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Position Statement

New Zealand Nurses Organisation

The place of Enrolled Nurses/Nurse Assistants in the health environment

I. INTRODUCTION

This document speaks specifically to the context and place of the Enrolled Nurse (EN) in the New Zealand health system. As Enrolled Nurses have had a long and chequered history, the focus of this document is primarily viewed from their perspective. However, NZNO does acknowledge the worth and contribution of Nurse Assistants (NAs) who now share a number of commonalities with the ENs. In contrast, Nurse Assistants have a much shorter history with their introduction to the nursing workforce in 2004. In the current environment, ENs and NAs have different scopes of practice yet share the same competencies as defined by the Nursing Council of New Zealand (NCNZ, 2004; 2005).

Enrolled nurses (EN) continue to make up a significant part of the regulated nursing workforce with around half of the group's 3370 members being employed in acute areas (NZHIS, 2006/07). Approximately 60% of all ENs are NZNO members, with the NZNO EN section having over 700 members. The Enrolled Nurses Section represents and supports Enrolled Nurses and Nurse Assistants (NA) across NZ. The Enrolled Nurses Section promotes and supports its members through: strategic planning; responsive communication networks; and representation and lobbying at national meetings (NZNO EN Section, 2007).

II. BACKGROUND

In response to a number of Health and Disability Commissioner reports (2003, 2007), there have been ongoing varying interpretations from employers to restrict and /or change employment conditions for the Enrolled Nurse.

The Ministry of Health and the Nursing Council (2003) jointly gave quite confusing advice that seemed to say enrolled nurses could not work in acute settings. Despite attempts to achieve clarification of the letter the confusion has persisted. In response to ongoing concerns in the sector about the proper application of the enrolled nurse scope of practice the Ministry of Health (2007) and the Nursing Council (2007 a, b) each circulated further letter(s).

Unfortunately, these letters have not aided clarity. This may be in part because of a lack of appreciation for the different roles that Nursing Council, employers, directors of nursing and practitioners play in making decisions about the application of scopes.

The Nursing Council of New Zealand (NCNZ) governs the practice of nurses. The Council's primary concern is public safety. It establishes scopes of practice (NCNZ, 2004) as part of its governance of practice

under the Health Practitioners Competence Assurance Act 2003 (HPCA). Nurses and employers often seek direction from the Council as to where enrolled nurses may work or what tasks they may undertake. This is driven by a concern to ensure enrolled nurses are not working outside their scope of practice. However, it is not the duty of the Council to make such decisions and it does not do so. The application of scopes of practice is a matter for those who are delivering nursing; employers of nurses, Directors of Nursing and the clinicians themselves, registered and enrolled nurses.

As a result of these pervading and conflicting messages, and actions/reactions taken by employers, a number of industrial and professional questions have been raised by NZNO members. This document outlines the position of the NZNO on the themes raised within these questions.

III. SCOPE OF PRACTICE

Section 8 of the Health Practitioners Competence Assurance Act 2003 (the "Act") requires health practitioners to practise within their scopes of practice.

The scope of practice for enrolled nurses was gazetted on 15 September 2004.

"Enrolled Nurses practise under the direction of a Registered Nurse or Midwife to implement nursing care for people who have stable and predictable health outcomes in situations that do not call for complex nursing judgement. The responsibilities of Enrolled Nurses include assisting clients with the activities of daily living, recognising the changing needs of clients and performing delegated interventions from the nursing or midwifery care plan."

This scope of practice was closed by the NCNZ with no further entries after 18 September 2004 when a notice of regulation was made.

There are significant problems associated with this September 2004 definition, including:

- The Nursing Council of New Zealand has not provided a definition of "stable and predictable". This leads to a local interpretation of this statement causing confusion for both the employer and the employee as to what activities/involvement this includes. Within this confusion are the implications for effective teamwork when members of the team do not understand the prescribed boundaries of other team members. Combined, these have led to a reduced role for enrolled nurses in certain activities despite their experience and safe practice to date (Annals, March 2007).

- Unrealistic expectations regarding the realities of patient management ie. A stable and predictable patient in any setting may have an evolving pathology that emerges during care as unstable. The mandate that RNs carry out effective first

assessments for nursing care, with follow-up assessments on a regular basis, is crucial to patient safety and accurate patient allocation to other staff members. Following on from these assessments is the process of ensuring patient care direction and delegation is being safely effected. Adequate staff resourcing (skill mix, knowledge and training) is vital to this equation.

