New Zealand Nurses Organisation

SUBMISSION ON

THE HEALTH PRACTITIONERS

COMPETENCE ASSURANCE BILL

DECEMBER 2002

1.0 Introduction

1.1 The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to presents its submission on the Health Practitioners Competence Assurance (HPCA) Bill. The regulatory act governing nurses' practice and education is the single most important piece of legislation to nurses, and for the NZNO. When enacted it will govern 73,000 health professionals - 47,000 of whom are nurses with an annual practising certificate (APC). The majority of these are NZNO members. Given nurses are the major group covered by this legislation it must be relevant and workable for nurses.

1.2 NZNO, with more than 32,000 members, is the largest professional and industrial organisation of nurses, midwives and health workers in New Zealand. NZNO's membership comprises registered nurses, midwives, enrolled nurses, student nurses, caregivers and allied health workers. NZNO is committed to representing its members and promoting nursing and midwifery. Honouring the Treaty of Waitangi, and through participation in health and social policy development, NZNO seeks to improve the health status of the tangata whenua and all the people of New Zealand.

1.3 NZNO's submission commences with an outline of principles relating to the goal of health professional legislation, patient safety, professional self regulation, consultation and the Treaty of Waitangi. The submission then comments on specific clauses of the HPCA Bill and suggests some alternative considerations. The submission concludes with the major NZNO recommendations. The appendix contains a selection of submissions from NZNO members and NZNO groups on the Bill, which demonstrates the basis of some of the NZNO positions on the Bill.

2.0 NZNO Principles

2.1 The goal of health professional legislation

2.1.1 NZNO recognises the need to make changes to the legislation that governs nurses. The Nurses Act (1977) does not reflect current day expectations and professional practice.

1.1.2 NZNO supports legislation to govern all health professionals on the basis of the common goal of protecting public health and safety, providing quality health care, the need for uniformity and recognising that many health statutes are out of date.

1.1.3 NZNO also recognises that the development of legislation to govern all health professionals is difficult and complex. NZNO is concerned, however, that the Bill in its current forms does not recognise the differences and variations between the needs, practices and issues of the health professional groups and that although nursing has many factors in common with other health professions, there are many differences as well.

2.1.4 NZNO anticipated new nursing legislation based on the Medical Practitioners Act (1995) with a strong emphasis on competency-based requirements. NZNO supports this emphasis because it considers the introduction of competence based practising regimes for health professionals sends an important signal to nurses, health workers, employers and consumers, that the public expects health practitioners to have up to date clinical knowledge and to undertake continuing education.

2.2 Patient Safety

2.2.1 The basis of much of the Bill is from the recommendations contained in the 2001 report " Review of Processes Concerning Adverse Medical Events " by Helen Cull QC (The Cull Report) commissioned following some high profile adverse medical outcomes. The purpose of this review was to investigate the current complaints process and make recommendations that would better protect the public, and ensure adverse medical outcomes were identified and appropriate and timely remedial action was taken.

2.2.2 NZNO is concerned that some of the recommendations of the Cull Report are punitive, will not improve patient safety and will have a detrimental effect on morale, recruitment and retention in the health sector.

2.2.3 NZNO also considers the prime objective of the Cull Report, which was to streamline the complaints process and reduce the length of time for investigation of a complaint, will not be satisfied through the HPCA Act, unless extra funding and resources are made available to the Health and Disability Commissioner's Office.

2.2.4 The Cull Report was very focussed on medical practitioners and NZNO considers its application in the Bill needs to be modified in relation to nurses, to take into account that the nursing workforce is a very different workforce to that of medical practitioners. Thus, given that nurses comprise 64 percent of health professionals currently covered by the proposed legislation, the impact of the Bill on the nursing workforce needs careful consideration. NZNO's submissions are therefore of vital importance and deserve thoughtful consideration.

2.2.5 NZNO is very aware of calls by the public for greater accountability of health professionals and for a more transparent and accessible complaint process. NZNO is a professional organisation committed to maintaining professional standards,

improving patient safety and upholding public confidence in the nursing profession.

1.3 Creating A Safety Culture

2.3.1 Complaints about health care and health professionals have increased significantly in the last ten years. There are multiple reasons behind this. The potential for errors in health care is always high and the environment in which health workers and nurses work is increasingly complex. NZNO has been disturbed by events and incidents where the health system has been found to fail patients and their families.

2.3.2 NZNO is concerned that the Bill in its current form focuses on the competence of individual health professionals and fails to acknowledge that latent defects, and errors in systems, play a major role in undermining an individual's competence (Reason, 2000).

2.3.3 NZNO considers the individual focus of this Bill will create more problems in the delivery of health care rather than reduce them. Solutions such as those implemented by the aviation industry should be examined closely and applied to the delivery of health care. A systems approach that identifies latent defects and active errors will be more effective in reducing professional error. The best approach, therefore, is to redesign systems within health care delivery to make it difficult for mistakes to occur and easier to detect and remedy mistakes if they do occur.

2.3.4 In NZNO's experience, adverse events and outcomes have rarely been the result of a single action, but rather the combination of multiple failures occurring at many levels. NZNO supports the sentinel events process that looks at the multiple

environmental and active systemic factors that have created adverse events rather than focusing exclusively on individual performance.

2.3.5 The emphasis of this Bill seems to be that errors are always the fault of individuals and strict, punitive measures need to be in place to manage health professionals who make an error. We believe this emphasis will be at the expense of developing a systems approach to reducing the chances of error occurring and the good management of error. NZNO supports the view offered by Leappe – a well known researcher into health care error - that health care systems lag behind other safety industries, because of their misplaced reliance on individual performance as the key to improvement in overall performance (Leappe, 2001).

