New Zealand Nurses Organisation

Submission to the Ministry of Health

on the

Review of the Health Practitioners Competence Assurance Act (2003)

December 21 2007 Extended to January 31 2008

Inquiries to: Marilyn Head
New Zealand Nurses Organisation
PO Box 2128, Wellington
Phone: 04 499 9533
DDI: 04 494 6372
Email: marilynh@nzno.org.nz

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to contribute to this timely Review on the Health Practitioners Competence Assurance Act (2003) which it advocated when the Act was being developed.
2. NZNO is a Te Tiriti o Waitangi based organisation. It is the leading professional body and nursing union in Aotearoa New Zealand, representing over 40 000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals. Te Runanga o Aotearoa NZNO comprises Māori membership and is the arm through which our Treaty based partnership is articulated.
3. NZNO strongly supports the principal purpose of the Act - to protect public health and safety by ensuring the competence of health practitioners (HPs). NZNO acknowledges that the Act was a step in the right direction in drawing together disparate legislation and establishing a uniform regulatory regime covering all health professions.
4. NZNO notes however that the Act does not recognise the partnership rights of the tangata whenua under the Te Tiriti o Waitangi, requiring neither Māori representation or consultation with Māori at any point. This is not only a violation of Treaty principles, but also embeds disparities in the public health system which continue to contribute to poorer health outcomes for Māori. It also robs all New Zealanders of the opportunity to benefit from the insight, learning and efficient uses of resources that a truly reciprocal bi-cultural relationship offers. NZNO strongly believes that Māori representation on Responsible Authorities (RAs) and consultation with Māori should be mandatory and that partnership principles should be intrinsic to this Act.
5. NZNO believes that the Act's accommodation of and respect for the professional expertise of different health professions has been an important factor in the successful maintenance of the high standards of competence of New Zealand's health practitioners. The Act has proven flexible in allowing the relatively seamless introduction of new RAs and scopes of practice in response to changing service needs and practice, which augers well for future challenges in the health environment.

6. However, as with all new legislation, there have been some unintended consequences. While there is little appetite for widespread change, it is clear that there is little consistency between RAs; that health practitioners are shouldering increased financial and workload burdens; that employers are also shouldering an increased financial burden; and that there is now a very large and expanding unregulated health workforce, all of which have serious implications for public health and safety.

7. NZNO acknowledges the valuable contribution and perspective that lay members bring to the RA boards but does not accept that Ministerial appointments alone can result in a robust representative system that enjoys both public and practitioner trust. The call for applications and then ministerial selection is no substitute for democratic participation and the lack of representation is contrary to the principles of partnership implicit in such initiatives as the Tripartite Agreement. Indeed NZNO has serious concerns about the way the selection process has been handled. Last month, without prior notification, NZNO discovered from the Ministry's *website* that nominations for appointments to the Nursing Council of New Zealand (NCNZ) were invited with a cut-off date of January 3rd! NZNO was subsequently notified and insisted on an extension to January 31, but such negligence in regard to genuine consultation with the most significant stakeholder is hardly inducive to the collaborative environment necessary to effect a well functioning health system.

8. Further, NZNO notes recent consultation with the New Zealand Medical Association (NZMA) regarding elected representation on the New Zealand Medical Council (NZMC) and is extremely disappointed that a similar opportunity was not extended to NZNO, considering nurses comprise by far the largest number of health practitioners. NZNO believes that modern healthcare systems require a multidisciplinary approach which respects the abilities of all health professions and eschews obsolete power imbalances. NZNO does not accept that consulting RAs, which are responsible to government, and precluding HPs whom they regulate, reflects fair or democratic processes. We have similar concerns over government consultation with DHBs and RAs on the terms of reference for the Health Practitioners' Competence Assurance Act (HPCA) review, but not with professional organisations which represent those for whom the Act is intended.

9. RAs are responsible for a broad range of functions including registration, certification of overseas applicants, issuing of Annual Practising Certificates (APCs) and collecting data. NZNO believes there should be greater coordination to reduce duplication and inconsistency and facilitate standardised collection of data to optimise workforce planning.

10. NZNO takes this opportunity to remind the Minster that the competence of HPs is only one factor in ensuring public safety in health and that a practitioner can only be as competent as the environment allows him/her to be. The alternative is for the HP to leave an unsatisfactory environment or even the health sector.

11. It is questionable whether the health and safety risks posed by the steady increase in entirely unregulated, untrained health care assistants (HCAs) who now constitute a significant proportion of the health workforce and for whom nurses have, by default, been forced to take responsibility for, can be offset by the introduction of more regulated scopes of nursing practice, or higher skill levels in a small number of regulated practitioners. There has been no evidence cited that would corroborate this intention widely practiced in some areas of the health workplace.

12. The risks are particularly clear in the chronically understaffed aged care sector where the *one* registered nurse (RN) required for each shift, is responsible for supervising the work of unregulated HCAs. The consequences of inadequate staffing numbers and skill sets is clear from the many high-profile cases referred to the Health and Disability Commissioner (HDC). Other examples are found in the disproportionate number of nurses working in professional isolation in residential hospitals and rests homes brought before NCNZ's Professional Conduct Committee (PCC). NZNO recommends that urgent attention be given to updating and regulating minimum safe staffing levels across this sector as recommended in the New Zealand Standards handbook *Indicators for Safe Aged-care and Dementia-care for Consumers (2005).*

13. NZNO notes that the high representation of Māori in the unregulated HCA workforce and also in areas of professional isolation such as rural and aged care, which contribute to inequitable outcomes.

14. More regulation of practitioners will not address wider public safety issues. Nor is it appropriate for the health workforce to be unfairly forced to assume responsibility for

safety issues outside its control. What is required is regulation for safe staffing of both regulated and unregulated carers, according to the seven key elements identified in the Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry (2006). NZNO was instrumental in setting up the Safe Staffing Health Workplaces Unit and members look forward to its recommendations being implemented for better outcomes for patient safety across the sector.

15. Aotearoa New Zealand's very high level of migration in the heath workforce (the highest proportion of migrant doctors among OECD countries and second highest for nurses) has not been allayed by the Act; emigration has doubled since the early 1990's (Dumonte & Zurn, 2007). It has, however, highlighted the lack of safety and discriminatory anomalies in the way migrant health practitioners are registered, and identified some disturbing trends in the high turnover of migrant staff and their vulnerability to exploitation. Dr Nicola North's research on unregistered immigrant doctors (North et al, 1999) demonstrated serious impacts on the health and well-being of those doctors and their families, and their perception of discrimination and prejudice in New Zealand.

16. Although the net outflow of New Zealand nurses more or less balances the net inflow, they are not equivalent. Put bluntly, Aotearoa is exporting its highly trained nurses, familiar with New Zealand mores and health system, to other OECD countries and taking in an increasing number of nurses from developing countries such as the Philippines, the Pacific Islands and India (North, 2007).

17. The competence requirements for immigrant HPs which use the International English Language Test (IELT) as a proxy for cultural competence are inadequate, unsafe and often discriminatory in practice. Since Irihapeti Ramsden's seminal article *"Cultural Safety in Nursing Education*" was first published in 1993, the concept of cultural safety developed by Māori nurses has led the way in establishing globally that all health care is provided in a social as well as an institutional context. Both individual attitudes and structural elements influence the quality of health care; inequalities in power between groups in society need to be addressed to ensure its equitable and safe delivery. In ignoring cultural safety requirements, which Māori consultation and representation would surely have forestalled, the competence of immigrant HPs practising in New Zealand cannot be assured.

18. Unnecessary obstacles to registration have prevented many Pacific Island nurses from working at the level of their level of their skill, and relegated them to lower paid HCA positions – a bargain for employers, but another means by which racial and socio-economic divides are maintained. It is also likely to be one of the reasons why so many unregulated HCAs are requested or tacitly required to perform nursing duties such as administering medications, even intravenously, which they are neither paid nor trained to do so.

19. Inadequate information and support must be seen as contributing factors to the high turnover of immigrant staff and the numbers referred for competency review. There is evidence that Aotearoa is a "stepping stone" for HPs from developing countries (Dumonte & Zurn, 2007). If this is the case, New Zealand bears the brunt and cost of competency issues, without the benefit of long-term staffing security. Both safety and workforce stability should be addressed with proper support and mentoring, and subsidised programmes to ensure overseas HPs gain the cultural and clinical competencies needed to ensure safe practice.

20. Apart from the impact of immigration on the New Zealand health system which has not been systematically investigated or analysed, there are wider ethical issues to be considered such as our responsibility to help develop the health potential in third world countries by not undermining it, and preventing exploitation. NZNO recommends that urgent attention be given to identifying and addressing the broad range of issues arising from migration in the health workforce.

21. NZNO also notes that the increasing overlapping of scopes of practice increases the need for consultation and dialogue between RAs so that common interests and expertise can be shared. Requirements for dual registration, where HPs have more than one scope, for example a nurse who is also a midwife, should be rationalised. Such dialogue would also lead to more consistent training across all health professions and avoid the requirements of one authority contradicting those of another.

22. The agreement between the NCNZ and the MCNZ whereby those holding a dual qualification (RN and RM) and who wish only to retain their nursing APC are

prevented from practising within a maternity setting delivering nursing care, is unfairly discriminatory and restrictive. Such agreements should be precluded.

23. NZNO acknowledges the sterling work of the RAs in identifying relevant competencies, setting standards and procedures and making educational opportunities available, but notes the wide range of requirements and validation for recertification and the additional financial and workload strains they impose on both individuals and employers without any evidence that they contribute to a safer health system. While specific competency requirements will differ between health professions, there should be some consistency in the amount, nature and validation required by RAs. NZNO recommends RAs be encouraged to collaborate in setting consistent standards and activities and keep recertification requirements to a minimum.
24. NZNO is concerned about the increasingly high number of nurses inappropriately referred to professional conduct committees (PCCs) for matters that should be dealt with at a lower level. Such cases indicate a lack of judgment on the part of the NCNZ.
25. NZNO considers that the current requirements for reporting complaints to the Health and Disability Commissioner (HDC) and the Health Practitioner Disciplinary Tribunal (HPDT) are working well and fairly. NZNO would oppose an extension to mandatory reporting by colleagues. NZNO particularly commends the publication and accessibility of the Commissioner's and the HPDTs investigations, reports and findings which substantially contribute to public confidence and safety thorugh their processes and transparency.
26. NZNO welcomes the extension into nursing of protected Quality Assurance Activities (QAAs) that the HPCA allows and looks forward to their wider implementation and availability.

