

**Report of the Review
of the Nurses Act 1991**

OCTOBER 2001



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EXECUTIVE SUMMARY

1. Introduction

The Council of Australian Governments' Competition Principles Agreement provides that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition and that the objectives of the legislation can only be achieved by restricting competition. The requirement for the Government to conduct a Competition Principles Agreement review of the Nurses Act 1991 has provided the Department of Health with an opportunity for a comprehensive review of the operation of the Act since its commencement in 1992.

The Department, in consultation with key stakeholders, identified a range of matters relevant to the regulation of nurses which required examination. An Issues Paper seeking public comment on those matters was released in July 1999. Forty-nine submissions were received by the Department in response to the Paper.

2. The Regulation of Nurses and Midwives in NSW

The Nurses Act provides that only those individuals who meet certain accreditation requirements can be registered or enrolled as nurses and authorised to practise midwifery in NSW. The Act also restricts the use of certain titles. The Act does not define or restrict the practice of nursing. Whilst the Act restricts the practice of midwifery to those registered nurses who hold an authorisation to practise midwifery there is no definition of the practice of midwifery.

The Act contains a two-tier disciplinary structure. The definitions of *unsatisfactory professional conduct* and *professional misconduct* are set out in section 4 of the Act. As a general rule, more serious complaints that may, if substantiated, provide grounds for suspension or cancellation of registration or enrolment are to be referred to the Nurses Tribunal. Less serious matters are referred to a Professional Standards Committee.

A number of services and practices of nursing are common to other health professional groups. These groups include medical practitioners, physiotherapists and podiatrists.

3. The Objectives of Legislation Regulating Nursing in NSW

The Nurses Act does not contain a statement of its objectives. However it is apparent that the underlying policy objective of the Act is the regulation of nursing and midwifery so as to minimise the potential risk of harm posed to members of the public by unqualified, unscrupulous or substandard practitioners in the fields of nursing and midwifery.

The rationale that underpins this objective is that within nursing and midwifery there is an imbalance of information. The imbalance of information is such that in the absence of government intervention consumers, including employers, may have difficulty identifying competent and ethical practitioners and the public may thereby be exposed to harm.

Recommendation 1 – Regulatory objective

That any regulation of nursing and midwifery have the objectives of:

1. Protecting the health and safety of members of the public by providing mechanisms to ensure that nurses and midwives are fit to practise.
2. Providing mechanisms to enable the public and employers to readily identify nurses and midwives who are fit to practise.

4. The Regulation of Nursing and Midwifery in NSW and Impacts on Competition*Regulation of nurses*

The Department is of the opinion that substantial public benefits will arise where risks to consumers/patients are averted. Therefore it is likely that the option that has the highest overall benefit will be the one that most effectively, yet simply, provides a mechanism to ensure that only qualified and competent practitioners may practise and provides information to consumers (including employers) to assist them in engaging the services of a qualified and competent practitioner.

Recommendation 2 – Regulation of nurses

That nurses continue to be regulated by title in New South Wales.

Regulation of midwives

The Nurses Act 1991 restricts the title *midwife* to registered nurses who have recognised qualifications in midwifery and hold an authority to practise midwifery. The Act also restricts the practice of midwifery to registered nurses who hold an authority and certain other occupational groups specifically exempted by the legislation, such as medical practitioners.

Consumers of midwifery services potentially face the same problems as those faced by consumers of other types of nursing care and similar market failures are evident in that market. Again the Department is of the opinion that substantial public benefits will arise where risks to consumers/patients are averted and a system that ensures that only qualified and competent practitioners may practise and provides relevant information to consumers (including employers) will provide the greatest benefit to the public.

Recommendation 3 – Regulation of midwives

That midwives continue to be regulated by title in New South Wales.

Organisation of the Register

The current Act provides that registered nurses with approved qualifications in midwifery may be granted approval to use the title *midwife* and to practise midwifery. There is no separate register of midwives and all approved midwives, whether they have nursing qualifications or not, must firstly be registered as nurses and are therefore entitled to hold themselves out as registered nurses.

The Department proposes that there be two registers a register of midwives and a register of nurses. Under this structure those practitioners with both qualifications in

nursing and midwifery would be registered on both the register of nurses and the register of midwives.

Recommendation 4 – Registers

That the Act establish two Registers:

- a Register of nurses; and
- a Register of midwives.

That the Act provide that people who are eligible for registration on both Registers shall hold dual registration with the same annual registration fee payable irrespective of whether a person's name appears on one Register or both.

Restricted titles

The Department considers that there is no public health and safety justification for introducing further restrictions on the title 'nurse'.

As the Department has recommended that a separate register of midwives be established a number of midwives with direct entry qualifications will no longer be registered nurses. Therefore those registered midwives without nursing qualifications will not be able to apply to be accredited as nurse practitioners. It is appropriate therefore that a separate title of *midwife practitioner* be created for those midwives who are accredited by the Board to practise at an advanced practice level.

Recommendation 5 – Restrictions on titles

That the titles *registered nurse, enrolled nurse, enrolled nurse (mothercraft), nurse practitioner, midwife* and *midwife practitioner* be restricted to people appropriately registered or enrolled by the Board.

Restricted practices

The current Act restricts the practice of midwifery although it does not provide a definition of midwifery. The Act then provides exceptions from the restriction for certain categories of health professionals and others.

It is evident that there are health care practices surrounding giving birth that should continue to be restricted in the public interest and it is recommended that the practice of *managing labour and the delivery of a baby* should be restricted.

Recommendation 6 – Restriction of practices

That the Public Health Act be amended to provide that the practice of managing labour and undertaking the delivery of a baby be restricted to

- registered midwives;
- registered medical practitioners;
- a registered nurse or an enrolled nurse acting under the appropriate supervision of a registered midwife or a registered medical practitioner;
- a midwifery or medical student acting under the appropriate supervision of a registered midwife;
- a medical student acting under the appropriate supervision of a registered medical

- practitioner; and
- any person who is rendering assistance to a woman who is giving birth to a child where the assistance is rendered in an emergency.

5. Types of Registration and Enrolment

The recommended amalgamation of the lists and creation of a separate register of midwives raises issues in relation to the types of registration that the Board should be empowered to grant.

Conditions on registration

The current provisions of the Nurses Act do not allow the Board to place conditions on a person's registration in the absence of a disciplinary finding or a practitioner's impairment and in this respect New South Wales appears to be out of step with other Australian jurisdictions.

In the interests of enabling the Board to protect the public from nurses and midwives with limited qualifications practising beyond their capacity the Board should be empowered to conduct an inquiry into the fitness of an applicant for registration. Where the Board is not satisfied that an applicant has the necessary qualifications or competence for comprehensive registration and practice.

Recommendation 7 – Conditions on registration/enrolment

That the Board have the power to inquire into the qualifications and competence of an applicant for registration or enrolment and where satisfied that the applicant is not fit for comprehensive practice the Board may grant registration or enrolment subject to conditions or refuse to register or enrol the applicant.

Recommendation 8 – Enrolment

The Act be amended to provide that the Board be empowered to grant both provisional and temporary enrolment.

Recommendation 9 – Refusal of registration/enrolment

That the Act be amended to provide that the Board may only refuse an application for registration or enrolment after it has given the applicant an opportunity to be heard in relation to the application.

6. Structure of the Board

As the Department has recommended changes to the regulatory structure for nursing and midwifery, with separate registers for practitioners with qualifications in nursing and practitioners with qualifications in midwifery, consideration must also be given to the structure of the Board.

The Department believes that the most effective and efficient mechanism for regulation of nursing and midwifery continues to be through a single registration board renamed the Nurses and Midwives Board.

The current Board consists of thirteen members. The Department considers that

given the Board's role in regulating a large and diverse profession it is important to have a membership drawn from all sectors of the profession. It is also important that there be academic representation, consumer representation, an officer of the Department of Health, or a public health organisation, and a legally qualified member. Therefore the Department recommends that the Board increase in size to 16 members.

Recommendation 10 – The Board

That the Nurses and Midwives Board comprise sixteen members and be constituted as follows:

- Three registered nurses elected by registered nurses;
- one registered midwife elected by registered midwives;
- one enrolled nurse or enrolled nurse (mothercraft) elected by enrolled nurses and enrolled nurses (mothercraft);
- two nurses engaged in the tertiary or pre-enrolment education of nurses or midwives in New South Wales selected by the Minister for Health;
- one registered nurse or registered midwife nominated by the New South Wales Nurses Association;
- one registered nurse or registered midwife nominated by the New South Wales College of Nursing;
- one registered nurse who practises in the field of mental health nursing selected by the Minister for Health;
- one enrolled nurse selected by the Minister for Health;
- one registered or enrolled nurse who is an employee of the Department of Health or the public health system selected by the Minister for Health;
- one legal practitioner selected by the Minister for Health; and
- three persons selected by the Minister for Health as representative of the community.

Standing committees

It is recommended that two standing committees, one for nursing called the Nurses Practice Committee and one for midwifery called the Midwives Practice Committee, be established with the Board having overarching control and responsibility for regulation, policy and direction, and disciplinary mechanisms, with the capacity for the Board to delegate functions to the Committees.

Recommendation 11 – Composition of the standing committees

That a Nurses Practice Committee and a Midwives Practice Committee be established.

The Nurses Practice Committee comprise at least seven members and be constituted as follows:

- two members of the Board selected by the Board;
- one nurse engaged in the tertiary education of registered nurses in New South Wales selected by the Board;
- one nurse engaged in the pre-enrolment education of enrolled nurses in New South Wales selected by the Board;

- one registered nurse engaged in nursing in New South Wales selected by the Board;
- one enrolled nurse engaged in nursing in New South Wales selected by the Board;
- one registered or enrolled nurse nominated by the Congress of Aboriginal and Torres Strait Islander Nurses;
- such other people as the Board determines.

The Midwives Practice Committee comprise at least five members and be constituted as follows:

- two members of the Board selected by the Board;
- one registered midwife engaged in the tertiary education of midwives in New South Wales selected by the Board;
- one registered midwife engaged in midwifery in New South Wales selected by the Board;
- one registered midwife engaged in midwifery in New South Wales nominated by the Congress of Aboriginal and Torres Strait Islander Nurses;
- such other people as the Board determines.

A member of each Committee who is also a member of the Board is to be appointed as Chair of the Committee.

Tenure of Board members

The Department supports the adoption of a limit on the number of terms that a person may continuously serve as a member of the Board to three terms of four years.

Recommendation 12 – Tenure of Board members

The Act provide that a person may not hold office as a member of the Board for more than three consecutive terms of four years each.

Board President and Deputy President

The Department considers that it is appropriate for a member of the profession to be appointed as President of the Board and therefore the Minister is to be able to select a nurse to be President of the Board.

Recommendation 13 – President

That the Act be amended to provide that the Minister for Health is to select a member of the Board who is a nurse to be President of the Board.

7. Entry Requirements

Courses

The Department endorses the current system whereby the Board accredits educational courses for registration purposes. While the current Act provides that educational courses are to be accredited by the Board there is no mechanism for an educational institution that is aggrieved by a decision of the Board to refuse

accreditation to appeal that refusal. The introduction of an appeal mechanism will assist in making the course accreditation process more open and transparent.

Recommendation 14 – Accreditation of courses

The Act be amended to provide that the Board be able to approve educational courses both from within and outside New South Wales. An educational institution that is aggrieved by a decision of the Board to refuse to accredit a course is to have a right of appeal to the Administrative Decisions Tribunal.

Age restrictions

There is no evidence that justifies retention of the age restriction on public health and safety grounds and the requirement that applicants complete tertiary education ensures that unreasonably young people will not apply for registration/enrolment.

Recommendation 15 – Age restrictions

The Act be amended to remove the requirement that applicants for registration and enrolment have reached the prescribed age.

Disciplinary action by other registration authorities

The Mutual Recognition Acts provide that where a person's registration has been cancelled, suspended or made subject to conditions in one jurisdiction their registration in all other jurisdictions is similarly effected. However where a practitioner has been subject to disciplinary action overseas resulting in deregistration, suspension or conditions on practice there is no requirement that notification be given or provision for that similar action to be taken. The Department considers it appropriate that the Nurses Registration Board be able to take action to protect the public where it is aware that a practitioner has been the subject of disciplinary proceedings overseas and their registration has been cancelled, suspended or made subject to conditions.

The Department considers that the recommendations with respect to disciplinary action taken by an overseas jurisdiction are equally applicable to action taken by another health registration board in NSW whether that action be taken following a disciplinary hearing or an impaired registrants panel inquiry.

In line with recommendation 19 which will require practitioners to submit an annual return, when renewing their registration, that amongst other things provides details of any disciplinary action taken against them in another jurisdiction. The Department recommends that the annual return also include details of any disciplinary action taken by another health registration authority in NSW.

Recommendation 16 – Action by other registration authorities

- (a) That the Act provide that where a practitioner's registration in a jurisdiction to which mutual recognition does not apply is cancelled, suspended or made subject to conditions the Board may take the same action, or lesser action as appropriate, in respect of the practitioner's registration in New South Wales.

A practitioner whose registration is cancelled or suspended under this provision is to have a right to appeal that action to the Tribunal.

- (b) That the Act be amended to provide that where a practitioner who is also registered with another health registration board in New South Wales has a disciplinary finding made against them by the other registration authority that finding may form the basis of a complaint to the Nurses and Midwives Board.
- (c) That practitioners be required to notify the Board if they are registered with a nurses or midwives registration Board overseas or another health registration board in New South Wales and that they also be required to notify the Board in the annual return if they are subject to a disciplinary finding by a nurses or midwives registration Board overseas or another health registration Board in New South Wales.
- (d) Where the Board is aware that a practitioner is registered with another health registration board it be required to notify that board of any disciplinary action taken against a practitioner and any suspension of registration or the imposition of conditions on registration as a result of the impairment process.

Practising without registration

Section 25 of the Nurses Act provides that a registered nurse who is registered elsewhere in Australia may practise in New South Wales without NSW registration for a period not exceeding 24 hours. The Department considers that the existing provisions of section 25 should be extended to include enrolled nurses and registered midwives.

Recommendation 17 – When registration/enrolment is not required

The Act be amended to provide that interstate nurses and midwives be allowed to practise nursing or midwifery in specified circumstances in New South Wales without New South Wales registration or enrolment for not longer than 24 hours.

Recommendation 18 – Regulation of Telenursing

That the Nurses and Midwives Board cooperate with other Australasian nursing and midwifery registration authorities to address jurisdictional issues surrounding the practising of nursing and midwifery by telecommunications facilities.

8. Continuing Registration/Enrolment*Annual renewal*

The Nurses Act requires nurses to renew their registration/enrolment each year. In renewing registration/enrolment the only obligation placed on nurses is to pay the prescribed fee. One of the primary objects of the Act is to provide

patients/consumers with information about the competence of practitioners. Concerns have been raised that there is no system to provide the Board with information about the ongoing competence of practitioners.

The Department has recommended that when renewing their registration nurses and midwives be required to provide information about their professional activities and ongoing fitness to practise. It is also recommended that nurses and midwives be required to provide the Board with detailed information on any criminal findings made against them in the previous year and criminal charges for sex and violence offences occurring in the course of practice or involving minors. Where the Board is not satisfied with a practitioner's declaration it will have the option of conducting an inquiry into their competence or fitness to practise. These provisions, which are in similar terms to recent amendments to the Medical Practice Act, are proposed for inclusion in all health professional registration Acts.

Recommendation 19 – Declaration as to professional activities

That applicants for renewal or restoration of registration/enrolment be required to make declarations on the following matters:

- practice status;
- suspension or cancellation of registration or the imposition of conditions on registration by another health registration board in New South Wales whether as a result of a disciplinary finding or an impairment process;
- registration with another health registration board in New South Wales;
- refusal of registration/enrolment, suspension or cancellation of registration/enrolment, and the imposition of conditions on registration/enrolment in another jurisdiction; and
- significant physical or mental illness that may reasonably be thought likely to detrimentally affect the nurse/midwife's capacity to practice.

Recommendation 20 – Declaration as to criminal matters

That applicants for renewal or restoration of registration/enrolment be required to make declarations on the following matters:

- criminal convictions;
- criminal findings for sex or violence offences and offences occurring in the course of practice where the offence has been proved but no conviction recorded pursuant to section 10 of the Crimes (Sentencing Procedure) Act (1999) or equivalent provision;
- charges laid against the nurse/midwife for sex or violence offences where the charges relate to conduct occurring in the course of practice; and
- charges laid against the nurse/midwife for sex or violence offences where the charges involve minors and charges for child pornography offences.

Restoration of registration or enrolment

Where a person seeks restoration of their registration the Board has no power or discretion to refuse that application despite concerns about their competence. The Board should be empowered to conduct an inquiry into the competence of a person

who seeks restoration of their registration or enrolment and where appropriate grant that restoration subject to conditions or refuse to grant restoration.

Recommendation 21 – Restoration of registration/enrolment

That the Board have the power to inquire into the fitness for registration/enrolment of a person who applies to have their registration/enrolment restored and where satisfied that the applicant is not fit for comprehensive practice the Board may restore the person's registration/enrolment subject to conditions or refuse to restore the person's registration/enrolment.

9. Complaints and Disciplinary Structure

The Nurses Act contains a two-tier disciplinary structure involving Professional Standards Committees (PSCs) and the Nurses Tribunal matched to a two-tier definition of misconduct, involving unsatisfactory professional conduct and the more serious professional misconduct. This disciplinary structure is complemented by the impaired practitioners system which is designed to divert impaired nurses and midwives into treatment and/or retraining before their impairment affects their practice and results in a formal complaint.

Investigation of complaints

The Board has no power to investigate or inquire into a complaint, other than its power to order a practitioner to be medically examined. This is in contrast to the power in other health professional registration Acts, such as the Medical Practice Act, the Pharmacy Act and the Dental Act, which provide the respective registration boards with the power to obtain further information on a complaint prior to determining what action to take.

In addition the Board has no power to appoint an Inspector to investigate instances of unregistered people holding themselves out as nurses or midwives or undertaking the restricted practices. It is proposed that the Nurses and Midwives Board have the power to appoint an Inspector to assist in its inquiries.

Recommendation 22 – Inquiries by the Board

That the Act provide that the Board have the power to obtain additional information about a complaint before determining how to manage the complaint.

That the Board be able to appoint inspectors to carry out inquiries.

Grounds for complaint

It is essential that the grounds for making a complaint about a nurse or midwife complement the grounds for refusing registration/enrolment. Where the grounds for making a complaint and refusing registration are not complementary conduct may be regarded differently depending on whether it is being considered in the course of an application for registration/enrolment or for the purposes of determining if disciplinary action will be taken.

Recommendation 23 – Grounds for complaint

That the grounds for a complaint about a registered or enrolled nurse and a registered midwife be amended to include findings of guilt in criminal matters.

Statutory declarations

While the current Act requires that all complaints, including those made by the Health Care Complaints Commission, are to be verified by statutory declaration the Department is not aware of any allegation that the Commission has inappropriately lodged complaints with the Board. The Department also believes that a similar exemption should be applied to a range of prescribed public office holders such as judicial officers and the Coroner.

Recommendation 24 – Verification of complaints

That the Health Care Complaints Commission and the holders of prescribed public offices be exempt from the requirement that complaints be verified by statutory declaration.

Notification of offences

The criminal justice system can provide information relevant to whether a practitioner's conduct or character are such that disciplinary action should be initiated. Similarly a case can be made in favour of the public benefit of practitioners being required to notify the Board when they are found guilty of an offence.

Recommendation 25 – Notification of offences

That:

- courts be required to notify the Board of any practitioner who is convicted of an offence or found guilty of a sex or violence offence (irrespective of whether a conviction is recorded or not);
- practitioners be required to notify the Board within seven days if they are convicted of an offence or found guilty of a sex or violence offence (irrespective of whether a conviction is recorded or not); and
- practitioners be required to notify the Board within seven days if charged with a sex or violence offence where the allegations relate to conduct occurring in the course of practice or involve minors.

A sex or violence offence is an offence involving sexual activity, acts of indecency, child pornography, physical violence or the threat of physical violence.

Codes of professional conduct

Section 43 of the Act gives the Board the power to establish codes of professional conduct to be observed by nurses and midwives in the course of practice. The Department supports the use of codes of conduct as they can assist in the recognition of appropriate professional standards and can provide information to assist consumers in selecting a practitioner whose practice complies with acceptable standards.

The Department considers it appropriate that there be an external mechanism for approval of codes of conduct which would help to ensure that any code of conduct for nurses and midwives does not sanction anti-competitive conduct or contain trivial matters, and that it serves the interests of consumers. Therefore the Department supports a code being made by the Board following a process of public consultation after which the Minister's approval must be obtained. A similar amendment has recently been incorporated in the Medical Practice Act.

Recommendation 26 – Codes of conduct

That the Act provide for the making of a code of conduct by the Board following public consultation and the Minister's approval.

That the Minister may direct the Board to make a code of conduct on a particular matter with the content of such a code being developed by the Board.

Disciplinary bodies

In line with the recommendation that the Board be renamed the Nurses and Midwives Board the Tribunal should also be renamed the Nurses and Midwives Tribunal.

The Department is of the view that in order to emphasise the transparency of the disciplinary process Board members should be precluded from sitting on the Tribunal. In light of the different role of Professional Standards Committees the Department considers that Board members should only be precluded from sitting on a Committee where they have prior involvement with the complaint or the nurse/midwife the subject of the complaint.

Recommendation 27 – Constitution of disciplinary bodies

That the Nurses Tribunal be renamed the Nurses and Midwives Tribunal.

That Board members be precluded from sitting on the Tribunal.

That Board members be precluded from sitting on a Professional Standards Committee where they have had prior involvement with the complaint or the nurse or midwife the subject of the complaint.

Disciplinary Proceedings

Proceedings before Professional Standards Committees are designed to be inquisitorial and informal while those before the Tribunal are more formal and adversarial.

Concerns have been raised that Professional Standards Committees are becoming excessively formal and are in effect mini tribunals. Such formality is not in keeping with the role Committees are designed to fulfil. The Department therefore proposes that the Act be amended to clarify the informal and inquisitorial nature of proceedings before Professional Standards Committees. The Department also considers there would be merit in having representatives of the Board, the Health Care Complaints Commission and the Nurses Association meet to discuss means of reforming the practice of Committees so as to ensure implementation of this recommendation.

Recommendation 28 – Disciplinary proceedings

That the Act provide that proceedings before Professional Standards Committees are to proceed with as little formality and technicality and as much expedition as appropriate given the nature of the complaint before the Committee.

That representatives of the Board, the Health Care Complaints Commission and the Nurses Association meet to discuss the reform of Committee practices so as to ensure the implementation of this recommendation.

Ex parte hearings

It is implicit within the Nurses Act that disciplinary hearings may take place in the absence of the practitioner the subject of the complaint and the Department recommends that the power to proceed ex parte be made explicit.

Recommendation 29 – Ex parte hearings

That the Act provide that where the Board refers a complaint about a nurse or midwife to a Professional Standards Committee or the Tribunal the Board must notify the nurse/midwife of that fact, and of any arrangements made for a hearing, in writing.

That the Act explicitly state that disciplinary hearings may proceed in the absence of the nurse or midwife the subject of the complaint.

Award of costs by the Tribunal

The Tribunal is empowered to award costs to the successful party following a hearing. The Department recommends that the Tribunal's power to award costs be restricted in line with the power given to the Administrative Decisions Tribunal.

Recommendation 30 – Costs awards

The Tribunal's power to award costs following a disciplinary hearing be modelled on section 88(1) of the Administrative Decisions Tribunal Act 1997.

*Publication of decisions***Recommendation 31 – Publication of disciplinary outcomes**

That the Board have the power to publish and disseminate the decisions of the Tribunal in any way it sees fit.

Emergency powers

The Board has the power, under s.48 of the Act, to suspend a practitioner's registration/enrolment without a disciplinary hearing where that suspension is to protect the life or the physical or mental health of any person, including the practitioner. The Department recommends that the emergency powers of the Board be updated in line with the amendments recently made to the Medical Practice Act.

Recommendation 32 – Emergency powers

That the Board's emergency powers be updated to provide that an order suspending a practitioner may be made for a period of up to eight weeks and to provide the Board with greater flexibility in managing serious cases of impairment.

*Time limits for lodging appeals***Recommendation 33 – Appeals**

That the time allowed for lodging an appeal against a decision of the Tribunal or a Committee be extended to 28 days.

Review of Tribunal decisions

Consistent with recent amendments to the Medical Practice Act the Department recommends that the Act be amended to clarify that a review of a decision by the Tribunal is a review to determine the ongoing desirability of the original decision and does not involve a reconsideration of any findings of fact unless significant fresh evidence is available.

Recommendation 34 – Review of Tribunal decisions

That the Act be amended to ensure that when a practitioner seeks a review under s.68 of the decision of the Tribunal to cancel or suspend their registration/enrolment such a review does not involve a challenge to the original Tribunal's findings of fact.

10. Impairment

The impaired practitioners system provides the Board with a means of managing nurses and midwives who may be impaired in their ability to practise without having to resort to lodging a formal complaint.

The power to require a practitioner to undergo a medical examination as a part of the impairment process would greatly assist the Board in dealing with notifications in the most sensitive and appropriate manner.

The Medical Practice Act was recently amended to provide that where conditions or a suspension has been agreed to the conditions or suspension can only be lifted following consideration by an Impaired Registrants Panel and the agreement of the Medical Board.

Recommendation 35 – Impaired Registrants Panels

That the Board have the power to require a practitioner the subject of a notification to undergo a medical examination either where a matter is referred to an Impaired Registrants Panel or it is proposed to refer the matter to an Impaired Registrants Panel.

That the Act be amended to provide that a practitioner who has agreed to having conditions imposed on his or her registration or to a suspension of that registration may only have the conditions or suspension lifted with the agreement of the Board

which will receive a recommendation from an Impaired Registrants Panel, with an accompanying right to appeal to the Nurses and Midwives Tribunal.

That the Act be clarified to ensure that information in the report of an Impaired Registrants Panel may be provided to the Health Care Complaints Commission where the Board has referred a complaint to the Commission based on the content of the report.

