current literature was reviewed to capture and identify the historical and contemporary perspectives of nursing and enrolled nursing.

**Analysis**

Chosen text has been summarised and analysed by focussing on the main points of an argument, and reporting the content. Critical interpretation was undertaken by asking specific questions of the text (Fairclough, 2005). This included a process of questions such as who made what statement, where was it made, when was it made and whose interests were being served. Key words and phrases from selected text were noted, and then put into groups, then in discussion with supervisors, two overarching discourses emerged. These discourses have been identified as the discourse of safety and the discourse of justice. These will be further explained in Chapter Five.

**Chapter Summary**

This chapter has discussed the choice and appropriateness of methodology to answer the research question, as well as identifying ethical considerations associated with undertaking the research. CDA is a useful research methodology when trying to determine causes for events
within society as a whole. Without using specific methodologies where discussion, interviews or written surveys are used, CDA is able to use text and historical evidence to formulate a specific rationale behind reasons for changes from a socio-political perspective. The next chapter will explore matters of history in nursing in New Zealand.
Chapter Four: History matters

Introduction
This chapter has a focus on the history of nursing and enrolled nursing in New Zealand, highlighting specific dates and the corresponding changes that occurred around them. It provides a background for identifying reasons associated with the various titles and restrictions of enrolled nursing.

As identified earlier, early nurse leaders, both nationally and internationally, lobbied for the advancement of nursing. For example, Grace Neill, who trained under the Nightingale system in London, influenced nursing education in New Zealand through political strategy. She recognised that in order to have a better standard of nursing practice there needed to be an equivalent input of training. Neill introduced the standardised three year training, the state examination, the five star medal and a national register (Papps, 2002).

These reforms, culminating in the Nurses Registration Act, 1901, supported the emergence of nursing into the professions. Yet while many nurses were skilled at negotiating the patriarchal systems, the medical profession retained significant influence by this statute in relation to the governance of nursing, both in terms of what nurses were to learn and be examined on. Papps, (1997) states that following the Nurses and Midwives Registration Act 1925, the control of nursing shifted to a board whose representation now included nurses. Hester Maclean was not only President of the New Zealand Trained Nurses Association at the time, but also the Registrar and Director of the Division of Nursing within the Department of Health (Wood & Papps, 2001). This restructuring was significant because it furthered the political positioning of nursing. It gave scope to implement initiatives that conformed to international developments in education, for example, in 1925 Otago University offered a Diploma of Nursing (Hughes, 1928) and in 1928 a Post Graduate School for Nurses was established under the Department of Health but with Victoria College, Wellington.

The beginning of enrolled nursing
In 1939 a register of nursing aids commenced. This was as a response to the Second World War, to keep up with the demand for health care workers; a shorter course of study was devised. An unexpected outbreak of tuberculosis required extra staffing to assist in the already busy hospitals and sanatoria, so as to free up the Registered Nurses to work on the front line, or with the acutely ill/injured. According to Lambie (1951) registered nursing aid training would best suit the girl who could not pass the registered nurse state final examination. It was
thought that the 18 month programme would suit girls of lesser abilities. This statement by Lambie is worth noting at this point, as later terminology used to describe enrolled nurses included ‘second level nurses’, which implies an individual of lesser ability, and defines or positions the enrolled nurse in relation to other nurses.

During the 1950s there were limited employment choices for women. The economy, recovering from the depression and war, and tradition, helped determine gendered occupation. Men were needed for skilled and unskilled labour, and schools directed girls’ towards prevocational subjects (Carpenter, 1971) This circumstance assisted nursing to retain tradition and remain the female orientated profession it had been since the 1840s when untrained wards-men staffed colonial hospitals (Liu, 2011).

Registered nurses, however, are not readily referred to as ‘first level’ nurses within New Zealand, although the International Labour Organisation used this terminology. First level nurses refer to a professional registered nurse who has completed three to four years of nursing education that leads to registration with the Nursing Council. The second level nurse refers to someone who has undertaken 12-24 months of nursing education and awarded the titled enrolled nurse, while untrained nursing aides are classed as third level practitioners (Meek, 2009, p.1).

The Nurses and Midwives Board 1945 still governed nursing; however the Nurses and Midwives Amendment Act 1945, with implications for training and regulation, and in 1971 eventually culminated in an independent body, the Nursing Council of New Zealand (NCNZ). The NCNZ continued to oversee decisions affecting regulation and education, with its purpose to protect the public of New Zealand (Wood & Papps, 2001). While nursing in New Zealand made an impact on United Kingdom politically; efforts to advance education were complex, with Nightingale’s influence and the socio-political context often presenting an opposing view.

Papps (1997) states that this two year training was reduced to eighteen months in 1949, which continued until the Nurses and Midwives Amendment Act 1965 created a new category for the registered nursing aid – the registered community nurse. The title of the nursing aid had connotations that this health care worker was no more than an assistant to the nurse, but not a nurse herself, which could influence the way the public viewed this category of nurse.

In 1971 schools of nursing began the transfer from training hospitals to polytechnics throughout the country for all registered nurses; however, enrolled nurses continued to have hospital based training. Many regarded this as the more practical aspect of training, for those
with less academic ability, as they would not cope in a tertiary education environment (Meek, 2009)

As a result of the Nurses Act of 1977, the registered community nurse title changed to enrolled nurse and with it a reduction in the length of training from eighteen months to one year. This new category of nurse was to further reinforce the two categories of nurses in New Zealand, those being the first level nurse or registered nurse and the second level nurse or enrolled nurse. This followed international nursing trends and was embedded in the International Council of Nurses in 1983 (Papps, 1997).

**Direction and supervision**

It was in 1983 when amendments to the Nurses Act (1977) brought in the requirement that enrolled nurses were required to practise under the direction and supervision of a Registered Nurse or Medical Practitioner. Dixon, (1996. p 6), notes that:

“In 1983 there were only two major nursing stakeholders, the New Zealand Nurses’ Association (NZNA), the main professional voice for this time, and the Department of Health whose main spokesperson was the Chief Nurse of New Zealand ... The point is that the 1983 amendment with respect to EN supervision could not have passed without the vote of these stakeholders. It had their support as they thought it would address the role relationship between registered and enrolled nurse practice”

Dixon (1996, p.6) further notes that even though the law changed, the perception of tension in practice between RNs and ENs was unabated. Arguably, the basis of this was that there was lack of clarity about what was meant by direction and supervision.

