COUNTIES MANUKAU HEALTH

Professional Development and Recognition Programme

Assessor's Manual

Prepared: *Counties Manukau District Health Board*

Contents

Introduction

The PDRP assessors' manual must be read in conjunction with the PDRP manual.

To become a Portfolio Assessor:

The skills and or qualifications required to be a portfolio assessor are as follows:

- a registered nurse with a current annual practicing certificate,
- be compliant with PDRP,
- the ability to assess portfolios from outside own area of practice,
- participate in a moderation workshop every year.

AND have completed at least one of the following:

- undertake and successfully completed a Preceptor programme which includes education on assessment,
- postgraduate study in adult education.

AND:

- successfully complete the CM Health PDRP Assessor programme or equivalent.

Assessment Principles

"A systematic procedure for collecting qualitative and quantitative data to describe process and ascertain deviations form expected outcomes and achievements" (NCNZ, 2011, p12).

Assessment of portfolios is undertaken to ensure that established standards are met (see table one below). The Health Practitioners Competence Assurance Act (HPCA Act) 2003 ensures patient safety by providing mechanisms to ensure the lifelong competence of health practitioners. NCNZ has developed sets of competencies for enrolled nurses, registered nurses and nurse practitioners. All nurses must demonstrate that they meet the competencies every 3 years.

Table 1 Assessment Principles:

Fairness	The assessment procedure must give all nurses the same chance of achieving the desired outcome. Is the assessor only assessing the evidence in the portfolio?
Openness	All parties involved in the assessment must be fully informed of all aspects; the content, the standard and the conditions under which the assessment takes place. The nurse needs to know: • what is to be assessed? • how will that information be gathered? • how will the judgements be made? • who will be doing the assessment?
Validity	The assessment tool has to be fit for purpose i.e. is it assessing what it is designed to assess?
Sufficiency	Is there enough evidence to make a sound judgement about the competence of the nurse?
Reliability	Is the judgment made consistent with the assessment criteria? Is it applied consistently across all portfolios? Objectively is the key to this process.
Authentic	Assessors must take care to ensure that any work submitted is the nurse's own.

Principles for assessing the practice of other nurses against the NCNZ competencies (NCNZ, 2011)

(Adapted from Australian Nursing Council (2002) *Principles for the Assessment of National Competency Standards for Registered and Enrolled Nurses*.)

As with all activities in practice, assessments should be undertaken only by those who understand the requirements of the activity. Each competency requires an example or evidence of an action or knowledge by the nurse being assessed which illustrates one or more of the indicators. Throughout New Zealand training is available in assessment for nurses who need to develop their understanding of the nature of workplace assessment.

Although the principles of assessment are the same, the complexity and nature of evidence and the professional assessment judgement required may be expressed differently in different clinical

settings and with nurses with different career trajectories. For example, a nurse who regularly assesses students at the end of the same degree programme will become very familiar with the competency outcomes in the same setting. However, when assessing an experienced new employee with a background unfamiliar to the assessor, development of the assessor's skills and processes may also be required.

Nurses involved in assessment (both the assessor and the nurse being assessed) are always governed by the ethical standards of their profession.

The following self-review questions are designed to assist an assessor in understanding the ethical principles involved and how they may be assured they have undertaken an ethical, rigorous and fair competence assessment of a colleague or employee.

1. Contextual assessment
    - What is the setting (e.g. the name and nature of the ward or clinic)?
    - What does the competency mean in relation to the nurse's practice setting?
    - Does the assessor have sufficient knowledge and understanding of the setting, the NCNZ competencies and indicators to make a judgement about another's practice?

2. Ethical assessment
    - Does the assessor have sufficient understanding to use a range of professional assessment practices?
    - Is there mutual respect, honesty, rigour and trust in the assessment and documented feedback process?
    - Does the assessor reflect on the ethical implications of the assessment?
    - What organisational support is available to assist those nurse undertaking assessments?

3. Accountability.
    - Does the assessor:
        - maintain confidentiality and disclose only through appropriate channels?
        - declare any conflict of interest?
        - report in a timely fashion and maintain standards of documentation?
        - engage in quality improvement of their own performance as an assessor?
        - provide feedback according to best professional practice?

4. Validity and reliability of assessment
    - Does the assessment actually measure what is intended? Does the assessment process measure the nurse against the NCNZ competencies?
    - Does the assessor have an understanding of the intended outcomes of the competencies and the indicators in the context/s in which the nurse is practising?
    - Is the assessment consistently applied across the whole process?
    - Would another assessor predict the same results for the same behaviours, knowledge, skills and attitudes/attributes?

5. Evidence-based assessment
    - Does the assessor have sufficient evidence?
    - Is there a variety of data sources? For example, observation of actions or documentation, interviewing, attestation by reliable informants, and/or testing(either paper-based or in simulation).

- Are any inferences checked to validate the assessment judgement?
- Is there enough evidence over a sufficient timeframe to predict that the person being assessed will perform the same way in similar situations and context?