1. INTRODUCTION

1.1 Background to the Review

The Competition Principles Agreement between the Commonwealth, State and Territory Governments requires Governments to review all legislation that has an effect on competition with a view to minimising, and where possible removing, those impacts on competition. The guiding principle of the agreement is that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition and that the objectives of the legislation can only be achieved by restricting competition. Furthermore Governments have agreed that legislative reviews will also:

- i. clarify the objectives of the legislation;
- ii. identify the nature of the legislation;
- iii. analyse the likely effects of the restriction on competition and the economy in general;
- iv. assess and balance the costs and benefits of the restriction; and
- v. consider alternative means of achieving the same result.

The requirement for the Government to conduct a Competition Principles Agreement review of the Nurses Act has provided the Department of Health with an opportunity for a comprehensive review of the operation of the Act since its commencement in 1992. Therefore a wide range of issues, including matters not directly relevant to the Competition Principles Agreement, have been canvassed in the review.

The Terms of Reference for the Review of the Nurses Act 1991 are attached at **Appendix A**.

1.2 Conduct of the Review

The Review has been carried out by the Department of Health's Legal and Legislative Services Branch. The Department, in consultation with key stakeholders, identified a range of matters relevant to the regulation of nurses which required examination. An Issues Paper seeking public comment on those matters was released in August 1999. The Issues Paper was published on the Department of Health's intranet and Internet sites and approximately 200 printed copies of the Paper were distributed to consumers and practitioners without access to the Internet. The Department received 49 written submissions in response to the Issues Paper. A list of submissions received is attached at **Appendix B**.

1.3 The Report

The Department of Health has prepared this Report for consideration by the Minister for Health and the Government in satisfaction of the review requirements of the Competition Principles Agreement.

2. THE REGULATION OF NURSES AND MIDWIVES IN NEW SOUTH WALES

2.1 Introduction

On 30 June 2000 there were 76,188 names on the Register of nurses and 16,136 names on the Roll of nurses in NSW. A nurse's name may not be on the register and roll at the same time. Of the registered nurses 19,498 were authorised to practise midwifery. The Australian Institute of Health and Welfare's report *Nursing Labour Force 1998* indicates that approximately 75% of both registered and enrolled nurses in New South Wales are practising, either full-time or part-time. These surveys also indicate that between 20% and 25% of authorised midwives are engaged in the practice of midwifery in NSW.¹

The Issues Paper noted that the estimated value of services provided by registered and enrolled nurses (including midwives) in NSW exceeds 1.7 billion dollars per annum.

2.2 The Nurses Act 1991

The Nurses Act 1991 replaced and updated the Nurses Registration Act 1953. Included among the significant changes introduced by the Nurses Act 1991 were:

- The two-tier definition of misconduct and the two-tier disciplinary process involving Professional Standards Committees and the Nurses Tribunal.
- Impairment provisions to allow the Board to manage and assist nurses who may be impaired in their ability to practice due to drug or alcohol dependence or some type of physical or mental incapacity.
- The reduction in the size of the Nurses Registration Board from 18 members to 10, although it has subsequently increased in size to the current 13 members.

Restriction on titles

The Act provides that only those individuals who meet certain accreditation requirements can be registered or enrolled as nurses in NSW. Only those individuals who gain registration are entitled to use the title *registered nurse*; only those who gain enrolment may use the title *enrolled nurse*; and only those who gain enrolment on list B of the Roll may use the title *enrolled nurse (mothercraft)*. The title *nurse practitioner* is restricted to those registered nurses who are accredited by the Nurses Registration Board as nurse practitioners. In addition to these title restrictions only those registered nurses who hold an authorisation from the Nurses Registration Board to practise midwifery may use the title *midwife*.

Restrictions on practice

The Act does not define or restrict the practice of nursing. Whilst the Act restricts the practice of midwifery to those registered nurses who hold an authorisation to practise midwifery there is no definition of the practice of midwifery.

Registration requirements

The Act provides for both registration and enrolment of nurses, the Register and Roll are each divided into lists A and B and registered nurses who hold approved

¹ Australian Institute of Health and Welfare *Nursing Labour Force 1998*, <http://www.aihw.gov.au/publications/health/nlf98.html>

qualifications in midwifery may be separately authorised to practise midwifery. In addition the Act provides for the registration of nurse practitioners who are registered nurses working at an advanced level in a specific area of practice.

In order to be eligible for registration or enrolment an applicant must:

- i. have attained the prescribed age (there is no age prescribed for registration and an age of 18 years is prescribed for enrolment);
- ii. possess recognised qualifications in nursing;
- iii. be competent to practise, ie have sufficient physical and mental capacity and an adequate command of the English language; and
- iv. be of good character.

A registered nurse who holds recognised qualifications in midwifery may apply to the Nurses Registration Board for an approval to practise midwifery. It is worthwhile to note that *direct entry* midwives (those practitioners whose primary qualifications are in midwifery rather than nursing) may be registered on List B of the Register and granted an approval to practise midwifery. In practice only direct entry midwives educated outside NSW are registered in this way.

In order to be eligible for registration as a nurse practitioner an applicant must:

- i. be eligible for registration on list A of the Register;
- ii. possess post registration qualifications, or equivalent enabling expert practice, in the relevant practice context;
- iii. have demonstrated 5000 hours of current practice in the relevant practice context, which articulates advanced competency standards;
- iv. demonstrate skills and knowledge associated with the relevant privileges of the practice context;
- v. demonstrate ongoing professional development; and
- vi. demonstrate awareness of current professional nursing issues.

Regulation of the conduct of nurses

One of the objects of the Act is to ensure that only persons of good character and adequate competency may be registered/enrolled as nurses and that once registered/enrolled, nurses adopt appropriate standards of professional conduct. The means by which this is done is the complaints system in the Act, which operates in conjunction with the provisions of the Health Care Complaints Act. A complaint can be made to the Board or the Health Care Complaints Commission (HCCC) that a nurse:

- i. has been convicted of an offence (either in or outside New South Wales) and the circumstances of the offence render the applicant unfit in the public interest to practise nursing, or
- ii. suffers from an impairment, or
- iii. has been guilty of unsatisfactory professional conduct, or
- iv. has been guilty of professional misconduct, or
- v. does not have sufficient physical or mental capacity to practise nursing, or
- vi. is not of good character.

The Act contains a two-tier disciplinary structure. The definitions of *unsatisfactory professional conduct* and *professional misconduct* are set out in section 4 of the Act, which is reproduced as **Appendix C** to this Report.

The Act currently contains a number of offence provisions (eg misrepresentations about registration or enrolment status and the making of false entries in the Register). Breaches of specific offence provisions of the Act can be pursued through criminal action in the Local Court, although the definition of “unsatisfactory professional conduct” is such that breaches of the Nurses Act and Regulation by registered and enrolled nurses can be pursued through the Act’s disciplinary system.

A complaint can be made to the Nurses Registration Board under the Nurses Act or to the HCCC in accordance with the provisions of the Health Care Complaints Act. Under the two Acts processes are in place to ensure that complaints are handled in a coordinated manner. In the first instance, complaints made to one body are referred to the other. Action on a complaint is then determined through consultation between the Board and the HCCC. Matters can be handled in a number of ways including referral to the Health Conciliation Registry for conciliation, referral to the HCCC for investigation and dismissal.

Following an investigation, the HCCC can make a recommendation that disciplinary action be taken. As a general rule, more serious complaints that may, if substantiated, provide grounds for suspension or cancellation of registration or enrolment are to be referred to the Nurses Tribunal. Less serious matters are referred to a Professional Standards Committee (PSC). Both a PSC and the Tribunal can inform themselves of any matter as they see fit, summon witnesses, take evidence and obtain documents. Neither body is bound by the rules of evidence. Legal representation is only permitted before the Tribunal.

A wide range of protective orders can be made by a PSC if it is satisfied a complaint is proved after a hearing. These orders are:

- a caution;
- an order that the nurse receive medical or psychiatric treatment or counselling;
- the imposition of conditions on registration/enrolment;
- an order that the nurse undertake continuing education; an order that the nurse report on his or her practice at the times and in the manner specified; and
- an order that the nurse take advice in relation to the management of his or her practice.

The Tribunal may exercise all of the powers exercisable by a PSC as well as suspending the nurse’s registration/enrolment for a specific period of time or cancelling the nurse’s registration/enrolment.

2.3 Other legislation

It is important to note the broader regulatory environment in which nursing and midwifery services are provided.

- Consumer protection laws (ie the Commonwealth *Trade Practices Act 1974* which is administered by the Australian Competition and Consumer Commission and the NSW *Fair Trading Act 1987* which is administered by the NSW Department of Fair Trading) prohibit nurses from making false and misleading representations in

the course of providing a service, for example, falsely claiming to hold qualifications. Recent amendments to the Public Health Act also make it an offence to promote a health service in a manner that is false, misleading or deceptive or that promotes the inappropriate or unnecessary use of the service.

- The HCCC has the power to investigate complaints about any person who provides a health service, whether registered or not.
- Drug administration by nurses and midwives is regulated by the Poisons and Therapeutic Goods Act.
- In the case of a dispute between a health professional and a consumer, either party could seek to resolve their differences through the civil legal system, although it is recognised that this is generally an expensive process and is unsuitable for minor complaints. As an alternative such matters and complaints about fees can also be heard before a Consumer Claims Tribunal which has the objective of providing a simple low cost mechanism for dispute resolution. These mechanisms are of most relevance where practitioners are self employed, eg independent midwives. In the case of practitioners employed in the public and private hospital systems, that is the vast majority of nurses and midwives, these mechanisms are indirectly relevant.

2.4 Other service providers

A number of services and practices of nursing are common to other health professional groups. These groups include medical practitioners, physiotherapists and podiatrists.

There are also a number of non-registered occupational groups such as assistants in nursing and residential care nurses who provide some services similar to those provided by nurses. The unregistered occupations are not subject to statutory oversight by a professional registration board, however they are subject to the Health Care Complaints Act, the Public Health Act and the consumer protection legislation outlined above.

2.5 The regulation of nursing in other jurisdictions

While all Australian jurisdictions provide for the establishment of a registration board and academic requirements for registration and enrolment, the detail of each registration scheme differs. For example, whilst NSW restricts the use of the titles *registered nurse*, *enrolled nurse* and *midwife* and restricts the practice of midwifery, other jurisdictions restrict different titles and different practices or do not restrict practice at all. A summary of the main features of legislation regulating nurses in other jurisdictions is provided at **Appendix D**.

2.6 Impact of the legislation on competition

Legislative controls imposed by government often have positive outcomes for the community where they effectively address problems that arise from the provision of services in an unregulated environment. These problems are sometimes known as ‘market failures’. An example of such a problem is where there is an imbalance of information between service providers and consumers, limiting the ability of the latter

to make informed choices when seeking services. However, regulation may also restrict competition among service providers. This may result in new problems or costs for business, consumers and government which are not justified having regard to the nature of the problem which the intervention was designed to address. Alternatively, regulation may not be effective in addressing the identified problems at all.

The principal requirements of the Act that may have an impact on competition can be summarised as follows:

- The restriction on the use of the titles *registered nurse*, *enrolled nurse* and *midwife* by unregistered persons may confer a competitive advantage on registered and enrolled nurses and midwives over other service providers.
- The Act imposes restrictions on who may practise midwifery. Midwifery may only be practised by a registered nurse who is authorised by the Nurses Registration Board to practise midwifery, a medical practitioner, a medical or nursing student acting under the supervision of a registered nurse authorised to practice midwifery, a medical student acting under the supervision of a medical practitioner, or a person rendering assistance in an emergency.
- The requirements for registration and enrolment may restrict competition where the number of persons that may gain registration or enrolment (and hence the right to use the restricted titles) and authorisation to practise midwifery is limited beyond that which is necessary to ensure that the objectives of the Act can be achieved. Limitations on the number of practitioners, whether those limitations are effected by requirements for academic qualifications or the imposition of specific requirements such as character, may result in a lessening of competition.

The guiding principles of the Competition Principles Agreement are that legislation is not to restrict competition unless the benefits to the community outweigh the costs and the objective of the legislation can only be met by restricting competition. The review has applied these guiding principles in assessing the restrictions outlined above and the alternatives raised in the Issues Paper.

3. THE OBJECTIVES OF LEGISLATION REGULATING NURSING IN NSW

3.1 Objectives of the Nurses Act 1991

To comply with the Competition Principles Agreement the NSW Government is required to identify the objectives of the Nurses Act and to consider whether there is a rationale for continuing to achieve those objectives through legislation. If it is established that there is a rationale for legislative intervention, the precise form of intervention must be considered.

The Nurses Act does not contain a statement of its objectives. Guidance is, however, available from the (then) Minister for Health's second reading speech when introducing the legislation to Parliament. The preamble to the Act and the functions of the Nurses Registration Board, as set out in s.10 of the Act, are also of assistance.

When the Nurses Bill was introduced the then Minister for Health, the Hon. P. Collins MP, noted in his second reading speech that:

“The object of the bill is to update the legislative framework for nurses by reforming the structure and operation of the Nurses Registration Board and by introducing a new disciplinary system.”²

The Minister went on to say that the Act will

“require the Board to promote and maintain professional standards of nursing practice in New South Wales...”³

The preamble to the Nurses Act states:

An Act to regulate the practice of nursing and to repeal the Nurses Registration Act 1953.

The functions of the Nurses Registration Board are set out in section 10 of the Act.

10(1) *The Board has the following functions:*

- (a) to promote and maintain professional standards of nursing practice in New South Wales,*
- (b) to promote the education of nurses and educational programs relating to nursing,*
- (c) to advise the Minister on matters relating to the registration and enrolment of nurses, standards of nursing practice and any other matter arising under or related to this Act or the regulations,*
- (d) to publish and distribute information concerning this Act and the regulations to nurses and other interested persons,*
- (e) to hold examinations for the purposes of this Act and to determine the character, subjects and conduct of those examinations,*
- (f) to appoint examiners and supervisors in respect of examinations referred to*

² Legislative Assembly Hansard, 20 March 1991, page 1442.

³ Ibid., page 1443.

- in paragraph (e),*
- (g) to appoint places and times at which examinations referred to in paragraph (e) are to be held,*
 - (h) for the purpose of facilitating under this Act the registration of nurses, the authorisation of registered nurses to practise midwifery and the enrolment of enrolled nurses and enrolled nurses (mothercraft), to grant recognition to:

 - (i). hospitals, nursing homes and educational and other institutions offering courses for the training of nurses, midwives and enrolled nurses and enrolled nurses (mothercraft), and*
 - (ii). the curricula for such courses, and*
 - (iii). diplomas, certificates, and other qualifications awarded to persons who successfully complete those courses**
 - (i) to impose requirements or conditions for or relating to registration as a nurse, authorisation to practise midwifery or enrolment as an enrolled nurse or enrolled nurse (mothercraft),*
 - (j) to grant to persons in prescribed circumstances or cases exemptions from a requirement or condition for or relating to registration as a nurse, authorisation to practise midwifery or enrolment as an enrolled nurse or enrolled nurse (mothercraft),*
 - (k) to cause the relevant particulars of qualified nurses to be entered in the Register, and the relevant particulars of qualified nurses to be entered in the Roll, in such manner as the Board may direct,*
 - (l) to cause particulars of the midwifery qualifications of registered nurses who are authorised by the Board to practise midwifery to be entered in the Register,*
 - (m) to determine in accordance with this Act applications for registration as a nurse, for authorisation to practise midwifery and for enrolment as an enrolled nurse or enrolled nurse (mothercraft),*
 - (n) to issue certificates of registration to registered nurses, certificates of authorisation to practise midwifery to registered nurses who are authorised by the Board to practise midwifery and certificates of enrolment to enrolled nurse or enrolled nurse (mothercraft),*
 - (o) to issue authorities to practise as a nurse as provided by section 33, and*
 - (p) generally, to do any other act or to exercise any other functions necessary for carrying the provisions of this Act into effect.*

It is apparent that the underlying policy objective of the Act is the regulation of nursing and midwifery so as to minimise the potential risk of harm posed to members of the public by unqualified, unscrupulous or substandard practitioners in the fields of nursing and midwifery.

3.2 Submissions

Submissions overwhelmingly supported the view that the objectives of the Act are the minimisation of the risk of harm posed to the public by unqualified, unscrupulous or substandard practitioners in the fields of nursing and midwifery and that those objectives remain valid.

“The College believes that the intent of the legislation remains valid...”⁴

⁴ Submission Royal College of Nursing Australia.

“The object of the Nurses Act are valid and should remain...”⁵

Further submissions universally supported the inclusion of an objects clause in the Act. A large number of submissions endorsed the objects clause suggested by the Health Care Complaints Commission, which was included in the Issues Paper. That is:

Promotion and maintenance of professional standards of nursing practice in New South Wales to facilitate public confidence in the profession and protect the community from unethical and incompetent practitioners.

3.3 Conclusions

The submissions support the view that the objective of the Act is the protection of the public by the minimisation of the risk of harm to consumers of nursing and midwifery services. The rationale that underpins this objective is that within nursing and midwifery there is an imbalance of information. The imbalance of information is such that in the absence of government intervention consumers, including employers, may have difficulty identifying competent and ethical practitioners and the public may thereby be exposed to harm.

A range of potential risks to consumers has been identified. The harm that the legislation seeks to address is not limited to injuries suffered by a patient at the hands of a registered or unregistered person but includes harm that may be suffered if a person is unable to access a service or is discouraged from seeking a service due to an inability to identify a competent practitioner. It is noted that the practice profile of nursing and midwifery is overwhelmingly within the public and private hospital systems and other public facilities such as community health centres. Nonetheless there are a number of independent practitioners, particularly within midwifery, and it is important for consumers of those services to be able to easily identify practitioners who have been judged as having the qualifications to practise safely. These risks can be summarised as follows:

- the risk of injury or death from inappropriate or improperly applied interventions;
- the risk of physical, sexual and emotional abuse from practitioners;
- financial losses due to injury or payment for ineffective services; and
- the risk of injury, or prolonged injury/suffering, due to an inability to identify competent practitioners and thereby access services.

The complaints history of the profession⁶ suggests that there is a risk of harm to patients from unethical, or substandard registered nurses, enrolled nurses and midwives. Over the reporting years 1995/6 to 1998/9 49% of complaints about nurses received by the Health Care Complaints Commission related to competence to practise and treatment and 36% related to character and ethical issues⁷. The carrying out of nursing and midwifery practices in an incompetent or unethical manner can expose consumers to harm and the objective of the Act, to minimise the risks of serious harm or injury to consumers, therefore remains valid.

⁵ Submission, TAFE NSW.

⁶ Appendix 2 Issues Paper for the Review of the Nurses Act 1991, July 1999.

⁷ Health Care Complaints Commission Annual Reports for the years 1995/6, 1996/7, 1997/8 and 1998/9.

It is proposed that if the objective is addressed through legislative intervention the legislation should include a specific statement of this objective.

Recommendation 1 – Regulatory objective

That any regulation of nursing and midwifery have the objectives of:

- 1 Protecting the health and safety of members of the public by providing mechanisms to ensure that nurses and midwives are fit to practise.
- 2 Providing mechanisms to enable the public and employers to readily identify nurses and midwives who are fit to practise.

4. THE REGULATION OF NURSING AND MIDWIFERY IN NSW AND IMPACTS ON COMPETITION

4.1 Introduction

The primary forms of intervention by which the Nurses Act seeks to achieve the objective outlined in the previous chapter are the registration system, the placement of restrictions on who may use the titles *registered nurse*, *enrolled nurse* and *midwife* and the restriction on who may practise midwifery. The restriction on title aims to achieve the objective of the legislation by providing consumers with a simple and understandable means of identifying practitioners considered qualified to provide nursing and midwifery services. By enabling consumers to identify such practitioners, risks of injury and the costs to consumers of seeking qualified practitioners will be reduced. The rationale behind the restriction on midwifery is to reduce the risk of serious health consequences that may be associated with aspects of that practice.

Although the Issues Paper noted that the prohibition on the use of the restricted titles by unregistered persons could have benefits for consumers, it was also noted that this might also have disadvantages or costs, primarily through its impact on competition. Restrictions on titles may confer competitive advantages on registered and enrolled nurses and midwives because it indicates that they are able to provide a superior service to unregistered people. By providing that certain standards and qualifications must be met to be registered or enrolled restrictions are placed on the number of practitioners who may be registered or enrolled. Restrictions on the number of practitioners may reduce competition among nurses and midwives and those who provide similar services, resulting in unnecessary costs for consumers. A restriction on the practice of midwifery confers on those people authorised to practise midwifery a further competitive advantage as there will be a near monopoly on the performance of particular procedures.⁸ If these restrictions cause prices to rise substantially, then consumers (including employers) could be discouraged from purchasing appropriate services.

This chapter will focus on the impact of the restrictions on titles and on who may practise midwifery, and whether these forms of intervention are necessary to achieve the objectives of the Act. Alternatives to these restrictions are considered to determine whether they can achieve the objective of the legislation at a lower cost and with less impact on competition. Before turning to these alternatives it is important to restate that the Nurses Act is not the only legislation which regulates the delivery of nursing and midwifery services. The Trade Practices Act, the Fair Trading Act, the Health Care Complaints Act, the Public Health Act and the Poisons and Therapeutic Goods Act are also relevant.⁹

4.2 The effect of regulation

The Issues Paper called for submissions on the need for the regulation of practitioners providing nursing and midwifery services and the effect of any regulation

⁸ Medical practitioners and supervised students are exempt from the prohibition, as are people providing assistance in an emergency.

⁹ See 2.3

on competition. Submissions were unanimous in the view that regulation of practitioners was essential.

“..the practices of nursing and midwifery provide .. privileged access to people’s bodies, minds, personal effects and even their homes. It is critical that ..abuse of such privilege carries professional sanctions.”¹⁰

“Significantly, in a totally deregulated system, consumers’ only recourse (and remedy) would be via civil litigation; a means to prevent unqualified practitioners from continuing to practise would not exist.”¹¹

A number of submissions also drew attention to the cost that de-regulation would impose on the health system.

“Without regulation the local employer will need to investigate potential employees regarding their skills. This will cause immense cost which will have to be taken from client service provision.”¹²

Most submissions did not address the impact of the current regulatory restrictions on competition and it is significant that submissions did not take issue with the suggestion made on page 23 of the Issues Paper that *[regulation provides] a competitive advantage to registrants...* One submission did however argue that

“..the current Act does not impose undue restrictions on competition as evidenced by the proliferation of other classifications of ‘care workers’ such as AINs, residential and personal care workers, and most recently, under the Charitable Sector Award, Care Service Employees. Each of these groups is performing work that is at times indistinguishable from nursing...”¹³

One submission went further and argued that restrictions on competition are appropriate in the public interest:

“There is a need to protect the public from harm by unethical or unprofessional practice. However, competition may have to be restricted in order to achieve this. To allow unethical, unprofessional or uneducated behaviour to occur, in order to promote competition, would be unacceptable and even damaging to the consumer.”¹⁴

4.3 Options for regulating nursing

Submissions were overwhelmingly supportive of continuation of a system of regulation in which specific titles are restricted.

¹⁰ Submission, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney.

¹¹ Submission, New South Wales Branch of the Australian and New Zealand College of Mental Health Nurses Inc.

¹² Submission, Community Health, Illawarra Area Health Service.

¹³ Submission, The New South Wales College of Nursing.

¹⁴ Submission, Southern Cross University, School of Nursing and Health Practices.

“.. title only regulation is supported, as attempts to restrict core or whole of practice would appear to be unwarranted in that it is overly restrictive and perhaps unworkable.”¹⁵

“The NRB is of the view that the current model should continue as it is consistent with a need for responsible and judicious implementation of policies which serve the public interest for safe and effective quality care, as well as providing the public with information on the standard of practice expected of qualified registered nurses, enrolled nurses and midwives...”¹⁶

A number of submissions went further and argued for practice restrictions, particularly in the area of midwifery. Notwithstanding the fact that all submissions supported the continuation of a regulatory system with a restriction on titles, the Department has given detailed consideration to all of the regulatory models examined in the Issues Paper.

The Issues Paper examined the following regulatory models ranging from no regulation through to title and whole of practice regulation.

Option 1: No regulation

This model involves the repeal of the Nurses Act. Under this system there would be no restriction on who may practise as a nurse, and/or a midwife, or hold themselves out as capable of so practising. Consumers could rely on a practitioner’s membership of a professional association as an indication that the practitioner is suitably qualified and subject to a disciplinary scheme. However, not all nurses, irrespective of qualifications, may join such an association. It is important to remember, however, that the overwhelming majority of nurses and midwives engaged in clinical practice are employed within a hospital or similar institutional setting. In such settings employers could take responsibility for ensuring that only appropriately qualified practitioners are employed.

Option 2: Co-regulation

Co-regulation encompasses a range of models with the common feature that regulatory responsibility is shared between government and industry. If such a system were adopted professional associations would set membership requirements and administer the disciplinary system to ensure the maintenance of professional standards. The Government would monitor and accredit professional associations to ensure they act in such a way as to protect members of the public.

Under such a system, a practitioner who is not a member of an accredited association would not be prevented from practising or from using the titles, or variations on the titles, *nurse*, or *midwife*.

Option 3: Title regulation

This is the current regulatory approach applied to nursing in which particular titles are restricted to registered/enrolled practitioners. Restriction on titles provides consumers (including employers) with a simple mechanism to verify that a person has the qualifications considered adequate for safe professional practice. Furthermore, title regulation provides an assurance to consumers that practitioners are subject to a statutory complaints handling and disciplinary system.

¹⁵ Submission, Division of Nursing and Clinical Services, South Western Sydney Area Health Service.

¹⁶ Submission, Nurses Registration Board of New South Wales.

Option 4: Title and core practice restriction

This form of regulation involves title restriction so consumers can identify qualified practitioners as well as the restriction of certain core practices that have been identified as carrying significant risks if performed by unqualified persons. Not all of the techniques used by the profession are restricted. Non-registered practitioners will remain able to provide services that do not carry significant risks but which nevertheless fall within the scope of practice of the regulated profession.

Option 5: Title and whole of practice restrictions

This is the most restrictive form of professional regulation and is the system currently applied to the practice of midwifery. Under this approach the entire scope of a professional practice or area of practice is limited to a particular professional group, although those Acts that adopt this system allow specific exemptions.

4.4 Assessment of options

Examination of these options has been undertaken with a view to determining which of the options achieves the greatest overall benefit for the community and is the most effective means of achieving the objectives of the Act. In conducting this assessment it is important to note that it is not possible to quantify the financial costs and benefits of any of the options, including the existing system, due to a lack of comparative data. Therefore cost and benefits have been described in qualitative terms only.