- Another valid point to question is the availability and quality of the nursing care plans that are, or are not, being provided in a number of settings. Without these care plans being written and updated regularly, based on sound assessments, weaknesses must follow in 'the system' in providing the enrolled nurse safe guidelines for practice.

It is interesting to note that a few years before the 2004 definition, the EN scope of practice had read as being focused on patients who were "relatively stable…" giving it quite a different perspective, and widening its application from the current definition. Susanne Trim challenged Marion Clark about the decision to remove the word "relatively" from the scope statement (this was during the debates in the consultation re wording for the Gazette Notice) when Marion admitted that there had been no formal decision by Council to remove the word "relatively", but that it had probably been a typing omission. This is a sorry reflection on the processes involved then and since because of the ensuing employment issues marked by confusion around the patient's status of stability.

NZNO recommends that any consideration of changes in nursing skill mix include careful assessment of the opportunities within the scope to maximise the contribution of enrolled nurses. There is nothing in the enrolled nurse scope of practice that prohibits enrolled nurses from working in any general setting, particular service arrangement or at certain times of day. Decisions about the proper application of scopes cannot be made generically on such broad parameters. They must be made with due consideration for the nursing needs of the particular patients concerned and the environment and context of their care. Decisions also require specific knowledge of the expertise of the individual enrolled nurse concerned and the registered nurse who is to provide them with direction. This involves dialogue with and between these clinicians. None of this suggests it is possible to make decisions about the appropriate application of scopes of practice according to generalities. These are case by case assessments requiring professional judgement at several levels (Annals, July 2007).

IV. EDUCATION AND TRAINING FRAMEWORK

NZNO had detailed its vision for a framework for enrolled nurses education programmes in the flowchart 'National Strategy Development Framework for Education Programme(s) for Enrolled Nurses' (NZNO, 2007). NZNO believes this framework provides a sound basis for achieving the necessary education objectives for second level nurses:

- To develop standards for second level nursing practice across the

continuum of care
- To ensure an adequately trained second level regulated nursing workforce

Developing the workforce to provide an integrated nursing team able to effectively influence patient outcomes.

V. MEDICINE ADMINISTRATION BY THE ENROLLED NURSE

NZNO has anecdotal reports of confusion among Health Professionals regarding medicine administration (including Controlled Drugs and injections) by Enrolled Nurses.

Nursing Council's 'Competencies for the nurse assistant and the enrolled nurse scope of practice' state that under Domain 2, Competency 2.1, one of the indicators as stated by Nursing Council is:

> *"Administers interventions and medications within legislation, codes, scope of practice and according to authorised prescription, established policy and guidelines"*

Administering medications, therefore, is one of the competencies that ENs must meet and is an expected component of their role.

The following information is an extract from the NZNO publication entitled Guidelines for Nurses on the Administration of Medicines (NZNO, 2007).

Any person may administer medicines (including controlled drugs[1]), but whoever administers these is required to do so in accordance with the directions of the prescriber.

All people in employment who administer medicines:

a. Must be familiar with their employer's policies and guidelines regarding medicine administration.
b. Regulated nurses/midwives need to understand their responsibilities and accountabilities related to their scope of practice, which are relevant to medicine administration.
c. Unregulated caregivers who administer medicines need to understand their responsibilities and accountabilities.

For residential care facilities specifically: The guideline entitled Safe Management of Medicines: A Guide for Managers of Old People's Homes and Residential Care Facilities (Medsafe, 1997, p.2) specifies "that nominated staff members must sign all entries in the (controlled drugs) register".

[1] Section 8(2)(d) of the Misuse of Drugs Act 1975 states "Any person having the care of a patient for whom a controlled drug is supplied by a medical practitioner or dentist, or prescribed by a medical practitioner or dentist and legally supplied, may administer that drug to that patient in accordance with the advice of the medical practitioner or dentist who supplied or prescribed it".