Competence:
Definition: *"the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse"* (NCNZ, 2011, p 12)

Competence can also be defined as:

- The person can perform the task to the standard or criteria required.
- The person can repeat the performance several times to the same standard each time- it is not just a one-off.
- The person can perform the task in the expected environment.

Underpinning knowledge is an important part of competence. A person is competent not only when the can demonstrate a skill but also when they can explain what they are doing and why.

When reviewing a portfolio:
The evidence needs to:

- Demonstrate currency and contemporary practice
- Contain a reflective or evaluative component
- Meet standards/competency identified
- Be validate by others
- Be accumulated over time and in a range of circumstances
- Be presented in a professional manner

Evidence required in the portfolio. (Table 2 below):

Table 2 Evidence required in a portfolio

Evidence	Requirements
Evidence of Cultural Safety	• This must be evident in the evidence presented. It is important to remember cultural safety's wide definition. For further information see Appendix II.
Evidence of TiKanga Best Practice	• Refer to the Tikanga Responsiveness Guidelines for PDRP • Are the Maaori Core Values evident?
Education/ professional development	• Number of hours- 60 hours within last 3 years. • Evidence of mandatory training every year. • Must demonstrate reflection on or describe the difference it has made to clinical practice. • Must be verified by line manager. • Journal reading may be considered a professional development activity if it takes place within a formal framework such as a journal club, a presentation to colleagues, or to inform an educational or quality improvement process. Meetings may be considered a professional development activity if they have an

	educational focus and include appropriate documentation (for example, minutes that clearly identify the education topic).
Practice Hours	• Must have a minimum of 450 hours or 60 days over 3 years. • Must be noted as hours or days not FTE. • Must be verified by line manager.
Presentation	• Must appear professional. • In a folder. • No loose pages, not in an envelope.
Level of practice	• Refer to the nationally agreed level of practice guidelines (appendix III). • Must have an application form that is signed by the line manager. • All criteria must be evident throughout the portfolio especially in the competencies self-assessment. • If the portfolio does not demonstrate proficient, expert/accomplished or senior level either the applicant can resubmit updated competencies that do demonstrate the criteria or they can submit an additional piece of evidence- see Appendix VI.
Writing styles	• This is not an academic exercise. This is the nurse demonstrating his/her level of practice. • Do not mark grammar and/or spelling. However you can comment if this is an issue- especially in the verbal feedback. • If the portfolio is not quite at the standard, then you can have a conversation to "fill" in the gaps. You just need to ensure that you document well in your assessment memo. • If there are wide gaps then it is acceptable to ask the applicant to resubmit.
Referencing	• Again this is not an academic paper. We do not expect APA referencing. • It is okay to use policies, procedures, protocols or guidelines as references. • There is no minimum or maximum number of references required.
Plagiarism	• Not acceptable. Other peoples must be acknowledged. • All work must be the nurse's own original work. • References must be provided for any copied work – including material from the World Wide Web. • Failure to acknowledge copied work will be investigated and depending upon the extent and significance, may result in a request for resubmission of all or part of the portfolio. • In extreme case of proven dishonesty, the NCNZ may be notified that the requirements for the portfolio have been met. Additionally a performance management process

	maybe initiated and disciplinary action taken for unacceptable behaviour or falsifying records. • If you as the assessor believe there is evidence supporting plagiarism please contact the Post Registration/PDRP Lead or CND/Nurse Leader.
Confidentially	• Do not name the organisation, colleagues, patients or their family/whaanau. • Remember that people can still be identified by dates, locations, specific operations etc.
Criticism	• No criticism of patients, colleagues and the organisation is permitted. This is a professional portfolio.
Performance reviews	• If the applicant's line manager has not completed a performance review then this is outside to the nurse's control generally. Therefore do not hold the portfolio back but talk to the line manager or escalate to the CND of the area.
Postgraduate education or equivalency (expert [Level 4] only)	• Has the applicant done and postgraduate education? If not then does the portfolio demonstrate the following: • *"The applicant is required to demonstrate within their portfolio the integration of the nursing knowledge at level 8 into their nursing practice. Evidence should include: post-registration and education relevant to current area of practice which impacts on practice at expert level; changes in attitudes and skills which have occurred as a result of this; demonstration of expert practice, critical analysis and reflection consistently in nursing practice and evidence throughout portfolio evidence."* (PDRP Evidential Requirements Working Party Final report, (2009) page 10).

Assessment Process

Assessment of portfolios should not take more than 8 weeks from submission of the portfolio. Occasionally there may be some exceptional circumstances which may delay the process. In these cases it is important the applicant be notified about any delays.

RN and EN portfolios will be assessed by trained assessors. The assessor may not work in the same clinical area. All expert (level 4) portfolios are to be moderated by the Clinical Nurse Director/Nurse Leader.

All CM Health senior nurse portfolios will be assessed by the Clinical Nurse Director of the area unless the CND requests another senior assessor to undertake the portfolio assessor.

