Nursing & Midwifery Council
New South Wales

Protecting the public
Regulating nurses and midwives

Committee on the HCCC Inquiry into Cosmetic Health Service Complaints in NSW
Attention: Jessica Falvey
A/Committee Manager
Legislative Assembly Committees
Parliament of New South Wales

RE: Response to Committee on the HCCC Inquiry into Cosmetic Health Service Complaints in NSW – 2 August 2018

I am satisfied that the transcript is correct in relation to the information I have provided to the Committee and have no corrections to make.

I have attached the following documents that have been developed or endorsed by the Nursing and Midwifery Board of Australia (NMBA) as requested by the Inquiry Committee. These documents guide nurses in relation to their conduct, scope of practice, delegation and supervision requirements

Guidelines relevant to nurses working in the cosmetic industry

1. Position statement nurses and cosmetic procedures – July 2016 (modified March 2018)
2. Guidelines for Advertising Regulated Health Services – May 2014
3. Fact sheet - The Use of Health Practitioner Protected Titles
4. Fact sheet – Continuing Professional Development

Professional standards

4. Codes of Conduct for Nurses – effective 1 March 2018

5. Standards for Practice:
    a. Registered Nurses - effective 1 June 2016
    b. Enrolled Nurse - effective 1 January 2016
    c. Nurse Practitioner Standards - effective 1 January 2014

Decision making framework

6. National Framework for Decision Making Tools for Nursing and Midwifery Practice – developed by the Australian Nursing and Midwifery Council in 2007 and endorsed by the Nursing and Midwifery Board of Australia in 2010
    a. Nurses Practice Decisions Summary Guide
    b. Nurses Practice Decision Flow Chart

Example of nursing

7. NCAT decision for Piper vs HCCC : HCCC v Piper [2014] NSWCATOD 62 - AustLII

Scope of practice will depend on several factors: including knowledge, skills, qualifications registration type, registration status and endorsement, legal requirements, standards for

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practice, code of conduct, context of practice and organisational support. The principles for considering these are provided in the framework for decision making.

Joanne Muller
Legal Member of the Nursing and Midwifery Council

16 August 2018

Position statement

March 2018

Nurses and cosmetic procedures

Introduction

The National Registration and Accreditation Scheme (the National Scheme) for health practitioners in Australia commenced on 1 July 2010 under the *Health Practitioner Regulation National Law Act* (the National Law) as in force in each state and territory.

Under the National Law, the Nursing and Midwifery Board of Australia (NMBA) is responsible for the regulation of the nursing and midwifery professions and is supported in this role by the Australian Health Practitioner Regulation Agency (AHPRA).

The NMBA has approved registration standards, codes, guidelines and standards for practice that together form a Professional Practice Framework (PPF). The PPF determines the requirements and expectations which guide the professional practice of nurses and midwives in Australia.

NMBA position on nurses providing cosmetic procedures

The NMBA recognises that nurses obtain and develop qualifications and expertise through the course of their careers. It is an expectation that nurses are educated and competent in the specific area of practice required to meet the needs of their client group. Employers should be aware of the scope of practice of nurses they employ.

Nurses working in the area of cosmetic procedures are required to comply with the NMBA standards, codes and guidelines including but not limited to:

- Registered nurse standards for practice
- Code of conduct for nurses
- Guidelines for advertising regulated health services, and
- National framework for the development of decision-making tools for nursing and midwifery practice.

Nurses working in the area of cosmetic procedures are required to know and comply with relevant state and territory drugs and poisons legislation (however titled) regarding using, obtaining, selling, storing, prescribing, administering and supplying scheduled medicines.

Nurses need to ensure that they are also compliant with local policies, protocols and guidelines when undertaking cosmetic procedures.

Nurses working in the area of cosmetic procedures should be aware of the Medical Board of Australia's (MBA) *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures,* in effect from 1 October 2016. These guidelines establish the MBA's expectations of medical practitioners who perform cosmetic medical and surgical procedures. The guidelines can be found on the MBA website.

Document control

Approved by	Nursing and Midwifery Board of Australia
Date approved	July 2016
Date commenced	July 2016
Date modified	November 2016, March 2018

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

For advertisers including registered health practitioners

GUIDELINES FOR **ADVERTISING REGULATED HEALTH SERVICES**

May 2014

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About the National Boards and AHPRA

The 14 National Boards regulating registered health practitioners in Australia are responsible for registering practitioners and students (except for in psychology, which has provisional psychologists), setting the standards that practitioners must meet, and managing notifications (complaints) about the health, conduct or performance of practitioners.

The Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with the National Boards to implement the National Registration and Accreditation Scheme, under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The core role of the National Boards and AHPRA is to protect the public.

About these guidelines

These *Guidelines for advertising regulated health services* were jointly developed by the National Boards under section 39 of the National Law. The guidelines were developed to help practitioners and others understand their obligations when advertising a regulated health service.

All obligations outlined in this document are those required under the National Law unless stated otherwise.

ADVERTISING GUIDELINES

Contents

Preface

The National Law and these guidelines aim to protect the public.[1] The guidelines explain the limits placed on advertising regulated health services imposed by the National Law. They do not explain how to advertise. The wording of section 133 of the National Law is broad and it is not possible to provide an exhaustive list of advertising that will, or will not, contravene it.

Anyone advertising regulated health services, including individual health practitioners, must make sure that their advertisements comply with the National Law and other relevant legislation.

Neither AHPRA nor the National Boards are able to provide advertisers with legal advice about their advertising, or approve advertising, and these guidelines are not a substitute for legal advice.

Section 133 of the National Law regulates advertising of regulated health services. It states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that—*

   a) *is false, misleading or deceptive or is likely to be misleading or deceptive; or*

   b) *offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or*

   c) *uses testimonials or purported testimonials about the service or business; or*

   d) *creates an unreasonable expectation of beneficial treatment; or*

   e) *directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.*

   Maximum penalty—

   a) *in the case of an individual—$5,000; or*

   b) *in the case of a body corporate—$10,000.*

2. *A person does not commit an offence against subsection (1) merely because the person, as part of the person's business, prints or publishes an advertisement for another person.*

3. *In proceedings for an offence against this section, a court may have regard to a guideline approved by a National Board about the advertising of regulated health services.*

4. *In this section — **regulated health service** means a service provided by, or usually provided by, a health practitioner.*

1 What is the purpose of these guidelines?

These *Guidelines for advertising regulated health services* were jointly developed by the National Boards responsible for regulating registered health practitioners in Australia. They:

- explain and provide guidance on the obligations of advertisers (see definition in Appendix 1) under the National Law
- describe advertising that is prohibited
- comment on the use of factual information in advertising
- explain that advertisers of regulated health services (whether registered health practitioners or not) have responsibilities under other legislation administered by other regulators, and
- explain the consequences of a breach of the advertising provisions of the National Law.

These guidelines are not intended to stop members of the community and patients from discussing their experiences online or in person. The guidelines only apply when a regulated health service is being advertised.

1 Available from the AHPRA website at www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx

2 What are the principles underpinning these guidelines?

The following principles underpin these guidelines:

- advertising can be a useful way to communicate the services health practitioners offer to the public so that consumers can make informed choices
- advertising that contains false and misleading information may compromise health care choices and is not in the public interest
- the unnecessary and indiscriminate use of regulated health services is not in the public interest and may lead to the public purchasing or undergoing a regulated health service that they do not need or require.

3 Do these guidelines apply to me?

These guidelines apply to any person (see definition of 'advertiser' in Appendix 1) who advertises a regulated health service or a business that provides a regulated health service, including:

- registered health practitioners
- non-registered health practitioners
- individuals, and
- bodies corporate.

A court may consider these guidelines when hearing advertising offences against section 133 of the National Law.

4 What must I do?

All advertisers of regulated health services must comply with:

- the National Law, including:
  - the advertising requirements under section 133
  - title and practice protection provisions under sections 113–120, and
  - all other applicable legislation, such as the Australian Consumer Law.

4.1 Other laws regulating advertising

Advertising of regulated health services often involves the advertising of products and/or therapeutic goods and you must take care that you comply with all relevant legislation. Australian regulators such as the Australian Competition and Consumer Commission (ACCC) and the Therapeutic Goods Administration (TGA) have a responsibility for laws governing the advertising of health products and services. More information about this is included in Appendixes 2, 3 and 4.

If a complaint about an advertisement may be of interest to another Australian regulatory authority such as the TGA or ACCC, AHPRA may refer the matter to the most appropriate regulator.

4.2 Additional obligations for advertisers who are registered health practitioners

You should read these guidelines with other codes and guidelines published by the National Boards that convey their expected standards of professional conduct for each regulated profession. Each National Board has published a *Code of conduct for registered health practitioners,* or similar document. You have a professional responsibility to be familiar with, and apply, this code. It describes the professional standards expected of practitioners, including when advertising.

5 What happens if advertising breaches the National Law?

A breach of advertising requirements is a criminal offence. A court may impose a penalty up to $5,000 for an individual and $10,000 for a body corporate.

Complaints about possible breaches of the National Law and these guidelines should be reported to AHPRA. Information about how to do this is available on the AHPRA website.[2]

2 Go to www.ahpra.gov.au and follow the *Make a notification* link.

If you are a current or previously registered health practitioner, you may also be subject to disciplinary action under Part 8 of the National Law (which relates to health, performance and conduct) for unprofessional conduct (described as 'unsatisfactory professional conduct' in NSW) in relation to advertising. One of the grounds for a voluntary notification is that the health practitioner has, or may have, contravened the National Law (see section 144).

The options available to the Boards/AHPRA if advertising breaches the National Law are summarised at Appendix 7.

6 What are the advertising provisions of the National Law?

The wording of section 133 is broad and it is not possible to provide an exhaustive list of advertising that will, or will not, breach the National Law. However, this section provides general guidance on the advertising requirements of the National Law.

6.1 Use of factual information in advertising

Factual information in advertisements, as described below, may help health consumers to make informed choices.

You should ask yourself whether your advertising is verifiable and meets the requirements of the National Law.

