

Response from Hauora Taranaki PHO. 36 Maratahu Street. PO Box 8196. New Plymouth.

Feedback is in bold - Collated by Jenny Ruddlesden (Director of Nursing – Primary Care).

Pharmacy Comments: Brian Irvine, Pharmacy Council Member 2003-2006, Currently Chair of Pharmacy Council Professional Conduct Committee. Clinical Facilitator HTPHO

Medical Comments: Dr Peter Catt, GP and Clinical Director at HTPHO.

Nursing and Other Comments: Jenny Ruddlesden, Director of Nursing, HTPHO.

Date: 21st November 2007

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

Nursing perspective

- ***It is difficult to know if the act is achieving it's purpose as competence to practise is a very personal thing – other than being required to demonstrate competence in terms of entry to the register competencies for the registration body, each nurse practises within their scope and scopes are really quite individual (can be narrow or very broad).***

- ***A more robust model of peer review would assist nurses to evidence their competence to practice.***

- ***Pharmacy***

As far as I can tell. It has been very positive in emphasising the public safety aspects for the profession. Lay participation on the Council and in the Professional Conduct Committee has been useful.

2. What evidence supports your answer?

- ***As above***

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

- ***A summary of activity and outcome would be useful. We are not convinced that the majority of individual professionals and/or employers have a clear understanding of their responsibilities under the HPCA Act in terms of competence and fitness to practise. A summary may heighten individual awareness of what is required. Appendix 5 (consultation document is a good start. It would be useful to know where the referral originated from i.e. colleague, employer etc. It would also be useful to see activity in the wider context of workforce size, for example appendix 5 states that 15 doctors and 80 nurses were subject of professional conduct committee proceedings in***

2007/8 it would be helpful to see this contextualised in terms of the workforce population i.e. 15 out of x number of doctors and 80 out of x number of nurses.

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

- **Yes**

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

- **The annual process is a little work intensive. Efficiencies could be gained by moving towards a two yearly practicing certificate and release efficiencies to deal with risks and competence reviews in a more timely manner.**
- **Recently, I did a credentialing check on a nurse and found that she had an APC that had a life of 15 months. I queried this with the Nursing Council to find that it is possible as she still had 3 months on her APC and she submitted an application for the next year. The problem was that this nurse had unresolved competency issues and so this quality check did not protect her new employer.**

- **Pharmacy**

Has a one year APC which is appropriate. Health issues are of concern with older pharmacists practising primarily due to shortages in the workplace.

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

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

Seems to be working well for pharmacy

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

- **See comments in 1 above**
- **There is a huge gap between the Registered Nurse scope and the nurse practitioner scope. Consideration needs to be given to developing scopes for nurses in advanced/specialist roles including education, research and management.**

Pharmacy:

Scope of practice needs to be more clearly defined for pharmacists working in specialised areas. The Pharmacy Council however is addressing this.

9. What, if any, comments do you have on the operation of the powers that registration authorities hold to allow conditions or authorisations on individuals' scopes of practice?
- **Individuals need to be registered with their professional organisation within their scope of practice and be subject to peer review within their scope. Authorities need to have powers to take action against those operating outside their scope of practice.**
 - **Concerns about how these conditions affect a small employer's ability to continue to deliver a full service when one of the employees is restricted. Larger organisations can absorb these restrictions but it is harder for primary care organisations to do so.**
 - **Professionals with conditional certificates who are not currently in the workforce will find it difficult to fund opportunities for themselves to work off the conditions.**
 - **Consideration should be given to having a 'workforce development risk fund' to allow individuals (un-employed) and small business employers to access and cover the out of pocket costs of assisting professionals back to full competence.**
10. Is the process for developing scopes of practice operating well (e.g., are there suitable mechanisms for ensuring scopes of practice reflect service need) and what, if any, changes would you recommend?
- **See comment 8 above. Also these have not been developed enough within various occupational groups.**
11. Do prescribed qualifications reflect scopes of practice? Please explain with reference to particular scopes of practice and considering whether a) the levels of qualification are too low or too high when considering their purpose of assuring public safety, and b) whether they meet the requirements of section 13.
- **There is huge debate as to whether the 3 year nursing degree and the 3 year midwifery degree reflects the scope of practise for these professions. The majority of nurses apply for the NetP programme suggesting that nurses are not work ready at the end of the 3 year programme. There is debate is around extending the training to 4 years for both professions to ensure the benefits of the first year of practice programme are incorporated...this however raises issues of cost, recruitment, clinical placement infrastructure etc.**
12. With regard to their purpose of assuring the competence of registered professionals, how well are the current recertification regimes working (where possible refer to particular professions)?