CM Health PDRP extended programmes will advise CM Health who the assessor(s) for the area will be so that they can attend a portfolio assessor workshop. A moderation process will be developed.

PDRP allowances are back dated to the date of the last successful application/submission date. Portfolio due dates do not change unless under extenuating circumstances.

Once the assessment process has begun the process will be completed by the primary assessor unless an alternative is agreed by the Post Registration/PDRP Lead or CND.

When the applicant is approved as competent and safe to practice and for the level of practice applied for at the time of assessment, the assessor shall not be accountable when the participant does not maintain these requirements.

Assessment process

Table 3 lists the process required to undertake when assessing a portfolio.

Table 3 Portfolio assessment process

<table>
<tr><td colspan="2">1. The applicant submits their completed portfolio to the assessor- it may not be an assessor from own area.
2. The assessor checks that all the evidence is present (if not returned to applicant).
3. The assessor enters the submission date into One Staff™
4. The assessor reviews all the evidence in the portfolio and reviews it to see if the evidence meets criteria</td></tr>
<tr><td>Portfolio meets the level required
5. A PDRP assessment memo is completed in accordance with CM Health requirements.
6. One Staff™ is updated with approval date and next submission due date.
7. Portfolio is returned to applicant.
8. Verbal and written feedback provided. The assessor sends a copy of the assessment memo to HR for filing.</td><td>Portfolio does not meet level required
a) A PDRP assessment memo is completed in accordance with CM Health requirements, clearly indicating the areas that required further development.
b) Portfolio is returned to applicant.
c) Verbal and written feedback provided.
d) A resubmission date is negotiated. Assessor updates One Staff™ with the agreed submission date.
e) Applicant updates portfolio to meet the required standards according to feedback.
f) Applicant resubmits portfolio by due resubmission date.
g) Assessor re-assesses portfolio.

Portfolio meets criteria- return to step 4</td></tr>
<tr><td></td><td>Resubmitted Portfolio does not meet criteria

• Application is declined.
• If application is for proficient or expert/accomplished level then the previous level will be maintained.
• If applicant does not demonstrate practice at a competent level then the line manager will be informed and performance management processes will be undertaken as per the HR discipline and dismissal policy
• The assessor sends a copy of the assessment memos to HR for filing.</td></tr>
</table>

One Staff™ Data Management

Data Management

All data relating to the PDRP is the responsibility of and entered into *One-Staff™* by the line manager or appropriate delegate and is completed as below:

Data entry requirements:

Event	Action required
Performance review	Date of performance review in Controller User fields. Level of practice (Skill & Job Class) confirmed in Controller User fields. PDRP due date confirmed in Personnel User fields. Check all Controller fields.
Portfolio submitted	Enter date of submission in Personnel User fields.
Portfolio returned	New Portfolio due date, pathway and level recorded in Personnel User fields and assessment date. Eligibility for PDRP allowance confirmed in Personnel User fields.
PDRP Allowance	Change request completed by line manager.
Portfolio approval	Date portfolio successfully assessed.

Table 3 below how the PDRP data is to be recorded in OneStaff.

Table 3 Accepted OneStaff™ entries

PDRP Path:	EN COMPETENT EN PROFICIENT EN ACCOMPLISHED RN COMPETENT RN PROFICIENT RN EXPERT RN SENIOR
Pfolio due:	Date full portfolio is due.
Pfolio Sub:	Date full portfolio is submitted.
PDRP allow:	YES for proficient/expert/accomplished, NO for competent and senior.
Pfol aprov:	Date portfolio is approved - this is the date NCNZ requires. If the portfolio approval date is more than three years, then NCNZ might request the nurse to undertake a recertification audit.
Resub due:	Date that portfolio is to be resubmitted by.

It is imperative that timely and correct data is recorded in One Staff™ for the quarterly NCNZ PDRP report, to monitor ongoing compliance, to determine PDRP compliance percentages for the Director of Nursing report and to ensure that the nurses receiving payment for proficient and expert levels remain compliant.

Moderation Process

The PDRP moderation process is designed to:

- ensure fair and equitable process across the DHB
- provide objectivity of assessment where there is complexity or uncertainty that the portfolio meets the requirements of the PDRP
- support assessors and
- verify new assessments skills and recommendations

New assessors are allocated advisors/moderators to verify their assessment skills and to provide guidance and support. If the assessor and the moderator do not agree with the assessment and they are unable to come to an agreement then the portfolio is sent to the Post Registration/PDRP Lead for assessment.

If assessments of portfolios are undertaken in a group/workshop environment, moderation will be undertaken at the same time. When this does not occur, then 1:8 portfolios are to be moderated. All assessors are to attend one moderation workshop per year (minimum).

CM Health will participate in external moderation as able and requested.

