New Zealand Nurses Organisation

Feedback to the Health and Disability Commissioner

on the

Review of Policy on Naming Providers in Public HDC Reports

29 February, 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

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to contribute to this timely discussion on the Health and Disability Commissioner's (HDC) policy review on naming providers in public HDC reports.

2. As representative of over 41,000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals, NZNO is keenly interested in the reporting processes relating to breaches of the Code of Health and Disability Services Consumers' Rights (the Code) as they affect our members and have a significant influence in the public health arena.

3. NZNO is committed to an open investigative and reporting environment tempered with the discretionary powers of the HDC which NZNO believes have been exercised in a fair and reasonable way. Consumer rights have been upheld with the HDC's thorough investigations of events, which have focused on unravelling the complex interaction of systemic and human errors, rather than seeking blame. In several instances the HDC's reports have highlighted deficiencies in the management of public health – appropriate staffing and skill levels, delegation, reporting processes, for example – which, if addressed, would greatly contribute to improving public health and safety.

4. NZNO notes however, that these reports have been subject to widely differing interpretation and, at times, quite inappropriate responses. An example is Capital and Coast DHB's (CCDHB) decision not to employ enrolled nurses (ENs) on night duty, following a HDC report last year (Health and Disability Commission, 2007), notwithstanding the seriously flawed rationale and evidence which informed the DHB's decision (NZNO, 2007). Conflicting advice from the NCNZ and the Ministry of Health regarding ENs scope of practice contributed to the confusion, but the replacement of highly experienced ENs with untrained HCAs is patently unsound. It does, however, underline the significance of HDC reports and their power to effect change.

5. Though naming providers, whether public, private or individual, has not been common in Aotearoa's health sector, NZNO agrees with the HDC in recognising that there is increasing public demand for greater transparency and accountability,

particularly to ensure that private and political health sector interests are not protected by name suppression above legitimate public concerns.

6. Where no breach of the Code is found, however, there is no legitimate basis for public interest and in such cases NZNO believes that providers should not be named. Providers should not be put at risk of embarrassment or distress by being named in an investigation where no fault has been found, since there is always the potential for misreporting or confusion. Nor should individual providers be named where a breach has occurred as a result of systemic rather than practitioner error, for similar reasons.

7. But where the Code has been breached "the public interest in the accountability of public institutions cannot be overstated", (Holt and Paterson, 2008). Internationally and nationally, the trend is towards more stringent scrutiny and open reporting of complaints and disciplinary procedures, partly to circumvent media distortions which proliferate in the absence of accurate information.

8. That said, it is of note that media interest rather than due process has driven changes in the public accountability of the health profession in the past twenty years, beginning with the 1988 Cartwright Report on the investigation of cervical screening research at National Women's hospital. That is cause for concern because the media is clearly profit-driven and no more likely to serve the public good than any other interest-driven group. There is at least as great a risk to both individuals and the public health system from the undue influence of the media as there is from purported medical "cover ups" which only an open investigative and reporting environment can address.

9. NZNO notes that there is a difference between promoting an open system of reporting errors within an organisation and a system where media are free to publish the names of practitioners involved in all investigations. The transition from the relatively closed environment which prevails in Aotearoa New Zealand, where public disclosure of the names of the few health practitioners found in breach of professional standards is rare, to a more open environment, where naming becomes the default position, will require a change in *culture* that will take time. NZNO welcomes the gradual and cautious approach the HDC is taking.

10. NZNO believes that discretionary provisions for naming providers based on consideration of each case on its own merits, gives adequate protection for those few who would be discouraged from reporting or unfairly disadvantaged by being named in public HDC reports. Generally, however, name suppression is not in the public interest. Innuendo, speculation, suspicion, 'trial by media' and, above all, *inaction* are the hallmarks of a closed reporting environment.

11. As the discussion document notes, most complainants want mistakes to be acknowledged and systems put in place to ensure they are not repeated. A climate of secrecy does not facilitate this. Little change has occurred as a result of the HDC's reports being referred to the Director-General of Health though policies have proliferated, as some HDC reports have noted.