27. NZNO is not confident that the Act has been adequately enforced either in ensuring that RAs are fulfilling their statutory obligations, or in operating effectively with the confidence of the professions. The NCNZ has not filed an annual report since 2004, without consequence; the Regulations Review Committee has found NCNZ's consultation processes faulty and there are longstanding professional, public safety, and health workforce issues which have not been resolved despite appeals to both NCNZ and the Ministry.

28. NZNO believes the Ministry needs to take a more active leadership role in ensuring RAs are operating efficiently, effectively and according to best practice. Evidently more robust monitoring processes and strategies for intervention need to be developed and implemented.

29. NZNO is aware that there are still some legislative anomalies between the HPCA Act and other health sector legislation, for example, the Health and Disability Safety Services Act and the Medicines Act, which precludes some HPs being able to practise as intended. For instance, experienced nurses can apply to NCNZ for endorsement to independently supply the Emergency Contraceptive Pill (ECP) but have no access to the funded supply.

1.	Is the Act achieving its purpose? Please explain.

The Act has been successful in putting in place an ongoing competency regime which has respected the professional expertise and differences between the health professions. However there is some confusion around the balance between regulating the professions and protecting the public.

Complex and widely varying recertification and professional development programmes; the proliferation of required competencies (standards), scopes of practice and RAs do not necessarily contribute to public health and the expense of administering competence and disciplinary procedures is a cost to the public health system. As the International Council of Nurses commented, “New Zealand becomes increasingly regulated at increasing expense but without evidence that it is making a difference to public safety and protection” (International Council of Nurses, 2004).

NZNO strongly supports RAs specific to each health profession, but there is a broad range of functions including registration, certification of overseas applicants, issuing of APCs and collecting data which could be rationalised for greater efficiency.

The non-standardised collection of such significant information about the health workforce prevents its optimal use for workforce planning, which is critical to the effective operation of a safe health system. NZNO suggests that integration of the operational and administrative aspects of RAs would provide economies of scale, accurate up-to-date workforce information and a more robust and consistent regulatory framework across all health professions.

NZNO agrees that “Professions need to be regulated by statute only if there is a risk of harm to the public” (Ministry of Health, 2007). While there is considerable support for the professional development and continuing education that has been developed by the RAs, recertification activities add to the stress and workload of HPs.

Recertification requirements pose additional strains and costs elsewhere in the health system, as experienced practitioners spend more time monitoring than practising. It is difficult to see how taking health professionals away from their core activities, especially when the workforce is already stretched, can contribute to public safety.

The situation is exacerbated in rural practices and aged care facilities where neither peer nor advanced practitioner review is easily accessed and where it is even more difficult to find time or relief staff to enable HPs to attend education courses. Yet evidence suggests that those practising in professional isolation are in need of the input that continuing education and professional development programmes provide. NZNO suggests resources for recertification activities should be targeted to this group.

A significant issue is the Act's inability to address the health and safety risks posed by the steady increase in unregulated, untrained health care assistants (HCAs), which now constitutes a significant proportion of the health workforce. There are no police or character checks for HCAs whose work brings them into intimate contact with people in extremely vulnerable situations. Since HCAs are unregulated they can, and do, perform tasks which are outside the narrowly defined scopes of practice of nurses who, nevertheless, under the Act, unfairly shoulder the full burden of responsibility for delegated work, regardless of the circumstances. Being subjected to a disciplinary process in itself is a huge strain for any health professional, let alone one who has been let down by systemic weaknesses and workforce shortages.

Neither their safety nor the public's safety can be protected where there are no safe staffing protocols for either regulated or unregulated caregivers as identified in the Safe Staffing/Healthy Workplaces Committee of Inquiry's Report (2006). Central to the report is that while mandated patient-staff ratios can provide a base level of staffing, a more comprehensive and flexible approach is needed to address the complexities of today's health care. An approach which considers such factors as skill mix, training, experience, workload and infrastructure is vital. The interdependent elements necessary to achieve safe nursing and midwifery identified in the Safe Staffing Healthy Workplaces Committee of Inquiry's Report (2006) are:

- The requirement for nursing and midwifery care
- The cultural environment
- Creating and sustaining quality and safety
- Authority and leadership in nursing and midwifery
- Acquiring and using knowledge and skills
- The wider team

- The physical environment, technology equipment and work design.

and are more fully described in the Report. NZNO considers these elements, and tools for monitoring quality and indicating safe levels of care, are fundamental to delivering safe health care and need to be taken into consideration when a HP's competence is called into question.

Given new paradigms underlining quality assurance processes (Nursing and Midwifery Advisory Committee, 2007) it is both unfair and counterproductive for individual HPs to be held responsible for systemic failures. Nor should one or two nurses at the end of a long chain of command bear the brunt of public opprobrium and professional scapegoating, which has occurred (see question 3), evidence that the HPCA's interdisciplinary approach has not mitigated the historic power imbalance that continues to flourish within the health hierarchies. Mutual respect and dialogue within health teams is often more theoretical than real, and the potential of the Act to deliver sound interdisciplinary processes through RA leadership has not been realised.

NZNO notes that the SS/HW Unit is operating within DHBNZ and warmly recommends its work in implementing safe staffing protocols.

Where conditions exist, such as in aged care facilities where DHBs require only *one* RN to be on duty each shift and a ratio of *ten* patients to one caregiver, the HPCA Act is irrelevant in terms of public safety. No amount of education, professional development, training or assessment will make it safe for a single nurse on a twelve hour shift to be responsible for the care of up to seventy patients. Without an appropriately resourced, well organised, health care delivery environment, even highly competent health professionals are at risk of being unable to achieve safe outcomes *through no fault of their own.* It is unacceptable that individual health practitioners should be held responsible for systemic failures outside their control.

NZNO notes that the lack of safety in some healthcare environments such as aged care is a significant factor in reducing the workforce through migration, burnout, or, more commonly, a rational decision not to accept the risk of practising in an unsafe

environment. Chronic staff shortages, which are one of the greatest threats to public safety in health, could be alleviated by a commitment to safe staffing and encouraging the return of nurses to the workforce. NZNO recommends that priority be given to updating and regulating minimum safe staffing levels across this sector where there is relative stability in resident populations, as recommended in the New Zealand Standards handbook *Indicators for Safe Aged-care and Dementia-care for Consumers (2005).*

NZNO also notes an unanticipated effect of the HPCA Act in the increasing trend of employers encouraging qualified regulated nurses to forgo renewing their APCs. This means the employer is not required to meet the collective employment agreements and ensure opportunities to meet the requirements of the HPCA. The net effect is a downgrading of the nurses qualification, restricted career opportunities as a result of losing their practising certificates and a reduction of the nursing workforce. Where HP knowledge or expertise contributes to an employment position, HPs should be both encouraged and enabled to ensure their APCs are kept current.

The attitude of employers is also influential and may be working against the intention of the Act with regard to competence. While competence review is aimed at supporting the practitioner to acquire the skills identified as lacking, in practice the system is often punitive because employers have proved reluctant to employ, supervise or support nurses with competency restrictions. NZNO suggests that this reflects employers' lack of knowledge and confidence about some aspects of the Act rather than the Act's provisions around competence.

The Act has not resolved the confusion that exists around scopes of practice for second level nursing. The relative duties and responsibilities of nurse practitioners (NPs); RNs some with special skills; nurse assistants (NAs) with scopes of practice endorsed to particular fields and enrolled nurses (ENs) ; and unregulated HCAs, is not clear even among health professionals. The public is manifestly unaware of such distinctions, since it is doubtful they would submit to being bathed and medicated by unregulated HCAs. The consequent risk to public health is evidenced by the many high profile cases brought before the Health and Disability Commissioner.

It should not be inferred from the above, however, that HCAs are entirely unskilled or that they should be regulated. It is evident from the existing and projected shortage of regulated health professionals that allocation of some routine tasks may be necessary in order to keep the health system working. Where proper training and good support has been given to HCAs as, for instance, by CCDHB's District Nursing Service programmes, the result has been very positive. District Nurses have been able to work alongside HCAs confident that the shared care provided is safe and HCAs have reported increased job satisfaction.

The Act is not working in terms of assuring the competence of immigrant HPs which constitute a significant proportion of HPs and which have a high turnover. The competence requirements for overseas HPs which use the IELT as a proxy for cultural competence are inadequate, unsafe and often discriminatory in practice. They do not prevent the exploitation of migrant workers; have contributed to keeping a significant number of professional health workers in low paying jobs not commensurate with their skills; and do not ensure public safety or equality in healthcare. In ignoring cultural safety requirements, the competence of immigrant HPs practising in New Zealand cannot be assured. NZNO notes that the lack of consultation with Māori and/or Māori representation on RAs required by the Act is a significant factor in maintaining a health system incapable of delivering equitable outcomes. Cultural safety is an evidence-based dimension of safe health practice and, as a leading proponent of its incorporation in HP training, New Zealand should "practise what it preaches" and ensure it operates within the regulatory environment.

There are some inconsistencies between the HPCA Act and other health sector legislation which need to be addressed to facilitate the full use of HP skills. For example in 2002 it was gazetted that experienced nurses could be endorsed to independently supply the ECP. In practice, however, they are precluded from doing so because there is a considerable difference in cost between Practitioner Supply Order (PSO) and pharmacy supplied ECP and access to funded supplies is restricted to doctors and midwives under the PSO.

2.	What evidence supports your answer?

See above and

Under the HPCAA, RNs scope of practice makes them legally responsible not only for their own work but also for that of the second level nurses and HCAs under them, regardless of circumstances and irrespective of systemic failures. Marion Clark, CEO of the NCNZ, has drawn attention to the disproportionate number of RNs working in isolation in residential hospitals and rest homes brought before the Council's Professional Conduct Committee (PCC).

A recent statement by experienced nurses working within the specialty of oncology & haematology expresses the concerns: *Patient care is often complex and highly-specialized; patients can be acutely unwell & medically unstable. The level of specialized nursing skills required to function effectively are developed over a substantial period of time, with commitment to specialty education.... Concerning us is the responsibility for the delegated/directed tasks falling on the senior nurse. Is the senior RN accountable for all care provided to patients? It would seem so, and this is daunting, and unsafe*.

Graphic illustrations of the safety issues surrounding the increased use of HCAs without ensuring adequate training or numbers of trained staff can be seen in the number of major inquiries into health and hospital services in several DHBs following high profile failures, such as Winifred Clemens who bled to death at St Helena's Rest Home, having not even been offered first aid. The Coroner's Report (Mclrea, 2006) which highlighted the fact that there is no requirement for a registered nurse to be present at all times in a rest home nor for caregivers to be formally trained in anything other than dementia care, specifically enjoined the Ministry of Health to include a requirement in the Aged Related Residential Care Agreements to ensure an adequately trained caregiver is present on each shift.