A Nursing Council of New Zealand (1999) position paper *Direction and Supervision*, offered guidelines to clarify the requirements; however it was acknowledged that the application of direction and supervision varied within different settings with much debate being had about levels of delegation and supervision, whether indirect or direct. Feedback from the 1996 NZNO Conference (Kai Tiaki, October, 1996 p.18), had suggested that NZNO no longer supported enrolled nurses having to work under the direction and supervision of a registered nurse. The 1996 NZNO Conference passed a remit, with minimal debate, from the enrolled nurses’ national committee stating that enrolled nurses would protect and promote the wellbeing of the patient/client at all times, practice safely and competently within their sphere of knowledge and experience and provide nursing care in co-operation with other health professionals.
According to Meek (2009), feedback from the 1996 conference reported that Margaret Pink, enrolled nurses’ committee chairperson, was thrilled the remit had passed, and said that it had taken a lot of hard work over a number of years to reach this point. However, the content of this remit was never enacted in law and the Nursing Council and the direction and supervision clause remained in the scope of practice for enrolled nurses, albeit under different terminology.

Financial and other issues affecting enrolled nursing

The 1990s brought further changes for enrolled nursing. Due to the increasing privatisation of aged care and contracting out of community health provision, a more cost effective source of staffing was in high demand. Enrolled nurses were seen as too expensive (Brownie, 1993), and due to their decrease in demand, institutes gradually closed courses (Kai Tiaki, 1993). The Department of Health and Department of Social Welfare initiated shorter courses of study, providing a cheaper workforce, this being the caregiver. The caregiver began replacing the more expensive enrolled nurse, but the caregivers were neither accountable through the Nursing Council, and the consistency of training was questionable (Meek, 2009).

In 1994 the Nursing Council revoked hospital schools of nursing. This meant that programmes for enrolled nurses would no longer be able to be provided, (unless in the polytechnic sector), and effectively was the end of long history of hospital based nursing training in New Zealand.

In 2006, nurse assistants (supported by NZNO) took NCNZ to court, regarding their name change from enrolled nurse to nurse assistant, as well as the new scope of practice. The nurses believed that as they had entered a programme of study with the understanding that they would qualify and be registered as an enrolled nurse, only to have this altered (Regulations Review Committee, 2007).

In 2007, NZNO complained to Regulations Review Committee (RRC) about the two titles and scopes of practice (SOP). RRC recommended the use of EN title. The Minister of Health formed a taskforce to discuss the introduction of a second tier workforce and announced a working party around second level nurses to support the RN (Regulations Review Committee, 2007).

Meek (2009) asserts that it was only in June 2008 when the publication by the Nursing Council of New Zealand Guideline: direction and delegation (2008), which replaced the 1999 Direction and Supervision guidelines that some clarity was given to the meaning of delegation and direction. Interestingly however, enrolled nurses and nurse assistants are not named in this document. Its focus appears to be the unregulated healthcare workers. It was suggested by...
Meek (2009) that this could be seen as a way to marginalize the second level workforce and reduce the role to that of an untrained health care worker.

**Clinical workforce to support the registered nurse.**

As a result of consultation in relation to a health worker to support registered nurses in practice environments. In June 2009, Dr Alison Dixon provided a commissioned report of an expanded role and training for enrolled nurses. The Minister of Health at the time, the Hon. T.Ryall, had commissioned the Ministry of Health to form a task force to research the clinical workforce requirements to support registered nurses. Dr Dixon’s report provided an overview of enrolled nursing in New Zealand and compared the current (then) enrolled nurse scope of practice in New Zealand to that of Australia, including summarising the Australian education model, and how this would transfer to New Zealand’s education standards.

A comparison was also made in this report of the qualification frameworks of New Zealand and Australia. New Zealand works with NZQA standards, which give clear levels of education and where certificates, diplomas, masters, doctorates, fit on this framework. This differs from Australia’s framework which has certificate one through to five levels of education, before reaching advanced diploma. Dr Dixon concluded her report by outlining the similarities and differences between Australia and New Zealand’s nursing framework. Her summarised recommendations were that enrolled nurse be the new title of the second level nurse, as the nurse assistant title confused the health workforce as to what their role was, the enrolled nurse and nurse assistant scopes of practice be made into one and look to Australia’s advanced enrolled nurse medication administration education. Levels of education and timeframe of study were discussed and that advance diplomas in specialities be developed to “aid in recruitment and retention of the EN workforce” (Dixon, 2009, p. 3).

Health Minister Tony Ryall subsequently confirmed, in 2009, the return of enrolled nurses and requested a revision of scope of practice. The NCNZ worked with NZNO on a proposed Scope of Practice (SOP). The NCNZ announced a broadened SOP and EN title was to be given to all future second level nurses (Dixon, 2009).

The NCNZ consulted on the Enrolled Nurse competency and education standards in 2010, by sending out a submission of the draft for review. The NCNZ set out a transition pathway for previously qualified nurse assistants to step up to the new EN SOP. The NCNZ approached all the schools of nursing to find out who would be interested in offering the new Diploma in Enrolled Nursing. Each interested school nominated a representative and a consortium was formed to consult on the new EN diploma. This consortium then decided on a national
framework from which to base the new diploma. Terms of reference, learning outcomes and an assessment framework were agreed to ensure national uniformity and the ability to share and network ideas, discuss what worked well within the method of delivery and what should be changed. This consortium agreed to meet up twice a year, once for group moderation of pre-selected papers and the other to make changes to the programme, as decided unanimously, as per the signed Consortium guidelines (Nursing Council of New Zealand, 2014).