12. It has been a source of frustration to NZNO that when challenged to produce evidence of the risks and problems associated with inadequate staffing levels or training, that relevant information in the reports of sentinel events has been effectively locked away from public scrutiny. It is only recently with the introduction of yearly reports that NZNO can engage in meaningful discussions with the DHBs and others about the health and patient safety issues emerging from them.

13. NZNO notes the good learning and good guidance resulting from United States' Joint Commission's <u>open</u> public information policy which "is committed to making relevant and accurate information about health care organizations available to interested parties" on the grounds that "Information regarding a health care organization's quality and safety of care helps organizations improve their services and may also help educate consumers and health care purchasers in making informed choices about health care."

14. Similarly, the introduction of a state-wide systematic process for examining serious events in the public sector in New South Wales in 2003 has led to marked improvements in quality.

15. In Aotearoa New Zealand, there is no such national reporting system or even agreement as to what constitutes a sentinel event; private providers apparently do not have to report them to the DHBs that contract them. This is of particular concern in the Aged Care sector where low levels of staffing, coupled with the total responsibility that health practitioners assume under the Health Practitioners

Competence Assurance Act 2003 (HPCAA), are not conducive to reporting or monitoring events. It is significant that one HDC inquiry was initiated by a funeral director who was concerned by the condition of the body he was asked to pick up. In such an environment, it is not surprising that there is a degree of cynicism around reporting of events, nor that complaints investigated by the HDC may represent a small proportion of endemic systems failures. It is the lack of consistent follow-up of HDC reports, even in response to sentinel events, which is the source of concern and frustration to nurses, not fear of being named.

16. NZNO draws your attention to the United Kingdom's independent Healthcare Commission, part of whose duties are to "*regulate the independent healthcare sector through registration, annual inspection,* ***monitoring complaints and enforcement****".* We suggest that a national reporting system so that events and as well as complaints can be monitored, and enforcement of recommendations which would lead to safer practice, are essential counterparts to establishing a more open and co-operative reporting environment. Naming on its own will not safeguard the public's right to good healthcare – it is just one factor amongst many that will help generate a culture of learning, respect and public confidence.

17. NZNO also notes that Registered Nurses (RNs) and ENs named in HDC reports are also referred to the Nursing Council of New Zealand (NCNZ) for review. NZNO would like to be assured that a similar process is carried out for other individuals and health practitioners responsible for errors. It seems that ,even in cases where a string of systemic failures are noted and where several health professionals have been found wanting, both publicity and response often centres unfairly on the health professional at the end – often a second level nurse. In these cases, not naming all the health professionals and administrators involved, has allowed the scapegoating of and discrimination against a whole class of health professionals, helping to maintain historic power imbalances which are inappropriate in a modern clinical environment where multidisciplinary teamwork is standard. Nurses are not afraid to admit mistakes but should not be forced to assume total responsibility, or bear the blunt of blame, because they are at the end of a long line of administrative and clinical decision-making they have little share of.

18. The question of responsibility is even more opaque when it comes to unregulated Health Care Assistants (HCAs) whom RNs are often put in charge of, again

particularly in the Aged Care sector. RNs scope of practice includes delegation and management of some duties to second level nurses, *and others.* However, this sensible provision to allow RNs to occasionally direct some ancillary staff where necessary, is currently being abused to the extent that RNs are being called upon to assume responsibility for supervising several HCAs, each able to care for up to 10 patients! At what point, and with how many patients, should the organisation rather than the individual RN be responsible?

19. NZNO contends that at the very least the *minimum staffing levels* developed and agreed to by representatives of all those involved in the aged care sector in the New Zealand Handbook*: Indicators for Safe Aged-care and Dementia-care for Consumers,* (New Zealand Standards, 2005) should be considered as indicative of individual or organisational responsibility.