As an expert witness in a later report by the HDC pointed out, however, the presence of a trained caregiver, at any level, cannot on its own ensure safety. "*The staffing level for nurses is a serious concern…. .It is difficult to see how a nurse looking after 16 patients (including many needing interventions and frequent monitoring) could possibly provide safe care* (Health and Disability Commission, 2007a)

It is evident from the number of overseas nurses who come up for review that competency in English as tested by IELTs is not an adequate measure of clinical or cultural competency, and that some of the Polytechnic and Industry Training organisations' (ITOs) training courses are not providing adequate training for immigrant nurses. Differences in culture and training are widely apparent from these cases, especially in terms of understanding medication and performing basic cares. Many overseas nurses are not trained to wash, feed or dress patients, for instance, because it is expected that families do that in their country; names of and systems for administering medications differ widely as do routine procedures for admissions, discharges, care plans and referrals. Since overseas nurses must be registered and issued with an APC before their competence can be assessed, it is only *after* they are practising that gaps in their knowledge and skill are recognised and they are referred for competence review.

Immigrant HPs are unlikely to be conversant with key cultural elements such as the principles of the Treaty of Waitangi or Aotearoa New Zealand's demographic composition. However, for those immigrant nurses who speak English as a first language, there is no requirement for undertaking even basic familiarisation with such features for registration, which undermines the concept of cultural competency and, by implication, other "core" competencies.

The only universal RA requirement for overseas health practitioners is a language test for those with English as a second language. In practice this is both discriminatory and unsafe. For example, many Pacific Island (PI) nurses from Tonga, Fiji and Samoa train, in English, for three years but still have to sit an English language test. This is unnecessarily bureaucratic and costly. And, according to the NCNZ, those requiring language passes are more likely to be required to undertake an individually designed competence course at a Polytechnic which they have to fund themselves. Considering the shortage of nurses, the numbers of Pacific Islanders in New Zealand and range of health issues specifically relating to them, it would seem sensible to facilitate the registration of PI nurses rather than putting obstacles in their way. NZNO notes that community leaders in Porirua recently expressed their concerns at the low numbers of PI HPs at an open forum with Capital and Coast DHB.

The $300 IELTS test is an academic test, not health-sector specific; it does not purport to measure intrinsic nursing skills such as clinical observation or empathy. The less widely recognised Occupational English Test is targeted at practical use in the health sector and has a strong cultural awareness and safety component, but the $1100 fee is prohibitive. In New Zealand, unlike Australia those who fail even part of the IELTS tests are faced with sitting and paying for the whole four part test again or, as often happens since they have little discretionary money, settling for poorer pay as HCAs, with no recognition of their level of skill.

The vulnerability of migrants to exploitation and discrimination should also not be overlooked and NZNO notes research led by Nicola North, Associate Professor at Auckland University's faculty of Medical and Health sciences University on the difficulties immigrants face in the health sector, both as patients and doctors (North et al, 2006, 1999). NZNO is also aware of unscrupulous health recruitment agencies charging exorbitant fees at both ends of the recruitment process, and has acted for Filipino nurses who have been bonded by private providers in New Zealand. New Zealand's needs should not be met at the expense of individual migrants' rights. Similarly, as a country which upholds the human rights, consideration should be given to the effect of the outward migration of skilled workers on developing countries. The World Health Organisation reports that 15 000 nurses leave the Philippines each year, yet 30 000 nursing vacancies there remain unfilled.

Evidently more comprehensive and facilitative measures need to be put into place to ensure public safety and effectively use and retain the skilled overseas workforce we have, rather than continue to exploit them. The high personal and institutional cost of inadequately informed and supported overseas nurses substantially contributes to their high turnover and the RA must take responsibility for failing both public and nurses in that respect.

NZNO recommends

- that safe staffing elements be considered in relation to HP competence issues
- that strategies such as a standard on-line learning package and test on the NZ health system and the Treaty of Waitangi be made available for all migrant HPs to complete.

- the provision of subsidies for programmes to support overseas nurses in gaining the cultural and clinical competencies needed
- provision for consultation with and representation of Māori

3.	What, if any, comments do you have on the adequacy of evidence available about the success of the Act and any changes needed – including, for example, any reporting requirements that might ensure more open access to evidence that the Act is being effective.

NZNO feels that that generally there is a low level of understanding of the HPCA Act and that more education is needed, particularly for employers whose inconsistent interpretation of some decisions has had the unanticipated effect of altering clinical roles, by default. An example is Capital and Coast DHB's (CCDHB) decision not to employ ENs on night duty, following a decision made by the Health and Disability Commissioner (Health and Disability Commission, 2007). The subsequent replacement of highly experienced ENs with untrained HCAs based on a misinterpretation of that decision, is patently unsound, and illustrates the bizarre outcomes that have arisen because of the uncertainty surrounding employer responsibility for the competence of HPs under the Act. Conflicting advice from the NCNZ and Ministry of Health regarding ENs scope of practice contributed to the confusion causing instability and undermining public confidence.

Similarly, although the Act makes provision for consultation, there is a poor understanding of what constitutes good consultation. Seeking feedback on a few predetermined options, for example, is not. NZNO draws the Ministry of Health's (MoH) attention to the Australian Health Ministry Advisory Council principles of consultation (National Nursing and Nursing Education Taskforce, 2005). Effective regulations, which enjoy the support of the profession and are crystal-clear to employers and the public, can only be arrived at through genuinely inclusive and open consultation.

The lack of consistent understanding and true consultation is reflective of the trend towards a detached governance that has caused major dislocation in the health sector (most recently in CCDHB), and NZNO believes that the MoH must be more proactive in

leading change and demanding sound processes are followed. The Tripartite Agreement provides an excellent opportunity to demonstrate such leadership.

There is some concern about the wide variation and lack of follow-up, in reporting incidents, accidents, near misses and adverse clinical events including medication errors which are not all reported or monitored nationally.

DHBs have different systems for reporting and some, such as Nelson Marlborough DHB, do not number their reportable event forms while others no longer provide a printed copy for the nurse, which makes it difficult to track and trace events. That is a source of considerable frustration to nurses who have expressed concern about the lack of feedback and records of reported incidents, particularly when the same incident has been repeatedly reported. Reporting in aged and primary care may be less consistent because of staffing issues.

The introduction of digital reporting with inadequate training or support has seen incident reporting drop substantially in some areas, which suggests that potential risks may be significantly under-reported. Since there is high mobility in the workforce, consistent reporting guidelines and national data collection of all incidents, not only sentinel events, would be useful to facilitate reporting and provide a nationally standardised base for comparison and best practice systems.

The current definition of what is termed a sentinel event is not clear and the degree of latitude this allows compromises the quality of the data on the only incidents where external reporting is required. Some DHBs have Sentinel Events Review panels, but do not have training programmes on how to investigate or respond to a sentinel event. An HDC report following an investigation into the death of a CCDHB patient admitted to care for acute breathlessness, highlighted the extreme inconsistency of the reportable event process. Incomplete, undated or wrongly dated, and inaccurate report forms were recovered; there was failure to communicate fully with the coroner, or to respond to the family's request for information. It was only through the family's persistence that the case was investigated at all and yet the HDC found significant failings in a number of other areas too, including staffing, careplanning, treatment as well as breaches by a consultant physician, a medical registrar, an RN and an EN (Health and Disability

Commission, 2007b). NZNO notes that both media attention and the CCDHB's actions focused almost exclusively on the role of the EN, reflecting the persistence of traditional power imbalances and regardless of modern best practice based on a systems approach to error reduction[1].

Of note in the subsequent review by Dr Mary Seddon into the safety of patients in New Zealand Hospitals (Seddon, 2007) only one DHB, Hutt Valley was confident that its processes would prevent a similar occurrence. Dr Seddon remarked that although almost all DHBs produced an abundance of policies, adherence to those policies is rarely audited. Clearly policies needed to be supported by educational programmes to ensure their proper implementation and compliance needs to be audited. NZNO would add that even with proper policies, processes and education, unless all seven elements of safe staffing are complied with, public health and safety are at risk.

Though some DHB's have monthly trending and analysis, clinical audits and quality improvement reports of all services going to their Boards, there is no requirement to report their results, so there is no way in which the health profession, the public or the Ministry can monitor what is happening in anything other than the most serious events. Inadequate and incomplete data are both unsafe and unnecessary.

NZNO notes that New South Wales, Australia has had a system to support *all* health care staff to report *any* incident relating to health and safety since 2004 (NSW Health, 2006). NZNO understands that the Ministry of Health intends establishing a standardised national approach to the management of incidents in the health and disability sector within two years and fully supports that initiative.

NZNO suggests that the HPCA Act could be tied more closely to the Health and Disability Services (safety) Act 2001 which is more specific about the standards, procedures and monitoring required, although it notes that these are currently being revised.

---

[1] See NZNO's booklet *Quality in the Workplace* written by the Nursing & Midwifery Advisory Committee for a concise reference list

NZNO recommends that medication errors and vaccination reactions should be recorded officially, rather than unofficially by Otago University's Centre for Adverse Reactions Monitoring (CARM), which it does in the absence of any other system.

4.	Are the provisions in section 7 of the Act operating in a way that ensures that non-qualified persons do not claim or imply to be qualified practitioners and what, if any, changes do you recommend (note that issues around enforcing breaches are dealt with in the section titled 'Enforcement of the Act' which is set out below)?

NZNO's Mental Health nurses share the College of Nurses Aotearoa's (CoNA) concern with the poor quality of counselling by people whose training, or lack of it, does not qualify them to be giving medical advice. NZNO feels this group constitutes a significant public health threat to those whose mental illness makes them particularly vulnerable and who cannot rely on either the clinical or ethical standards demanded by regulated HPs. Recently a long term mental health consumer who was being treated for depression, was diagnosed by a counsellor as having multiple personality syndrome, a condition which has no clinical recognition and which doesn't seem to exist anywhere outside popular fictional writing. The patient's health was jeopardised by interference with prescribed medication, and the counsellor was unavailable when needed.

Considering the potential and actual damage done by non-qualified people, the penalty of $10 000 under this section of the Act is totally inadequate.

There are inadequate provisions for health workers with qualifications or scopes which are not regulated in Aotearoa and who are therefore not covered by the HPCA Act. NZNO is aware that employers are actually advertising for such HPs. For example Mercy and Ascot Hospitals are currently advertising for Scrub Registered Operating Department Practitioners (RODPs), who are registered in the United Kingdom by an RA but who are not regulated in New Zealand. In this case the HPCA regulations are circumvented; employers rather than RAs are making decisions about whether people are qualified. This is a loophole which needs to be addressed (www.mercyascot.com)

NZNO is frustrated by advertisements in the classified columns for massage, sex and fantasy which consistently refer to "nurse" and which seem to go unchallenged.