The Department is of the opinion that substantial public benefits will arise where risks to consumers/patients are averted. Therefore it is likely that the option that has the highest overall benefit will be the one that most effectively, yet simply, provides information to consumers (including employers) to assist them in engaging the services of a qualified and competent practitioner. The benefits provided by the system can then be compared with its costs, including the impact on competition, to determine the system that generates the greatest overall benefit to the community.

Option 1: No regulation

Removal of registration would have the benefit of removing any adverse impacts on competition. However, there would be a reduction in the amount of information readily available to consumers and an increase in the potential for physical harm and associated increased costs to consumers and the economy.

This system would have the following **advantages**:

- There will be no restrictions on competition as any person will be able to hold themselves out as a nurse or midwife and as being capable of undertaking the practices of nursing and midwifery. Theoretically this will increase the pool of available practitioners and decrease, or help prevent an increase in, prices.
- There will be no regulatory costs and only those practitioners who make the choice to join a professional association will incur costs associated with that membership.

Such a system would have **disadvantages** or costs, as outlined below:

- Although consumer protection legislation would assist consumers in the choices they make by precluding practitioners from engaging in false, misleading and deceptive conduct, it would not be effective in situations where qualifications are held but are not of a sufficient standard for the services the consumer is seeking. This is significant because it is possible that consumers will not be in a position to identify which qualifications are necessary and appropriate for the purpose of practising nursing and midwifery safely. In the absence of extensive, and possibly expensive, promotional activities by practitioners consumers are likely to incur significant transaction costs in seeking to do this.
- Most consumers in the market for professional health care services lack specialised knowledge and as a result have a limited ability to distinguish competent from incompetent practitioners, assess the quality of the services offered and whether those services are excessive or inadequate in relation to their needs. These distortions may result in an increase in injuries and costs associated with receiving care that is inappropriate or delayed.
- While the Health Care Complaints Act enables consumers to make a complaint about any health service provider, registered or not, specific disciplinary action can only be taken where the person is registered. Although complaints could be referred to a professional association for action, this may be inadequate as not all nurses and midwives choose to become members of a professional association and the sanctions available to professional associations are limited.
- Consumers may place unwarranted weight on the fact that a practitioner is a member of a professional association and may require assistance identifying those associations that play an active role in relation to monitoring the professional standards of their members.
- A disciplinary system administered by professional associations may lack transparency.
- While there would be no costs associated with a registration board, there would be costs connected with professional bodies assessing qualifications for the purpose of determining entry criteria and the promotion to consumers of the benefits of membership of a particular professional body.
- In the absence of a centralised body to assess practitioners' qualifications and competence employers (including the public health system) may be forced to establish, either separately or cooperatively, their own mechanisms to accredit individual practitioners. The costs of these bodies would be passed onto health consumers or the public health system.
- Court action against an unethical or incompetent practitioner could be expensive and slow.

On balance, the Department considers that in view of the disadvantages identified above this option would not meet the identified objectives of the current legislation which are the protection of the public by the minimisation of the risk of harm to consumers of nursing and midwifery services and the provision of mechanisms to enable the public and employers to readily identify nurses and midwives who are fit to practise.

Option 2: Co-regulation

This option allows for government to withdraw from actively registering nurses and midwives and therefore the impact of that registration on competition is removed. The Government would, however, maintain a mechanism to provide consumers with information about practitioners offering services. As noted above co-regulation could be achieved by the Government monitoring and accrediting professional associations. The Government would then publish a list of those accredited associations and promote the benefits of dealing with a practitioner who is a member of an accredited association. The Government could also publish details of the qualifications that are considered to equip a practitioner for competent practice, this would help to ensure that practitioners are not de facto forced to join a professional association.

This system would have **advantages** as outlined below:

- There will be no restrictions on competition as any person will be able to hold themselves out as a nurse or midwife and as being capable of undertaking the practices of nursing and midwifery.
- There will be no regulatory costs and only limited costs associated with accreditation of associations and the publication of relevant information.
- Only those practitioners who make the choice to join a professional association will incur costs associated with that membership.
- Membership of a professional association may provide some guarantee for consumers that practitioners are subject to a disciplinary structure.

Such a system would have **disadvantages** or costs, as outlined below:

- While the Health Care Complaints Act enables consumers to make a complaint about any health service provider, registered or not, specific disciplinary action can only be taken where the person is registered. Although complaints could be referred to a professional association for action, this may be inadequate as not all nurses and midwives may choose to become members of a professional association and the sanctions available to professional associations are limited, the maximum being expulsion from the association.
- Membership requirements may be more restrictive and more expensive than under the existing Nurses Act.
- For a disciplinary structure to provide sufficient information to consumers about the ongoing competency of practitioners it must be transparent, open to public scrutiny and adequately represent the interests of consumers. The disciplinary structures in professional associations may not possess these necessary qualities. In addition, a professional association may lack the power to impose sanctions, however the presence of Government accreditation may help to ensure the disciplinary structure remains accountable, transparent and impartial.
- While there would be no costs associated with a registration board, there would be costs connected with professional bodies and the Government assessing

qualifications for the purpose of determining entry criteria and the promotion to consumers of the benefits of membership of a particular professional body.

- In the absence of a centralised body to assess practitioners' qualifications and competence employers (including the public health system) may be forced to establish, either separately or cooperatively, their own mechanisms to accredit individual practitioners. The costs of these bodies would be passed onto health consumers or the public health system.
- Court action against an unethical or incompetent practitioner could be expensive and slow.
- Sanctioning or removing the accreditation of non-complying associations may be problematic.

The Department considers that this system provides greater opportunity for consumers to access relevant information about practitioners offering services. However, in the absence of restrictions on relevant titles there may be transaction costs associated with consumers seeking that information and a risk that not all consumers, especially in critical situations, will do so.

The realisation of the benefits of this model depend on the ability of the Government to effectively publish information that is meaningful and of use to consumers as well as the ability and inclination of consumers to access that information. Further the system fails to adequately acknowledge that many patient injuries are caused by, or attributed to, qualified and registered practitioners. Co-regulation provides an effective complaints mechanism only in respect of suitably severe injuries that justify civil legal action and even then only for those members of the public who have the financial and emotional resources to sustain such action. The complaints history of nursing and midwifery suggests that there is a need for ongoing independent monitoring of professional standards and practice, notwithstanding that the incidence of complaints is low when considered in the context of the number of registrants. Obviously the Health Care Complaints Commission could undertake this complaints monitoring role but in the absence of statutory regulation and the ability to apply sanctions in the worst cases the Commission's ability to be an effective complaints management body would be severely compromised.

Therefore, on balance, the Department considers that this system is unlikely to deliver a net benefit to the public. The model will not meet one of the key objectives of the legislation, protection of the public from incompetent or unscrupulous practitioners as, in the absence of an independent disciplinary system that can effectively sanction practitioners, the incompetent or unethical can continue to practise.

Option 3: Title regulation

This is the regulatory system that currently applies to nursing. Under this system the Nurses Registration Board is created and only those practitioners who are registered with the Board may adopt the titles *registered nurse*, *enrolled nurse* and *enrolled nurse (mothercraft)*. Only practitioners who hold recognised qualifications may be granted registration or enrolment. In addition to the title restrictions there is a disciplinary system which allows the Board to monitor and enforce accepted standards of professional conduct and competence within the profession.

The system allows employers and consumers to quickly, and easily, determine those practitioners who are registered or enrolled and therefore can be assumed to hold recognised qualifications and adhere to recognised professional and practice standards.

The **advantages** of this model are:

- A restriction on title is a means of providing a signal that a registered person possesses qualifications that have been assessed as appropriate. This is useful to both individual consumers and to employers who on sighting a current practising certificate can be assured that the registered/enrolled practitioner possesses qualifications and is subject to an independent disciplinary structure designed to maintain standards.
- The imposition of qualification and training requirements for registration and enrolment results in more competent practitioners. The more competent practitioners are the lower the risk of harm to patients, their families and the community.
- An independent disciplinary system enshrined in legislation that considers complaints relating to professional conduct reinforces for consumers the trust and faith that is placed in registered/enrolled practitioners.
- A disciplinary system that is transparent and fair to all parties will provide consumers with information on the competency of practitioners.
- Improved use of appropriate health service providers by patients operates to reduce the social costs of illness to individuals, the community and the health system.

The **disadvantages** associated with this model are:

- There are costs associated with obtaining the qualifications an individual must have for registration or enrolment.
- There are costs associated with administering a system of registration/enrolment. The practice of the Board is for all costs to be recovered through registration fees. The Board's administration costs for the 1999/2000 financial year were \$3.87 million.
- A portion of the costs associated with administering the Health Care Complaints Commission relate to the management of complaints about nurses. The following statistics provide some guide as to costs involved:
 1. The cost of running the HCCC in 1998/9 was \$5.7 million;
 2. 8.4% of complaints received in 1998/9 were about nurses and midwives;
 3. 16% of Professional Standards Committee and Tribunal hearings and court appeals in 1998/9 concerned nurses and midwives; and
 4. 9.5% of finalised complaints concerned nurses and midwives.¹⁷

¹⁷ Health Care Complaints Commission, Annual Report 1998/9

- Registration/enrolment and regulation may allow registered practitioners to attach a price premium to their services above that which would be expected to occur in a fully competitive market. Although isolating a premium for any profession is complicated and even where a price premium is observed it may not be possible to directly attribute this to registration.

The Department considers the system of registration and enrolment by title provides consumers with an effective means of identifying those practitioners who have the qualifications considered necessary for competent practice. The coupling of this system with a disciplinary structure provides consumers with the further assurance that registered and enrolled practitioners' practice and ethical standards are subject to monitoring and that practitioners who practise inappropriately may be subjected to sanctions.

A registration system involves costs, as detailed above, however as the costs of running the Board and disciplinary system are recovered from registration fees, currently \$35 per annum, the Department considers that these costs are not significant. It is important to note that the administration of the Board is a minimal cost to the Government as the Board is self funding.

The registration system also impacts on competition by potentially restricting the number of practitioners in the market, although given the large number of qualifications which are accepted by the Board¹⁸ and the fact that there is no practice restriction in nursing the effects on competition are considered to be limited.

Option 4: Title and core practice restriction

This option applies title restrictions and the disciplinary system as outlined above under option 3 as well as restricting those practices, not otherwise regulated, that are considered to require particular skills and training and that carry serious risks if performed by unqualified people. This system allows consumers to easily identify those practitioners with the qualifications considered necessary for competent practice as well as providing them with assurances that dangerous practices will only be carried out by registered, and therefore qualified, practitioners.

The **advantages** associated with core practice restrictions are as follows.

- The fact that a practice is restricted will provide consumers with information that there is a significant risk of injury associated with it. This information may assist consumers in making informed decisions about their treatment needs.
- Non-registered/enrolled practitioners would be able to compete with registered and enrolled nurses and midwives by providing services that do not carry significant risks but which nevertheless fall within the scope of practice of nurses and midwives.

The **disadvantages** of core practice restrictions are as follows.

¹⁸ A list of the courses accepted by the Nurses Registration Board may be obtained from the Board's Internet website:

<http://www.nursesreg.nsw.gov.au/recog.htm> (registration)

<http://www.nursesreg.nsw.gov.au/recog2.htm> (midwifery)

<http://www.nursesreg.nsw.gov.au/recog3.htm> (enrolment).

- Core practice restrictions result in the creation of a limited number of registered practitioners who can perform certain procedures. This may result in restriction on the availability of services and inflation in cost. The Department's experience with practice restrictions is that professions often expend more effort in seeking to prevent other registered health professional groups gaining access to the restricted practice area than in policing the genuine risks associated with untrained and unregistered persons undertaking restricted practices.
- Practice restrictions can have an adverse impact on competition and result in increased costs. This may occur because:
 - (i) innovation and improved techniques both within the registered group and by other professional groups with closely related areas of practice have been hindered; and
 - (ii) there is a public perception that the restriction is an indication of superior quality on the part of practitioners permitted to perform the procedure over the other practitioners not permitted to perform the procedure.
- Practice restrictions are of limited effect in that they do not apply to instances of members of the registered group practising beyond their level of competence.
- The task of drafting workable definitions of practices which only registered practitioners may provide that do not unnecessarily overlap with the legitimate scope of practice of other service providers is difficult.
- The enforcement of practice restrictions can be difficult as a court must be satisfied that a particular procedure that is proscribed has been performed.

A number of submissions argued that the regulation of nursing should be by title and core practice although the submissions did not seek to define those core practices that should be restricted. The holistic nature of much nursing practice suggests that nurses apply skills from across a very wide range of health care disciplines and attempting to isolate and define the relevant core practices is not feasible.

The Department does not consider that a system of title and core practice registration is appropriate to the profession of nursing and believes that such a system provides no real benefits, while increasing public costs, over title registration only.

Option 5: Title and whole of practice regulation

This option involves title regulation and a disciplinary system as described under option 3 in conjunction with restriction of the entire scope of nursing practice. This is the most restrictive form of regulation. The immediate impact of such a system would be to confer a monopoly over an entire professional area and substantially reduce competition. This option fails to recognise that there is some overlap between the legitimate scope of practice of most professions. This overlap is particularly pronounced in the case of nursing where, as noted above, nurses practise in an holistic fashion applying skills from across a very wide range of health care disciplines.

The Department considers that this system provides no real benefits to consumers over title registration and has the potential to significantly increase costs and reduce competition in the provision of health care services.

Recommendation 2 – Regulation of nurses

That nurses continue to be regulated by title in New South Wales.

4.5 Midwifery

The Nurses Act 1991 restricts the title *midwife* to registered nurses who have recognised qualifications in midwifery and hold an authority to practise midwifery. The Act also restricts the practice of midwifery to registered nurses who hold an authority and certain other occupational groups specifically exempted by the legislation, such as medical practitioners. This is in essence title and whole of practice restriction. It is of interest that the Act restricts the practice of midwifery yet does not in any way seek to define it.

As noted in the Issues Paper the practice of midwifery involves caring for women and their babies before, during and immediately after birth and carries with it the potential for serious and in some cases fatal complications. The potential for serious outcomes from the inappropriate practice of midwifery is evidenced by two recent judgements of the Nurses Tribunal.^{19,20}

Consumers of midwifery services potentially face the same problems as those faced by consumers of other types of nursing care and similar market failures are evident in that market. As the Issues Paper noted the problems faced by consumers may be more pronounced in the market for midwifery services due in part to the longer tradition and greater acceptance of independent practice in midwifery. However it was also noted that there are a number of factors associated with the practice of midwifery, particularly independent midwifery, that may reduce the impact of market failures and information disparities and therefore reduce the need for regulation.

Most submissions addressed the issue of the regulation of midwifery and of those that did there was universal support for continued regulation. The following points were made in support of continued regulation:

“The suggestion that where midwives are employed in institutional settings that the employing agency will ensure that midwives are suitably qualified and experienced in the absence of regulation is impractical, costly and unreliable.”²¹

“The number of cases referred to midwifery standards committees (sic) or tribunals attests to the fact that ‘organisations and particularly consumers of maternity services are [not always] able to identify or employ midwives who are suitably qualified and experienced’.”²²

¹⁹ Reasons for decision of the New South Wales Nurses Tribunal in the matter of Maggie Lecky-Thompson, delivered on 9 November 1998.

²⁰ Reasons for decision of the New South Wales Nurses Tribunal in the matter of Margaret Gillian Watson Lecky-Thompson, delivered on 7 December 1998.

²¹ Submission, South Eastern Sydney Area Health Service

²² Submission, Central Coast Area Health Service, Division of Obstetrics

“It cannot be assumed that consumers seeking the services of a midwife have the knowledge and understanding to assess the qualifications and experience of their midwifery (sic). An example of this would be the problems that have been experienced by patients undergoing plastic surgery by inexperienced GPs and others.”²³

On balance the Department considers that the evidence indicates a need for the regulation of midwifery to continue in New South Wales. Practice restrictions in the area of childbirth are considered in **section 4.8**.

Recommendation 3 – Regulation of midwives

That midwives continue to be regulated by title in New South Wales.

4.6 The form of nursing and midwifery regulation

The current Act provides that registered nurses with approved qualifications in midwifery may be granted approval to use the title *midwife* and to practise midwifery. There is no separate register of midwives and all approved midwives, whether they have nursing qualifications or not, must firstly be registered as nurses and are therefore entitled to hold themselves out as registered nurses. This has been identified as a problem and it is alleged that direct entry trained midwives may be practising, or being compelled by employers to practise, in areas that are beyond their competence or training.

The Issues Paper noted that a number of midwives and professional associations representing midwives assert that nursing and midwifery are separate professions and that a separate authority should therefore regulate midwifery. The Issues Paper also noted that a large number of midwives and practitioners who identify themselves as nurses take the view that nursing and midwifery are separate professions, although linked, and that the two professions should be regulated by an authority which recognises the special status of midwifery.

The Department has therefore considered a number of different structures for the regulation of midwives in New South Wales. These structures are:

- the status quo;
- a separate Midwives Act which establishes a Midwives Registration Board; and
- separate registers for midwives and nurses under a single Act.

4.6.1 The status quo

Retention of the current system would mean that in order to be authorised as midwives all qualified people will have to be registered as nurses whether they have nursing qualifications or not.

A small number of submissions advocated retention of the status quo and that from the Australian Nursing Council is indicative:

²³ Submission, Northern Sydney Area Health Service

“No jurisdiction in Australia has a separate Act to regulate midwifery, nor is midwifery included in the title of any other Australian Nurses Act. There would appear to be no benefit to the consumer in the interests of public health and safety in having separate legislation if midwifery practitioners are already regulated under the present Act. The setting up of regulatory practices, should a separate Act be agreed to, would be very costly to the consumer and professionals.

...

A Nurses and Midwives Act based on the premise of recognition of one group as being equal to another is not the purpose of regulation.”²⁴

There have been two problems identified as arising from the current system. These problems are:

- members of the public being misled about the qualifications of those registered nurses with direct entry midwifery qualifications; and
- employers requiring registered nurses with direct entry midwifery qualifications to practise beyond their level of training and expertise.

The Department believes that providing the Board with a power to register or enrol a person subject to conditions (see **section 5.2** below) will partially address these concerns by notifying the public and employers about limitations in the practitioner’s area of practice. However there remains a possibility that members of the public could be misled in a number of ways, for example:

- Members of the public may not actively enquire about limitations on practice and some practitioners may not consider it necessary to offer that information in the absence of such an inquiry. Consumers could thereby remain under the misapprehension that a practitioner using the title registered nurse has comprehensive nursing qualifications when in reality their qualifications are in midwifery.
- Those members of the public who are aware that a person’s practice is restricted to midwifery may assume that such a limitation is an indication of inferior qualifications or that the limitation has been imposed following disciplinary proceedings.

On balance the Department is of the view that continuation of this system would not be in the best interests of the public and consumers of nursing and midwifery services.

4.6.2 A separate Midwives Act

During the initial stages of this review many midwives and organisations representing midwives called for the separate regulation of nursing and midwifery by separate Acts and registration boards. If this approach were taken a person with qualifications in both nursing and midwifery could register with the Nurses Registration Board as a nurse and with the Midwives Registration Board as a midwife while a practitioner with qualifications in midwifery alone would only register with the Midwives Registration Board as a midwife.

²⁴ Submission, Australian Nursing Council Inc.

The claimed advantages of this approach are:

- That it would recognise midwifery as a separate profession to nursing and thereby raise the profile of midwifery and its attractiveness as a career.
- That statutory recognition of the status of midwifery would help to reverse the drift of practitioners away from the profession.
- That it would foster the development of undergraduate (or direct entry) midwifery programs in New South Wales.

Few submissions in response to the Issues Paper pursued this option and those that did pursue it did so in terms of the benefits for midwives and not the benefits to the public. For example:

“The demand for a separate Midwifery Act has been generated from the poor management practices of individual health facilities in their treatment of midwives.

...

A separate Act would enable midwives, regardless of their route of entry to the profession, a measure of protection in determining their practice area.”²⁵

Establishing separate registration for nurses and midwives would however be problematic, particularly in an environment where a great many practitioners who are authorised to practise midwifery, and who do in fact practise midwifery, consider themselves to be nurses and part of the nursing profession. There is no consensus amongst practitioners on the status of midwifery, and it is suggested by some that the majority of authorised midwives continue to favour the joint regulation of nursing and midwifery.

Given the lack of evidence that there would be a benefit to the public from establishing a separate regulatory system for midwifery, the lack of support for separate regulation from authorised midwives and the inconvenience and potential cost to registrants and employers of such a system the department does not support separate registration Acts for nursing and midwifery.

4.6.3 Separate registers for nurses and midwives under a single registration Act

Under this system there would be a single registration Act and Board with separate registers for nurses and midwives. A number of submissions from a diverse range of organisations, including the Australian Midwifery Action Project, the NSW Midwives Association, the NSW College of Nursing and area health services, supported this approach in one form or another.

“..midwifery should continue to be regulated within the Nurses Act but it should be renamed the Nurses and Midwives Act and amended .. which would allow for those qualified as midwives only, to practice (sic) and hold themselves out as such, but would not allow them to practice (sic) as nurses.”²⁶

²⁵ Submission, School of Nursing and Health Care Practices, Southern Cross University.

²⁶ Submission, New South Wales College of Nursing

“To have a separate regulatory body would be expensive and would duplicate many of the existing roles of the Board. It would seem simplest and most efficient to retitle the Act the Nursing and Midwifery Practice Act and to amend the legislation accordingly.”²⁷

“The two professions of nursing and midwifery differ in their practice and education, but they share common values and principles that mean that they can effectively come together in the public interest for the purpose of statutory regulation.

*...
To reduce excessive infrastructure costs associated with two separate regulatory bodies, a change in the title of the Act to the “Nurses and Midwives Act” would appear the most appropriate amendment to the legislation.”²⁸*

In considering this approach the Department is mindful of the fact that practitioners can obtain recognised midwifery qualifications through either undergraduate (direct entry) midwifery programs or post-graduate programs that rely on the participant having recognised qualifications in nursing and current registration (currently the overwhelming majority of practitioners in NSW). While it is recognised that both educational mechanisms produce practitioners who are considered competent in midwifery the competence of those practitioners with post-graduate qualifications in midwifery relies to a large extent on the skills and knowledge attained in nursing studies and practice.

4.6.4 Conclusion

The Department proposes that there be two registers, a register of midwives and a register of nurses, and a roll of nurses. Under this structure a practitioner with primary qualifications in nursing alone would be registered on the register of nurses and a practitioner who has primary qualifications in midwifery alone would be registered on the register of midwives. Those practitioners with both qualifications in nursing and midwifery would be registered on both the register of nurses and the register of midwives.

The Department acknowledges that the compulsion for practitioners with both nursing and midwifery qualifications be registered on both registers may be regarded by some as unreasonable. However, if practitioners with both nursing and midwifery qualifications were able to maintain midwifery registration alone there may be a significant adverse impact on the flexibility that employers currently enjoy with respect to staffing. This flexibility allows for the movement of appropriately qualified and registered staff between nursing and midwifery positions based on staff availability and patient loads. The potential adverse impact would be particularly pronounced in rural and regional areas and in some cases may in fact lead to small local hospitals finding themselves unable to offer midwifery services.

It is also important to acknowledge that many existing employment arrangements in both the public and private health systems are based on the current registration system and the dual capacities of practitioners with both

²⁷ Submission, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney

²⁸ Submission, New South Wales Midwives Association

nursing and midwifery qualifications. The Department considers it important that these employment arrangements not be impacted by the current changes proposed for the Nurses Act, although it may be necessary for the issue of compulsory dual registration to be revisited at some time in the future.

The Department is therefore of the view that maintaining a single registration Act with two separate registers, and provision for dual registration, is the most appropriate regulatory mechanism in this area. Such a system will improve the provision of information to the public by providing mechanisms to assist consumers in easily identifying practitioners with qualifications in midwifery alone. Furthermore this system will provide that information and associated regulatory structures at lower cost and inconvenience to practitioners, employers, consumers and the Government than establishing separate Acts and Boards.

4.7 Lists A and B of the Register and Roll

Section 16(2) of the Nurses Act provides that the Register is to be divided into lists A and B and section 26(2) provides that the Roll is to be divided into lists A and B.

List A of the Register contains the names of those nurses who are considered to have comprehensive training while List B contains the names of those nurses who have more restricted training such as a two year qualification in an area such as geriatric or infants nursing; and, prior to 1973, NSW based direct entry midwifery programs. Any recent additions to List B are due to the registration of Sick Children's Nurses and direct entry midwives trained abroad.

List A of the Roll contains the names of nurses who have completed 12 months training for the purposes of enrolment while List B of the Roll contains the names of nurses who completed the now discontinued mothercraft nursing course of 16 months duration.

The Issues Paper noted that division of the Register and Roll has no legal effect, other than only list B enrolled nurses may use the title *enrolled nurse (mothercraft)*, and questioned whether lists A and B should be merged. In practice the notation on a registered nurse's practising certificate of their status as a list B nurse simply serves as an indication to employers that the nurses education may have been limited to midwifery, infants or geriatric nursing only.

In New South Wales there were, on 30 June 2000, 76,188 registered nurses (being 75,925 List A nurses and 263 List B nurses), and 16,136 enrolled nurses (being 15,715 List A nurses, 421 list B nurses and 58 List A and List B nurses).²⁹

The majority of submissions addressed this issue with most supporting merging of the lists.

“It is the responsibility of employers to ensure that nurses have the appropriate qualifications to fulfil the role and function for which they are employed.”³⁰

²⁹

New South Wales Nurses Registration Board.

³⁰ Submission, South Western Sydney Area Health Service.

“There is utility and administrative efficiency in merging the A and B lists provided appropriate notations are made on the Register and Roll of the qualifications obtained and area of practice and this information can be accessed by the public.”³¹

“There has been a trend in other states towards a single register for nurses, with provision for the regulatory authorities to authorise practice in certain specialties.”³²

However some submissions supported retaining separate lists. Among the reasons advanced for retaining separate lists are:

“.[separate lists assist] the employer in determining both educational and clinical backgrounds of registered nurses. The separate lists also allow for recognition of overseas qualifications, which may not be directly comparable to Australian qualifications, where training has been focused on a particular clinical specialty.”³³

Submissions on this issue focused on the effect that merging the lists would have on registered nurses, but merging lists A and B of the Roll raises a different range of considerations. There is an argument, which the Department accepts, that mothercraft nurses have qualifications and training that are distinct from the qualifications and training of enrolled nurses, particularly in the area of medication administration, and that merging lists A and B of the Roll may disadvantage the public. Therefore the Department recommends that the Roll of nurses continue to be divided into lists A and B.