2.3.6 Nurses are used to working with processes for capturing errors e.g. incident reporting. In many hospitals it is the nurses who manage incident reporting and response to critical incidents and events. These processes have been in place for many years and there has been a high rate of error capture. It is worth noting that during the health reforms, incident-reporting systems were dismantled, intentionally and unintentionally, because nurses and doctors were removed from front line positions.

2.3.7 There is compelling evidence that inadequate staffing resources present a serious threat to the safety and quality of health care (Aiken, 2002). NZNO's believes this is consistently under-recognised. Aiken describes nurses as the "surveillance system" in hospitals (Aiken, 1994), yet there is a shortage of nurses and inadequate nursing staff levels in many New Zealand hospitals.

2.3.8 Quality and safe health care are inextricably intertwined with sufficient investment in the recruitment, training, retention and involvement of health professionals in all systems. When systems break down through lack of resources, it is neither just, nor sufficient, to find and blame the individual who inevitably triggered the event. NZNO considers the current problems with recruitment and

retention of nurses, inevitably lead to inadequate capture of errors and near misses. This means it is very difficult to prevent further similar errors, thus patient safety is at risk. Measures to increase the recruitment and retention of nurses are, therefore, vital

2.3.9 NZNO is committed to the development of systems that provide safe and quality care, that are responsive to patients needs, are fair and workable and provide the best environment in which health professionals can practise.

2.3.10 NZNO is opposed to mandatory reporting processes that over-emphasise the reporting of individuals, rather than incidences of error and systems failures. In order to achieve a reduction in error the focus must be on the error and what caused it, including systems issues, not on the individual who is often likely to be the last link in a chain of latent defects and systems errors. There is no robust evidence that proves mandatory reporting of individuals reduces error rates and achieves improved patient outcomes. NZNO considers mandatory reporting will undermine open reporting systems. NZNO supports the development of open reporting processes that enable all weaknesses in systems to be quickly exposed, and practices and customs to be changed where necessary.

2.3.11 Furthermore, the establishment of mandatory reporting systems of individuals is inconsistent with the approaches being promoted from the Ministry of Health in the sentinel events framework, and with the directions outlined in the Health Workforce Advisory Committee discussion document " Framing Future Directions".

2.3.12 A culture that has a focus on reporting the individual, rather than the incident, and attributing fault for an error or incident without full exploration of the factors that contributed to the individual's actions is simplistic, flawed and will have detrimental consequences on the future health work force. It encourages

concealment and delay when rectifying an error requires prompt and open inquiry.

2.3.13 Nurses have a very good record and a long tradition of reporting incidents. NZNO supports a system committed to the identification of errors and near misses and resolution at the lowest level and closest to where the incident occurred.

2.4 Self Regulation – the Role of Professional Regulation

2.4.1 An underlying assumption of this Bill seems to be that health professionals have a strong investment in protecting themselves inappropriately, and that professional self-regulation is incompatible with public safety. NZNO considers this assumption incorrect.

2.4.2 NZNO has always placed a strong emphasis on the role of professional self-regulation. NZNO has 21 professional colleges and sections. These groups are professional specialty nursing groups. They have input into ethical codes and promote and develop standards for their own specialty areas. NZNO maintains professional nursing groups need to be encouraged, and their role as guardian of ethical and professional standards strengthened.

2.4.3 The Bill does not encourage the involvement of the professions in the regulation of their profession. This is a major omission. The involvement of health professionals, through their professional organisations, is vital. Mechanisms for regulation must extend beyond regulatory bodies. These regulatory bodies are statutory bodies and are not primarily responsible for developing professional standards, or as the Bill stands obliged to consider and consult with the wider profession. NZNO considers the Bill should contain mandatory requirements for parliamentary bodies and regulatory authorities to consult with professional organisations and representatives of the professions.

2.5 The Treaty of Waitangi

2.5.1 NZNO expects the Treaty of Waitangi to be explicitly recognised in the new legislation governing health professionals. Te Runanga O Aotearoa NZNO also expects equitable representation for Maori as a matter of right on tribunals and authorities.

1.4.2 The Bill has a peculiarly monocultural air. Given the inequality between Maori and non-Maori morbidity and mortality statistics, this must be acknowledged in what is a fundamental piece of health legislation.

1.4.3 The 2002 HWAC report states that 6.3 percent of APCs for nurses and midwives are issued to Maori, who make up around 14 percent of the population. The necessary additional recruitment of Maori to the health workforce will be enhanced if the regulatory legislation acknowledges the treaty of Waitangi.

2.5.4 The emphasis on primary health care has brought a number of iwi-based health providers into the field. Thus in health figures, employment and training, and in health delivery there are specific Maori concerns that need to be acknowledged.

3.0 Specific Clauses of the Bill

Part I Preliminary and Key Provisions

Clause 3 Purpose of Act

NZNO recommends the Act contain a separate clause referring to the Treaty of Waitangi, as is included in the New Zealand Public Health and Disability Act 2000 (section 4) along the lines of:

In order to recognise and respect the Treaty of Waitangi, Te Tiriti of Waitangi, the Act provides for mechanisms for equitable representation on the Health Disciplinary Tribunal and regulatory authorities.

Clause 5 Interpretation

In the interpretations section, the term **"medical practitioner"** is defined but no other health practitioner is so defined.

