

Enhancing and Standardising Regional Training Programmes in Nursing Mapping Exercise

Report from the Consultants

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COMPLETION REPORT

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Acronyms and Abbreviations

ANMC	Australian Nursing and Midwifery Council
APNLC	American Pacific Nurse Leaders' Council
AusAID	Australian Agency for International Development
AUT	Auckland University of Technology
CPE	Continuing Professional Education
HCW	Health Care Worker
ICN	International Council of Nurses
JCU	James Cook University
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non Government Organisation
NP	Nurse Practitioner
NUS	National University of Samoa
NZAID	New Zealand Agency for International Development
PIFS	Pacific Islands Forum Secretariat
PICs	Pacific Islands Countries
PNG	Papua New Guinea
POLHN	Pacific Open Learning Health Network
PHC	Primary Health Care
RN	Registered Nurse
SPCNOA	South Pacific Chief Nursing Officers Alliance
UPNG	University of Papua New Guinea
USP	University of South Pacific
WHO	World Health Organization
WP/SEAR	Western Pacific/South East Asia Region

1. Executive Summary

A consultancy team from James Cook University, Townsville, Australia was appointed, in March 2007, to undertake a mapping exercise of current educational provisions and standards necessary for member countries of the Pacific Island Forum Secretariat. A proposal for “enhancing and standardizing regional training programmes in nursing” which is initiative 7.2 under Sustainable Development in the Pacific Plan (2005), prompted the mapping exercise as an essential first step in implementation. The exercise was stimulated by the recognition in the Pacific Island Countries (PICs) that the current variation in the licensing and education of nurses impacts on the quality of nursing care available in member countries, and that diverse qualification and registration processes impede movements of nurses for purpose of work and study in the region. In June 2007, the American Pacific Nurse Leaders’ Council also endorsed a workforce, education and regulatory study.

This mapping exercise was undertaken on behalf of the Pacific Islands Forum Secretariat (PIFS), the SPCNOA and the World Health Organization (WHO) who agreed the terms of reference for the project. The project coheres with other key initiatives to improve health care and health education in the region; of particular relevance to this project is the ongoing development by WHO of a model text/template for the legislation of nurse regulation The Pacific Plan, which was endorsed by Leaders at the Pacific Islands Forum meeting in October 2005, is based on the concept of regionalism which, under the Plan, implies no limitation on national sovereignty.

Countries from both the north and south pacific regions were included in this study. The countries included in this study were: Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Nauru, Niue, Palau, Papua New Guinea, Republic of the Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu. The Federated States of Micronesia and the Republic of the Marshall Islands are North Pacific countries which, although they are not members of the SPCNOA, are members of the Pacific Islands Forum.

Data collection took place during May and June 2007 and included: a literature review which took account of relevant government and non-government reports; the development,

distribution and analysis of three questionnaires (see Annex 1) relating to (a) legislation, (b) nursing education/training, and (c) employment; and telephone and onsite visits to Fiji and Samoa for focus group interviews (see Annex 3). The telephone calls and visits to Fiji and Samoa for focus group interviews resulted in more comprehensive information which assisted with the final analysis and recommendations.

Although the data received from the participants was obtained from both self administered questionnaires and some from focus group interviews, there were some gaps in the data, especially in the curriculum material supplied. The data analysis of the material gathered demonstrated marked variability in the standards of nursing education across the Pacific Island nations, thus supporting the views of the Chief Nursing Officers. It also demonstrated clearly that nursing curricula and training programmes vary considerably in relation to quality and that nurse education does not always currently meet specific regional needs for the provision of effective nursing practice. This is true for both basic/undergraduate nurse education and postgraduate nurse education (e.g. Midwifery courses range in duration from 6-24 months, and some postgraduate courses were reported as having no review or credentialing requirement). In addition, wide variation exists in legislation, regulation, accreditation, salary structures and career pathways across the region.

Core competencies for Registered Nurse (RN) education and practice in the Western Pacific/South East Asia Region do exist; these were agreed at the meeting of the Western Pacific and South East Asia Regulatory Authorities in Singapore, 2004 (WP/SEAR, Australian Nursing and Midwifery Council, 2006). There is no evidence, however, that they are currently utilised widely as a framework for the development of RN nursing curricula or for the regulation of nursing practice within the PICs.

Recommendations

In order to:

- strengthen nursing and nursing education in the Pacific region to promote effective, efficient and safe care for the people of these countries;
- standardize regional nurse training programmes;
- increase stakeholder understanding of the range of qualifications available;

- facilitate the standardization of qualifications for nurses across the PICs;
- the Project Consultants recommend the following:

LEGISLATION:

1. Provide technical support to MoH, nurse leaders and nursing/midwifery bodies or councils and, where appropriate, the MoE in each PIC that has no nursing regulatory framework to draft legislation for nursing regulation using the model text/template prepared by WHO.
2. Following enactment of the legislation, support the establishment of the regulatory authorities in those PICS where they currently do not exist and support the operationalization of these authorities.
3. Support the development or review of relevant legislation where needed, outlining the ‘scope of practice’ of nurses and midwives in generalist, advanced and specialist roles to ensure quality of practice and safety of the public.

WORKFORCE PLANNING/ EMPLOYMENT:

4. Develop a process for the conduct of a need’s analysis of the numbers and types of nurses required for the next decade. This will provide the data to support adequate educational and recruitment planning.
5. Support MoH or MoE in each PIC to enable an increase in the intakes in Schools of Nursing to prepare sufficient nurses to cover both local needs and anticipated nurse migration. It is important that the overall quality of the graduates is maintained and strengthened during this process. This would encompass, among others, an increase in budgetary allowances for Schools of Nursing, repair to existing infrastructure as well as implementation of the recommendations following (see Recommendation 16).
6. Request the Pacific Island Forum Secretariat to include on the agenda of the Regional Meeting of the employment agencies of nurses (Public Service Commissions), the development of mutually recognised employment protocols for nurses in PICs. Ministries of Health will need to be integrally involved in the development of these.

EDUCATION:

7. Use the strengths of the well-established Schools of Nursing in the Pacific region in, for example, Samoa, Fiji, Guam, Hawaii and Papua New Guinea, to act as expert 'hubs' (appropriate nomenclature to be decided by the participants) to support designated smaller countries in their own development of sustainable regional nurse education. These hub schools would require strengthening and assistance in human, technical and material resources in order to adequately fulfil regional activities. The support provided by hub schools should include:
 - training students from other islands in part or all of the general nurse training (RN) programme;
 - providing student exchange arrangements to enable student nurses from the smaller islands to experience tertiary and/or different rural settings;
 - providing faculty exchange arrangements and using identified expert nurse educators to mentor educators from less well-resourced PICs to increase regional capacity in nursing education;
 - acting as regional centres of excellence for the conduct of postgraduate and continuing professional development courses; these courses offered by the hub Schools should be recognised by MoH/MoE (as appropriate) and PSCs as accredited credentialing institutions as one established pathway for salary increments and career progression;
 - developing workshops, and intensive training programmes for the continuing education of nurse teachers;
 - liaising with regional and partner institutions in Australia, New Zealand, the United States and elsewhere and with donor agencies to further develop nurse education relevant to the PICs;
 - collaborating with other Schools within the region (i.e. within New Zealand, Australia and elsewhere) to maximise the sharing of resources and expertise.

8. Support a process for regular review (every 5-7 years) of curricula in PIC's Nursing Schools to ensure that they are informed by contemporary curriculum theory and are focussed on emerging health care trends such as population health, primary health care and current models of service provision.

9. Provide external support to any School which has not reviewed its curriculum in the past 5-7 year period to do so within the next year.
10. Establish a foundation year, based on the National University of Samoa's Foundation programme for those Schools of Nursing which do not incorporate one in their requirements. This foundation year should promote the acquisition of necessary skills in (for example) reading, study, problem solving, math, science and English language prior to entering formal nursing studies. This year could be delivered at either the local School of Nursing or at some other institution prior to the commencement of nurse education proper.
11. Consider the establishment of selection committees in each PIC for intakes of nursing students with the Principal Nurse Educator being responsible for coordinating the selection process and chairing the selection committee. Develop common guidelines for selection committees that focus on the School's mission, the health needs of the population, and measures of equity including culture, gender and socio-economic status.
12. In the next phase of the project, establish a Nurse Educator taskforce composed of nurse educators, clinicians, regulatory body representatives and is sanctioned by the relevant nurse leaders and council to develop a common core of curriculum material. This common core material should be informed by the agreed competencies for RN licensure and should be implemented by each country in its own context. This taskforce of nurse educators would also be charged with the development of a quality academic framework for undergraduate and postgraduate nursing education.
13. Encourage feedback from nurse educators and clinical nurses from the PICs on the Western Pacific and South East Asia Region (WP/SEAR) Common Competencies for Registered Nurses once they are ratified by the PICs Regulatory bodies (available at www.anmci.org.au/wpsear/index.php).
14. Develop a systematic progression pathway between secondary schools, the education system, and Schools of Nursing in the region to ensure that student nurses are appropriately advised and prepared to undertake nursing studies.
15. Begin work toward the development of a regional or sub-regional accreditation review system and council for Nursing Schools, courses and curricula which would allow mutual recognition or reciprocity of licensure for all levels of nursing and midwifery across the region/sub-region.

16. Within the Schools of Nursing, the following recommendations will require concurrent work:
 - Support countries to select and prepare, to baccalaureate level, an appropriate number of RNs with clinical experience and an interest in teaching to become nurse educators.
 - Advance and support ongoing professional development of nurse educators to assist their growth in educational skills and to foster the use of participatory adult learning techniques to promote active, deep learning, critical thinking, reflective practice and effective problem solving.
 - Provide financial and technical support to upgrade library (including electronic library resources) and teaching resources such as clinical laboratories in under-resourced PICs Nursing Schools.
 - Provide financial and technical support for each School of Nursing to ensure adequate and reliable access to the internet.
 - Provide computer training programmes for teachers and students in Schools of Nursing. (POLHN could usefully take the lead on this.)
 - Ministries responsible for Schools of Nursing should provide ongoing budget allowances for regular renewal and upgrade of School of Nursing computer hardware and software.
17. Establish a centre in one School of Nursing to enable sharing and coordination of information related to improvements in nurse education and nursing practice. In addition, fund a position of one RN or administrator who will act as a coordinator of a secretariat for improvement processes for regional nurse education and continuing professional development. This could incorporate an active web net of linkages.
18. Encourage international and multi-lateral donor agencies, nursing and education networks to work in partnership with each School of Nursing to ensure a coordinated approach to nurse education and to promote resource sharing, quality and efficiency so that overall population health outcomes are improved.

2. Background

The nursing workforce is integral to the effectiveness of health care. The PIFS (2005) mandated the strengthening of nursing and nurse education, and the promotion of effective, efficient and safe nursing care for the peoples of the PICs. At their meeting in Apia, Samoa in September 2006, the South Pacific Chief Nursing Officers Alliance (SPCNOA) highlighted the issue of variation of standards of initial nursing education and midwifery education across the Pacific region. Such variation impedes both standardisation in quality of care and the possibility of employment opportunities across the region.

To address the issue the SPCNOA resolved to work with PIFS in undertaking a mapping exercise of current educational provision and registration standards in member countries. This was supported by the World Health Organization (WHO). The APNLC (2007) also determined that such an exercise was a key component of their regional nursing strategic plan.

In addition, in Bangkok, Thailand in December 2006, WHO convened 30 international nursing and midwifery leaders to further develop draft global standards for nursing and midwifery education. The participants at this meeting noted that:

- (i) nursing education around the world is highly variable, taking place in a myriad of programmes at the secondary school level, hospitals, technical institutes and institutions of higher education (Jean Yan, WHO Chief Scientist for Nursing and Midwifery/Co-Chair – Planning Group);
- (ii) the lack of global education standards creates issues for quality care, the immigrating nurse, the potential employing agency and the recipient country;
- (iii) over the decades, organisations and governments have developed statements, regulations and standards for nursing practice and education. Many, however, only apply to a specific global region or country.

To address these issues, the meeting resolved “to draw on existing standards and the expertise and experience of global health care leaders to develop a single set of educational standards that can be adopted and implemented worldwide” (WHO press release, 2006).

Clearly, this has implications for Pacific Island Countries (PICs) in relation to nursing and midwifery education, accreditation and legislation. The PICs encompass several small island states, which vary in size from tiny Tuvalu (26 sq km) (WHO 2006h) to Papua New Guinea (600 islands with a total land area of 462,840 sq km) and population sizes that range from 1,515 in Tokelau (WHO 2006e) to 5.8 million in PNG (WHO 2006g). Each of these island nations is a sovereign entity, with a history of gaining independence from one of the larger, more developed countries, and although each possesses a unique cultural signature it values its ties to other PICs. These nations fiercely defend their national identity and strongly resist external attempts to impose solutions to their health and nursing challenges.

Notwithstanding the variety and differences in size and population, the PICs share many demographic and health care commonalities. Demographically, populations are skewed towards the young with up to 35 - 40% of the population being younger than 15 years of age (WHO 2006a-h). The geographical and population spread is immense with some of the PICs extending over millions of square kilometres of the Pacific Ocean. In terms of health, WHO (2006a-h) notes the common increase in non-communicable diseases (obesity, diabetes, hypertension, coronary artery disease and cancer) and high infant and childhood mortality, (generally) due to diarrhoeal and respiratory infections. Some of the islands continue to cope with vector borne diseases (dengue in particular) and persistent infectious disease (tuberculosis). Injuries and trauma are increasing with increasing economic development. In addition, health spending is very limited with most of the expenditure related to personnel costs. This is exacerbated by inequitable distribution of insufficient economic resources.

3. Methodology

Structured Questionnaires

Three questionnaires were developed based on the Terms of Reference and the requested final outputs of the project. These were structured questionnaires but space was provided for respondents to comment. The three questionnaires (see Annex 1) were developed separately under the topic headings of:

- Education
- Legislation
- Employment.

A specific education questionnaire for Federated States of Micronesia, Nauru, Niue and Tuvalu was also developed, as these PICs do not currently have nursing schools. The questionnaires were sent in draft form to PIFS for comments from the Project Committee. They were revised in light of the comments received from PIFS.

Distribution of Questionnaires

The questionnaires were sent electronically, along with a covering letter outlining the aims and methodology of the project, to all countries and to personnel at two different levels in each country. The countries included were:

- Cook Island
- Fiji
- Kiribati
- Marshall Islands
- Federated States of Micronesia
- Nauru
- Niue
- Palau
- Papua New Guinea
- Samoa
- Solomon Islands
- Tonga
- Tuvalu
- Vanuatu.

The PIFS had previously forwarded a Circular to all its official contacts within the Forum Island Countries explaining the project and requesting the countries to cooperate with the team and complete the questionnaires (see Annex 2).

One questionnaire went to a designated senior person at Ministry of Health (MoH) and one was sent to a 'nursing focal person'. These names and addresses were provided by WHO. This list was supplemented from the personal knowledge of PICs by the project team. The electronic posting was followed by an email requesting confirmation of receipt of material. The countries that did not send email confirmation were followed-up through other channels, e.g. telephone.

Minor problems with contacting the appropriate person were generally overcome (see **Limitations** below). The material was sent again.

In addition, the questionnaires were originally sent in PDF format which was incompatible with local software systems. The questionnaires were reformatted as Word documents and sent again to all PICs with an accompanying explanation of how to open, complete and return them as attachments. None of the recipients requested clarification regarding the completion of questionnaires. However, designated project participants in some countries indicated that sections of the questionnaires would need to be sent to other Ministries/Department for completion. The Employment questionnaire was the most common in this category, but also part of the Education questionnaire sometimes needed to be redirected. This occurred when either the Nursing Schools were not under MoH control or they were in some other geographical location. In addition, the very different responsibilities of PICs Chief Nurses (if there was one) and the Head of the School of Nursing also impeded the expeditious completion of questionnaires. These officers had different parts to complete. Had the Project Consultants been aware of these differing responsibilities the sequencing of the questionnaires may have been altered.

Return of Questionnaires

Weekly follow-ups were sent to ‘nursing focal persons’ and fortnightly to the designated person in the MoH to prompt the return of the completed questionnaires. Returning the questionnaires was problematic, however; there was too much material to scan. To address this, and to prevent unexpected expense for the MoH, a ‘reverse charge’ courier system was used to return the material to Australia. Two courier companies were utilised as all the PICs did not use the same service.

Telephone Follow-Ups

After six weeks, the focal person or designated MoH person was telephoned to obtain further informal information regarding the country and to ensure that the ‘focal persons’ understood the reasons for the project and the importance of completing the questionnaires. This informal information was extremely useful in supplementing the data gained from the questionnaires. See Annex 8 for a list of those people consulted by email and /or telephone during the project.

Final Follow-Ups

Two weeks before the scheduled completion of the draft report further emails and phone calls were made to countries that had not returned their completed questionnaires. It was

explained to each focal person that without the information there could not be a complete analysis of the nursing situation in PICs. It was made clear that if the Project Team did not receive their questionnaires in time they would only be able to use the government and non-government material that was available for their country. In addition, it was also made clear that if there was no such material available or the material was not up to date, then nothing would be used. This was particularly pertinent for those employing authorities that were reluctant to provide the information requested in questionnaires and/or to provide the relevant requested documentation. It was decided that anecdotal information was not appropriate for this project. The outcome was that only 2 out of 14 countries did not return completed or partly completed questionnaires. The overall response rate was 87.5% which is unprecedented in this region.