Having considered the arguments advanced in submissions, and reviewed the registration of nurses in other Australian jurisdictions the Department is of the opinion that lists A and B of the Register should be merged.

Recommendation 4 – Registers

That the Act establish two Registers:

- a Register of nurses; and
- a Register of midwives.

That the Act provide that people who are eligible for registration on both Registers shall hold dual registration with the same annual registration fee payable irrespective of whether a person’s name appears on one Register or both.

4.9 Restrictions on titles

As the Department has recommended that nurses and midwives continue to be regulated by title the issue of what those restricted titles should be must be addressed. As noted above the Nurses Act 1991 restricts the titles *registered nurse*, *enrolled nurse*, *enrolled nurse (mothercraft)*, *nurse practitioner* and *midwife*. As

³¹ Submission, Health Care Complaints Commission.

³² Submission, Australian Nursing Council.

³³ Submission, Northern Sydney Area Health Service.

detailed in **Appendix D** title restrictions vary quite markedly across the different Australian jurisdictions.

A small number of submissions considered the question of what titles should be restricted with all calling for greater regulation of the ‘wider’ nursing workforce and regulation of the title nurse and its variants. However, none of those submissions that called for regulation of the title ‘nurse’ demonstrated that there is a risk to the public from unregistered people, eg assistants in nursing and residential care nurses, using the concept of nursing in their titles or job descriptions. One submission suggested that the current situation allowed for employers to cut costs and threaten nursing positions. This suggests increasing restrictions on the use of titles and lessening competition would be in the interests of the nursing rather than the broader public.³⁴

The Department considers that there is no public health and safety justification for introducing further restrictions on the title ‘nurse’.

Under the structure proposed in **recommendation 4** a person who is a registered nurse could use the title registered nurse, a person who is a registered midwife could use the title midwife (or registered midwife), and a person who is a registered nurse and midwife could use the titles registered nurse and midwife (or registered midwife) either individually or in combination.

As noted above the Department has recommended that a separate register of midwives be established with the effect that a number of midwives will no longer be registered nurses. In this situation those registered midwives without nursing qualifications will not be able to apply to be accredited as nurse practitioners. It is appropriate therefore that a separate title of *midwife practitioner* be created for those midwives who are accredited by the Board to practise at an advanced practice level. It is important to note that this does not create an additional class of practitioner as currently any midwife is entitled to apply to become a nurse practitioner and some could be expected to do so. The provisions governing the accreditation and employment of midwife practitioners would be expected to reflect those for nurse practitioners.

Recommendation 5 – Restrictions on titles

That the titles *registered nurse*, *enrolled nurse*, *enrolled nurse (mothercraft)*, *nurse practitioner*, *midwife* and *midwife practitioner* be restricted to people appropriately registered or enrolled by the Board.

4.10 Practice restrictions affecting childbirth

4.10.1 Current position

As noted above the current Act restricts the practice of midwifery, other than in emergencies, to registered nurses authorised to practise midwifery, with exemptions for medical practitioners, medical and nursing students, and accredited nurses practising under the supervision of a midwife. Although the Act restricts the practice of midwifery it does not provide a definition of midwifery.

³⁴ Submission, Albury base Hospital Nursing Council

The Department notes the current anomalous position whereby medical practitioners are exempted from the restriction on midwifery when in fact they practise obstetrics rather than midwifery. The purpose of the current restriction and exemptions would therefore seem to be aimed at restricting certain practices common to midwifery and medicine (obstetrics) rather than enabling other practitioners to purport to be engaged in midwifery practice.

The Department is of the view that professions define and determine their own areas of practice which are not static but develop as a result of social, educational and technological changes. Therefore the Department believes that a definition of midwifery should only be included if it is proposed to restrict the entire scope of midwifery practice and that such a definition, and exemptions from the restriction, must be very carefully drawn so as to not impinge on the legitimate practice areas of other health service providers. The Issues Paper asked for submissions on what, if any, definition of midwifery should be inserted in the Act and what practices, if any, should be restricted.

4.10.2 Submissions

Submissions were divided on the form of practice regulation that is appropriate in this area with submissions arguing in favour of title and whole of practice regulation, title and core practice regulation and a large number arguing in favour of title regulation only. It is of interest at this point to note that other Australian jurisdictions take the following approaches to the regulation of midwifery:

- Title regulation only: Australian Capital Territory, Tasmania and Victoria.
- Title and core practices: Queensland, the core practice is “care for a woman in childbirth”.
- Title and whole of practice: Northern Territory, the restricted practice is “nursing” which includes midwifery.
South Australia and Western Australia, an unregistered person cannot practise nursing (which includes midwifery) for fee or reward.

Those submissions that called for title and whole of practice regulation and title and core practices regulation were generally unable to define midwifery or to set out those practices in childbirth that are so inherently dangerous if performed by the unauthorised that they should be restricted. The submissions that attempted to define midwifery or its core practices tended to do so in terms of the World Health Organisation endorsed definition of a midwife:

“A Midwife is a person who having been regularly admitted to a midwifery education program, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour, and post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and

the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the woman, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, health units, clinics, domiciliary conditions or in any other service”.

The above definition does not assist the Department in drafting a practical and enforceable statutory definition of midwifery practice, and any definition based on it would be very broad and be likely to unreasonably impact on other health professionals and individuals in the community who may be able to offer valuable services to pregnant women thereby restricting the health care choices available to pregnant women and couples.

However, there were a few submissions that attempted to set out some of the practices that are claimed to require restriction.

“Practice areas to be considered are aspects related to the provision of antenatal care, supervision of labour and delivery.”³⁵

“Core practices to be restricted to midwifery include caring for women and families antenatally, intrapartally and postnatally.”³⁶

In considering these suggestions the Department has had recourse to definitions of prenatal (antenatal), intrapartur care and postnatal:

Prenatal: *Occurring or existing after conception but before birth.*³⁷

*[O]ccuring or existing before birth, referring to both the care of the woman during pregnancy and the growth and development of the fetus.*³⁸

Intrapartur care: *Care of a pregnant woman from the onset of labour to the completion of the third stage of labour with the expulsion of the placenta.*³⁹

Postnatal: *Occurring after birth or pertaining to the period following birth.*⁴⁰

It can be seen from these definitions that the core practices suggested cover an extremely large area and their adoption could have the effect of severely limiting the choices women have available to them during pregnancy and in giving birth. Such restrictions would also have the potential to significantly

³⁵ Submission, Royal College of Nursing Australia

³⁶ Submission, Western Suburbs Sub-branch of the New South Wales Midwives Association

³⁷ Churchill’s Illustrated Medical Dictionary, (Churchill Livingstone, 1989)

³⁸ Mosby’s Medical Dictionary 3rd edition, (CV Mosby and Co, 1990)

³⁹ *ibid*

⁴⁰ Churchill’s Illustrated Medical Dictionary, (Churchill Livingstone, 1989)

impact on the practices of other health practitioners, both regulated and unregulated.

The Nurses Registration Board has submitted that

“midwifery should be defined by case law rather than by statute as this allows for a more contemporaneous assessment of midwifery practice, and what is involved in practice, from expert evidence.”⁴¹

The Association of Neonatal Nurses sounded a note of caution when considering practice restrictions in this area.

“Neonatal nurses .. are able to undertake for both healthy and sick newborns: neonatal resuscitation, routine care of the newborn such as physical examination and assessment, assist with breast feeding, provide education and support for new mothers and undertake community care/home visiting. Restriction of these practices would be anti-competitive.”⁴²

The Department has therefore examined the practices that are restricted in other jurisdictions, both interstate and internationally.

- The United Kingdom’s *Nurses, Midwives and Health Visitors Act 1997* provides that only a registered midwife or a registered medical practitioner can attend a woman in childbirth.
- The Ontario *Regulated Health Professions Act 1991* provides that managing labour or conducting the delivery of a baby is a restricted practice. The Ontario *Midwifery Act 1991* provides that a midwife is entitled to undertake the management of labour and spontaneous vaginal deliveries.
- The Queensland Nurses Act provides that a person who is not a midwife (or otherwise exempted) may not care for a woman in childbirth. The Queensland Nursing Council reports that this restriction is limiting and difficult to enforce.⁴³

4.10.3 Proposed practice restrictions relating to childbirth

Earlier comment (**section 4.10.1**) notes the anomalous nature of the current exemptions whereby medical practitioners are exempted from the restrictions on midwifery practice notwithstanding that they practice obstetrics rather than midwifery. Earlier comments also note that the policy intent of the current restrictions and exemptions is to restrict certain inherently dangerous practices which are common to both midwives and medical practitioners rather than to create a situation which purports to have medical practitioners engaged in midwifery.

Indeed a number of submissions from midwives took exception to the suggestion that health practitioners other than midwives are allowed to practise midwifery. For example:

⁴¹ Submission, Nurses Registration Board of New South Wales

⁴² Submission, Association of Neonatal Nurses of NSW (Inc)

⁴³ Submission, Queensland Nursing Council

“The Act precludes the practice of midwifery by persons not registered as a midwife, with certain exceptions (section 7.2) [of the Issues Paper]. The Act implies that care provided by such persons is midwifery which is both misleading and undermining to the profession of midwifery. Midwives provide a unique service to women which neither the nursing or medical profession are able to provide in the true sense. While such people listed under section 7.2 may provide some ‘maternity or obstetric care’, either with or without supervision, it should not be construed or portrayed as ‘midwifery care’ – since it isn’t.”⁴⁴

Having considered the evidence provided in submissions, the approach to regulation in other jurisdictions (see sections 4.10.1 and 4.10.2) and the Department’s own research (including consideration of judgements of the Nurses Tribunal as noted above in section 4.5) it is evident that there are health care practices surrounding giving birth that should continue to be restricted in the public interest. However, the Department does not consider a whole of practice restriction of “midwifery”, with exemptions for certain professions, to be either feasible or in the interests of the public or professions.

It is therefore recommended that the practice of *managing labour and the delivery of a baby* should be restricted. In proposing this restriction the Department is mindful of the practice areas of other health practitioner groups and has attempted to set the restricted core practice so as to ensure public health and safety whilst minimising the impact of the restriction on those groups.

The current exemptions in the Act from the restriction on midwifery practice must now be considered in the context of the above proposal that certain practices associated with childbirth, rather than midwifery as a whole, be defined and restricted.

Some submissions expressed concern as to the meaning of supervision, as in “under the supervision of a (midwife)” and there were a number of calls for this concept to be prescriptively defined. However, the Department does not believe that the concept of supervision is amenable to statutory definition. An experienced registered nurse may require less supervision than a junior registered nurse or an enrolled nurse. Similarly midwifery and medical students would generally require substantially more supervision than an experienced registered nurse. It is also the case that a registered nurse caring for a woman during a reasonably straightforward delivery is likely to require substantially less supervision than the same practitioner assisting in a more complicated delivery. Any legislated definition of supervision would have to attempt to address all of these situations and the Department does not believe it is practical to attempt to do so. The Department does however support the amendment of the provision to provide that the supervision required is supervision appropriate to the circumstances. Such an amendment will assist in impressing upon practitioners the need for professional judgement when determining the level of supervision required in each particular case.

⁴⁴ Submission – New England Branch of the New South Wales Midwives Association Inc.

The Department is not aware of any complaints that have been made to the Health Care Complaints Commission or the Board alleging that midwives have failed to provide proper supervision of other practitioners caring for women in childbirth. No evidence was presented to the Department to suggest that the existing provisions in the Act create a risk to the health and safety of mothers and babies, nor was any evidence presented to suggest that practitioners and students other than those currently exempted should be able to assist in childbirth. However advice provided by the Office of the Chief Nursing Officer confirms that nursing students no longer require an exemption as notwithstanding the fact that nursing students may gain some supervised practical experience in a labour or maternity unit they are in no way responsible for the management of labour or the delivery of a baby.

4.11 Practice restrictions – the Public Health Act 1991

Any analysis of practice restrictions is not complete without consideration being given to the context and manner of its enforcement.

It has previously been noted that the only justification for any restrictions on practices is the existence of risks to public health and safety. In reviews of a number of other health professional registration Acts the Department has determined that restrictions on practices carrying significant inherent risks should not be placed in individual professional registration Acts. This conclusion has been reached as:

- (i). Practice restrictions are imposed to protect the health and safety of the public, and not to delineate or protect the area of practice of a particular profession or professions.
- (ii). Most restricted practices are restricted to a number of professions, eg spinal manipulation may be performed by chiropractors, osteopaths, medical practitioners and physiotherapists, and to place such a restriction within any one registration Act may imply professional ownership of the practice.

The Public Health Act already plays a key role in regulating practices that are associated with risks to public health and safety. For example, under the *Public Health Regulation 1991* a person other than a medical practitioner or dentist (or a person under their supervision) must not carry out acupuncture, tattooing, ear piercing, hair removal or any other procedure that involves skin penetration unless certain requirements, set out in the Regulation, are met.

The Department is of the view that placing professional practice restrictions in the Public Health Act will remove any sense that a particular profession ‘owns’ particular practices to the exclusion of other practitioners. Therefore the fact that other practitioners, such as the medical profession, are able to undertake the restricted practice of managing labour and delivering a baby will in no way suggest that they practise midwifery, just as it will not suggest that midwives practise obstetrics.

It is essential to emphasise that enforcement of the restriction on managing labour and caring for a woman in childbirth will not be effected by placing the restrictions in the Public Health Act. The existing restriction in the Nurses Act can be enforced by any person or body, including but not limited to the Board and its officers, undertaking to prosecute an unauthorised person who engages in the practice of

midwifery. The existing situation whereby any person or body can seek to enforce the restriction will be retained when it is placed in the public health Act and the Board, its officers and any other person or body will be able to instigate the prosecution of a person for breaching the restriction.

Recommendation 6 – Restriction of practices

That the Public Health Act be amended to provide that the practice of managing labour and undertaking the delivery of a baby be restricted to

- registered midwives;
- registered medical practitioners;
- a registered nurse or an enrolled nurse acting under the appropriate supervision of a registered midwife or a registered medical practitioner;
- a midwifery or medical student acting under the appropriate supervision of a registered midwife;
- a medical student acting under the appropriate supervision of a registered medical practitioner; and
- any person who is rendering assistance to a woman who is giving birth to a child where the assistance is rendered in an emergency.

5. REGISTRATION AND ENROLMENT

5.1 Introduction

The Department has recommended that nurses and midwives continue to be registered or enrolled and that lists A and B of the Register be amalgamated. The amalgamation of the lists and creation of a separate register of midwives raises issues in relation to the types of registration that the Board should be empowered to grant. This issue and a number of other issues, particularly related to the types of enrolment that can be granted, were raised in the Issues Paper.

5.2 Conditions on practice

The Issues Paper raised for discussion whether the Board should have the power to impose conditions on a person's registration or enrolment on initial application as well as following a complaint and disciplinary hearing. Most submissions that advocated merging lists A and B (see **section 4.7**) endorsed the request of the Nurses Registration Board that it be empowered to place conditions on the registration of those practitioners who would have been registered on list B. The current provisions of the Nurses Act do not allow the Board to place conditions on a person's registration, except in the case of an impairment, in the absence of a disciplinary finding and in this respect New South Wales appears to be out of step with other Australian jurisdictions (see **Appendix D**). The Queensland Nursing Council in its submission reported favourably on its experience in placing conditions on registration and the public benefit that arises. The Council made particular reference to the increasing trend for nurses and midwives to practise independently or semi-independently and the benefit that is provided to consumers of these practitioners' services by a clear indication of the limits on the nurse's practice.

The Nurses Registration Board in its submission recognised that

“placing of conditions on practice may be viewed as being potentially more restrictive”

but went on to note that

“the gaining of a licence to practise with conditions is better than the refusal to register as required under s.21 of the Act.”

Whilst the Department acknowledges that it may be in the public interest for the Board to impose conditions on the registration or enrolment of certain practitioners with limited qualifications, or where there are concerns about a practitioner's fitness to practise, no evidence was provided to the review in support of the need for the Board to have such a power in the absence of an inquiry into the practitioner's fitness to practise. However, a case can be made for the Board having power to register or enrol a person subject to conditions following an inquiry into that person's fitness to practise. The introduction of such a power is consistent with provisions in Schedule 1 of the Medical Practice Act, and a number of other health professional registration Acts.

Therefore in the interests of enabling the Board to protect the public from nurses and midwives with limited qualifications practising beyond their capacity the Board should be empowered to conduct an inquiry into the fitness of an applicant for registration where it is not satisfied that an applicant has the necessary qualifications or competence for comprehensive registration and practice. Following such an inquiry the Board may register or enrol the person subject to conditions or refuse to register or enrol the person. In appropriate cases, such as where further qualifications are obtained, the person may apply to the Board for lifting or variation of the conditions.

Recommendation 7 – Conditions on registration/enrolment

That the Board have the power to inquire into the qualifications and competence of an applicant for registration or enrolment and where satisfied that the applicant is not fit for comprehensive practice the Board may grant registration or enrolment subject to conditions or refuse to register or enrol the applicant.

5.3 Types of registration/enrolment

The Issues Paper noted that the Board is able to grant registered nurses both temporary and provisional registration but can not offer enrolled nurses the same degree of flexibility. Only one submission, that from South Eastern Sydney Area Health Service, addressed this issue and it supported the amendment of the Act to provide the Board with the power to grant enrolled nurses provisional and temporary enrolment.

Recommendation 8 – Enrolment

The Act be amended to provide that the Board be empowered to grant both provisional and temporary enrolment.

5.4 Refusal of registration/enrolment

The Issues Paper noted, at 6.3, that the Board may only refuse an application for registration or authority to practise midwifery after it has given the applicant the opportunity to be heard, eg make a submission to the Board, in relation to the application. The Issues Paper then noted that an applicant for enrolment is not guaranteed the same opportunity to be heard. The Department is unaware of any justification for this situation and those few submissions that considered the point provided no justification for its existence or continuation.

Recommendation 9 – Refusal of registration/enrolment

That the Act be amended to provide that the Board may only refuse an application for registration or enrolment after it has given the applicant an opportunity to be heard in relation to the application.

6. STRUCTURE OF THE BOARD

6.1 Introduction

As the Department has recommended changes to the regulatory structure for nursing and midwifery, with separate registers for practitioners with qualifications in nursing and practitioners with qualifications in midwifery, consideration must also be given to the structure of the Board.

6.2 The Nurses and Midwives Board

Evidence provided to the Department shows that nursing and midwifery have to a large extent developed from a common foundation and they continue to share a significant number of core values and practices. It must be acknowledged that many nurses with authority to practise midwifery, and who do in fact practise midwifery, regard themselves as members of the nursing profession rather than a separate midwifery profession. The Department is not in a position to determine whether nursing and midwifery are separate professions and the question of professional identity is ultimately a matter for the relevant professionals themselves to determine. Professionals practising midwifery have yet to reach a consensus on this issue.

Given this lack of agreement the Department believes that the most effective and efficient mechanism for regulation of nursing and midwifery continues to be through a single registration board. However the Department has been influenced by arguments from both midwives and nurses that the Act should be amended to acknowledge the position of midwifery with its unique focus, practices, history and traditions, which has led to the strong view by some practitioners that it is a distinct profession rather than a specialty of nursing. The Department therefore recommends that the Board be renamed the Nurses and Midwives Board.

6.2.1 The existing Board

Section 9 of the Nurses Act provides that the Board consists of thirteen members and is constituted as follows:

- three registered nurses elected by registered nurses;
- one enrolled nurse or enrolled nurse (mothercraft) elected by enrolled nurses and enrolled nurses (mothercraft);
- one registered nurse who is authorised to practise midwifery elected by registered nurses; (the Department understands this to be a drafting error and that the provision was intended to provide for election by registered nurses authorised to practise midwifery)
- one registered nurse nominated by the New South Wales Nurses Association;
- one registered nurse nominated by the NSW College of Nursing;
- one registered nurse who is an officer of the Department of Health, an Area Health Service, the Ambulance Service of New South Wales or the [Health Administration] Corporation, nominated by the Minister;
- one registered nurse jointly nominated by the Minister for School Education and Youth Affairs and the Minister for Further Education, Training and Employment who is an educator of nurses;

- one registered nurse nominated by the Minister who practises in the area of mental health;
- a barrister or solicitor nominated by the Minister; and
- two persons nominated by the Minister as representative of consumers.

6.2.2 Composition of the Board

The Issues Paper sought comment on the composition of the Board and identified a number of possible changes. Whilst a number of submissions, including that from the NSW College of Nursing, suggested that the current structure and composition of the Board remains appropriate, a far greater number recommended changes. Some of the changes advocated include:

- Increasing the number of academics on the Board.⁴⁵
- Increasing the representation of midwives on the Board.⁴⁶
- Making greater use of elections, and correspondingly lesser use of Ministerial nominations.⁴⁷
- Removing the automatic right of the New South Wales Nurses Association and the New South Wales College of Nursing to nominate Board members.⁴⁸
- Reserving a place on the Board for a nurse or midwife from rural or remote New South Wales.⁴⁹
- Changing the process by which the mental health nurse on the Board is chosen.⁵⁰

The Department considers that given the Board's role in regulating a large and diverse profession it is important to have a membership drawn from all sectors of the profession. It is also important that there be academic representation, consumer representation, an officer of the Department of Health, or a public health organisation and a legally qualified member. Therefore the Department recommends that the Board increase in size to 16 members.

Elected members

Submissions were strongly supportive of the election of practitioners to positions on the Board, with a number advocating greater use of elections. The Department considers that the election of Board members provides an opportunity for members of the profession to be involved in their professional regulation. Election of members also provides an opportunity for individual practitioners, with standing in the profession, but who may not otherwise be nominated for appointment, to seek the endorsement of their peers by election to the Board.

⁴⁵ Submission, Nurses Registration Board of New South Wales

⁴⁶ Submission, New South Wales Midwives Association

⁴⁷ Submissions, New England Area Health Service; Institute of Nursing Executives of New South Wales and the ACT Inc; Nepean Health.

⁴⁸ Submissions, Clinical Nurse Consultants, Sydney Children's Hospital; Institute of Nursing Executives of New South Wales and the ACT Inc; Nepean Health; Northern Sydney Area Health Service; Royal College of Nursing Australia; and the Health Care Complaints Commission.

⁴⁹ Submissions, Albury Base Hospital Nursing Council; Northern Sydney Area Health Service; Far West Area Health Service.

⁵⁰ Submissions, Clinical Nurse Consultants, Sydney Children's Hospital; Australian and New Zealand College of Mental Health Nurses (NSW Branch); Association of Neonatal Nurses of NSW (Inc).

The Department recommends that the Board continue to include five elected practitioners. Of the elected practitioners three are to be registered nurses elected by registered nurses; one is to be an enrolled nurse or enrolled nurse (mothercraft) elected by enrolled nurses and enrolled nurses (mothercraft); and one is to be a registered midwife elected by registered midwives.

Academic members

The current board includes a member, jointly nominated by the Minister for School Education and Youth Affairs and the Minister for Further Education, Training and Employment, who is an educator of nurses. The Issues Paper sought comment on whether an additional academic position should be created. This issue elicited surprisingly little comment in submissions although the Nurses Registration Board has strongly argued that the Board should include additional academic representation.

The Department recognises the need for significant academic input into the deliberations of the Board, particularly as the Board accredits university and TAFE courses for the purposes of registration and enrolment. Therefore it is recommended that the Board include two academic members.

The current academic member of the Board is the joint nominee of the Minister for School Education and Youth Affairs and the Minister for Further Education, Training and Employment. This situation is in contrast to the academic members of other health professional boards such as the Dental Board and the Physiotherapists Registration Board where the academic members are nominated by the Minister for Health. The Department is not aware of any rationale for this situation and recommends that the academic members of the Board be nominees of the Minister for Health.

Nominees of professional organisations

Under the existing provisions of the Nurses Act both the New South Wales Nurses Association and the New South Wales College of Nursing nominate a member of the Board. The Issues Paper sought comment on whether it was appropriate for the Act to recognise particular professional organisations through their right to nominate Board members and whether it might be more appropriate for the Minister for Health to seek nominees from a wide range of professional organisations when appointing Board members.

The New South Wales Nurses Association

The Department acknowledges that the New South Wales Nurses Association represents almost 50,000 nurses and midwives and is the largest and most representative nursing and midwifery body in New South Wales. The Association provides an additional structure through which nurses and midwives can raise their individual concerns and professional issues with the Board. The Department therefore believes it is appropriate in the interests of keeping the procedures and workings of the Board open and accessible to individual practitioners to retain the New South Wales Nurses Association's nominee on the Board.

The New South Wales College of Nursing

The NSW College of Nursing is the peak nursing professional body in New South Wales and provides a forum for the consideration of those professional

issues that affect clinical practice. In these circumstances the Department considers it appropriate for the College to be represented on the Board thereby providing a means by which serious professional issues faced by the professions may be brought to the Board for consideration.

Enrolled nurses

The current provisions of the Nurses Act provide that there is one reserved position on the Board for an enrolled nurse, that is an elected position. The Issues Paper sought comment on whether this was appropriate given that there are nine registered nurses on the Board. Three submissions addressed this point and all supported an increase in the number of enrolled nurses on the Board.

The Department recommends that in addition to the enrolled nurse elected to the Board the Board include a member who is an enrolled nurse nominated by the Minister for Health.

Other positions

The Board currently includes one position for a registered nurse who practises in the area of mental health nursing. The Department believes it is appropriate to retain this position in the interests of addressing many of the serious professional issues facing mental health nursing.

The Department recommends that there continue to be specific representation from either the Department of Health or the public health system on the Board. The Department therefore recommends that the Minister for Health appoint to the Board a nurse or midwife who is an employee of the Department of Health or the public health system.

The role of the Board is the protection of the public and for this reason it is appropriate that there is representation of the community on the Board. The current Act allows for two community representatives on the Board and most submissions argued that this is appropriate. The exception was the Health Care Commission which argued that one third of the Board should be constituted of community representatives. The Department is not aware of any evidence or complaints that the Board has acted inappropriately or contrary to the interests of consumers but considers that an increase in community representation to three members is appropriate.