Either all health practitioners should be defined or none should be defined. If all are to be defined, then **"nurse"** should be defined as meaning *a health practitioner who is, or is deemed to be, registered with the Nursing Council of New Zealand, continued by Section 110(1)(a) as a practitioner of the profession of nursing.*

"Midwife" should also be included and defined as *a health practitioner who is, or is deemed to be, registered with the Midwifery Council of New Zealand established by Section 110(2) as a practitioner of the profession of midwifery.*

The phrase "nurse practitioner" has a meaning specific to a particular scope of practice of a nurse and this should not be used to defined nurses generally.

NZNO recommends including the definition of the term **"restricted activity**". It is suggested this is defined as *a service that carries with it a risk of serious or permanent harm, and that has been declared a restricted activity by Section 9 of this Act".*

Clause 7 Unqualified person must not claim to be a health practitioner

NZNO considers this clause to be ambiguous. It is not clear why there is one list of prohibited acts in (1) and a different list in (2), regarding those holding practising certificates.

In Clause 7 (1) it is not clear what *"qualified to be registered*" means, as there appears to be no definition. Our assumption is that it would not mean the same thing as being actually registered.

The limitations in Clause 7 only concern health professionals of a particular kind. NZNO considers that the titles "health practitioner" (meaning a health practitioner registered with one of the authorities under this Act) and "health practitioner under the HPCA Act" should be given protection under this Act.

Clause 7 (3) is at best obscure and NZNO believes this would benefit from rewriting to make its intent clearer.

It is unclear in this clause which body prosecutes offences under clause 7(4). NZNO's past experience is that the Nursing Council of New Zealand has not prosecuted in the courts offences under the Nurses Act. This may be because it does not consider it has the power to do so.

Clause 8 Health practitioners must not practise outside scope of practice

The heavy penalties for breaches of this section means the description and range of scopes of practice need to be very clear. This emphasises the necessity of ensuring the scopes of practice are developed in consultation with the professions, and Clauses, 10,11, and 12, must ensure that this is mandatory. This is the core of the legislation and any uncertainty in this part undermines the whole Bill.

NZNO believes general scopes are essential. However, the list of limitations as outlined in Clause 21(3) imply a degree of inflexibility that would make it very difficult to employ an adequate health labour workforce. It would also involve a lot more detailed work for the authorities.

Under this clause only health practitioners would commit the offence set out in Clause 8(4). NZNO considers it would be more appropriate to make a breach of Clause 8(1) and (2) one of the categories of professional misconduct for which a health practitioner may be subject to disciplinary action, rather than a criminal or quasi-criminal offence.

Clause 9 Restricted activities

Clause 9 is ambiguous. It does not reflect the commentary/analysis of page 5 (Clause 9) or the 2000 discussion paper on the Bill – Health Professional's Competency Assurance Discussion Paper: page 11, question 4(c).

There is no definition of restricted activity within the Bill and it is unclear how a particular potential restricted activity comes to the attention of the Minister. Does the Ministry draw up a list of practices and then put that out for consultation to the various health practitioner authorities, or do the profession/authorities propose to the Minister that a particular activity be declared an activity restricted to a particular scope of practice within that particular profession?

NZNO's view is that whatever process is used for declaring an activity to be restricted, then Clause 9 should make that clear. Also, Clause 9 should reflect the discussion paper's statement that restricted activities should not be confined to one profession.

Restricted activities should not be able to be used by one professional group to restrict another group where an overlap in practice occurs. There will be a number of practices or activities that could be declared restricted activities that will fall within more than one scope of practice within a single profession, and/or within scopes of practice of more than one profession. In other words, some restricted activities could be competently and safely carried out by more than one type of health professional. The ability to restrict an activity must not become a means by which one profession obtains exclusive domain over an activity.

Thus, there needs to be a mandatory requirement for consultation in Clause 9 between the various professions. Also Clause 9 should be altered as follows to acknowledge that there will be restricted activities overlapping professions:

9(1)(b) Entitle an authority, or authorities…

9(2)(a) Who are registered with the authority, or authorities…

The phrase "*members of the public*" within Clause 9(2) should clearly include an unborn child. Some of the activities could cause serious or permanent harm to an unborn child. At present it is unclear if "*members of the public*" includes unborn children.

NZNO believes the determination of restricted activities should not be made by the Minister, but by an independent body with clinical knowledge, representing all groups of health practitioners regulated by the Act. Alternatively if the Select Committee considers the Minister should determine what is a restricted activity there should be mandatory consultation with the professions before the activity is declared a restricted one.

Part 2 Registration of, and Practising Certificates for, Health Practitioners

Clause 10 Authorities must specify scopes of practice

The term "scopes of practice" is currently is used by the Nursing Council of New Zealand to describe the clinical settings in which nurse prescribing is permitted. It is not used in this context to define the parameters of nurses' own practice. If scopes of practice are introduced NZNO believes the Bill will need to clearly emphasis that the term scope of practice will be used as a means of defining the parameters of a practitioner's practice. (The current term "scopes of practice" in relation to the clinical settings in which nurses may currently prescribe should then be altered by the Nursing Council to differentiate it from the term "scope of practice".)

There have been mixed signals from officials in the Ministry of Health as to whether the intention of the legislation is to have general or precise scopes of practice. If the scopes of practice are too precise, it will create difficulties for many nurses who frequently work across a number of specialties. It will also create difficulties for the employment of casual or pool nurses who are essential to the maintenance of most hospitals and other health institutions.

The Select Committee should be aware of the extent of the nursing shortage and the amount of over-time, call backs and recourse to casual employment required to keep the system operating. If this part of the proposed legislation is defective and the necessary flexibility lost, the health system will cease to function adequately, or the legislation will be ignored, neither of which NZNO sees as desirable.