Publishers are evidently unaware of the Act. There needs to be more clarity in the Act about reservation of title and breaches need to be acted upon. Similarly some employers do not understand the provisions in section 7 and to whom they apply.

The fact that HCAs are working in the same workplace and performing some duties previously carried out by nurses is sufficient to convey the impression to the general public, who are not familiar with the differences, that they are "nurses". This puts undue pressure on HCAs who often feel obliged to respond to patient and/or employers requests, sometimes with disastrous results[2]. Similarly, as hospital complaints records will show, confidence in nursing staff is undermined when it appears that 'nurses' (that is, HCAs) are either unresponsive (because they correctly will not undertake inappropriate activities) or are not competent (because they try to 'help').

Although this problem may be specific to nursing, which encompasses a broad range of activities, the Act needs to be strengthened to ensure that, where confusion around the nursing role is likely to arise, employers must ensure that the public is made aware of the distinction.

NZNO again notes that the recent introduction of the Nurse Assistant title and scope of practice to second level nursing has added to the confusion.

NZNO strongly recommends

- that the accepted titles Registered Nurse, Nurse Practitioner and Enrolled Nurse should be retained to facilitate public understanding of their roles from the unregulated HCA.

5. Are the provisions in section 8 operating effectively and what, if any, changes would you recommend?

Section 8 is operating effectively in that it has been flexible enough to allow the devolution of some standard tasks from one group of HPs to another to increase

[2] In the United Kingdom, for example, a patient choked to death after an HCA gave him the piece of toast he asked for regardless of the "Nil by Mouth" notice above his bed. The case has led to considerable litigation and, interestingly, most headlines proclaimed that "nurses" rather than HCAs were responsible – evidently confusion around the role of "nursing" exists in the UK too. http://www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=486673&in_page_id=1770 .

efficiency and reduce cost. RNs, for example, now routinely remove veins for coronary artery bypass grafts, a repetitive task formerly performed by Registrars. Similarly, to address a general six week waiting list for the procedure, Family Planning nurses, in consultation with medical colleagues, were trained to insert Intra Uterine Devices (IUDs). NZNO would like to draw the Ministry's attention to the exemplary training process, which includes mentoring and direct supervision, that the New Zealand Family Planning instigated and follows in order to assure nurse competency in inserting IUDs. It is the quality of this training that is the most effective guarantee of the HP's competency and public safety, not whether it is performed by a doctor or a nurse, yet there has been little movement towards establishing commonality of training where scopes overlap.

The HPCA has the potential to deliver coherent training and competence assurance for procedures that apply to all HPs based on the evidence that they work, rather than having different requirements depending on the RA administering them.
However, the consequences for a health professional acting outside the scope of practice are not clear. NZNO believes this section could be strengthened by detailing a standard procedure to follow if a HP is suspected of acting outside the Act, and having appropriate penalties for offences.

6. Are the provisions in section 9 and the current list of restricted activities operating effectively and what, if any, changes, amendments or additions would you recommend?

The section on restricted activities is vague and difficult to interpret and it is not clear who is responsible for interpreting what a restricted activity is or who is eligible to perform it. The Ministry's website definition under Guidelines for the operations of Restricted Activities under the HPCA is not helpful either and adds to the confusion around the role of HCAs. It refers to *"**minor** tasks and **simple** procedures undertaken by caregivers such as lancing boils or pulling out loose teeth"* yet HPs have to be trained for both these activities - lancing a boil on a diabetic is neither minor nor simple! It is confusing to have *specific* activities restricted to HPs *generally* and unnecessary when scopes of practice fulfil the same function. Generally speaking, changing technologies, medical procedures and contexts make restricted activities more of a liability than an assurance of safety.

NZNO draws the Ministry's attention to the excellent processes developed by the Australian Nursing and Midwifery Council to determine safe practice of healthcare activities. The Nursing Practice Decision flowchart developed as part of the *Project To Produce A National Framework For The Development Of Decision-Making Tools For Nursing And Midwifery Practice* presents a clear pathway to determine competence to achieve beneficial patient outcomes for activities not specified within a particular scope of practice. It could be adapted to meet the intended aims of the restricted activities section of the Act to prevent any health care worker, whether regulated or unregulated from carrying out procedures for which they are not competent.

7. Is the Ministry approach to enforcement of the Act in keeping with the purpose of the Act and what, if any, changes would you recommend?

The Ministry approach to enforcement of the Act has clearly been inadequate. The NCNZ has not fulfilled its statutory obligations to file an annual report since **2004**, without consequence. Nor, according to the Regulation Review Committee (RRC), has it followed proper, inclusive consultative processes in determining scopes of practice (Regulation Review Committee, 2007). Since a second consultation on the same subject used the same flawed process, it must be concluded that the RRC's ruling was similarly inconsequential. That such limited consultation along a pre-determined pathway is detrimental to both the profession and public safety was highlighted in NZNO's recent submission to the NCNZ (NZNO, 2007).

It is clearly untenable for an RA to be determining something as basic as a scope of practice which is not recognised by practising clinicians without proper consultation especially when it goes against long-established practice. The continuing fall-out from this ill-conceived dichotomy of second level nursing has been considerable and illustrates how the Act can be a serious barrier to, rather than a protector of, public health safety. In some cases ENs have effectively been disenfranchised and replaced with HCAs (See Section 3) and, inconsistently, NAs have been barred from some HCA roles (see Section 8). Both consequences are contrary to commonsense and public safety, yet, in spite of repeated appeals to the NCNZ and the Ministry, the situation remains, an indictment on the limited insight into the emotional, professional and employment aspects this protracted devolution has had on ENs and NAs.

NZNO also draws attention to the issues raised by NZNO Chief Executive Geoff Annals in an article in *Kai Tiaki Nursing Journal* (Kai Tiaki, 2007), Citing the HDC's report on the investigation into the care of Mark Burton in Southland DHB[3], he points out that of the 51 recommendations made by the HDC to Southland DHB, 11 concerned nursing practice issues which were not being addressed, while ENs were scapegoated. This indicates the need for greater educational and professional consultation in developing training programmes to deliver consistent professional standards of practice.

Since there is a degree of uncertainty about the circumstances in which the Minister has the power to act or intervene, if the NCNZ chooses not to follow the recommendations of the RRC, there is no authority to require them to. In other words there is no means of ensuring that the RA is functioning properly. This is clearly something which needs to be addressed urgently. Similarly if there is no stewardship to ensure matters arising from the HDC reports are properly addressed, the Act safeguards neither HPs nor public health.

NZNO strongly recommends

- elected representation on RAs;
- that the Ministry take a more active role in monitoring RA decisions and actions as a result of RRC recommendations; and
- that provision for review and/or appeal be included in the Act to prevent the above lapses.

8. Are scopes of practice achieving their intent? Please explain.

The number of new scopes of practice is clear evidence of the impact of new technologies, medical advances and changing demographic needs on the health workforce, but whether prescriptive 'scopes of practice' which under the HPCA describes the content of what a professional group does rather areas of specialty nursing (for example, child health) can deliver a flexible, quality health workforce is open to debate. Australian Health Researcher Stephen Duckett notes current role allocations may be

[3] Mark Burton was discharged from psychiatric care against his family's wishes and subsequently killed his mother.

technically inefficient. “Registration Acts should eschew scope of practice control instead allowing employer flexibility to develop new position descriptions and employment opportunities within appropriate credential processes” (Duckett, Pers. Comm.).

This is particularly relevant in the light of the introduction of unregulated HCAs who, unlike regulated HPs, are not “mandated out” of performing certain tasks. In this sense scopes of practice are actually *undermining* health care with service providers, employers and, to some extent, the professions themselves, having to work around the law.

Notwithstanding the acute shortage of HPs, many Nurse Assistants have been unable to get employment as NAs and have taken unregulated HCA jobs, at lower wages. These have a variety of titles including caregiver, HCA, health assistant and psychiatric assistant. Waitemata DHB employed several NAs as psychiatric assistants before the NCNZ decided that the work that they were doing qualified as nursing work so they needed an APC. But, since NA training only covers the specialty areas of rehabilitation and aged care, and psychiatric nursing lies outside the NA scope of practice, NAs cannot be employed as psychiatric assistants. In other words regulated trained HPs are *prevented* from working in a health care role which unregulated untrained workers can undertake.

Other examples of scopes of practice acting as a barrier to prevent the sensible use of expertise abound. A highly competent EN, with Immunisation Advisory Centre (IMAC) training, for example was prevented from being a general practice vaccinator once *an official* in the Ministry of Health determined, by referencing the NCNZ website, that it was not in her scope, regardless of the fact that *qualified practitioners* considered she would be extremely capable and an asset. Similarly, experienced ENs who for years had trained new RNs in peritoneal dialysis were suddenly stopped from doing so on the basis that it could be “outside their scope of practice”, to general frustration and the detriment of RN training.

These are not only serious public safety and credibility issues, they are also employment rights and economic issues. It is clearly a waste of public and private resources to train

people and not use their skills and it is a gross violation of fair employment practices to consistently employ people at a lower wage than their skills and qualifications warrant.

This highlights the critical interaction and communication necessary between regulatory and education authorities, DHBs (as employers) which the Ministry is responsible for, and the professions themselves to ensure that common sense as well as public safety and employment equity prevails. There is a considerable risk with narrowly or obscurely defined scopes of practice that HPs will be either pressured to act outside them, or the employer will take the cheaper, less confusing option of bypassing them. Scopes should not be subject to varying interpretation by employers and the RA must ensure that the scopes are meaningful in the context of the workplace.

There is potential for similar confusion and barriers to flexible nursing practice if the many specialty areas of advanced nursing practice are restricted by narrow scopes as the second level nurses have been. Nursing covers a particularly wide field from primary to intensive care in both general and specialist roles, and its scopes of practice overlap other health professionals. Nurses are uniquely positioned to quickly adapt to the changing needs of the health system; care should be taken that they are not regulated out of it. Regulation should allow the development of a continuum of competencies from simple to complex, rather than the NCNZ approach to second level nursing which focuses on a fragmented, modular approach to specialisation, for example with aged care, long-term care and rehabilitation, and perioperative models. Scopes need to be broad and enabling to allow nursing practice to change in response to new challenges, knowledge systems and technologies. The risk of over regulation is that nurses are constrained and unable to meet public need, and that new cadres of unregulated workers will emerge to replace them.