The Board's role in administering the Act and the disciplinary system requires that it have legal expertise readily available to it. For this reason the Board, in common with all other health professional boards, includes a legal practitioner. No submission took exception to this state of affairs, although one suggested the legal practitioner should also be an accredited nurse.⁵¹ The Department considers that it is not appropriate to reduce the field of eligible candidates for this position and recommends there be no change to the criteria or mechanism for appointment as the Board's legal member.

⁵¹ Submission, Enrolled Nurses Education Program, Department of Technical and Further Education

Recommendation 10 – The Board

That the Nurses and Midwives Board comprise sixteen members and be constituted as follows:

- Three registered nurses elected by registered nurses;
- one registered midwife elected by registered midwives;
- one enrolled nurse or enrolled nurse (mothercraft) elected by enrolled nurses and enrolled nurses (mothercraft);
- two nurses engaged in the tertiary or pre-enrolment education of nurses or midwives in New South Wales selected by the Minister for Health;
- one registered nurse or registered midwife nominated by the New South Wales Nurses Association;
- one registered nurse or registered midwife nominated by the New South Wales College of Nursing;
- one registered nurse who practises in the field of mental health nursing selected by the Minister for Health;
- one enrolled nurse selected by the Minister for Health;
- one registered or enrolled nurse who is an employee of the Department of Health or the public health system selected by the Minister for Health;
- one legal practitioner selected by the Minister for Health; and
- three persons selected by the Minister for Health as representative of the community.

6.3 Standing Committees

Reflecting the recommendations in **Chapter 5**, and the above recommendations for changes to the Board's composition, it is recommended that two standing committees, the Nurses Practice Committee and the Midwives Practice Committee, be established. Under the proposed structure the Board will have overarching control and responsibility for regulation, policy and direction, and disciplinary mechanisms, although many of the Board's functions could be delegated to the Committees. As it is anticipated that the Committees will be responsible for carrying out certain of the Board's existing functions including accreditation of educational courses it is important that the Committees include Board members, academics and practitioners from the relevant professional streams.

In addition the Department supports moves to encourage indigenous people into nursing and other health care professions. The Issues Paper acknowledged that the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) has called for all nursing regulatory authorities to include specific representation from indigenous nurses. Submissions that addressed this point were overwhelmingly supportive of this suggestion. The Department therefore recommends that each of the Committees include a nominee of CATSIN from the relevant professional stream. These practitioners will assist the Committees, and thereby the Board, in setting policies and practices that encourage indigenous practitioners as well working with educational institutions to facilitate an increase in the number of indigenous people taking up nursing and midwifery studies.

In order to facilitate communication between the Board and the Committees it is recommended that the Chair of each Committee be a member of the Board from the relevant professional stream.

Recommendation 11 – Composition of the Standing Committees

That a Nurses Practice Committee and a Midwives Practice Committee be established.

The Nurses Practice Committee comprise at least seven members and be constituted as follows:

- two members of the Board selected by the Board;
- one nurse engaged in the tertiary education of registered nurses in New South Wales selected by the Board;
- one nurse engaged in the pre-enrolment education of enrolled nurses in New South Wales selected by the Board;
- one registered nurse engaged in nursing in New South Wales selected by the Board;
- one enrolled nurse engaged in nursing in New South Wales selected by the Board;
- one registered or enrolled nurse nominated by the Congress of Aboriginal and Torres Strait Islander Nurses;
- such other people as the Board determines.

The Midwives Practice Committee comprise at least five members and be constituted as follows:

- two members of the Board selected by the Board;
- one registered midwife engaged in the tertiary education of midwives in New South Wales selected by the Board;
- one registered midwife engaged in midwifery in New South Wales selected by the Board;
- one registered midwife engaged in midwifery in New South Wales nominated by the Congress of Aboriginal and Torres Strait Islander Nurses;
- such other people as the Board determines.

A member of each Committee who is also a member of the Board is to be appointed as Chair of the Committee.

6.4 Tenure of Board members

The Act does not place a limit on the length of time a person may serve as a member of the Board. The Issues Paper noted that the Medical Practice Act limits the length of time a member may serve to three terms of four years each and that the draft template for health professional legislation in Western Australia provides for a maximum of two terms of four years each with staggered appointments.

There was unanimous support from submissions for a limit on the length of time that a Board member can serve with periods ranging from four to twelve years. There

was also significant support for the introduction of staggered appointments, as in the Western Australian model. There was little discussion of the reasoning behind calling for a limit on the length of membership although those submissions that provided reasons generally held that a limit would

“[F]acilitate appropriate turnover of representation on the Board and overcome the problem of entrenched members remaining on the Board for an inordinate number of years.”⁵²

The Department supports the adoption of a limit on the number of terms that a person may continuously serve as a member of the Board to three terms of four years. The limit on the number of terms will allow fresh perspectives to be introduced to the Board while allowing for retention of the corporate memory of the Board.

Recommendation 12 – Tenure of Board members

The Act provide that a person may not hold office as a member of the Board for more than three consecutive terms of four years each.

6.5 President and Deputy President

The Act provides that one of the members of the Board who is a registered nurse is to be appointed as President of the Board and another member (who need not be a nurse) is to be appointed as Deputy President. The Issues Paper raised for discussion whether the Deputy President should also be a nurse.

Submissions on this issue were almost unanimous in recommending that the Deputy President be an accredited nurse. The exceptions were the Health Care Complaints Commission which argued that both the position of President and that of Deputy President should be available to all Board members; the faculty of Health at the University of Western Sydney Hawkesbury which suggested the Deputy President should be an accredited midwife (presumably with the President being an accredited nurse); and the clinical nurse consultants from Sydney Children’s Hospital who advocated the status quo.

On balance the Department considers that it is appropriate for a member of the profession to be appointed as President of the Board and therefore the Minister is to select a nurse, who may also be a midwife, to be President of the Board.

Submissions have generally put the view that the Deputy President of the Board should be a professional member as well and argued that this is required as the Deputy President often stands in for the President in her/his absence. However, no submission has suggested that a non-practitioner member of the Board is incapable of fulfilling the role of Deputy President much less provided any evidence to support such a suggestion. Therefore the Department recommends that the Minister for Health remain able to select any member of the Board to be Deputy President.

Recommendation 13 – President

That the Act be amended to provide that the Minister for Health is to select a member of the Board who is a nurse to be President of the Board.

⁵² Submission, Health Care Complaints Commission

6.6 Leave of absence

The current Act provides in effect that if a member of the Board is absent from four consecutive meetings of the Board without the leave of the Minister for Health he or she is taken to have vacated their office as a member of the Board. A number of submissions supported the Board being able to grant a leave of absence but suggested that such leave of absence should not be longer than three months. While another submission agreed with the Board being able to grant a leave of absence of up to three months but also said:

“A leave of absence that is extended and occurs frequently during a term is unacceptable... People elected/nominated to the Board need to be committed to the length of their term of office.”⁵³

It is important to note that the current provisions do not prevent the Board approving a member’s leave of absence but merely provides that a member’s term of office is deemed to be vacated if the members misses four consecutive meetings without being excused by the Minister. There would therefore appear to be no need for the Act to be amended to allow for the Board to grant a member a leave of absence.

⁵³ Submission, Faculty of Health, University of Western Sydney, Hawkesbury

7. ENTRY REQUIREMENTS

7.1 Introduction

The Nurses Act includes a number of criteria for registration and enrolment and the Board may refuse to register or enrol an applicant on a number of grounds. It is important to note that failure to gain registration or enrolment prevents use of the restricted titles but does not prevent a person from providing or offering to provide nursing services, although failure to obtain an authorisation to practise midwifery does prevent a person from practising midwifery or offering to provide midwifery services. If entry level requirements are set artificially high, this may restrict the number of people able to seek registration or enrolment, with a resultant impact on competition. Alternatively, although the barriers may not be high or onerous, there may be limited access to appropriate educational courses and supervision opportunities thereby restricting entry to the profession for intending practitioners.

The existing registration and enrolment criteria have been assessed in accordance with the Competition Principles Agreement.

7.2 Registration/enrolment procedures

Requirements vary depending upon the type of registration/enrolment that is sought although there are a number of common requirements. These include that the applicant has:

- received a nursing or midwifery qualification approved by the Board;
- satisfied the Board that he or she is of good character and fit to practise nursing and/or midwifery in New South Wales; and
- satisfied the Board that he or she is proficient in the English language.

The Board may refuse to register/enrol a person who is otherwise qualified and entitled to registration/enrolment where he or she has been convicted of an offence which renders him or her unfit in the public interest to practise or where he or she lacks the physical or mental capacity for practise. In the case of application for enrolment the applicant must also have attained the prescribed age of 18 years.

The Issues Paper sought comment on whether the existing criteria remain appropriate. To this end submissions were encouraged on the existing requirements and in particular changes to the mechanism by which courses are approved; changes to the requirement for applicants to be of good character; and the need for competence in the English language.

7.2.1 Approval of courses

Of those submissions that addressed the issue there was extensive support for the existing system of course accreditation. Both the Nurses Registration Board and the NSW Nurses Association expressed support for the current system.

“The NRB is of the view that the current processes for accreditation of courses are appropriate and that appropriate mechanisms are in place to ensure their ongoing review.”⁵⁴

“The Association is of the opinion that current mechanisms for assessing competency are adequate and offer protection for the public. We view the current range of qualifications recognised by the Board as appropriate.”⁵⁵

However the Board has raised the issue of its inability to approve courses conducted outside New South Wales.

“The NRB considers that an amendment to enable the Board to have a discretion to accredit courses may be of assistance in the future.”⁵⁶

In the current climate in which professionals and students are highly mobile, and where that mobility is facilitated by the Mutual Recognition Acts, it is appropriate that the Board be able to accredit courses both from within and outside NSW.

The Department endorses the current system whereby the Board accredits educational courses for registration purposes. The Board has developed accreditation criteria for educational courses and these are published on the Board’s Internet site.⁵⁷ While the current Act provides that educational courses are to be accredited by the Board there is no mechanism for an educational institution that is aggrieved by a decision of the Board to refuse accreditation to appeal that refusal. In reviews of other health professional registration Acts the Department has recommended that there be a right of appeal to the Administrative Decisions Tribunal where an institution is aggrieved by a Board decision to refuse accreditation to an educational course. The introduction of an appeal mechanism will assist in making the course accreditation process more open and transparent.

Recommendation 14 – Accreditation of courses

The Act be amended to provide that the Board be able to approve educational courses both from within and outside New South Wales. An educational institution that is aggrieved by a decision of the Board to refuse to accredit a course is to have a right of appeal to the Administrative Decisions Tribunal.

7.2.2 Good character

The Issues Paper asked for submissions on whether or not the requirement for applicants to be of good character should be retained in the Act and if so whether or not it should be considered in more ‘objective’ terms.

An argument can be made, and it was raised in the Issues Paper, that character requirements can be applied subjectively and used to restrict entry to the

⁵⁴ Submission, New South Wales Nurses Registration Board.

⁵⁵ Submission, New South Wales Nurses Association.

⁵⁶ Submission, New South Wales Nurses Registration Board

⁵⁷ http://www.nursesreg.nsw.gov.au/reg_guid.htm (nurse registration)

http://www.nursesreg.nsw.gov.au/get_98_1.htm (midwifery)

http://www.nursesreg.nsw.gov.au/get_98_2.htm (enrolment)

http://www.nursesreg.nsw.gov.au/np_cours.htm (nurse practitioner)

profession. However, it was also noted that the requirement for good character can, if applied in an objective fashion, ensure that dishonest or unethical people are unable to register/enrol and practice as nurses or midwives. The requirement can therefore play an important role in minimising the risk of harm posed by inappropriate or unethical conduct.

Most submissions addressed this issue and the overwhelming response was that good character be retained as a requirement for registration/enrolment.

“The Commission is strongly of the view that good character should remain a criteria (sic) for registration. It is a requirement for registration under all relevant registration Acts... The public interest requires that only persons of good character have the privileges, opportunities and responsibilities afforded by membership of the nursing profession.

...

It is a requirement .. which is well understood and which is required to be determined objectively in any particular case. There [is no] reason to consider that the Nurses Registration Board is not as capable as other registration boards to determine whether applicants for registration possess the good character necessary for registration as a nurse or that the Board would approach its task in this regard subjectively rather than in the objective manner required by law.”⁵⁸

The Issues Paper raised the question of defining and restricting good character to matters specifically related to practice. Approximately half of the submissions that considered this question asserted that consideration of good character should be restricted to those instances where it relates to professional practice. However, none of those submissions provided compelling reasons to restrict consideration of character and the Department endorses the view of the Health Care Complaints Commission that there is neither evidence nor reason to believe that the Board would apply this requirement in a subjective or discriminatory manner. Further the Department is concerned that any attempt to limit the application of the character test may result in courts interpreting the requirement narrowly and in a manner that is inconsistent with the public interest.

7.2.3 Competence in the English language

Section 31 of the Nurses Act provides that a person can not be registered/enrolled unless he or she satisfies the Board of his or her competence in the English language. The Issues Paper asked for submissions on whether or not competence in the English language should remain a prerequisite for registration/enrolment.

Submissions on this point were unanimous in arguing that the requirement for nurses and midwives to be competent in English is in the public interest and should be retained. It is relevant that the vast majority of nurses and midwives practise within institutional settings and that they are therefore required to regularly interact and cooperate with a large number of other health care professionals and service providers.

⁵⁸ Submission, Health Care Complaints Commission

“The requirement for competence in the English language should be retained...[T]he language medium used for day to day communication within the health care setting is English. The ability to carry out nursing practise and to function safely in an emergency depends upon English language competence. Nursing Acts in all other [Australian] jurisdictions require English proficiency...”⁵⁹

*“The requirement for applicants to be able to speak English should be retained. Overseas qualified nurses **may** be able to practise nursing only with clients who speak that language, however, nursing presupposes team work with other health professionals. Such team work is dependent on clear communication, and competence in English is therefore essential.”⁶⁰*
(original emphasis)

On the basis of the submissions received and the Department’s own research into the nature of nursing and midwifery practice, the requirement for nurses and midwives to be competent in the English language is considered to be in the public interest and should therefore be retained. In reaching this conclusion the Department has considered the impact of this restriction on competition and is of the opinion that there is no evidence that competent people are prevented from practising nursing or midwifery due the requirement to be competent in English.

7.2.4 Age restrictions

One of the requirements for registration/enrolment under the current Act is that an applicant must have reached the prescribed age. The Issues Paper noted that the Nurses (General) Regulation 1997 prescribes an age of 18 years for enrolment, but no age is prescribed for registration.

Submissions on this issue were evenly divided between those that supported retaining the age restriction and those that consider it unnecessary. Those submissions that supported retaining the age restriction tended not to provide reasons in support of that argument. However the Far West Area Health Service argued in its submission that the age restriction should be retained as

“A certain level of maturity is required to deal with death, emotion and conflict etc.”

On the other hand those submissions that argued for removing the age restriction provided the following reasons:

“[A]ll RNs and ENs have been through a process of tertiary education and as such, will be at least 18 years of age.”⁶¹

“Age barriers should be removed as it is more important to concentrate on minimal educational requirements.”⁶²

⁵⁹ Submission, Australian Nursing Council

⁶⁰ Submission, Queensland Nursing Council

⁶¹ Submission, New South Wales College of Nursing

⁶² Submission, New South Wales Operating Theatre Association Inc

“The College believes that to restrict entry to the profession based on age is not warranted because there is no evidence that supports this restriction.”⁶³

The Department is of the view that there is no evidence that justifies retention of the age restriction on public health and safety grounds. While the argument that a certain level of maturity is required to deal with some of the situations a practitioner may face is compelling, the Department does not believe that an arbitrary age restriction guarantees that practitioners will have the level of maturity required. Furthermore the requirement that applicants complete tertiary education ensures that unreasonably young people will not apply for registration/enrolment.

Recommendation 15 – Age restrictions

The Act be amended to remove the requirement that applicants for registration and enrolment have reached the prescribed age.

7.3 Additional Registration Requirements

7.3.1 Mental and physical capacity to practise and criminal convictions

The Board has the power to refuse to register/enrol a person who lacks the physical or mental capacity to practise or who has been convicted of an offence which, in the Board’s opinion, renders them unfit in the public interest to practise nursing. The Department considers that there are substantial benefits to the public in the Board being able to refuse registration/enrolment in circumstances where it is demonstrated that an applicant lacks the physical or mental capacity to practise safely. In addition, due to the high degree of trust and faith that both patients and the health system place in nursing and midwifery staff there may be individual cases where an applicant has particular criminal convictions which show that s/he is not fit to be endowed with that level of trust and should therefore not be granted registration/enrolment.

Submissions on this issue were generally supportive of the existing provisions in the Act.

“If a person who applies for entry onto the Roll or Register has known physical, mental or character impairments .. likely to put their patients, colleagues or other at risk .. then we believe the Act/Board has the right to refuse to accredit that person.”⁶⁴

“The Commission supports a power being provided to the Board to refuse registration to persons whom it is not satisfied are competent to practice nursing in accordance with the model under section 13 of the Medical Practice Act 1992. This covers medical, physical and mental capacity of applicants and proficiency in English.”⁶⁵

The Department is not aware of any evidence that the Board is exercising its powers in this area in a way that is inappropriate or discriminatory. Given the

⁶³ Submission, Royal College of Nursing Australia

⁶⁴ Submission, South Eastern Sydney Area Health Service

⁶⁵ Submission, Health Care Complaints Commission

lack of evidence that these powers are being misused and the support for their continued availability the Department does not propose any changes.

7.3.2 Recency of practice

The Issues Paper asked for submissions on whether there is merit to introducing a recency of practice requirement into the legislation and if so what period of time should be covered. This is an issue that drew comment from the majority of submissions and all submissions were supportive of the need for practitioners to maintain their professional competence and to engage in professional development. A number of submissions called for the introduction of a recency of practice requirement.

“There is some merit for including recency of practise (sic) requirements in the legislation. This would prevent persons who have been out of clinical practice for greater than 5 years entering the market and potentially causing harm to the public.”⁶⁶

“In all other jurisdictions the Nurses Acts contain a 5 year recency of practice clause. This has been used as one measure of continuing competence.”⁶⁷

However, a far greater number of submissions argued that a strict recency of practice requirement would not provide a guarantee that practitioners remain competent. A number of submissions also commented that it is the professional obligation of nurses and midwives to only practise in those areas where they are competent and that employers should also ensure they only employ practitioners whose professional skills are appropriate for the position they are employed to fill.

“The NRB recently supported research into “Indicators of Clinical Competence conducted through ANCI”. Evidence that recency of practice leads to competence is not demonstrated by this study.”⁶⁸

“[It is] the responsibility of individual nurses to maintain their competence to practise, [and] the responsibility of the employer to select staff whose practice was current or, in the alternative, to provide mechanisms to ensure that staff who had not practised recently were brought up to date.”⁶⁹

“There is no merit in including a recency of practice requirement – it should be based on the individual and the assessment of the organisation where the person is potentially going to work.”⁷⁰

In addition a number of submissions, including those from South Eastern Sydney Area Health Service and the New South Wales College of Nursing, drew attention to the administrative costs of such a system and the practical difficulties that would be faced in attempting to define nursing and midwifery practice.

⁶⁶ Submission, Far West Area Health Service

⁶⁷ Submission, Australian Nursing Council

⁶⁸ Submission, New South Wales Nurses Registration Board

⁶⁹ Submission, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney

⁷⁰ Submission, Faculty of Health, University of Western Sydney, Hawkesbury

Having considered the submissions received on this issue, the difficulties that would be faced in defining practice and the effect on individual practitioners who may be returning to the workforce following a period of study or raising a family, the Department does not consider that the adoption of a recency of practice requirement can be justified. This position has been reached notwithstanding the fact that all other Australian jurisdictions have some form of recency of practice requirement. The Department has recommended (**recommendation 7**) that the Board have the power to inquire into the fitness of an applicant for registration/enrolment and such an inquiry can include matters relating to recency of practice. Where an inquiry demonstrates that the applicant is not competent to practise registration can be refused. If an inquiry demonstrates that there are concerns with the person's competence which are not substantial enough to warrant refusal of registration then registration may be granted subject to conditions. Under this system there would be a right of appeal to the Tribunal if an applicant is unhappy with a decision of the Board with respect to their application for registration or enrolment.

7.4 Mutual recognition

A number of submissions to the review used discussion of mutual recognition as an opportunity to advocate a system of national registration. Discussion of national registration is outside the scope of this review and is an issue that requires the cooperation and agreement of all State and Territory Governments.

A number of submissions argued that the mutual recognition process should be incorporated into the Act. However, other submissions argued that for a variety of reasons mutual recognition should not be incorporated into the Act. Some of the reasons advanced in support of this view include:

“The College believes that nurses, employers and indirectly the community, will not benefit from incorporating mutual recognition of regulation within the NSW Nurses Act, and the Mutual Recognition Act eliminates the need to do so.”⁷¹

“[[I]t is understood that provisions in the Medical Practice Act were introduced before the mutual recognition legislation was proclaimed and has subsequently never been used..”⁷²

In addition to the arguments advanced in submissions, the Department considers that the type of administrative oversight that resulted in the lapse of the Victorian Mutual Recognition Act is unlikely to recur. Furthermore Australia wide mutual recognition is now such an accepted feature of professional regulation that it is extremely unlikely that a State or Territory will withdraw from the scheme. Therefore the Department believes that incorporation of the mutual recognition principle into the Act is unnecessary.

⁷¹Submission, Royal College of Nursing Australia

⁷²Submission, New South Wales Nurses Registration Board

7.5 Disciplinary action by other registration authorities

7.5.1 Disciplinary action in another jurisdiction

The Mutual Recognition Acts provide that where a person's registration has been cancelled, suspended or made subject to conditions in one jurisdiction their registration in all other jurisdictions is similarly effected. With the proviso that the registration authorities of the secondary jurisdictions may choose to apply lesser sanctions. The Mutual Recognition Acts also require registration authorities to notify each other about disciplinary action taken against registrants and such notification is provided to all interstate boards irrespective of whether a person is registered in those jurisdictions.

However where a practitioner has been subject to disciplinary action overseas⁷³ resulting in deregistration, suspension or conditions on practice there is no requirement that notification be given or provision for that similar action to be taken. This is in contrast to the provisions of the Medical Practice Act which provides in sections 32 and 33 that where a person is deregistered, for misconduct or lack of capacity, or has conditions placed on their registration under an overseas law the Medical Board may deregister the person or impose equivalent conditions on their registration. The Medical Practice Act provides that the practitioner has a right to appeal any such cancellation or suspension of registration to the Medical Tribunal.

Given the reasonably large number of overseas trained nurses that register in New South Wales the Department considers it appropriate that the Nurses Registration Board be able to take action to protect the public where it is aware that a practitioner has been the subject of disciplinary proceedings overseas and their registration has been cancelled, suspended or made subject to conditions. A practitioner whose registration is cancelled or suspended is to have a right to appeal to the Tribunal.

7.5.2 Disciplinary action by another health registration board in NSW

There are a large number of registered health practitioners who are registered in more than one profession. Within this group are a not insignificant number of nurses who are registered with two or more registration boards, for example those who are registered as both nurses and psychologists and those who are registered as both nurses and podiatrists. The Nurses Act, along with other health registration Acts, makes no provision for the sharing of information between boards nor does it allow for a complaint to be made or action to be taken against a practitioner based on a disciplinary finding by another board.

Clearly there can be instances where the actions of a practitioner, such as sexual misconduct, in a particular professional context demonstrate that the practitioner is unfit for registration as a health practitioner in any context. Equally certain professional shortcomings which fall short of justifying deregistration, such as a failure to comply with infection control standards, may justify the imposition of conditions on the practitioner's registration in a number of professional contexts, for example nursing and podiatry.

⁷³ This would not apply to New Zealand which is a party to the mutual recognition system.

However, due to differences between health professions, the conduct of a practitioner in one professional context may be of a nature that justifies deregistration while the same conduct in another professional context may require only that the practitioner undertake additional education or that conditions be placed on registration. The effect of particular conduct in each professional context is a matter for individual registration boards and disciplinary bodies to determine when deciding if a practitioner is guilty of unsatisfactory professional conduct or professional misconduct under each relevant health registration Act.

The Department is therefore of the view that where a health registration board in NSW takes disciplinary action against a practitioner and the board is aware that the practitioner is, or has been, registered with another health registration board or boards the first board should be under a duty to notify each other relevant board about disciplinary findings and the orders made as a result of those findings. The second board/boards could then, where appropriate, make a complaint about the practitioner and institute disciplinary proceedings. In extreme cases a second board could take emergency action to protect the public by suspending the practitioner and then make a complaint and initiate disciplinary proceedings.

7.5.3 Impairment action by another health registration authority

The above discussion relating to disciplinary action taken by another health registration authority can equally apply to action taken on the basis of a practitioner's impairment. Impairment action is taken by a registration board in order to protect the public from a practitioner whose ability to practice is impaired whether that be due to drug or alcohol addiction or to physical or mental incapacity. The Department therefore recommends that it be a condition of the impairment process that where the primary board is aware that a practitioner is registered with a secondary board it notify the secondary board of any suspension of a practitioner's registration or the placing of conditions on that registration.

7.5.4 Notification of disciplinary action and secondary registration by practitioners

It is recommended below, see **8.3 and Recommendations 19 and 20**, that practitioners submit an annual return, when renewing their registration, that amongst other things gives details of any disciplinary action taken against them in another jurisdiction. The Department recommends that the annual return also include details of any disciplinary action taken by another health registration authority in NSW as this will assist the Board in ensuring it has considered all relevant matters that may affect a practitioner's ability and fitness to practise.

The Department also recommends that practitioners be required to notify the Board of their registration with a nurses or midwives registration Board overseas as well as with another health registration board in New South Wales, as this will assist all boards in protecting the public interest by ensuring that professional shortcomings are addressed by all relevant registration

boards. Notification of registration with another board should be required when the practitioner seeks initial registration and in their annual return.

Recommendation 16 – Action by other registration authorities

- (a) That the Act provide that where a practitioner's registration in a jurisdiction to which mutual recognition does not apply is cancelled, suspended or made subject to conditions the Board may take the same action, or lesser action as appropriate, in respect of the practitioner's registration in New South Wales.