Appeals Process

An appeal may be initiated by an applicant at any time during the assessment process by contacting the Post registration/PDRP Lead in writing and supplying 3 copies of the disputed portfolio or an electronic version (table 4 below outlines the appeals process). Each appeal will be managed on a case by case basis. Necessary and appropriate will be undertaken to resolve the issue/s.

A panel of representatives from the PDRP Governance committee will review the portfolio and make a decision. The final decision for any unresolved conflict rests with the Director of Nursing.

Table 4 Appeals Process

Written appeal with 1 electronic version or 3 hard copies of portfolio, including assessment memos lodged with the Post Registration/PDRP Lead
↓
Letter sent to person appealing process and the assessors involved stating the appeal has been lodged-by Post Registration/PDRP Lead
↓
PDRP Coordinator notifies Appeal Panel* Members and all review portfolio (2 weeks)
↓
Panel convenes and discusses portfolio and makes decision (2 weeks)
↓
Applicant is informed in writing of progress /outcome of appeal
↓
Unresolved appeals relating to the assessment of the portfolio is referred to the DoN.

* Panel will be comprised of members of the PDRP steering committee and the NZNO Professional Nurse Advisor.

References

National Framework for Nursing Professional Development & Recognition Programmes and Designated Role Titles Working Party. (2005*). Report to the National Nursing Organisations from the National Professional Development & Recognition Programmes working party*. New Zealand. Author.

Nursing Council of New Zealand. (2010). *Guideline: Expanded practice for registered nurses,* Wellington , New Zealand. Author.

Nursing Council of New Zealand, (2012). *Competencies for registered nurses*. Wellington, New Zealand. Author.

Nursing Council of New Zealand. (2012). *Competencies for enrolled nurses*. Wellington, New Zealand. Author.

Nursing Council of New Zealand. (2013). *Framework for the approval of professional development and recognition programmes to meet the continuing competence requirements for nurses*. Wellington, New Zealand. Author.

Nursing Council of New Zealand. (2011). *Guidelines for competence assessment*. Wellington, New Zealand. Author.

Appendix I NCNZ Treaty of Waitangi

"The articles of the Treaty of Waitangi contain the principles of kawanatanga (the governance principles that recognises the right of the Crown to govern and makes laws for the common good) and tino rangatiratanga (which allows Maaori self-determination). The principles of the Treaty of Waitangi form the basis of interactions between nurses and Maaori consumers of the services they provide.

Principle One:
Tino rangatiratanga enables Maaori self-determination over health, recognises the right to manage Maaori interests and affirms the right to development, by:

1.1. enabling Maaori autonomy and authority over health.
1.2. accepting Maaori ownership and control over knowledge, language and customs and recognising these as toanga.
1.3. facilitating Maaori to define knowledge and worldviews and transmit these in their own way.
1.4. facilitating Maaori independence over thoughts and action, policy and delivery, and content and outcome as essential activities for self- management and self-control.

Principle Two:

Partnership involves nurse working together with Maaori with the mutual aim of improving health outcomes for Maaori by:

2.1 acting in good faith as Treaty of Waitangi partners.
2.2 working together with an agreed common purpose, interest and cooperation to achieve positive health outcomes.
2.3 Not acting in isolation or unilaterally in the assessment, decision making and planning of services and service delivery.
2.4 ensuring that the integrity and wellbeing of both partners is preserved.

Principle Three:

The nursing workforce recognises that health is a toanga and acts to protect it by:

3.1. recognising that Maaori health is worthy of protection in order to achieve positive health outcomes and improvement in health status.
3.2. ensuring that health services and diverse are appropriate and acceptable to individuals and their families and are underpinned by the recognition that Maaori are a diverse population.
3.3. facilitating wellbeing by acknowledging beliefs and practices held by Maaori.
3.4. promoting a responsive and supportive environment.

Principle Four:
The nursing workforce recognises the citizen rights of Maaori and the rights to equitable access and participation in health services and delivery at all levels.

4.1. facilitating the same access and opportunities for Maaori as there are for non- Maaori
4.2. pursuing equality in health outcomes."
(NCNZ, 2011, page 12-14)

Appendix II NCNZ Cultural Safety

Definition:
"The effective nursing practice of a person or family form another culture, and is determined by that person or family. Culture includes , but is not restricted to, age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual. (NCNZ, 2011, page 7-10)

Cultural Safety Principles
Cultural safety is underpinned by communication, recognition of the diversity of the worldviews (both within and between cultural groups). And the impact colonisation processes on minority groups. Cultural safety is an outcome of nursing education that enables a safe, appropriate and acceptable service that has been defined by those who receive it.

Principle One:
Cultural safety aims to improve the health status of New Zealanders and applies to all relationships through:

1.1. An emphasis on health gains and positive health outcomes
1.2. Nurse acknowledging the beliefs and practices of those who differ from them. For example, this may be by:
- Age or generation
- Gender
- Sexual orientation
- Occupation and socioeconomic status
- Ethnic origin or migrant experience
- Religious or spiritual belief
- Disability.