It is NZNO's view there has been insufficient discussion on the legal implications of defining scopes of practice and the process for their development. Thus health practitioners and health officials are confused about the difference between scopes of practice, specialist registration and specialty practice.

Therefore, criteria for determining the breadth of a particular scope of practice should be included in the Act to guide the regulatory authorities. NZNO considers that broad scopes of practice rather than narrow ones will be the only practical way of proceeding.

Nursing is a broad-based discipline and nurses frequently work in multiple areas or across specialties. NZNO recommends that scopes of practice should be based on the existing registration types: registered psychiatric nurse, registered comprehensive nurse, registered obstetric nurse, registered general nurse, registered general and obstetric nurse, registered nurse and registered psychopaedic nurse.

There should be mandatory consultation by the regulatory authorities with professional bodies prior to determination of the scopes. NZNO fears that if there is no such mandatory consultation, some of the existing nursing categories such as enrolled nurses could cease to exist. NZNO wants to ensure these nurses are protected by legislation.

NZNO considers that scopes of practices should be established by regulations rather than be published in the *Gazette*.

In summary, NZNO recommends that:

- Scopes of practice are defined by regulations
- Nursing scopes of practice be based on existing registration types
- There be a mandatory requirement for the regulatory authorities to consult with the professions on defining scopes of practice.

Clause 15 Fitness for registration

In general, NZNO supports this clause but has concerns that student nurses, and enrolled nurses who are bridging to comprehensive status, could be disadvantaged if they have to wait to register in a situation where they are subject to a Health and Disability Commissioner's investigation. Many investigations can take up to two years and a large number of investigations are either discontinued midway through the investigation, or ~~result in a finding that the nurse did not breach the Health and Disability Code.~~

There should be provision for fast track investigation in these circumstances, otherwise there could be hardship and great disadvantage to student nurses and enrolled nurses bridging to comprehensive status.

Clause 16 Applications for APC

NZNO considers that Clause 16(4) allowing for fines and costs awards to be collected, as a condition of a health practitioner making a scope of practice application, is unnecessarily punitive. The order may only have been made days before the scope of practice application is made, and repayment in such a period is not reasonable.

Also, it is not uncommon for the Nursing Council, in the case of nurses who do not the have earning capacity to make a one-off lump sum payment, to arrange for payments over a period of time. It would be unfair for applications not to proceed in such circumstances. NZNO proposes that this clause be deleted.

Clause 18 Authority may obtain information about applicant

In Clause 18(2) the regulatory authority is able to seek information from anyone but the process for doing so is unspecific and unclear so the applicant would not be aware of what information was being sought. This needs to be made more specific and clearer.

In Clause 18(3) it is not clear whether the authority or the applicant nominates the body from whom information is sought. This should be clarified.

Clause 21 Contents of authorisation of scopes of practice

Clause 21(3) gives registering authorities very broad powers to impose conditions on scopes of practice without consulting applicants. Thus an authority may impose conditions on authorised scopes of practice, including practising under supervision or oversight, disallowing activities to be performed, employment conditions (e.g. practise only as employee of a nominated person), and time limitations without prior consultation. NZNO believes consultation with the applicant should occur before these powers are exercised.

Clause 26 Restrictions on issue of APC

Under Clause 26(1)(d) an application for an APC is to be referred to a regulatory authority if applicant has not had an APC of that sort before, or has not worked in the profession, within the last three years.

NZNO's view is that three years is too short a period and that five years would be more appropriate. Nursing is a predominantly female profession, and it would be common for many women to have more than three years away from practice because of childcare responsibilities. The New Zealand Nursing Council guidelines for the establishment of competence based practising certificates identified five years as the appropriate timeframe for nurses. NZNO believes this is realistic and has been preparing nurses for this requirement on the basis of these guidelines.

26 (1) (e) For the same reason as above, NZNO recommends five years as the time period.

Part 3: <u>Competence, fitness to practise and quality assurance</u>

Frequently the Bill refers to interventions, such as suspension, being on the basis of not meeting standards of competence - specifically that the practitioner poses a risk of harm ~~to the public. NZNO is of the view that the threshold in all these cases is too low.~~

Clause 33 Standards of competency

Clause 33(1) NZNO believes the threshold of notification that " *may pose a risk of harm to the public"* is too low and recommends a change to " *a risk of serious harm".*

NZNO opposes Clause 33(3). It imposes an obligation on employers to notify the authority when a health practitioner resigns or is dismissed for reasons relating to competency. There is no definition of competency. Therefore, employers will have to make assessments themselves about whether a resignation or dismissal relates to competency.

Also, it is not always clear why a person resigns, or the reason they give may not be entirely accurate. A resignation that includes a minor aspect of slightly impaired competency could see the employer having to refer to the regulatory authority. This provision could result in a large number of unnecessary referrals to the regulatory authority. There is also some potential for malicious reports.

Clause 34 Authority must notify certain persons of risk of harm to public

NZNO is opposed to Clause 34 as it currently reads. Firstly, the notification could well occur before there has been much or any investigation of the situation by the regulatory authority. Secondly, "has reason to believe" is not a sufficiently high standard upon which to report.

Further, it is unclear what the authorities are going to do with this information. NZNO is concerned that the information may be collected and used against a health practitioner in an informal way, to make the authority which has received the information more inclined to make a finding against the practitioner in other future cases. This is inappropriate.

There is no obligation to inform the health practitioner about the notification. Thus the health practitioner has no chance to dispute it. If the notification requirement remains

there should be an obligation to let the practitioner know it is to occur. In addition, the practitioner should be given the opportunity to make a submission on the notification issue.