In February 2011 the EN diploma started, and later guidance on direction and delegation of care to enrolled nurses was released by the NCNZ. The first school of nursing to receive accreditation for the new EN diploma was CPIT (on the 28th September 2010), with Whitireia and Northtec following suit shortly afterwards. The first intake of Diploma in Enrolled Nursing commenced at the Southern Institute of Technology in February 2011, after successfully passing the Nursing Council of New Zealand audit and with support from community stakeholders to offer clinical learning experience for the student enrolled nurses, followed by Christchurch Polytechnic Institute of Technology (CPIT) and Nelson Marlborough Institute of Technology (NMIT) in the South Island, as well as and six North Island Polytechnics. 1

The Diploma in Enrolled Nursing now consists of five level 4 papers, totalling 90 credits. These level 4 papers consist of professional practice, study of the human body in health and illness, clinical skills, sociology for enrolled nurses and foundations of enrolled nurse practice, including simulation. There is a 250 hour aged care clinical component incorporated into this part of the programme. Lastly, the diploma takes the learner through three level 5 papers totalling 90 credits, covering acute care, rehabilitation and long term care and mental health and addiction. Each of these three level 5 papers includes a 150 hour clinical component which gives the enrolled nursing student a solid foundation of which to enter the health workforce (Nursing Council of New Zealand, 2014).

**Chapter summary**

This chapter has provided an overview of historical events. It was not intended to be a complete history of enrolled nursing; rather it shows that there have been a number of changes around enrolled nursing since approval for hospital schools of nursing were revoked by the NCNZ in 1994. Changes were made in an attempt to clarify the issue of direction and supervision, revising this to delegation and direction. The scope of practice for enrolled nurses, with associated competencies resulted from the HPCA Act 2003. Finally, there appears to be a

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1 The reference for this information is from personal papers of the author of this thesis.
clear understanding between all Schools of Nursing which offer the Diploma in enrolled
nursing, to maintain a national framework of education, including paper descriptors, learning
outcomes, an assessment framework, and an agreed external moderation process to ensure
that these are being met. The next chapter provides an analysis of issues and influences on
enrolled nursing within the context of the two discourses of safety and justice.
Chapter Five: Analysis.

This chapter provides details of how data were analysed for this thesis in terms of the discourses of safety and justice. As discussed in Chapter Three, the data for this thesis was the text of various legal, organisational and policy documents. The reason for selecting CDA as an approach to analysis of the data was outlined and discussed in Chapter Three; that is, it was determined to be the most suitable methodology to answer the research question.

It became apparent when reviewing the data, and in discussion with supervisors, that there were themes in language of enrolled nursing in New Zealand each time there was a change in legislation. As a way of interpreting that language, a framework for identifying these changes was utilised in order to who made what statement, where was it made, when was it made and whose interests were being served. This approach enabled critical interpretation to be undertaken by asking specific questions of the text (Fairclough, 2001).

The language relating to enrolled nursing, as identified in Chapter Three, contains a number of words and statements specific to enrolled nursing (and its precursors), and positioned enrolled nurses as “other”, in the sense that they were defined in relation to someone or something else. Words such as ‘lesser ability’, ‘second level’, ‘aid’, ‘assist’, ‘direction and supervision’, delegation and direction’ are apparent in the data.

In the earlier history of the enrolled nurse, the language uses notions of ‘aid’ or ‘assist’, ‘second level’, and, in the example of the introduction of the registered nursing aid, the suggestion that this group of health workers were of lesser ability than registered nurses. As noted earlier, Lambie (1951, p.16) asserted that:

“... registered nursing aid training would best suit the girl who could not pass the registered nurse state final examination. It was thought that the 18 month programme would suit girls of lesser abilities”.

Further, in a later document, the role was about:

“... performing specific tasks related to patient care that required considerably less use of judgement” (Department of Health, 1969, p.64).

The terms ‘direction’ and ‘supervision’ provided the first legally defined distinction between registered and enrolled nurses, and linked it to an offence. The Nurses Amendment Act 1983,
which amended the Nurses Act 1977, did this with a statement about direction and supervision:

Every enrolled nurse commits an offence and is liable on summary conviction to a fine not exceeding $1000 who, other than in an emergency, practises nursing other than under the direction and supervision of a registered nurse or medical practitioner (Nurses Amendment Act 1983, Section 53A).

The reason for the introduction of this new legal requirement for direction and supervision is not clear, and, as identified earlier in this thesis, was problematic and open to interpretation (Dixon, 1996; Meek. 2009).

Other language used to situate enrolled nurses included statements about health care consumers, such as ‘stable health conditions’, ‘predictable health outcomes’, and ‘situations that do not call for complex nursing judgement’. A later requirement for enrolled nurses to provide care for persons with stable health conditions, and use of some of the language noted above, as well as the change to the areas in which enrolled nurses could and could not be employed, could be seen as a response by the NCNZ to address confusion and interpretation of the issues of direction, supervision and delegation. Yet while enrolled nurses could not be employed in acute care environments, they could be employed in aged care environments.

The language of the text discussed above, has a focus on safety, and can be related back to the earlier use of terms such as ‘lesser ability’, and ‘less judgement’. It should be considered that this language suggests the aged care setting is a place where there are ‘predictable health outcomes’, ‘stable health conditions’ and ‘situations that do not call for complex nursing judgement’. This could be interpreted to mean that the population in aged care settings actually meet these criteria for employment of enrolled nurses. Given the comorbidities and issues of polypharmacy in the elderly population, it could be more appropriate to employ registered nurses.

**The safety discourse**

The safety discourse is apparent in legislation, as well as in guidelines and documents of the NCNZ. However, the discourse of safety is also apparent in other text, for example in the position of the College of the College of Nurses (Aotearoa) New Zealand relating to a submission on the proposed EN scope of practice changes:

“The College continues to hold the firm view that the re-establishment of the enrolled nurse position and title would be an unfortunate step with prolonged and wide-spread consequences. We are fully supportive of the need for a second level position, which at most
should be recognized as a Nurse Assistant. The title describes the role more accurately than the enrolled nurse title, which may have some historical meaning, but is not adequately descriptive. The use of the term 'assistant' is more aligned to other nomenclature, which is appearing in the sector e.g. Health Care Assistant; Physician Assistant. Physician assistants are not referred to as doctors because it is recognized that they have only a partial preparation in medicine. We think the parallel is instructive and the lack of confusion ensures public safety through limiting the potential for misuse.” (Submission on the EN/NA Scope of Practice, 2009, p. 2).