Section 11 (2) describes the ways in which authorities can describe"*without limitation"* scopes of practice. NZNO suggests that the deletion of subsection 2 would resolve the problem of restricting nurses to narrow scopes of practice limited by listed activities, and would correct the erroneous public perception that if a specific activity is not written down, it is excluded.

The lack of co-ordination of authorities regulating even predictable, complementary scopes of practice, for example a nurse who is also a midwife, currently penalises the most advanced practitioners with double fees and double recertification requirements. This is not only a poor reward for the individual, but directly undermines the acknowledged need for a more flexible, multi-skilled health workforce. Increasingly, scopes of practice encompass skills and knowledge which are not exclusive to one profession (DeAngelis et al) and RAs need to collaborate to ensure that consistent standards for training and procedures apply to all HPs and do not vary with the authority overseeing them. The criteria for performing functions safely, without risk of harm to the public, are the only justifiable conditions for defining scopes of practice.

Further, the agreement between the NCNZ and the MCNZ whereby those holding a dual qualification (RN and RM) and who wish only to retain their nursing APC are prevented from practising within a maternity setting delivering nursing care, is unfairly discriminatory and restrictive. Such agreements should be precluded.

9.	What, if any, comments do you have on the operation of the powers that registration authorities hold to allow conditions or authorisations on individuals' scopes of practice?

These have worked quite well, allowing a more flexible response whereby conditions can be tailored to meet the specific circumstances of the individual. However, in practice its effectiveness in supporting practitioners is limited because many employers don't have a clear understanding of what the limitations mean and are unable or unwilling to employ new HPs with restrictions. Clinical supervision is time consuming, expensive and not always easy to provide especially in small PHOs where there might only be one Practice nurse.

For nurses, restrictions very often mean that they move to other areas such as aged care, where there is even less support. If the restriction applies to administering medications, however, even that avenue of employment is cut off as aged care facilities typically work with only one RN. In this way the sensible intent of the Act, to support HPs to practice in areas where they are competent, and to provide opportunities for training in areas where they aren't, is undermined. Better education and support/guidelines for

employers may help to facilitate the cooperative and fair environment the Act seeks to establish.

It is also not always clear how much time a HP with restrictions to his/her practice has to develop competency before their APC is withdrawn and there should be provision to ensure a reasonable period is allowed for this.

10.	Is the process for developing scopes of practice operating well (eg, are there suitable mechanisms for ensuring scopes of practice reflect service need) and what, if any, changes would you recommend?

No. Consultation has often been inadequate between RAs and the professions even when the latter have directly been affected. The Midwifery Council did not consult with the Medical Council on the proposed new scope of practice for Midwifery Assistants, for instance. NZNO has been invited to provide feedback on the proposed new scope of practice for Advanced Physiotherapists, however.

But, as previously pointed out, feedback and consultation are not synonymous. Instead of providing leadership and guidance around scopes of practice, ensuring that they reflected actual practice, were relevant to service needs and that training and education were appropriate, the NCNZ has added to public confusion and lost the confidence of the profession on key issues, as can be inferred from recent NZNO submissions on the title and scope of second level nursing subsequent to the RRC ruling that they had not consulted properly in the first instance (NZNO, 2007a, 2007b).

Equally, the Ministry of Health's lack of leadership in ensuring that standards of consultation and professional congruity were met, and the disparity between their own and NCNZ's interpretations have not inspired either public or professional confidence.

NZNO

- recommends elected representation to the RA to avoid similar stalemates using the Medical Council process as the model;
- supports the CoNA recommendation for a regular review of scopes of practice and proposes this to be on a quadrennial basis;

- recommends there is only one title and scope of practice for each level of HP in each discipline; and
- recommends proper consultation guidelines be set and included in Section 14(2)

11.	Do prescribed qualifications reflect scopes of practice? Please explain with reference to particular scopes of practice and considering whether a) the levels of qualification are too low or too high when considering their purpose of assuring public safety, and b) whether they meet the requirements of section 13.

Some training for both HCAs and regulated NAs is provided at the same level, level 4 of the National Qualifications Framework, and care should be taken to ensure that training reflects the difference between unregulated HCAs and nurses. There needs to be further work on a progressive educational framework, more comprehensive than the Ministry of Health's Career Framework which needs further development.

It is timely that an applied undergraduate degree such as that for RNs is reviewed. NZNO is aware that the CoNA recommends a four year degree and will be reviewing its position on the length and outcomes of the educational programme this year. While agreeing that a gap still exists between theory and clinical practice, NZNO will review any other measures which could reduce that, as well as the length of the qualifying programme. Any change in length of the programme will have financial implications in terms of funding through Vote Education and student loans/debt as well as clinical placement availability. The quality of clinical instruction is highly variable and there is an urgent need for real dialogue and effective structures supporting the education process to be instigated so that they meet service and education needs. For instance, the Nursing Entry to Practice Programme needs to be made widely available to all graduates, including those from overseas.

The difficulties in aligning overseas and local qualifications and experience are acknowledged, but with the precedent of the Trans Tasman Mutual Recognition Act 1997, and the ongoing high levels of migration, NZNO recommends priority be given to developing other bilateral agreements, particularly with the Pacific Islands, and specific migration programmes.

NZNO congratulates the NCNZ's initiative in working with the Department of Immigration to develop reciprocal agreements over recognition of certificates which both require, for example police certificates and looks forward to a more streamlined registration process for immigrant nurses as a result.

12. With regard to their purpose of assuring the competence of registered professionals, how well are the current recertification regimes working (where possible refer to particular professions)?

There is generally strong support for a recertification process, particularly for those returning to the workforce, although the expense of recertifying to the individuals in this group continues to be a barrier. (NZNO notes research showing that it is cheaper and safer in the long term for employers to pay for local nurses to retrain than to continue paying the high costs of a constantly mobile workforce (Long, 2007).

There is however the "catch -22" situation where a nurse undergoing recertification needs to demonstrate clinical competence to get an APC but has to have one in order to practise at all. Evidently there is a need to provide sound mentoring, information and support for these people (and similarly for immigrant HPs). Many nurses have Interim Practising Certificates (IPCs) during this period, which are effective but run into the same problems with employers' reluctance to take on nurses with restrictions.

NZNO notes the wide range of RA requirements and validation for recertification from completely self directed, self assessed and self-declaring to highly specific and mandatory activities, specified hours and third party verification. While specific competency requirements will differ between health professions, there should be some consistency in the amount, nature and validation required by RAs. 'Recertification' includes a plethora of other terms such as minimum practice hours, continuing education (CE), professional development (PD), continuing competencies frameworks, portfolios, and Professional Development and Recognition Programme (PDRP) and commonality should be sought.

There is concern about the workload recertification imposes, particularly for midwives, and the potential for it to become overly-bureaucratic. Staff shortages and high staff turnover make it very difficult to plan for adequate training and it is difficult to see how further demands on already stretched HPs contribute to public safety. There are also very real difficulties for those working in professional isolation to fulfil all the conditions. NZNO notes that a significant proportion of competence requirements are met through attendance at the shorter mandatory organisational safety courses such as fire safety, for this reason. While such courses are essential and educational, they do not constitute the main motivation behind professional development.

There is a risk that the certificates for course attendance and evidence of self-reflective activities (for example writing about and/or discussing recent research) are more for the sake of "proving" that the *RA* has done its job in assuring the HP is up to date, than in actually guaranteeing professional competence. Putting into practice the learning from CE and PD is a complex and dynamic process and it is a moot point whether the imposition of a string of mandatory activities which are not necessarily relevant to individuals' needs or even accessible, and which require time-consuming record-keeping and a costly bureaucracy to audit, is the most cost-effective means of enhancing competence. There is little evidence that it does so, but there is evidence that timely education, relevant to specific needs, is highly beneficial and resources may be better directed there. Third party validation of recertification requirements is quite unnecessary and certification by managers raises the question of how their competence to assess is assured.

HPs who are routinely trusted with people's lives should be trusted to supervise their own learning to maintain good standards and should be supported with educational and employment opportunities to do so, rather than being overloaded with mandatory activities needing an expensive bureaucracy to certify.

Recertification has a direct impact on the cost of an APC and already seven percent of midwives identified cost as the reason for not renewing their midwifery APC. Under the NZNO's DHB MECA, DHBs reimburse nurses for the cost of their APCs, so the cost of recertification has a direct impact on the public health budget. In countries where there

are some mandatory CE requirements - usually for advanced nursing only - cost is of increasing concern.

The requirement for PD also raises the question of whether standards are set to maintain competency and keep abreast of new developments or, as in the case for the PDRP included in the NZNO's MECA, for upskilling. In this sense there is some lack of clarity around the function of the RAs which is to regulate for public safety not regulate for advancement of the profession.

The Midwifery Council of New Zealand (MCNZ), for example, has extremely wide ranging re-certification requirements which have proved a financial and organisational burden to both midwives and employers. Clarity between the RA role of public safety and the role of the professional organisations in advancing the profession is blurred. The MCNZ has contracted solely with the New Zealand College of Midwives (NZCOM) to undertake the Midwifery Standards Review component and has ignored the role of employer quality and leadership programmes (similar to nursing PDRP) in assessing a midwife's practice against the standards and competencies. The introduction of this expensive and time consuming recertification process has resulted in numbers of midwives exiting the profession and has thus contributed to the current midwifery shortage.

Other RAs have negotiated contracts for the provision of PD and CE programmes which either partially or totally relieves them of the responsibility of auditing, since the service provider reports directly back. This has required investment by both providers and RAs in new support systems, but has also reduced the workload of the RA and made compliance easier for the HP.

There does not appear to have been much attempt by the RAs to collaborate with recertification and there is a repetition of the inconsistency and duplication which besets much of the implementation of the Act. Vaccination training for instance is accepted as a recertification activity by one RA but not another, even though it is the same nurse undertaking it. Recertification/CE activities relevant to several or all health professions could easily be standardised. A good opportunity exists with the training for cessation of

smoking programmes that the Quit group has developed which, having been approved by the NZMC for CE, could apply to all HPs, if suitable mechanisms were put in place.

A synchronised time scale would enable flexible cross crediting to encourage skilled practitioners to have or retain more than one scope of practice; currently the double recertification requirements for HPs with dual scopes are a formidable barrier. NZNO suggests it may be appropriate to consider a two year term, though the cost implications would need further consideration.

NZNO notes that a new development has occurred since the Act with PDRP programmes for nurses run by organisations which report directly back to NCNZ. Those nurses on recognised PDRP programmes, provided by the DHBs under the DHB MECA for instance, are exempt NCNZ's auditing processes; in effect the NCNZ does not have to verify the recertification requirements before issuing a PC since the employer is doing so. A similar situation exists with NZNO's College of Practice Nurses who also run a PDRP programme. The cost of recertification in this case is transferred from the RA to the DHB.