Information commonly included in health services advertising[3]

- Office details
  - contact details
  - office hours, availability of after-hours services
  - accessibility (such as wheelchair access)
  - languages spoken (this does not affect other guidance provided by the National Board about use of qualified interpreters where appropriate)
  - emergency contact details
- Fees
  - a statement about fees charged (price information must be exact), bulk-billing arrangements, or other insurance plan arrangements and instalment fee plans regularly accepted
- Qualifications and experience
  - a statement of the names of schools and training programs from which the practitioner has graduated and the qualifications received, subject to the advice in Section 6.2 of these guidelines on advertising of qualifications and memberships
  - whether the practitioners have specialist registration or endorsement under the National Law and their area of specialty or endorsement
  - what positions, currently or in the past, the practitioners have held, together with relevant dates
  - whether the practitioner is accredited by a public board or agency, including any affiliations with hospitals or clinics
  - whether the practice is accredited and by whom
- For any surgical and/or invasive procedures, the appropriate warning statement in a clearly visible position[4]
- Photos or drawings of the practitioner or their office
- Any statement providing public health information that helps consumers to improve their health (this information should be based on reputable evidence wherever possible)

3 The list is not intended to be exhaustive.

4 Note that some National Boards may provide specific guidance on the use of warning statements for surgical and invasive procedures. See Appendix 6.

6.2 Prohibited advertising under the National Law

Section 133 of the National Law prohibits advertising that:

- is false, misleading or deceptive or is likely to be so
- offers a gift, discount or other inducement to attract a user of the health service without stating the terms and conditions of the offer
- uses testimonials or purported testimonials
- creates an unreasonable expectation of beneficial treatment, and/or
- encourages the indiscriminate or unnecessary use of health services.

The sections below explain each part of section 133.

6.2.1 Misleading or deceptive advertising

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    a) *Is false, misleading or deceptive or is likely to be misleading or deceptive*

A common meaning of 'mislead or deceive' is 'lead into error'. The courts have considered the phrase 'mislead or deceive'. People who are misled are almost by definition deceived as well. Misleading someone may include lying to them, leading them to a wrong conclusion, creating a false impression, leaving out (or hiding) important information, and/or making false or inaccurate claims.

As the ACCC explains, 'Patients can be physically, psychologically or financially affected by misleading conduct, and these effects can be long lasting. It is essential that patients be given honest, accurate and complete information in a form they can understand.'[5]

Examples of advertising that may be false or misleading include those that:

- mislead, either directly, or by implication, use of emphasis, comparison, contrast or omission
- only provide partial information which could be misleading
- use phrases like 'as low as' or 'lowest prices', or similar words or phrases when advertising fees for services, prices for products or price information in a way which is misleading or deceptive
- imply that the regulated health services can be a substitute for public health vaccination or immunisation
- use words, letters or titles that may mislead or deceive a health consumer into thinking that the provider of a regulated health service is more qualified or more competent than a holder of the same registration category (e.g. 'specialising in XX' when there is no specialist registration category for that profession)
- advertise the health benefits of a regulated health service when there is no proof that such benefits can be attained[6], and/or
- compare different regulated health professions or practitioners, in the same profession or across professions, in a way that may mislead or deceive.

Using comparative advertising often risks misleading and/or deceiving the public because it can be difficult to include complete information when comparing one health service with another.

The ACCC has provided tips on how to avoid being misleading and deceptive when advertising. They may be useful for advertisers considering the requirements of the National Law:

- *Sell your professional services on their merits.*
- *Be honest about what you say and do commercially.*
- *Look at the overall impression of your advertisement. Ask yourself who the audience is and what the advertisement is likely to say or mean to them.*

5 www.accc.gov.au/business/professional-services/medical-professionals

6 Australian Competition and Consumer Commission, *Misleading and deceptive conduct*, www.accc.gov.au/consumers/misleading-claims-advertising/false-or-misleading-claims

- *Remember, at a minimum, that it is the viewpoint of a layperson with little or no knowledge of the professional service you are selling that should be considered.*[7]

More information about the meaning of 'mislead or deceive' is available on the ACCC website.[8]

6.2.2 Gifts and discounts

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    b) *Offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer*

Any advertisement that offers gifts, prizes or free items must state the terms and conditions of the offer. The use of unclear, unreadable or misleading terms and conditions attached to gifts, discounts and other inducements would not meet this requirement.

Consumers generally consider the word 'free' to mean absolutely free. When the costs of a 'free offer' are recouped through a price rise elsewhere, the offer is not actually free.

An example is an advertisement which offers 'make one consultation appointment, get one free', but raises the price of the first consultation to largely cover the cost of the second (free) appointment. This type of advertising could also be misleading or deceptive.

The terms and conditions should be in plain English, readily understandable, accurate and not in themselves misleading about the conditions and limitations of the offered service.

Advertising may contravene the National Law when it:

- contains price information that is inexact
- contains price information that does not specify any terms and conditions or variables to an advertised price, or that could be considered misleading or deceptive
- states an instalment amount without stating the total cost (which is a condition of the offer), and/or
- does not state the terms and conditions of offers of gifts, discounts or other inducements.

6.2.3 Testimonials

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    c) *Uses testimonials or purported testimonials about the service or business*

The National Law does not define 'testimonial', so the word has its ordinary meaning of a positive statement about a person or thing. In the context of the National Law, a testimonial includes recommendations, or statements about the clinical aspects of a regulated health service.

The National Law ban on using testimonials means it is not acceptable to use testimonials in your own advertising, such as on your Facebook page, in a print, radio or television advertisement, or on your website. This means that:

1. you cannot use or quote testimonials on a site or in social media that is advertising a regulated health service, including patients posting comments about a practitioner on the practitioner's business website, and
2. you cannot use testimonials in advertising a regulated health service to promote a practitioner or service.

Health practitioners should therefore not encourage patients to leave testimonials on websites health practitioners control that advertise their own regulated health services, and should remove any testimonials that are posted there.

7 Australian Competition and Consumer Commission, *Professions and the Competition and Consumer Act, 2011*

8 www.accc.gov.au/business/advertising-promoting-your-business/false-or-misleading-claims

The National Law does not directly regulate social media. However, testimonials used in advertising a regulated health service through social media may contravene the National Law.

There are many opportunities for consumers or patients to express their views online that are not affected by the National Law restriction on testimonials in advertising. Patients can share views through their personal social media such as Facebook or Twitter accounts or on information sharing websites or other online mechanisms that do not involve using testimonials in advertising a regulated health service.

For example, consumer and patient information sharing websites that invite public feedback/reviews about experience of a regulated health practitioner, business and/or service are generally intended to help consumers make more informed decisions and are not considered advertising of a regulated health service.

To clarify, practitioners are not responsible for removing (or trying to have removed) unsolicited testimonials published on a website or in social media over which they do not have control.

6.2.4 Unreasonable expectation of beneficial treatment

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    d) *Creates an unreasonable expectation of beneficial treatment*

This can arise when advertisers take advantage of the vulnerability of health consumers in their search for a cure or remedy. The claims of beneficial treatment can range from unsubstantiated scientific claims, through to miracle cures. Advertising of treatments or services must not encourage or promote unreasonable expectations.

For example, advertising may contravene the National Law when it:

- creates an unreasonable expectation (such as by exaggerating or by providing incomplete or biased information) of recovery time after providing a regulated health service
- fails to disclose the health risks associated with a treatment
- omits the necessary warning statement about a surgical or invasive procedure[9]
- contains any inappropriate or unnecessary information or material that is likely to make a person believe their health or wellbeing may suffer from not taking or undertaking the health service, and/or
- contains a claim, statement or implication that is likely to create an unreasonable expectation of beneficial treatment by:
    - either expressly, or by omission, indicating that the treatment is infallible, unfailing, magical, miraculous or a certain, guaranteed or sure cure, and/or
    - a practitioner has an exclusive or unique skill or remedy, or that a product is 'exclusive' or contains a 'secret ingredient' that will benefit the patient.

6.2.5 Encouraging indiscriminate or unnecessary use of health services

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    e) *Directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services*

The unnecessary and indiscriminate use of regulated health services is not in the public interest and may lead to the public purchasing or undergoing a regulated health service that they do not need or require.

Advertising may contravene the National Law when it:

9 Note that some National Boards may provide specific guidance on the use of warning statements for surgical and invasive procedures. See Appendix 6.

- encourages a person to improve their physical appearance together with the use of phrases such as 'don't delay', 'achieve the look you want' and 'looking better and feeling more confident'
- provides a patient or client with an unsolicited appointment time
- uses prizes, bonuses, bulk purchases, bulk discounts or other endorsements to encourage the unnecessary consumption of health services that are unrelated to clinical need or therapeutic benefit
- uses promotional techniques that are likely to encourage consumers to use health services regardless of clinical need or therapeutic benefit, such as offers or discounts, online/internet deals, vouchers, and/or coupons, and/or
- makes use of time-limited offers which influence a consumer to make decisions under the pressure of time and money rather than about their health care needs. An offer is considered time-limited if it is made to purchase for a limited or specific period of time, or available for use within a limited period of time or by a specific date, without an option to exit the arrangement.

7 Further information about specific types of advertising

These guidelines cover all types of advertising, including social media, blogs and websites. The following sections discuss some aspects of advertising in more detail, to provide further guidance to practitioners.

7.1 Social media

Social media includes work-related and personal accounts on social networks such as Facebook, LinkedIn and Twitter.

A person is responsible for content on their social networking accounts even if they were not responsible for the initial posting of the information or testimonial. This is because a person responsible for a social networking account accepts responsibility for any comment published on it, once alerted to the comment. Practitioners advertising through social media should carefully review content regularly to make sure that all material complies with their obligations under the National Law.

These guidelines should be read in conjunction with the *Social media policy*, published on National Boards' websites.

7.2 Advertising qualifications or memberships

Advertising qualifications or memberships may be a useful way to provide the public with information about the experience and expertise of health practitioners. However, it may be misleading or deceptive if the advertisement implies that the practitioner has more skill or experience than is the case.