Principle Two:
Cultural safety aims to enhance the delivery of health and disability services through a culturally safe nursing workforce by:

2.1 Identifying the power relationship between the service provider and the people who use the service. The nurse accepts and works alongside others after undergoing a careful process of institutional and personal analysis of power relationships.
2.2. Empowering the users of the service. People should be able to express degrees of perceived risk or safety. For example, someone who fells unsafe may not be able to take full advantage of a primary health care service offered and may subsequently require expensive and possibly dramatic secondary or tertiary intervention.
2.3. Preparing nurses to understand the diversity within their own cultural reality and the impact of that on any person who differs in any way from themselves.

2.4. Applying social science concepts that underpin the art of nursing practice. Nursing practice is more that carrying needs in a way that the people who use the service can define as safe.

Principle Three:
Cultural Safety is broad in its application:

3.1. Recognising inequalities with health care interactions that represent the microcosm of inequalities in health that have prevailed throughout history and within our nation more generally.
3.2 addressing the cause and effect relationship of history, political, social, and employment status, housing, education, gender and personal experience upon people who use nursing services.
3.3. accepting the legitimacy of difference and diversity in human behaviour and social structure.
3.4. accepting that the attitudes and beliefs, policies and practices of health and disability service providers can act as barriers to service areas.
3.5. concerning quality improvement in service and consumer rights.

Principle Four:
Cultural safety has a close focus on:

4.1. understanding the impact of the nurse as a bearer of his/her own culture, history, attitudes and life experiences and the response other people make to these factors.
4.2. challenging nurses to examine their practice carefully, recognising the power relationship in nursing is biased toward the provider of the health and disability service.
4.3. balancing the power relationships in the practice of nursing so that every consumer receives an effective service.
4.4. preparing nurses to resolve any tension between the cultures of nursing and the people using the services.
4.5. understanding that such power imbalances can be examined, negotiated and changed to provide equitable, effective, efficient and acceptable service delivery, which minimises risk to people who might otherwise be alienated from the service.

An understanding of self, the rights of others and legitimacy of difference should provide the nurse with the skills to work all people who are different from them.

Appendix III Nationally Agreed Levels of Practice Definitions:

Table 3 below contains the Enrolled Nurse level of practice.

Table 3 Enrolled Nurse (Generic pathway) level of practice

(The term client means patient, client, family, whanau, community)

Competent (Level 2)	Proficient (Level 3)	Accomplished (level 4)
Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe. Under the direction of the Registered Nurse, contributes to assessment, planning, delivery and evaluation of nursing care. Applies knowledge and skills to practice. Has developed experiential knowledge and incorporates evidence-based nursing. Is confident in familiar situations. Is able to manage and priorities assigned client care/workload appropriately. Demonstrates increasing efficiency and effectiveness in practice. Responds appropriately in emergency situations.	Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines culturally safe. Has an in-depth understanding of Enrolled Nurse practice. Utilises broad experiential knowledge and evidence-based knowledge to provide care. Contributes to the education of Enrolled Nursing students, new graduate Enrolled Nurses, care givers/healthcare assistants, competent and proficient Enrolled Nurses. Acts as a role model and leader to their peers. Demonstrates increased knowledge and skills in a specific clinical area. Is involved in service, professional or organisational activities. Participates in change.	Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines culturally safe. Demonstrates advancing knowledge and skills in a specific clinical area within the Enrolled Nurse scope. Contributes to the management of changing workloads. Gains support and respect of the health care team through sharing of knowledge and making a demonstrated positive contribution. Undertakes any additional responsibility within a clinical/quality team, e.g. resource nurse, health and safety representative, etc. Actively promotes understanding of legal and ethical issues. Contributes to quality improvements and change in practice initiatives. Acts as a role model and contributes to leadership activities.

Table 4 below contains the Registered Nurse level of practice

Table 4 Registered Nurse (Generic pathway) level of practice

(The term client means patient, client, family, whanau, community)

Competent (Level 2)	Proficient (Level 3)	Expert (Level 4)
Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe. Effectively applies knowledge and skills to practice. Has consolidated nursing knowledge in their practice setting. Has developed a holistic overview of the client. Is confident in familiar situations. Is able to manage and prioritise assigned client care/workload. Demonstrates increasing efficiency and effectiveness in practice. Is able to anticipate a likely outcome for the client with predictable health needs. Is able to identify unpredictable situations, act appropriately and make appropriate referrals.	Participates in changes in the practice setting that recognise and integrate the principals of Te Tiriti o Waitangi and cultural safety. Has a holistic overview of the client and practice context. Demonstrates autonomous and collaborative evidence based practice. Acts as a role model and a resource person for other nurses and health practitioners. Actively contributes to clinical learning for colleagues. Demonstrates leadership in the health care team. Participates in changes in the practice setting. Participates in quality improvements in the practice setting. Demonstrates in-depth understanding of the complex factors that contribute to client health outcomes.	Guides others to apply the principals of Te Tiriti o Waitangi and to implement culturally safe practice to clients. Engages in Post Graduate level education (or equivalent)[1]. Contributes to speciality knowledge. Acts as a role model and leader. Demonstrates innovative practice. Is responsible for clinical learning/development of colleagues. Initiates and guides quality improvement activities. Initiates and guides changes in the practice setting. Is recognised as an expert in her/his area of practice. Influences at a service, professional or organisational level. Acts as an advocate in the promotion of nursing in the health care team.