Three additional points require mention. Firstly, some of the information received from PICs was known from the personal experience of the Project Consultants and a range of other anecdotal sources to be incorrect. As the formal responses to the questionnaires, however, such information had to be included. This should be borne in mind when using the data to inform any future project design; project designs should be sufficiently flexible to allow on-site changes when information discrepancies are discovered. Secondly, the volume of any supporting documentation should be considered in any future project design. The electronic submission of voluminous documentation can be hugely problematic, especially in countries where electronic systems are (or may reasonably be expected to be) unreliable. Thirdly, the excessive costs of both telephone and internet access will need to be factored in to any future project plans for PICs.

On-Site Focus Group Interviews

Visits to the two countries with large nursing schools i.e. Fiji and Samoa, were undertaken in the beginning of July. Two focus group interviews were carried out in both countries. A brief summary of the reports from these groups can be found in Annex 3.

4. Literature Review

Nursing is the largest of the health workforce and nurses are instrumental ‘in shaping the health status of the world population and will continue to be the “front-line” health care provider’ (Kulwicki 2006, p.396). In view of this, health care systems require well-

qualified and experienced practitioners to function effectively. Effective functioning, i.e. nursing competently, is, in turn, a result of a clear understanding of one's scope of practice, appropriate preparation for such practice and continuing maintenance of professional competence. These issues are addressed in the legislative regulation of nursing (Pearson et al. 2002) which aims to protect the safety of the public. Importantly, too, such regulation also protects nurses themselves as they work to improve the health care of their communities. With the rapid changes in health care delivery, global nursing shortages, and greater demands for cost containment (Tabari Khomeiran et al. 2006) nursing competency has become a high priority for nurse educators, nurse managers and health care systems. Legislative regulation has implications for the education of nurses as nurse education institutes are required to prepare nurses to meet the appropriate competency standards and to work within their scopes of practice.

Nursing standards and competencies vary across the globe, depending on the context of the region, and this can have deleterious effects on both health care and nurse education. To address this WHO aims "to develop a single set of [nursing] educational standards to be adopted and implemented worldwide" (WHO press release 2006). The WHO draft global nursing standards aim 'to facilitate equity and understanding of the education process essential for all nurses and midwives to practice safely and effectively' (Morin and Yan 2006 p.202). Implementing this set of standards, however, may be protracted; in each nation different socioeconomic, political, historical and developmental impediments may be encountered. The status of nursing will require alteration to enable nurses to become leaders and change agents for health within their country. Once there is both agreement and the will to implement the standards, assessment of the resultant graduates will be needed. As a start, Cowan et al. (2007) report on the development of a self-assessment tool for nurses to use to determine their competency base against those of European countries.

Labour intensive health care systems need well qualified and experienced practitioners to function effectively. This is particularly true of countries like PICs where nursing personnel outnumber physicians by 4 to 13 times. The immense geographical spread of the various PICs, lack of financial resources in health ministries and relative lack of physicians increases the PICs' dependence on nursing (WHO 2006a-i). Low ratios of doctors and nurses to population and the lack of capacity to educate sufficient health care workers contribute to the relatively poor health of the people of the PICs (Watters & Scott 2004).

Nursing is pivotal to health care in PICs (ANMC 2007a-o) yet the shortage of nurses on national, regional and global levels clearly affects the PICs (ANMC 2006).

The globalisation of nursing has already produced a very serious side effect in these island countries. Out-migration of senior and experienced health personnel has become a feature in most PICs due to a range of factors (WHO 2006a-i). This out-migration of well-educated, more senior nurses contributes to the paucity of well equipped clinical supervisors and tutors as well as to shortages of nurses in the health care system (Troy, Wyness & McAuliffe 2007). Another contributing factor to the loss of nursing expertise in many of the PICs is forced retirement (WHO 2006g) of the experienced and senior nursing personnel. Other countries in the region, e.g. Australia, have moved away from mandatory retirement policies in order that the skills and contribution of older members of the profession can continue to be used within the workforce. Tonga has approached the problem by increasing the annual intake of student nurses 'several fold, to makeup for the continuous loss of nurses' (WHO 2006f, p.344), indicating that this is an appropriate and plausible solution to a serious shortage.

However, retention of well-educated nurses is not just a matter of increasing numbers and improving education standards; it is a complex issue and involves raising wages, improving working conditions, developing career ladders, creating professional development opportunities (Brush & Sochalski 2007, p.40) as well as improving the health care system of the country. Postgraduate skills acquisition and post basic nurse education will help to bring the profession's status into line with other professions (Pearson & Peels 2001a) and assist in recruitment and retention. Continuing professional development is necessary to maintain standards of care and for nurse retention and career development. Continuing professional development should be a condition of registration and any professional development programme should be based on assessment, be well structured for learning, address more competencies than just knowledge acquisition, and be deemed necessary for safe and competent practice in the individual's context (Swankin, LeBuhn & Morrison 2006, p.viii).

Another important strategy to retain nurses is provision of sufficient health care personnel to permit the workers to feel safe in their workplaces. They should be confident that they will not be expected to work outside their scope of practice. In addition, they should be

confident that they will not need to be responsible for more numbers of patients than they can care for and will not feel as stressed (Troy 2007). This constitutes a major challenge to PICs; high levels of absenteeism, insufficient mentors and supervisors and worsening working conditions with higher workloads, reduced work satisfaction and low morale result from large numbers of nurses migrating to the industrialised countries in search of higher salaries, better working conditions and career paths (Kingma 2007, p.1286). This results in a spiralling effect which weakens the less developed country's health care system and ability to prepare more nurses. Immigrant nurses do not return home to work in their country of origin because of the depressed working conditions (Troy et al. 2007) although it has been suggested that they remit wages to their home country (Connell & Brown 2004, Brown & Connell 2006).

Within the nursing community, education is considered a national responsibility. Health care systems exist within a socio-political system (Jeon & Chenoweth 2007, p.16) as do education institutions, and this needs to be taken into consideration when examining education and developing curricula. Curricula need to be based on the local/regional context to develop graduates who are safe in their environment and with the available resources.

Key areas to be considered for nursing curricula include those identified in the draft Global Standards for Initial Nurse and Midwifery Education (WHO 2006j), i.e. primary health care, ethics, health sciences, communication, culture, use of research, social sciences, leadership, health promotion, region specific disease management and population health policy and environmental health behaviours. The core content of all nursing programmes must include nursing principles and therapeutics. Core content for all midwifery programmes must include the pregnancy continuum and women's and family health. Nursing and midwifery schools must include supervised practice experience in their programmes (WHO2006j). Competency standards and ongoing education need to be developed to fulfil the expectations of communities for safe and competent nursing care (Tabari Khomeiran et al. 2006).

Tabari Khomeinan et al. (2006) along with WHO (2006k) believe that student nurses require adequate supervision, to make appropriate use of the theoretical knowledge they have gained in order to develop clinical competence. In this case, competence involves

more than skills acquisition; it is an interaction between cognitive, psychomotor, and attitudinal skills (Ramritu & Barnard 2001; McGrath et al. 2006) that reflects the global standards for nurse and midwifery education put forward by WHO. The ICN, WP/SEAR and PNG have all developed competency standards for the registered nurse that are consistent with these.

The availability of adequate supervision of students is dependent on having a well supported, well educated and experienced nursing workforce, including nurse educators. The qualifications and experience of the educators of the next generation of nurses and midwives will shape the health care outcomes for the next several years. Well educated and visionary nursing educators can prepare their students to meet the challenges they will face, armed with the tools to implement innovative and effective programmes within their communities. Retaining and better equipping experienced nurses is necessary to lift the standard of the nursing graduate. Preparing RNs with practical experience and an interest in teaching to a baccalaureate level is a starting point for improving nursing standards

To enable regional movement of nursing personnel, common competencies must be identified and incorporated into each PIC curriculum. Use of a common language and understanding and developing a tolerance of cultural differences are necessary to produce nurses with complex skills to work in their home nations and who also have regionally and internationally recognised abilities and credentials. Cultural differences include lifestyle, health assumptions, economic and health resources, political systems and economic realities (Zheng et al. 2001). One difficulty in the PICs is the low achievement of English language proficiency. Mastering English for patient safety and learning basic computer skills are major challenges for nurses from non-English speaking backgrounds (Nicols 2006). Education of the student nurse builds a solid foundation in nursing knowledge and skills which are enhanced with the addition of critical thinking and problem solving skills (Hillard, 2005).

One means of improving education within a restructured curriculum is the use of innovative approaches to teaching, such as internet use. Once internet resources are sufficient and sustainable, there are large numbers of already prepared instructional tools (Elbon et al. 2006) and programmes available (POLHN, for instance) for students to use that could standardise education across the region.

5. Report on Project Work as Outlined in the Terms of Reference

5.1 Review of curricula and training programmes, including descriptors of each course

A summary description of every PIC nurse education/training programme submitted to the Project Consultants is included in this Report (see Annex 4). The Report is based only on the material submitted for this project. There will be other, additional data available that could be used for a more comprehensive analysis, offering alternate interpretations and conclusions.

5.2 Report on graduate qualities

Postgraduate Education

The key post-registration qualifications in the participating PICs are those of Midwifery and Nurse Practitioner. The international maternal and newborn morbidity and mortality statistics have demonstrated the effectiveness of midwifery intervention, and most of the countries in the Pacific use midwifery personnel. There is, however, a great variation in the education of this category of health care personnel, with post-RN training ranging from six months to two years in duration and, in some of the smaller countries, no regulation of the professional midwife available. Nurse Practitioners are nurses who have gained advanced critical thinking, problem solving, and decision-making skills to enable them to work in rural and remote areas of their countries without the immediate support of a hospital or physician. Again, their education and experience vary and some countries (Cook Islands, Kiribati, Nauru, Niue, Tuvalu, Vanuatu) employing NPs did not report any supporting legislation. However, 6 of the PICs did report regulatory mechanisms for advanced nursing practice. There are a number of legislative reviews, surveys, mission reports and other supporting material that exist beyond the data gathered for this report.

There are clearly defined programmes offered by the larger Schools of Nursing in the Pacific region for postgraduate education to which the smaller PICs send their staff for further postgraduate specialist programmes:

- Fiji offers Midwifery, Mental Health, Public Health and Nurse Practitioner programmes.

- Samoa offers Nursing Leadership and Management, Certificates in Emergency, High Dependency and Acute Care Nursing, Midwifery, Mental Health and Primary Health Care.
- PNG offers a Bachelor of Clinical Nursing in which there are specialties of Midwifery, Child Health, Acute Care and Mental Health. In addition, PNG provides a Bachelor of Nursing (Post-Registration), and Bachelor of Education as well as a Diploma of Health Teaching and Education.

Australia, New Zealand and the United States also offer a range of postgraduate courses that are taken up by individuals in the PICs. Some examples are: Masters of Advanced Nursing, Bachelor of Education and Post Graduate Certificates in Intensive Care, Coronary Care, Perioperative Nursing, and Mental Health to name a few. Although there was no supporting data from the questionnaires, it is noted that the University of Guam and Hawaii support Bachelor of Nursing courses and other advanced nursing education in the North Pacific region in a culturally appropriate context.

In order to build sustainability within the region and minimise out-migration from the region, identified centres – notably, Guam, Hawaii, Samoa, Fiji and Papua New Guinea - should be recognised for their expertise and further development in postgraduate nursing courses to service the region would be most economically concentrated and resourced in these centres. PICs would then be encouraged to send their staff to these centres for education and training. In this way centres of excellence would be built or strengthened within the Island Nations and sustainability of programmes should result. It should also serve to minimise outward migration as a result of staff not returning from courses attended outside of the PICs, although, due to existing work shortages and salary differentials among the PICs, some experienced nurses do not return to their country of origin after obtaining advanced qualifications (personal comm. I. Rabuka, Feb 2007). With advances in technology, concerted efforts at resource sharing, networking, assistance from the larger, more developed PICs and future developments, smaller PIC schools may be assisted to educate some nurses to an advanced level *in situ*, to meet the needs of their people.

5.3 Report on country resources and ability to provide basic health care resources

Information on the country resources was not sought nor given in the questionnaires, but as these resources are integral to nurse education, a brief summary of information found on the WHO websites is presented. Based on the WHO reports from 2006 (WHO 2006a-i), the PICs cannot provide basic health care resources and health education for their populations without assistance from outside agencies. Many of the countries have no-growth economic outlooks and some, e.g. Vanuatu, are facing serious economic downturns. The economies of the PIC rely mainly on fishing rights, remittances from overseas citizens, tourism for a few, subsistence farming and fishing. Although the larger PICs utilise a taxation base for their health services, international financial aid is generally required by each of the PICs to provide these for all of their citizens.

Primary curative and preventative care are provided to some degree in all the island countries. The smaller PICs have little access to tertiary care and citizens seek specialist care in larger PICs (PNG, Samoa, Fiji), Australia or New Zealand. Typically, health care is provided by the government, with private health care being available only on some of the larger PICs. National health plans for the next decade indicate that the PICs are attempting to deal with the transition from a communicable and infectious (typhoid, tuberculosis) disease burden to a lifestyle disease burden (obesity, diabetes, hypertension, cardiac disease, cancers) characteristic of the more developed countries. This imposes a double burden on public health and primary health care sectors.

Basic health resources obviously include nursing and health care personnel and nursing and other health care personnel account for up to 67% (WHO 2006a-i) of some of the PIC health budgets. This is despite recruitment and retention problems exacerbated by poor infrastructure, lack of equipment and shortages of basic consumables. Tonga is the most affluent of the PICs, with the highest per capita income. However, Tonga has a very small population base which limits its ability to fund the necessary infrastructure for health.

5.4 Ability of current training programmes to meet specific regional guidelines, standards and competencies, reflecting nursing practice in country/Possible regional standardization of training programmes

The current situation is one in which nurse education/training programmes are unable to consistently meet the requirements for effective nursing practice. The following

information was gleaned from the 'qualitative' sections of the questionnaires. Infrastructure and resources (equipment, consumables, desks, black/whiteboards) of some of the nurse education institutions is old, in disrepair or inadequate to meet the needs of the students. Information available in some of the schools is not adequate or current. For example, some of the textbooks sighted by members of the project team within the past year present material that has been demonstrated to be inaccurate in recent years. Medical and surgical textbooks assume a level of sophistication of resources and infrastructure that is not possible in most of the PIC health care systems. Computers and internet availability is intermittent in most of the Schools of Nursing and this makes accessing information difficult. Students rely on Information Technology technicians to assist them to use computers to access information and these people are frequently not available or unable to assist.

One critically important strategy to address these issues is the development of capacity-building partnerships between countries. Partnerships could be established on a 'hub' basis where the larger, more resourced 'hub' schools mentor satellite schools to improve the standards of nurse education within the respective countries. The involvement of Institutes of Higher Education from already existing and successful partnerships with Samoa, Fiji, Australia, New Zealand and the United States could be strengthened to provide input from this sector. In addition, the credentialing of graduates of a school involved with an international partnership could result in registration across all of the participating PICs and enable the regulation requirements of the host countries to be more easily addressed.

It is recommended that 'hub' schools of nursing (for instance, Samoa, PNG, Hawaii, Guam and Fiji) develop a student and faculty exchange in order that nurses from the smaller islands can experience nursing in a tertiary setting and faculty can benefit from working in a larger, more developed school. A common set of entry criteria; standards of teaching; equipment and materials; some core curriculum content and structure; specification of the mandatory level of education of tutors; accreditation of the course; and, a set of completion criteria would need to be developed by a nurse educators' consortium or contributed from some of the larger islands such as PNG, Samoa and Fiji. This will ensure consistency and safety of the graduate's practice.

It is strongly recommended that a standard setting exercise be undertaken under the auspices of the SPCNOA and APNLC. Representatives of nursing bodies/councils, nurse regulatory representatives, nurse academics, WHO representatives and members of Schools of Nursing could be charged with setting nursing standards as part of ongoing regional and global work on nursing effectiveness. Then a group of nurse educators from the established schools in the PICs could be brought together to develop a quality education framework based on the agreed standards. This would fulfill the need to strengthen nurse education networks, communication and resource in the sub-regions and throughout the Pacific region.

5.5 Report on review of legislation and recommended changes to reflect nursing and midwifery scope of practice/Relationships between national nursing regulatory bodies and regional regulatory authorities

Regulation and Legislation

In most Westernised countries, the state regulates such professional practices as medicine, pharmacy and nursing. Standards of care are established in order to minimise harm that might come to the citizens of the state if unregulated persons practiced in these potentially harmful professions. The scope of the professional's practice, the preparation required to practice and the maintenance of the professionals' competence are amongst the areas addressed in the regulation of the profession (Pearson et al. 2002). Competency standards and ongoing education need to be developed to fulfill the expectations of communities for safe and competent nursing care (Tabari Khomeiran et al. 2006).

