Subject: FW: Recency of practice

To whom it may concern:

I have emailed, as I found the online survey insufficient to be able to detail my concerns in relation to the proposed recency of practice standards as they relate to nurse practitioners.

The proposed recency standards are inequitable for nurse practitioners, limit nurse practitioners' job opportunities and limit the professions' ability to utilise the clinical expertise of nurse practitioners. The systems in our public and private healthcare services are not designed at present to support nurse practitioners to have dual roles in leadership/management and clinical. Likewise, our academic positions are rarely designed to support a dual clinical and academic position.

Nurse practitioners are our most skilled and advanced clinical nurses and we need to encourage them to bring this expertise to leadership positions within nursing and healthcare more broadly. The proposed requirement for nurse practitioners to have direct clinical practice to maintain recency places unnecessary restrictions on this cohort of nurses. There are many barriers, particularly in the public health systems, that prevent nurse practitioners from holding leadership positions and maintaining direct clinical practice – this forces the nurse practitioner to choose between leadership and clinical work, rather than having the ability to bring their skills to a leadership role.

It would appear that if a nurse practitioner took a leadership, managerial or academic role which did not involve direct clinical care, that they would not be able to return to a nurse practitioner role after 5 years. Does this mean that they would lose their endorsement and have to do their entire master's again? There are no bridging courses at present that would support a return to clinical practice.

As described in the change of practice context section, it should be the nurse practitioner and employer's responsibility to ensure that they have adequate clinical skills to fulfil a clinical role if they chose to return to one and that they should not have to repeat their base qualification or a nurse practitioner master's degree.

There is a different standard being applied to nurse practitioners than to registered nurses, midwives or registered nurses with endorsement for scheduled medicines. Every category of nurse or midwife is required to maintain adequate connection to the profession, and it is on the professional with a changing context (non-clinical to clinical) to ensure that they are safe and competent to practice in that context. The proposal is that nurse practitioners be held to a different standard, having to demonstrate direct clinical contact, despite any other connection they may have to the profession, and that the nurse practitioner, as a professional does not have the ability to assess whether they are safe and competent to practice in a clinical role. This situation applies to nurse practitioners who are academics, managers, leaders or business owners where their duties take them away from direct clinical practice.

I believe that the requirement for direct clinical practice for nurse practitioners to maintain recency will be detrimental to nursing more broadly, will further isolate nurse practitioners from decision making and leadership within nursing and reduce the influence of nursing on the broader healthcare agenda.

I would appreciate feedback following your consideration of the points raised in this email.

Kind regards

Lee