Some events in clinical areas have influenced changes to enrolled nursing, which emphasise the discourse of safety. Enrolled nurses were removed from the acute mental health inpatient environment in 2001 after a highly publicised case involving a Southland mental health patient, who killed his mother, after being discharged from this unit by an enrolled nurse, then himself. The Burton Inquiry was only made public in late September 2001 which was six months after the incident. This would have been enough time for the health sector and general public to formulate their own opinions about the possible outcome. It was found the enrolled nurse who was the carer for Mr Burton was not ultimately responsible for the tragedy; however it was due to the lack of support for this enrolled nurse by the registered nurse and health care team (Health and Disability Commissioner, 2001).

At a later date, but related to the investigation of the Health and Disability Commissioner in 2001, and other publicised events involving enrolled nurses in mental health, a letter was sent to District Health Board Chief Executive Officers (CEOs). This letter states:

“We request that you pay due consideration to the configuration of mental health services, systems and processes need to be in place to ensure that Enrolled Nurses are not inappropriately utilised in acute mental health units. We ask that you work with your Mental Health Nursing Advisor/ Director of Mental Health Nursing to address this issue if you indeed have Enrolled Nurses in acute mental health inpatient units”

The letter referred to the enrolled nurse scope of practice in the New Zealand Gazette (12 September 2006):

“The Nursing Council of New Zealand scope of practice for enrolled nurses states “Enrolled nurses practise under the direction of a registered nurse or midwife to implement nursing care for people who have stable and predictable health outcomes in situations that do not call for complex nursing judgement. The responsibilities of enrolled nurses include assisting clients with the activities of daily living, recognising the changing needs of clients and performing delegated interventions from the nursing or midwifery care plan ...”.

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The letter went on to comment that:

“What While Enrolled Nurses are a valuable part of the healthcare team, the scope of practice for
Enrolled Nurses is limited to working with people who have predictable health outcomes in
situations that do not call for complex nursing judgement. Clearly acute mental health units do
not have predictable health outcomes and the scope and competence of enrolled nurses
would generally preclude them from practising in these settings (Chaplow and Jones, 2007,
p.2).

Soon after this letter, the Registrar of the Nursing Council of New Zealand sent a letter to
District Health Boards CEOs, outlining that:

“Employment decisions are the role of employers, not the Council. The prescribed scope of
practice, however, should guide these decisions, as health practitioners must work within their
scopes of practice.

The scope of practice makes it clear that enrolled nurses are competent to work only with
people with predictable health outcomes in situations that do not call for complex nursing
judgement. This restricts the number of acute settings in which enrolled nurses are competent
to practise. Nursing care provided in acute settings generally requires complex professional
nursing judgements and expertise from nurses educated and qualified for this role. In acute
settings, nursing care is most appropriately provided by registered nurses. Some patients in
acute units, however, may have stable and predictable health outcomes in which case,
enrolled nurses may appropriately care for those patients within their scope of practice. In
relation to mental health, because of the complex nature of mental illness, mental health
clients receiving care and treatment in acute mental health units usually do not have
predictable health outcomes” (Clark, 2007).

These letters identify that the safety discourse was paramount in terms of enrolled nursing
practice. It could be interpreted that while the NCNZ was confident that scopes of practice
was a means of ensuring that enrolled nurses did not practice outside this, the Ministry of
Health was not confident in employers’ ability to ensure this. It raises an issue in terms of
interpretation of enrolled nursing and interpretation of the scope of practice for enrolled
nurses, in much the same way as interpretation of the language of ‘supervision and direction’,
and the later language of ‘delegation and direction’.

The justice discourse
Justice is an ethical principle associated with fairness, although it is more than fairness
(Johnstone, 2012). For this reason it has been used in this thesis to illustrate that justice has
been at the forefront of the role of the NZNO in events influencing recent changes to enrolled
nursing and enrolled nurses.
In the previous chapter it was noted that in December 2006, the NZNO made a complaint against the Nursing Council of New Zealand (NCNZ) to the Regulation Review Committee, under the Health Practitioners Competence Assurance Act of 2003 (HPCA Act Part 2 Section 17). The NZNO is the largest professional body for nurses and the leading nursing union in New Zealand. Its members include nurses, enrolled nurses, midwives, students, health care workers and other health professionals.

The complaint was aimed at targeting the particular decisions made in 2004 and 2006, in accordance with the HPCA Act around the title, scopes of practice, and status of second level nurses, specifically enrolled nurses and nurse assistants which had regulatory statuses attached. The executive summary states that under the Nurses Act 1977 and Nurses Regulations 1986, the term ‘enrolled nurse’ was used to describe a second-level nurse who provided support under the direct supervision of a registered nurse.

As noted previously, on 18 September 2003, the Health Practitioners Competence Assurance Act (HPCA Act) repealed the Nurses Act 1977 and became the legislative basis for the regulation of nursing, including the specified title “enrolled nurse”. The HPCA Act (2003) required each regulatory authority to develop one or more scopes of practice for the particular profession it was empowered to regulate. The purpose of the scopes of practice is to describe the profession so the public and health service providers have a clear understanding of the skills and qualifications of different categories of health practitioners and the particular work they are entitled to undertake. The HPCA Act required the Nursing Council to consult with all groups that might be affected before setting or amending scopes of practice, which are published in the New Zealand Gazette.

The NCNZ had consulted on scopes of practice for nursing, in March 2004. Within the second-level nursing section three questions were asked relating to the preferred title, scope description, and qualifications and examples of conditions for second-level nurses; 273 submissions were received. The most frequently cited preference was for the retention of the enrolled nurse title (42%) (Regulations Review Committee, 2007).

In the opinion of NZNO, the survey sent out to members was misinterpreted by the NCNZ. In NCNZ’s July 2006 newsletter, it was noted that:

“... at the time of the introduction [of the HPCA Act 2003] and during the consultation process that preceded it, a consensus on an appropriate title for second-level nurses could not be reached by nurses and stakeholders” (Regulations Review Committee, 2007, p. 7).
NCNZ however, went ahead in 2004, to introduce four scopes of practice, which included two for second level nurses; one for enrolled nurses and one for nurse assistants. The enrolled nurses who qualified prior to 2000 were to remain enrolled nurses. Those who qualified after 2000 were thereafter to be titled nurse assistants. This included enrolled nurses who had already graduated and students attending enrolled nurse programmes, at the time of the announcement. NZNO, on behalf of its members, took exception to this change, objecting to splitting the second level workforce into these “two groups” (Regulations Review Committee, 2007).