A practitioner whose registration is cancelled or suspended under this provision is to have a right to appeal that action to the Tribunal.

- (b) That the Act be amended to provide that where a practitioner who is also registered with another health registration board in New South Wales has a disciplinary finding made against them by the other registration authority that finding may form the basis of a complaint to the Nurses and Midwives Board.
- (c) That practitioners be required to notify the Board if they are registered with a nurses or midwives registration Board overseas or another health registration board in New South Wales and that they also be required to notify the Board in the annual return if they are subject to a disciplinary finding by a nurses or midwives registration Board overseas or another health registration Board in New South Wales.
- (d) Where the Board is aware that a practitioner is registered with another health registration board it be required to notify that board of any disciplinary action taken against a practitioner and any suspension of registration or the imposition of conditions on registration as a result of the impairment process.

7.6 When registration/enrolment is not required.

Section 25 of the Nurses Act provides that a registered nurse who is registered elsewhere in Australia may practise in New South Wales without NSW registration for a period not exceeding 24 hours. This provision applies only to those functions relating to medical care or treatment prescribed by the Regulation. Clause 6 of the Nurses (General) Regulation 1997 provides that the prescribed functions are:

- functions exercised to meet the needs of organ transplant patients and patients donating organs;
- functions exercised as a member of a retrieval team that enters New South Wales to pick up a patient;
- functions exercised while a nurse is on escort duty accompanying a patient on a journey that begins or ends outside New South Wales.

The Issues Paper asked whether the provision for practise in NSW without NSW registration should be extended to include enrolled nurses and whether practise without registration/enrolment should be allowed for greater than 24 hours.

The overwhelming majority of submissions on this point agreed that the exemption in section 25 be retained and most endorsed its extension to enrolled nurses, there was

no real consensus in the submissions as to the length of time that practise should be allowed.

“While it is difficult to imagine the circumstances where an enrolled nurse may need a similar grace period, it seems unnecessarily discriminatory to apply the provision only to registered nurses.”⁷⁴

The Department considers that the existing provisions of section 25 should be extended to include enrolled nurses. Consideration of any extension to the existing time limit should take place in the context of a broader discussion of cross border practice and recognition of interstate registration.

Recommendation 17 – When registration/enrolment is not required

The Act be amended to provide that interstate nurses and midwives be allowed to practise nursing or midwifery in specified circumstances in New South Wales without New South Wales registration or enrolment for not longer than 24 hours.

7.7 Telenursing

A small number of submissions including that from the Nurses Registration Board raised the issue of nurses practising across State borders by use of telecommunication facilities, what has become known as “telenursing” or more generically “telemedicine”.

As there are no practice restrictions within nursing and as the proposed practice restriction relating to childbirth cannot realistically be undertaken by telecommunication facilities it could be said that there is no need for the NSW legislation to make express provision for nurses providing services across State borders by telecommunications facilities. However the issue has been raised of a practitioner who engages in conduct that may warrant disciplinary action whilst practising with the aid of telecommunications facilities. In such a case a question would arise as to which jurisdiction is the appropriate jurisdiction to undertake any disciplinary action required. This is an issue that cannot be addressed by the NSW Board acting alone and requires a cooperative approach by all Australasian registration authorities.

Therefore the Department considers that it would be premature for the Act to seek to regulate telenursing at this stage. However the Department recommends that the Board, in conjunction with other nursing and midwifery registration authorities, examine the jurisdictional issues surrounding the professional use of telecommunication facilities in order to ensure that the community is protected from incompetent and unethical practitioners.

Recommendation 18 – Regulation of telenursing

That the Nurses and Midwives Board cooperate with other Australasian nursing and midwifery registration authorities to address jurisdictional issues surrounding the practising of nursing and midwifery by telecommunications facilities.

⁷⁴ Submission, Queensland Nursing Council

7.8 Student registration/enrolment

In response to a request from the Nurses Registration Board the Issues Paper raised the question of student registration/enrolment in line with existing provisions of the Medical Practice Act. If student registration/enrolment were introduced it would allow the Act's impaired practitioner system to apply to student nurses, who have significant patient contact during the course of clinical placements. Student registration under the Medical Practice Act does not involve the payment of a fee by students and the administrative cost of registration and any impairment proceedings are met by the Board from existing resources.

A number of submissions have supported student registration/enrolment, including the Nurses Registration Board, the views of which were set out in the Issues Paper:

“Registration of students, similar to the Medical Practice Act, is important because it provides a screening process so that students who are not fit and proper persons or clinically competent do not become registered.”⁷⁵

“Accreditation of students is in keeping with the concerns about safety of the public and the risks of having students performing potentially dangerous procedures or care even with supervision.”⁷⁶

However, a larger number of submissions have rejected the call for student registration/enrolment and argued that supervision and monitoring of students is more appropriately a matter for individual educational institutions. Some of those submissions have also drawn attention to the cost and administrative burden involved in requiring the Board to register/enrol students.

“Currently, students are heavily supervised, by both universities and health care organisations, with the organisation having the right and responsibility to remove any student demonstrating unsafe practice or unprofessional conduct. To accredit student nurses would incur considerable (sic) increased administrative costs for the NRB which would ultimately increase registration costs for qualified nurses.”⁷⁷

“The Branch cannot envisage any public benefit arising from the accreditation of students of nursing. Such a scheme would be both costly and cumbersome to administer. Governance of the practice of students of nursing is, and in our view should remain, the purview of Universities, Colleges of Technical and Further Education, and health care agencies.”⁷⁸

“The College believes it is neither appropriate or necessary for students of nursing to be accredited by the Board as is the case for Medical Students. Rather we argue it is the responsibility of the individual universities and health care agencies with whom they have clinical placement arrangements... It would be unnecessarily cumbersome to have a student register or enrol and would be a difficult and expensive process for the Board to administer.”⁷⁹

⁷⁵ Submission, Health Care Complaints Commission

⁷⁶ Submission, Association of Neonatal Nurses of NSW (Inc)

⁷⁷ Submission, Northern Sydney Area Health Service

⁷⁸ Submission, Australian and New Zealand College of Mental Health Nurses Inc (NSW Branch)

⁷⁹ Submission, New South Wales College of Nursing

“Students studying to be registered or enrolled nurses do not need to be accredited. There is no evidence to suggest that this will be in the public interest. It may have the unintended consequences of making the process of learning nursing so cumbersome as to discourage participation in nursing studies.”⁸⁰

On balance the Department considers that the financial costs to the Board, the profession and individual students of nursing, and the administrative inconvenience to the Board and students outweighs the public benefit that may be achieved by accrediting student nurses. The Department considers that the educational and clinical systems incorporate adequate mechanisms to monitor the performance of nursing students and where an impairment is detected to manage that impairment or bring it to the attention of the Board if the student qualifies and seeks registration or enrolment. The Department has recommended, see **5.2** and **recommendation 7**, that the Board be empowered to hold an inquiry into an applicant’s capacity and fitness to practise when they seek registration/enrolment. This mechanism will allow the Board to place appropriate conditions on a person’s registration or enrolment and in appropriate cases refuse to grant registration or enrolment.

⁸⁰ Submission, New South Wales Nurses Association

8. CONTINUING REGISTRATION/ENROLMENT

8.1 Introduction

The Issues Paper noted that the Nurses Act requires nurses to renew their registration/enrolment each year. In renewing registration/enrolment the only obligation placed on nurses is to pay the prescribed fee. One of the primary objects of the Act is to provide patients/consumers with information about the competence of practitioners. The existing Act relies upon initial registration/enrolment criteria, each practitioner's professional obligation to maintain their skills and the complaints/disciplinary system to detect those practitioners who practise improperly or beyond their area of competence. Concerns have been raised that this system does not allow the Board to adequately monitor the ongoing competence of practitioners.

The Queensland Nursing Council in its submission put the view, which the Department endorses, that:

“A licence to practice (sic) should signal to all potential employers (large and small) that the person holding the licence is currently competent to practice, not just that at some time in the past they received a recognised qualification that made them eligible for registration or enrolment.”

The Issues Paper noted a number of strategies that have been suggested to enable the Board to play a more active role in the ongoing maintenance of professional standards. These strategies are:

- the Board having the power to conduct regular competency assessments and/or the power to assess an individual practitioner's performance;
- mandatory continuing professional education; and
- the development of a more comprehensive annual renewal process for practitioners.

8.2 Strategies for maintenance and monitoring of professional standards

8.2.1 Regular competency assessment and individual performance assessment

One mechanism that is claimed to ensure that practitioners maintain their skills and remain up to date with developments in their profession is routine competency testing. Where testing shows the practitioner's performance to be below the required standard the Board could direct him or her to undertake a retraining program or institute a Board inquiry which may impose conditions on the practitioner or, in the most serious cases, order suspension or cancellation of registration/enrolment. The Issues Paper noted that the introduction of competency testing would result in significant costs to the profession and the community.

The Health Care Complaints Commission in its submission put the following view:

“The Commission strongly supports the introduction of annual or other regular competency assessment of nurses for renewal of registration. The

Board should also have the power to enable it to conduct performance assessments, and to require a nurse to undertake an examination when there are reasonable grounds to do so and require remedial activities to be undertaken if necessary.

...

*Introduction of competency assessment and mandatory continuing education does involve additional costs for nurses and the Board but the benefits to the community outweighs any cost considerations.*⁸¹

The Far West Area Health Service in its submission also supported the introduction of some form of regular competency assessment for nurses⁸² while the Northern Rivers Area Health Service endorsed the proposition that the Board be empowered to conduct performance assessments where there are reasonable grounds for doing so.⁸³

Regular performance assessments would impose substantial administrative costs on the Board as well as disrupting the practices of the practitioners assessed and their employers. On balance the Department considers that the cost of performance assessments cannot be justified given the complaints history of the profession and the fact that the existing complaints system allows for the assessment of practitioners whose performance is identified as falling short of the required standard.

8.2.2 Mandatory continuing professional education

As noted in the Issues Paper practitioner participation in continuing professional education is desirable and may even be seen as an essential component of professionalism. A large number of submissions addressed this issue and supported the concept of continuing education. Submissions were divided between those that supported a Board administered scheme and those that argued that continuing education is a matter for the individual nurse and her/his employer to determine.

Submissions that advocated Board administered continuing education included the following:

*“Consideration should also be given to the introduction of mandatory continuing education ... It is important that nurses continue to upgrade their knowledge and skills and remain competent due to the nature of the services they provide... Many nurses without some sort of coercion may not voluntarily undertake ongoing education.”*⁸⁴

*“There should be a minimum level of continuing professional activities that should be necessary to remain registered/enrolled.”*⁸⁵

“[T]here should be continuing accreditation of registered and enrolled nurses. Part of the accreditation process would be evidence of continuing education that is provided at the time of licence renewal, with the

⁸¹ Submission, Health Care Complaints Commission

⁸² Submission, Far West Area Health Service

⁸³ Submission, Northern Rivers Area Health Service

⁸⁴ Submission, Health Care Complaints Commission

⁸⁵ Submission, New South Wales Operating Theatre Association Inc.

*possibility of licence renewals every three years rather than annually.*⁸⁶

Submissions which argued the Board should not administer a continuing education scheme and that continuing education is the responsibility of individual nurse, and her/his employer, included the following:

*“There is sufficient regulation within the profession and the health care industry to ensure nurses are competent to practice. Furthermore, regulating or prescribing that nurses participate or attend courses/conferences and seminars does not guarantee competency.”*⁸⁷

*“It is the Association’s view that any process linked to mandatory assessment of continuing competence will be costly, labour intensive, and achieve no better outcome than those offered by the current system. Mandatory assessment of continuing competence has not been shown to lead to improved safety for the public in the northern hemisphere countries where such practices are widely regarded as little more than an effective application of bureaucratic zeal.”*⁸⁸

“There is no evidence to support the notion that nurses are not meeting their professional obligation to maintain skills and knowledge at an appropriate standard.

*... Ensuring that staff are up-to-date should be a joint professional obligation worked out by the nurse and his/her employer.”*⁸⁹

*“It should be the responsibility of the employing body to ensure that professional standards are achieved and maintained through the process of competency assessment within the workplace.”*⁹⁰

*“[Ongoing competency] is the responsibility of the employer and should be addressed through the employee performance appraisal process... The employer should then report any further concerns, regarding competence, to the Board.”*⁹¹

*“It is submitted that the burden of identifying competency to practise ought to rest with the employer, not the registering authority.”*⁹²

The Department considers that a system of mandatory continuing education should only be introduced where there is an identified problem of practitioners failing to maintain their skills and competence rather than isolated cases of a lack of skill or competence. Where practitioners and their professional bodies recognise the need for and promote ongoing education there is little benefit in making participation mandatory. As the vast bulk of practitioners in both nursing and midwifery are employed and practise in institutional settings amongst their

⁸⁶ Submission, Clinical Nurse Consultants from Sydney Children’s Hospital

⁸⁷ Submission, South Eastern Sydney Area Health Service

⁸⁸ Submission, New South Wales Nurses Association

⁸⁹ Submission, Southern Cross University, School of Nursing and Health Care Practices

⁹⁰ Submission, New England Area Health Service

⁹¹ Submission, Northern Sydney Area Health Service

⁹² Submission, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney

peers mechanisms already exist to monitor performance and provide additional training as required. Therefore the Department does not support a system of mandatory continuing education.

8.2.3 Development of a more comprehensive annual renewal process

As noted above nurses who seek to renew their registration/enrolment are only required to pay a fee. The Department has raised for consideration whether or not nurses should be required to provide detailed information about their professional activities and ongoing fitness to practise. A number of submissions have supported this approach being taken:

“We would support the following declarations being included in the annual renewal process

- *charges laid against the nurse for offences of a serious nature that relate to conduct occurring in the course of practice;*
- *criminal convictions and cases where the offence has been proved but no conviction recorded pursuant to section 556A of the Crimes Act (1900) or equivalent provision;*
- *complaints investigated by the Health Care Complaints Commission;*
- *verdicts and settlements in civil action taken by a patient;*
- *significant illness;*
- *continuing education activities.*⁹³

“It is suggested that as evidence of maintenance of competence nurses should be required to complete a declaration of self-assessment on renewal of regulation. The declaration should also include statements regarding the fitness to practice as outlined in 7.3 [of the Issues Paper].”⁹⁴

“We concur with the proposal in the Discussion Paper under point 7.3 that on application for renewal of their accreditation that in addition to paying the prescribed fee, the nurse submits declarations...”⁹⁵

Requiring practitioners to provide these declarations will involve additional time and effort for individual practitioners and administrative expense in the Board processing the declarations and in considering those declarations the Board considers should be investigated further. However, the Department considers this to be the approach that involves the least cost while providing the Board with sufficient information to fulfil its role of protecting the public.

8.3 Conclusions

In the 1997/8 reporting year the Health Care Complaints Commission received 38 complaints about nurses and midwives that involved impairment, capacity, quality of care and treatment, and in 1998/9 76 complaints about nurses and midwives concerned these matters.⁹⁶ This compares with the Department of Health’s 1997 workforce survey for the Nursing profession which reports that there were in excess

⁹³ Submission, Australia and New Zealand College of Mental Health Nurses Inc (NSW Branch)

⁹⁴ Submission, Royal College of Nursing Australia

⁹⁵ Submission, New South Wales College of Nursing

⁹⁶ Health Care Complaints Commission, Annual Reports 1997/8 and 1998/9.

of 51,000 nurses and midwives practising in NSW in 1997.⁹⁷ These figures demonstrate that the incidence of complaints relating to ongoing competence of nurses is at most 1 in 1500 and when it is considered that a number of complaints are dismissed and that the workforce survey may under report the size of the workforce, the incidence of complaints may be even lower.

The strategies outlined above in **8.2** would, to a greater or lesser degree, impose costs upon the Board, individual nurses and midwives and consumers of nursing and midwifery services. The Department of Health will only support such strategies where the benefits to the public outweigh those costs. The Department has not been provided with any information that supports the contention that nurses and midwives are failing to maintain their skills and therefore pose a risk to the public.

However, the Department considers that the public interest and the Board's role in protecting the public would be enhanced, and the importance of ongoing education would be reinforced at minimal cost if practitioners turned their attention to their ongoing education activities on a regular basis. Therefore the Department supports the inclusion of questions with respect to continuing education activities in the regular workforce survey (distributed with registration renewal notices). It is important to again emphasize that continuing education would not be mandatory.

The Department does not believe that requiring practitioners to disclose details of civil cases and settlements is necessary in the interests of public health and safety.

The Department therefore recommends that when renewing their registration nurses and midwives be required to provide information about their professional activities and ongoing fitness to practise. Those declarations are to cover the following matters:

- practice status;
- refusal of registration/enrolment, suspension or cancellation of registration/enrolment, and the imposition of conditions on registration/enrolment in another jurisdiction;
- suspension or cancellation of registration or the imposition of conditions on registration by another health registration board in New South Wales whether as a result of a disciplinary finding or an impairment process; (this matter was considered in section **7.5**)
- registration with another health registration board in New South Wales; and
- significant physical or mental illness that may reasonably be thought likely to detrimentally affect the nurse/midwife's capacity to practice.

It is also recommended that nurses and midwives be required to provide the Board with detailed information on any criminal findings made against them in the previous year and criminal charges for sex and violence offences occurring in the course of practice or involving minors. Those declarations are to cover the following matters:

- criminal convictions;
- criminal findings for sex or violence offences and offences occurring in the course of practice where the offence has been proved but no conviction recorded pursuant to section 10 of the Crimes (Sentencing Procedure) Act (1999) or equivalent provision;

⁹⁷ New South Wales Department of Health, *Profile of the Registered and Enrolled Nurse Workforce, NSW, 1997*.

- charges laid against the nurse/midwife for sex or violence offences where the charges relate to conduct occurring in the course of practice; and
- charges laid against the nurse/midwife for sex or violence offences where the charges involve minors and charges for child pornography offences.

Where the Board is not satisfied with a practitioner's declaration it will have the option of conducting an inquiry into their competence or fitness to practise. These provisions, which are in similar terms to recent amendments to the Medical Practice Act, are proposed for inclusion in all health professional registration Acts.

Recommendation 19 – Declaration as to professional activities

That applicants for renewal or restoration of registration/enrolment be required to make declarations on the following matters:

- practice status;
- suspension or cancellation of registration or the imposition of conditions on registration by another health registration board in New South Wales whether as a result of a disciplinary finding or an impairment process;
- registration with another health registration board in New South Wales;
- refusal of registration/enrolment, suspension or cancellation of registration/enrolment, and the imposition of conditions on registration/enrolment in another jurisdiction; and
- significant physical or mental illness that may reasonably be thought likely to detrimentally affect the nurse/midwife's capacity to practice.

Recommendation 20 – Declaration as to criminal matters

That applicants for renewal or restoration of registration/enrolment be required to make declarations on the following matters:

- criminal convictions;
- criminal findings for sex or violence offences and offences occurring in the course of practice where the offence has been proved but no conviction recorded pursuant to section 10 of the Crimes (Sentencing Procedure) Act (1999) or equivalent provision;
- charges laid against the nurse/midwife for sex or violence offences where the charges relate to conduct occurring in the course of practice; and
- charges laid against the nurse/midwife for sex or violence offences where the charges involve minors and charges for child pornography offences.

8.4 Restoration of registration/enrolment

Section 33(4) of the Act provides that where a nurse's registration or enrolment cancelled for failure to pay the annual renewal fee he or she is entitled to have that registration/enrolment restored on making an application in writing accompanied by the prescribed fee. The Board has no power or discretion to refuse to restore a person's registration or enrolment despite concerns about their competence. The Department is of the view that concerns about competence are as relevant when a person seeks restoration of their registration/enrolment as they are when the person seeks initial registration or enrolment. Therefore the Board should be empowered to

conduct an inquiry into the competence of a person who seeks restoration of their registration or enrolment and where appropriate grant that restoration subject to conditions or refuse to grant restoration.

Recommendation 21 – Restoration of registration/enrolment

That the Board have the power to inquire into the fitness for registration/enrolment of a person who applies to have their registration/enrolment restored and where satisfied that the applicant is not fit for comprehensive practice the Board may restore the person's registration/enrolment subject to conditions or refuse to restore the person's registration/enrolment.

9. COMPLAINTS AND DISCIPLINARY STRUCTURE

9.1 Introduction

The Nurses Act contains a two-tier disciplinary structure involving Professional Standards Committees (PSCs) and the Nurses Tribunal. The two-tier disciplinary structure is matched with a two-tier definition of misconduct, involving unsatisfactory professional conduct and the more serious professional misconduct (see **Appendix C** for definitions). This disciplinary structure is complemented by the impaired practitioners system which is designed to divert impaired nurses and midwives into treatment and/or retraining before their impairment affects their practice and results in a formal complaint.

An effective complaints and disciplinary system plays a central role in achieving an underlying objective of the Nurses Act, the protection of the public from incompetent and unethical practitioners. A disciplinary system that is independent, transparent, accountable to the public and fair to all parties will protect the public and maintain professional standards by facilitating the taking of action against incompetent or unethical practitioners. Complaints about nurses and midwives may be made to the Board or to the Health Care Complaints Commission (HCCC).

Clearly disciplinary investigations and hearings involve costs for the HCCC, the Board and for individual nurses and midwives. The Department considers that these costs are far outweighed by the benefits of removing incompetent or unethical practitioners from the market or imposing conditions on their practice in the interests of public safety.

Alternatives to a statutory disciplinary system include professional associations and employers monitoring standards, private legal action for compensation following an adverse outcome of treatment, and private action under the Fair Trading Act (NSW) or the Trade Practices Act (Cth). However, none of these alternatives will achieve the objective of the Nurses Act as in the absence of a statutory disciplinary system there will be no mechanism to prevent a practitioner who practises incompetently or unethically from remaining registered/enrolled and using one of the titles registered nurse, enrolled nurse or midwife. Furthermore private legal proceedings require the individual concerned to invest substantial financial and emotional resources in pursuing their cause of action.

9.2 Relationship with the Health Care Complaints Commission

The Issues Paper noted that the Board and the HCCC are required to consult each other on the action to be taken in regard to a complaint and where the Board requires that a complaint be investigated the HCCC must undertake the investigation. However, the HCCC has a complete discretion as to which complaints it will prosecute before a PSC or the Nurses Tribunal. In the past this has resulted in situations where the HCCC has refused to prosecute certain complaints which in the opinion of the Board raise significant issues of professional standards. In these cases the Board has privately engaged the Crown Solicitor to prosecute the complaints and in 1997/8 two such complaints against registered nurses were found to be proven with the nurse's registration suspended in one case and cancelled in the other.

As a result of this situation the Board has sought an amendment to the Act to give it the power to review a decision by the HCCC to not prosecute a complaint and in appropriate circumstances to require the HCCC to undertake a prosecution. The Issues Paper noted that such a power may have the effect of impinging on the HCCC's legitimate prosecutorial discretion and asked for submissions on this point.

The majority of submissions reflect the view that the HCCC fulfils the role of independent prosecutor and that to provide the Board with a mechanism to review, and potentially override, the Commission's decision may affect that independence.

“The Branch cannot see any reason to include a provision to permit the Nurses Registration Board to review decisions of the Health Care Complaints Commission in relation to not prosecuting complaints. We submit that such a mechanism would inevitably compromise the independence and legitimate prosecutorial discretion of the Commission.”⁹⁸

Comments were also received that the existing system allows for action to be taken where the HCCC decides to not prosecute a complaint, and that the system of engaging the Crown Solicitor to prosecute a complaint has been used successfully in the past.

The Department is of the view that it is not appropriate for the Board to have additional powers to review the decision of the HCCC in regard to prosecuting a complaint. The Board can continue to engage the Crown Solicitor to prosecute complaints in those cases where the HCCC declines to do so.

9.3 Investigation of complaints

The Health Care Complaints Act provides that the HCCC can deal with a complaint in a number of ways including referring it to another body for investigation. When a complaint is referred to the Board it must as soon as practicable do one of the following:

- refer the complaint to an Impaired Nurses Panel;
- refer the complaint to a Professional Standards Committee;
- refer the complaint to the Tribunal;
- direct the practitioner in question to attend for counselling;
- direct the practitioner in question to attend a medical examination arranged by the Board; or
- take no further action.

It would appear that the Board has no power to investigate or inquire into a complaint, other than its power to order a practitioner to be medically examined. The Board has obtained advice from the Crown Solicitor's Office that confirms its lack of power in this area. The absence of a power in the Act for the Board to inquire into complaints is in contrast to the power in other health professional registration Acts, such as the Medical Practice Act, the Pharmacy Act and the Dental Act, which

⁹⁸ Submission, Australian and New Zealand College of Mental Health Nurses Inc (New South Wales Branch)

provide the respective registration boards with the power to obtain further information on a complaint prior to determining what action to take.

It is in the interests of both practitioners and consumers that the Board has sufficient information on complaints before determining how they are to be dealt with so that they may be handled in the most efficient and appropriate manner, including dismissal or referral for disciplinary action. For this reason the Department considers that the Board should be able to obtain additional information about a complaint prior to determining what action should be taken.

The Nurses Registration Board is also unable to appoint an inspector to conduct investigations for the Board. The role of inspectors appointed under other registration Acts, such as the Physiotherapists Registration Act, includes investigation of complaints about unregistered people and complaints that a person's registration has been obtained by fraud. The Health Professionals Registration Boards (the administrative structure under which the Nurses Board operates) has an Inspections Office which carries out inspections on behalf of the other registration boards and this structure could be used to provide the Board with an inspector or inspectors.

It is important to emphasise that providing the Board with the power to obtain information about complaints and to appoint an inspector would not override the obligation of the Board and the HCCC to inform each other of complaints and consult on the manner in which complaints are to be dealt with. In addition providing the Board with these powers would not interfere with the primacy of an investigation by the HCCC, where either the HCCC or the Board considers that a complaint should be investigated by the Commission the Health Care Complaints Act provides that it must be so investigated.

Recommendation 22 – Inquiries by the Board

That the Act provide that the Board have the power to obtain additional information about a complaint before determining how to manage the complaint.

That the Board be able to appoint inspectors to carry out inquiries.