[1] *"The applicant is required to demonstrate within their portfolio the integration of the nursing knowledge at level 8 into their nursing practice. Evidence should include: post- registration and education relevant to current area of practice which impacts on practice at expert level; changes in attitudes and skills which have occurred as a result of this; demonstration of expert practice, critical analysis and reflection consistently in nursing practice and evidence throughout portfolio evidence."* (PDRP Evidential Requirements Working Party Final report, (2009) page 10.

		Delivers quality client care in unpredictable challenging situations. Is involved in resource decision making/strategic planning. Acts as leader for nursing work unit/facility.

Reference: National Framework for Nursing Professional Development & Recognition Programmes and Designated Role Titles. (2005) Report to the National Nursing Organisations from the National Professional Development & Recognition Programmes Working Party. New Zealand.

Appendix VI Additional evidence

Proficient, expert and accomplished nurses can provide additional pieces of evidence (table 5 below) to demonstrate their level of practice if they are unable to demonstrate the level of practice in the NCNZ competencies.

Table 5 Additional evidence suggestions

Additional pieces of evidence for proficient and expert/accomplished only if level not demonstrated in portfolio	Additional evidence may include one piece of evidence from the following list. Evidence: • demonstrates involvement in practice change or quality initiative (EN/RN Proficient [Level]/Expert [Level 4], EN Accomplished [Level 4]) • of teaching or preceptoring or supporting a skill development of colleagues (RN Proficient [Level 3]) • illustrating ability to manage and coordinate care processes for patients with complex needs (RN proficient [Level 4]) • showing in-depth understanding of patient and care coordination within scope of practice (EN Proficient [Level 4]) • demonstrating contribution to speciality knowledge or innovation in practice and the change process in quality improvement activities (RN Expert [Level 4],) • describing and reflecting on responsibility or learning and/or development of colleagues (RN expert [Level 4]) • showing engagement and influence in wider service, professional or organisational activities. Advocacy for nursing needs to be shown (RN Expert [Level 4]) • showing expert knowledge and application of expert practice to care of the complex patient and clinical leadership in care coordination (RN Expert [Level 4]) • showing engagement and influence in professional activities (EN Accomplished [Level 4]) • showing in depth understanding of patient care and care coordination as within scope of practice, and the ability to identify changes in patient health status and action this appropriately (EN Accomplished [Level 4]).

Appendix V Tikanga Responsiveness

Guidelines for Professional Development and Recognition Programme

To promote a seamless Continuous Quality Improvement (CQI) approach in cultural responsiveness to facilitate best practice for all CMDHB staff. To implement Maaori Core Values (table 6 lists the Maaori Core Values) and Maaori Quality Standards (table 5 lists the Maaori Quality Standards) within service delivery.

Table 6 Maaori Quality Standards

TE KAUPAPA PAEREWA – Maaori Quality Standards
Te Kaupapa Paerewa (Maaori Quality Standards – MQS) includes four standards which are designed to assess and measure cultural responsiveness in the workplace. Te Tutakitanga *(Encounter and Engagement)* and Te Mahitahi *(Working Together)* CMDHB staff are able to greet and engage patients/clients, whaanau and other health professionals in a culturally responsive manner. All mediums of encounters are inclusive of contacts (face to face and verbal – phone) and non-contact (letter, email) applications. Te Poroporoaki *(Disengagement)* and Te Whai Mana Painga *(Empowerment)* CMDHB staff are able to disengage/discharge and transition patients/clients, whanau and other health professionals in a culturally responsive manner. All mediums of communication are applied.

Table 7 Maaori Core Values

MAAORI CORE VALUES	
Kaitiakitanga Guardian, Stewardship	• Exercising the responsibility that tangata whenua have to whaanau, hapu, and iwi and the environment. • Responsibility to care for selves and whaanau, hapu, iwi. • To encourage participation in healthy mental, spiritual, physical and family lifestyles. • The responsibility you have to your role & position e.g. how you care for your environment & resources (holistically). • The responsibility to look after a resource.