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NZNO believes the safe administration of medicines by the regulated nurse/ midwife requires the exercise of professional judgement, which involves the applications of knowledge and experience to the situation. This judgement is directed to fulfilling the standards for the administration of medicines as outlined in *Guidelines for Nurses on the Administration of Medicines.*

NZNO acknowledges that there is a wide spectrum of situations in which medicines are administered. At one extreme, is the client in an intensive therapy unit who is totally dependent on qualified staff for her or his cares. At the other extreme, is the person in her or his own home administering her or his own medicines or being assisted in this respect by a relative or another person. The answer to the question of who should administer a medicine must largely depend on where within that spectrum the recipient of the medicines lies.

It is NZNO's position that, at or near the first stated end of that spectrum, it is vital that there is assessment of response to treatment and speedy recognition of contra-indications and side effects of prescribed medicines. Therefore, NZNO recommends that medicines in these settings should only be administered by regulated nurses/midwives who are competent for the purpose and aware of their personal accountability.

(Authors' note: this is an extract only, further details are obtained by reading this publication).

Enrolled Nurses and Nurse Assistants can administer injections. It is noted that injection technique is taught in current Nurse Assistant Programmes (CPIT, 2007), and was also taught in Enrolled Nurse training programmes.

NZNO also notes that some Registered Nurses make decisions regarding patient allocation to an Enrolled Nurse based on whether a patient has an intravenous or subcutaneous infusion. NZNO believes that infusions are not the basis on which a patient allocation is to be made, rather the decision must be based on the relative stability of the patient along a projected pathway.

Finally, Australian literature (Nurses and Midwives Board of New South Wales, 2006; Queensland Nursing Council, 2005) indicates it is practice to endorse Enrolled Nurses for further skills in medication administration.

VI. HEALTH AND DISABILITY COMMISSIONER COMMENTS AND/OR RECOMMENDATIONS RE ENROLLED NURSES IN THE FOLLOWING CASE:

It would seem that the Southland/Burton case have been misquoted or misinterpreted on a number of occasions by senior nurse leaders, including the Ministry of Health (2003) who have then acted to diminish

the role of the Enrolled Nurse.

The following are the direct and relevant quotes from the Commissioner's reports in an attempt to clarify any misunderstandings regarding the practice of Enrolled Nurses.

Southland / Burton case:

The misinterpretation of this case was confounded by a joint letter issued by the Ministry of Health and the NCNZ (2003) which essentially recommended that Enrolled Nurses be withdrawn from acute mental health setting. Varying interpretations were placed on this letter by employers around the country causing confusion, and potentially compromising patient safety. However, the following quotes state the Commissioner's actual recommendations:

"Southland DHB to ensure sufficient supervision and staffing support to ensure the practice of enrolled nurses remains within enrolled nursing scope of practice (p. 218)."

"Review the employment of ENs in the acute psychiatric setting, including consideration of whether there is a place for enrolled nurses, and if so, ensure implementation and audit of policy with regard to scope of practice (p. 220)."

VII. DIRECTION AND DELEGATION

There is nothing in the enrolled nurse scope of practice that prohibits enrolled nurses from working in any general setting, particular service arrangement or at certain times of day. Decisions about the proper application of scopes cannot be made generically on such broad parameters. They must be made with due consideration for the nursing needs of the particular patients concerned and the environment and context of their care.

Decisions also require specific knowledge of the expertise of the individual enrolled nurse concerned and the registered nurse who is to provide them with direction. This involves dialogue with and between these clinicians. None of this suggests it is possible to make decisions about the appropriate application of scopes of practice according to generalities. These are case by case assessments requiring professional judgement at several levels (Annals, July 2007).

The process involved around the EN/NA reporting to a RN is another issue worth noting. A number of organisations/DHBs are requiring RNs to countersign progress notes so that it is clear which staff members were involved in the delivery of care. This is not required but there needs to be a record of the RN providing direction either through the rostering system, or signature on a care plan, or if the EN/NA has consulted a RN then that RN's name needs to be documented in the notes.

As far as nursing care plans are concerned, some nurses / managers

seem to be under the impression that ENs/NAs cannot contribute to the care plan or make alterations. This is not so as is described in the NCNZ competencies (see NCNZ Competencies 2.1 & 2.4). Contribution and changes can be made by the Enrolled Nurse but the RN needs to be informed and consulted appropriately.