Including professional qualifications in an advertisement that also promotes the use or supply of therapeutic goods may be interpreted as a professional endorsement. Professional endorsements of therapeutic goods are prohibited under the *Therapeutic goods advertising code 2007*.

Patients or clients are best protected when advertisers promote practitioners' qualifications that are:

- approved for the purposes of registration, including specialist registration and endorsement of registration
- conferred by approved higher education providers[10], or
- conferred by an education provider that has been accredited by an accreditation authority.

A list of accreditation authorities and approved qualifications for each health profession is available on the relevant National Board's website.

10 Within the meaning of the *Higher Education Support Act 2003* (Cth).

Helpful questions to consider

Practitioners who are considering the use of titles, words or letters to identify and distinguish themselves in advertising, other than those professional titles protected under the National Law for their profession, are encouraged to ask themselves the following questions:

- Is it appropriate for me to use this title, qualification, membership, words or letters in advertising material?
- Am I skilled in the services I am advertising?
- If I display or promote my qualifications in advertising materials, is it easy to understand?
- Is there any risk of people being misled or deceived by the words, letters or titles that I use?
- Is the basis for my use of title, qualification, membership, or other words or letters:
  - relevant to my practice
  - current
  - verifiable, and
  - credible?

7.3 Use of titles in advertising

The National Law regulates the use of certain titles. Misuse of a protected title is an offence under the National Law. The misuse of titles in advertising may also contravene other sections of the National Law related to title protection (please refer to Appendix 5(a)). For specific guidance on use of titles in the psychology and physiotherapy professions, please refer to Appendix 5(b).

Advertisers should be aware of the protected titles for the profession that they are advertising.[11]

There is no provision in the National Law that prohibits a practitioner from using titles such as 'doctor' but there is potential to mislead or deceive if the title is not applied clearly. If practitioners choose to adopt the title 'Dr' in their advertising and they are not registered medical practitioners, then (whether or not they hold a Doctorate degree or PhD) they should clearly state their profession.

Advertisers should avoid developing abbreviations of protected titles as these may mislead the public (e.g. 'pod', 'psych', 'RN'). It may also be misleading to use symbols, words or descriptions associated with titles.

Clarity may be achieved by including a reference to the health profession whenever the title is used, such as:

- Dr Isobel Jones (Dentist), and
- Dr Walter Lin (Chiropractor).

7.4 Advertising specialties and endorsements

The National Law allows for and protects specialist titles and endorsements (an endorsement on a practitioner's registration indicates that the practitioner is qualified to engage, for example, in a wider scope of practice than other registrants).

A registered health practitioner who does not hold specialist registration may not use the title 'specialist', or through advertising or other means, present themselves to the public as holding specialist registration in a health profession.

The National Law prohibits claims of:

- holding a type of registration, including specialist registration, or endorsement of registration not held, and/or
- being qualified to hold an endorsement they do not hold.

While the National Law protects specific titles, use of some words (such as 'specialises in') may be misleading or deceptive as patients or clients can interpret the advertisements as implying that the practitioner is more skilled or has greater experience than is the case.

These words should be used with caution and need to be supported by fact. Words such as 'substantial experience in' or 'working primarily in' are less likely

11 Refer to the relevant National Board website for a list of the endorsements and recognised specialties for that profession.

to be misunderstood as a reference to endorsement or specialist registration.

A registered health practitioner who does not hold an endorsement may not, through advertising or other means, present themselves to the public as holding such an endorsement (such as using professional titles that are associated with an approved area of practice endorsement).

A list of health professions with approved specialties, endorsements, including endorsements for scheduled medicines and area of practice endorsements, is available on the websites of the relevant National Board. These websites also explain the titles that a registered health practitioner with an area of practice endorsement may use.

7.5 Advertising price information

Any information about the price of procedures in advertising of regulated health services must be clear and not misleading.

It is often difficult to provide an accurate price for a regulated health service in an advertisement due to the individual nature of services and the number of variables involved in the treatment. If fees and price information are to be advertised, then price information should be clear, with all costs involved and out of pocket expenses clearly identifiable, and any conditions or other variables to an advertised price or fee disclosed. This is to avoid misleading consumers and ensure they are fully informed and able to provide their full consent about health services.

Use of phrases like 'as low as' or 'lowest prices', or similar words, phrases or questions when advertising fees for services, prices for products or price information, or stating an instalment amount without stating the total cost may be misleading and could contravene the advertising provisions of the National Law.

7.6 Use of scientific information in advertising

To not mislead or create false impressions, caution should be taken when using scientific information in advertising.

When a practitioner chooses to include scientific information in advertising, the information should:

- be presented in a manner that is accurate, balanced and not misleading
- use terminology that is understood readily by the target audience
- identify clearly the relevant researchers, sponsors and the academic publication in which the results appear, and
- be from a reputable (e.g. peer reviewed) and verifiable source.

7.7 Advertising therapeutic goods

The Therapeutic Goods Administration (TGA) is responsible for regulating therapeutic goods including medicines, medical devices, biologicals, blood and blood products.

If the advertising only comprises pricing for prescription-only (Schedule 4 and 8) and certain pharmacist-only (Schedule 3 of the Poisons Standard) medicines, then the advertisement must comply with the *Therapeutic Goods Act 1989,* Therapeutic Goods Regulations 1990, the *Therapeutic goods advertising code 2007* and the *Price information code of practice*. A list of practitioners permitted to advertise price information for certain Schedule 3, Schedule 4 and Schedule 8 medicines is included in the *Price information code of practice*, available via the TGA website: www.tga.gov.au.

If the advertising promotes one or more therapeutic goods (under the *Therapeutic Goods Act 1989*), then the advertising must comply with the *Therapeutic Goods Act 1989*, Therapeutic Goods Regulations 1990, the *Therapeutic goods advertising code 2007* and, where relevant, the *Price information code of practice*.

Advertisers should note the definition of 'advertisement' in the *Therapeutic Goods Act 1989*.

See Appendix 4 for more information about advertising therapeutic goods.

8 Definitions

A list of definitions is included in Appendix 1.

Restrictions on advertising are included in other legislation. Advertisers should note that definitions in other legislation may be different to the definitions in these guidelines and should refer to the relevant definitions to ensure they comply with all relevant legislation.

Associated legislation and agencies are listed at Appendix 2.

9 Associated documents

These guidelines should be read in conjunction with codes and guidelines published by National Boards that describe the standards of professional practice expected by National Boards.

Review

Date of issue: 20 May 2014

Date of review: These guidelines will be reviewed from time to time as required. This will generally be at least every three years.

Appendix 1 Definitions

Advertiser

Any person or business that advertises a regulated health service.

Advertising

For the purpose of the guidelines, advertising includes but is not limited to all forms of printed and electronic media that promotes a regulated health service and includes any public communication using:

- television
- radio
- motion pictures
- newspapers
- billboards
- books
- public and professional lists
- pictorial representations
- designs
- mobile communications or other displays
- internet
- social media
- all electronic media that promote a regulated health service
- business cards, announcement cards
- office signs
- letterhead
- public and professional directory listings, and
- any other similar professional notice (e.g. patient recall notices).

Advertising also includes situations in which practitioners make themselves available or provide information for media reports, magazine articles or advertorials, including when practitioners make comment or provide information about particular products or services, or particular practitioners for the purposes of promoting or advertising a regulated health service.

This definition *excludes*:

- material issued to patients or clients during consultations when this material is designed to provide the person with clinical or technical information about health conditions or procedures, and when the person is given adequate opportunity to discuss and ask questions about the material. The information should not refer to services by the practitioner that could be interpreted as promoting that practitioner's services, as opposed to providing general information to the patient or client about a procedure or practice
- material issued by a person or organisation for the purpose of public health information, or as part of a public health program or to health promotion activities (e.g. free diabetes screening, which confer no promotional benefits on the practitioners involved)
- tenders, tender process, competitive business quotations and proposals, and the use of references about non-health services in those processes, provided the relevant material is not made available to the general public or used for promotional purposes (such as being published on a website), and
- comments made by a patient/consumer about a practice or a practitioner where –
    i. the comments are made on a social media site or account or patient/consumer information sharing site or account which is not used to advertise a regulated health service, and
    ii. that site or account is not owned, operated or controlled by the practice or practitioner referred to in the comments.

The definition of 'advertising' and 'advertisement' may be different in other legislation. These definitions should be taken into account when considering compliance with that legislation. In particular the definition of 'advertisement' in the *Therapeutic Goods Act 1989* should be noted.

AHPRA

AHPRA is the abbreviation for the Australian Health Practitioner Regulation Agency. AHPRA's operations are governed by the National Law (defined below), which came into effect on 1 July 2010. AHPRA supports the 14 National Boards that are responsible for regulating the health professions. The primary role of the National Boards is to protect the public and they set standards and policies that all registered health practitioners must meet.

Health practitioner

A health practitioner means an individual who practises a health profession.

Health service

A health service includes the following services, whether provided as public or private services:

1. services provided by registered health practitioners
2. hospital services
3. mental health services
4. pharmaceutical services
5. ambulance services
6. community health services
7. health education services
8. welfare services necessary to implement any services referred to in 1 to 7 above
9. services provided by dieticians, masseurs, naturopaths, social workers, speech pathologists, audiologists or audiometrists, and
10. pathology services.

Also refer to the definition of regulated health service.

Invasive procedure

For the purposes of these guidelines, invasive procedure means any operation or other procedure that:

1. penetrates or pierces the skin by any instrument other than a needle, other than minor dental or minor podiatric procedures, or
2. is an elective procedure requiring more than local anaesthetic or sedation, or
3. requires admission to a day procedure centre (DPC) or hospital, or
4. involves significant risk associated with surgical and/or anaesthetic complications.

National Board

National Board means a National Health Practitioner Board established by section 31 of the National Law.

National Law

The 'National Law' means the Health Practitioner Regulation National Law, as in force in each state and territory.

Person

A person includes an individual or a body politic or corporate.

Purported testimonial

A purported testimonial is a statement or representation that appears to be a testimonial.