Mana Whenua Local People	• The responsibility to connect people to their uukaipoo (origin), tuurangawaewae (place where one has rights of residence and belonging through kinship), takiwaa (district) and rohe (Region). • Expressing the authority that whaanau, hapu and iwi have over their ancestral land and resources. • Whaanau, hapu, iwi determination of their health and wellbeing. • Understanding that CMDHB has a formal relationship with mana whenua and as so we work responsively with Maaori & all people in our care. • Authority and control within a defined land area.
Mana Tupuna/Whakapapa Ancestral, Genealogy	• Links to all things are maintained and protected. • Role of whaanau in decision-making as part of the informed consent process (if that is the wish of the patient). • Understanding that genealogy can be vital to the process of caring for whaanau. • Divine authority handed down through genealogy.
Te Reo Maaori Maaori Language	• Te Reo – the repository of maatauranga (knowledge) Maaori that sustains the people and the culture. • Requirement that DHB and PHO staff learn pronunciation of Te Reo Maaori and be given the opportunity to further learn the language as part of their job. • The Maaori language. Pronunciation of names and greetings in Te Reo Maaori, advantageous to healing.
Manaakitanga Caring, Nurturing	• The expression of affection, hospitality, generosity and mutual respect. • The sharing of knowledge and resources within the health sector. • The promotion of whaanau as a model for ensuring individuals and groups take responsibility for themselves and for each other. • Honour, respect and to give the best of your ability and available resources. • The responsibility to care for others.
Whanaungatanga Making Connections	• Affirming the relationships that tangata whenua (indigenous people of the land) and other people have to each other individually or at whaanau, hapu (subtribe), iwi (tribe) level through common whakapapa and reciprocal obligations inherent in whakapapa relationships. • Promoting activities that enhance and strengthen whaanau participation in healthcare. • Making links and relationships. • Rituals of encounter are consistent and welcome.

	• Relationship building -asking for advice e.g. calling in whaanau support when in need of assistance.
Wairuatanga Spiritual Aspect	• Connecting and maintaining the vitality of the relationships between tangata (people), whenua (land), atua (deity), and tupuna (ancestors). • Respecting other people's beliefs regardless of your own. Maaori still believe and practice in a metaphysical realm. • Spiritual aspect.
Rangatiratanga Leadership	• Self-determination of tangata whenua (indigenous people of the land) through mana atua, mana tupuna and mana whenua. • Self-determination underpins good health and wellbeing and the power to protect, define and decide on health matters. • Being responsible for yourself to give of your best to your role & being able to empower others to be responsible to the process of their healing.

NGA WHAKAATURANGA – Evidence

Demonstrate and implement the use of Maaori Core Values and Maaori Quality Standards in your daily practice. Provide sufficient evidence.

- Explain how you have implemented the Maaori Core values and the Maaori Quality Standards in your daily practice.

- Was the rationale for your work of cultural intervention identified?
  Example: Cultural competence
  Performance development

- Who was involved? Patient/client/whaanau/colleagues/other health professionals/other services.

- Were quality outcomes identified and achieved? If so, highlight the achievements, if not, why, and what would you do differently next time? Where would you seek advice or support?
  Example: Enhancement to patient care
  Changes in practice

- Have you clearly achieved cultural competence in your nursing actions?

- Give evidence of professional growth and or further education eg Tikanga in Practice, Health Disparities – Vulnerable Populations, Te Reo Maaori Course, Tikanga Course etc.

- Feedback on performance. - Patient, Whaanau & Peer.

How does your Reflection Exemplar contribute to recording evidence of change and or behavioural patterns? Consider client and whaanau perspectives of care. What feedback have you sought and received from peers?

Table 8 contains the Standards of Competence of the levels of practice.

Table 8 Standards of Competence

STANDARDS OF COMPETENCE		
Competent	Proficient	Expert
Tikanga Best Practice must be completed. It is expected that new staff complete in the first 6 months of employment (mandatory for new staff). Identifies gaps for further learning. Uses own initiative to seek appropriate support or learning from the TIP team. Records implementation process of Maaori core values and has documented the learning.	Tikanga Best Practice must be completed. Tikanga In Practice must be completed. Implement Maaori Core Values and Maaori Quality Standards into your daily practice. Utilises CMDHB health care services that are available to support Maaori clients e.g. Whaanau Support Workers, Hauora Workers, Kaumaatua, Interpreting Service, Chaplaincy Service. Is proficient in recording processes, highlighting achievements and necessary courses of action and change. Seeks to develop further learning through post graduate studies or other relevant study options.	Tikanga Best Practice must be completed. Tikanga In Practice must be completed. Implement Maaori Core Values and Maaori Quality Standards into daily practice. Demonstrates leadership qualities. Has a knowledge base of tikanga and te reo Maaori and is able to utilise it with clients and whaanau. Consults with Mana Whenua, POU and Te Kaahui Ora when developing health practices and services to enhance the health of Maaori. Contributes to policy making, credentialing, and standards of nurse care practice and or research that contributes to the health and well being of Maaori.