The basis of NZNO’s complaint was that aspects of that Regulation offended against the provisions of Standing Order 315, in that it was not in accordance with the general objects and intentions of the statute under which it is made. The personal rights and liberties had trespassed unduly on, and the title change is retrospective, where this is not expressly authorised by the empowering statute. It appeared to make some unusual or unexpected use of the powers conferred by the statute under which it is made, and was not made in compliance with particular notice and consultation procedures prescribed by statute (Regulations Review Committee, 2007).

Recommendations made by NZNO included the need to review the decision by the NCNZ to close the enrolled nurse roll and change the scope of practice for second level nurses under the Health Practitioners Competence Assurance Act, 2003. It was also noted that in 2004 the Health Select Committee (Petition 2002/133) was clearly concerned about students who enrolled in the ‘enrolled nurse’ course as having a legitimate expectation that on graduation they would be known as ‘enrolled nurses’ and that the title ‘nurse assistant’ created a perception that no formal training had been undertaken.

NZNO believed that the NCNZ should be directed to allow those enrolled nurses who trained post-2000 to practise under the title and scope of an enrolled nurse, because these nurses had the explicit expectation that this would be the case. The Health Select Committee strongly recommended that the NCNZ should undertake a revision of the title in consultation with affected parties; however the content of the consultation was re-interpreted by the Nursing Council to support its previous decisions rather than accurately consider the legitimate expectations of affected parties. The NZNO also recommended that the NCNZ should be directed to rescind its decision and discriminatory treatment of second level nurses by allowing all second level nurses to practise under the same title and scope of practices, that is enrolled nurse, with appropriate application of conditions where required, because this would remove
the confusion created to the public and health service providers (Regulations Review Committee, 2007).

It was not until six months later, in July of 2007 that this complaint was reported to the House of Representatives. This was the opportunity for NZNO to voice their complaint and the NCNZ to address these issues. The issues considered relevant to discuss included: Retrospective effect – all those enrolled in second level nurse programmes of study after 2000, but before 18 September 2004, would be informed by the institute that trained them that they would graduate as enrolled nurses, but have since had their title changed to nurse assistant, as changed by the NCNZ. NZNO felt that those who enrolled in a programme of study to become an enrolled nurse had an expectation that once successfully completed, they would become an enrolled nurse (Regulations Review Committee, 2007).

The NZNO asserted that the NCNZ discriminated against enrolled nurses, in the way they handled the qualification of the registered nurse and second level nurse differently. Since registered nurses have a single scope of practice with eight categories which allows for various conditions to be attached their scope. Second level nurses have been given two different titles as well as two different scopes of practice (Regulations Review Committee, 2007).

The Regulations Review Committee (2007) stated that the NCNZ failed to comply with prescribed notice and consultation procedures under the HPCA act 2003, which meant the NCNZ was obliged to consult regarding the changes to title and scopes of practice. Their initial round of consultation demonstrated majority support for the second level nurse title to be that of enrolled nurse. NZNO stated they were concerned with the way that the NCNZ interpreted this, with NCNZ’s findings stating that a consensus on an appropriate title could not be reached by nurses and stakeholders, and that NCNZ had therefore misinterpreted their findings (Regulations Review Committee, 2007).

The NZNO, while emphasising discrimination and fairness, also referred to safety. There was a claim that the term ‘nurse assistant’ caused confusion amongst employers, providers and colleagues and could easily be confused with unregulated health workers, such as nursing assistant, nurse aide, hospital assistant and healthcare assistant. It was suggested that this confusion could affect public safety as it could increase the substitution of unregulated health care workers for regulated ones with a similar title. The placement of the word ‘nurse at the beginning of the title, rather than the end, it was argued, suggested that the person was neither qualified, nor regulated. It was argued that the result of this, for nurse assistants who
were previously enrolled nurses, was that they felt undervalued (Regulations Review Committee, 2007).

Ultimately NZNO wanted the NCNZ to review its decision regarding the change in title from enrolled nurse to nurse assistant and scope of practice (Regulations Review Committee, 2007). The NCNZ subsequently did this through gazetting a replacement scope of practice, for enrolled nurses, which revoked the nurse assistant scope of practice. At the 2010 NZNO Enrolled Nurse Conference held at Otago University in Dunedin, Carolyn Reed, CEO and Registrar of the NCNZ opened her address to the conference with an apology to all enrolled nurses for the hurt and distress that the Council had caused enrolled nurses over the years. She also acknowledged that there was a place for them within the health care team and thanked the enrolled nurses for their patience and made a personal commitment to the work (NZNO Enrolled Nurse Conference Newsletter. 2010).

**Strategic plan for enrolled nursing**

In August 2013 the NZNO developed a Strategic Plan for Enrolled Nurses. The plan outlines a mission statement, vision, strategic aims, membership, organisation and social structure (New Zealand Nurses Organisation, 2013).

The mission statement states that the Enrolled Nurse Section is the professional recognised group within NZNO for Enrolled Nurses, promoting the role and value of the Enrolled Nurse in all areas of health care in Aotearoa New Zealand, which influences health policy, promoting health workforce development by lobbying relevant organisations. Their members are made up of ENs, who are united in the achievement of their professional and industrial aspirations. The EN members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships and they actively work in accordance with Te Tiriti o Waitangi (NZNO, 2013). The vision is that The Enrolled Nurse Section NZNO will be the key stakeholder and the lead voice for ENs in formulating and developing policy related to second level nursing in Aotearoa New Zealand. The strategic aim of the EN section is that the leading consultant role for enrolled nursing is maintained in areas including; Enrolled nursing policy, enrolled nursing education, to contribute to health policy in New Zealand, to build ethically based partnerships with the community and consumer groups, to establish a strong public image of enrolled nursing and NZNO and lastly to increase and broaden enrolled nursing and membership of the Enrolled Nurse Section NZNO (New Zealand Nurses Organisation, 2013, p. 2).
NZNO aims to achieve this by promoting and supporting ENs professional development and to raise members’ awareness and be responsive to membership issues. Objectives include increasing members’ participation through the annual Enrolled Nurse Section Conference and to achieve fair remuneration and safe working conditions for Enrolled Nurses (NZNO, 2014). Within the organisation, financial and functional effectiveness throughout the Enrolled Nurse Section National Committee and all Regional Enrolled Nurse Section structures and processes must be demonstrated by supporting members and assisting with their professional development through the Annual Enrolled Nurse Conference. The Regional Enrolled Nurse Section aims to organise and host regional study days to assist with professional development of its members, to be innovative and responsive to emerging trends affecting the profession of Enrolled Nursing in New Zealand and lastly to protect the interests of Enrolled Nurse Section members and uphold the NZNO values (NZNO, 2013).