Medical and Nursing General Practice

- **Recertification programme can be passed by emphasising strengths. Weaknesses can be hidden or not recognised.**

Pharmacy

The above is also true. Pharmacy Council conducts random audits on pharmacists regarding their stated outcome competence measurements against their areas of activity. Each pharmacist is subject to an audit every three years.

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

Medical and Nursing General Practice and pharmacy

- **Need regular assessment (knowledge and practice based). Competency reviews should become part of regular assessment. This has issues of expense and having the workforce to do the work. It could however be focussed on professionals perceived at higher risk such as the older professional and the isolated professional with random audits for others.**
- **Nursing: we need to fund peer review/supervision opportunities within whole time equivalent hours to ensure that we have the workforce and capacity to engage in self and peer regulation.**

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

Medical General Practice

- **Compliance costs**
- **Nursing and pharmacy: as above comment 13.**

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

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

Gains would be a competent work force

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

Medical General Practice

- *Don't know.*

Pharmacy:

- *Authorities are not always made aware when a person is at risk either as to competence or health issues. Some improvements need to be made. However once a person has been reported to the Pharmacy Council the situation is well handled either by competency reviews or health update reports.*

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

Medical General Practice

- *PHOs must be added to lists for agencies – they have a contractual relationship with their providers. They also have a responsibility to their enrolled population.*
- *See comment to question 3*

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

Medical General Practice and pharmacy

- *See answer to 13 above.*
- *Nursing: Should be done in a timely manner. Currently it takes about 6 months to do a competence review.*

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

- *The 'may' and 'must' requirements are confusing. It should be every professional's duty to report up through the chain of management concerns about other professionals' ability to do their job safely. It should be a management/senior professional decision, following risk assessment to report or not. Unless professionals engage in self and peer regulation, some employers will have no idea as to what risks they are trying to manage.*
- *Based on experience, once professional reports, the regulating authority will follow up and request additional supportive evidence. This process can be quite burdensome for individuals and small business, as can the corrective action.*

- ***From experience, employers can find themselves between a rock (HPCA Act and hard place (Employment Legislation) when concerns about competence/fitness to practice arise. This is a particular risk for employers with a small workforce where a suspension may result in the total loss of a profession from the team and the cost of replacing the professional to ensure service access and continuation is a huge financial burden.***

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

- ***See comments above and to question 3.***

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

Medical General Practice

- ***Problem with suspending doctors from practice as for a majority of GPs, they are self employed, therefore no income. In large employer situations can be suspended on pay during the investigation.***
- ***In respect to nurses working in general practice, many practices only have one nurse. There is no contingency workforce and so to suspend the nurse would be a financial burden but also a burden in terms of delivering the service contract.***
- ***Work force issues also arise with pharmacy***

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

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

- ***Comments as for question 20***

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

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

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

Pharmacy

Yes I chair one. Used in dealing with complaints referred by the Complaints Assessment Committee, fraud, unbecoming professional conduct.

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

It has its palce

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

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

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

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

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

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

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

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

They appear to be working

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

Medical General Practice and pharmacy

- ***Elections yes...Lay majority.***
- ***Pharmacy: support lay members but not in majority. Mix for Pharmacy Council seems about right.***

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

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

The Pharmacy Council appears to be operating well and in unison with other registering organisations.

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

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

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

They seem appropriate

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