Appendix VI Portfolio assessment memo hints

Portfolio Assessment
Generic/Senior Pathway

Delete the non-relevant

Name of Nurse:	
Name of Assessor:	
Date Assessed:	
Level of practice applied for:	Competent Proficient Expert Accomplished Senior

Delete the non-relevant

Evidential Requirements	**Included**	**Assessor Comments**
Incorporation of principles of Treaty of Waitangi/Tikanga Best Practice Demonstrated	Met or Not met	Use of Maaori Core Values/ TiKanga Responsiveness Guidelines especially the Levels of practice- at least one Maaori Core Value per domain. How does the nurse demonstrate partnership, protection and participation?
Cultural Safety demonstrated	Met Not met	Encourage wider examples of culture not just race e.g. gender, age or generation, occupation and socioeconomic status, sexual orientation, ethnic or migrant experience, religious or spiritual beliefs and disability.
Performance Review/s	Met Not met	Do not penalise if performance review not done. Out of nurse's control.
Self-assessments against NCNZ competencies: Scope of practice • Examples of how competency is met in day to day practice • Reflects everyday practice • Demonstrates level of practice applied for	Met Not meet	Specific practice examples- if some competencies not complete outline what these are. If uncertain re clinical content consult the area educator. Level of practice must be evident. Do you see **all** the requirements of proficient or accomplished /expert in the portfolio Senior portfolios- is there evidence of leadership, coaching and mentoring, teaching & support staff, innovation in practice, QI activities etc. Discuss important points/themes- highlighting achievements Has the nurse discuss situations that might not demonstrate competent practice e.g. medication errors- get them to redo the competency. Is there criticism of colleagues etc.- get the nurse to resubmit the competency.
Senior nurse assessment NCNZ competencies: • Examples of how competency is met in day to day practice • Reflects everyday practice	Met Not met	As above. Ensure that the senior nurse has not copied the self-assessment comments and changed 'I' to the nurse's name. If the senior nurse comments are not specific enough, then it is okay to contact then directly.
Practice hours verified	Met	Put actual hours here. FTE not acceptable.

Refer to the National levels

(450 hours in 3 years)	Not met	Is the application form signed by the line manager? Have they worked more than 450 hours in the last 3 years?
Professional Development hours *(60 hours in 3 years)* • Demonstration of key learning point and application to practice • Includes mandatory training	Met Not met	Is the mandatory training done? Has the nurse described the key learning points? How have they applied it to practice? Is the application from signed by the line manager? Have they undertaken more than 60 hours in the last 3 years? Note: Postgraduate papers- each point the paper is worth equals 10 hours e.g. 15 points= 150 hours, 30 points= 300 hours, etc.
Evidence Based Practice Demonstrated	Met Not met	Have they used policies, procedures, protocols and guidelines? Senior nurse- involved in development of PPPGs. Acknowledging the work of others is required however no strict way to reference as long as it noted.
Endorsement letter • Reflects Level applied for *(Proficient and Expert only)*	Met Not met	Have they described how the nurse meets the level of practice- the person writing this should refer to the national levels?
Copy of Annual Practicing Certificate (both sides)	Met Not meet	A print out from the NCNZ website acceptable also.
Curriculum Vitae (senior/proficient/expert only – full portfolio or going up a level)	Met Not met	Format not an issue however you can discuss and suggest changes when you provide verbal feedback
20 Hours Professional Supervision *(New Graduate Mental Health only)*	Met Not met	
Presentation – presented in a folder, date, name included	Met Not met	Presented in a folder – do not accept if not presented in a professional manner.
Confidentiality – colleagues and clients confidentiality maintained	Met Not met	Have they included dates or place? Could the patient/family/whaanau or colleagues be identified at all?

Additional Comments:

Is there any plagiarism? Look at the last memo if you have it.

Assessor Name	
Assessor Signature	
Assessor Designation	
Date Portfolio submitted	Put date into One Staff as soon as possible after portfolio submitted
Date Portfolio Assessed	Should be within 2 months
Date resubmission due	Negotiate with applicant- usually 1 month
Date Portfolio Approved	Really important for NCNZ reports
Date Onestaff Updated	Accepted OneStaff™ entries PDRP Path: EN COMPETENT EN PROFICIENT EN ACCOMPLISHED RN COMPETENT RN PROFICIENT RN EXPERT RN SENIOR Pfolio due: date full portfolio is due. Pfolio Sub: date full portfolio is submitted. PDRP allow: YES for proficient /expert /accomplished, NO for competent & senior. Pfol aprov: date portfolio is approved- this is the date NCNZ want. If the approval date is more than three years, the NCNZ may request the nurse complete a recertification audit. Resub due: date that portfolio is to be resubmitted by.
Portfolio moderated	1:8 needs to be moderated. If assessed in a workshop type environment then that is moderation- just remember the memo. And attend one moderation workshop per year
Next full portfolio due date	Not to be changed unless exceptional circumstances. Remember NCNZ go on approval dates. Not due dates.

Disclaimer: When the applicant's portfolio has been approved as competent, safe to practice and for the level of practice applied for at time of assessment, the assessor shall not be accountable if the participant does not maintain these requirements.

CC Health Alliance:
The Mail Room
Health Alliance
Staff Service Centre
Penrose
(Private and confidential for filing)