The social aspect has a focus on strengthening Enrolled Nurse Section members’ ability to understand, engage and actively recognise and implement Te Tiriti o Waitangi principles in nursing practice and in everyday activities by opposing injustice and inequality wherever it impacts upon the health and wellbeing of New Zealanders (NZNO, 2013).

Overall, this strategic plan proposes a clear plan for supporting enrolled nurses within the health workforce. NZNO have identified a mission statement and vision for the future of enrolled nurses, and proposed how this will support current and future development of enrolled nursing in New Zealand.

**Chapter summary**

This chapter has provided an analysis of the discourses of safety and justice in terms of what influenced changes to enrolled nursing in New Zealand, through an exploration of events and language. The discourse of safety is evident in legislation as well as in position statements and statements organisations and groups. The discourse of justice is more apparent in the work of the NZNO in initiating a legal process which challenged the NCNZ decision to introduce a new scope of practice of nurse assistant, as well as developing a strategic plan for supporting enrolled nursing.

The discourse of safety is the dominant discourse for the NCNZ, who must ensure public safety of nurses through the HPCA Act 2003. The discourse of justice is the dominant discourse for the NZNO, although the discourse of safety is also apparent. These discourses are not necessarily mutually exclusive, and overlap at times in the way in which enrolled nursing and enrolled nurses currently exist in New Zealand.
Chapter Six: Conclusion, limitations and recommendations

This final chapter provides a summary of issues outlined in this thesis, and provides a conclusion in relation to the research question: *What influenced changes to enrolled nursing in New Zealand*. Limitations of the methodology are addressed as well as implications for practice, education and research, and suggestions around future research will be made.

Nursing literature and other publications have been utilised as the text for analysis in this thesis in order to identify social discourses and political change which had an influence on changes to enrolled nursing. While some research literature has been identified around enrolled nurses transitioning to become registered nurses, as well as differences between first and second level nurses’ roles, there is limited research around enrolled nurses and enrolled nursing in New Zealand.

Historical, social, legal and political issues have been identified which highlight enrolled nursing throughout its history in New Zealand. Each of these issues uses specific language. Attention has been paid to changes either in legislation or as a result of the Nursing Council of New Zealand’s guidelines and publications, as well as the positions of various nursing organisations in relation to enrolled nursing.

The methodology of CDA informing this thesis allowed for deeper exploration of enrolled nursing to identify particular words and patterns which were organised into two overarching discourses: the safety discourse and the justice discourse. This was also useful in terms of the framework used to determine who made what statements and whose interests were being served.

There are limitations to both the methodology and the research undertaken for this thesis. In regard to the methodology itself, as identified in Chapter Three, it is subjective and reflects the writer’s opinion and interpretation. However a limitation was the use of CDA for a novice researcher, as well as maintaining objectivity by not including personal opinion. There may also be literature and documents that have not been included or that the researcher did not know existed.

The safety discourse is dominant in the text legislation, policy documents and guidelines, and position statements in submissions. This has been a major factor influencing enrolled nursing in that safety was paramount, and possibly this safety discourse began in the language of ‘lesser ability’.
This research has also highlighted that the justice discourse is apparent through the support from the NZNO to defend their title and scope of practice supported through a legal process against the New Zealand Nursing Council. Support for enrolled nurses by the New Zealand Nurses Organisation whose strategic plan for enrolled nurses continues to monitor progress and actively maintain the enrolled nurses’ professional status within the health workforce of New Zealand has also been discussed.

**Personal reflection**

The reintroduction of ENs into the workforce seems to me to be fraught with on-going confusion and lack of clarity about the role. In my role as a nurse educator I have encountered both positive and negative attitudes within the clinical environment, with some nurses refusing to work with enrolled nurses as they feel that their workload is already heavy, without having to “babysit” an enrolled nurse.

One of my responsibilities as a nurse educator is to co-ordinate and facilitate clinical learning for enrolled nursing students. This involves going to each clinical environment and educating the staff around the new enrolled nurse scope of practice and their role within the acute health care environment. Two groups of nurses required this education - those who had previously worked with enrolled nurses and those who had never previously worked with enrolled nurses. It was apparent to me that knowledge varied between facilities and institutions; however there were some commonalities which included: What enrolled nurses could do, what enrolled nurses were not allowed to do.

Undertaking this thesis has challenged me in terms of maintaining a neutral and objective perspective to ensure the integrity of the data analysis. However, it has allowed me to develop an understanding of discourse analysis which has enabled me to see a different perspective of political, social and legal issues around public safety and justice or fairness in terms of the history of what influenced changes to enrolled nursing in New Zealand.

**Implications for nursing education, practice and future research**

It was noted in Chapter Five that that there is range of views about the recent changes to the scope of practice for enrolled nurses, and a range of experiences and perceptions of the role and the esteem in which the role is held. It was also noted that there was apprehension about future employability of enrolled nurses, and resentment and resignation by some for the need to undertake more training and accreditation.
Delegation and supervision of enrolled nurses is a competency for the registered nurse scope of practice and is included in undergraduate nursing curricula. It seems that there remains an issue around the role of the enrolled nurses despite its scope of practice and guidelines provided by the NCNZ. In terms of further research, there is potential for a study to explore understanding about the scope of practice of enrolled nurses from the perspective of both enrolled nurses and registered nurses.

Additionally, as it seems that since the introduction of the direction and supervision requirement for enrolled nurses this has been a significant influence in changes to enrolled nursing over the last thirty years. Thus there is potential for further research in terms of what is understood by the guidelines for the responsibilities of direction and delegation of care to enrolled nurses.
Competencies for enrolled nurses

Te whakarite i nga mehi tapuhia tikanga ai te haumaru aviri
Regulating nursing practice to protect public safety

April 2012
Introduction

The scope of practice for enrolled nurses and nurse assistants changed on 31 May 2010. The new scope of practice enables enrolled nurses to make a broader contribution to health services and give greater support to registered nurses. The Nursing Council of New Zealand (the Council) has developed new competencies to reflect changes to the scope of practice and for students to be assessed against at the end of the new 18 month diploma in enrolled nursing programme at level 5 on the New Zealand Qualification Authority-National Qualifications Framework and accredited by the Council.