The position of the RN regarding direction and delegation of patient care is made clear in NCNZ's Competency 1.3 (2005) which states that the RN:

"Demonstrates accountability for directing, monitoring and evaluating nursing care provided by nurse assistants, enrolled nurses and others.

Indicator: Understands accountability for directing, monitoring and evaluating nursing care provided by nurse assistants, enrolled nurses and other.

Indicator: Seeks advice from a senior registered nurse if unsure about the role and competence of nurse assistants, enrolled nurses and others when delegating work.

Indicator: Takes into consideration the role and competence of staff when delegating work.

Indicator: Makes appropriate decisions when assigning care, delegating activities and providing direction for enrolled nurses, nurse assistants and other."

The Nursing Council of NZ still has their Direction and Supervision document on the NCNZ website which is based around the Nurses Act 1977. NZNO has requested that this be updated around the requirements of the HPCA on a number of occasions. Changes to this document are currently being drafted by the Council.

NZNO supports the principles of delegation / delegate as described by the Australian Nursing & Midwifery Council (ANMC, 2007). Relevant visual tools developed by the ANMC (2007) are Diagram 1: Nursing Practice Decision Flowchart, and Diagram 1A: Nursing Practice Decisions Summary Guide.

VIII. CONCLUSION

Enrolled nurses have much experience and expertise to offer. NZNO believes their contributions should not be unnecessarily constrained. In order to provide the level and quality of care required by the patients for their safety, NZNO believes health providers must engage all levels of nursing to their full potential. Team structures must be shaped to match skill to patient health need. Leadership is essential in developing nursing services that are safe and responsive to patient need, while providing practice environments that are safe and positive for nurses, and other

members of the healthcare team.

With the advent of the Safe Staffing Unit being established it is imperative to embrace the Safe Staffing Elements (2006, p. 8) as guiding principles for patient safety. These include:

- 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.

The time is ripe for a comprehensive review of the many issues surrounding the second level nurse, including their regulation and employment. The New Zealand public deserves an effective healthcare team working to capacity to further improve health outcomes.

Anne Brinkman
Charlotte Thompson
Professional Nursing Advisors
August 2007

IX. CONCLUSION

Active Enrolled Nurses Working in NZ by Work Type 206/07 NZHIS

Annals, G. (March 2007). *Letter to David Chaplow re: Registered Nurses supervising Enrolled Nurses practising in acute mental health units*. Wellington: Author.

Annals, G (July 2007). *Letter to CEOs, DoNs re: Employment of Enrolled Nurses.* Wellington: Author.

Australian Nursing & Midwifery Council (2007). *A national framework for the development of decision-making tools for nursing and midwifery practice.* Canberra: Author.

District Court at Wellington (2007). *Judgement of Judge T.J. Broadmore.* Wellington: Author.

Health & Disability Commissioner (2003). *Southland DHB Mental Health Services. Wellington: Author.*

Health & Disability Commissioner (2007). *Capital and coast DHB. Wellington: Author.*

Healthy Workplaces Committee of Inquiry (2006). *Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry.* Wellington: Author

Ministry of Health & Nursing Council of New Zealand (23 May 2003). *Letter to health sector re: Employment of enrolled nurses within acute settings.* Wellington: Author.

New Zealand Health Information Services (2006/07). *Enrolled Nurses Working in NZ by Work Type.* http://www.nzhis.govt.nz/stats/nursestats.html#02, accessed 20 August 2007.

NZNO (2007). *Guidelines for Nurses on the Administration of Medicines.* Wellington: Douglas Pharmaceuticals.

NZNO (2007). *National strategy development framework for education programme(s) for enrolled nurses.* Wellington: Author.

NZNO National Enrolled Nurses Section (2005/2008). *Strategic Plan*. Wellington: Author.

Nurses and Midwives Board of New South Wales (2006). *Nmb:update.* Sydney: Author.
http://www.nmb.nsw.gov.au, accessed 15 August 2007.

Nursing Council of New Zealand (2004). *Scopes of Practice.* http://www.nursingcouncil.org.nz/scopes.html, accessed 3 August 2007.

Nursing Council of New Zealand (2005). *Competencies for the nurse assistant and enrolled nurse scope of practice.* http://www.nursingcouncil.org.nz/competenciesna.pdf, accessed 15 August 2007.