20. A snapshot of staffing levels in a variety of aged care sites carried out by NZNO in 2005, for instance (NZNO, 2005), found that staffing levels for both nursing and caregiver were well below even the lowest indicator level across all sites. In rest homes, staffing levels for nurses were at 53 percent of those expected by the indicators, and although total caregiver hours were at 95 percent of indicator levels in the hospitals, the staffing skill mix was not optimal. Under these circumstances, individual errors must be seen to have arisen from systemic failure for which the individual cannot be held accountable and therefore should not be named. NZNO is aware that some providers in the aged care sector make huge profits from understaffed facilities where wages and conditions for their health care workers that are well below those provided by the DHBs. It is definitely in the public interest that they are named and made to provide appropriate wages and workloads which enable qualified health professionals to do the job they are trained for.

21. The steady increase in the number of unregulated HCAs has unfairly impacted on RNs who, under the Health Practitioners' Competence Assurance Act 2003 (HPCAA), are held responsible for their supervision. Equally unfairly, HCAs are sometimes asked by employers to carry out nursing duties such as administering medications – even intravenously - and bathing. NZNO believes it is the employers' responsibility to ensure HCAs understand the conditions of their employment and the distinction between nursing and their duties and that nurses should not be held accountable, or named, for breaches of the Code by HCAs.

22. NZNO does note however that organisations are made up of individuals and that the competence of executives, managers, administrators and advisors directly impacts on the ability of health professionals to do their jobs. Consequently DHB officials and Rest Home managers, for example, should be held just as accountable as clinicians and also be subject to naming. That may encourage more communication and clinical input into executive and management decisions so that workable policies based on evidence for safe practice could be developed and put into practice.

23. NZNO notes that the lack of provision for appeal against the HDC is problematic and places an enormous responsibility on the individual HDC, who may prove not to be as fair or considered as expected. Decisions which are not robust, especially those based on one case, can lead to bad practice so it is incumbent on the HDC to ensure that expert advice is properly peer reviewed. However, consumers do have access to other processes, albeit more expensive and time consuming, and any system is only as a robust as its constituents. NZNO notes that there are criteria and processes for the selection and appointment of the Commissioner commensurate with other appointments in our judicial and legislative systems, and trusts that they are robust enough to deliver a fair and discerning person.

24. NZNO believes that the high regard in which nurses are held will not be compromised by the naming of individuals in the event of a breach of the Code. Although it is evident that individuals can and are deeply, and sometimes unfairly, adversely affected by investigations and disciplinary procedures, normalising the reporting environment so that naming is standard will, over time, ensure that provision is made for supporting nurses facing untoward attention. Research on the impact on people undergoing breach investigations would inform the development of useful processes and NZNO recommends urgent consideration be given to undertaking such research which is currently lacking.

25. The discussion document suggests that, with no mandatory requirement for reporting, health practitioners may be more reluctant to report substandard practice under the HPCA Act if they believe it will lead to more adverse publicity and impact on individual careers because of naming. NZNO believes that these reservations stem from a misconception about why mandatory reporting is not supported by health professionals, which is that it is not as effective, efficient or fair as voluntary reporting, which generally seems to be working well.

26. In general NZNO believes that the circumstances outlined in the discussion document in which the Commissioner would consider naming providers in breach of the Code, including responses to Official Information Act requests, are reasonable providing that where systemic errors that are not the responsibility of the individual occur, then only the organisation should be named.

27. NZNO also believes that where cases are referred on to any other agency for investigation, for example to the Coroner, Accident Compensation Corporation, or the RA, as well as the Health Practitioners' Disciplinary Tribunal, individuals should not be named.

28. NZNO believes that an open reporting system, where the default position is to name providers unless there are serious extenuating circumstances should be part of a multi-pronged strategy to protect the rights of consumers and expose poor practitioners and systems. NZNO believes that such an environment where the facts on both sides are freely available, offers the best opportunity for fair decisions, rational discussion and learning.

29. In summary NZNO supports the HDC's move towards a more open reporting environment where a breach of the Code has occurred and believes that rest homes, private hospital and residential care facilities, medical centres and pharmacies, and individual providers names, as well as those of the DHBs, should be released in the public HDC reports in the event of a breach of the Code having regard to the criteria outlined in the discussion document and in this submission.

SUBMISSION

1. Do you consider that providers not found in breach of the Code should also be named in publicly released HDC reports**.**

No. In these circumstances providers should not be named since no fault was found and providers have a right to privacy.