In the PICs, however, legislation for the regulation of nursing varies greatly. Many of the PICs are already using a robust regulatory body and have a regulatory mechanism for advanced practice nursing (for example Fiji, PNG, Solomon Islands, Samoa, Tonga). The first step for the PICs which have no nurse regulation legislation is to establish a nurse regulatory body with an Act that governs the regulation and registration of nurses and midwives and advanced practice nurses such as NPs. It would define and govern their scope of practice. Once it becomes available, the model legislative text/template currently being developed by WHO (South Pacific Office) would facilitate the processes of mutual recognition in licensing of practitioners across the South Pacific region, setting standards for entry to the profession and managing issues related to the ongoing competence for

practice. The North Pacific region may need to adapt their legislation template to accommodate their close association with the United States of America. When this is in place for all the island nations, then collaboration and coordination can occur between all the nurse regulatory bodies and the regional nurse regulatory forum. The role of the regional nurse regulatory forum and its interface with the PICs boards and councils should be further examined in the next phase of this project.

In addition, a further and future addition to the legislative framework (or text/template) for advanced independent and specialist practice will be required for the PICs. This development could be included in, or should at least follow, the implementation of nursing legislation to cover registration and licensing of nurses and midwives in all PICs.

Fiji has an excellent scope of practice and legislation/regulation system that was developed in conjunction with both nurse educators and practitioners (Nurses, Midwives and Nurse Practitioner's Act 1999; Nursing Scope of Practice Fiji Ministry of Health 2006) and outlines the scope of practice expected from Nurse Practitioners. It is recommended that this model also inform the development of the model text for other PICs to assist them to construct appropriate legislative regulation, particularly as this relates to advanced practice roles.

Licensing and Competency Assessment

With the rapid changes in health care delivery, global nursing shortages, and greater demands for cost containment (Tabari Khomeiran et al. 2006) nursing competency has become a high priority for nurse educators, nurse managers and health care systems.

Part of the regulating process is ensuring the quality of care delivered over time by the professional. To achieve this, annual licensing with competency assessment requirements is necessary to maintain and elevate the basic professional standards set for registration. Two PICs license practitioners for life, four have no annual license but did not say whether they licensed for life and it is uncertain that they have a licensing system. Other PICs issue an annual license to those nurses and midwives holding registration. Only four of the PICs have mandatory professional continuing education requirements for annual renewal of licenses (see Annex 5). In addition, it is unclear, apart from a small number of stated hours, as to the type and requirements of continuing education that are necessary to demonstrate

continuing competence. It is also unclear if there are assessment or enforcement procedures in place. The development of a competency assessment programme should occur during a future stage of this project following the agreement, testing and validation of regional competencies.

Accreditation Systems

Not all countries have structures and processes for review of the initial nurse education curriculum or for the accreditation of the nursing school. Some schools of nursing within the region are based within, or are associated with the higher education institution within that country, for example, Samoa, Republic of the Marshall Islands (University of Guam). As a result the school and its programmes/courses will be subject to the accreditation and approval processes required by that institution. Other schools of nursing situated within the health or education sectors are subject to professional approval processes required by a nurses' board or council as well as the relevant Ministry. However, not all PICs have systems of accreditation and there are countries with only nursing boards or councils in place (see Annex 5). The accreditation of schools of nursing, curricula and courses across the region would require the establishment of combined review and accreditation systems with appropriate representation from stakeholder groups on the panel for each purpose. A regional panel or sub-regional groups with external nursing education expert representation could be formed and trained to utilise accreditation standards and review those island states that do not have schools of nursing within the higher education sector and/or that do not have accreditation systems in place. Standards for accreditation and a model accreditation system should be developed and tested through research and evaluation prior to the implementation of such a system.

[Some of the PICs have a national nursing examination, the successful completion of which is required for registration. The PICs surveyed from the North Pacific utilise a National Council Licensure Examination (NCLEX) which is an examination required by the USA for licensure in that country. However, it is noted that such examinations test theoretical knowledge, not the competency to practice as a safe professional nurse.]

5.6 Nursing employment framework inclusive of salary structure and career pathways

Employment and Retention Issues

Retention of well-educated nurses is not just a matter of improving the education of the students. It involves raising wages, improving working conditions, developing career ladders, and creating professional development opportunities (Brush & Sochalski 2007, p.40) as well as improving the health care system of the country. The PIC Ministries of Health generally provide minimal or no opportunities for nurses to develop or follow a career pathway (this needs a reference ?Lorraine). Promotion is dependent in many of the PICs on seniority and years of service. Motivating and invigorating courses from accredited sources are scarce, and undertaking such a course often does not assist the nurse to move upward in her or his career.

Many nurses from one PIC move to other PICs or to Australia, New Zealand, United Arab Emirates, Canada, and to other countries in pursuit of higher salaries, educational opportunities for themselves or their families or other personal reasons. Public service bodies need to take this into consideration when salaries are set in order to retain sufficient nursing personnel. Remuneration within the region needs to be equitable across island countries if migration between PICs because of salary differentials is to be reduced.

6. Conclusions

Comparability and compatibility of nursing training programmes at a regional and national level

Curricula

Samoa, Fiji, Tonga, the Cook Islands and PNG all have curricula for nursing education that are generally comparable in terms of content, clinical requirements and assessment. These curricula address both major health problems and contextual and cultural issues of the country for which they were written. Much of this material is able to be extrapolated into a regional context. Community nursing, maternal and infant care, and Primary Health Care are all evident as organisers in all of these curricula. [According to Tenn et al. (1994), Tonga's curriculum was developed with a PHC focus; this is not evident, however, in reading the material supplied for this survey.]

However, some of the curricula (for example, Kiribati) are grounded in ‘traditionalist’ nursing and medical models. The major emphasis is on task mastery and skill acquisition and sometimes outmoded nursing rituals. Generally, again from the material supplied for this survey, minimal education is given in the areas of effective communication, competence assessment, critical thinking and clinical decision making, ethical thinking, organised problem solving or self-reflection. This results in the potential for the ‘training’ of a mechanistic health care workforce, which has difficulty in adapting to ever-changing health care situations, and lacks the skills to develop innovative solutions to presenting problems. This workforce, therefore, is of less utility to the country of origin and less desirable to any country of potential migration.

Many of the smaller PICs did not submit a curriculum for perusal (see Annex 6). Schools that have not undertaken a formal curriculum review within the past 5 - 7 years should be encouraged and assisted to do so.

PNG has developed a set of competency standards for RNs (PNG Nursing Competency Standards 2002) and both PNG and Fiji have utilised nursing competencies as a teaching and assessment strength within their curricula. Graduates from these schools of nursing are potentially registrable for practice across the region and could be utilised in emergency situations in any PIC.

Curriculum Review

Curriculum review is a lengthy process but must be accepted by all schools of nursing in the PICs as an essential quality improvement requirement. However, in those schools where curricula are out of date (i.e. more than 5 -7 years old), curriculum review is now urgent. To be successful, the school’s stakeholders, including the nurse educators, the nursing administration, the nursing council or regulatory body and clinical nurses, must be convinced that a review and possible rewrite of the current curriculum is required. This will require comprehensive discussion and expert use of interpersonal skills by those proposing the review. Discussions, involving all of the school of nursing staff, regarding context, evidence based ideas, culture, ethics, values and critical thinking skills must occur along with discussions about content, sequencing, clinical experience and supervision. The previous curriculum will need to be examined for material that remains relevant and valid, and new or emerging evidence-based material added to it.

The curriculum document should be written by the school of nursing staff with encouragement and assistance from a curriculum consultant. During this process, nurse educator qualifications should be upgraded and physical resources of the school enhanced to enable implementation of a new curriculum. When the curriculum is written, teaching and learning workshops should be undertaken by all of the staff of the school of nursing to assist with teaching methods, assessment preparation, examination construction and other teaching-learning issues. Each new staff member needs to be fully oriented into the new curriculum and the teaching methods of the school. The curriculum consultant should be engaged periodically over an initial three-year implementation of the curriculum to assist the staff of the school to introduce and manage the process.

The development of education and training programmes for nurses at all levels should contain outcomes that:

- fulfil the regional nursing competency standards;
- have a focus on population health as well as care of the individual;
- enhance the nurses' capacity to respond to current and future population health needs and models of health service provision in a range of practice contexts;
- are congruent with models of contemporary health care and a diverse range of practice contexts;
- draw stimulus material for learning from actual practice and from different local contexts;
- have outcome statements that are embedded in and framed by practice; that is roles and functions, context and systems and processes;
- incorporate context and processes on contemporary leadership and management practices;
- allow for flexibility in modes of delivery – basic, CPE and postgraduate –for example, radio/television/telephone as well as internet or CDs.

Core Competencies

The Australian Nursing and Midwifery Council (ANMC) have coordinated the development of core or common competencies for registered nurses which:

It is envisaged ...will support the role of nurses within the region, provide direction for the recognition of qualifications and for multi-country licensure programs and guidance for those countries that have not yet developed their specific competencies for nurses. (ANMC 2006)

These core competencies, together with those of ICN, WP/SEAR (see annex 7) and PNG, should be analysed and consideration of sub-regional needs (EG NCLEX in Republic of the Marshall Islands) given in order to formulate a potentially regionally recognised nursing curriculum. Stakeholder distribution, discussion and review should be scheduled at relevant SPCNOA and APNLC meetings. Then the stakeholders of the PICs (the Chief Nurses and Nurse Educators) should be provided with the developed competency document and invited to comment. Their suggestions would be incorporated into a revised document. This should then be distributed to a wider group of stakeholders, including national nursing associations, for ratification; these regional competencies should then become the cornerstone of curricula across the PICs. Using them as such would require a curriculum review by many of the schools of nursing. In time, however, it would ensure that nursing education standards across the PIC were aligned.

Tutor Qualifications/Continuing Professional Education of Teachers

Clinical competencies of graduates of the established nursing schools in the PICs often come under question because of inadequate clinical supervision and non-practising/non-expert clinical nursing/midwifery educators (Nursing and Midwifery Summit Draft Report 2007). Tabari Khomeinan et al. (2006) believe this occurs because without adequate supervision students cannot make appropriate use of the theoretical knowledge they have gained. Out-migration of experienced and well-educated more senior nurses contributes to the paucity of well-educated clinical supervisors and tutors (Troy et al. 2007).

The formal replies from the Schools of Nursing surveyed indicated that educational qualifications of tutors were very good, being at bachelor or master's level. The qualifications and experience of the educators of the next generation of nurses and midwives will shape the health care outcomes for the next several years. Well-educated and visionary nursing educators can prepare their students to meet the challenges they will face, armed with the tools to implement innovative and effective programmes within their

communities. Retaining and better equipping experienced nurses is necessary to maintain and lift the standard of the nursing graduate. Preparing RNs with practical experience and an interest in teaching to a baccalaureate level is an ongoing necessity for improving nursing standards.

Equipping nursing tutors with educational skills and new approaches to teaching and learning through intensives, workshops and seminars as well as formal education courses would assist them to make learning more meaningful. The survey indicated that few of the Schools of Nursing had had any 'educational skills' up-skilling within the past year (Fiji, Tonga, Kiribati Samoa). Priority should be placed on offering regular intensive workshops in-country and more broadly, within the region, for nurse educators in schools of nursing located outside of the higher education system to up-skill their curriculum development and teaching skills. These workshops should be required for teachers who are inexperienced in non-traditional teaching methods if the graduate outcome is to be a practitioner prepared for the primary health care role and to be capable of critical thinking. To build sustainable capacity in nurse education for the region as well as in-country, excellent nurse educators could be identified and invited to work with teachers from smaller schools to share their knowledge and enthusiasm.

Recruitment and Entry Requirements

The selection of students for entry to nursing programmes varies across the PICs. Most countries report the involvement of the Chief Nurse, Public Service or Ministry of Health officer or a medical officer in the selection process. The principal nurse educator of the school of nursing is not always involved in the selection of students. In selecting students it is not only the character and achievement of the student to date which needs to be considered, but the ability and motivation of the student to successfully complete the course is also important. Principal nurse educators normally have a sound and substantial understanding of the programme and the indicators of successful student progression and completion. It is critical, therefore, that the person responsible for the education programme be involved in the selection of students. Principal nurse educators should coordinate student selection processes and chair student selection committees.

Age ranges for nursing student entry vary from one PIC to the next, with the youngest acceptable student at 16 years of age, and the oldest mature student at 45 years of age. Two

of the participating PICs stated they gave preference to female applicants. Intake numbers vary with the size of the country ranging from a low of 5 per year in Kiribati to 250+ in PNG. Completion of Form 6 or Grade 12 (with a sound grade in English, Mathematics and Biology) is a common requirement of the schools of nursing; this is consistent with the WHO global standards for nursing. However, the standards of education vary across the PICs, making this sort of requirement difficult to equate. It is suggested that an entry examination set at the level of Form 6/Grade 12 based on these three subjects would be beneficial. An even better exemplar is provided by Samoa; it requires the entering student to undertake a foundation year at NUS.

English language capability is a problem that requires urgent attention. English would seem to be the preferable choice for a common language as most of the PICs have an English language component in their school curricula, and a large percentage of the recruiting countries for RNs are English speaking. Mastering English for patient safety and learning basic computer skills are major challenges for nurses who are educated in non-English speaking programmes (Nicols 2006). In addition, textbooks and other materials are available in English with few if any translations into the island languages.

Recruitment from rural areas and outlying islands is difficult due to geographical and financial reasons and the outer island students are often disadvantaged by not having had the English language education available in the urban centres (Personal Communication, Mrs Tarua Tong, Tungara School of Nursing, Kiribati, April 2006).

To ensure that all students begin their nursing course at a common level of knowledge, a foundation year (based on for example, the National University of Samoa scheme or the similar ones offered at community colleges in the North Pacific), delivered either at the local school of nursing or at some other learning institution, would be the most effective method of gaining this common level of knowledge. A foundation year for enhancing English language skills, writing skills and technical terminology would assist students to move more freely amongst the PICs and into the regional or international nursing market. During this foundation year, students would be prepared to undertake academic work and could be employed in a Nurses Aide capacity in order to defray the costs of their room and board and contribute to their tuition.

There are other solutions. In the short term, (2-5 years) compulsory upgrading modules or courses, including online or CD based ones, could be developed to strengthen math, science, English, study, writing and problem solving skills of incoming students. Long term policy development with planning between education stakeholders addressing primary and secondary education standards in relation to the needs of higher education students is advisable.

Educational Resources

Some schools of nursing in the Pacific Island Countries are poorly resourced. The lack of personnel, classrooms and other infrastructure necessary to conduct initial nurse education often hampers efforts to maintain standards. Other schools are better resourced. For example, the Fiji School of Nursing (FSN) has undergone rapid expansion over the last few years. In conjunction with that development, the FSN has had the opportunity to upgrade the clinical teaching laboratories, classroom resources, library facilities and teaching staff qualifications to coincide with the introduction of a new, revised curriculum that was introduced in 2004 (Usher et al. 2004). The FSN also offers an annual upgrade to Bachelor degree and some postgraduate certificates to selected registered nurses in conjunction with the James Cook University School of Nursing, Midwifery and Nutrition in Queensland, Australia (Stewart et al. 2006). In Samoa there has been a development strategy implemented over many years with a progressive upgrading and reform of nurse education and the transfer of nurse education to the higher education sector. A School of Nursing was established at the National University of Samoa, which offers a range of nursing and midwifery programmes. Tonga, in collaboration with AUT is also in the process of developing its' nurse educator cohort, strengthening its' curriculum and educational processes. RMI is undertaking significant infrastructure development.

These countries are useful exemplars and could be drawn upon for experienced personnel and models for the use of the smaller schools of nursing as they build their capacity and develop or reform their curricula.

Library/Internet/Clinical Resources

All those who answered questions about the library claimed to have staff and resources for students' use, but personal experience of some of these libraries demonstrated textbooks that were outdated by 25 years or more, the number of books was very limited and much of

the material inappropriate to the context (e.g. limited public health or primary health care information). Comments about required resources ranged from specific items such as simulators and cameras to 'upgrade all' and 'clinical laboratory'.

Access to the internet and to other technologies for both students and teachers also allows the delivery of courses by distance education. It would facilitate the students accessing courses provided through networks such as the Pacific Open Learning Health Net (POLHN) and courses provided in distance mode by other international partners and educational providers. Three of the PIC schools indicated that they were accessing the courses provided by the POLHN but they reported difficulties in accessing the internet on a regular basis. If good technology support is not provided to the schools it makes it very difficult for them to maximise the educational resources which are available through such networks. Utilising the expertise from these sources is critical to supplement the expertise of teaching teams available in each PIC.

Many countries report that access to the internet is available for nursing students and teachers. There are, however, several island countries which do not have internet access available. When access is available, the hours for use vary and not all systems are reliable or have the necessary technical support to ensure they are consistently operational. With the rapid production of new knowledge, teachers and students need to be able to access electronic resources and data bases to ensure they are working from the most recent knowledge base. Having a reliable service would also significantly reduce the need and costs associated with equipping libraries to support the nursing education programme. Many libraries contain nursing textbooks that are out of date and the cost of renewing library resources is usually in excess of the funds available for such a purpose within the school budget. Arrangements should be negotiated for each school to ensure access to an electronic library and electronic books and journals to support the teaching and learning programme. Technical officers should be funded to support the computer facilities for each school. Budgets should include provision for renewal of hardware and software on a regular basis.