9.4 Grounds for making a complaint

The Issues Paper noted that a complaint may be made that a registered/enrolled nurse

- has been convicted of an offence (either in or outside New South Wales) and the circumstances of the offence render the applicant unfit in the public interest to practise nursing, or
- suffers from an impairment, or
- has been guilty of *unsatisfactory professional conduct*, or
- has been guilty of *professional misconduct*, or
- does not have sufficient physical or mental capacity to practise nursing, or
- is not of good character.

The Issues Paper went on to ask whether there should be changes to the grounds for making a complaint.

9.4.1 Unrecorded convictions

It is essential that the grounds for making a complaint about a nurse or midwife complement the grounds for refusing registration/enrolment (see 7.3). Where the grounds for making a complaint and refusing registration are not complementary conduct may be regarded differently depending on whether it is being considered in the course of an application for registration/enrolment or for the purposes of determining if disciplinary action will be taken. Therefore, as it has been recommended that both criminal convictions and instances where an offence is proven but no conviction is recorded will constitute grounds for refusing or placing conditions on registration/enrolment the Department recommends that the grounds of complaint should be amended to include those instances where an offence is proved but no conviction recorded.

Recommendation 23 – Grounds for complaint

That the grounds for a complaint about a registered or enrolled nurse and a registered midwife be amended to include findings of guilt in criminal matters.

9.4.2 Expanding the definition of unsatisfactory professional conduct

As noted above the Nurses Act incorporates a two-tier definition of misconduct involving unsatisfactory professional conduct and the more serious professional misconduct. Suspension or cancellation of a practitioner's registration/enrolment may only occur following a finding of professional misconduct and such a finding may only be made by the Nurses Tribunal. The Issues Paper sought comment on the adequacy of the current definitions of misconduct and canvassed amendments to those definitions.

The majority of submissions supported the retention of the two-tier definition of misconduct and the existing definitions of unsatisfactory professional conduct and professional misconduct.

“The two-tiered definition of professional misconduct is considered fair, reasonable and appropriate.”⁹⁹

“The College believes that the two-tiered definition of ‘professional misconduct’ is satisfactory as it stands and does not need amending.”¹⁰⁰

However there was one submission that suggested the two-tier definition is confusing and that

“One definition of professional misconduct/unprofessional conduct would be advantageous in the interests of simplicity.”¹⁰¹

The Department considers that the two-tier definition of misconduct allows a broad range of complaints to be considered and dealt with in an appropriate manner. The two-tier definition has served nursing well since its introduction and is consistent with existing definitions in the Medical Practice Act and definitions recommended for introduction to the Chiropractors Act, Optometrists Act, Osteopaths Act and Psychologists Act.

⁹⁹ Submission, South Eastern Sydney Area Health Service

¹⁰⁰ Submission, New South Wales College of Nursing

¹⁰¹ Submission, Australian Nursing Council Inc

The Issues Paper also discussed changes to the definition of unsatisfactory professional conduct that had been raised in the review of the Medical Practice Act. Those changes are inclusion of a community standard in complaints of lack of skill, and inclusion as a specific ground of complaint that a practitioner has engaged in sexual misconduct.

Some submissions supported the inclusion of these provisions in the definition:

“There is a significant amount of disagreement among the health professions in relation to whether sexual contact between practitioners and patients is always a breach of professional ethics... We would argue that including a reference to, and a definition of ‘sexual misconduct’ would assist in resolving this debate by clarifying those circumstances which could reasonably be held to form misconduct.”¹⁰²

“The Commission .. submits that the current definition of unsatisfactory professional conduct is unsatisfactory because of its lack of any reference to a community standard.

...

...it is a matter for the expert statutory Tribunal or Committee to determine whether any particular conduct is adequate having regard not only to the views of the profession but also the community’s reasonable and legitimate expectations.”¹⁰³

However, far more submissions argued that the existing definition of misconduct is adequate. Those submissions argued that it would be a mistake to include a community standard in the definition and that any type of sexual misconduct can be captured by section 4(2)(e) of the Act namely “any other improper or unethical conduct relating to the practice of nursing”.

“An allegation of any other improper or unethical conduct in the practice of nursing falls clearly within section 4(2)(e) of the Act. We submit that it is unnecessary to make ‘Sexual Misconduct’ a separate ground for complaint.”¹⁰⁴

“We do not support a definition which also includes the public perception of professional standards and conduct because such perceptions would be difficult to determine and validate.

...

...sexual misconduct does not need to be separately mentioned under the Act. It is sufficiently covered within 4(2)(e).”¹⁰⁵

“The inclusion of the expected standard of care as judged by the public is a particularly difficult point, as it would be difficult to argue that a nurse should be found guilty of professional misconduct if the ‘reasonable nurse’ would have acted in the same way. If this standard is not satisfactory to the public, change at the macro level of professional practice or

¹⁰² Submission, Australian and New Zealand College of Mental Health Nurses Inc (NSW Branch)

¹⁰³ Submission, Health Care Complaints Commission

¹⁰⁴ Submission, New South Wales Nurses Association

¹⁰⁵ Submission, South Eastern Sydney Area Health Service

organisational policy is warranted, but not prosecution of an individual nurse.”¹⁰⁶

The Department considers that the view put by the Queensland Nursing Council is correct and community expectations of the profession should be addressed at the macro level. It is also the case that there is community representation on all disciplinary bodies created under the Nurses Act and that the public’s views are represented in that manner.

In relation to the inclusion of sexual misconduct as a specific ground of complaint the Department is of the view that there are more appropriate ways of conveying to the profession what constitutes sexual misconduct and that it will not be tolerated. These mechanisms include education campaigns conducted by the profession and universities and dissemination of information by the Board through its publications and codes of conduct. Furthermore recent Court and Nurses Tribunal hearings make it clear that sexual misconduct is included within the existing definition of unsatisfactory professional conduct. Therefore the Department does not consider it necessary to create a separate category of unsatisfactory professional conduct for sexual misconduct.

9.5 Verification of complaints

Section 44(3) requires that a complaint to the Board must, amongst other things, be in writing and be verified by a statutory declaration. The Department considers that while the requirement for a complaint to be verified by statutory declaration can protect practitioners from improper or baseless complaints there are instances where it is unnecessary.

In its submission the Health Care Complaints Commission argued that it should be exempt from the requirement that complaints to the Board must be verified by statutory declaration. The main arguments in favour of exempting the Commission from this requirement are that s.23 of the Health Care Complaints Act provides that the Commission may only investigate a complaint that the complainant has verified by statutory declaration, and that the Commission is a public body whose actions are open to scrutiny by a number of authorities including Parliament and the Ombudsman. The Department is not aware of any allegation that the Health Care Complaints Commission has inappropriately lodged complaints with the Board. The Department also believes that a similar exemption should be applied to a range of prescribed public office holders such as a judicial officers and the Coroner.

Recommendation 24 – Verification of complaints

That the Health Care Complaints Commission and the holders of prescribed public offices be exempt from the requirement that complaints be verified by statutory declaration.

9.6 Criminal convictions and charges

The Nurses Act currently places no obligation on courts or individuals to notify the Board of practitioners who incur convictions or are charged with serious offences.

¹⁰⁶ Submission, Queensland Nursing Council

The only time that a person is required to notify the Board of an offence is on application for initial registration/enrolment.

The criminal justice system can provide information relevant to whether a practitioner's conduct or character are such that disciplinary action should be initiated. The Department has been considering all health professional registration Acts to ensure that they continue to reflect the high standards expected by the community by adequately addressing questions of character and criminal conviction. The Department has identified a number of strategies that would be of assistance in this regard. They are as follows:

- Requiring courts to notify the relevant registration board of any practitioners who are convicted of offences or found guilty of sex or violence offences irrespective of whether a conviction is recorded. The Medical Practice Act contains such provisions requiring notification by the courts.
- Placing a positive obligation on practitioners to notify their registration board if they are convicted of an offence or found guilty of a sex or violence offence irrespective of whether a conviction is recorded. This would provide an additional means for obtaining relevant information in a timely manner and will emphasise to practitioners the potential seriousness with which criminal convictions should be regarded.
- Placing practitioners under an obligation to notify their registration board within seven days if charged with an offence where the allegations relate to conduct occurring in the course of practice or sex or violence offences involving minors.

A sex or violence offence is an offence involving sexual activity, acts of indecency, child pornography, physical violence or the threat of physical violence.

The vast majority of submissions supported the Act being amended to provide that courts be required to notify the Board if a practitioner is found guilty of an offence. The recommendation that findings of guilt where no conviction is recorded are to provide a basis for a complaint about a practitioner requires that these offences be treated in the same fashion as recorded convictions. The majority of submissions were also supportive of individual practitioners having an obligation to notify the Board when they are found guilty of an offence.

The Department therefore recommends that individual practitioners be under an obligation to notify the Board if they are convicted of an offence or found guilty of an offence or found guilty of a sex or violence offence where the offence occurred in the course of practice or involved minors whether or not a conviction is recorded. In order to complement this obligation and ensure that the Board is advised of serious offences, without imposing unnecessary work on the criminal justice system, courts will be required to notify the Board when a practitioner is convicted of an offence or found guilty of a sex or violence offence whether a conviction is recorded or not.

Requiring practitioners to notify the Board about charges for offences that occur in the course of practice is an attempt to balance the presumption of innocence (a criminal law concept) with the Act's objective of protecting the public. The criminal charge per se would not constitute the basis for disciplinary action. Rather, the charge and the circumstances surrounding it can be relevant to a practitioner's

overall competence to practise and to questions of character. The requirement that practitioners notify sex or violence charges where the conduct complained of involves minors reflects the particularly vulnerable position of children in relation to this type of offence.

Self-reporting of sex or violence charges is not unprecedented in the health system. For example the *Health Services Act 1997* requires NSW health service employees and visiting practitioners who have been charged with a serious sex or violence offence to report that fact to the chief executive officer of the relevant public health organisation. Medical Practitioners are now required by the Medical Practice Act to self report serious charges and similar provisions have been recommended for other registered health professionals in the reviews of the relevant registration Acts.

Recommendation 25 – Notification of offences

That:

- courts be required to notify the Board of any practitioner who is convicted of an offence or found guilty of a sex or violence offence (irrespective of whether a conviction is recorded or not);
- practitioners be required to notify the Board within seven days if they are convicted of an offence or found guilty of a sex or violence offence (irrespective of whether a conviction is recorded or not); and
- practitioners be required to notify the Board within seven days if charged with a sex or violence offence where the allegations relate to conduct occurring in the course of practice or involve minors.

A sex or violence offence is an offence involving sexual activity, acts of indecency, child pornography, physical violence or the threat of physical violence.

9.7 Code of professional conduct

Section 43 of the Act gives the Board the power to establish codes of professional conduct to be observed by nurses and midwives in the course of practice. The Issues Paper sought comment on a number of matters relating to codes of conduct including the desirability of codes, their impact on competition and whether they should be subject to a different approval process.

The Board has developed a code of conduct which is attached at **Appendix E**. The existing code states that its purpose is to:

- inform the profession of the minimum standards for professional conduct;
- inform the public of the minimum standards for professional conduct; and
- provide appropriate bodies with a basis for decisions regarding standards of professional conduct.

Statutory codes of conduct may have unintended consequences through altering the behaviour of practitioners and thereby affecting competitive conduct. Such restrictions on competitive conduct may impose costs on the profession and consumers. However while concerns that codes of conduct can adversely affect competition are valid it is important to consider that in the absence of statutory codes

of conduct professional bodies may seek to set standards of practice that impose greater restrictions on practitioners. Those increased restrictions may flow through to increases in compliance costs for the profession and transaction costs for consumers.

Nearly all submissions on the subject supported the adoption of statutory codes of conduct, and there was some limited and qualified support for approval of codes by an independent body.

“The Commission supports the desirability of professions publishing Codes of Professional Conduct particularly for the educative value they have for health care consumers and for the members of the profession and for the benefit in declaring acceptable professional conduct.

...

The Commission does see merit in Codes of Professional Conduct being approved by an appropriate independent body. However, it should be appreciated that such a process may undermine the evidentiary value of Codes of Professional Conduct in that it would then be open to suggest that such a Code does not represent the standards accepted within the profession but rather are standards imposed from outside the profession which may or may not have general acceptance.”¹⁰⁷

The Department supports the retention of a power for the Board to make or adopt codes of conduct as they:

- are a valuable tool for directing practitioners on the standards to be adopted;
- can be used by disciplinary bodies to assist in defining standards of acceptable practice;
- are readily accessible and provide information to consumers as to the standards of practice expected of practitioners; and
- provide information to assist consumers in selecting a practitioner whose practice complies with acceptable standards.

The Issues Paper canvassed a range of options for making codes of conduct including requiring them to be approved by the Minister for Health, the Department or another appropriate body; subjecting the codes to the potential for disallowance by Parliament under the *Interpretation Act 1987*; and establishing a formal system for developing the codes involving a process similar to the RIS process under the *Subordinate Legislation Act 1989*.

The Nurses Registration Board’s submission raised the point that the Board has adopted the Australian Nursing Council Incorporated’s (ANC) Code of Conduct and that when the Code was developed it was subject to extensive consultation both within the profession and in the broader community.

Nonetheless the Department considers it appropriate that there be an external mechanism for approval of codes of conduct. External approval of a code of conduct would help to ensure that any code of conduct for nurses and midwives does not sanction anti-competitive conduct or contain trivial matters, and that it serves the interests of consumers. Therefore the Department supports a code being made by

¹⁰⁷ Submission, Health Care Complaints Commission

the Board following a process of public consultation, similar to that provided for in the Medical Practice Act, after which the Minister's approval must be obtained. The process of public consultation would require a proper assessment of the respective advantages and disadvantages of a code's provisions.

The recent review of the Medical Practice Act identified a need for the Minister to have the power, in the public interest, to require the Board to develop a code on particular issues. The Medical Practice Act has recently been amended to incorporate this power and it is proposed that all health professional registration Acts will be amended to include it. It is emphasised that the actual content of a code is a matter for the Board although the content of the code will require the Minister's approval.

Recommendation 26 – Codes of conduct

That the Act provide for the making of a code of conduct by the Board following public consultation and the Minister's approval.

That the Minister may direct the Board to make a code of conduct on a particular matter with the content of such a code being developed by the Board.

9.8 Composition of disciplinary bodies

The Nurses Act creates a two-tier disciplinary structure to complement the two-tier definition of misconduct. The disciplinary structure involves Professional Standards Committees and the Nurses Tribunal. Professional Standards Committees are constituted by three members, two nurses/midwives and one lay person, while the Nurses Tribunal is constituted by four members, two nurses/midwives, one lay person and is chaired by a legal practitioner with extensive experience. Only the Nurses Tribunal may order the cancellation or suspension of a nurse's accreditation.

The Issues Paper raised for discussion the questions of whether chairpersons of Professional Standards Committees should have any particular qualifications or training for the position; whether there should be a more structured mechanism for appointment of lay persons to the panel of lay persons eligible to sit on Professional Standards Committees and the Tribunal; and whether members of the Board should be eligible to sit on Professional Standards Committees and the Tribunal.

9.8.1 The Tribunal

In line with the recommendation that the Board be renamed the Nurses and Midwives Board the Tribunal should also be renamed the Nurses and Midwives Tribunal.

The Department understands that where a complaint is referred to the Tribunal the Board has always constituted the Tribunal to ensure that professional representatives are peers of the nurse or midwife the subject of the complaint. That is, where a complaint concerns a midwife and the provision of midwifery services the professional members of the Tribunal have involved midwives, and where a complaint concerns a mental health nurse nurses experienced in mental health nursing have sat on the Tribunal. The Department therefore sees no reason to further legislate the composition of the Tribunal and believes the Board

will exercise its discretion to constitute the Tribunal appropriately for each individual complaint.

9.8.2 Chairpersons of Professional Standards Committees

Professional Standards Committees are intended to be a form of peer review of professional conduct and are designed to be reasonably informal and inquisitorial. In the recent past the lay member of the Committee, who is also the Board's legal member, has chaired all Professional Standards Committees. It is necessary to acknowledge that difficult procedural issues may arise in the course of a hearing and it is important in such cases for the chairperson to understand the requirements of natural justice.

A large number of the submissions on this issue called for the chairperson to be a registered nurse. However, a small number of submissions, including those from the NSW Midwives Association and the Faculty of Nursing Midwifery and Health at the University of Technology, Sydney, argued in some detail that the chairperson must have legal qualifications. The Board argued that the current provisions allow it to appoint an appropriately qualified person to be chairperson of the Committee depending upon the issues in question in each case.

The Department is not aware of any circumstances where it is claimed that an inappropriate person has been appointed to be chair of a Professional Standards Committee and supports the view of the Board that the current provisions are appropriate. The Department also supports the actions of the Board in providing training in procedural and natural justice issues for Tribunal and Committee members.

9.8.3 Panel of lay persons

All submissions received on this point supported the introduction of a more structured mechanism for the appointment of lay persons to the panel of lay persons for Professional Standards Committees and the Tribunal. The Department supports the creation of a single panel to provide lay members for the disciplinary bodies of all registration boards for which the Health Administration Corporation provides administrative support. This recommendation does not require legislative amendment and will facilitate the achievement of consistency of approach across a number of health professions and reduce administrative costs associated with the establishment of separate panels.

9.8.4 Eligibility of Board members to sit on disciplinary bodies

Submissions on whether Board members should be precluded from sitting on Professional Standards Committees and the Tribunal were almost unanimous in agreeing that Board members should be excluded where they have had prior involvement with the complaint. A majority of submissions took this argument further and agreed that in the interests of natural justice Board members should be precluded from sitting on the Tribunal in all cases.

The Department is of the view that in order to emphasise the transparency of the disciplinary process Board members should be precluded from sitting on the Tribunal. The Department considers that Professional Standards Committees fulfil a different role to the Tribunal in that they offer a forum for less formal peer review of a nurse's/midwife's conduct and practice and they are generally held in

the absence of the public. In light of the different role of Professional Standards Committees the Department considers that Board members should only be precluded from sitting on a Committee where they have prior involvement with the complaint or the nurse/midwife the subject of the complaint.

Recommendation 27 – Constitution of disciplinary bodies

That the Nurses Tribunal be renamed the Nurses and Midwives Tribunal.

That Board members be precluded from sitting on the Tribunal.

That Board members be precluded from sitting on a Professional Standards Committee where they have had prior involvement with the complaint or the nurse or midwife the subject of the complaint.

9.9 Proceedings before disciplinary bodies

Proceedings before Professional Standards Committees are designed to be inquisitorial and informal while those before the Tribunal are more formal and adversarial. Both the Tribunal and Committees can conduct proceedings as they see fit, are not bound by the rules of evidence and may summons witnesses to give evidence and produce documents. Only the Tribunal can award costs.

9.9.1 Proceedings of Professional Standards Committees

Legal representation is not allowed before a Professional Standards Committee unless the complaint concerns the physical or mental capacity of the practitioner and the Committee grants leave for legal representation. The Issues Paper asked the question whether legal representation should be allowed as of right before a Professional Standards Committee.

Submissions on this issue were divided with a number arguing that a Professional Standards Committee inquiry can have a serious impact on a practitioner's career and that the interests of natural justice require legal representation.

“In our view, procedural fairness can only be upheld if the respondent is afforded the right to be “legally represented” in the fullest meaning of the term.”¹⁰⁸

“Even though the current system is not unfair, it could be improved with legal representation or an experienced advocate permitted at the Professional Standards Committee level.”¹⁰⁹

The Department has not been made aware of any instances where lack of legal representation before a Professional Standards Committee has resulted in unfairness nor is the Department aware of any appeal to the Nurses Tribunal from a Committee decision.

¹⁰⁸ Submission, New South Wales Nurses Association

¹⁰⁹ Submission, Faculty of Health, University of Western Sydney, Hawkesbury

A number of other submissions have argued that legal representation should not be allowed and that to do so would so change the character of Professional Standards Committee hearings as to turn them into de facto Tribunal hearings.

“The Commission objects strongly to any proposal to allow legal representation at Professional Standards Committee as it would undermine the philosophical and operational basis for the conduct of those inquiries.”¹¹⁰

“..it is the view of the NRB that legal representation would only serve to make Professional Standards Committees more adversarial. If amendments are made to allow for legal representation above that currently provided for, then one would question why have a two tier system at all.”¹¹¹

Other submissions have drawn attention to the belief that the current system does not produce unfairness and therefore does not require amendment.

“The current system is fair as legal advice is available and the non adversarial nature of the PSC is upheld.”¹¹²

“In the absence of categorical evidence that the current system has resulted in unjust outcomes, the Branch is, at this stage, inclined to argue in support of the maintenance of the current system.”¹¹³

As expressed in the submissions of both the Nurses Registration Board and the Health Care Complaints Commission the philosophical underpinning of Professional Standards Committees is different to that of the Tribunal and Committees provide a less formal means of dealing with less serious complaints. In light of the views put in submissions the Department considers that allowing legal representation before Professional Standards Committees is not warranted and would steer Professional Standards Committees away from their intended informal inquisitorial nature. There is no evidence of unfairness as a result of the absence of legal representation, and allowing representation would cause proceedings to become more adversarial and legalistic rather than an inquiry by the practitioner’s peers. The existence of a right of appeal from a decision of a Professional Standards Committee to the Tribunal, where legal representation is allowed, provides appropriate safeguards.

Concerns have also been raised that Professional Standards Committees are becoming excessively formal and are in effect mini tribunals. Such formality is not in keeping with the role Committees are designed to fulfil. The Department therefore proposes that the Act be amended to clarify the informal and inquisitorial nature of proceedings before Professional Standards Committees. By way of example the Mental Health Tribunal, created under the Mental Health Act, is required to conduct its meetings with “as little formality and technicality, and with as much expedition, as the requirements of [the Mental Health] Act and

¹¹⁰ Submission, Health Care Complaints Commission

¹¹¹ Submission, New South Wales Nurses Registration Board

¹¹² Submission, Northern Sydney Area Health Service

¹¹³ Submission, Australian and New Zealand College of Mental Health Nurses, New South Wales Branch

the regulations and as the proper consideration of the matters before the Tribunal permit.”¹¹⁴

The Department also considers there would be merit in having representatives of the Board, the Health Care Complaints Commission and the Nurses Association meet to discuss means of reforming the practice of Committees.

Recommendation 28 – Disciplinary proceedings

That the Act provide that proceedings before Professional Standards Committees are to proceed with as little formality and technicality and as much expedition as appropriate given the nature of the complaint before the Committee.

That representatives of the Board, the Health Care Complaints Commission and the Nurses Association meet to discuss the reform of Committee practices so as to ensure the implementation of this recommendation.

9.9.2 Admission of evidence

Both the Tribunal and Professional Standards Committees may inform themselves of a matter in any way they see fit and are not bound by the rules of evidence. There was limited meaningful comment on this issue but of those submissions that addressed the issue there was significant support for maintenance of the current procedures, and no evidence of injustice attributable to the inappropriate admission, or exclusion, of evidence.

The Department, having considered the submissions received and the protective nature of the jurisdiction exercised by health professional disciplinary bodies, considers there is no justification for altering the procedures for admission of evidence.

9.9.3 Ex parte hearings

It is implicit within the Nurses Act that disciplinary hearings may take place in the absence of the practitioner the subject of the complaint. The Issues Paper asked whether this is appropriate and if so whether the power to proceed ex parte should be expressly set out in the Act.

There are situations where disciplinary hearings have proceeded ex parte as despite the best efforts of the Board it has been unable to contact the practitioner or s/he has either refused to respond to the Board’s approaches or refused to attend the hearing. The jurisdiction of health professional disciplinary bodies is protective and there are circumstances where a complaint concerns matters serious enough to warrant action to protect the public notwithstanding the practitioner’s absence.

The majority of submissions that addressed this point supported the view that hearings should be able to take place ex parte where all reasonable efforts have been made to inform the practitioner of the hearing and secure his or her attendance. A few submissions did however draw attention to the belief that to proceed in the absence of the practitioner was a breach of natural justice.

¹¹⁴ Section 267(1) of the Mental Health Act 1990 (NSW).

“We do not .. believe any hearings should take place without the nurse being present to defend herself or himself.”¹¹⁵

However many more submissions supported the power to proceed ex parte provided that there are provisions in place which ensure that proper steps are taken to inform the practitioner about the proceedings. These provisions include a requirement that the Board notify the practitioner of the hearing in writing.

“Power to proceed ex parte should be expressly set out. Every attempt should be made to contact the nurse, one of which should be in writing.”¹¹⁶

“Ex parte hearings should be permitted when all reasonable efforts to contact the nurse and encourage her/his participation have failed. Part of this process should include the requirement that the nurse be notified in writing...”¹¹⁷

“The College believes that the Act should state explicitly that a hearing may proceed ex parte so that nurses are aware of this possibility and may take a pro-active stance to ensure they are available when summonsed to a hearing (and be aware that failure to do so may jeopardise their future in the profession).”¹¹⁸

Recommendation 29 – Ex parte hearings

That the Act provide that where the Board refers a complaint about a nurse or midwife to a Professional Standards Committee or the Tribunal the Board must notify the nurse/midwife of that fact, and of any arrangements made for a hearing, in writing.

That the Act explicitly state that disciplinary hearings may proceed in the absence of the nurse or midwife the subject of the complaint.

9.10 Protective orders

There was very broad agreement in submissions that the current range of protective orders is appropriate and allows disciplinary bodies to draft their orders so as to protect the public. Therefore the Department recommends that there be no change to the range of protective orders that may be made by a Professional Standards Committee or the Tribunal.

9.11 Award of costs following disciplinary proceedings

The Tribunal is empowered to award costs to the successful party following a hearing. The Department understands that the Tribunal does not award costs as a matter of course but considers the conduct of parties over the course of the hearing in reaching a decision with respect to costs. It is however true that in a number of cases the Tribunal has made substantial costs awards in favour of the Health Care Complaints Commission against nurses and midwives who have not been insured for such costs.

¹¹⁵ Submission, New South Wales Operating Theatres Association

¹¹⁶ Submission, Association of Neonatal Nurses NSW (inc)

¹¹⁷ Submission, South Eastern Sydney Area Health Service

¹¹⁸ Submission, New South Wales College of Nursing

The Department has received submissions, both prior to and during this review, to the effect that as the majority of nurses and midwives are employees and do not hold indemnity cover and as the Health Care Complaints Commission is a publicly funded body the Tribunal should have no power to award costs. The alternative view argues that it is appropriate to award costs where the actions of a party in the conduct of a matter have resulted in unreasonable delay and therefore cost to the other party. It is also the case that if the Tribunal's power to award costs were removed it would be unable to award costs to a nurse or midwife who successfully defended a complaint before the Tribunal.