Product

For the purpose of these guidelines, a 'product' is a therapeutic good within the meaning of the *Therapeutic Goods Act 1989* (Cth) and does not apply to the advertising of other products that are not associated with the provision of regulated health services.

Regulated health service

Means a service provided by, or usually provided by, a health practitioner (as defined in the National Law).

Social media

'Social media' describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips and includes websites and applications used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), WOMO, True Local and microblogs such as Twitter, content sharing websites such as YouTube and Instagram, and discussion forums and message boards.

Appendix 2
Associated legislation and agencies

Legislation	Responsible agency	Further information
Australian Consumer Law	Australian Competition and Consumer Commission (ACCC) and relevant state and territory consumer protection departments and agencies	www.accc.gov.au
• *Therapeutic Goods Act 1989* (Cth) • Therapeutic Goods Regulations 1990 • *Therapeutic goods advertising code 2007* • *Price information code of practice*	Department of Health–Therapeutic Goods Administration	www.tga.gov.au
Poisons Standard (Standard for the Uniform Scheduling of Medicines and Poisons)	Department of Health–Therapeutic Goods Administration	www.tga.gov.au

Legislation	Responsible agency	Further information
Drugs and poisons legislation	Agencies in each Australian state and territory	**Queensland**: Health (Drugs and Poisons) Regulation 1996, www.legislation.qld.gov.au/OQPChome.htm **New South Wales**: *Poisons and Therapeutic Goods Act 1966*, Poisons and Therapeutic Goods Regulation 2008, www.legislation.nsw.gov.au **Victoria:** *Drugs, Poisons and Controlled Substances Act 1981*, Drugs, Poisons and Controlled Substances Regulations 2006, www.legislation.vic.gov.au/ **Tasmania**: *Poisons Act 1971*, www.thelaw.tas.gov.au **ACT:** *Medicines, Poisons and Therapeutic Goods Act 2008*, Medicines, Poisons and Therapeutic Goods Regulation 2008, www.legislation.act.gov.au **South Australia:** *Controlled Substances Act 1984*, Controlled Substances (Poisons) Regulations 2011, www.legislation.sa.gov.au **Western Australia:** *Poisons Act 1964*, Poisons Regulations 1965 www.slp.wa.gov.au/legislation/statutes.nsf/default.html **Northern Territory:** *Poisons & Dangerous Drugs Act*, www.dcm.nt.gov.au/strong_service_delivery/supporting_government/current_northern_territory_legislation_database

Appendix 3
The Australian Consumer Law

In addition to complying with these guidelines, regulated health services need to comply with the Australian Consumer Law (ACL) which commenced on 1 January 2011. The ACL harmonised the consumer protection provisions in the *Trade Practices Act 1974* (TPA) and in state and territory fair trading laws, and replaced consumer protection provisions in at least 20 different Commonwealth, state and territory laws with one law.

The ACL is a national law that applies in the same way to all sectors and in all Australian jurisdictions. This means that all consumers in Australia enjoy the same rights and all businesses have the same obligations, irrespective of which state or territory they engaged in transactions.

The ACL covers general standards of business conduct, prohibits unfair trading practices, regulates specific types of business-to-consumer transactions, provides basic consumer guarantees for goods and services and regulates the safety of consumer products and product-related services.

The ACL is located in Schedule 2 of the *Competition and Consumer Act 2010* (Cth).

The ACL includes:

- a national unfair contract terms law covering standard form consumer contracts
- a national law guaranteeing consumer rights when buying goods and services
- a national product safety law and enforcement system
- a national law for unsolicited consumer agreements covering door-to-door sales and telephone sales
- simple national rules for lay-by agreements, and
- new penalties, enforcement powers and consumer redress options.

The ACL applies nationally and in all states and territories, and to all Australian businesses. For transactions that occurred before 1 January 2011, the previous national, state and territory consumer laws continue to apply.

The ACL is administered and enforced jointly by the Australian Competition and Consumer Commission and the state and territory consumer protection agencies, with the involvement of the Australian Securities and Investments Commission for financial services matters.

Advertisements must comply with all requirements of the ACL in addition to compliance with these guidelines.

Appendix 4
Advertising therapeutic goods

As stated, compliance with these guidelines does not exempt advertisements for regulated health services from the need to comply with other applicable laws. This includes legislation administered by the Therapeutic Goods Administration (TGA).

The TGA is part of the Australian Government Department of Health and Ageing, and is responsible for regulating therapeutic goods including medicines, medical devices, biological, blood and blood products.

Certain advertisements directed at consumers require approval before broadcast or publication.

The advertising of therapeutic goods to consumers and health practitioners is controlled respectively by statutory measures administered by the TGA and self-regulation through codes of practice administered by the relevant therapeutic goods industry associations. Certain advertisements directed to consumers require approval before being broadcast or published.

Advertisements for therapeutic goods in Australia are subject to the requirements of the *Therapeutic Goods Act 1989*, Therapeutic Goods Regulations 1990, the *Therapeutic goods advertising code* and the *Price information code of practice* (collectively the 'therapeutic goods legislation') and other relevant laws including the *Competition and Consumer Act 2010.*

Health practitioners should note the definition of 'advertisement' in the *Therapeutic Goods Act 1989* when considering their compliance with the therapeutic goods legislation. Implicit and explicit references to specific therapeutic products as well as more generic references may fall within the meaning of 'advertisement'.

In general, the advertising to the public of 'prescription medicines' (Schedule 4) or 'controlled drugs' (Schedule 8) and certain 'pharmacist-only medicines' (Schedule 3 of the Poisons Standard) is prohibited by the therapeutic goods legislation. Exceptions to this are set out in the therapeutic goods legislation.

The purpose of these requirements is to protect public health by promoting the safe use of therapeutic goods and ensuring that they are honestly promoted as to their benefits, uses and effects. Controls are placed on the advertising of therapeutic goods (medicines and medical devices) to ensure advertisements are socially responsible, truthful, appropriate and not misleading.

Further information on Australia's advertising regulation for therapeutic goods, including details of the Complaints Resolution Panel (TGACRP) and the Complaints register, may be obtained from the TGACC website and the TGACRP website.

This includes:

- advertising to consumers
- advertising prescription medications to health practitioners (including *Best practice guideline on prescription medicine labelling)*
- advertising medical services that include Schedule 4 (prescription) substances
- *Price information code of practice*, and
- the application and approval process for advertising of therapeutic goods.

Those intending to advertise therapeutic goods are advised to familiarise themselves with the requirements of the therapeutic goods legislation in addition to any requirements under the National Law and in these guidelines.

Appendix 5
Title protection

A5(a) Summary of relevant sections of the National Law

Sections 113–119 describe the title and practice protections under the National Law including the penalties for offences by individuals and bodies corporate.

Section 113 provides that a person cannot knowingly or recklessly take or use a protected title found in the table of that section or a prescribed title for a health profession which would induce a belief that the person is registered in that profession.

Section 115 provides that a person cannot knowingly or recklessly take or use the titles, 'dental specialist', 'medical specialist' or 'a specialist title for a recognised specialty' unless the person is registered under that specialty.

Section 116 provides that a person who is not a registered health practitioner must not knowingly or recklessly (i) take or use the title 'registered health practitioner' or claim to be so registered or (ii) take or use a title, name, initial, symbol, word or description to indicate the person is a health practitioner or claim to be a health practitioner or (iii) indicate the person is authorised or qualified to practise as a health practitioner.

Section 117 provides that a person must not knowingly or recklessly claim or hold him or herself out to be registered or qualified to practise in a health profession or a division of a health profession if the person is not so registered. Section 117 also provides that a person cannot use or take a title which would induce a belief that such a person is so registered.

Section 118 provides that a person who is not a specialist health practitioner must not knowingly or recklessly take or use the title 'specialist health practitioner'. Further a person must not use a title, name, symbol, word or description that would induce a belief that a person is or is authorised or qualified as a specialist health practitioner. Further the person must not claim or hold out to be registered in a recognised specialty or claim to be qualified to practise as a specialist health practitioner.

Section 119 provides that a person must not knowingly or recklessly make claims about a type of registration, endorsement, or registration in a recognised specialty, that the person does not have. Further, a person must not knowingly or recklessly make claims about another person having a type of registration, endorsement, or registration in a specialty that the person does not have. These are called 'holding out' provisions.

Note: *the above is a summary only – please consult the National Law for more detail.*

A5(b) Board-specific advice on the use of titles in advertising

Some Boards have developed statements to assist in the use of titles by the practitioners of the specific profession.

Psychology Board of Australia

The Psychology Board of Australia advises registered psychologists that use of the title 'doctor' in their practice has the potential to mislead members of the public.

Specifically, the use of tiles may be misleading into believing that the practitioner is a psychiatrist when they are not. Therefore, registered psychologists may not use such a title unless they hold a doctoral qualification from an approved higher education provider or an overseas institution with an equivalent accreditation status.

Where a registered psychologist holds a doctoral qualification that meets the above, if they advertise their services to the public, they should make it clear when using the title 'doctor' that they are not a registered medical practitioner or psychiatrist, for example:

- Dr Vanessa Singh (Psychologist), and
- Dr Ivan Hassam (Doctor of Psychology).

Physiotherapy Board of Australia

The Physiotherapy Board of Australia recognises the established history of specialised physiotherapy practice achieved through recognised higher education through the Australian College of Physiotherapy. As such the Board considers that appropriate use of qualifications in advertising is acceptable when accompanied by wording that establishes those credentials.

For example: 'Mr P Smith, Specialist Musculoskeletal Physiotherapist (as awarded by the Australian College of Physiotherapists in 2008)'.

Appendix 6
Use of graphic or visual representations and warning statements for surgical or invasive procedures

A6(a) Use of graphic or visual representations

If a practitioner chooses to use any graphic or visual representations in health service advertising (including photographs of patients, clients or models; diagram; cartoons; or other images), they should be used with caution.

If photographs of people are used in advertising of treatments, use of a real patient or client who has actually undergone the advertised treatment by the advertising practitioner or practice, and who has provided written consent for publication of the photograph in the circumstances in which the photograph is used, is less likely to be misleading.