Summary

In summary, this survey was instigated, along with other key initiatives, in order to improve health care and health education in the region. Fourteen countries from both the north and south pacific regions were included in this study. Data collection took place during May and June, 2007 and included: a literature review which took account of relevant government and non-government reports; the development, distribution and analysis of three questionnaires (see Annex 1) relating to (a) legislation, (b) nursing education/training, and (c) employment; and telephone interviews and onsite visits to Fiji and Samoa for focus group interviews (see Annex 3). The data analysis of the material gathered demonstrated marked variability in the standards of nursing education across the Pacific Island nations, thus supporting the views of the Chief Nursing Officers. It also demonstrated clearly that nursing curricula and training programmes vary considerably in relation to quality and that nurse education does not always currently meet specific regional needs for the provision of effective nursing practice. This is true for both basic/undergraduate nurse education and postgraduate nurse education (e.g. Midwifery courses range in duration from 6-24 months, and some postgraduate courses were reported as having no review or credentialing requirement). In addition, wide variation exists in legislation, regulation, accreditation, salary structures and career pathways across the region.

7. Limitations to this Study

Design

The survey design is not an efficient data gathering method for this type of a project for many reasons (see further limitations outlined in the next paragraph). However, the major problem in this case was that the design depended upon the knowledge, willingness, time availability and integrity of the person completing the survey. Many of the responses needed further explanation, which was often not provided, leaving the survey incomplete and in some cases contradictory to the personal knowledge of the researchers of the situations in some of the countries. For any further scoping activities to be completed about nursing in the PICs would be better served using more in-country data gathering.

Methodology

In some countries questionnaires were not received – this was because:

- the wrong focal person was identified, as the WHO information was out of date (this was the most common problem);
- the focal person was out of the country – temporarily or permanently (this was the next most common problem);
- an incorrect email address was used – returned as ‘not received’ (this occurred in a small number of countries);
- the relevant officer at the MoH was not available as the ministry was moving premises and had not been reconnected to an email system (one country);
- in many instances staff in MoHs were continually out of the country at international conferences or workshops or attending local training courses or workshops and not able to access emails;
- the email service in many PICs proved to be unreliable.

Problems in countries

Only two (i.e. Marshall Islands and Vanuatu) out of the 14 participating PICs failed to return their questionnaires. However, of those questionnaires that were returned, not all were comprehensively completed; no explanations were given. It will be important to seek explanations for these omissions in order to improve any future survey returns. The two PICs which failed to return their completed questionnaires also submitted very limited up-to-date ‘official’ documentation. Unsolicited comments from the questionnaires were utilised within the report, but there was no formal report (ie table) of these as they could not be categorized into the tables.

Timeframe

The timeframe for this study proved to be very short. The contract was complete in March and the draft report was initially due at the end of June, and extended to the beginning of August. Eight weeks for data gathering was insufficient to retrieve replies (as outlined above), and information continued to come to the team until the day prior to the submission of the Draft Report.

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Enhancing and Standardising Regional Training Programmes in Nursing Mapping Exercise

Report from the Consultants

**Professor Kim Usher
Professor Genevieve Gray
Mrs Joanne Tollefson
Ms Lorraine Kerse**

ANNEXES TO REPORT

July 2007

**Prepared for the Forum Secretariat,
the South Pacific Nursing Officers Alliance,
and the World Health Organization (WHO)**



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ACRONYMS

AusAID	Australian Agency for International Development
BE	Bachelor of Education
BN	Bachelor of Nursing
CC	Coronary Care
CDU	Charles Darwin University, Darwin, Australia
Cert	Certificate
CN	Community Nursing
CPE	Continuing Professional Education
CQU	Central Queensland University, Brisbane, Australia
CSU	Charles Sturt University, Wagga Wagga, NSW, Australia
Dip	Diploma
DoH	Department of Health
DPH	Diploma Public Health
EN	Enrolled Nurse
FSM	Fiji School of Medicine
FSN	Fiji School of Nursing
IC	Intensive Care
IMCI	Integrated Management of Childhood Illnesses
JCU	James Cook University, Townsville, Qld, Australia
Med Assist	Medical Assistant
MoE	Ministry of Education
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSI	Marshall Islands
NA	Nurse Anaesthetist
NCLEX	National Council Licensure Examination
NCN	Nagano College of Nursing, –Nagano, Japan
NP	Nurse Practitioner
NUS	National University of Samoa
NZAID	New Zealand Agency for International Development
PBE	Post Basic Education
PC	Perioperative Care
PCC	Palau Community College
PHN	Public Health Nursing
PICs	Pacific Island Countries and Territories
POLHN	Pacific Open Learning Health Network
UoA	Auckland University – Faculty of Nursing and Midwifery, New Zealand
UoG	University of Guam
UoO	University of Otago, New Zealand
UNFPA	United Nations Population Fund
UPNG	University Papua New Guinea
USA	United States of America
USAID	US Agency for International Development
USP	University of South Pacific
UTS	University of Technology Sydney, Australia
UT	University of Technology, Auckland New Zealand
RH	Reproductive Health
RN	Registered Nurse
WHO	World Health Organization

ANNEX 1

Questionnaires

ENHANCING AND STANDARDIZING REGIONAL TRAINING PROGRAMMES IN NURSING - MAPPING EXERCISE

A project conducted by the School of Nursing, Midwifery and Nutrition at James Cook University on behalf of the Pacific Island Forum Secretariat (PIFS), the World Health Organization (WHO), and the South Pacific Chief Nursing Officers Alliance (SPCNOA).

Research Team:

Professor Kim Usher

Ms Joanne Tollefson

Ms Lorraine Kerse (Consultant)

Nursing Training/Education Questionnaire

Please complete the following questionnaire as it relates to the current nurse training/education in this country. If there is more than one nursing school in your country please fill in this questionnaire for each school if possible. If it is not possible please state why this information is not available.

Definitions of terms used in the questionnaire

The **Registered Nurse (RN)** is a health care professional who has undertaken an extended period of post-secondary education (usually 3 years or more) at a School of Nursing to attain a certificate or diploma and has passed the requisite examinations to demonstrate their knowledge. They are eligible to be registered as a RN in their home country and/or to (if there is no registering body) undertake nursing duties within a defined scope of practice expected of the Registered Nurse.

Nurse is the term used to cover any categories of nurses in your country such as Enrolled Nurse (EN); Licensed Practical Nurse (LPN) or any nursing personnel who has received a qualification from a post secondary school programme. These nurses are usually delegated certain nursing tasks and duties and are mostly supervised/evaluated by the 'RN'.

Nursing Aides (or other names that your country has for health workers) are usually 'trained' on the job and have minimal theoretical input.

Pre-service nurse education is the course of study that prepares the student to undertake Registered Nursing duties.

Pre service Nursing Training/Education for the Registered Nurse

Is there an analysis of the number of nurses required in this country annually (supply against the service needs (demand):

YES NO

If YES, are there currently sufficient nursing graduates to meet the demand.

YES NO

What is the usual number of intakes per year? _____

What is the usual number of students in each intake? _____

Are there prerequisite requirements for entry into pre-service nursing courses?

YES NO

If YES, what level is required?

Are there any specific secondary/high school subjects needed for acceptance? Please list:

Please specify the lowest acceptable age for acceptance into a nursing training/education course? _____

What is the upper limit age for accepting students? _____

Are females given priority in entry to the nursing course? YES NO

Is there a specified ratio of males to females? YES NO

If YES, state ratio: _____

If you accept mature aged students, are they exempt from academic requirements?

YES NO

If YES, what are their entry requirements?

Is there any targeting of high schools/secondary schools to encourage students to consider a career in “health services”?
YES NO

If YES, please briefly outline the programme and indicate by whom it is done (Health Ministry/Education Ministry):

Is there any other recruitment strategies used (e.g. advertising in newspaper or on radio)?
Please state what is used to recruit students into nursing:

What does the application process involve (please tick):

- Form completion
- Essays
- Interviews
- Examinations
- Physical assessment of the prospective student

Other, please explain: _____

Who makes the decision to accept individual students?

Is there an appeal process to enable unsuccessful applicants to reapply?
YES NO

Is there a progression policy that outlines what happens if students fail to meet certain standards during the course?
YES NO

If YES, please attach a copy of the relevant policy/policies. [Please tick if attached.](#)

Nursing Regulation

Does your country regulate nursing and midwifery education for entry to practice?
YES NO

If YES, please attach a copy of the standards. [Please tick if attached.](#)

Who sets your educational standards for the nursing course?

Who decides about the basic educational modules within the course?

Who accredits the nursing education programmes?

Is there regular discussion with the Ministry of Health on health services to be provided by different levels of graduate nurses? YES NO

If YES, outline the review of curriculum/competencies process:

Nursing Curriculum

Please attach a copy of the curriculum.

Please tick if attached.

If your pre-service nurse education is competency-based, please attach a copy of the competencies to be demonstrated.

Please tick if attached.

How are the competencies used within the curriculum?

What is the length of your nurse education course?

What is the percentages/proportion/number of hours of the nursing programme for:

Theory: _____

Clinical practice: _____

What is the theoretical basis of the curriculum (principles, competencies, systems model)?

Are the clinical placements located in:

Please give amount of time the students spend in each location:

- | | |
|--|-------|
| <input type="checkbox"/> Hospital | _____ |
| <input type="checkbox"/> Primary Health Clinics | _____ |
| <input type="checkbox"/> Community outreach services | _____ |
| <input type="checkbox"/> Urban Locations | _____ |
| <input type="checkbox"/> Rural Locations | _____ |
| <input type="checkbox"/> Isolated (e.g. Outer islands) | _____ |
| <input type="checkbox"/> Others (please list) | _____ |

Are the clinical placements in urban and rural services and how much time is spent in each?

Urban No. hours urban: _____

Rural No. of Hours rural: _____

Are there clinical placements in semi private or private health facilities?

YES NO

If YES, does this require payment to the facility for accepting the students?

YES NO

What are the staff student ratios in clinical practice areas?

Do students receive any sort of stipend during their course? YES NO

Do you have rules of progression for students to advance within the program?

YES NO

Is there a final examination that the students must pass? YES NO

Is there a process for students during the course to resit any failed modules or parts of the course? YES NO

If YES, outline processes:

What is the percentage of students entering the nursing programme who graduate from the programme – for last five (5) years?

2002 _____ 2003 _____ 2004 _____

2005 _____ 2006 _____

Faculty for Nursing School/Institution

Who is the employing agency of the faculty staff in the nursing school – Ministry of Health, Ministry of Education, Private?

How many staff are there in the nursing school?

Academic faculty _____
Clinical teachers _____
Librarian (full or part time) _____
Administrative and support staff _____

How many of the academic faculty are: Full-time: _____
Part-time: _____

Is there a requirement for post basic educational qualifications of faculty?
YES NO

How many of the faculty do have tertiary (university degree) qualifications?

Bachelors degree _____
Postgraduate degree _____
Masters Degree _____
PhD _____

Do you have one or more faculty with teaching/learning expertise?
YES NO

If YES how many? _____

Have there been any workshops on Teaching/Learning strategies within the past twelve (12) months?
YES NO

Is there formal faculty development plans for continuing education for nurse educators?
YES NO

Teaching Materials and Resources

Do you have a designated library for use of nursing students? YES NO

If YES, please give brief description of library resources:

Is there a computer within the library that can be accessed by students?

YES NO

Can students conduct data searches on the library computer?

YES NO

Do you have computers with internet access available for nursing students?

YES NO

If YES, please give numbers of computers, hours they are available, and how this is set up for the nursing students' usage:

Do nursing students have any computer training during the course?

YES NO

Are they required to develop computer-based skills during the course (such as submitting assignments that are wordprocessed?)

YES NO

Can students access online resources such as electronic journals and databases?

YES NO

What materials are currently used in the nursing school for teaching and learning?

- | | |
|---|---|
| <input type="checkbox"/> Published /printed materials | <input type="checkbox"/> Printed Pictures |
| <input type="checkbox"/> Pictures developed in-house | <input type="checkbox"/> Video Tapes |
| <input type="checkbox"/> Audio Tapes | <input type="checkbox"/> Case Studies |
| <input type="checkbox"/> Material developed in-house | <input type="checkbox"/> Slides |

Computer software – CD/DVD

Online, web-based, internet, POLHN
(Pacific Open Learning Health Network)

Other, please be specific: _____

Does your nursing school collaborate with other teaching facilities, either in your country or overseas (e.g. Australian or other universities)? YES NO

If YES, which countries: _____

What resources do you currently have in the nursing school for use in a clinical teaching and learning environment? Please feel free to add or delete items from the following list:

- A designated clinical laboratory area where skills can be taught and practiced?
- Basic equipment such as running water and soap, sphygmomanometers, thermometers, penlight, scales, dressing sets, dressings, drapes, a dressing trolley, injection materials, sharps disposal unit, personal hygiene materials (basin, urinal bedpan), an autoclave, beds, forceps, scissors, IVT equipment, blood glucose monitoring equipment, medication trolley and equipment.
- Optimal equipment such as ECG machine, disposable gloves, disposable dressing and injection materials, manikins, bed linen of various sorts.

Are these materials and equipment in working order? YES NO

Does the nursing school use any of the following external resources and/or field work for teaching and learning (other than hospitals)?

- External resource people/experts
- Non-governmental organizations
- Supervised rural/island clinical practice
- Community-based fieldwork
- Community groups
- Observational field visits
- Supervised urban clinical practice
- Other, please be specific:

Continuing Professional Education (CPE)

Does Government support CPE for nurses – clinical and/or academic?

YES

NO

If YES, please identify the Ministry/Department responsible for supporting and funding:

Is there any strategic plan for CPE for nurses?

YES

NO

If YES, please attach a copy or outline of the plan?

Please tick if attached.

Is there a programme for CPE?

YES

NO

If YES, please attach.

Please tick if attached.

If YES, where is funding from?

- Government – name department/ministry
- AID – direct or bilateral
- Self-Funded
- Bilateral
- Type of scholarship/fellowship
- Other support (please list):

Please list CPE courses that have been available for nurses over the last twelve 12 months:

Who has provided these courses? Please list organizations or government departments:

Does the nursing school have input in CPE plan? YES NO

If YES, please explain this role:

Are there any CPE courses available by Distance Learning or e-Learning? YES NO

If YES, please list the courses which nurses enrolled into over last 12 months:

If YES, what internet access is available for nurses?

Post Basic Education

If nurses who have more extensive education than the RN (i.e. post-basic qualifications) are employed in your country, please indicate by ticking the following boxes:

- | | |
|--|--|
| <input type="checkbox"/> Midwifery | <input type="checkbox"/> Child Health Nursing |
| <input type="checkbox"/> Public Health Nursing | <input type="checkbox"/> Community Nursing |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Medical Assistant |
| <input type="checkbox"/> Bachelor degree (Nursing) | <input type="checkbox"/> Bachelor degree (Education) |
| <input type="checkbox"/> Intensive Care | <input type="checkbox"/> Coronary Care |
| <input type="checkbox"/> Nurse Anaesthetist | <input type="checkbox"/> Perioperative Care |
| <input type="checkbox"/> Other, please state: | |

Is there any opportunity for post basic education for nurses?

YES NO

If YES, what are the top three (3) programmes (this includes next level from basic nurse qualifications as well as offshore University degrees)?

Do these post-basic nurses obtain their qualifications in your country?

YES NO

If NO, where have the majority of these nurses obtained the post-basic qualification?

If YES, please outline their training/education separately. Please use the same criteria as for the pre-service training program.

Are there any courses available by Distance Learning or e-Learning?

YES

NO

If YES, please list the courses which nurses enrolled into over last 12 months:

Is there computer laboratory or internet access for nurses undertaking post basic/post graduate courses?

YES

NO

Thank you very much for completing this questionnaire.

Please send completed questionnaire to:

Professor Kim Usher
School of Nursing, Midwifery & Nutrition
James Cook University
Townsville Qld 4811 Australia

OR

Scan and attach to an email to:

kim.usher@jcu.edu.au

ENHANCING AND STANDARDIZING REGIONAL TRAINING PROGRAMMES IN NURSING - MAPPING EXERCISE

A project conducted by the School of Nursing, Midwifery and Nutrition at James Cook University, Australia on behalf of the Pacific Island Forum Secretariat (PIFS), the World Health Organization (WHO), and the South Pacific Chief Nursing Officers Alliance (SPCNOA).

Research Team:

Professor Kim Usher

Ms Joanne Tollefson

Ms Lorraine Kerse (Consultant)

Legislation Questionnaire

This questionnaire relates to the legislation relevant to nursing and nursing education in your country. Please answer the questions and attach as much additional information as available to assist us with our final deliberations. We have included a list of definitions below that may be useful to you as you complete the questionnaire.

Definitions

The **Registered Nurse** (RN) is a health care professional who has undertaken an extended period of post-secondary education (usually 3 years or more) at a School of Nursing to attain a certificate or diploma and has passed the requisite examinations to demonstrate their knowledge. They are eligible to be registered as an RN in their home country and/or (if there is no registering body) to undertake nursing duties within a defined scope of practice expected of the Registered Nurse.

Nurse is the term used to cover any categories of nurses in your country such as Enrolled Nurse (EN); Licensed Practical Nurse (LPN) or any nursing personnel who has received a qualification from a post secondary school programme. These nurses are usually delegated certain nursing tasks and duties and are mostly supervised/evaluated by the 'RN'.

Nursing Aides (or other names that your country has for health workers) are usually 'trained' on the job and have minimal theoretical input.

Regulation is the act of controlling performance in accordance with laws. Requirements for working as a nurse can include licensing, credentialing, certification and registration.