Although there is the obligation to follow up under Clause 34(2), the initial information will presumably be kept by the recipients. There should be an obligation on recipients to destroy the material if there is a notification under Clause 34(2).

Clause 36 Matters to be observed in reviewing competence

NZNO believes this clause in its current form gives the regulatory authorities too much discretion.

NZNO recommends that Clause 36 includes the requirement that "- *a review of competence must comply with principles of natural justice."*

Clause 38 Interim suspension

NZNO is opposed to the provision for interim suspension in Clause 38. The test of *"poses a risk to the public"* is a low standard and such a clause should instead look to "*risk of serious harm*". Suspension has very serious implications for a practitioner in terms of whether their employment continues, financial implications and their reputation. Clause 38 currently allows for suspension to occur before there has been a proper investigation of the circumstances.

Clause 39 Competence programmes

Clause 39 gives the regulatory authority broad powers to impose programmes on individuals or groups, as does Clause 40. There should be some obligation to consult with professional bodies and employers.

NZNO submits that Clause 39(3) (e) should have added to it *subject to the consent of the clients.*

Clause 42 Unsatisfactory results of competence programme

NZNO supports the provision in Clause 42(5) that failure to satisfy competence or a certification programme is not of itself grounds for disciplinary action.

Clauses 44 Inability to perform required functions

NZNO supports protecting the public from nurses who insist on practicing when they are physically or mentally unfit to practice. This Clause 44(1)(b) provides for mandatory reporting by health professionals. This means peers and colleagues of a nurse will be required to report a nurse they consider to be mentally or physically unwell, and unfit to practise.

Clause 44(1)(b) appears to have been drafted for a situation where there is no person in charge and no employer, e.g. a group GP practice. In such a case it may well be appropriate to have a reporting mechanism from fellow partners, but it is unwise to leave Clause 44(1)(b) as it is, in relation to the nursing workforce who almost invariably are employees.

NZNO's concern is that nurses may report other nurses as having a mental condition and unfit or unable to practise, when in fact this will not be found to be the case. This will mean more notifications to the regulatory authority, more investigations and more costs. This could also be an unnecessary barrier to people entering or remaining within the nursing profession. Currently if a colleague notifies an employer that a nurse is unwell and unable to practice, the employer investigates. In many cases after investigation it transpires there is no inability to perform or unfitness to practice due to ill health, and instead the issue is an industrial one.

NZNO thus prefers Clause 44(1) to state that subsection (2) applies to a person who –

a) *is in charge of an organisation that provides health services; or*

b) *is an employer of health professionals; or*

c) *is a medical officer of health; or*

d) *is a health professional in attendance professionally on the health professional to whom subsection (2) applies: provided that*

Where no person referred to at a), b), c) or d) is available, then subsection (2) applies to a person who is a health practitioner currently working within their scope of practice.

The phrase *"currently working within a scope of practice"* is important for NZNO as an organisation, because many of its staff will come within the definition of health practitioner, but will not be currently working within a scope of practice. They are employed by NZNO as organisers or advisors and represent or advocate for nurses who might be unwell. These NZNO staff cannot in all fairness be obliged to notify the authority about NZNO members whom they are representing.

Clause 44(3) is, in NZNO's opinion, too broad and if enacted, would lead to abuse. To permit any member of the public to report a nurse they believe to be unfit to practise would lead to clogging of the notification mechanisms, more unnecessary investigations and greatly increased costs. There should be something definite on which the member of the public bases their opinion and some limitation must be written into this provision.

Clause 46 Interim suspension of practising certificate

The power of the regulatory authority to order suspension of an APC without notice would have a serious impact on the profession. Notice would be required so arrangements could be made for a replacement for the nurse and the organisation of sick leave and or special pay.

NZNO has concerns that unless an employer made the notification and therefore acceded to the need for a nurse to be suspended, it would be very difficult to persuade the employer to pay the nurse during the period of interim suspension. This is why NZNO does not support notification by other health practitioners or by neighbours, flatmates, or family (as is contemplated by Clauses 44(1) (b) and 44(3)). Nurses are often primary

breadwinners and the effect of interim suspension on their family is potentially devastating.

Again, NZNO believes the threshold for making an order for suspension – "*if the authority considers the health professional may be unable to perform the functions required for his/her practice because of some mental* or *physical condition"* - is too low.

On what grounds will the authority base the order? Until the authority has determined whether there is a mental or physical condition, by way of a medical examination, then there should be no power to make an order to suspend based simply on the notification alone. NZNO does not consider it necessary to revoke the right to practise without full knowledge of whether in fact a mental or physical condition exists and is causing impairment. Any concerns that a nurse's present impairment could pose a danger to patients during the period of investigation could be dealt with by imposing conditions on their practice while the investigation is underway.

Thus in Clause 46, NZNO advocates the inclusion of *"an order for interim suspension should only be made after a medical examination has been carried out and a medical report obtained"*. This must be clearly stated in the legislation in order to provide guidance to the regulatory authorities.

Setting a time period for suspension of up to 20 days will only be effective in keeping the nurse from working if the matter is determined no longer than 20 days after the suspension order is made. It is not clear how this will be achieved. Currently the time period from when the medical report is received to the date the matter is heard and determined by the Health and Disability Committee of the Nursing Council varies from one week to 40 days.

~~Clauses 50 Quality assurance activities~~

NZNO welcomes extending provisions for quality assurance activities to nurses. It will protect the public and enhance support for the profession. NZNO's concern, however, is that "*specific significant incidents"* are excluded from quality assurance activities.