Queensland Nursing Council (2005). *Policy on medication administration by enrolled nurses [2005].* Brisbane: Author.

Safe Staffing/Healthy Workplaces Committee of Inquiry (2006). *Report of the safe staffing/healthy workplaces committee of inquiry.* Wellington: Author.

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Part 2 – Enrolled Nurse/Nurse Assistants Frequently Asked Questions (FAQs):

I. IS IT VALID TO DISALLOW ENROLLED NURSES FROM ADMINISTERING MEDICATIONS?

The Nursing Council's 'Competencies for the nurse assistant and the enrolled nurse scope of practice' is that under Domain 2/Competency 2.1 one of the indicators as stated by Nursing Council is:

"Administers interventions and medications within legislation, codes, scope of practice and according to authorised prescription, established policy and guidelines"

Administering medications therefore is one of the competencies that ENs must meet.

It is NZNO's view that the (potential) actions of a DHB in deciding to reduce the skill base of ENs by disallowing them to administer medications constitutes an unjustified disadvantage in accordance with s. 103 (1) (b) of the Employment Relations Act 2000.

(Please refer to Part 1, Section V. for further medicine administration information).

II. SHOULD ENROLLED NURSES BE ABLE TO DO NIGHT DUTY?

In the interests of patient safety, so long as there is an adequate level of registered nurse cover so that patient assessment, and the subsequent direction and delegation to ENs can be managed within the prescribed EN scope of practice, then the actual time of the shift is not relevant. However, if the staffing levels were compromised then having ENs as members of that shift's nursing team warrants close assessment so that competent, effective care can be received by the patient.

NZNO recommends that any consideration of changes in nursing skill mix include careful assessment of the opportunities within the scope to maximise the contribution of enrolled nurses. There is nothing in the enrolled nurse scope of practice that prohibits enrolled nurses from working in any general setting, particular service arrangement or at certain times of day. Decisions about the proper application of scopes cannot be made generically on such broad parameters. They must be made with due consideration for the nursing needs of the particular patients concerned and the environment and context of their care. Decisions also require specific knowledge of the expertise of the individual enrolled nurse concerned and the registered nurse who is to provide them with direction. This involves dialogue with and between these clinicians. None of this suggests it is possible to make decisions about the appropriate application of scopes of practice according to generalities. These are case by case assessments requiring professional judgement at several levels (Annals,

Letter to CEOs and DoNs, 2007).

III. WHERE IS THE PRESSURE COMING FROM TO RETAIN THE TITLE NURSE ASSISTANT INSTEAD OF THE TITLE, ENROLLED NURSE?

For some years a relatively small group of nurses has held to the notion that nursing should have only one level of practitioner, a bachelor degree prepared registered nurse. In recent years this has expanded to recognising the need for a second level but at the advanced practice level, with bachelors prepared registered nurses and masters prepared nurse practitioners. In the view of this 'anti-EN' group, the existence of enrolled nurses is outdated, considered to be detrimental to nursing and jeopardises public safety. This view has shaped much nursing policy and is the apparent driver behind the Nursing Council decision to change to a title that is more commonly understood to denote an unregulated and unskilled worker. However, it is important to note that it is widely recognised and accepted that economic and social circumstances have long since put the nursing ideal of an all-registered-staff to bed. This ideal has proven to be unaffordable, and also unattainable given "a national and worldwide shortage of nurses". (Huntington, Radio New Zealand, 23 April, 2007).

IV. HOW DOES THE TITLE CHANGE TO NURSE ASSISATANT IMPACT ON PUBLIC SAFETY?

The most direct impact is that it hampers efforts to rebuild, and maintain, adequate numbers of regulated second level nurses as is evidenced by the falling numbers in student enrolments since the 2004 title changes. Secondly, by increasing the necessity for service providers to engage unregulated care workers inappropriately in nursing services, it diminishes safety. When safety issues arise with unregulated workers there is no recourse to a regulating authority on their nursing care. The public is thus exposed to nursing outside the regulatory framework set up to assure the public of protection. Thirdly, the public does not recognise that the title Nurse Assistant is one which implies that this is a regulated position. It is confused with non-regulated titles.