2. What are your comments if any on the criteria for naming DHBs in publicly released HDC reports? 3. Are there any other criteria that should be considered?

NZNO agrees with the rationale for the adoption of the practice of naming DHBs and notes the positive responses and learning this seems to have generated. The criteria for considering naming which are broad, allowing for interpretation of each event according to the nature and circumstances and timing of the event, are sound and fair. Each breach must be considered on its own merits and standardised responses would be inappropriate. NZNO agrees there is a risk that an individual might be occasionally be identified by virtue of the DHB being named, but, as long as the individual is not named and is not at fault, considers the risk small. The example given, of a dietician being identified by virtue of being the only one in that role in a small DHB, would be equally applicable for any individual working in any large organisation and is a consequence of an open justice system. In any employment situation, both individuals and organisations are at risk of being compromised by each other's activities and it is difficult to see how that can be avoided.

4. What are your comments, if any, on the criteria for naming rest homes, private hospitals and residential carer facilities in publicly released HDC reports?

5. Are there any other criteria that should be considered?

The evidence is clear that nurses working in these situations are at higher risk of being referred to competence review and the criteria for naming needs to reflect this. NZNO strongly believes that where standards fall below the Standards New Zealand *Indicators for Safe Aged-Care and Dementia-care for Consumers* which are minimal and we believe require upgrading, it is essential that the provider, but not individual nurses and HCAs, be named in the event of a breach of the Code.

NZNO is aware that many providers in this sector rely on migrant nurses who, in some cases, have been exploited and who have often come from developing countries in need of their own health professionals. NZNO believes that the poorer wages and conditions which do not match those in the DHBs Multi Employer Collective Agreements, is a significant factor in these facilities being under-resourced and relying on migrant staff. NZNO does not accept that difficulty in employing staff in these circumstances justifies any consideration of name suppression, particularly when these facilities are being run as businesses. Several highly profitable facilities are largely overseas-owned and it is incumbent on our regulatory systems to ensure that New Zealand's standards of health care, pay levels and working conditions are not compromised.

There is no indication that there is a reluctance for providers to get into aged care; rest homes are being built at an astonishing rate, although their distribution is uneven. Senior citizens spending their life savings and considering the precious last years of their lives, are entitled to quality information about the care they will receive in, not only the buildings they will occupy. Sometimes small rest homes that offer quality care and struggle to meet the highest standards are at a disadvantage when it comes to competing against large providers advertising 'designer' facilities but whose staffing policies fall well short of safe standards. NZNO strongly believes that these facilities, many of which have featured in HDC reports and inquiries, should be named and made to resource them adequately, keeping staff safe from errors and complaints and able to deliver quality care. NZNO delegates in the aged care sector consistently remark that the workload, lack of staff and high turnover leaves them feeling unsafe with little or no job satisfaction. It is not surprising so many nurses opt not to work in the sector. The suggestion that some private facilities risk loss of livelihood from adverse publicity because of a health professional's error rather pales in the face of the nurses who are daily risking their livelihoods – their PCs – for lower wages and poor conditions.

In spite of the aged care sector having agreed "that a minimum number of staff is required to ensure safe care" (Standards New Zealand, 2005), the minimum levels agreed upon in the same document New Zealand Handbook*: Indicators for Safe Aged-Care and Dementia-Care for Consumers* are rarely met; nor has the Ministry of Health instigated a trial or monitored the application and efficacy of the indicators in terms of the safety of patient outcomes to "enable informed decisions to be made on the full adoption of the handbook as a National Standard…" as expected. Nurses who work in this sector continue to be at higher risk for referral to professional conduct and competence review, and serious health and safety breaches in rest home facilities continue to constitute a significant proportion of high profile investigations by the HDC and others. Clearly, health professionals should not be carrying the full responsibility for endemic failure to meet minimum standards and these facilities should be named. Equally clearly the minimum levels outlined in the aforementioned Handbook should be updated and made mandatory so the HDC can do more than make recommendations.