Under the current Medical Practitioners Act 1995, any Commissions of Inquiry, Health and Disability Commissioner investigations, Director General of Health investigations, police investigations or any other external investigations undertaken in relation to specific significant incidents are carried out separately from quality assurance activities.

Specific significant incidents as defined by Clause 51, do not usually occur as a result of a single mistake by an individual or individuals, but are much more often the result of failures brought about by the alignment of a whole serious of latent defects in the system, as well as active errors. Enabling full and frank discussion of the circumstances surrounding an error or serious incident is vitally important in preventing future incidents of the same kind occurring again.

If specific significant incidents are excluded from quality assurance activities, then information provided to an internal inquiry will not be able to be kept confidential. It is likely, therefore, that health professionals will simply not participate in internal investigations as they will feel unable to give full and frank information without compromising themselves.

NZNO considers that information collected under a quality assurance activity in relation to a specific significant incident is valuable and could reduce the risk of similar incidents occurring. Other investigations can be carried out separately to quality assurance internal investigations.

Part 4 Complaints and Discipline

~~Clause 66 Interim suspension of practising certificate~~

Where a person is charged with a criminal offence, that person has the right, in relation to determination of the charge, to be presumed innocent until proved guilty according to law (NZ Bill of Rights Act, Section 25(c)).

If the regulatory authority suspends prior to the determination of the criminal matter by the court, this has the effect of treating the health practitioner as guilty until they are proved otherwise innocent. This effect will be achieved because, before the facts of the allegation are properly established, the practitioner's reputation and status will be affected and his/her right to earn a living in the manner for which he/she is qualified will be compromised. This is a complete inversion of modern day principles of justice.

Protecting the public interest does not justify suspension whilst a criminal proceeding or investigation by the Health and Disability Commissioner or regulatory authority is in progress. This is because a disciplinary tribunal will have the power to de-register the practitioner if and when they are convicted, or if and when they are charged with professional misconduct. In the interim, conditions can be placed on their practice.

NZNO believes there needs to be a threshold of "*a risk of serious harm"* before any suspension is ordered. There is no clear threshold for interim suspension in Clause 66. The threshold appears to be that of "*if the conduct casts doubt on the appropriateness of the practitioner's conduct in his/her professional capacity"*. The standard of "*casts doubt*" is extremely low and ambiguous.

Extreme caution should be exercised before an authority exercises a power to suspend and at the very least, statutory guidance as to a proper threshold for interim suspension should be provided to assist the authorities. At a minimum, the phrase *"casts doubt on the appropriateness of the practitioner's conduct"* in Clause 66(1)(b) should be replaced by the phrase *"the practitioner's conduct constitutes a risk of serious harm".*

The length of time a professional could be suspended for, pending criminal proceedings or a Health and Disability Commissioner investigation or other investigation could be

excessive. Given the current length of time it takes the Health and Disability Commissioner to investigate a matter, it could be up to years.

If the health practitioner is found not guilty, or no adverse finding is made by the Health and Disability Commissioner, then the practitioner would have been unable to practise, and unable to keep up his or her skills, would have lost his or her reputation and possibly livelihood, and would have no means of redress or compensation.

NZNO considers that whilst the stated purpose of the Bill is to assure the public that health professionals are competent, and to protect the public from incompetent practitioners, interim suspension contains a punitive element, as it could cause extreme hardship.

Clauses 68 Complaints investigation committees (CICs)

NZNO supports a clear demarcation between the CICs which investigate complaints against nurses and the regulatory authority.

In relation to the CIC's power to suspend where the public are at risk, NZNO reiterates the same concerns as stated above in relation to Clause 66. The threshold for suspension should be changed, if suspension is to occur at all, to a threshold of one at which the CIC has reason to believe that the practitioner's practice poses *a " risk of serious harm to the public".*

HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

~~Clause 80 Establishment of Tribunal~~

NZNO welcomes the establishment of a single disciplinary tribunal to consider breaches of the legislation (Clause 81) but is concerned that the Tribunal will be very expensive and consequently insurance premiums and costs will rise.

This single Tribunal is an important step towards uniformity of treatment of professionals and the maintenance of confidence in the health system. NZNO also supports the appointment of a legally qualified chair, and the maintenance of a panel of competent professionals and lay members, as important elements in ensuring confidence in the health system (Clause 82/83).

The provision whereby the Minister is required to consult before appointing a chair or deputy chair is supported, but we note the omission of this requirement when the panel of practitioners and lay persons is being drawn up (Clause 83). It seems to NZNO that consultation on these members is as important, if not more so, on the appointment of the chair and deputy chair, and NZNO recommends the inclusion of consultation requirements.

NZNO also opposes Clause 84 that establishes the constitution of the Tribunal for hearings. The Bill as presently drafted provides for a five-person Tribunal comprising; a chair (the barrister who is a lay person), two professionals, and two lay members. This produces a minority of professionals. NZNO submits that the balance should be changed to only one layperson, additional to the chair, and three professional peers of the health practitioner.

There are a number of important points to be made in support of this. First, the practice of self-regulation of professions, including the setting of standards, the detection of shortfalls from these, the disciplining of members, and the maintenance of confidence in the profession, are all of vital interest to professionals. The Bill must contain discipline by peers as a core and important element. In recognition of the public interest, the chairing of the Tribunal, and membership by lay representatives is important, but it is the

professional peers that have both the necessary expertise and commitment to maintain the necessary standards.