A recent coroner's case (McElrea, 2007) illustrated this threat to patient safety clearly when the caregivers, who didn't even hold current first aid certificates, could only offer the rest home resident comforting words and prayers while the resident bled to death waiting for the arrival of the registered nurse. The Coroner noted the impact of insufficient nurses, registered and enrolled, on this outcome. He writes that, "Neither of the two caregivers on duty on the night in question had the training or experience to have a senior role during the night shift (ibid, p. 12)". He implied, through his statements, that patient safety would have been enhanced through the education of staff. He writes, "Earlier discovery of the bleeding and appropriate consequent action could well have prevented the death (ibid, p. 11)". Enrolled nurses have received at least one year of training (formerly 18 months) so are versed in the basic cares and needs of the patients. This in itself is an important aspect of patient

safety within the nursing cares delivered.

V. WHY WAS ENROLLED NURSES TRAINING STOPPED?

Hospital based schools of nursing were closed in 1993 for both RNs and ENs. Given the drive at the time by some senior nurse leaders for an all-RN workforce, the impetus was lost to continue the EN training. It was with support from Annette King, before the election in 1999, that the EN training was reintroduced in 2000, first at Northland Polytechnic, followed by Christchurch Polytechnic Institute of Technology.

VI. DID SOME NURSE ASSISTANTS TAKE THE NCNZ TO THE DISTRICT COURT IN SEPTEMBER 2006?

Yes, they did with the Appeal being centred around issues concerning their scope of practice, and title.

Judge Broadmore concluded that:

[64] The conclusion I have reached, therefore, is that the decisions by the Council complained of by the appellants did not impose conditions within the meaning of s 106(1) of the HPCA Act on the scope of practice of those in the appellants' position. They are therefore not capable of appeal to the District Court.

[107] Although the appellants have failed, that is not because I consider that they do not have substantive grounds for complaint about the decisions. To the contrary, I have considerable sympathy for their concerns. Whether those concerns can be substantively addressed, or the decisions of which they complain reversed, through legal process is not for me to say. It is inappropriate for me to say anything further about the merits, save that my views are such that I do not consider it appropriate to award costs to the council.

[108] I bear in mind also that a substantial part of the argument was taken up with issues on which the appellants have succeeded.

VII. WHAT WAS THE OUTCOME OF THE NZNO COMPLAINT TO THE REGULATIONS REVIEW COMMITTEE IN MAY 2007?

(Complaint regarding notice – on 18 September 2004 – of scopes of practice and related qualifications prescribed by the Nursing Council of New Zealand).

In response to the NZNO's complaint regarding the scopes of practice and related qualifications as prescribed by the NCNZ, the Regulations Review Committee (RRC) found that:

"In our opinion, the complainant [NZNO] has made out this aspect of its complaint. We consider that the Notice has had a retrospective effect that is not expressly authorised by the Health Practitioners Competence

Assurance Act 2003. In particular, we think that the group of second-level nurses who began training or graduated between the year 2000 and 18 September 2004 have been affected by the Notice, which has retrospectively altered their title without express authorisation.

We note the Nursing Council's comment that there have been a number of retrospective title changes to people in the nursing profession. We note that in this case the reason the matter has come to our attention is because, as the complainant said, this change matters to the affected second-level nurses (p. 13).

Therefore, the RRC has recommended that the group of second-level nurses who began training or graduated between the year 2000 and 18 September 2004 should be in a position to be registered as Enrolled Nurses, not Nurse Assistants.

The Government has 90 days to respond and has indicated that it will table a Government response on 17 September 2007.

It is noteworthy that this decision will create a further anomaly whereby those nurses trained as Nurse Assistants after September 2004 by the same programmes will have a different title.

VIII. WHAT ARE THE RECOMMENDATIONS FOR NURSING FROM THE RECENT H&DC'S CAPITAL & COAST CASE?

The Capital & Coast case:

There were a number of breaches made by members of the health care team, with a registered nurse and enrolled nurse having breached Right 4 of the Code. As well, the Commissioner found that the DHB must be held accountable for the systems failures. He stated that:

…There are, however, some cases where the accumulation of errors is so egregious that something more is required. I consider that this is such a case.

I have concluded that there is a public interest in Capital and Coast District Health Board being referred to the Director of Proceedings… for the purpose of deciding whether any proceedings should be taken (p. 112).

