Subject: FW: Recency of practice

Hi NMBA

I am a nationally recognised endorsed NP, in a higher leadership position, who has mapped out an NP practice competency, that meets ongoing recency of practice requirements for NP endorsement. This is a positive way forward, in recognising and supporting the value of an NP endorsement in the broader nursing profession, not just aligning it to purely full-time NP clinical activity. I have been asked to input into the current NMBA NP recency of practice consultation from a number of professional organisations and government bodies. I am not confident however, that my input has been documented amongst the various group's competing interests.

I acknowledge the early-career NP requirements, and the work around better defining how many years post endorsement, must NP practice commence (similar to an RN post initial registration prior to work timeframes). While there are slightly different aspects to consider, this needs to be better defined. But in that light particular to NP endorsement, should an early career NP not gain employment during the prescribed period, the profession also needs to have a mechanism for NP supervision for re-entry into practice (something that doesn't exist at the moment).

As one of the few endorsed NPs in the country in a designated senior nursing leadership role, recency of practice throughout an NP's career is of significant interest to me. But also, I provide a lens of practicality within the broader system, while acknowledging the value of the title. Just to note, it has only been just over 12 months since I was in a full-time NP role, so my thoughts and suggestions are about future proofing the profession, as opposed to any personal gain.

I would not be able to lead and drive the advanced practice nursing agenda for nurse practitioners, unless I was an NP myself. Having an understanding of the depth of the role and potential, as well as a lived experience of actively practicing as an NP, makes me substantially qualified and informed on how we can influence and innovate the system for more nurse-led positive outcomes and move our profession's credibility and value forward. My current leadership role includes working with my fellow nursing leaders, to assist their understanding of the actual and potential of advanced practice nursing roles including nurse practitioners, as well as aligning this potential to the health system's priorities. I agree that I do not see and treat patients full-time as the primary function of my role anymore, but my lack of full-time primary contact clinical care delivery, should not necessarily lead to my recognition as an NP being dissolved either.

Over the last 20 years, the NP unfortunately has been labelled in a somewhat parallel hierarchy by many of our nursing leaders, cutting off the growth potential for our professional career advancement. The NP role however, is the peak advanced practice role of nursing, and it should not be considered an outcast of our profession. While an NP goes through the multi-year learning and development NP journey to become endorsed and practice clinically, a clinical only capacity is not necessarily where their ambitions are for the rest of their career. We don't want to regulate becoming an NP, to the level that it impedes the professional growth opportunities in nursing. While I have had somewhat success in being recognised for leadership beyond my NP role, the proposed focus on only clinical activity for NP recency of practice, would negatively impact this growth potential more broadly and more long term. There are elements of this current NMBA consultation impacting NP regulation, that are not dissimilar to parts of the journey of the midwife. A registered midwife in a higher leadership role, may no longer deliver babies or provide direct clinical care, but the loss of the midwife title would be to the detriment of their midwifery identity and credibility.

There are a couple of us in the health sector across the country in leadership roles, who currently bring the skills and expertise of an NP to a higher level in the system. This number will only increase over time with the right regulation and level playing field with the rest of nursing, which is why it is so important that we get it right. I don't believe the opinion of one nursing union branch who stated "..we'll just mandate NP clinical time for higher nurse leaders

through the Enterprise Agreement process..” as an appropriate method of regulation for inclusion of direct clinical care. We may need to consider moving towards a US model, whereby the NP title is maintained, and a separate board-certified practicing certificate is issued per annum. I don’t believe that the NP is only a clinical role and therefore recency of practice needs to be contemporary and should align to the broader registered nurse’s definition for title recognition.

Recency of practice is defined by NMBA as: *“…means that the nurse/midwife has maintained an adequate connection with and recent practice in the profession… practice means any role where individual uses their skills and knowledge as a health practitioner in their profession… practice is not restricted to direct clinical care… also includes working in management, admin, education, research, advisory, regulatory or policy roles that impact the delivery of services in the profession… clinical practice is providing direct clinical care or oversight of direct clinical care such as clinical education… minimum hours of practice is 450hrs per 5 years to maintain endorsement*.”

The success of our future NP workforce, is with mentoring from our existing senior NPs, some of these being in non-NP roles (or will be in the future). Clinical mentoring is captured under the above NMBA definition of recency of practice, “…*oversight of direct clinical care such as clinical education*...”. The credibility, wisdom and mentoring that a senior NP can deliver, is no longer relevant if they do not still have connection to the title of NP. A senior NP no longer in a pure NP specialist role, can safely maintain competency as an NP generalist and recency of practice, under the clinical mentor NP model of care.

So my recommendation for this body of work you propose on better defining NP recency of practice, is that all NPs are assessed for “adequate connection with and recent practice in the NP profession (including working in management, admin, education, research, advisory, regulatory or policy roles that impact the delivery of services), where an NP if not providing direct clinical care, has continued input into the mentoring and direct supervision of junior NPs and NP students providing direct care on a regular basis (at a minimum of 450hrs/5yrs)”.

I would be delighted to be part of further discussions on this topic.

Chris