Without a majority of professionals on the Tribunal the health professional may not be truly disciplined by his/her peers. This is contrary to the implied intent in Clause 95(2) that professional misconduct means conduct that in the judgement of the Tribunal amounts to such conduct. The intent of Clause 95(2) equivalent in the Nurses Act 1977 has been canvassed by Appellate Courts both in New Zealand and Scotland and these courts have been reluctant to overturn the findings of a professional body on the basis that the profession knows best what is professional misconduct.

If a majority of lay people can determine a charge of professional misconduct, it will not be the professionals who are determining what is professional misconduct. This could lead to an Appellate Court more readily overturning the Tribunal's decisions.

Given the detailed factual evidence that will be presented, it would be unfortunate if the professions did not have confidence that the Tribunal was fully capable of understanding and assessing the importance of this evidence in the context of professional practice. Although public confidence in the system is essential, acceptance and confidence by the professions is also necessary, and it is NZNO's view that this balance would be best achieved by the changes in composition of the sitting Tribunal as outlined above.

A further concern is that the lay members of the Tribunal and the sitting chair may sit mainly on hearings relating to medical practitioners rather than nurses, and may be unclear about the variations between professional disciplines and the different requirements of the professional disciplines. NZNO believes that the lay representative on the Tribunal should be drawn from a panel of 15 or more, each of whom is appointed to a particular professional discipline.

Clause 95 Grounds on which health practitioners may be disciplined

NZNO supports clause 95(2)(a)(i) & 95(2)(a)(ii). This is currently the wording used in the Nurses Act 1977.

Part 5 Appeals

Clause 101 Appeals

There are several decisions that a registering authority can make which have serious implications but which do not currently appear to be subject to appeal. These may be accidental omissions. We are referring to:

(a) A decision of a registering authority to decline to register a person's scope of practice.

(b) A decision on the length of the APC under Clause 29.

(c) A decision on the imposition of competency or recertification programmes; and

(d) A decision on interim suspension under Clause 38.

NZNO considers that these decisions should be able to be appealed against or be subject to review and appeal. Clause 101 should be amended accordingly.

Clause 101(2) Rights of Appeals

There should be grounds of appeal against a finding of professional misconduct. It is not currently included, yet other grounds of appeal are specifically and particularly set out.

If there is no specific grounds of appeal against a finding of professional misconduct, the High Court will still be likely to hear such appeals under its inherent jurisdiction. This

however is discretional and though it is likely that such an appeal will be heard, appeals against a finding by the Tribunal should be available as of right.

There should definitely be a specific ground of appeal against a finding of professional misconduct, if the make up of the Tribunal were to have a majority of laypersons. This is because a majority of lay people will be able to determine the charge. In such a case an Appeal Court would not be able to say, as it does currently, that it would not lightly overturn a finding of a professional tribunal, because the profession knows best what amounts to professional misconduct. A ground of appeal against that finding should therefore be specifically available.

Clause 108 Publication

Recourse to the High Court to try to challenge publication is expensive. An application might not be able to be made in time to prevent publication. If there is to be publication, there should be clearly stated sanctions if orders made against publication are breached.

Part 6 Structures and Administration

Clause 111 Authorities may be appointed in respect of additional professions

Clauses 110 and 111 anticipate the emergence of new health professions that may need to be included in this legislation in the public interest. The means proposed to enable this to be done is by Order in Council - effectively the Cabinet, on the recommendation of the Minister. Although there is provision for the Minister to consult with any organisation that in the Minister's view has an interest in the matter (Clause 112), NZNO is concerned that a new authority and profession could be established with minimum public awareness.

Legislation is preferred to an Order in Council. No profession emerges with such speed as to make the need for amending legislation an obstacle, and given the widespread and

diverse views on the use of new technologies, public debate and discussion should be encouraged, not suppressed.

If Clauses 111 and 112 are not omitted from the Bill, a separate body should be established to determine the acceptance of any new profession. Such a body should include both lay and professional representatives.

Clause 114: Functions of Authorities

Clause 114 (i) gives the regulatory authority the power to "*set standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners of the profession".*

NZNO believes that standards of clinical competence should be set by the practitioners who are in current clinical practice rather than by a regulating authority. It is the experienced health practitioner in clinical practice who is most aware of the standards and knowledge required to practise to a level that maintains and provides safety to the public. The same applies to cultural competencies and ethical conduct. The cultural competencies need to be identified by a cultural group, rather than the regulating authority.

NZNO suggests that Clause 114 (i) include *"following consultation with the relevant clinical health professional and cultural advisors"* and that this proceed the words *"..to set standards…"*.

MEMBERS OF AUTHORITIES

Clause 116 Membership of Authorities

The Bill proposes that the Minister shall appoint the members of regulatory authorities after consultation with "*any group that promotes the interests of the health practitioners".* The exception to this is the provision for regulations to be made which allows for the appointment of a practitioner who has been elected from the group. This provision seems to be available at the Minister's discretion.

NZNO wants to see provision for professional groups to elect a majority of the professional members of the regulatory authority with the remainder appointed directly by the Minister. For a Nursing Council of 14 members, which would have 11 professionals, this would mean that six professionals could be elected and five appointed directly. As the Minister appoints the three lay members, only a minority would be elected. The majority would be direct Ministerial appointments. NZNO supports the appointment of lay members to the regulatory authorities.

The composition of the regulatory authorities and the panels for the Tribunal should make provision for Maori concerns by ensuring, as far as possible, there is Maori representation. This may not always be possible in the numerically smaller professions, but it is certainly possible for the numerically larger ones, such as nurses and doctors.