Practitioners should not use photographs of actual patients or clients if the patient or client is vulnerable as a result of the type of treatment involved, or if their ability to consent may be otherwise impaired.

Use of 'before and after' photographs in advertising of regulated health services has a significant potential to be misleading or deceptive, to convey to a member of the public inappropriately high expectations of a successful outcome and to encourage the unnecessary use of health services.

Use of 'before and after' photographs is less likely to be misleading if:

- the images are as similar as possible in content, camera angle, background, framing and exposure
- there is consistency in posture, clothing and make-up
- there is consistency in lighting and contrast
- there is an explanation if photographs have been altered in any way, and
- the referenced procedure is the only visible change that has occurred for the person being photographed.

The guidelines do not limit use of stock photographs and models other than in relation to the advertising of particular treatments, provided that the provisions of the National Law and these guidelines are otherwise met. However, practitioners should exercise caution due to the potential to mislead consumers.

A6(b) Use of warning statements for surgical or invasive procedures

Where a surgical (or 'an invasive') procedure is advertised directly to the public, the advertisement should include a clearly visible warning, with text along the following lines:

'Any surgical or invasive procedure carries risks. Before proceeding, you should seek a second opinion from an appropriately qualified health practitioner.'

If the text of any warning label is in smaller print than the main text or placed in an obscure position of an advertisement, the advertisement may contravene the National Law.

Appendix 7
Options available to the National Boards/AHPRA if advertising breaches the National Law

Who breached the National Law or guidelines	Options available to the Boards/AHPRA
• Registered health practitioners • Persons who are not currently registered but who have previously been registered as health practitioners	• Prosecute under the advertising provisions of the National Law in the relevant state or territory magistrates court, which may lead to a financial penalty • Take action under the National Law for unprofessional conduct (described as 'unsatisfactory professional conduct' in NSW) • Take action under the title protection provisions of the National Law, as relevant • Refer the matter to another regulator for investigation of a potential breach of other legislation • A person (see definition in Appendix 1) may also be disciplined under the National Law as a result of action taken under other legislation. This can occur regardless of whether or not they are prosecuted under the National Law or any other legislation
• Persons who are not registered health practitioners • Bodies corporate	• Prosecute under the advertising provisions of the National Law in the relevant state or territory magistrates court, which may lead to a financial penalty • Take action under the National Law regarding the use of protected titles • Refer the matter to another regulator for investigation of a potential breach of other legislation

Nursing and Midwifery Board of Australia

Fact sheet

November 2016

The use of health practitioner protected titles

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public.

Title protections

The National Law has clear restrictions on the use of protected titles. These are addressed in sections 113, 116, 117, 119 and 120 of the National Law. Only people who have met the requirements of the National Law can use a protected title.

The protected titles that apply to nurses and midwives are:

- Nurse
- Registered nurse
- Enrolled nurse
- Nurse practitioner
- Midwife
- Midwife practitioner

It is an offence for anyone either knowingly or recklessly to use any of the protected titles to make another person believe that you are registered under the National Law unless you are registered in the profession.

To use these protected titles in contravention of this legislation is called ‘holding out’.

A contravention of these provisions this may be an offence under the National Law and they may be prosecuted in a court for the offence of holding out. Their actions may also constitute behaviours for which health, conduct or performance actions may be taken.

Likewise, any nurse or midwife who is registered with conditions must not knowingly or recklessly claim, or hold him or herself out to be registered without the conditions or any conditions. Employers cannot knowingly or recklessly use any of the protected titles to make another person believe their employees are registered under the National Law unless the employee is actually registered in the profession.

These requirements apply whether the title is used with or without any other words and whether in English or any other language.

Penalties apply to any contravention of this section of the National Law.

Registered nurses and midwives

Nurses and midwives who are registered under the National Law must not knowingly or recklessly claim to be registered in any division or other part of the register than they are.

A nurse or midwife is also not able to knowingly or recklessly claim to have completed qualifications leading to a change in their registration status unless they have actually done so.

The Australian Health Practitioner Regulation Agency (AHPRA), on behalf of the NMBA, assesses the validity and approval status of all qualifications when processing an application for registration. Over time,

the qualification needed to gain registration has changed. The qualification published on the national register is commonly the qualification that led to eligibility for registration at the time of initial registration.

Penalties for contravening the National Law on protected titles

Individuals can face fines of $30,000 and employers (or a body corporate) $60,000 if found guilty of an offence by the court.

If a registered health practitioner contravenes these provisions, their actions may also constitute behaviours for which health, conduct or performance actions may result.

How to check if someone is registered as a nurse and/or midwife

A national register for nursing and midwifery is published on the Australian Health Practitioner Regulation Agency (AHPRA) website.

Under the National Scheme, there is a register of nurses, and a separate register of midwives. On the register of nurses there are two divisions – registered nurses and enrolled nurses. You can search the register to find out someone's registration status and details.

AHPRA issues a certificate of registration to all registered health practitioners after they renew their registration each year. The certificate includes all the registration details reflecting the health practitioner's registration status at the time the certificate was issued. However, a search of the national register of practitioners ensures the most up to date verification of a health practitioner's registration status.

An application for registration has been lodged, when can I start calling myself a nurse or midwife?

You must wait for this application to be finalised and receive advice that you are registered before using any of the protected titles.

I am not currently practicing as a nurse or midwife. Can I maintain my registration?

You can apply for non-practising registration. This registration type only allows you to use the title 'nurse' or 'midwife' however does not allow you to practise as a nurse or midwife.

Find out more information about non-practising registration for nurses and midwives on the NMBA website.

Definitions

Practice

Practice is any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of the Board's standards, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

For more information

- Visit www.nursingmidwiferyboard.gov.au under *Contact us* to lodge an online enquiry form
- For registration enquiries: 1300 419 495 (in Australia) +61 3 8708 9001 (overseas callers)

Document control

Approved by	Nursing and Midwifery Board of Australia
Date approved	February 2014
Date commenced	February 2014
Date modified	March 2015, November 2016

Nursing and Midwifery Board of Australia

Fact sheet

November 2016

Continuing professional development

Introduction

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing standards, codes and guidelines for nurses and midwives in which they are required to practice.

The NMBA's Registration standard: Continuing professional development requires nurses and midwives to complete a minimum number of continuing professional development (CPD) hours directly relevant to a nurse or midwife's context of practice.

The following questions address common queries that you might have about the *Registration standard: Continuing professional development*.

What is CPD?

CPD is the means by which members of the professions maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities needed throughout their professional lives.

What do you mean by practice?

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession.

I am currently not working in the profession but I am still registered (because I am on maternity leave, travelling etc.). Do I still need to do CPD?

As a nurse or midwife you may choose not to work in the profession for a variety of reasons (such as maternity leave, extended overseas travel, moving overseas, an extended career break or retirement), however, you may want to keep registration.

Under these circumstances, you must continue to complete CPD in relation to your context of practice. See section below on 'How do I describe my context of practice'. Remember that 'context of practice' is not restricted to providing direct clinical care.

You may request to register as 'non-practising' – in this case you do not need to do CPD while you are on the non-practising register. For more information refer to the NMBA's Fact sheet: Non-practising registration for nurses and midwives.

How do I describe my context of practice?

Context of practice refers to the conditions that define an individual's nursing and/or midwifery practice. These include:

- the type of practice setting (e.g. clinical care, management, administration, education, research)
- the location of the practice setting (e.g. urban, rural, remote)
- the characteristics of patients (e.g. health status, age, learning needs)
- the focus of nursing and/or midwifery activities (e.g. health promotion, research, management)
- the degree to which practice is autonomous, and
- the resources that are available, including access to other healthcare professionals.

How do I record my CPD?

A template is provided in Appendix 1 which can be used to document your self-directed learning and CPD activities and reflections.

What sort of records will I need to produce?

If you are selected for audit you will need to complete an audit checklist that outlines the documents you need to show as evidence of completing your CPD.

CPD records may include participation in the following activities:

- tertiary, vocational and other accredited courses including distance education (should relate to context of practice)
- conferences, forums, seminars and symposia
- short courses, workshops, seminars and discussion groups through a professional group or organisation who may issue a certificate of compliance/completion
- mandatory learning activities in the workplace in the area of practice
- self-directed learning, and
- any other structured learning activities not covered above.

How many CPD hours do I need to complete?

Type of Registration	Minimum Hours	Total Hours
Registered nurse or Enrolled nurse	20 hours	20 hours
Midwife	20 hours	20 hours
Registered nurse and midwife	Registered nurse – 20 hours Midwife – 20 hours	40 hours
Enrolled nurse and midwife	Enrolled nurse – 20 hours Midwife – 20 hours	40 hours
Nurse practitioner	Registered nurse – 20 hours Nurse practitioner endorsement – 10 additional hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours

Type of Registration	Minimum Hours	Total Hours
Midwife practitioner	Midwife – 20 hours Midwife endorsement – 10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Registered nurse with scheduled medicines endorsement (Rural and remote)	Registered nurse – 20 hours Scheduled medicines endorsement –10 additional hours relating to obtaining, supplying and administration of scheduled medicines	30 hours
Midwife with scheduled medicines endorsement	Midwife – 20 hours Scheduled medicines endorsement –10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostics investigations, and consultation and referral	30 hours
Registered nurse and midwife with scheduled medicines endorsement	Registered nurse or enrolled nurse – 20 hours Midwife – 20 hours Scheduled medicines endorsement –10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostics investigations, consultation and referral	50 hours

I am registered as both a nurse and a midwife. Can I count relevant CPD activities towards the CPD hours for both professions?

If CPD activities are relevant to both nursing and midwifery professions, those activities may be counted as evidence for both nursing and midwifery CPD hours. The activities should be relevant to your context of practice and improve your knowledge, expertise and competence as a nurse and midwife.

How long do I need to keep a record of the evidence of my CPD, including 'self-directed learning'?

The NMBA recommends that you keep evidence of CPD, including self-directed learning, for a period of five years.