All enrolled nurses have been given the opportunity to complete a transition into the new scope of practice by being assessed against the new competencies. Enrolled nurses who do not transition by 1 July 2011 will have a condition included in their scope of practice restricting them to working with health consumers with stable and predictable outcomes. Some enrolled nurses who completed a level 4 certificate will already have a condition included in their scope of practice restricting them to working in a specific area of practice e.g. long-term care and rehabilitation. They will retain this condition until they complete part of an enrolled nurse programme at a polytechnic/institute of technology school of nursing.

Enrolled nurses who do not complete the transition requirements will not be expected to meet competencies 2.1, 2.2, 2.3, 2.6, 3.2, 3.3, 4.2, and 4.3. These competencies describe areas where the scope has broadened to allow enrolled nurses to contribute more to the following areas:

- contributing to nursing assessments
- working as part of a team with registered nurses when nursing acutely ill or complex health consumers
- observing and reporting changes in health consumers conditions
- working with health consumers with mental health concerns
- co-ordinating a team of health care assistants under the direction and delegation of a registered nurse
- working under the direction of a health practitioner who is not a nurse.

Enrolled nurse scope of practice

Enrolled nurses practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings. Enrolled nurses contribute to nursing assessments, care planning, implementation and evaluation of care for health consumers and/or families/wānau. The registered nurse maintains overall responsibility for the plan of care. Enrolled nurses assist health consumers with the activities of daily living, observe changes in health consumers’ conditions and report these to the registered nurse, administer medicines and undertake other nursing care responsibilities appropriate to their assessed competence.

In acute settings, enrolled nurses must work in a team with a registered nurse who is responsible for directing and delegating nursing interventions. In some settings, enrolled nurses may coordinate a team of health care assistants under the direction and delegation of a registered nurse. In some settings, enrolled nurses may work under the direction and delegation of a registered health practitioner*.

Appendix 2 EN competencies

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*A person who is registered under the Health Practitioners Competence Assurance Act e.g. midwife, medical practitioner, occupational therapist.

In these situations the enrolled nurse must have registered nurse supervision and must not assume overall responsibility for nursing assessment or care planning. Enrolled nurses are accountable for their nursing actions and practise competently in accordance with legislation, to their level of knowledge and experience. They work in partnership with health consumers, families/whānau and multidisciplinary teams.

**Domains of competence**

There are four domains of competency for the enrolled nurse scope of practice. Evidence of safety to practise as an enrolled nurse is demonstrated when the applicant meets the competencies in the following domains:

**Domain one: Professional responsibility**

This domain contains competencies that relate to professional, legal and ethical responsibilities and cultural safety. These include being accountable for one’s own actions and decisions within the enrolled nurse scope of practice.

**Domain two: Provision of nursing care**

This domain contains competencies related to assessment and provision of nursing care for health consumers when working under the direction of a registered nurse.

**Domain three: Interpersonal relationships**

This domain contains competencies related to interpersonal communication with health consumers, their families/whānau and other nursing and healthcare staff.

**Domain four: Interprofessional health care and quality improvement**

This domain contains competencies related to working within the interprofessional health care team and contributing to quality improvement.

**Competencies and indicators**

The competencies in each domain have a number of key generic examples of competent performance called indicators. These are neither comprehensive nor exhaustive; rather they provide examples of evidence of competence. The indicators are designed to assist the assessor when using his/her professional judgement in assessing the attainment of the competencies.

In addition, the indicators assist curriculum development for the enrolled nurse programme. All competencies are assessed on an ongoing basis during the education programme and will be assessed for entry to the enrolled nurse scope of practice upon the completion of the programme.

*Note: Please read the glossary of terms on page 46 of this document.*
Domain one: Professional responsibility

Competency 1.1 Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements.

Indicator: Demonstrates knowledge of relevant legislation pertaining to the delivery of health consumer care.

Indicator: Ensures practice is within the scope of practice and adheres to legislated requirements and relevant ethical codes, policies and procedural guidelines.

Indicator: Accepts responsibility for actions and decision making within the enrolled nurse scope of practice.

Indicator: Identifies breaches of law that occur in practice and reports them to the registered nurse/manager.

Competency 1.2 Demonstrates the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice.

Indicator: Understands the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand.

Indicator: Applies the principles of the Treaty of Waitangi/Te Tiriti Waitangi to nursing practice.

Indicator: Demonstrates knowledge of differing health and economic status of Maori and non Maori and how this impacts on health outcomes.

Competency 1.3 Demonstrates understanding of the enrolled nurse scope of practice and the registered nurse responsibility and accountability for direction and delegation of nursing care.

Indicator: Recognises and acts in accordance with the enrolled nurse scope of practice, organisational policy and own level of competence.

Indicator: Demonstrates understanding of the registered nurse’s role to direct, delegate, monitor and evaluate nursing care.

Indicator: Consults with the registered nurse to ensure that delegated tasks and responsibilities are commensurate with own level of competence.

Indicator: Seeks guidance from a registered nurse when encounters situations beyond own knowledge, competence or scope of practice.

Competency 1.4 Promotes an environment that enables health consumer safety, independence, quality of life, and health.

Indicator: Identifies and reports situations that may impact on the safety of health consumers or staff.

Indicator: Adjusts the physical and social environment in order to maximise health consumer wellbeing.
Indicator: Adheres to standards and procedures related to restraint minimisation, infection control, safe handling, pressure area prevention and the administration of medicines.

Indicator: Initiates appropriate interventions in emergency situations.

Indicator: Supports the right of health consumers to maintain independent lifestyles with dignity in their own environment.

Competency 1.5 Participates in ongoing professional and educational development.

Indicator: Undertakes regular review of own practice by engaging in reflection and identifying ongoing learning needs.

Indicator: Takes responsibility for own professional development and maintenance of competence.

Indicator: Takes opportunities to learn with others contributing to health care.

Competency 1.6 Practises nursing in a manner that the health consumer determines as being culturally safe.