Legislation

Is there a regulatory mechanism that controls requirements for working as a nurse in this country? YES NO

If there is a regulatory mechanism, please attach a copy to the completed questionnaire. Please tick if attached.

If YES, what is the Authority or formal body and what Government Department/Ministry does it come under and please attach a copy of the relevant legislation?

Please tick if attached.

Is a national nursing examination required for entry into practice/licensure as a registered nurse in this country? YES NO

If you answered NO to the above question, please outline the mechanisms used to ensure competency for entry into practice/licensure.

Is there a regulatory mechanism that controls requirements for working as an advanced practice nurse, for example nurse practitioner, in this country? YES NO

Does your country have a system of ongoing or annual renewal of certification or registration/licensing for nurses and midwives? YES NO

Is there a specific “scope of practice” for each category of ‘nurse’ in this country? YES NO

If you answered YES to either of previous two questions, what is the Authority or formal body that registers nurses? Please attach a copy of the legislation to the questionnaire.

Please tick if attached.

Do the different categories of nurses require?

Certification YES NO
License YES NO
Registration YES NO

Other – please be specific: _____

Is there legislation for employment/registration of nurses/midwives from outside your country? YES NO

If YES, please attach copy of legislation or regulations? Please tick if attached.

Do you have a professional nursing association? YES NO

If YES, please explain function and role and attach a copy of relevant legislation?

Please tick if attached.

Are nurses required to take the NCLEX (National Council Licensure Examination)? YES NO

If YES, what is the annual pass rate for that examination for the last 5 years?

Pass rate 2006 _____
Pass rate 2005 _____
Pass rate 2004 _____
Pass rate 2003 _____
Pass rate 2002 _____

Thank you very much for completing this questionnaire.

Please send completed questionnaire to:	Professor Kim Usher School of Nursing, Midwifery & Nutrition James Cook University Townsville Qld 4811 Australia
OR	
Scan and attach to an email to:	kim.usher@jcu.edu.au

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Ms Lorraine Kerse (Consultant)

Employment Questionnaire

There are separate questionnaires for each of the areas and I would ask if you could complete this section which relates to Employment structures.

Definitions

The **Registered Nurse (RN)** is a health care professional who has undertaken an extended period of post-secondary education (usually 3 years or more) at a School of Nursing to attain a certificate or diploma and has passed the requisite examinations to demonstrate their knowledge. They are eligible to be registered as an RN in their home country and/or (if there is no registering body) to undertake nursing duties within a defined scope of practice expected of the Registered Nurse.

Nurse is the term used to cover any categories of nurses in your country such as Enrolled Nurse (EN); Licensed Practical Nurse (LPN) or any nursing personnel who has received a qualification from a post-secondary school programme. These nurses are usually delegated certain nursing tasks and duties and are mostly supervised/evaluated by the ‘RN’.

Nursing Aides (or other names that your country has for health workers) are usually ‘trained’ on the job and have minimal theoretical input.

Public Service Commission or Personnel Departments

Employment Framework

Which Department/Ministry/Health Institution is responsible for employment criteria of the categories of nursing staff?

Is this Department/Ministry responsible for setting numbers of nursing staff to be employed by the Government? YES NO

Is this Department/Ministry responsible for levels (seniority) of nurses? YES NO

If YES, does the Ministry/Department of Health influence these numbers? YES NO

Do all the categories of nurses have a specific career pathway (this is not promotion just salary levels)? YES NO

If YES, please list categories and levels available:

Is moving up a level automatic with length of service? YES NO

If NO, how is the movement up the levels achieved?

What are the promotional levels for nursing personnel? Please either list or attach the relevant documents. Please tick if attached.

How is promotion decided for each level of nursing personnel - automatic or by applications?
Please describe:

Please attach protocols for promotion. Please tick if attached.

Are there job descriptions for each level of nursing personnel? YES NO

If YES, please attach job descriptions. Please tick if attached.

Are there incentives for nurses to enrol in continuing education courses?
YES NO

If YES, please give incentives used:

When nurses return from working abroad are the experiences/skills taken into consideration when they re-enter the workforce? YES NO

If YES, please explain:

Is there a performance evaluation system for nursing personnel and including nursing teachers? YES NO

If YES, how often is it done? _____

If YES, attach a copy of the criteria. Please tick if attached.

In your opinion, is it effective in improving staff performance? YES NO

Do you have expatriates working in nursing education and/or clinical practice (as part of the Government service as opposed to advisers)? YES NO

Are the salary scales for local recruits and expatriate nurses the same? YES NO

Are there any requirements for those nurses who have their education/training paid for by Governments to remain in the country? YES NO

If YES, please explain what these are or attach guidelines. [Please tick if attached.](#)

Are these effective? YES NO

If NO, are there any plans for reviews? YES NO

Thank you very much for completing this questionnaire.

Please send completed questionnaire to:	Professor Kim Usher School of Nursing, Midwifery & Nutrition James Cook University Townsville Qld 4811 Australia
OR	
Scan and attach to an email to:	kim.usher@jcu.edu.au

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Questionnaire for Federated States of Micronesia, Nauru, Niue, Tuvalu

Provision of Basic/Pre-service Nursing Training Education

Where do you currently send your students to complete their nursing education/training?

Is the current nursing education/training satisfactory for the provision of health services provided in your country? YES NO

If NO, please list areas where further education/training is needed:

Are there government/other funding opportunities available to support basic/pre-service nursing education/training? YES NO

If YES, please list where funding is obtained:

What is the current percentage of 'expatriates' in your nursing workforce? _____

In which countries did they graduate? Please list:

Do 'expatriates' require registration/accreditation to practise nursing in your country?

YES NO

If YES, please attach protocols.

Please tick if attached.

Post Basic Education

Are there opportunities for nurses to access Post Basic/Postgraduate courses?

YES NO

If YES, please list courses supported by Government/Other Agencies over last 12 months:

Who funded the courses?

How is it determined which courses are supported or used?

Which institutions and countries are currently used to provide post basic/post graduate education for nurses?

Is distance learning/e-learning used in these courses? YES NO

Is there a computer laboratory available for nurses to use when undertaking post basic or continuing education? YES NO

Is there a 'computer laboratory' for nurses to access the internet? YES NO

Continuing Professional Education (CPE)

Does the Government support CPE for nurses – clinical and/or academic? YES NO

If YES, please identify the Ministry/Department responsible for supporting and funding the courses:

Is there a strategic plan for CPE for nurses? YES NO

If YES, please attach a copy or outline of the plan. [Please tick if attached.](#)

Is there a programme for CPE? YES NO

If YES, please attach. [Please tick if attached.](#)

If YES, where is the funding derived?

Government – name department/ministry:

AID – direct or bilateral and agency names – list:

Self-Funded

Type of scholarship/fellowship:

List other type of support:

Please list CPE courses that have been available for nurses over the last 12 months. Who has provided these courses? Please list organizations or government departments:

Are there any courses available by Distance Learning or e-Learning?

YES

NO

If YES, please list the courses which nurses enrolled into over last 12 months:

Thank you very much for completing this questionnaire.

Please send completed questionnaire to:	Professor Kim Usher School of Nursing, Midwifery & Nutrition James Cook University Townsville Qld 4811 Australia
<u>OR</u>	
Scan and attach to an email to:	kim.usher@jcu.edu.au

ANNEX 2

**Circular dated 12 April 2007 from
Pacific Island Forum Secretariat
(Mr Greg Urwin, Secretary General)
to Member Governments**



CIRCULAR

Private Mail Bag, Suva
Telephone (679) 331 2660
Fax (679) 330 5573 / 330 1366
Email info@forumsec.org.fj
Website <http://www.forumsec.org.fj>

CIRCULAR NO : 81/07

EP/15/5

12 April 2007

TO : OFFICIAL CONTACTS OF MEMBER GOVERNMENTS

[Australia, Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Republic of Marshall Islands, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu]

FROM : GREG URWIN, SECRETARY GENERAL

SUBJECT : **ENHANCING AND STANDARDIZING REGIONAL TRAINING PROGRAMMES IN NURSING – MAPPING EXERCISE BY JAMES COOK UNIVERSITY, APRIL 2007.**

1. The Forum Secretariat, in partnership with WHO and the South Pacific Chief Nursing Officers Alliance (SPCNOA), undertook in 2006 to investigate the potential for enhancing and standardizing regional training programmes in nursing. This exercise is an essential first step towards addressing the proposal for “enhancing and standardizing regional training programmes in nursing”, which is initiative 7.2 under Sustainable Development in the Pacific Plan.
2. Following the call for expressions of interest in December 2006, the Forum Secretariat recruited **James Cook University (JCU)**, Townsville, Queensland to undertake the exercise in mapping current nursing educational provision and standards required for registration in member countries.
3. The mapping exercise should ensure understanding amongst stakeholders of the full range of qualifications available, how these relate to each other and how and where different qualifications can contribute to the learning process. This, in turn, should contribute to recognition and comparison of nursing qualifications across the region as well as provide the base for a consistent regional approach to qualifications.
4. JCU will undertake this mapping exercise from April 2007 with the final report expected by the end of July 2007.
5. I would like to request members of the Pacific Islands Forum to assist and support JCU in this important mapping exercise.
6. For any further queries and/or clarifications regarding this mapping exercise, please contact Ms Monica Driu Fong, HRD Policy Officer (Facsimile: +679 322 0249) or Email to monicaf@forumsec.org.fj

Greg Urwin
Secretary General

c.c. : FSM Embassy, Suva
: Kiribati High Commission, Suva
: Nauru High Commission, Suva
: Republic of the Marshall Islands Embassy, Suva
: Tuvalu High Commission, Suva
: CROP [FSMed, FFA, PIDP, SOPAC, SPBEA, SPC, SPREP, SPTO, USP]
: WHO, Suva
: Chair, SPCNOA

ANNEX 3

Reports from Focus Group Meetings

Participants Focus Group Meeting Mapping Nursing Education Pacific Island Countries

Meetings were in Suva, Fiji with following people. The purpose of the meeting was to discuss the Pacific Island Forum Secretariat (PIFS)/World Health Organization (WHO) project above.

10 and 11 July 2007

Participant	Organisation	E-mail Address
Zac Morse	Fiji School of Medicine (FSM)	z.morse@fsm.ac.fj
Praveen Maharaj	FSM	p.maharaj@fsm.ac.fj
Jalal Mohammed	FSM	m.jalal@fsm.ac.fj
Narendra Singh	Secretariat of South Pacific (SPC)	narendras@spc.int
Takako Ito	JICA	gimpea@yahoo.co.jp
Chieri Yamanda	JICA	cyamada-hsph@hotmail.com
Ryosuke Yoshida	JICA	Yoshida.ryosuke@jica.go.jp
Iloi Rabuka	Fiji School of Nursing(FSN)	rabuka_fsn@yahoo.com
Rigietia Nadakitavuke	FIJI	dennis19@connect.com.fj
Lola Tuiloma	Ministry of Health	ltuiloma@health.gov.fj
Sachida Nand	NZAID	sachido.nand@mfat.govt.nz
Juliet Fleischl	WHO	fleischlj@sp.wpro.who.int
Albert Wong	POLHN, WHO	Wonga@sp.wpro.who.int
Monica Fong	Forum Secretariat	monicaf@forumsec.org

The organisations attending discussed activities which they have developed or are implementing with relevance to Mapping project

SPC – Developed a ‘field epidemiology’ training course which is being accredited by Fiji School of Medicine (FSM). This has been field tested in CNMI. Elearning components with short incountry teaching.

FSM – Pharmacy School has developed modules for the Diploma and Bachelor degree which can be taken incountry thru Elearning and remainder on campus at FWM. This has been well received by countries and students.

FSM – Have developed an HR committee which is in early stage but will develop appropriate regional strategies for planning, development and quality control for HR in Pacific Island countries.

FSN – First graduates from new curriculum will graduate this year. Many students are bridging to bachelor degree and undertaking Masters degree. The basic nursing course is available to other countries in Region and most students are from Tuvalu, Nauru, and Tuvalu. The school offers following post graduate courses for nurses in the Pacific Region:

Midwifery – this is a required qualification before Nurse practitioner course can be undertaken.

Nurse practitioner

Public health

Management

Mental health

Others are being developed

JICA – Currently are providing inservice education for Community Health Nurses in Fiji and are planning to extend this to other Pacific countries. Dependant on resources available and evaluation report of the project in Fiji.

POLHN – offers various courses through the computer laboratories in 11 countries. Currently Diabetes management and series of Laboratory modules.

Public Service Commission (PSC) – Employ all health workers in Fiji and terms of employment, job descriptions etc. Provide generic training courses for all Public Service staff in Fiji – some staff from Ministry of Health are able to attend. Places in courses are allocated to various Departments. There is to be a regional meeting of Public Service employing ministries/departments supported by the ‘regionalisation’ project of the PIFS in the coming months.

General Discussion

Education

Problems exist throughout Pacific island Countries and Territories (PiCTs) with level of education when students graduate from secondary schools. Fiji School of Medicine previously had their off shore students attend a Foundation course (including English) at University of South Pacific (USP). This enabled these students to be bought to level which enabled them to enter and cope with first year at FSM. In the past this had been a major problem and caused many academic and social problems for these students.

USP have now stopped this course and FSM had plans to start one within the school. Unfortunately, due to lack of resources this isn't on their plan in next 2 years.

FSN have some problems with students from other PICTs but not with local students but to assist those that have a problem the school tutors undertake extra tuition.

For CPE (PG courses) FSM need to recognise the basic qualification and FSN accept any nurses registered within their own country.

It was suggested that some sort of 'bridging/foundation' course was developed for use of countries who encountered this problem. Anecdotally the group felt this was a problem in many countries with nursing students especially considering experience at FSM. The organization PREL was suggested. This organization works with all Northern Pacific Ministries of Education (MoE) in countries to increase capacity of teachers and improve the curriculum.

There is also the South Pacific Board of Educational Associations based in Fiji which could also be approached for development of some type of bridging project.

Basic Nursing Education

Discussion was mostly based on anecdotal information. Major issues identified were:

If nursing education was under MoE there wasn't sufficient dialogue with MoH to ensure education reflected requirements of health services.

Review of curriculum needed in some countries to reflect actual work of nurses. With shortage of doctors/dentists nurses were carrying out procedures which were traditionally practice of other health professionals.

There was some discussion on this and most of the participants felt that now was time for traditionally held areas of practice by health professionals to be 'merged' or officially recognised that other professions were able to do these.

EG – nurses doing dental treatment including extractions. Dispensing drugs. Obstetric care above the level of their 'training'.

Continuing Professional Education CPE

All agreed that there wasn't any overall planning for nurses CPE. Focus has mostly been on Continuing Medical Education (CME) in PICTs. There has been continuing focus in Northern Pacific countries by US government with lots of resources allocated.

Most reasons for difficulty in CPE for nurses were from lack of financial resources in governments who had to rely on donors and the problem of lack of staff when staff went on CPE programmes. If one nurse left country for CPE it usually meant that there wasn't another nurse to take that position. Then the migration issue – if nurse obtained formal PG qualification it was difficult to retain them.

FSN offered formal postgraduate courses. Nurses from other countries were attending many of them. Requirement for entry was the same as for local nurses and no formal entry examinations were carried out.

FSM also offers PG courses for nurses – MPH was most popular. No nurses from other countries have been enrolled. But they were happy to accept if places were available. They are starting MPH Research course.

It was suggested that there is also a lack of communication between countries about the courses that were offered on a Regional basis from FSM and FSN and also POLHN. The meeting was informed that it was outside the scope of this project but could be considered in recommendations.

There are a number of courses which are carried out by donors and are usually carried in Suva or Nadi. A lot of concern was expressed by all participants that these courses carried no form of 'accreditation' or 'recognition'. It was not just the 'formal' recognition but these courses did not add to the nurses' incremental movements or recognition for promotion. The same situation occurred for inservice courses.

The PSC said that they realised this but the process to accredit them was convoluted. But she also stated that very few of these courses were requested to be accredited.

It was suggested by the group that PIFS secretariat put on the agenda for the coming meeting of all PICTs Public Service employing Ministries/Departments some discussions on aspects of employment of nursing. This could be used as a pilot for regionalisation within these Ministries/Departments.

Employment

The group discussion focussed on the problem with the employment of health workers being separate from workplace. All agreed that this was not an ideal situation and should be focussed on.

Job descriptions were one area of difficulty of current situation in Fiji but most of group felt similar problems existed throughout PICTs.

Yearly appraisals were used as a basis for yearly increments for PSC and clinical appraisals were carried for measurements of nurses' practice. It was suggested by the group that these be used more specifically for training needs. It was also suggested that these could be used in training needs analysis (TNA) for CPE of nurses.

Official Career Paths for nurses were also lacking in most PICTs.

Legislation for registration and practice

Fiji has very good legislation for nurses and midwives. A nurses and midwives board is set up under the Nurses and Midwives Act and they have responsibility for the registration and practice of all nurses and midwives. They also have excellent gazetted rules on 'scope of practice' for the Nurse Practitioner category.

Nurses from other countries who were in FSN for PG courses needed to be registered in Fiji to enable them to perform clinical practice which is part of the courses. No formal assessments were done with these students.

Most participants were concerned that many countries did not have this legislation and some form of legislation should be considered a priority in this project.