What form should my evidence of CPD (including self-directed learning) take?

Your documentation of the identified learning need, a learning plan, your participation in the learning activity, and the outcome achieved will form the evidence of CPD you may need to provide. References to the articles that you have read are needed for self-directed activities.

The table in Appendix 1 gives you an example of how to enter information about your CPD activities.

Will everyone be audited?

No. The NMBA has the discretion to select a random number of nurses and midwives to be audited at any time.

You will need to show evidence that you have completed the requirements and provide a copy of your CPD plan for the previous year (1 June – 31 May).

Several professional organisations offer CPD contribution in terms of points. How do I equate this to hours?

Nurses and midwives need to speak to the relevant professional organisation to confirm the hours-equivalent of CPD from points they have completed.

Can I claim my cardiopulmonary resuscitation (CPR) or fire training that I have to do at work as CPD activities?

Mandatory learning activities in the workplace may be counted as CPD provided that they are relevant to your context of practice and that they include new learning.

What if I don't meet my CPD quota?

At the time of renewal, you need to make a declaration about your CPD. You are able to apply to the NMBA for an exemption in exceptional circumstances if you feel that you have not met your minimum hours for CPD. If you declared that you do not meet met your quota for CPD you may be contacted to provide additional information. Following a review of the information you give, the matter may be referred to the NMBA for consideration.

How do I apply for an exemption?

The registration standard states that the NMBA reserves the right to grant exemptions in individual cases. Refer to the Policy: exemption from continuing professional development for nurses and midwives on the NMBA website.

For more information

- Registration standard: Continuing professional development
- Guidelines for continuing professional development
- Policy: Exemption from continuing professional development for nurses and midwives
- Audit information is available on the NMBA website
- Visit www.nursingmidwiferyboard.gov.au under *Contact us* to lodge an online enquiry form
- For registration enquiries: 1300 419 495 (in Australia) +61 3 9275 9009 (overseas callers)

Appendix 1 – Sample template for documenting CPD

Date	Source or provider details	Identified learning needs	Action plan	Type of activity	Description of topic (s) covered during activity and outcome	Reflection on activity and specification to practice	No./Title/ Description of evidence provided	CPD hours
17/5/15	NMBA	RN competency standard Practises in accordance with legislation affecting nursing practice and health care.	1.2 Clarify responsibility for aspects of care with other members of the health team. Unsure of my delegation responsibilities in the workplace. Plan: Access and review decision making framework	Self-directed learning. Review of decision making framework from the NMBA website: www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx	Reviewed my scope of practice and the scope of practice for my profession. Understood the principles I need to apply when making decisions about my nursing practice and when and how I decide to delegate activities to other registered nurses and enrolled nurses.	This activity has enabled me to achieve my learning need as per my learning plan. As a team leader working in intensive care I will be able to apply the Nursing decision making framework when I allocate staff to patient care and delegate tasks as they arise during a shift.	Refer to item 6	2 hours
23/5/15	Advanced Life Support in practice (XYZ provider)	N/A	N/A	Workshop	Advanced Life Support reaccreditation	This activity provided me with new theory and a practical competence assessment in relation to advanced life support. I will be able to apply this to patients in respiratory/cardiac arrest and when part of the medical emergency team.	Refer to item 7 Certificate of Attendance	3 hours
30/5/15	Obstetric emergency training (XYZ provider)	N/A	N/A	Workshop	Obstetric emergency reaccreditation	This activity provided me with new theory and a practical competence assessment in obstetric emergencies.	Refer to item 8	3 hours

Nursing and Midwifery Board of Australia

Code of conduct for nurses

Nursing and Midwifery Board of Australia
G.P.O. Box 9958 | Melbourne VIC 3001 | www.nursingmidwiferyboard.gov.au

Foreword

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing standards, codes and guidelines that together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

In developing the *Code of conduct for nurses,* and consistent with its commitment to evidence-based structures, systems and processes, the NMBA carried out a comprehensive review that was informed by research and by the profession. The research included an international and national literature review of other codes and similar publications, a comparative analysis of the predecessor code of conduct to other codes and an analysis of notifications (complaints) made about the conduct and behaviour of nurses. Input was extensively sought in the form of focus groups, workshops, an expert working group and other consultation strategies which included the profession, the public and professional organisations.

The *Code of conduct for nurses* (the code) sets out the legal requirements, professional behaviour and conduct expectations for nurses in all practice settings, in Australia. The code is written in recognition that nursing practice is not restricted to the provision of direct clinical care. Nursing practice settings extend to working in a non-clinical relationship with clients, working in management, leadership, governance, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills.

The code is supported by the NMBA Standards for practice and, with the other NMBA standards, codes and guidelines, underpins the requirements and delivery of safe, kind and compassionate nursing practice.

Associate Professor Lynette Cusack, RN

Chair
Nursing and Midwifery Board of Australia

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Introduction

The *Code of conduct for nurses* sets out the legal requirements, professional behaviour and conduct expectations for all nurses, in all practice settings, in Australia. It describes the principles of professional behaviour that guide safe practice, and clearly outlines the conduct expected of nurses by their colleagues and the broader community.

Individual nurses have their own personal beliefs and values. However, the code outlines specific standards which all nurses are expected to adopt in their practice. The code also gives students of nursing an appreciation of the conduct and behaviours expected of nurses. Nurses have a professional responsibility to understand and abide by the code. In practice, nurses also have a duty to make the interests of people their first concern, and to practise safely and effectively.

The code is consistent with the National Law. It includes seven principles of conduct, grouped into domains, each with an explanatory value statement. Each value statement is accompanied by practical guidance to demonstrate how to apply it in practice. Underpinning the code is the expectation that nurses will exercise their professional judgement to deliver the best possible outcomes in practice.

This code applies to all nurses

The principles of the code apply to all types of nursing practice in all contexts. This includes any work where a nurse uses nursing skills and knowledge, whether paid or unpaid, clinical or non-clinical. This includes work in the areas of clinical care, clinical leadership, clinical governance responsibilities, education, research, administration, management, advisory roles, regulation or policy development. The code also applies to all settings where a nurse may engage in these activities, including face-to-face, publications, or via online or electronic means.

Using the code of conduct

The code will be used:

- to support individual nurses in the delivery of safe practice and fulfilling their professional roles
- as a guide for the public and consumers of health services about the standard of conduct and behaviour they should expect from nurses
- to help the NMBA protect the public, in setting and maintaining the standards set out in the code and to ensure safe and effective nursing practice
- when evaluating the professional conduct of nurses. If professional conduct varies significantly from the values outlined in the code, nurses should be prepared to explain and justify their decisions and actions. Serious or repeated failure to abide by this code may have consequences for nurses' registration and may be considered as unsatisfactory professional performance, unprofessional conduct or professional misconduct[1], and
- as a resource for activities which aim to enhance the culture of professionalism in the Australian health system. These include use, for example, in administration and policy development by health services and other institutions; in nursing education, in management and for the orientation, induction and supervision of nurses and students.

The code is not a substitute for requirements outlined in the National Law, other relevant legislation, or case law. Where there is any actual or perceived conflict between the code and any law, the law takes precedence. Nurses also need to understand and comply with all other NMBA standards, codes and guidelines.

[1] As defined in the National Law, with the exception of NSW where the definitions of unsatisfactory professional conduct and professional misconduct are defined in the Health Practitioner Regulation National Law (NSW)

Code of conduct for nurses: domains, principles and values

These domains, principles and values set out legal requirements, professional behaviour and conduct expectations for all nurses. The principles apply to all areas of practice, with an understanding that nurses will exercise professional judgement in applying them, with the goal of delivering the best possible outcomes.

(To note: **Person or people is** used to refer to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. See the glossary for further detail).

Domain: Practise legally

1. **Legal compliance**
   Nurses respect and adhere to their professional obligations under the National Law, and abide by relevant laws.

Domain: Practise safely, effectively and collaboratively

2. **Person-centred practice**
   Nurses provide safe, person-centred and evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals.

3. **Cultural practice and respectful relationships**
   Nurses engage with people as individuals in a culturally safe and respectful way, foster open and honest professional relationships, and adhere to their obligations about privacy and confidentiality.

Domain: Act with professional integrity

4. **Professional behaviour**
   Nurses embody integrity, honesty, respect and compassion.

5. **Teaching, supervising and assessing**
   Nurses commit to teaching, supervising and assessing students and other nurses, in order to develop the nursing workforce across all contexts of practice.

6. **Research in health**
   Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of people who participate in research.

Domain: Promote health and wellbeing

7. **Health and wellbeing**
   Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality.

Domain: Practise legally

Principle 1: Legal compliance

Value
Nurses respect and adhere to professional obligations under the National Law, and abide by relevant laws[2].

1.1 Obligations

It is important that nurses are aware of their obligations under the National Law, including reporting requirements and meeting registration standards. Nurses must

a. abide by any reporting obligations under the National Law and other relevant legislation. Please refer to sections 129, 130, 131 and 141 of the National Law and the NMBA Guidelines for mandatory notifications

b. inform the Australian Health Practitioner Regulation Agency (AHPRA) and their employer(s) if a legal or regulatory entity has imposed restrictions on their practice, including limitations, conditions, undertakings, suspension, cautions or reprimands, and recognise that a breach of any restriction would place the public at risk and may constitute unprofessional conduct or professional misconduct

c. complete the required amount of CPD relevant to their context of practice. See the NMBA Registration standard: Continuing professional development, Policy: Exemptions from continuing professional development for nurses and midwives and Fact sheet: Continuing professional development for these requirements

d. ensure their practice is appropriately covered by professional indemnity insurance (see the NMBA Registration standard: Professional indemnity insurance arrangements and Fact sheet: Professional indemnity insurance arrangements), and

e. inform AHPRA of charges, pleas and convictions relating to criminal offences (see the NMBA Registration standard: Criminal history).