NZNO does not believe there is an undue risk of certified persons being adversely affected by negative publicity. Similar publicly available lists are held for many businesses, trusts and organisations where private individuals, including accountants, teachers and prominent persons, lend their professional profiles to endorse particular activities. There is no reason why persons certifying profitable healthcare businesses should be treated any differently.

6. What are your comments, if any, on the criteria for naming medical centres and pharmacies in publicly released HDC reports?

7. Are there any other criteria that should be considered?

Medical centres and pharmacies may be group providers owned by individuals but they are still businesses, often operating limited liability companies, and cannot be exempt from naming just because they are in the health sector. Naming may also help to uncover patterns of repeated errors, which would be useful.

8. What are your comments, if any, on the criteria for naming individual practitioners in publicly released HDC reports?

9. Are there any other criteria that should be considered?

1. *Public safety concerns*: NZNO notes that the processes available to protect the public that the registration authorities can impose upon individuals only apply regulated health care workers, and there is no such process available for unregulated HCAs. This vacuum should be met by ensuring that the employing authority is responsible for managing competence or disciplinary recommendations for HCAs. NZNO strongly supports the spirit of the HPCAA with regard to supporting health professionals through fitness and competence issues where possible, and believes the processes we have are sound.

NZNO shares the concern expressed with regard to unregistered providers such as the natural therapist referred to, particularly with those who deal with people with mental illness. As with the field of complementary medicine, there is a spectrum of opinion and risk and educated consumers are perhaps the only protection against the most unsafe. In this respect, NZNO believes the clear and accessible processes of the HDC and

publication of reports has made a significant contribution to public awareness and education about good and safe healthcare.

2. *Non-compliance with HDC recommendations:* NZNO has some reservations about recommendations to relevant registration authorities, for the re-issuance of a practising certificate (PC) dependent on compliance with the Commissioner's recommendations. Our experience is that employers are most reluctant to employ anyone with restrictions on their PCs, so, effectively, that may lead to loss of employment. NZNO would not support universal application of such a recommendation, when there does not seem to be pressing requirement for it. NZNO does support robust processes for ensuring that recommendations are met and believes there should be some process for checking that all health professionals comply. NZNO is concerned that such a recommendation might be more easily applied to those whose scope of practice is more straightforward and easier to monitor. If such recommendations were to be adopted, it would be important to ensure that an enrolled nurse would be no more likely to have a recommendation for re-issuance of a practising certificate, than a consultant for example.

With regard to refusal to comply with "minor recommendations", NZNO does not regard an apology to be a minor issue and is quite comfortable with an individual being named if non-compliant. Again this recommendation should apply to all people involved in an investigation.

3. *Frequent Breaches:* NZNO assumes that the latitude of waiting for three rather than merely the second breach is to allow for any timing issues. NZNO supports naming of any practitioner found in breach of the code three times in five years.

4. *Public interest:* NZNO believes that there is valid cause for concern where similar practitioners may fall under suspicion because of a naming convention, for example, *Hawkes Bay surgeon*. NZNO is confident that such factors will be considered in regard to the circumstances of each case. However, it is equally true that naming the surgeon in the same circumstances could prevent suspicion falling on those not involved.

10. What are your comments, if any, on the commissioners practice in releasing names in response to an OIA request?

NZNO supports the rationale and approach the HDC has adopted with regard to OIAs.

11. What are your comments if any on the legal context for the commissioners naming decisions?

NZNO supports the Commissioner's proposals for naming individuals as long as it is applied equitably.

12. What other relevant public interest factors support name disclosure?

Public interest factors against name disclosure NZNO believes the factors have been covered comprehensively but makes the following comments on respective clauses:

1. The question of negative media publicity with regard to practitioners found wanting is worthy of consideration, but should not override public interest. NZNO doubts whether many people interested in pursuing a career in health would be put off by such cases, especially when balanced by a greater number of 'good news" stories about clinicians. Good training, support, pay and working conditions are proven factors in attracting and retaining clinical staff as the Magnet Credentialling System for hospitals, developed by the American Nurses Association testifies to. "A Magnet hospital is stated to be one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution."