The example of the Primary Care Practitioner qualification that was initiated by FSM some years back was used - where the graduates were unable to practice in their own countries due to lack of legislation covering their 'scope of practice'.

At the end of the meeting all organizations offered to be of assistance in any way for this project.

Meeting with AusAID

They were very supportive of the project as they have an increased interest in Human Resource development in PICTs and are interested in the report giving some appropriate strategic direction for nursing in PICTs.

They are very pleased with our methodology and the response we have from the countries – usually not such a good return for requests for information.

AusAID and WHO are strongly supporting Fiji School of Medicine and part of the support is for HR activities – a data base for HR and a HR committee.

They would like to put results from this project onto the database and make available for countries.

L. Kerse
Consultant

Participants Focus Group Meeting

Mapping Nursing Education Pacific Island Countries

Meetings were held in Apia, Samoa with following people. The purpose of the meeting was to discuss the ToR of the Pacific island Forum Secretariat (PIFS)/World health Organization (WHO) project above.

17 and 18 July 2007

Participant	Organization	E-mail Address
Fulisia Pita-Uo Aiavao	Dean Faculty of Nursing and Health Science	f.aiavao@nus.edu.ws
Ulisesse Tapuvae	Clinical Nurse Coordinator Nursing and Integrated Community Health Services	maotasesa@health.gov.ws
Sara Filemu	HSPQANM Infection Control Coordination	saraf@health.gov.ws
Tapai Tauielu	Principal Nurse, Professional Development and Research Section, Nursing and Midwifery Division MoH	tapait@health.gov.ws
Iokapeta Enoka	Senior Lecturer Faculty of Nursing and health Science	i.enoka@nus.edu.ws
June Scanlon Lui	Principal Nurse, TTM, National Health Services (NHS)	junes@health.gov.ws

A short presentation was given on the background and progress of the project.

The focus group meeting with above participants made following points:

Education

The NUS have compulsory 'foundation' course for all students for their first year. There are a number of generic modules and then others directly related to the courses of the students choice.

This it could be used as 'example' for countries for their nursing students and this may overcome the problem which seems to be widespread for education level of nursing students.

The Nursing School curriculum is reviewed 5 yearly and in accordance with legislation.

The school has the following PG programmes

Midwifery – there is Credentialing programme by UTS and Charles Darwin University being carried out. This midwifery course could be used as a 'regional system for post graduate education'.

Mental Health – becoming more popular. In the past there have been problems in mental health care in community. Therefore it is felt that this is needed by the Public Health Nurses

Acute Care and Emergency Nursing

Inservice/Continuing Professional Education for Nurses

Each Section of National Health Service now does a training needs analysis each year to enable plans to be made for inservice which is carry out every week. These training sessions are for improving clinical practice mostly and aren't accredited to enable staff to get salary increases or to be used in grade increases.

No evaluation is done of impact or effectiveness of the inservice. The inservice is done by the MoH and the Nursing School is consulted when courses are 'education' based.

The idea of Nurses Forum or Dialogue facilities was discussed and the staff from Nursing School had been thinking of this – also a Pacific Nursing College. This was also discussed 'informally' at recent Northern Pacific Nurses Meeting.

Legislation

Good nursing legislation and Samoa have well functioning Nurses and Midwives Board. They have Practising certificates and to renew these nurses have to do 20 hours of continuing education. No impact studies have been done

They encourage migration of the registered nurses as this brings in remittances.

Employment

The Public Service Commission have had some of their responsibilities devolved to MoH under the Good Governance and Reform Projects carried out over last 8 years thru AusAID.

There is well defined Career Path for nurses and it appears that it works well for nurses.

Meeting with CEO Ministry of Health

Dr Toelupe was given an outline of the project and she was pleased to learn that the project was not focussed on a Regional Nursing School as she had the same misconception that others have had, that outcome was Regional nursing school

The CEO said that the arrangement with the devolution of PSC responsibilities has potential to work but lots of things need to be worked on. PSC still retain 'policy' and budget. MoH can only make decisions within certain parameters.

We had discussion on concept of 'Forum/Dialogue' for educator nurses in Pacific and she was supportive as long as it didn't overlap with other 'Pacific nursing organizations'.

She also gave permission for Samoa material to be used as example.

Meeting with WHO Samoa

Discussions were had with WR and Programme Management officer on nursing in Samoa. They felt nursing was in good state in Samoa although there was a problem of acceptance of Nurse Practitioner (the graduates can be classed as this under legislation). The public preferred a medical doctor and needed some PR to educate them to the role and skills of NPs.

They felt the Foundation course compulsory for all students at NUS was good solution to get all students up to University level.

There was not funds allocated in Country budget for nursing activities and most of the funding came from other donors and from individual donor projects.

Conclusions

There are many examples from Samoa that could be used – similar good legislation as Fiji. Tonga also may have same as they have had support from NZAID for improvement of their nursing.

The concept of Forum/Dialogue could be suggested with funding for a coordinator and minimum support (computer etc) to enable a repository for examples of competencies, legislation, and employment processes etc. It could also be used for CPE courses available within PICTs and vehicle for discussions of clinical interests.

This type of facility is lacking in PICTs and nurses would welcome some sort of informal methods of sharing information and support.

L. Kerse
Consultant

ANNEX 4

Report on Education Programmes

Report on Curricula from the Various Schools of Nursing in the Pacific Island Countries (PICs)

Curricula information was received from four of the PICs (Samoa, Cook Islands, Tonga and PNG [one of the seven schools]). Some of this information was minimal (a list of subjects offered), and some included subject outlines only. More global information was received from Tonga and PNG. One of the team has possession of the curriculum from Fiji and curricula information Kiribati (JT). These curricula were examined for consistency as much as possible, however, there were large gaps in the information available.

Four of the six curricula had been reviewed since 2000. No information on this was obtained from Samoa, however, since it is associated with an institute of higher education, it is assumed that a curriculum review is required on a regular basis of 5-7 years. The Cook Islands last curriculum review was in 1991, Kiribati is also in need of an urgent review.

The theory hours of those curricula available indicate an emphasis on medical and surgical nursing, and one wonders at the level and applicability of information that is presented to the students, used for their assessment, and incorporated into their clinical practice.

There is a lack in some of the curricula (Tonga, Cook Islands, Kiribati) of professional issues such as legal and ethical thinking, critical thinking, evidence-based practice, and the place of research. These may be subsumed into other subjects, but were not apparent from the material provided.

Primary Health Care, although espoused as a curriculum priority, is not apparent either in these three curricula. PNG and Fiji have based their curricula on the concepts and principles of PHC and these are carried through most of the subjects. Samoa mentions PHC in many of their subject outlines.

Competency assessment is also a priority for PNG and Fiji – PNG has developed a set of national Nursing Competency Standards (2002) that are used within the curriculum and Fiji utilised the South Pacific Nursing Competency Statements (Draft) from 2002 as one of their organisers. These are used in both theoretical teaching and in clinical practice.

All of the curricula require 1200 - 1500 hours of theoretical knowledge and most reported an equal amount or more of required clinical practice (ratios of about 1:1.8). Clinical practice was stated to be overwhelmingly based on hospital nursing (e.g. Tonga sends students to community and clinic placements for 135 hours versus 2000 hours of hospital based nursing) which calls into question the stated primary health care focus of the curriculum. However, how the various 'specialty areas' such as obstetrics, mental health, and paediatric nursing are implemented could mitigate this finding.

The preponderance of medical-surgical nursing experience in the hospital is also very disturbing because of the lack of resources within the health care systems e.g. Kiribati struggles with basic pharmacological supplies and often material is out of date or unavailable [IV solutions, medications], unit maintenance is not attended leaving gaps in working equipment [narcotic cupboards without locks], technical procedures are outmoded and ritualistic [giving injections with a full aseptic tray set up], and nursing is very physician orientated.

Assessment was very difficult to evaluate. Information provided was very general, only stating some variation of '50% assignment and 50% examination' in each curriculum seen. However, this does indicate that students are invigilated for about half of their assessment and would have to know the information to pass the subject. As well, assignments are usually used to determine higher thinking skills, so a pass in such an assignment would, to some extent, indicate their ability to reason.

In conclusion, the curricula viewed indicate that there are several very solid curricula available in the PICs along with many that are outmoded and emphasise inappropriate aspects of nursing. These findings are very general because there were few actual curricula to evaluate, and most of the comments have been made without the full information required for in-depth analysis and observations.

ANNEX 5

Legislation Data [Summary]

LEGISLATION

	COOK ISLANDS	FEDERATED STATES OF MICRONESIA	REPUBLIC OF FIJI ISLANDS	KIRIBATI	MARSHALL ISLANDS	NAURU	NIUE
ISSUES							
Regulatory mechanism for nursing practice	Yes	Yes (Health Professional Act)	Yes	Yes (Medical Act)		No	No
Nursing Council / Board	Yes	Yes	Yes	Yes		No	No
National nurse examination	Yes	No	Yes	Yes		No	Yes
Regulatory mechanism advanced nursing practice	No	Yes	Yes	No		No	No
Scope of practice legislation	No	Yes	Yes	No		No	No
Annual renewal/licensing system	Yes	Yes	Yes	No (valid for life)		No	No
Mandatory Continuing Professional Education (CPE) for licence renewal	No	Yes	No	No		No	No
Legislation (safety to practise) of migrant nurses	Yes	Yes	No	No		No	No
National Council Licensure Examination (NCLEX)	Yes	No	No	No		No	No

LEGISLATION – Cont'd

	PALAU	PAPUA NEW GUINEA	SAMOA	SOLOMON ISLANDS	TONGA	TUVALU	VANUATU
ISSUES							
Regulatory mechanism for nursing practice	Yes	Yes	Yes	Yes	Yes	No	Yes
Nursing Council / Board	Yes Board of Health Professionals under MOH	Yes	Yes	Yes	Yes	No (Group for support and strengthening nursing)	Yes (Non-functioning)
National nurse examination	No	Yes	Yes	Yes	Yes	No	Yes
Regulatory mechanism advanced nursing practice		Yes	Yes	Yes	Yes	No	No
Scope of practice legislation	Yes	Yes	No	No	No	No	No
Annual renewal/licensing system	Yes	Yes	Yes	Life (Soon to be annual)	Yes	No	Not enforced
Mandatory Continuing Professional Education (CPE) for licence renewal		Yes	Yes (20 hrs yearly)	No	No	No	No
Legislation (safety to practise) of migrant nurses	Yes	Yes	No	Yes	Yes	No	No
National Council Licensure Examination (NCLEX)	No	Yes	No	Yes	No	No	No

ANNEX 6

Training / Education Data [Summary]

TRAINING / EDUCATION

	COOK ISLANDS	REPUBLIC OF FIJI ISLANDS	KIRIBATI	MARSHALL ISLANDS	PALAU	PA;UA NEW GUINEA	SAMOA	SOLOMON ISLANDS	TONGA	VANUATU
PRE SERVICE										
Analysis – supply and demand	No	Yes	Yes		Yes	No	Yes	Yes	Yes	
Nursing intakes annually (include student number)	12 – 20	100 – 200	5 – 30		0 – 1	200 – 250	15 – 20		30 – 35	
Pre-requisite subject levels (Pacific Senior Secondary Certificate – PSSC)	Maths, English, Science, Computer, Geography	English, Science, Biology	English, Biology, Chemistry, Physics		English, Science, Health	English, Maths, Science	NUS Foundation Certificate	English, Maths, Science	English, Maths, Biology, Science	
Age range	18 – 45	18 – 25	18 – 35		17 – 50	16/17 – 19/21	18+		18 – 31	
Gender priority	None	Females	No		No	Yes (females)	No	No	No	
Recruitment strategies (include school marketing)	Career Expo MoE	Career Expo MoE	Career Fair by Peace Corps		Social Marketing at MoH	Guidance & Career Week (MoE)	National Nursing Marketing Plan	None	MoE Career Promoting in schools	
Application process – who decides	Director of Nursing, Secretary of Health	FSN / MoH / PSC	Nursing Education Training Committee		PCC Admissions & MoH	Deans & Higher Education Office	Dean	Nursing School	PSC, Principal Nurse & Medical Officer	
NURSING EDUCATION REGULATION										
Regulation / approval of curriculum	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	
Sets educational standards / modules	Nursing School, Nursing Council	Nursing Board, FSN	No		PCC Board of Regents	Nursing Council, University Council	Nursing Council & Senate of University	Nursing Council, Education & Accreditation Program	Nurses Board, Nurse Consultant Partner School (NZ)	

TRAINING / EDUCATION - Cont'd

	COOK ISLANDS	REPUBLIC OF FIJI ISLANDS	KIRIBATI	MARSHALL ISLANDS	PALAU	PA;UA NEW GUINEA	SAMOA	SOLOMON ISLANDS	TONGA	VANUATU
NURSING CURRICULUM										
Curriculum provided	Yes	Yes	No			Yes	Yes	No	Yes	
Competencies within curriculum	Yes	Yes	No			Yes	Yes		Yes	
Length of nurse education course	3 years	3 years	3 years			3 years	Foundation = 1yr Diploma = 2yrs Bachelor = 3yrs	RN = 3yrs RN Aide = 1yr	3 years	
Theory/clinical practice (hours or percentage)	Th = 1500 hrs CI = 2820 hrs	Th = 45% CI = 65%	Th = 1800 hrs CI = 54 wks			Th = 2000 hrs CI = 1600 hrs	Th = 50% CI = 50%		Th = 3871 hrs CI = 2135 hrs	
Theoretical basis for curriculum	PHC	Pacific Nurses Competencies Model	Henderson & Orem Theories			PHC	Holistic model culturally-based philosophy of nursing		Eclectic based	
Clinical placements	All areas	All areas – specially in diabetes, STI	All areas + laboratory			All areas	All areas		Hospital, PHC clinics, urban/rural	
Staff : Student Ratio – clinical	1 : 2	1 : 10	1 : 6			1 : 10	1 : 8-10		1 : 6-10	
Stipend – Government	No	Yes	Yes			Yes	Yes		Yes	
Rules of progression	No	Yes	Yes			Yes	Yes		Yes	
Final evaluation	Yes	Yes	Yes			Yes	Yes		Yes	
Progression (failure) process	Yes	Yes	Yes			Yes	Yes		Yes	
Graduation percentages / numbers (last five years)	2003 = 100 2006 = 100	2002 = 100% 2003 = 100% 2005 = 98% 2006 = 99%	2002 = 80% 2003 = 100% 2004 = 100% 2005 = 77% 2006 = 63%			2003 = 93% 2004 = 73%	2002 = 14 2003 = 43 2004 = 36 2005 = 14 2006 = 28		2002 = 79% 2003 = 85% 2004 = 88% 2005 = 80%	

TRAINING / EDUCATION - Cont'd

	COOK ISLANDS	REPUBLIC OF FIJI ISLANDS	KIRIBATI	MARSHALL ISLANDS	PALAU	PA;UA NEW GUINEA	SAMOA	SOLOMON ISLANDS	TONGA	VANUATU
FACULTY										
Employs faculty (staff)	MoH	MoH / Private	MoH			MoE/Private, MoH	National Univ of Samoa (NUS)	MoH, MoE, Private	MoH	
Tertiary Qualifications	BA MA	BA MA	BA MA			BN Masters	BN Masters		BN Masters	
Teaching/Learning Workshop in last 12 months?	No	Yes	Yes			No	Yes		Yes	
Formal CPE Nurse Educators	No	Yes	Yes			Yes	Yes		Yes	
TEACHING MATERIALS AND RESOURCES										
Library for nursing students	No	Yes	No			Yes	Yes (NUS, MoH)	Yes	Yes	
Library well resourced (staffed)	No	Yes	Closed Temporarily			UPNG	Yes		Yes	
Computer with internet in library	No	Yes	No			Yes	Yes		Yes	
Computer with internet access available to nursing students	Yes	Yes	No			No	Yes		Yes	
Computer training during course	Yes	Yes	No			No	Yes		Yes	
Access to electronic journals	Yes	Yes	No			No	Yes		Yes	
Satisfactory other teaching resources	No	Yes	No			Not really	Yes		Yes	
Collaboration with other teaching facilities	Yes USP, NZ	Yes JCU	Yes Tarawa Tech Institute, NZ, Aust			Yes UPNG	Yes MOU, NCN, Japan, UoA, UoG, UoO, UTS		Yes UT (NZ)	
Resources needed	Simulators, Cameras		Upgrade all			Clinical equipment	Some		Clinical laboratory	

TRAINING / EDUCATION - Cont'd

	COOK ISLANDS	FEDERATED STATES OF MICRONESIA	REPUBLIC OF FIJI ISLANDS	KIRIBATI	MARSHALL ISLANDS	NAURU	NIUE
CONTINUING PROFESSIONAL EDUCATION							
Government support	Yes	Yes	Yes	Yes		Yes	Yes
Strategic Plan	Yes	No	Yes	Yes		No	No
Programme	No	No	Yes	Yes		No	No
Funding arrangements	Government, Donors, Self-funded, Others		Government, Donors, Self-funded, Others	Government, Donors, Self-funded		Donors	NZAID
Recent (12 months)	Midwifery, attachment in NZ hospitals – Masters	Diabetes Management	Neonatal, Theatre, Mental Health, Diabetes, Trauma & Emergency, Disaster Management	BN, IMCI, Nursing Management, short courses, Midwifery, PHN, Med Assist		Midwifery, Eye Course	Ophthalmology, short courses
Distance / e-learning		Yes (POLHN)	Yes (POLHN)	No		No	No