1.2 Lawful behaviour

Nurses practise honestly and ethically and should not engage in unlawful behaviour as it may affect their practice and/or damage the reputation of the profession. Nurses must

a. respect the nurse-person professional relationship by not taking possessions and/or property that belong to the person and/or their family

b. comply with relevant poisons legislation, authorisation, local policy and own scope of practice, including to safely use, administer, obtain, possess, prescribe, sell, supply and store medications and other therapeutic products

c. not participate in unlawful behaviour and understand that unlawful behaviour may be viewed as unprofessional conduct or professional misconduct and have implications for their registration, and

[2] The code does not address in detail the full range of legal and ethical obligations that apply to nurses. Examples of legal obligations include, but are not limited to, obligations arising in Acts and Regulations relating to privacy, the aged and disabled, child protection, bullying, anti-discrimination and workplace health and safety issues. Nurses should ensure they know all of their legal obligations relating to professional practice, and abide by them.

d. understand that making frivolous or vexatious complaints may be viewed as unprofessional conduct or professional misconduct and have implications for their registration.

1.3 Mandatory reporting

Caring for those who are vulnerable brings legislative responsibilities for nurses, including the need to abide by relevant mandatory reporting requirements as they apply across individual states and territories. Nurses must:

a. abide by the relevant mandatory reporting legislation that is imposed to protect groups that are particularly at risk, including reporting obligations about the aged, child abuse and neglect and remaining alert to the newborn and infants who may be at risk, and

b. remain alert to other groups who may be vulnerable and at risk of physical harm and sexual exploitation and act on welfare concerns where appropriate.

Domain: Practise safely, effectively and collaboratively

Principle 2: Person-centred practice

Value
Nurses provide safe, person-centred, evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals.

2.1 Nursing practice

Nurses apply person-centred and evidence-based decision-making, and have a responsibility to ensure the delivery of safe and quality care. Nurses must:

a. practise in accordance with the standards of the profession and broader health system (including the NMBA standards, codes and guidelines, the Australian Commission on Safety and Quality in Health Care and Standards for aged care)

b. provide leadership to ensure the delivery of safe and quality care and understand their professional responsibility to protect people, ensuring employees comply with their obligations, and

c. document and report concerns if they believe the practice environment is compromising the health and safety of people receiving care.

2.2 Decision-making

Making decisions about healthcare is the shared responsibility of the person (who may wish to involve their nominated partners, family and friends) the nurse and other health professionals. Nurses should create and foster conditions that promote shared decision-making and collaborative practice. To support shared decision-making, nurses must:

a. take a person-centred approach to managing a person's care and concerns, supporting the person in a manner consistent with that person's values and preferences

b. advocate on behalf of the person where necessary, and recognise when substitute decision-makers are needed (including legal guardians or holders of power of attorney)

c. support the right of people to seek second and/or subsequent opinions or the right to refuse treatment/care

d. recognise that care may be provided to the same person by different nurses, and by other members of the healthcare team, at various times

e. recognise and work within their scope of practice which is determined by their education, training, authorisation, competence, qualifications and experience, in accordance with local policy (see also the NMBA Decision-making framework)

f. recognise when an activity is not within their scope of practice and refer people to another health practitioner when this is in the best interests of the person receiving care

g. take reasonable steps to ensure any person to whom a nurse delegates, refers, or hands over care has the qualifications, experience, knowledge, skills and scope of practice to provide the care needed (see also the NMBA Decision-making framework), and

h. recognise that their context of practice can influence decision-making. This includes the type and location of practice setting, the characteristics of the person receiving care, the focus of nursing activities, the degree to which practice is autonomous and the resources available.

2.3 Informed consent

Informed consent is a person's voluntary agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved. In supporting the right to informed consent, nurses must:

a. support the provision of information to the person about their care in a way and/or in a language/dialect they can understand, through the utilisation of translating and interpreting services, when necessary. This includes information on examinations and investigations, as well as treatments

b. give the person adequate time to ask questions, make decisions and to refuse care, interventions, investigations and treatments, and proceed in accordance with the person's choice, considering local policy

c. act according to the person's capacity for decision-making and consent, including when caring for children and young people, based on their maturity and capacity to understand, and the nature of the proposed care

d. obtain informed consent or other valid authority before carrying out an examination or investigation, provide treatment (this may not be possible in an emergency), or involving people in teaching or research, and

e. inform people of the benefit, as well as associated costs or risks, if referring the person for further assessment, investigations or treatments, which they may want to clarify before proceeding.

2.4 Adverse events and open disclosure

When a person is harmed by healthcare (adverse events), nurses have responsibilities to be open and honest in communicating with the person, to review what happened, and to report the event in a timely manner, and in accordance with local policy. When something goes wrong, nurses must:

a. recognise and reflect on what happened and report the incident

b. act immediately to rectify the problem if possible, and intervene directly if it is needed to protect the person's safety. This responsibility includes escalating concerns if needed

c. abide by the principles of open disclosure and non-punitive approaches to incident management

d. identify the most appropriate healthcare team member to provide an apology and an explanation to the person, as promptly and completely as possible, that supports open disclosure principles

e. listen to the person, acknowledge any distress they experienced and provide support. In some cases it may be advisable to refer the person to another nurse or health professional

f. ensure people have access to information about how to make a complaint, and that in doing so, not allow a complaint or notification to negatively affect the care they provide, and

g. seek advice from their employer, AHPRA, their professional indemnity insurer, or other relevant bodies, if they are unsure about their obligations.

   See also the Australian Commission on Safety and Quality in Health Care's Australian Open Disclosure Framework.

Principle 3: Cultural practice and respectful relationships

Value
Nurses engage with people as individuals in a culturally safe and respectful way, foster open, honest and compassionate professional relationships, and adhere to their obligations about privacy and confidentiality.

3.1 Aboriginal and/or Torres Strait Islander peoples' health

Australia has always been a culturally and linguistically diverse nation. Aboriginal and/or Torres Strait Islander peoples have inhabited and cared for the land as the first peoples of Australia for millennia, and their histories and cultures have uniquely shaped our nation. Understanding and acknowledging historic factors such as colonisation and its impact on Aboriginal and/or Torres Strait Islander peoples' health helps inform care. In particular, Aboriginal and/or Torres Strait Islander peoples bear the burden of gross social, cultural and health inequality. In supporting the health of Aboriginal and/or Torres Strait Islander peoples, nurses must:

a. provide care that is holistic, free of bias and racism, challenges belief based upon assumption and is culturally safe and respectful for Aboriginal and/or Torres Strait Islander peoples

b. advocate for and act to facilitate access to quality and culturally safe health services for Aboriginal and/or Torres Strait Islander peoples, and

c. recognise the importance of family, community, partnership and collaboration in the healthcare decision-making of Aboriginal and/or Torres Strait Islander peoples, for both prevention strategies and care delivery.

   See the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

   See also Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

3.2 Culturally safe and respectful practice

Culturally safe and respectful practice requires having knowledge of how a nurse's own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. To ensure culturally safe and respectful practice, nurses must:

a. understand that only the person and/or their family can determine whether or not care is culturally safe and respectful

b. respect diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among team members

c. acknowledge the social, economic, cultural, historic and behavioural factors influencing health, both at the individual, community and population levels

d. adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs)

e. support an inclusive environment for the safety and security of the individual person and their family and/or significant others, and

f. create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues.

3.3 Effective communication

Positive professional relationships are built on effective communication that is respectful, kind, compassionate and honest. To communicate effectively, nurses must:

a. be aware of health literacy issues, and take health literacy into account when communicating with people

b. make arrangements, whenever possible, to meet the specific language, cultural, and communication needs of people and their families, through the utilisation of translating and interpreting services where necessary, and be aware of how these needs affect understanding

c. endeavour to confirm a person understands any information communicated to them

d. clearly and accurately communicate relevant and timely information about the person to colleagues, within the bounds of relevant privacy requirements, and

e. be non-judgemental and not refer to people in a non-professional manner verbally or in correspondence/records, including refraining from behaviour that may be interpreted as bullying or harassment and/or culturally unsafe.

3.4 Bullying and harassment

When people repeatedly and intentionally use words or actions against someone or a group of people, it causes distress and risks their wellbeing. Nurses understand that bullying and harassment relating to their practice or workplace is not acceptable or tolerated and that where it is affecting public safety it may have implications for their registration. Nurses must:

a. never engage in, ignore or excuse such behaviour

b. recognise that bullying and harassment takes many forms, including behaviours such as physical and verbal abuse, racism, discrimination, violence, aggression, humiliation, pressure in decision-making, exclusion and intimidation directed towards people or colleagues

c. understand social media is sometimes used as a mechanism to bully or harass, and that nurses should not engage in, ignore or excuse such behaviour

d. act to eliminate bullying and harassment, in all its forms, in the workplace, and

e. escalate their concerns if an appropriate response does not occur.

For additional guidance see the Australian Human Rights Commission Fact sheet

See also Nurse & Midwife Support, the national health support service for nurses, midwives and students

3.5 Confidentiality and privacy

Nurses have ethical and legal obligations to protect the privacy of people. People have a right to expect that nurses will hold information about them in confidence, unless the release of information is needed by law, legally justifiable under public interest considerations or is required to facilitate emergency care. To protect privacy and confidentiality, nurses must:

a. respect the confidentiality and privacy of people by seeking informed consent before disclosing information, including formally documenting such consent where possible

b. provide surroundings to enable private and confidential consultations and discussions, particularly when working with multiple people at the same time, or in a shared space

c. abide by the NMBA Social media policy and relevant Standards for practice, to ensure use of social media is consistent with the nurse's ethical and legal obligations to protect privacy

d. access records only when professionally involved in the care of the person and authorised to do so

e. not transmit, share, reproduce or post any person's information or images, even if the person is not directly named or identified, without having first gained written and informed consent. See also the NMBA Social media policy and Guidelines for advertising regulated health services

f. recognise people's right to access information contained in their health records, facilitate that access and promptly facilitate the transfer of health information when requested by people, in accordance with local policy, and

g. when closing or relocating a practice, facilitating arrangements for the transfer or management of all health records in accordance with the legislation governing privacy and health records.