NZNO recommends that

- RAs be encouraged to collaborate in setting consistent requirements, sharing a common vocabulary and time frame, developing training/activities across all health professions where possible; and
- recertification requirements should be minimal.

13. What changes, if any, are needed to improve the evidence available to answer the previous question?

Clearly there is a need for much greater communication and coordination between RAs to find common ground and rationalise requirements on the basis of evidence that they contribute to safe healthcare. Currently doctors can provide immunisation without the specific training that is required of others, for instance. If there is evidence that special

training is needed for vaccinators to operate safely, it must apply to every vaccinator regardless of which RA they come under for the system to be coherent and transparent. Competence requirements should be addressed from an evidence base which ensures standards are maintained consistently across all professions, especially in the light of increasing overlapping areas of health.

Requirements to keep abreast of current practice are unlikely to be met in any but the most rudimentary way unless there are adequate resources to enable them. Consideration could be given to directing resources for recertification activities to those areas where evidence suggests they are most needed, such as rural practice and aged care.

Recertification requirements are more likely to be appropriate and manageable if they are set by a RA which included elected HPs who are in touch with the day to day challenges of working in the health sector. NZNO recommends that membership of the RAs include elected practising HPs.

NZNO suggests that, where possible, validation, for example, certificates from courses should be managed directly by coordination between training providers and RAs, as already happens with some professions, to reduce the burden of paperwork and increase efficiency.

14.	Where recertification arrangements are in place, what issues arise and what changes, if any, would you suggest (eg, in respect of the nature of the programmes, the level of compliance, monitoring practitioners' compliance, the costs and other impacts on practitioners employers etc)?

NZNO recommends working towards a more consistent framework and suggests that there is some merit in having a two year recertification programme which would be easier and less costly to administrate, though it may affect RA income streams.

Provision for cross crediting for those HPs with dual professions would be desirable.

NZNO recommends immediate attention be given to reducing the recertification workload for Midwives which are unusually onerous, costly and time consuming.

15. Where recertification programmes have not been introduced how do the authorities assure competence, and are there ways that these processes could be improved?

N/A

16. What would be the gains or problems associated with requiring all authorities to institute recertification programmes?

Some professions with smaller numbers may not have the resources to implement and monitor such programmes effectively in which case there might be need for international collaboration or financial support from government. The expense may unfairly fall on a few HPs in this case.

17. Registration authorities have to judge when a practitioner 'may pose a risk of harm to the public' and trigger notification: is this working effectively and what, if any, suggestions do you have to improve effectiveness?

NZNO believes current processes are working well in this area except for the length of time it takes for resolution which, in the case of nurses, can take up to a year. Being able to appoint replacement committee members from the pool of approved people without going through the NCNZ meeting process, may help to speed up the process.

As some HPs opt to resign rather than go through the competence review process, there may be an issue as to whether a potential employer should be alerted. On the whole NZNO feels that that would not be useful as incompetence has not been proven and employers have a responsibility to check employment records.

18. Is it appropriate that authorities must notify a particular set of agencies: what changes, if any, are needed?

Yes.

19. At what times, if any, other than when there is a concern of a risk of harm to the public, should a registration authority exercise its power to review the competence of a health practitioner?

Most RAs have adequate auditing programmes (5 – 10%) which are sufficient to maintain public trust in the competency of HPs. The potential for problems when a nurse changes scopes or moves between specialties is addressed by the Code of Conduct which requires that nurses do not practice without appropriate orientation and adequate training.

20. Is voluntary reporting by practitioners of possibly unfit practitioners working, on what do you base this opinion, and, in the light of experience, what are your views on making it a requirement to report concerns about a possibly unfit practitioner?

Yes. The alternative of mandatory reporting is too onerous, works against collaboration between HPs, is punitive, may give rise to nuisance or malicious reporting and would outstrip available resources. The spirit of the Act quite properly focuses on cooperation and support through what is generally a short period in a potentially long career in healthcare. There is no evidence to show that mandatory reporting by colleagues or associated HPs gives rise to a safer environment, but there is evidence to show that it can lead to an oppressive one. We trust HPs to act responsibly, intelligently and with compassion and, in the rare instances where fitness to practise is an issue, they should be entrusted to exercise the same qualities with their colleagues. Indeed HPs are more likely to notice fitness to practise issues quickly and to know how to encourage their colleague to seek appropriate help.

21. Is compulsory reporting by employers of possibly unfit practitioners working, on what do you base this opinion?

Yes. There are good examples of employers, such as MidCentral DHB, who have instituted excellent learning contract systems using human resource principles which are clear, fair and effective. The number of self-referred HPs is a good indication that, given a supportive environment, unfit HPs will seek help rather than try to cover up deficiencies which is the best possible protection for the public. Where HPs are not self-referred, employers are taking responsibility for referring them to the appropriate authorities. There is no reason to believe that unfit or incompetent HPs are going unreported.

22.	Are the interests of the public and of practitioners being balanced when dealing with the risk of harm from practitioners who are deemed to fail to meet required standards of competence? Please explain.

Generally yes. In the first instance, it is recognised that competence issues have complex causes, cover a wide range of areas and degree of seriousness. Skilled professionals assess the specific needs of individual HPs who are not meeting competence assessments and work with them to design individually-based programmes which maximises the opportunities for good outcomes.

Where there are more serious issues they are dealt with appropriately by the HPDT. The mix of lay and professional input protects both the public and the HPs.

However, currently with regard to the scope of the Health Committee to make recommendations, the only options are to suspend, impose conditions or not. Since having conditions attached to the APC has, at times, a disproportionately negative effect on opportunities for employment, it would be useful if the health committee were also able to accept an undertaking from the nurse that they will comply with - for example the recommendations of a psychology report - within a specified timeframe. This would mean that there were no conditions on their PC which can sometimes make it difficult or impossible for them to gain employment.

The risk to public safety is heightened by the high turnover of migrants so that it is not uncommon, for instance, to have a new migrant Registrar working with a new migrant nurse, a New Zealand nurse *translating* for another HP, or facilities and areas almost wholly dominated by foreign staff. As already indicated, competence assessment can only take place after a problem is identified and there are no provisions for ensuring cultural competence. A more proactive induction system for immigrant HPs is needed.

23.	In practice, do competence and recertification programmes differ, are both sets of provisions needed or should changes be made?

They do differ – recertification includes competency.

There has been some concern about the wide variation in competence assessment programmes offered by different educational institutions and NZNO notes with approval that the NCNZ has undertaken an audit of them with a view to establishing consistency.

NZNO again notes the high cost of undertaking recertification for those whose APCs have lapsed after 5 years. The availability of courses and the reluctance of employers to retrain nurses into the workforce, despite the advantages of doing so, can also be problematic. Subsidising recertification programmes has proven an effective strategy in attracting HPs back into the health workforce with the added advantage that they tend to live locally, and are therefore familiar with the community, and stay longer (Long, 2007).

24.	Should any other parties be obliged to inform the registrar of a practitioner's inability to perform their required functions because of a mental or physical condition?

NZNO believes that the existing regulations are working well and that there is no need to extend mandatory reporting. We feel that such a move would be counterproductive in that

- precious resources would be wasted investigating malicious or inappropriate reporting;
- effective investigation would therefore be delayed;
- it could jeopardise cooperative relationships amongst HPs; and
- it would be contrary to the rest of the Act which sensibly focuses on ensuring support for the HP to meet requirements, rather than punishing them for not.

NZNO draws attention to the difficulties arising from mandatory reporting of child abuse which directly conflicted with and undermined the trust essential the therapeutic work of Child, Youth and Family Service officers.

25.	Are the interests of the public and of practitioners being balanced when dealing with fitness to practise issues? Please explain.

Usually HPs who are not fit to practise are being identified, assessed and appropriately dealt with. Public resources are not being wasted on unnecessary investigations, nor are the skills and careers of HPs being unnecessarily inhibited because of a temporary or manageable problem. The regulations are fair, humane and sensible.

26.	Are protected QAAs operating in areas you are familiar with: are they valuable, are there any problems, are the reporting requirements appropriate, should there be any changes to the QAA arrangements, should QAAs continue? Please explain.

NZNO understands that, as yet, few protected Quality Assurance Activities have been approved for nurses, but believes they are an essential part of maintaining high standards. NZNO notes that effective provisions operating under the previous Medical Practitioners Act were for doctors only and welcomes the fact that the HPCA has enabled all HPs to seek protection from them also. We note, however, that social workers who are frequently part of multi-disciplinary teams are not covered by these provisions. Nurses within the Māori mobile nursing service, for instance, work alongside social workers with vulnerable groups and should have the same protection.

Hawkes Bay DHB has a protected QAA operating with its nursing PDRP programme which has proved highly effective and could be replicated in other DHBs. Pinnacle Group Limited has protected QAAs supporting 650 doctors and nurses working in general practices in their PHO network spread over five DHB areas. Though there will always be some tension between open disclosure and providing a safe environment for disclosure, the increasing uptake of the opportunity for anonymous reporting of events over the past two years suggests it is necessary and working well in the PHO environment. 150 events have been reported, which should make an important contribution to the process of reducing the risk of harm. However the potential for further use of their anonymous database seems limited when none of the required annual reports to the Minister have been acknowledged, let alone acted on.

NZNO would like to see more protected QAAs operating and would like to see some investigation on the effectiveness of QAAs as a quality assurance tool.

27.	Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?

Yes. NZNO is concerned about the increasingly high number of nurses inappropriately referred to professional conduct committees (PCCs) for matters that should be dealt with at a lower level. Confusing NCNZ changes in the timing of issuing PCs, for instance, has seen dozens of responsible, highly competent nurses brought before PCCs, basically for

late renewal of PCs. Most were self-referred. The stress, disruption and expense caused have been unnecessary and unacceptable. Quite clearly the three month threshold NCNZ has adopted is too short a time, especially when there have been changes to an established system.

Such cases indicate a consistent lack of judgment on the part of the NCNZ. While it is disturbing to note that only the NCNZ seems to have taken such an extreme position, evidently the degree of latitude allowed by the Act is too wide for consistency. Had there been elected representation to the RA, and had Annual Reports been published as required, it would have been evident how out of step the NCNZ was with other RAs.

Some delays with PCC processes could be avoided if replacement committee members could be co-opted directly from the pool of approved members, rather than having to go through NCNZ meeting approval process.

28.	To what extent is the suspension of an annual practising certificate and referral of a practitioner to the HPDT effective in protecting the public?

This is effective and does provide some international safeguards since most countries will check that nurses have not been suspended or have a pending case against them. This is one of many reasons to explore the opportunities for developing joint standards not only with Australia, but also other countries and particularly the Pacific Islands.