TRAINING / EDUCATION – Cont'd

	PALAU	PAPUA NEW GUINEA	SAMOA	SOLOMON ISLANDS	TONGA	TUVALU	VANUATU
CONTINUING PROFESSIONAL EDUCATION							
Government support		Yes	Yes	Yes	Yes	Yes	
Strategic Plan		No	Yes	Yes	Yes	Yes	
Programme		No	Yes	Ongoing inservice	Ongoing inservice and radio	No	
Funding arrangements			Government Nursing Budget, Donors	Government, Donors	Government, Donors, self-funded	Government, Donors	
Recent (12 months)		Midwifery, BN, BE, Bachelor Clinical Nursing, Diploma in Health	Short clinical courses	Bachelor Clinical Nursing (Mental Health, Acute Care), DPH, BN	Cert Critical Care, Cert Health Professional Education	BN, Midwifery, PHN, RH, Neonatal	
Distance / e-learning		No	No	No	Yes (Radio)		

TRAINING / EDUCATION - Cont'd

	COOK ISLANDS	FEDERATED STATES OF MICRONESIA	REPUBLIC OF FIJI ISLANDS	KIRIBATI	MARSHALL ISLANDS	NAURU	NIUE
POST BASIC EDUCATION							
Current PBE qualifications	Midwifery, PHN, NP, BN		Midwifery, PHN, NP, BN, IC, BE, CC, PC	NR, Diabetes, HIV			
Top Basic courses	Midwifery, BN, MA	Midwifery	Midwifery, BN, NP	Midwifery, PHN, Med Assist			BN, Diploma Eye Care
Availability in-country	No	No	Yes	Yes		No	No
Which other countries	Fiji New Zealand Samoa	Guam Fiji USA		Fiji Samoa Australia		Fiji Samoa Australia	Fiji New Zealand
Course providers for distance or e-learning	POLHN USP CSU		Management in Nursing	No		No	No

TRAINING / EDUCATION – Cont'd

	PALAU	PAPUA NEW GUINEA	SAMOA	SOLOMON ISLANDS	TONGA	TUVALU	VANUATU
POST BASIC EDUCATION							
Current PBE qualifications		Midwifery, BN, BE, CN, Med Assist, PC, MH	BN, Masters	Midwifery, BN, Diploma of Nursing	Midwifery, PHN, NP, BN	Midwifery, PHN, BN	
Top Basic courses		Diploma, Masters	Midwifery, MN, Acute Care, PHC	Midwifery, CN, PHN, BN, NA, CN, BE	Nursing Education, Midwifery, Bridging for diploma nurses	BN, Midwifery, RH, PHN	
Availability in-country		Yes	Yes	Midwifery	Yes	No	
Which other countries		No	New Zealand Australia	BN (UPNG)	New Zealand Fiji	Fiji CNU CDU	
Course providers for distance or e-learning		Yes (UPNG)	No	Yes	Yes	No	

TRAINING / EDUCATION – Cont'd
FEDERATED STATES OF MICRONESIA / NAURU / NUIE / TUVALU

	FEDERATED STATES OF MICRONESIA	NAURU	NUIE	TUVALU
BASIC				
Partner country – nurse education/training	MSI Community College of Nursing, UoG, FSN	FSN, Kiribati School of Nursing	FSN, Manukau Technology Institution (NZ)	FSN, Kiribati School of Nursing
Effectiveness education for health service provision	Yes, but shortage of nurses	Yes but shortage of nurses	No, little access to modern technology in Nuie	Yes
Funding arrangements	Government	Government, AusAID, MOU	NZAID, WHO	WHO, NZAID
Expatriates in nursing workforce	10-15%	28%	Nil	Nil
Expatriates – country(ies) of origin	Philippines	Fiji, Philippines	Nil	Nil
Registration of expatriates	Yes	Yes	No	Nil
POST BASIC				
Post basic / Postgraduate education	Yes	Yes	Yes	Yes
Funding post basic / postgraduate education	Yes Government, USAID, WHO	Yes AusAID	Bilateral	Yes WHO, NZAID, AusAID, UNFPA
Funding source post basic / postgraduate education	WHO	WHO, AusAID, MOU	New Zealand	WHO, NZAID, AusAID, UNFPA
Partner countries – post basic / postgraduate education	Guam, Fiji	Fiji	New Zealand	Fiji, CQU, CDU
Distance / e-learning	Yes	No	No	No
Computer laboratory	POLHN	No	No	No
Internet access	Yes	No	No	No

ANNEX 7

WP/SEAR Common Competencies for the Registered Nurse

*Available in PDF format only.
Have imported into this Word document as
a '.txt' document – formatting will differ
from original document but content
is the same.*

Common Competencies for Registered Nurses Western Pacific and South East Asian Region

March 2006 Western Pacific & South East Asia Region

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WPSEAR Common Competencies for the RN

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Foreword

The WPSEAR Common Competencies have been formulated over a 6 year time frame. Coordination of the work has been undertaken by a secretariat at the Australian Nursing and Midwifery Council Incorporated (ANMC) (formerly the Australian Nursing Council, ANC) in Canberra, Australia. During the development phase many nurses representing the following countries of the region have been involved in the process. This was achieved through representation on working groups, through workshop participation and through the provision of input to formal feedback mechanism established by the secretariat. Their contribution is gratefully acknowledged.

- Australia
- Bangladesh
- Brunei Darussalam
- Cambodia
- Cook Islands
- Fiji
- Hong Kong
- India
- Indonesia
- Laos
- Malaysia
- Nepal
- New Zealand
- Niue Island
- Papua New Guinea
- Philippines
- Republic of China
- Republic of Kiribati
- Republic of Korea
- Republic of Marshall Islands
- Samoa
- Singapore
- Solomon Islands
- Thailand
- Tonga
- Vanuatu
- Vietnam

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At the 2nd meeting of the Nurse Regulatory Authorities of the Western Pacific and South East Asian Region (WPSEAR) at Brisbane in 1998, it was agreed by the members that the development of regional core competencies would be useful. Following that meeting, all members, on request, were asked to send any current competencies or professional standards to the secretariat. This information was collated by Marilyn Gendek, CEO of the Australian Nursing Council, Marion Clark, CEO of the Nursing Council of New Zealand and representatives from the Thailand Nursing Council and Thailand Nursing Association.

The 3rd meeting at Bangkok in 2000 focused heavily on the development of the core competency standards. A keynote address on the development of competencies was followed by group discussion and debate on the draft standards and ideas were sought on how any competency standards would be used. Following the meeting, the Nursing Council of New Zealand undertook to incorporate the feedback into the first draft and a new draft was circulated. The region was delighted that the Philippines and Papua New Guinea both used the information gained in Bangkok to develop their own competencies and move to competency-based regulation.

The 4th meeting of WPSEAR was held in Hong Kong in 2002. Following further discussion on the redrafted standards and presentations from the Philippines and Papua New Guinea, a working party was established to oversee the final preparatory work prior to anticipated approval at the 5th WPSEAR meeting in September 2004 in Kuala Lumpur. Members of the working party were:

- Dr Stephanie Fox-Young • Associate Professor Dr Prakin Suchaxaya • Dr. Remedios Fernandez • Ms June Lui • Ms. Rita Konilio • Ms. Margaret Proctor (since February 2004)

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Introduction

This publication concerning common competencies for registered nurses was developed as an initiative of nurse leaders attending meetings of the nurse regulatory authorities of the Western Pacific and South East Asian Region (WPSEAR). The common competencies have been formulated over the past 10 years in consultation with nurses representing countries of the region.

At the first WPSEAR meeting held in Wellington, New Zealand in 1996, the increasing trend of nurses moving from country to country was seen as an important issue for regulators, for maintaining nursing standards, and for the public interest. While it is acknowledged that at a global level nurses have much in common, as they all play similar roles as health care providers and in delivering a public service to the world's populations, in the WPSEAR there are considerable differences in the education and structure of nursing and in the health care systems in which nurses work. These variations can be found in the regulation of their practise, in their educational preparation, in their professional roles, in their cultural settings and in their social and legal status. The recognition of qualifications, when nurses seek registration to enable them to work or study in different countries is made more complex when the differences outlined above are taken into account.

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Agreement was reached by attendees at WPSEAR meetings of nurse regulatory authorities that the Common Competencies should be generic and broad in nature so they are applicable to each country context. It is acknowledged that at a specific national level additional development and adjustments, and interpretation of the competencies may be required to ensure their relevance at a performance and cultural level. Furthermore, it is acknowledged that the WPSEAR Common Competencies will require regular review as nursing practice continues to evolve and the context in which nurses work changes. It should also be noted that participants at the WPSEAR meetings have endorsed the International Council of Nurses Principles of Regulation (ICN 1986) and the ICN Code of Ethics (ICN 2000).

This document details background information, the competency development process, the proposed WPSEAR Common Competencies, suggestions for their application and a Glossary of Terms.

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Background

In the past decade we have seen the emergence of global markets and regional treaties or agreements that are designed to improve the free movement of goods and services across national boundaries. The opportunities for nurses, as health care professionals to move more freely from country to country has been expanded by these trends. It was as a result of these developments that the formulation of a set of common competencies for nurses in the region was firmly placed on the agenda of the WPSEAR meetings. Nurses as health professionals are accountable to the community they serve and have a duty of care to meet professional standards. The WPSEAR Common Competencies for Registered Nurses assist in providing a guiding framework to inform interested parties about the expected competency standards of nurses in the region. Other standards that shape the professional practice of nurses include Codes of Ethics, Codes of Professional Conduct and various practice standards.

It is envisaged that these common competencies will support the role of nurses within the region, provide direction for recognition of qualifications and for multi-country licensure programs and guidance for those countries that have not yet developed their specific competencies for nurses.

As stated above nursing leaders in the Western Pacific and South East Asian region recognised the need to formulate a set of common competencies and developed a strategy to ensure their development. The contextual background to this initiative is important, as it can be argued that this context was the driving catalyst to the decision to formulate the common competencies. Three major elements are involved in this context, global developments, changes in how health services are delivered, and changes in the professional role and

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function of the nurse. This context has also been seen as pivotal in competency development by the International Council of Nurses (ICN), which has published the ICN Framework of Competencies for the Generalist Nurse (ICN 2003). The authors of this publication suggest that nurses are among groups of professionals who seek international recognition of their professional qualifications and competencies (ICN 2003 p5). In discussing the context underpinning the development of the ICN Framework for Competency Development for the Generalist Nurse, the ICN (2003 p9) has also put forward three important elements:-

- global trends,
- health services, and
- nursing.

This view supports the rationale for the development of common regional competencies as proposed by nurse leaders in the WPSEAR.

Global and Regional Developments.

The development of a global economy, the movement of masses of people around the world in short time frames, the constant and fast exchange of goods and services between countries, the development of many international treaties and laws and the mammoth technological and electronic advances that let us exchange information and knowledge at an extraordinary rate, are all important factors in the global context. Phrases like “we live in a global village”, and “the world is getting smaller” are relevant to the health care context and therefore impact on how and where nurses work and live.

At the same time various regional trade agreements have emerged which resulted in closer economic ties between countries of the region, making reciprocity of professional qualifications an important factor for regulatory authorities in maintaining nursing standards. In Australia, there was also commitment by the federal government to facilitate the removal of technical barriers to trade in the context of the World Trade Organisation

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(WTO) and the Asia Pacific Economic Cooperation group (APEC). As well, the barriers with the Association of South East Asian Nations (ASEAN) were to be reduced. Examples of developments in regional trade treaties include the Trans Tasman Agreement between Australia and New Zealand; the Indian Ocean Rim Association for Regional Cooperation (involving 18 members); Singapore–Australia Free Trade Agreement; Thailand–Australia Free Trade Agreement. Over the timeframe of the WPSEAR Common Competencies development, other trade agreements in the region have been formalised.

Health Service Delivery

Health care delivery systems in the WPSEAR have advanced at a rapid pace as many countries in the region have progressed through a stage of development. Reforms in these systems are constant as they respond to changes in priorities, knowledge and information bases and financial capacity. While there is still great diversity in political systems, economics, and social and cultural norms, health care systems within the region are still affected in the same way by global trends. There are consequences for health systems in all countries of the region as a direct result of the expansion in technology and knowledge, fast communication and emerging human rights and ethical issues. The increasing cost of running very expensive technological health services, which focus on sickness has proved to be not viable and rationalisation of resources has been necessary. In acknowledging that people’s health status is significantly influenced by their life situation, their wealth, their housing, their environment and their employment, there has been a shift to focussing health care systems to a primary health care model. This view has been supported by the World Health Organisation’s Western Pacific Region in its policy document, “New Horizons in Health” which articulates the reforms in health services as a directional change “from disease-centred to people-centred, with a focus on positive health as a part of human development”(WHO 1995).

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Professional Role and Function of the Nurse

Globally, nurses are the largest group of health care professionals, and therefore they have the potential to improve the health of the peoples of the world. They play a vital and influential role in health care systems, in developing health care policy, in promoting health and preventing illness, and in caring for people who are sick and for those that require rehabilitation.

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The WPSEAR Common Competencies Development Process

The Common Competencies development process has been in progress since 1998. This extended timeframe has been necessary to allow consultation with and input from nurses in the region. Given the vast differences in cultures, nursing education programs, nursing structures and health systems in the region, it was essential to allow sufficient time for agreements on principles and to establish ownership of the content of the common competencies.

The development process has been punctuated by discussions and decisions made by attendees at the various WPSEAR meeting. Between these meetings a number of groups have been delegated the task of progressing the developmental work under the guidance of the secretariat at the Australian Nursing and Midwifery Council Incorporated (ANMC). Specific important milestones and high points in the development process on the common competencies are chronicled below:

- **1996 – 1st WPSEAR Meeting Wellington, New Zealand** – A key matter identified at this meeting was the barriers to movement of nurses across national and country borders. The meeting participants agreed that this trend would require urgent attention from nurse regulatory authorities in the region (Australian Nursing Council 2000a).

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- **1998 – 2nd WPSEAR Meeting Brisbane, Australia** – “Regional collaboration on standards of practice and education” and “reciprocity arrangements between countries of the region” were scheduled as major agenda items. An outcome of this meeting was the establishment of a Task Force, comprising representatives of Nepal, Thailand, Singapore, India, Australia and New Zealand, to develop an action plan concerning reciprocity matters. Representatives from Fiji agreed to convene an action plan for countries in the region without a nurse regulatory authority. The ANC was to act as the secretariat to the task force (ANC 2000a).
- **1999 – 2000** – The plan devised in 1998 (above) involved an investigation as to what each country was doing in regard to core competency development. The ANC consequently surveyed WPSEAR nurse regulatory authorities to gain this information. Countries responding included Fiji, Singapore, Papua New Guinea, Cook Islands, New Zealand, Sri Lanka, the Philippines, and Australia. The information supplied to ANC was analysed by a consultant to identify consistent competency components and draw together potential common competencies for the region.
- **2000 – 3rd WPSEAR meeting Bangkok, Thailand** – A large part of this meeting was allocated to regional common competency development. The concept was explored through a series of paper presentations and workshops. Seven groups of nurses from the region examined and discussed a regional common core competency framework, including identification of potential common competencies, and actions to achieve the development and implementation of common competencies. At the end of this meeting it was determined that a Steering Committee would work to continue to refine the work achieved at

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the meeting. It was also agreed that ANC would continue to act as the secretariat (ANC 2000b).

- **2002 – 4th WPSEAR meeting Hong Kong** – The ANC formulated a Discussion Paper for consideration at the meeting. Following the workshop and examination of the work undertaken by the steering committee, a small working group was formed to develop an action plan to complete this project. It was envisaged that a final draft document on the WPSEAR Common Competencies would be presented at the 5th WPSEAR meeting in Kuala Lumpur in 2004 (Australian Nursing Council 2003).
- **2004 – 5th WPSEAR meeting Kuala Lumpur** – the draft WPSEAR Common Competencies were put to the meeting and subsequently were approved and adopted.

Many nurses representing the following countries of the region have provided input during the timeframe involved in the development of the Regional Common Competencies. Their contribution is gratefully acknowledged.

- Australia
- Bangladesh
- Brunei Darussalam
- Cambodia
- Cook Islands
- Fiji
- Hong Kong
- India
- Indonesia
- Laos
- Malaysia
- Nepal
- New Zealand
- Niue Island
- Papua New Guinea
- Philippines
- Republic of China
- Republic of Kiribati
- Republic of Korea
- Republic of Marshall Islands
- Samoa
- Singapore
- Solomon Islands
- Thailand
- Tonga
- Vanuatu
- Vietnam

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Benefits and Application of Common Regional Competencies

As our world becomes more global and the nursing profession becomes universal through advances in technology and improved communication the need for agreed Regional Common Competencies has become more critical. Throughout the lengthy development process the benefits and uses of the Common Competencies for the nursing profession and regulatory authorities in the region have been explored. Nurse leaders attending the WPSEAR meetings have had the opportunity to identify, discuss and document the benefits and application of the competencies during purposely organised workshops. The ICN (2003 p16 and p31) has also suggested specific uses for a competency framework. It is intended that the Common Competencies will have application in the region to:

- facilitate reciprocity of qualifications and skills of nurses from other countries and for multi-country licensure programs,
- guide development of definitions especially those related to scope of practice,
- guide educators when developing and reviewing nursing programs for entry to practice and with assessment processes,
- provide the basis for formulating common education and professional standards,
- increase movement, flexibility and adaptability of nurses to new work and study environments,
- increase knowledge and understanding of cultures, values, and beliefs in the region,
- enable professional misconduct to be dealt with by various jurisdictions and under diverse legislations thus helping to ensure protection of the public,
- assist in the development of educational codes and practices,

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- help promote individual and collective professional accountability,
- assist in clarifying the role and responsibilities of nurses,
- increase regional collaboration and communication,
- help nurses to develop a common language and therefore have a greater understanding of each other,
- guide institutions in developing educational programs for foreign nurses,
- assist universities when establishing exchange programs, and
- enhance nursing standards and therefore improving health care provided to populations in the region.