The following quotes illustrate the recommendations that were actually made regarding the nurses practice:

Janet Hewson, the expert nursing witness provided the following advice in answer to the posed question:

Q: Comment on whether [EN] was working outside her scope of practice. If she was, whose responsibility was this?

Yes, [EN] was working outside her scope of practice. [Mr A] was a complex patient whose condition was neither predictable nor straightforward. He presented with many challenging behaviours and was not physically improving despite treatment [over] almost 36 hours. The overall responsibility for ensuring health professionals work within their scope of practice [lies] with the individual (Nursing Council of New Zealand (2005) competencies 1.3, 1.4, 1.5) and in this case the employer, CCDHB. The duty manager, who is acting for the CCDHB out of hours, was aware of the situation on [the ward] the night of 24 to 25 September. It was clear from the internal review interviews that [EN] was not receiving direction and supervision from the registered nurses due to the busyness of the ward. [Mr A] was assigned to [EN] without considering his complexity. [Ms G], [Ms H] or [the clinical co-ordinator on the evening shift] should have recognized he was not an appropriate patient for an enrolled nurse.

Comment: The standard of care provided to [Mr A] by the nursing staff varied. Clearly the omissions of collecting and documenting observations were not to the expected standard and the lack of direction for [Ms I, the Enrolled Nurse] was unacceptable (pp. 42 – 43).

Ron Patterson, Health & Disability Commissioner comments on C&CDHB case:

Scope of practice

"[EN] worked outside her scope of practice by caring for Mr A, a patient who required more complex care than she, as an enrolled nurse, was professionally capable of providing. In particular, the Nursing Council's statement on scope of practice describes a patient of an enrolled nurse as one that has "stable and predictable health outcomes in situations that do not call for complex nursing judgement". Mr A was clearly not such a patient.

CCDHB was aware of the shortage of nursing staff through the duty manager, and further steps should have been taken to resolve this problem.

Following the internal inquiry, CCDHB accepted that [EN] worked outside her scope of practice on the night of 24/25 September. CCDHB advised that as a consequence of this case, enrolled nurses no longer work on night duty.

Being aware that Ward 17 was poorly staffed on the night of 24/25 September, and that an enrolled nurse was caring for Mr A (outside her scope of practice), CCDHB breached Right 4(2) of the Code" (pp. 105 –

106).

NZNO recommends all Health Professionals read the full cases before accepting an isolated recommendation, given out of context, for their individual setting. This will also afford the reader an understanding of the total case and the ability to participate in informed debates.

IX. WHAT DOES THE AUSTRALIOAN NURSING AND MIDWIFERY COUNCIL (ANMC) HAVE TO SAY ABOUT DELEGATION?

The ANMC have recently published 'A national framework for the development of decision-making tools for nursing and midwifery practice' (April 2007) which is designed to foster national consistency by:

- Identifying the agreed foundation principles for decision-making tools implemented by nursing and midwifery regulatory authorities (NMRAs)
- Demonstrating the application of the principles and concepts in nursing, and midwifery.

The ANMC report defines delegation as follows:

A delegation relationship exists when one member of the multidisciplinary health care team delegates aspects of consumer care, which they are competent to perform and which they would normally perform themselves, to another member of the health care team from a different discipline, or to a less experienced member of the same discipline. Delegations are made to meet consumers' needs and to ensure access to health care services; that is, that the right person is available at the right time to provide the right service to a consumer. The delegator retains accountability for the decision to delegate and for monitoring outcomes.

Delegation may be either the:

- Transfer of authority to a competent person to perform a specific activity in a specific context OR
- Conferring of authority to perform a specific activity in a specific context on a competent person who does not have autonomous authority to perform the activity.

Delegation is a two-way, multi-level activity, requiring a rational decision-making and risk assessment process, and the end point of delegation may come only after teaching and competence assessment. Delegation is different from allocation or assignment which involves asking another person to care for one or more consumers on the assumption that the required activites of consumer care are normally within that person's responsibility and scope of practice. Many of the same factors regarding competence assessment and supervision that are relevant to delegation also need to be considered in relation to allocation/assignment (pp. 15-6)

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MISSION STATEMENT

NZNO is committed to the representation of members, the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.