The Department has identified three alternative means through which the Act might deal with the issue of costs:

- (a) retain the status quo;
- (b) remove the Tribunal's power to award costs; or
- (c) restrict the Tribunal's power to award costs in the same manner as the Administrative Decisions Tribunal's power to award costs is limited.

The Administrative Decisions Tribunal's power to award costs is found in section 88 of the Administrative Decisions Tribunal Act. Section 88(1) provides:

... the Tribunal may award costs in relation to proceedings before it, but only if it is satisfied that there are special circumstances warranting an award of costs.

Five submissions, including those from the NSW Midwives Association and the NSW College of Nursing, support retaining the status quo. The Queensland Nursing Council states in its submission that

"As professionals nurses have individual accountability for their own actions. If those actions are not of a standard that is acceptable to the profession, and there are no extenuating circumstances such as ill health, it seems unreasonable that the cost of removing the person from the register or of ensuring that they receive appropriate rehabilitation, should be borne solely by the public or the profession."

Three submissions supported removing the Tribunal's power to award costs altogether. The NSW Nurses Association in its submission put the view that:

"We submit that the power given to the Tribunal to award costs against nurses in the disciplinary proceedings is unfair and inappropriate. Our conclusions relate to the following observations made over many years of involvement with nurses facing the Nurses Tribunal:

- *Costs, amounting to thousands of dollars (sometime tens of thousands of dollars), could be imposed on a person who has been deprived of earning a livelihood because their registration may have been suspended or they may have been deregistered.*
- *Nurses generally are employees and do not have sufficient resources to meet these costs...*
- *As employees, nurses do not carry professional indemnity insurance to cover these costs.*

- *Awards of costs are personal and levied against the individual nurse.*
- *The HCCC, to who these costs are awarded, is a publicly funded statutory authority similar to that dealing with criminal cases. The prosecution costs are not awarded in criminal matters, as distinct from ‘court costs’.*
- *Experience reveals that nurses generally do not attempt to defend the indefensible in relation to the defence of complaints against them.*

...

We submit that the power of the Tribunal to award costs should either be removed or significantly curtailed.”

Seven submissions, including those from a number of area health services and educational institutions, argued that the Nurses Tribunal should retain a power to award costs but that it should be a power in similar terms to the costs power of the Administrative Decisions Tribunal. The Board also supported this point of view.

On balance, and given the views in the submissions outlined above, the Department recommends that the Tribunal’s power to award costs be restricted in line with the power given to the Administrative Decisions Tribunal.

Recommendation 30 – Costs awards

The Tribunal’s power to award costs following a disciplinary hearing be modelled on section 88(1) of the Administrative Decisions Tribunal Act 1997.

9.12 Notifying other authorities of disciplinary outcomes

There was overwhelming support in submissions for the Board to have the power to release Tribunal decisions to overseas accreditation authorities. There was also significant support for the more general publication of Tribunal decisions including making them available on the Board’s Internet site. The majority of submissions argued that such a power was appropriate in the interests of public health and safety and given the Board’s protective jurisdiction.

Recommendation 31 – Publication of disciplinary outcomes

That the Board have the power to publish and disseminate the decisions of the Tribunal in any way it sees fit.

9.13 Board emergency powers

The Board has the power, under s.48 of the Act, to suspend a practitioner’s registration/enrolment without a disciplinary hearing where that suspension is to protect the life or the physical or mental health of any person, including the practitioner. When an emergency suspension is made a complaint must be lodged with either the Tribunal or a Professional Standards Committee. A suspension can be made for a maximum of 30 days although it may be renewed. The Issues Paper asked for comments on the operation and appropriateness of the Board’s emergency powers and any suggestions for modification of the emergency powers.

Amongst those submissions that commented on the Board’s emergency power there was unanimous agreement that the powers are necessary for the protection of the public. Submissions also overwhelmingly supported retention of the status quo.

However recent amendments to the Medical Practice Act have extended the length of time that an order may be made for to eight weeks as well as providing that where the Medical Board uses its emergency powers to impose conditions on a medical practitioner's registration because the practitioner suffers from an impairment the matter can be dealt with as either a complaint or, with the agreement of the Health Care Complaints Commission, referred to an impaired practitioners panel. The Department therefore recommends that the emergency powers of the Board be updated in line with the amendments recently made to the Medical Practice Act.

The impaired registrants system is dealt with in greater detail in **chapter 10**.

Recommendation 32 – Emergency powers

That the Board's emergency powers be updated to provide that an order suspending a practitioner may be made for a period of up to eight weeks and to provide the Board with greater flexibility in managing serious cases of impairment.

9.14 Appeals

9.14.1 Appeals from Professional Standards Committees and the Tribunal

The findings of a Professional Standards Committee and the exercise of any of its powers can be appealed to the Tribunal as can the Board's exercise of its emergency powers under s.48 of the Act. Appeals from the Tribunal are allowed on a point of law and the Tribunal's exercise of its disciplinary powers only and not findings of fact. Appeals from the Tribunal are made to the Supreme Court. The Issues Paper sought submissions on whether these appeal rights are adequate and whether they should be amended.

Of the submissions that addressed this point there was a significant majority opinion that the existing appeal mechanisms are appropriate and that there is no need for change. However, a small number of submissions argued that the appeal mechanisms require amendment.

The most frequent amendment advocated was to allow appeals from the Tribunal on matters of fact as well as points of law. The Department does not support this suggestion on the basis that the Tribunal is an expert panel, with two of its four members being nurses or midwives and peers of the nurse or midwife the subject of the complaint. The Tribunal is therefore qualified to make findings on matters of fact. It is also important to consider that appeals on matters of fact could involve a full re-hearing of the complaint and involve significant delays and costs for both the practitioner and the complainant, whether that is the Board or the Health Care Complaints Commission.

The New South Wales Nurses Association also argued that the time period allowed for lodging an appeal is insufficient. The Association's argument is based on the fact that 21 days are allowed for lodging an appeal but that both the Tribunal and Professional Standards Committees have 30 days following the handing down of a decision to give reasons for that decision. The Department does not consider that the time for lodging an appeal is insufficient having regard to Clauses 20 and 24 of the Nurses (General) Regulation which provide that an appeal against a decision of a Committee (Clause 20) or the Tribunal (Clause 24) is to be lodged within 21 days of the Committee or Tribunal providing its reasons

for decision. However, recent health professional Acts allow an appeal to be lodged within 28 days of the handing down of the reasons for decision and in the interests of consistency the same time period should apply to nurses and midwives.

The Nurses Association also argued that appeals from the Tribunal should be to the Administrative Decisions Tribunal rather than the Supreme Court due to the cost and delays associated with hearings in the Supreme Court. The Department does not support this suggestion as appeals from the Tribunal are limited to points of law and severity of order and the Administrative Decisions Tribunal is no better qualified to make a ruling on these matters than the Tribunal which is of a similar status and chaired by a senior legal practitioner.

Recommendation 33 – Appeals

That the time allowed for lodging an appeal against a decision of the Tribunal or a Committee be extended to 28 days.

9.14.2 Review of suspension or cancellation of registration/enrolment by the Tribunal

Section 68 of the Nurses Act provides that if a practitioner's registration or enrolment has been suspended or cancelled by the Tribunal he or she may apply to the Tribunal for a review of the suspension or cancellation. An application for review can only be made following the expiration of the period of time during which the Tribunal has ordered the person not be able to apply for a review.

The Court of Appeal in *Rohatgi v HCCC* (Handley JA unreported 20 July 1996), which concerned the same provision in the Medical Practice Act, determined that the word 'review' in this context means that the practitioner in a review application may seek to go behind the decision of the original Tribunal and challenge any findings of misconduct made by that Tribunal. In effect an applicant may during a review, which may be made a number of years after the original hearing, revisit issues of fact and seek to effectively have the original Tribunal's findings quashed.

The Health Care Complaints Commission has submitted that this is not appropriate and was not the intention of the legislature when enacting either the Medical Practice Act or the Nurses Act. The Department agrees with the HCCC's submission and proposes that s.68 be amended to ensure that a practitioner whose registration/enrolment has been cancelled or suspended cannot, when seeking to have their name restored to the Register or Roll, question the factual basis on which the original Tribunal order was made unless significant fresh evidence is available that was not available when the original findings were made. A similar amendment has recently been made to the Medical Practice Act.

Recommendation 34 – Review of Tribunal decisions

That the Act be amended to ensure that when a practitioner seeks a review under s.68 of the decision of the Tribunal to cancel or suspend their registration/enrolment such a review does not involve a challenge to the original Tribunal's findings of fact.

10. IMPAIRMENT

10.1 Introduction

The impaired practitioners system provides the Board with a means of managing nurses and midwives who may be impaired in their ability to practise without having to resort to lodging a formal complaint. The impairment process can include a practitioner agreeing with the Board that conditions will be placed on his or her registration or that his or her registration may be suspended. Amongst the conditions that can be agreed with the Board are ongoing medical or psychiatric monitoring and management of the practitioner.

10.2 Disclosure of conditions by impaired practitioners

The Issues Paper asked for submissions on whether or not practitioners should be required to disclose to their employers the fact of their impairment and any conditions on their practice that have been agreed to as a result of the impairment process. Submissions were divided on this issue with the Nurses Registration Board, the Health Care Complaints Commission and a number of area health services arguing that the discretion of Impaired Registrants Panels in this regard should be removed.

“It has been found in the past that when a nurse has had conditions placed on her registration, he or she has not informed her employer about those restrictions. This has led to scenarios where the support and supervision being offered to the staff member concerned has been compromised. When conditions are imposed on a nurse’s registration it is appropriate that the employer is kept in the information loop, in order to assist the impaired staff member to maintain those restrictions.”¹¹⁹

However, a larger number of submissions including those from professional associations, educational institutions and some area health services have called for the discretion of Impaired Registrants Panels to be maintained.

“[D]iscretion is an important feature of the impaired panel process and should not be removed. Each impaired nurse is different, and a blanket rule as to informing employers may not be appropriate in every case.”¹²⁰

It is common for the conditions agreed to by nurses and midwives following Impaired Registrants Panels to include a requirement that they inform their employer of the impairment and any conditions on their practice. The Board has implemented a number of strategies to ensure that employers are in fact informed and officers of the Board report themselves satisfied that those strategies are effective. Therefore the Department does not consider it appropriate to remove the discretion of Impaired Registrants Panels with respect to notifying employers about a nurse’s/midwife’s impairment and any consequent conditions on his or her practice.

¹¹⁹ Submission, Ms Sandy Ozols, Drug and Alcohol Project Officer, Northern Rivers Area Health Service

¹²⁰ Submission, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney

10.3 Other modifications to the impaired practitioners system

(a) Medical examination

Section 45(5) of the Nurses Act allows the Board to direct that a practitioner who is the subject of a complaint attend for a medical examination at the Board's expense. However where the Board has been notified that a practitioner may suffer from an impairment but no complaint has been made there is no power to order a medical examination.

The Health Care Complaints Commission has recommended that the Board should be empowered to require a practitioner to submit to a medical examination at any time there is a concern about their ability to practise, irrespective of whether a complaint or notification has been made. Whilst such a medical examination would assist the Board in determining whether a complaint should be made it would be highly intrusive upon practitioners.

However, the power to require a practitioner to undergo a medical examination as a part of the impairment process would greatly assist the Board in dealing with notifications in the most sensitive and appropriate manner. Providing the Board with this power would be subject to a proviso that the power should only be exercised where that approach is reasonable given the nature of the notification to the Board. A failure by a practitioner to attend a medical examination without reasonable cause should be evidence that the practitioner lacks the physical or mental capacity to practise. A similar amendment has recently been incorporated in the Medical Practice Act. The Department considers that such an amendment strikes the appropriate balance between protection of the public and fairness to practitioners.

(b) Voluntary suspension or conditions on registration

Section 70I(2) of the Act provides that where a practitioner has voluntarily agreed to conditions being placed on his or her registration or that registration being suspended the Board must lift the conditions or suspension on a written application from the practitioner.

Not all practitioners who are subject to the impairment system have insight into the nature and effect of their impairment. The requirement allowing protective measures to be lifted at the request of the practitioner raises serious concerns in those cases. This issue was canvassed in the review of the Medical Practice Act and many submissions to that review supported the introduction of a system in which the practitioner would have the opportunity to present arguments to the Panel as to why there should be a variation or lifting of conditions or a suspension.

The Medical Practice Act was recently amended to provide that where conditions or a suspension has been agreed to the conditions or suspension can only be lifted following consideration by an Impaired Registrants Panel and the agreement of the Medical Board. Where a practitioner is unhappy with the decision of the Board he or she may appeal to the Medical Tribunal. The Department believes that similar concerns are applicable to nurses and midwives and therefore supports the inclusion of a similar amendment in the Nursing and Midwifery Act.

(c) The report of an Impaired Registrants Panel

The Health Care Complaints Commission has drawn the Department's attention to the application of s.70K(1) of the Act which provides that information in the report of an Impaired Registrants Panel is not to be divulged except in the exercise of functions under the Act. In the past the Board has interpreted this to preclude it from providing information to the Commission where following an Impaired Registrants Panel a complaint is made about a nurse or midwife to the Commission. The Commission has argued that this application of the provision impedes the efficiency of the legislation and is not consistent with the overall objectives of the Act.

The Department agrees with the Commission's views but notes that the Board has received advice from the Crown Solicitor that supports the contrary view. In order that there be no confusion the Department recommends the amendment of s.70K(1) to expressly provide that information in the report of an Impaired Registrants Panel may be provided to the Health Care Complaints Commission where the Board refers a complaint to the Commission based on the content of the report. A similar amendment has recently been incorporated in the Medical Practice Act.

(d) Mandatory reporting of impairment

The Health Care Complaints Commission has suggested that there be a positive obligation on practitioners and employers to notify the Board and the Commission about nurses or midwives who are believed to be suffering from an impairment. The Commission has argued that such an obligation would be in keeping with the protective nature of the Board's jurisdiction and would assist in protection of the public. The Department is however, unaware of a significant problem of nurses and midwives continuing to practise with an impairment and that impairment not coming to the Board's attention before a member of the public is adversely affected. Further the Department believes that it would be effectively impossible to define impairment so as to inform practitioners and employers of their obligations with any precision, and that such a requirement would therefore be unenforceable.

Recommendation 35 – Impaired Registrants Panels

That the Board have the power to require a practitioner the subject of a notification to undergo a medical examination either where a matter is referred to an Impaired Registrants Panel or it is proposed to refer the matter to an Impaired Registrants Panel.

That the Act be amended to provide that a practitioner who has agreed to having conditions imposed on his or her registration or to a suspension of that registration may only have the conditions or suspension lifted with the agreement of the Board which will receive a recommendation from an Impaired Registrants Panel, with an accompanying right to appeal to the Nurses and Midwives Tribunal.

That the Act be clarified to ensure that information in the report of an Impaired Registrants Panel may be provided to the Health Care Complaints Commission where the Board has referred a complaint to the Commission based on the content of the report.

11. MISCELLANEOUS

The final chapter of the Issues Paper raised for discussion two miscellaneous issues professional indemnity insurance and access by members of the public to information on the Register and the Roll.

11.1 Professional indemnity insurance

According to workforce data in excess of 95% of both nurses and midwives in practice are employees.¹²¹ As employees nurses and midwives are indemnified by their employers for events occurring and claims arising from their normal work. The Department is concerned that making professional indemnity insurance a requirement for accreditation is therefore an unnecessary cost to impose on nurses and midwives.

Only a very small number of submissions addressed this point and with the exception of the Health Care Complaints Commission there was agreement that insurance should only be required for nurse or midwife practitioners and nurses or midwives in private practice.

The Department proposes that detailed consideration of this matter be left until such time as the Board amends its code of practice.

11.2 Public access to information on the Register and Roll

The Act currently provides that the details recorded on the Register and Roll in respect of a nurse or midwife, with the exception of their address, are available to members of the public on payment of the prescribed fee of \$10. The Issues Paper asked for comment on the dissemination of information to the public including whether a fee should be charged and whether additional information such as the outcome of disciplinary hearings and conditions on a nurse's or midwife's practice should be included. This matter is of particular interest given the development of the Internet over recent years and the Board's proposal to publish the Register and Roll on its Internet site.

Those submissions that addressed this issue were divided with a number calling for all information on the Register and Roll, including conditions and disciplinary outcomes, to be freely available to the public.¹²² Other submissions argued that information on the Register and Roll should only be available free of charge to employers and that consumers should be charged a fee and even then not have access to information on conditions and disciplinary outcomes.¹²³

On balance the Department believes that it is important for the public to have access to information on the Register and Roll including a practitioner's registration/enrolment status, qualifications, any conditions on registration and whether those conditions have been imposed as a result of disciplinary proceedings. It is not appropriate for information about a practitioner's address or contact details to be made available.

¹²¹ NSW Department of Health *Profile of the Registered and Enrolled Nurse Workforce, NSW, 1997*

¹²² Submissions, Health Care Complaints Commission; New South Wales College of Nursing; N Jennaway.

¹²³ Submissions, New South Wales Nurses Association; South Eastern Sydney Area Health Service.

The Board already has the power to waive any fee in whole or part. Therefore the Board could choose to make information contained in the Register and Roll available for no fee over the Internet and to charge a fee only where the Board's administrative staff are required to spend time extracting the information for a person who attends the Board's offices or who makes a written request for information. The current provisions are sufficiently flexible to allow the Board to adapt to changes in technology and the Department believes there is no need for legislative change in this area.

APPENDIX A**TERMS OF REFERENCE FOR THE REVIEW OF
THE NURSES ACT 1991**

1. The New South Wales Department of Health will review the *Nurses Act 1991* in accordance with the terms for legislative review set out in the Competition Principles Agreement. The guiding principles of the review are that legislation should not restrict competition unless it can be demonstrated that:
 - i) The benefits of the restriction to the community as a whole outweigh the costs; and
 - ii) The objectives of the legislation can only be achieved by restricting competition.
2. Without limiting the scope of the review, the Department shall:
 - i) clarify the objectives of the legislation and their continuing appropriateness;
 - ii) identify the nature of the restrictions on competition;
 - iii) analyse the effect of the identified restrictions on the economy generally;
 - iv) assess and balance the costs and benefits of the restrictions; and
 - v) consider alternative means for achieving the same results including non-legislative approaches.
3. When considering the matters in (2) the review should also identify potential problems, for consumers seeking to use nursing services, which need to be addressed by the legislation.
4. In addition to considering the matters identified above the Department will consider:
 - i) the effectiveness of the current Act, in particular registration requirements and disciplinary arrangements; and
 - ii) the interrelationship of the Act with the *Health Care Complaints Act 1993*.
5. The review will consider and take account of the relevant regulatory schemes in other Australian jurisdictions and any recent reforms or proposals for reform, including those relating to competition policy.
6. The Department will consult with and take submissions from health professions, relevant industry groups, Government and consumers.

APPENDIX B**SUBMISSIONS RECEIVED**

Albury Base Hospital Nursing Council
Association of Neonatal Nurses of NSW (Inc.)
Australian and New Zealand College of Mental Health Nurses Inc.
Australian Midwifery Action Project
Australian Nursing Council Inc.
Australian Society of Independently Practising Midwives
Australian Women's Health Nurse Association
Avondale College School of Nursing
Central Coast Health – Division of Obstetrics
Congress of Aboriginal and Torres Strait Islander Nurses
Faculty of Health, University of Western Sydney, Hawkesbury
Faculty of Nursing Midwifery and Health, University of Technology, Sydney
Fairfield Health Service
Far West Area Health Service
M Harvey
Health Care Complaints Commission
High Performance Healthcare
Illawarra Area Health Service – Community Health
Institute of Nursing Executives of NSW and ACT Inc.
N Jennaway
John Hunter Hospital
Midwifery Practice and Research Centre
Midwives Act Lobby Group
Midwives from the John Hunter Hospital
Nepean Hospital
New Children's Hospital
New England Area Health Service
New England Midwives Association
New South Wales College of Nursing
New South Wales Midwifery Educators Advisory Group
New South Wales Midwives Association (Inc.)
New South Wales Midwives Association Western Sydney Sub-branch
New South Wales Nurses' Association
New South Wales Operating Theatre Association
Northern Rivers Area Health Service
Northern Sydney Area Health Service
Nurses Registration Board of New South Wales
Ms Sandy Ozols – Drug and Alcohol Services Northern Rivers Area Health Service
Pharmaceutical Health and Rational use of Medicines Committee
Psychologists Registration Board of New South Wales
Queensland Nursing Council
Royal College of Nursing Australia
School of Nursing and Health Care Practices, Southern Cross University
South Eastern Sydney Area Health Service
South Western Sydney Area Health Service
Sydney Children's Hospital
TAFE New South Wales
Wentworth Area Health Service
Western Sydney Area Health Service

APPENDIX C**Nurses Act 1991, Section 4 definition of *professional misconduct* and *unsatisfactory professional conduct*.**

4. "Professional misconduct" and "unsatisfactory professional conduct"
- (1) For the purposes of this Act, professional misconduct, in relation to an accredited nurse, means unsatisfactory professional conduct of a sufficiently serious nature to justify the removal of the nurse's name from the Register or the Roll.
- (2) For the purposes of this Act, unsatisfactory professional conduct, in relation to an accredited nurse, includes any of the following:
- (a) any conduct that demonstrates a lack of adequate:
- (i) knowledge,
 - (ii) experience,
 - (iii) skill,
 - (iv) judgment, or
 - (v) care,
- by the nurse in the practice of nursing,
- (b) the nurse's contravening (whether by act or omission) a provision of this Act or the regulations,
- (c) the nurse's failure to comply with an order or determination made or a direction given under section 48, 55 or 64 or with a condition of registration,
- (d) a nurse's holding himself or herself out as having qualifications in nursing other than:
- (i) those in respect of which the nurse's registration or enrolment was granted, or
 - (ii) those recorded in the Register or the Roll in respect of the nurse,
- and
- (e) any other improper or unethical conduct relating to the practice of nursing.

APPENDIX D**Features of nurse registration legislation in other Australian jurisdictions.**

	Register	Enrol	Title restriction	Practice restriction	Registration subject to conditions	Student registration	Mandatory continuing education	Recency of practise
NSW Nurses Act 1991	Yes	Yes	Yes ³	Midwifery (undefined)	Yes ¹³	No	No	No
QLD Nursing Act 1992	Yes	Yes	Yes ³	Yes ¹⁰	Yes	No	No	Yes 5 Yrs
ACT Nurses Act 1988	Yes	Yes	Yes ⁴	Yes ¹¹	Yes	No	No	Yes on initial reg 5 Yrs
VIC Nurses Act 1993	Yes	No ¹	Yes ⁵	No	Yes	No	No	Yes 5 Yrs
TAS Nursing Act 1995	Yes	Yes	Yes ⁶	No	Yes	No	No	Yes 5 Yrs
SA Nurses Act 1999	Yes	Yes	Yes ⁷	Yes ¹¹	Yes	No	No	Yes 5 Yrs
NT Nursing Act 1999	Yes	Yes	Yes ⁸	Nursing	Yes	No	No	Yes 5 Yrs
WA Nurses Act 1992	Yes	No ²	Yes ⁹	Yes ¹²	Yes ¹⁴	No	No	Yes 5 Yrs

Notes:

1. The Register is divided into 5 divisions one of which equates to enrolment as an enrolled nurse and one of which equates to enrolment as an enrolled nurse (mothercraft).
2. The Register is divided into 6 divisions with Division 2 including those nurses who would be an enrolled nurse or an enrolled nurse (mothercraft) in New South Wales.
3. Registered nurse, enrolled nurse and midwife.
4. Section 70(1)(a) of the Nurses Act 1988 (ACT) provides that a person other than a registered or enrolled nurse may not *take or use ... the name or title of a nurse or a name, title, addition or description (including initials or letters placed after his or her name) indicating or implying that the person is a registered or enrolled nurse or that the person is a person who practises or is qualified to practise nursing.*
5. Registered nurse.
6. Nurse, registered nurse, enrolled nurse, certified nurse, licensed nurse, qualified nurse, authorised nurse, midwife, psychiatric nurse and such other title as may be prescribed.
7. Registered nurse, enrolled nurse, mental health nurse, psychiatric nurse, midwife.
8. Nurse, registered nurse, midwife, licensed nurse, qualified nurse, enrolled nurse.
9. Nurse.
10. An unregistered person cannot practise nursing for fee or reward. Midwifery is not defined although s.142(5) of the Nursing Act 1992 (Qld) provides that *A person who does not have current authorisation from the Council to practice as a midwife must not care for a woman in childbirth.*
11. An unregistered person cannot practise nursing for fee or reward.
12. Section 46(1)(a) of the Nurses Act 1992 (WA) provides that an unregistered person is not to be employed or remunerated in connection with the practice of nursing.
13. Impairment matters only.
14. Honorary, provisional and temporary registration only.

APPENDIX E

Nurses Registration Board Code of Professional Conduct

Note: This code has been adapted from the *Code of Professional Conduct for Nurses in Australia* produced by the Australian Nursing Council.

CODE OF PROFESSIONAL CONDUCT

The purpose of the Code of Professional Conduct is to:

- Inform the profession of the minimum standards for professional conduct;
- Inform the public of the minimum standards for professional conduct; and,
- Provide appropriate bodies with a basis for decisions regarding standards of professional conduct.

Each nurse will

- 1) Provide safe and competent nursing care.
- 2) Uphold the agreed standards of the profession.
- 3) Practise in accordance with laws relevant to the nurse's area of practice.
- 4) Respect the dignity, culture, values and beliefs of patients/clients and significant others in the provision of nursing care.
- 5) Promote and support the health, well-being and informed decision-making of patients/clients in the provision of nursing care.
- 6) Promote and preserve the trust that is inherent in the privileged relationship between nurses and their patients/clients with respect to both their person and their property.
- 7) Treat as confidential personal information obtained in a professional capacity.
- 8) Refrain from engaging in exploitation, misinformation and misrepresentation in regard to health care products and nursing services.

Persons registered or enrolled with the Nurses Registration Board of New South Wales shall at all times act in such a manner to justify public trust and confidence, uphold the good standing of the profession, serve the public interest and those for whom they care.