9. NZNO believes that compliance with recommendations should be enforced.

10. Mandatory reporting works against collaboration between HPs, is punitive, may give rise to nuisance or malicious reporting and would outstrip available resources. The spirit of the HPCA A 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. 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.

Rather than discouraging HPs from taking an active interest in their colleagues professional wellbeing, NZNO believes that, under the current system of voluntary reporting, the risk of being named in the event of a breach will encourage HPs to take action *before* such an event occurred, which is the best outcome.

11. NZNO strongly endorses research findings which show that medical errors are more often attributable to oversight or systems issues than to incompetence, carelessness or recklessness.

12. NZNO notes that the lack of provision for appeal against the HDC places an enormous responsibility on the individual HDC. Decisions which are not robust, especially those based on one case, can lead to bad practice so it is incumbent on the HDC to ensure that expert advice is properly peer reviewed. For example, a recommendation for patients presenting with Deep-Vein Thrombosis in Emergency Departments having to be seen within ten minutes was made on the strength of judgment of one "expert witness" in one HDC case (01HDC11475, 4 March 2003), yet experts in the field would argue that the recommendation was unnecessary and could not be met. NZNO recommends a panel of experts to peer review recommendations to guard against decisions impacting on general clinical practice/guidelines.

13. NZNO believes that as the naming of providers becomes established, practitioners will be <u>more</u> likely to cooperate because there will be <u>less</u> to fear without the atmosphere of suspicion and innuendo generated by ignorance and speculation. But this would only be possible in a fully open and responsive environment, where naming was one part of a system that encouraged reporting of all events, robust data collection and analysis, and appropriate follow up.

13. Should HDC ever name a provider (group or individual) if the provider has been referred to the Director of Proceedings (and further proceedings are possible)?

No

14. Should the reputation/commercial interests of group providers be given the same protection as the privacy interests of individual providers?

15. Should HDC apply different criteria is an organisation employs only a small number of practitioners and there is a risk that they will all fall under suspicion if the organisation is named? How should this be weighted against the public interest?

In both cases they are businesses and only the same protection that applies to other businesses that breach relevant codes of practice should apply. For example, small construction companies are no less likely to be named for breaching building standards or Occupational Health and Safety codes than large companies. In this context it is also worth noting that the overwhelming majority of New Zealand businesses *are* small and it is difficult to see why healthcare businesses should be exempted from common business risks. Nurses, even Nurse practitioners, are generally unable to directly contract to the DHBs so are not even in a position to use their skills as a basis for a business, so this group constitutes a small minority in the health sector and very small minority in the business sector. Since the HDC considers each case on its merits only there is the opportunity to avoid naming in the circumstances already outlined.

16. What other relevant public interest factors oppose name disclosure?

NZNO reiterates that where systemic issues are uncovered which impact on the individual practitioners' ability to reasonably perform his or her duties then that practitioner should not be named. To assist assessment of that we urge consideration of the minimal levels outlined in the *New Zealand Handbook: Indicators for Safe Aged-care and Dementia-care for Consumers* for the aged care sector. Elsewhere, and particularly in the DHBs we recommend consideration of the seven key elements identified in the Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry (2006).

ABOUT THE NEW ZEALAND NURSES ORGANISATION

1. 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.

2. The NZNO vision is “Freed to care, Proud to nurse”. Te Runanga o Aotearoa’s vision is “Hei oranga motuhake mo ngā whānau me ngā hapū me ngā iwi”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships. Our members are united in the achievement of their professional and industrial aspirations.

3. NZNO has consulted its members in the preparation of this submission in particular NZNO staff (Management, Professional Nursing Advisors, Policy Analysts, and Industrial Advisors) and NZNO members (Te Runanga, Colleges and Sections, Board Members and other health care workers). Our members include nurses, midwives, students, health care workers and other health professionals.

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

REFERENCES

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

Holt, S. and Paterson, Ron. 2008. Medico-l;egal Secrecy in *New Zealand.Journal of Law and Medicine*. Vol 15, No. 4, p.602

NZNO *Submission To Capital and Coast District Health Board On C&CDHB Consultation document Enrolled Nurse Scope of Practice*, 5th July 2007, Wellington: Author.

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

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