29.	What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?

Reasonable time and opportunities should be given to gain extra competencies. For example it is not possible to train over the extended Christmas/New year period as nursing competency courses are not held, nor are APCs issued over this period.

30. What, if any, benefits or problems have arisen from having a single tribunal for all regulated professions and what, if any, changes would you recommend?

NZNO believes the tribunal is working effectively and fairly. Though there has been the occasional surprising decision and the involvement of lawyers adds to the expense, it is generally robust, transparent and consistent.

There is some concern, however, about the selection of expert witnesses, who may be expert practitioners but not in the particular field. An example of this is a case which called for an Emergency Department expert, where the expert witness actually had limited after-hours ED experience. Adequate consultation is necessary to ensure the best expertise is made available. This may indicate the need for a stronger advisory capacity for the HPDT.

31. Is the current membership structure of the HPDT operating and are there any changes you would recommend (for example, the mix, the selection and appointment processes, training of members)?

NZNO believes the mix of lay and practitioner members is right as evidenced by the fact that there have been no appeals against a tribunal decision. NZNO does not support greater lay representation on the Tribunal. The cases before the HPDT are complex and serious and although training is always valuable, it cannot replace the comprehensive experience of trained practitioners who have a thorough knowledge of accepted clinical and ethical standards.

32. Is there a need for the HPDT to have the capacity to deal with multi-practitioner/ team-based disciplinary matters and, if so, how should this be organised?

No. NZNO believes it is appropriate to have representation from the specific profession on the Tribunal and recommends that when the HPDT is reconvened that there should be *three* members from the representative profession.

33.	Are the current arrangements for financing and supporting the HPDT, appropriate and what, if any, changes would you recommend (including the costs of taking cases to the tribunal and sustaining the operation of the tribunal)?

NZNO notes that some RAs have already foreshadowed a rise in the PC levy in order to pay for disciplinary procedures and recommends that a cap should be put on the amount that can be levied for this purpose. Disciplinary procedures have already arisen because of lack of judgment on the part of the RA, (see question 27) and, as pointed out elsewhere, HP competence is only one aspect of a number of elements that make up a safe health environment. HPs should not be held accountable or have to pay for systemic failures which prevent them from being able to practise safely. Safe health care cannot be delivered even by competent health professionals in an unsafe environment and there should be a limit to the financial responsibility HPs are expected to take.

NZNO would be interested in knowing what steps, if any, have been taken to monitor the costs of implementing the HPCA Act and recommends that costs are monitored closely.

34.	Are the appeal provisions operating well and what, if any, changes would you recommend?

No comment

35.	How do you think the current number and mix of professions and authorities is operating and what, if any, changes do you think should be made?

Although there is concern at the increasing number of RAs, NZNO is strongly in favour of continuing to have separate RAs specific to professions, rather than have specialist areas of health practice subsumed into a general health authority. The scope, complexity and exponential advances in health care today make it more important than ever that the complementary specialist skills of each profession are retained and valued. In nursing, the increasing focus on complex technical procedures and corresponding pressure to devolve routine tasks, risks compromising the very skills which are intrinsic and particular to nursing, and which underpin good health care. “Routine tasks” disguise the empathy and skill with which nurses monitor patients for the subtle changes which indicate progress or deterioration. Separate RAs strengthen and endorse the skills of

each profession, underlining why it is necessary to have elected representation and a strong educational and clinical focus on councils.

However there is an obvious need for greater collaboration and rationalisation between the RAs. NZNO does not see that additional RAs should be problematic if there is a consistent operational framework to slot into.

In relation to the proposed regulation of anaesthetic technicians, where a separate RA has not been allowed, NZNO suggests that either the NZMC or Medical Radiation Technologists Board would be appropriate authorities.

36.	Are the provisions for adding new professions or health services working and what, if any, changes would you make?

See above.

37.	Are the current membership and appointment provisions working (eg, is the size and mix right, are people with the best skills being appointed, should the power to hold elections be retained and/or used, are lay and professional members appropriately trained and supported) and what changes, if any, would you recommend?

NZNO believes that designated Māori positions on RAs are a Treaty obligation and moreover, would improve the health of Māori and reduce health inequalities. NZNO notes and applauds the RAs which have made a concerted effort to include Māori representation in spite of the Act's lack of direction in this regard. However, it is acknowledged that there may be concerns with the potential of all RAs to have Māori representation especially those RAs with small numbers of Māori HPs. Accordingly, NZNO proposes adding a further clause (d) to Section 120 (2) which reflects the intent of Māori representation:

The membership of an authority must include*:*

(d)"As far as practicable two persons to each responsible authority who have knowledge skills and experience in Māori health and Māori health inequalities and have an understanding of the principles of the Treaty of Waitangi".

NZNO notes that six percent of the nursing workforce is Māori and with almost 3000 Māori nurses, Māori representation on NCNZ should not present a problem. NZNO acknowledges the College of Nurses Aotearoa's (CoNA) call for greater educational representation on the Regulatory Authorities to ensure a seamless process between setting standards and their delivery through consistent educational programmes, we suggest that the greatest deficiency on NCNZ is the lack of grounding in the day to day reality of nursing. NZNO recommends that membership of the authority should include nurses currently practising in a clinical setting. The NCNZ's work could be enhanced by ensuring that there was a sound knowledge of the private aged care sector and mental health nursing amongst membership.

Section 120 2 (a) states that the authority must include *"a majority of members who are health practitioners*", but does not specify the health profession. NZNO recommends that the section be amended to read "a majority of members who are health practitioners "*regulated by that authority".* Similarly, to ensure they are up to date, appointees should be currently practising, managing, advising or teaching the profession.

NZNO believes there should be provision for "elected council members" to be elected by their professions. The definition of a lay person as someone who is neither registered nor qualified to be registered as a health practitioner is too broad as it allows for others with interests in the health sector to be appointed which may potentially lead to a conflict of interest. NZNO recommends that this definition be replaced with the more specific definition set by the National Ethics committee and published by the Ministry of Health in 2002, which says:

A *lay person is a person who is not:*

- *currently, nor has recently been, a registered health practitioner (for example, a doctor, nurse, midwife, dentist, pharmacist);*
- *an officer of, or someone otherwise employed by, any health board, health authority, the Ministry of Health, or medical school;*
- *involved in conducting health or disability research or who is employed by a health research agency and who is in a sector of that agency which undertakes health research; or*

- *construed by virtue of employment, profession or relationship to* have a potential conflict or professional bias in a majority of protocols reviewed.

38.	What deletions, amendments or additions, if any, do you recommend to the list of functions – and why?

NZNO believes the list is comprehensive but would recommend that authorities be required to do more than just liaise with other authorities about common interests under the Act. In the interests of consistency, fairness, efficiency and sound workforce planning, they should be required to seek commonality of systems, particularly for data collection and reporting.

A number of factors, including high global migration, and the rapid exchange of information that information and communication technologies allow, underlines the fact that New Zealand is not operating in isolation and that national health policies and regulations have international effects. For this reason the RA should be required to be cognisant of international developments in research and best practice and be given authority to collaborate with other countries in setting standards.

NZNO recommends

- that the words *"consistent with the outcome of research and international educational data*" be added to Section 118 (j) *To promote education and training in the profession,* and that consideration should be given to encouraging RAs to collaborate with their international counterparts.

39.	How well are authorities carrying out their functions and what changes, if any, do you recommend?

NZNO notes that the Nursing Council has not fulfilled its statutory obligations to file an annual report since 2004; nor, according to the Regulation Review Committee has it followed proper, inclusive consultative processes in determining titles and scopes of practice, resulting in the continuing debate over second level nursing. The former makes it extremely difficult to access essential information.

The NCNZ website has contained outdated and inaccurate information regarding direction and supervision policy from the Nurses Act 1977, rather than providing up-to-date guidance and leadership in professional standards although this is being addressed currently.

The overzealous use of PCCs has been expensive, time-consuming and stressful to all concerned, for no good purpose. Similarly there are examples of overly bureaucratic responses to minor problems with the issuing of APCs.

NZNO acknowledges that the NCNZ has, by far, the greatest workload of any RA, but believes that "red tape" should not stand in the way of commonsense, nor should nurses feel intimidated or frustrated by a barrier of paperwork when meeting their professional obligations. Consideration should be given to systems which facilitate compliance, and which will provide recent, relevant information in realtime, as has been achieved with online access to the registrar of nurses for which the NCNZ deserves credit. NZNO notes that some RAs have excellent online facilities which enable such things as members updating addresses and recording recertification activities and recommends that full advantage be taken of information and communication technologies to provide an efficient and consistent HPCA system.

NZNO acknowledges the difficulties of verifying the legitimacy of some overseas qualifications, for example with nurses from Zimbabwe, but in these situations where it takes time to clarify the situation, the nurses have been left in a very vulnerable position and have been given little information which is not acceptable. NZNO feels the RAs need to be more proactive in supporting immigrant HPs.

40.	Are there any specific legislative requirements that regulatory authorities are currently subject to that they should not be? Please explain.

Under Section 118, one of the functions of the RAs (Section 118 (i)) is to set standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners of the profession. While the first two are clearly the function of the RA, NZNO believes that ethical standards should be set by the profession, that is the professional associations. Ethical standards usually operate within the law but, historically, there have been times of conflict, for example in World War 2, between what

is sanctioned by the government and what the profession considers ethical. It is more appropriate that ethical standards of the profession are guarded by the profession itself rather than being subject to political influence and social pressure. Recent debate over issues such as pre-genetic diagnoses, xenotransplantation and euthanasia, for example, suggest that there is potential for a lot of contention in those areas and it should be up to those who are working in the area to set ethical standards they are to comply with.

NZNO recommends

- that the words "*and ethical conduct"* be deleted from Section 118(i)

41.	Are there any specific legislative requirements that regulatory authorities should be subject to that they are currently not? Please explain.

RA authorities should be required to consult profession *responsibly* and the process of true consultation, such as the steps outlined by the Australian National Nursing and Nursing Education Taskforce (2005) should be set out. There also needs to be a clear pathway for professions to challenge RA decisions effectively, with binding decisions. Although the Regulations Review Committee pointed out that NCNZ had not properly consulted over the title of ENs in 2004, for example, it did not prevent the repetition of exactly the same faulty process the next time in 2007.

NZNO recommends

- the addition of a clause describing what is meant by proper consultation processes be added to Section 14 (2)

42.	To what extent are the current powers of the Minister of Health appropriate to the purpose and effectiveness of the Act and what changes, if any, do you recommend?