Indicator: Demonstrates ability to provide culturally safe care to meet health consumers’ individual needs, beliefs and values.

Indicator: Reflects on own practice and values that impact on cultural safety.

Indicator: Takes opportunities to gain feedback from health consumers to determine own practice is culturally safe.

Indicator: Avoids imposing prejudice on others and reports any observed occurrences of prejudice to the registered nurse.

Indicator: Appropriately challenges practices that compromise health consumer safety, rights, privacy or dignity.
Domain two: Provision of nursing care

Competency 2.1 Provides planned nursing care to achieve identified outcomes.

Indicator: Contributes to the development of care plans in collaboration with the registered nurse and health consumers, and clarifies responsibilities for planned care with the registered nurse.

Indicator: Promotes independence while assisting health consumers to undertake activities of daily living, such as nutrition, hydration, elimination, mobility, social functioning and personal hygiene.

Indicator: Uses nursing knowledge and problem solving skills when carrying out professional responsibilities.

Indicator: Prioritises and manages time.

Indicator: Carries out procedures competently and safely.

Indicator: Administers nursing interventions and medications within legislation, codes, scope of practice and according to prescription, established organisational policy and procedures.

Competency 2.2 Contributes to nursing assessments by collecting and reporting information to the registered nurse.

Indicator: Completes assessment tools as delegated by the registered nurse.

Indicator: Uses a range of data gathering techniques including observation, interview, physical examination and measurement.

Indicator: Assists with routine examinations and routine diagnostic investigations.

Indicator: Applies understanding of the different developmental stages of the life span.

Competency 2.3 Recognises and reports changes in health and functional status to the registered nurse or directing health professional.

Indicator: Observes for changes in health consumers’ health and functional status in the course of nursing practice.

Indicator: Communicates observations to the registered nurse and appropriate members of the health team.

Indicator: Reports changes in health status in a timely manner and is aware of procedures for responding to concerns which are escalating in the health care setting.

Competency 2.4 Contributes to the evaluation of health consumer care.

Indicator: Monitors and documents progress towards expected outcomes.

Indicator: Contributes to the review of care plans in collaboration with the registered nurse.
Competency 2.5 Ensures documentation is accurate and maintains confidentiality of information.

Indicator: Observes, reports, records and documents health status.

Indicator: Records information in a systematic way that is in line with organisational policy and procedures.

Indicator: Ensures written communication is comprehensive, logical, legible, clear and concise, using only accepted abbreviations.

Indicator: Maintains confidentiality of documentation/records and interactions with others.

Competency 2.6 Contributes to the health education of health consumers to maintain and promote health.

Indicator: Provides accurate and culturally appropriate education to health consumers or groups to maintain or promote health in consultation with the registered nurse.

Indicator: Determines consumer understanding by seeking feedback on information given.

Indicator: Demonstrates an understanding of how health and disease are affected by multiple and interconnected factors.
Domain three: Interpersonal relationships

Competency 3.1 Establishes, maintains and concludes therapeutic interpersonal relationships.

Indicator: Establishes rapport and trust with the health consumer and or family/whanau.

Indicator: Demonstrates respect, empathy and interest in the health consumer.

Indicator: Is able to establish relationships and effectively and culturally appropriately communicate with health consumers.

Indicator: Appropriately terminates therapeutic relationships.

Indicator: Understands therapeutic relationships and professional boundaries.

Competency 3.2 Communicates effectively as part of the health care team.

Indicator: Communicates orally and in writing appropriately and effectively.

Indicator: Demonstrates understanding of the need for different communication styles and approaches in different situations.

Indicator: Engages with colleagues to give and receive constructive feedback that enhances service delivery to health consumers.

Indicator: Contributes to a positive working environment.

Competency 3.3 Uses a partnership approach to enhance health outcomes for health consumers.

Indicator: Understands and applies the principles of a recovery centred\(^1\) approach to nursing care within different health care settings.

Indicator: Understands the impact of stigma and discrimination on health outcomes for health consumers and is able to implement nursing interventions that enhance fairness, equality and self determination.

Indicator: Understands and uses the resources in the health consumer’s community to improve health outcomes.

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\(^1\) Mental Health Commission March (2001) Recovery Competencies for New Zealand Mental Health Workers
Domain four: Interprofessional healthcare and quality improvement

Competency 4.1 Collaborates and participates with colleagues and members of the healthcare team to deliver care.

Indicator: Understands and values the roles, knowledge and skills of members of the healthcare team in relation to own responsibilities.

Indicator: Supports the therapeutic activities of other team members in the provision of health care.

Indicator: Provides other members of the team with accurate and relevant information to assist in decision making and provision of care.

Indicator: Contributes to discussion related to nursing practice, systems of care planning and quality improvement.

Competency 4.2 Recognises the differences in accountability and responsibility of registered nurses, enrolled nurses and healthcare assistants.

Indicator: Clarifies enrolled nurse role and responsibilities in the context of health care settings.

Indicator: Acts as a resource and role model for nurse students and healthcare assistants.

Indicator: Prioritises the delivery of nursing care to health consumers as guided by the registered nurse.

Indicator: Co-ordinates provision of care by healthcare assistants within the team as delegated by the registered nurse.

Competency 4.3 Demonstrates accountability and responsibility within the healthcare team when assisting or working under the direction of a registered health practitioner who is not a nurse.

Indicator: Understands the enrolled nurse role and boundaries in relation to the scopes of practice of other registered health practitioner.

Indicator: Practises within legislative requirements, organisation policy and refers issues outside scope to a registered nurse supervisor.

Indicator: Works under the direction of an identified health practitioner and reports observations, changes in health status and escalating concerns to that health practitioner.
Appendix Two

Reference Number 39/13

9 September 2013

Lucy Prinsloo
C/- Faculty of Health Sciences
EIT

Dear Lucy

I am pleased to inform you that your research notification “What influenced changes to enrolled nurses in New Zealand” was received and formally endorsed by the Research Ethics & Approvals Committee at their meeting of 30 August 2013.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number of all correspondence to the Committee.

Please provide the Committee with a progress report after one year of the project and a brief summary at the conclusion.

The Committee wish you well for the project.

Yours sincerely

Jeanette Fifield
Secretary – Research Ethics & Approvals Committee
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