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WPSEAR Common Competencies

At the 4th meeting of the Regulatory Authorities of the Western Pacific and South East Asian Region in 2002 workshops were held to review and determine the ongoing development of the WPSEAR Common Competencies. The outcome of this meeting was an acceptance of the following Common Competencies for the Registered General Nurse. It was agreed that the term common competencies would be used rather than core competencies as this would allow for the differences in nursing roles and health contexts in the region.

The WPSEAR Common Competencies reflect the comments and contribution from each workshop held during the process of development. They have been formulated with input from nurses in the region, many who have previously developed and are using a competencies framework and from other nurses who are in the process of developing competencies.

It is assumed that the WPSEAR Common Competencies are underpinned by the successful completion of the highest level of nursing education provided for registration as a nurse in a specific country. Education courses leading to registration are usually at least 3 years (6 semesters) in duration. The accepted desirable goal is that the minimum education for registered nurses will be to a bachelor (baccalaureate) degree level. Nurse regulatory authorities in the region acknowledge that a bachelor degree is not currently available for registered nurse education in all countries. Recognition is also given to varying key factors existing in different national contexts, including varied health care priorities and cultural differences.

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The WPSEAR Common Competencies have been grouped under the following 3 domains:

- Legal and Ethical Framework of Nursing Practice
- Management of Care (comprising Professional Practice, Consumer Rights and Professional Advancement and Development)
- Leadership and Nursing Management

Each domain has an associated competency unit and competency elements. A Competency Unit represents a major function/functional area in the total competencies of a Registered Nurse in a nursing context representing a stand alone function which can be performed by an individual. A Competency Element represents a sub function of the unit (Australian Nursing Council 2000c). A Competency Element is not comprehensive or exclusive and it may apply to more than one domain of nursing practice.

The competencies listed below reflect the views presented and the agreements made on essential competencies at a workshop held during the 4th WPSEAR meeting in Hong Kong 2002. They were further developed by the working party prior to the 5th meeting in Kuala Lumpur, where they were approved and adopted.

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WPSEAR Common Competencies for Registered Nurses.

DOMAIN 1: LEGAL AND ETHICAL FRAMEWORK OF NURSING PRACTICE COMPETENCY UNIT 1 RECOGNISES AND ACCEPTS PERSONAL ACCOUNTABILITY AND RESPONSIBILITY FOR ALL ASPECTS OF PROFESSIONAL PRACTICE

Competency Element 1.1

Practices in accordance with current competencies and scope of practice.

Competency Element 1.2

Performs nursing interventions according to recognised standards of practice.

Competency Element 1.3

Clarifies responsibility for aspects of care with other members of the health team.

COMPETENCY UNIT 2 UNDERSTANDS AND DEMONSTRATES KNOWLEDGE OF THE LEGAL AND ETHICAL FRAMEWORK OF THE HEALTH SYSTEM THAT RELATES TO NURSING

Competency Element 2.1

Recognises and acts upon breaches of law relating to nursing practice and/or professional code of conduct.
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Competency Element 2.2

Practices in accordance with relevant legislation, national and local policies and procedural guidelines.

Competency Element 2.3

Maintains clear and legible documentation and records.

COMPETENCY UNIT 3 UNDERSTANDS AND UTILISES AN ETHICAL DECISION MAKING FRAMEWORK

Competency Element 3.1

Practices in a manner that conforms with an agreed Code of Ethics.

Competency Element 3.2

Engages effectively in ethical decision making.

Competency Element 3.3

Demonstrates an understanding of the challenges to ethical decision making in a broad range of circumstances and practice settings including conflict and natural disaster situations.

Competency Element 3.4

Maintains patient confidentiality and security of patient information.

COMPETENCY UNIT 4 PROVIDES CULTURALLY SENSITIVE CARE

Competency Element 4.1

Respects the values, customs, spiritual beliefs and practices of individuals and groups (from ICN).

Competency Element 4.2

Recognises own beliefs and values and how these may influence care giving.
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DOMAIN 2: MANAGEMENT OF CARE

The "Management of Care" domain draws together the areas of

- a). Professional Practice,
- b). Communication,
- c). Consumer Rights, and
- d). Professional Advancement and Development.

A) Professional Practice

COMPETENCY UNIT 5 CONTRIBUTES TO EFFECTIVE MULTIDISCIPLINARY TEAM WORK BY MAINTAINING COLLABORATIVE RELATIONSHIPS

Competency Element 5.1

Collaborates with and co-ordinates health and social care teams.

Competency Element 5.2

Demonstrates critical thinking and decision-making skills.

Competency Element 5.3

Participates with members of the health and social care teams in decision making concerning patients/clients (from ICN).

COMPETENCY UNIT 6 ENSURES CONSISTENT, CONTINUOUS HOLISTIC QUALITY OF CARE

Competency Element 6.1

Undertakes a comprehensive and systematic assessment involving analysis and interpretation of data.

Competency Element 6.2

Formulates a plan of care in collaboration with the patient/ client and/ or significant other.
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Competency Element 6.3

Implements and documents planned nursing care.

Competency Element 6.4

Evaluates and documents progress towards expected outcomes and uses evaluation data to modify the plan of care.

Competency Element 6.5

Utilises well-conducted/evaluated research findings in practice as appropriate (practice based on evidence).

Competency Element 6.6

Makes clinical judgements and provides appropriate nursing therapeutic interventions and procedures for the individual patient, family and community.

Competency Element 6.7

Teaches patients/families/carers/health professionals aspects of care as appropriate.

Competency Element 6.8

Ensures that no action or omission on the part of the nurse, or within the nurse's sphere of responsibility, is detrimental to the patient, family and community.

Competency Element 6.9

Works collaboratively with nursing colleagues to ensure continuity of quality nursing care.

Competency Element 6.10

Reflects on practice outcomes and makes changes to practice when appropriate.

Competency Element 6.11

Maintains and updates technical skills.
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COMPETENCY UNIT 7 CREATES AND MAINTAINS A SAFE ENVIRONMENT THROUGH THE USE OF QUALITY ASSURANCE AND RISK MANAGEMENT STRATEGIES

Competency Element 7.1

Participates in continuous quality improvement and quality assurance activities.

Competency Element 7.2

Acknowledges limitations in knowledge and competence and declines any duties or responsibilities unless able to perform them in a safe and skilled manner.

Competency Element 7.3

Delegates, monitors and supervises work performed by assistants.

Competency Element 7.4

Provides a safe environment for patient(s) and staff, including implementing infection control procedures.

COMPETENCY UNIT 8 DEMONSTRATES UNDERSTANDING OF TRADITIONAL HEALING PRACTICES WITHIN AN INDIVIDUAL'S, FAMILY'S AND/OR COMMUNITY'S HEALTH BELIEF SYSTEM

Competency Element 8.1

Seeks out knowledge about specific traditional healing practices that are culturally relevant to individuals and communities.

Competency Element 8.2

Makes changes to practice when appropriate.
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COMPETENCY UNIT 9 DEMONSTRATES AN UNDERSTANDING OF NATIONAL HEALTH, SOCIAL AND POLITICAL PROCESSES

Competency Element 9.1

Actively seeks to participate in health policy development and evaluation, and program planning.

Competency Element 9.2

Accepts leadership responsibility in the delivery of nursing and health care.

B) Communication

COMPETENCY UNIT 10 ESTABLISHES INTERPERSONAL RELATIONSHIPS BASED ON PUBLIC TRUST AND CONFIDENCE

Competency Element 10.1

Listens and interacts clearly by verbal, written and electronic means as appropriate, to patients/clients, families, carers and other health professionals.

Competency Element 10.2

Respects the professional boundaries of therapeutic relationships.

COMPETENCY UNIT 11 DISPLAYS CULTURAL AWARENESS AND SENSITIVITY IN RELATION TO VERBAL/NON VERBAL COMMUNICATION

Competency Element 11.1

Accesses and provides appropriate written resources for patients and their carers when needed.

Competency Element 11.2

Uses appropriate professional interpreters when needed.
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Competency Element 11.3

Involves an advocate for the patient/client if necessary to ensure effective communication.

COMPETENCY UNIT 12 USES HEALTH and INFORMATION TECHNOLOGY EFFECTIVELY AND APPROPRIATELY

Competency Element 12.1

Communicates and clarifies advances in appropriate technologies to the patient/client.

Competency Element 12.2

Uses available information technology to access information and new knowledge.

Competency Unit 12.3

Undertakes training in the application of new health technologies as necessary.

C) Consumer Rights

COMPETENCY UNIT 13 RESPECTS EACH PATIENT/CLIENT IRRESPECTIVE OF THEIR ETHNIC ORIGIN, RELIGION OR OTHER FACTORS

Competency Element 13.1

Respects the patient's/client's rights to access information, privacy, choice and self-determination.

Competency Element 13.2

Responds appropriately to comments or complaints from patients/clients and co-operates with complaints procedures.

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COMPETENCY UNIT 14 PROVIDES AN ADVOCACY ROLE FOR PATIENTS' RIGHTS AND EMPOWERS PATIENTS/CLIENTS TO MAKE DECISIONS REGARDING THEIR CARE

Competency Element 14.1

Protects and safeguards the interests and well-being of the patients /clients.

Competency Element 14.2

Recognises and respects patients'/clients' and carers' involvement in the planning and delivery of care.

Competency Element 14.3

Respect patients'/clients' rights to access information.

d) Professional

COMPETENCY UNIT 15 MAINTAINS COMPETENCE BY UNDERTAKING ACTIONS FOR PROFESSIONAL DEVELOPMENT AND EDUCATION

Competency Element 15.1

Applies evidence-based and/or best practice knowledge and technical skills.

Competency Element 15.2

Participates in and contributes to research.

Competency Element 15.3

Contributes to the education and professional development of others.

Competency Element 15.4

Takes steps to remedy any deficits in skill or personal knowledge.

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DOMAIN 3: LEADERSHIP AND NURSING MANAGEMENT

COMPETENCY UNIT 16 UNDERSTANDS THE PRINCIPLES OF CONTINUOUS QUALITY IMPROVEMENT (CQI), AND INCORPORATES THIS IN PRACTICE

Competency Element 16.1

Collects, analyses and utilises data about incidents and trends and implements remedial changes to improve care delivery.

Competency Element 16.2

Demonstrates an understanding of efficient resource utilisation and human resource management.

Competency Element 16.3

Uses the ability to think proactively, laterally and critically within a problem-solving context.

COMPETENCY UNIT 17 HOLDS AND COMMUNICATES A CLEAR VISION OF NURSING WITHIN THE HEALTH STRUCTURE IN WHICH SHE/HE WORKS

Competency Element 17.1

Promotes and maintains the professional role of the nurse.

Competency Element 17.2

Initiates and participates in dialogue about new initiatives and change processes in nursing and health care.

Competency Element 17.3

Demonstrates the ability to make appropriate management decisions.

Competency Element 17.4

Demonstrates the ability to think laterally and critically within a problem-solving context.
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Competency Element 17.5

Supports, collaborates and co-operates with colleagues.

COMPETENCY UNIT 18 PROVIDES A SAFE WORKING ENVIRONMENT

Competency Element 18.1

Demonstrates knowledge of relevant aspects of occupational health and safety legislation.

Competency Element 18.2

Recognises the need for rest and diversion activities to prevent burnout.

Competency Element 18.3

Manages workloads effectively.

Competency Element 18.4

Acts as a collaborative team member.

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Glossary of Terms

Many of the terms in this glossary have been adapted /copied from the glossary in the ICN Framework of Competencies for the Generalist Nurse 2003.

Accountability: The state of being answerable for one's decisions and actions. Accountability cannot be delegated (Hospital Authority of Hong Kong 1997 in ICN 2003).

Advocacy: Speaking on behalf of another, in circumstances where patients are unable to represent themselves, their needs, wishes, values and choices.

Appropriate: Matching the circumstances, meeting needs of the individual, groups or situation.

Attributes: Characteristics which underpin competent performance.

Carer: A person, paid or unpaid, who regularly helps another person, often a relative or a friend, with all forms of care required as a result of illness or disability. The term incorporates spouses, partners, parents, other relatives, guardians, and voluntary health carers who are not health professionals (ICN 2003).

Clinical Judgement: Those decisions made by nurses in interaction with individuals/ groups about: the type of data collected; evaluation of the data and derivation of meaning from that data; nursing actions that should be taken.

Code of Ethics: A collective statement of rules governing proper conduct/ standards of behaviour for one particular group, derived from parent principles of ethics.

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Common competency standard: Competency standards reflecting a commonality across the WPSEAR.

Competence: The combination of skills, knowledge, attitudes, values, and abilities that underpin effective performance in a professional/occupational area.

Competency: An attribute of a person which results in effective performance.

Competency Element: Represents a sub-function of the competency unit.

Competency Standards: Consists of competency units and competency elements.

Competency Unit: Represents a major function/functional area in the total competencies of a Registered Nurse in a nursing context representing a stand-alone function which can be performed by the individual.

Competent: The person has competence across all domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed.

Context: The setting /environment where competence can be demonstrated or applied, for example, hospital, residential, geographic location, community, school.

Delegation: Delegation is the conferring of authority to perform activities of care for a patient/client on an individual.

Domain: An organised cluster of competencies in nursing practice.

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Duty of care: The principle which underlies the concept of negligence. It is owed to patients/ clients and fellow employees. Its meaning reflects the degree of care and skill to be expected from the average, reasonable, ordinarily careful and competent practitioner of a particular class.

Ethical problem: A situation that requires ethical consideration or ethical decision making, or a conflict of moral values.

Ethics: The moral practices, beliefs, and standards of an individual/s and/ or a group.

Evidence-based assessment: An assessment based on evidence which justifies an assessment judgement.

Generalist Nurse: In some countries, the nurse, on entry to practice after successful completion of his/her country's initial education is called a Registered Nurse (RN), in others a Licensed Nurse or qualified nurse. The scope of preparation and practice enables the generalist nurse to have the capacity and authority to competently practice primary, secondary and tertiary health care in all settings (ICN 1986).

Health technology: An intervention used to promote health, prevent illness, diagnose or treat disease, provide rehabilitation or long term care.

Healthcare workers: Healthcare workers are those that assist in the delivery of healthcare.

Individual/Individuals: Refers to a person/ persons receiving nursing care.

Information technology: The broad subject concerned with all aspects of managing and processing information, especially within a large organisation or company (sited in ICN 2003).

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Multidisciplinary: Involves more than one discipline.

Mutual Recognition: Mutual recognition is a vehicle for regulatory co-operation, and it may be based on harmonisation, equivalence, or external criteria such as the host country's standards or other mutually agreed standards, or international standards. In a mutual recognition agreement, two or more parties agree to recognise and accept all, or selected aspects of each other's regulatory results because they are harmonised or judged to be equivalent, or because they satisfy other agreed upon external criteria. Results may include assessment outcomes, qualifications, standards, rules, titles, and quality assurance system standards. (Adapted from TACD, 2000)

Patient/ client: User(s) of health care services, whether healthy or sick (ICN, WHO 1999).

Plan of care: Written guidelines for care for the individual/ group to ensure continuity of care; contains the identified problems/needs/nursing diagnoses of the individual/ group, expected outcomes (goals), priorities and prescribed nursing interventions.

Professional Boundaries: Means the limit of a relationship between a nurse and an individual and any other significant other persons which facilitate safe and therapeutic practice and results in safe and effective caring practice.

Registered Nurse: A person licensed to practise nursing under the relevant state or country regulation.

Responsibility: The obligation that an individual assumes when undertaking to carry out a delegated function. The individual who authorises the delegated function retains accountability.

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Significant others: Those persons of whatever affinity/relationship to the patient/client, who play an important role in the life of that individual.

Standard/s: The term standards includes national policies, position statements, best practice standards, guidelines.

Supervision: Supervision incorporates the elements of direction, guidance, oversight and co-ordination of activities. The requirements for supervision of the enrolled nurse, either direct or indirect, may be specified in relevant state/territory legislation and/or policies.

Traditional Medicine or Healing Practices: The sum total of knowledge, skills practices based on the theories, beliefs and experiences indigenous to different cultures whether explicable or not, used in the maintenance of health as well as in the diagnosis, improvement or treatment of physical and mental illness (WHO).

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Evaluation and Review

Nurses in the Western Pacific and South East Asian region acknowledge that the Common Competencies will be further developed as the role of the nurse changes. The WPSEAR Common Competencies will be reviewed under the auspices of the WPSEAR meetings and as determined by that meeting. .

Comments concerning the competencies should be forwarded to:

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ANNEX 8

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