NZNO would recommend that the clauses covering appointments by the Minister to panels and regulatory authorities require the Minister of Health to consult with the Minister of Maori Affairs prior to reaching a final decision. This would ensure Maori representation where this is possible. A similar provision exists for the appointments to the Tertiary Education Commission

Clause 125 Overlapping scopes of practice

The Bill in its current form provides for disputes on overlapping scopes of pratice to be resolved by the Minister. NZNO considers this inappropriate and suggests any disputes about overlapping scopes be resolved by an independent body with input from the professional disciplines concerned. NZNO believes this process is more open and also democratic.

Clause 126 Authorities may prescribe fees

As the incomes of the different professional groups vary, their capacity to meet fees imposed by the regulatory authorities also varies. NZNO recommends the inclusion of a clause requiring the regulatory authority to take account of the earning capacity of the professional when fees are set.

Clause 127 Disciplinary levy

Concern has been expressed about the open-ended nature of the powers given by this clause. NZNO suggests that there should be some limit imposed on the levy, e.g. it being not more than 50 percent of the cost of the APC in any one year.

Clause 154 Application of Trans Tasman Mutual Recognition Act 1997(TTMRA)
Clause 154 provides for the TTMRA to override the HPCA Act. Currently, medical practitioners are exempted under schedule 4 of the TTMRA. NZNO is concerned that the effect of the TTMRA overriding the HPCA will result in Australian registered nurses receiving automatic registration in New Zealand and that the significant requirement of cultural safety will not be part of the nursing registration requirements.

Mutual recognition is acceptable only where qualifications are comparable. Competence and safety requirements and scope of practice for practitioners are not the same in the two countries - e.g. midwifery requirements.

Part 8: Amendments to Health and Disability Commissioner Act 1994

Clause 231 Aggrieved person may bring proceedings before Tribunal

If a breach of the Code has been found but the Commissioner decides not to refer the matter to the Director of Proceedings because he does not think the breach serious enough, Clause 231 amends the Health and Disability Commissioner Act by allowing the consumer to take a matter to the Human Rights Review Tribunal themselves to seek monetary compensation for, among other things "*humiliation, loss of dignity and injury to feelings*". The Tribunal has the power to award up to $200,000 in compensation.

NZNO strongly opposes this amendment. It will mean greatly increased potential liability and stress for nurses who have been found in breach, but not serious breach of the Code. It could lead to a rash of claims against nurses for grief, anxiety or other " feelings " that would not be compensated in a civil action case. This will not achieve the aim of both the Cull Report and the Health and Disability Commissioner Act, which is the timely resolution of complaints. The increase in liability will also make it far more difficult to attract nurses to the profession.

An NZNO nurse member responding to request for submissions on the Bill expressed it in these words, "*The community deserves protection from incompetent health practitioners, but health practitioners also deserve protection from situations of unresolved grief, unrealistic expectations of health care delivery, or a determination to blame someone for the death of a family member. It may be that no error has actually occurred, but that the failure of health care funding or health care delivery in New Zealand, for example, or a failure of the family to understand the limits of the physical condition of the patient, or a failure to understand withdrawal of treatment is the problem. While these may sound like simple communication issues, many nurses can testify to having to deal with… (this).*

Schedules

Schedule 4 Acts Amended

Burial and Cremation Act 1964 No 75

The reading of the proposed definition of **midwife** suggests that any midwife can sign a certificate. It should be made clear that only the midwife present at the birth could sign the written certificate.

Parental Leave and Employment Protection Act 1987

Whilst not provided for in the HPCA Bill, it would be a timely place to repeal the terms "sickness certificate" and "medical certificate" These terms give the impression that pregnancy is an illness. It is not and the term "pregnancy certificate" should be used instead.

Schedule 5 Amendments to Accident Insurance Act 1998 for transitional purposes (page 202)

Midwife should be included.

Other Issues

~~Review of HPCA Act~~

The HPCA Act is an important piece of legislation and will substantially change the way health professionals are regulated and disciplined in New Zealand. The effects of this change are in many ways difficult to predict. NZNO believes it would be appropriate for a review to be built into the HPCA Act so Parliament reconsiders the legislation within three years of the time it takes effect.

Conclusion

NZNO supports legislation that updates and brings uniformity to some of the legislation regulating health professionals in New Zealand. However NZNO believes much could be done to improve this legislation and we have made this submission in that spirit. Our process in preparing this submission has involved extensive discussion and consultation with the NZNO Board of Directors, NZNO members and other relevant professional bodies and organisations. This submission has involved discussion with specialist staff whose work involves extensive use and knowledge of the Nurses Act.

The submission commenced with an outline of NZNO principles. Specific recommendations were made on the basis of those principles and previous policy. An issue that is fundamental to NZNO is the need for increased consultation on specific clauses of this Bill. It is our contention the Bill in its present form will not develop the culture that is required to prevent the incidence of errors, or that it is fair for health professionals and health workers.

In conclusion we present the major recommendations made in this submission:

- The inclusion of consultation with professional bodies before scopes of practice are introduced into legislation

- Inclusion of explicit reference to the Treaty of Waitangi in the Act and Maori representation on regulatory authorities and the Health Disciplinary Tribunal

- Limiting provisions for mandatory reporting clauses for physical or mental impairment of health professionals

- A different representation of lay persons on disciplinary bodies and authorities than that proposed by the current Bill

- The restoration of the right of election of some nurse members to the Nursing Council

- An independent body to be established to deal with disputes relating to scopes of practice and restricted activities

- The requirement for new health professions to be established by legislation

- A review of the legislation within three years of enactment.

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Appendix 1

A selection of submissions to NZNO on the Health Practitioners Competence Assurance Bill from NZNO members and NZNO groups.