NZNO considers that Minister's powers are too extensive in some areas, particularly in having the sole authority to appoint *all* RA members which is unnecessary, undemocratic and has not seen the best outcomes in our view. An RA which is not accountable to the profession it regulates risks being out of touch with current clinical practice, professional development, education and training. Although it is acknowledged that the Minister

seeks recommendation, a truly robust representative system, with elected representation from members is the only democratic and effective way ensuring the RAs enjoy both public and practitioner trust. Appointments by the Minister can and have been construed as an avenue for political interference.

Although the powers of the Minister do extend to resolving disputes, in practice these have not been used, as evidenced by the continuing dispute over titles and scopes for second level nursing, possibly because the relevant section, section 125, requires an audit first. Section 124 gives the Minister power to audit authorities to ascertain compliance with the provisions of the Act," *including, without limitation, the principles set out in Section 13",* but since section 13 merely covers the principles guiding the prescribing of qualifications the intent is ambiguous.

NZNO is particularly concerned about the lack of Māori representation and consultation and in addition to its recommendation for Māori representation on RAs, recommends that the minister be required to consult with the Minister of Māori affairs where possible, as for instance in Section 116. In this section the Minister may consult with "any organisation" that has an interest in the designation of health services as a health profession.

NZNO recommends

- that the words "*including*" and "*the principles set out in section 13"* be deleted from section 124 so that the Minister is given power to audit compliance with the provisions of the Act without limitation.
- deleting the words "*following audit"* in the title of section 125 and the words "*after consideration of an auditor's report completed under section 124 about an authority"* in Section 125 (1) to clarify the Minister's powers to direct the resolution of disputes.

43.	What changes, if any, do you recommend to matters covered by the provisions of Part 7 of the Act?

No comment

44. What changes, if any, do you recommend to specific wording in the Act in order to clarify or address technical issues not otherwise covered already?

No comment

45. What, if any, other matters are you aware of in respect of the operation of the Act and what changes do you recommend?

NZNO is aware that in rare instances people have been accepted for nurse training but have subsequently not been registered by NCNZ because of differences in the definition of 'good character' and this anomaly should be addressed.

CONCLUSION

NZNO considers that the HPCA has gone a long way towards meeting its primary objective to regulate all HPs consistently while ensuring the sensible degree of self regulation that varying disciplines require. However, more needs to be done to rationalise administration, especially in terms of data collection and management, to minimise mandatory recertification activities and to effect more collaboration between the RAs to avoid further fragmentation and duplication.

It is evident that elected representation by the professions is absolutely necessary to ensure that the RAs are in touch with current health practice. This is particularly important for nurses since nursing covers such a range of areas and activities and makes up the vast majority of the health workforce – they need to be listened to. The protracted dispute around second level nursing is evidence both that the NCNZ is not attuned to the profession and that mechanisms for resolving disputes are inadequate or not properly enforced. Although disciplinary procedures especially with the HDC and HPDT are working admirably, there is a lack of understanding by employers and the public around restricted activities and scopes of practice in particular.

Two important factors that impact heavily on the health workforce which are not considered in the Act are the significant number of unregulated HCAs and immigrant HPs. A clear distinction needs to be made between regulated and unregulated activities to prevent HCAs assuming nursing duties and to avoid the ludicrous situation of some HPs being precluded by their scopes from duties which non-regulated workers do. Similarly much more needs to be done to identify and address the particular needs of and barriers to the safe induction and retention of immigrant HPs. The IELTs by itself is inadequate: we need *appropriate* regulation. New Zealand risks being at the end of the long line of countries needing more HPs in the future unless it develops and implements sound policies to facilitate the entry of immigrant HPs in a way that ensures their confidence and public safety.

Priority should be given to addressing legislative anomalies where the intent of the HPCA Act. For example, where nurses endorsed to supply ECP are prevented from doing so because of provisions around accessing funded supplies.

Finally, NZNO believes that HP competence is inextricably interlinked with the other key elements the Safe Staffing Healthy Workplaces Committee of Inquiry identified and that these need to be considered in investigations of competence. NZNO strongly recommends that safe staffing protocols including minimum levels in the aged care sectors are implemented.

RECOMMENDATIONS

The New Zealand Nurses Organisation recommends that you:

- **note** that HP competence is only one factor contributing to a safe health environment ;
- **agree** that the key elements of safe staffing as identified in the Safe Staffing Healthy Workplaces Committee of Inquiry Report (2006) are fundamental to the delivery of safe healthcare and should be taken into consideration when a health practitioner's competence is questioned;
- **agree** that minimum levels in aged care need to be regulated for the protection of both public and health practitioner safety;
- **add** provisions for the appointment of members to responsible authorities to include elected representation on RAs from professional associations;
- **note** the low level of understanding of the HPCA, particularly of employer responsibility, which has contributed to confusion about scopes of practice, particularly for second level nurses, and unregulated health workers;
- **agree** that a national reporting system to support *all* health care staff to report *any* incident relating to health and safety is a priority;
- **resolve** the confusion surrounding title and scope of practice for second level nursing through proper consultation processes
- **note** NZNO's recommendation for one title and scope of practice for each level of HP in each discipline to
- **note** the lack of clarity and contradictions relating to restricted activities
- **agree** to regular four-yearly review of scopes of practice in the HPCAA
- **add** provision for appeal against RA decisions
- **consider** a two year term of APC and recertification activities
- **note** the increasing numbers of unregulated Health Care Assistants and clarify who should be responsible for them in a clinical setting

- **agree** to address the broad range of issues arising from the high levels of migration in the health workforce especially in ensuring immigrant practitioners are supported with programmes to gain the cultural and clinical competencies needed to practise safely in New Zealand
- **agree** to develop bilateral agreements particularly with the Pacific islands
- **agree** to implement strategies such as a standard on-line learning package and test on the NZ health system and the Treaty for all migrant HPs to complete
- **show leadership** in ensuring RAs are consultative, cooperative and consistent
- **add** a clause describing proper consultation processes to Section 14 (2)
- **delete** section 11 (2)
- **delete** the words "*and ethical conduct"* from Section 118(i)
- **delete** the words *"including"* and *"the principles set out in section 13"* from section 124
- **delete** the words *after consideration of an auditor's report completed under section 124 about an authority* in Section 125 (1)
- **add** the words "*regulated by that authority"* after the words "*a majority of members who are health practitioners*" in section *120 2 (a)*
- **add** the words **"***consistent with the outcome of research and international data"* after the words **"***To promote education and training in the profession"* to Section 118 (j)
- **add** the following clause to Section 120 (2) *"As far as practicable two persons to each responsible authority who have knowledge skills and experience in Māori health and Māori health inequalities and have an understanding of the principles of the Treaty of Waitangi".*

References

Annals, Geoff. 2007. *Kai Tiaki Nursing New Zealand.* Debunking the Myth of Unsafe enrolled Nurse Practice Vol. 12 No 5 p 29

Australian Nursing and Midwifery Council. 2007. Project to produce a National Framework for the Development of Decision-making tools for Nursing and Midwifery Practice (national DMF) as retrieved January 2008 from http://www.anmc.org.au/projects/past_projects.php

DeAngelis, Donna et al, *Changes in Healthcare Professions' Scope of Practice: legislative considerations,* Association of Social Work boards and 5 other healthcare

Dumonte, Jean-Christophe, Zurn, Pascal 2007 *Health Workforce And International Migration: Can New Zealand Compete?* OECD, DELSA/ELSA/WP2/HEA(2007)3

Health and Disability Commission. 2007a. *A Report by the Health and Disability Commissioner: Case 05HDC11908.* HDC p 55

Health and Disability Commission. 2007b. *A Report by the Health and Disability Commissioner: Case 05HDC11908.* HDC pp19-21

International Council of Nurses. 2004 Credentialing forum 2004 as retrieved January 2008 from http://www.icn.ch/CFCountryReport2004.pdf

Long, Janet. 2007. *Australian Journal of Advanced Nursing*. Returning to nursing after a Career break: elements of successful re-entry. Vol 25, No 1.Pp 49-55

McElrea, Richard. 2006. *Findings of the Coroner in the Matter of an Inquest into the death of Winifred Constance Clements*, Coroners Court, Christchurch

National Nursing and Nursing Education Taskforce. 2005. *Principles for Working Together,* Australian Health Ministry Advisory Council, as retrieved January 2007 from http://www.nnnet.gov.au/downloads/n3et_draft_principles.pdf

North, Nicola, Trlin, Andrew and Singh, Rajapuri (1999) Characteristics and difficulties of unregistered immigrant doctors in New Zealand, *New Zealand Population Review*, 25(1/2): 133-143. (also as Reprint No.7).

North, Nicola, Lovell, Sarah & Trlin, Andrew (2006). Immigrant Patients and Primary Health Care Services in Auckland and Wellington: A Survey of Service Providers. *New Settlers Programme Occasional Publication No. 12.* New Settlers Programme, Massey University, Palmerston North.

North, Nicola. 2007. International Nurse Migration, *Policy, Politics, and Nursing Practice.* Vol.X No. X, Month XXXX, pp1-9

NSW Department of Health, 2006, *Patient safety and Clinical Quality Programme: third report 2005-2006*. NSW Department of Health, North Sydney. P2

NZNO. 2007a. *Submission for the Nursing Council of New Zealand consultation document on the Registration of nurse assistants who qualified in New Zealand between 2001 and 2005.* as retrieved December 2007 from http://www.nzno.org.nz/Site/Submissions/Recent/NCNZ_EN_Submission.aspx

Nursing and Midwifery Advisory Committee. 2007. *Quality in the Workplace*, NZNO. Wellington

NZNO, 2007b. *Draft guideline: direction and delegation consultation document* retrieved December 2007 from http://www.nzno.org.nz/Site/Submissions/Recent/Direction_and_Delegation.aspx

Regulations Review Committee. 2007. *Complaint regarding Notice of Scopes of Practice and Related Qualifications prescribed by the Nursing Council of New Zealand* retrieved December 2007 from http://www.parliament.nz/en-NZ/SC/Reports/1/3/a/13aa0823b5924ef7adeb2e2aee55c317.htm

Safe Staffiing/Healthy Workplaces Committee of Inquiry. 2006. *Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry* retrieved January 2007 from http://www.nzno.org.nz/Site/Campaigns/safestaffing.aspx

regulatory organisations, USA as retrieved January 2008 from https://www.ncsbn.org/ScopeofPractice.pdf

Seddon, Mary. 2007. *The safety of patients in New Zealand Hospitals: A progress report.* HDC

Standards New Zealand.2005. *New Zealand Handbook*: *Indicators for Safe Aged-care and Dementia-care for consumers*, SNZ HB 8163:2005, NZ Standards Council