3.6 End-of-life care

Nurses have a vital role in helping the community to deal with the reality of death and its consequences. In providing culturally appropriate end-of-life care, nurses must:

a. understand the limits of healthcare in prolonging life, and recognise when efforts to prolong life may not be in the best interest of the person

b. accept that the person has the right to refuse treatment, or to request withdrawal of treatment, while ensuring the person receives relief from distress

c. respect diverse cultural practices and beliefs related to death and dying

d. facilitate advance care planning and provision of end-of-life care where relevant and in accordance with local policy and legislation, and

e. take reasonable steps to ensure support is provided to people, and their families, even when it is not possible to deliver the outcome they desire.

See also the Australian Commission on Safety and Quality in Health Care - End-of-Life Care

Domain: Act with professional integrity

Principle 4: Professional behaviour

Value
Nurses embody integrity, honesty, respect and compassion.

4.1 Professional boundaries

Professional boundaries allow nurses, the person and the person's nominated partners, family and friends, to engage safely and effectively in professional relationships, including where care involves personal and/or intimate contact. In order to maintain professional boundaries, there is a start and end point to the professional relationship and it is integral to the nurse-person professional relationship. Adhering to professional boundaries promotes person-centred practice and protects both parties. To maintain professional boundaries, nurses must:

a. recognise the inherent power imbalance that exists between nurses, people in their care and significant others and establish and maintain professional boundaries

b. actively manage the person's expectations, and be clear about professional boundaries that must exist in professional relationships for objectivity in care and prepare the person for when the episode of care ends

c. avoid the potential conflicts, risks, and complexities of providing care to those with whom they have a pre-existing non-professional relationship and ensure that such relationships do not impair their judgement. This is especially relevant for those living and working in small, regional or cultural communities and/or where there is long-term professional, social and/or family engagement

d. avoid sexual relationships with persons with whom they have currently or had previously entered into a professional relationship. These relationships are inappropriate in most circumstances and could be considered unprofessional conduct or professional misconduct

e. recognise when over-involvement has occurred, and disclose this concern to an appropriate person, whether this is the person involved or a colleague

f. reflect on the circumstances surrounding any occurrence of over-involvement, document and report it, and engage in management to rectify or manage the situation

g. in cases where the professional relationship has become compromised or ineffective and ongoing care is needed, facilitate arrangements for the continuing care of the person to another health practitioner, including passing on relevant clinical information (see also 3.3 Effective communication)

h. actively address indifference, omission, disengagement/lack of care and disrespect to people that may reflect under-involvement, including escalating the issue to ensure the safety of the person if necessary

i. avoid expressing personal beliefs to people in ways that exploit the person's vulnerability, are likely to cause them unnecessary distress, or may negatively influence their autonomy in decision-making (see the NMBA Standards for practice), and

j. not participate in physical assault such as striking, unauthorised restraining and/or applying unnecessary force.

4.2 Advertising and professional representation

Nurses must be honest and transparent when describing their education, qualifications, previous occupations and registration status. This includes, but is not limited to, when nurses are involved in job applications, self-promotion, publishing of documents or web content, public appearances, or advertising or promoting goods or services. To honestly represent products and regulated health services, and themselves, nurses must:

a. comply with legal requirements about advertising outlined in the National Law (explained in the NMBA Guidelines for advertising regulated health services), as well as other relevant Australian state and territory legislation

b. provide only accurate, honest and verifiable information about their registration, experience and qualifications, including any conditions that apply to their registration (see also Principle 1: *Legal compliance*)

c. only use the title of nurse if they hold valid registration and/or endorsement (see also the NMBA Fact sheet: The use of health practitioner protected titles), and

d. never misrepresent, by either a false statement or an omission, their registration, experience, qualifications or position.

4.3 Legal, insurance and other assessments

Nurses may be contracted by a third party to provide an assessment of a person who is not in their care, such as for legal, insurance or other administrative purposes. When this occurs the usual nurse-person professional relationship does not exist. In this situation, nurses must:

a. explain to the person their professional area of practice, role, and the purpose, nature and extent of the assessment to be performed

b. anticipate and seek to correct any misunderstandings the person may have about the nature and purpose of the assessment and report, and

c. inform the person and/or their referring health professional of any unrecognised, serious problems that are discovered during the assessment, as a matter of duty-of-care.

4.4 Conflicts of interest

People rely on the independence and trustworthiness of nurses who provide them with advice or treatment. In nursing practice, a conflict of interest arises when a nurse has financial, professional or personal interests or relationships and/or personal beliefs that may affect the care they provide or result in personal gain.

Such conflicts may mean the nurse does not prioritise the interests of a person as they should, and may be viewed as unprofessional conduct. To prevent conflicts of interest from compromising care, nurses must:

a. act with integrity and in the best interests of people when making referrals, and when providing or arranging treatment or care

b. responsibly use their right to not provide, or participate directly in, treatments to which they have a conscientious objection. In such a situation, nurses must respectfully inform the person, their employer and other relevant colleagues, of their objection and ensure the person has alternative care options

c. proactively and openly inform the person if a nurse, or their immediate family, has a financial or commercial interest that could be perceived as influencing the care they provide

d. not offer financial, material or other rewards (inducements) to encourage others to act in ways that personally benefit the nurse, nor do anything that could be perceived as providing inducements, and

e. not allow any financial or commercial interest in any entity providing healthcare services or products to negatively affect the way people are treated.

4.5 Financial arrangements and gifts

It is necessary to be honest and transparent with people. To ensure there is no perception of actual or personal gain for the nurse, nurses must:

a. when providing or recommending services, discuss with the person all fees and charges expected to result from a course of treatment in a manner appropriate to the professional relationship, and not exploit people's vulnerability or lack of knowledge

b. only accept token gifts of minimal value that are freely offered and report the gifts in accordance with local policy

c. not accept, encourage or manipulate people to give, lend, or bequeath money or gifts that will benefit a nurse directly or indirectly

d. not become financially involved with a person who has or who will be in receipt of their care, for example through bequests, powers of attorney, loans and investment schemes, and

e. not influence people or their families to make donations, and where people seek to make a donation refer to the local policy.

Principle 5: Teaching, supervising and assessing

Value
Nurses commit to teaching, supervising and assessing students and other nurses in order to develop the nursing workforce across all contexts of practice.

5.1 Teaching and supervising

It is the responsibility of all nurses to create opportunities for nursing students and nurses under supervision to learn, as well as benefit from oversight and feedback. In their teaching and supervisor roles, nurses must:

a. seek to develop the skills, attitudes and practices of an effective teacher and/or supervisor

b. reflect on the ability, competence and learning needs of each student or nurse who they teach or supervise and plan teaching and supervision activities accordingly, and

c. avoid, where possible, any potential conflicts of interest in teaching or supervision relationships that may impair objectivity or interfere with the supervised person's learning outcomes or experience. This includes, for example, not supervising somebody with whom they have a pre-existing non-professional relationship.

5.2 Assessing colleagues and students

Assessing colleagues and students is an important part of making sure that the highest standard of practice is achieved across the profession. In assessing the competence and performance of colleagues or students, nurses must:

a. be honest, objective, fair, without bias and constructive, and not put people at risk of harm by inaccurate and inadequate assessment, and

b. provide accurate and justifiable information promptly, and include all relevant information when giving references or writing reports about colleagues.

See also the NMBA Supervision guidelines for nursing and midwifery.

Principle 6: Research in health

Value
Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of people who participate in research.

6.1 Rights and responsibilities

Nurses involved in design, organisation, conduct or reporting of health research have additional responsibilities. Nurses involved in research must:

a. recognise and carry out the responsibilities associated with involvement in health research

b. in research that involves human participants, respect the decision-making of people to not participate and/or to withdraw from a study, ensuring their decision does not compromise their care or any nurse-person professional relationship(s), and

c. be aware of the values and ethical considerations for Aboriginal and/or Torres Strait Islander communities when undertaking research.

See also the National Health and Medical Research Council publication: Values and Ethics - Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research

See also Principle 2 on the application of evidence-based decision-making for delivery of safe and quality care.

Domain: Promote health and wellbeing

Principle 7: Health and wellbeing

Value
Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality.

7.1 Your and your colleagues' health

Nurses have a responsibility to maintain their physical and mental health to practise safely and effectively. To promote health for nursing practice, nurses must:

a. understand and promote the principles of public health, such as health promotion activities and vaccination

b. act to reduce the effect of fatigue and stress on their health, and on their ability to provide safe care

c. encourage and support colleagues to seek help if they are concerned that their colleague's health may be affecting their ability to practise safely, utilising services such as the national health support service for nurses, midwives and students

d. seek expert, independent and objective help and advice, if they are ill or impaired in their ability to practise safely. Nurses must remain aware of the risks of self-diagnosis and self-treatment, and act to reduce these, and

e. take action, including a mandatory or voluntary notification to AHPRA, if a nurse knows or reasonably suspects that they or a colleague have a health condition or impairment that could adversely affect their ability to practise safely, or put people at risk (see Principle 1: Legal compliance).

7.2 Health advocacy

There are significant disparities in the health status of various groups in the Australian community. These disparities result from social, historic, geographic, environmental, legal, physiological and other factors. Some groups who experience health disparities include Aboriginal and/or Torres Strait Islander peoples, those with disabilities, those who are gender or sexuality diverse, and those from social, culturally and linguistically diverse backgrounds, including asylum seekers and refugees. In advocating for community and population health, nurses must:

a. use their expertise and influence to protect and advance the health and wellbeing of individuals as well as communities and populations

b. understand and apply the principles of primary and public health, including health education, health promotion, disease prevention, control and health screening using the best available evidence in making practice decisions, and

c. participate in efforts to promote the health of communities and meet their obligations with respect to disease prevention including vaccination, health screening and reporting notifiable diseases.

See also the NMBA Position statement on nurses, midwives and vaccination

Glossary

These meanings relate to the use of terms in the C*ode of conduct for nurses.*

Advance care planning is an on-going process of shared planning for current and future healthcare. It allows an individual to make known their values, beliefs and preferences to guide decision-making, even after when the individual cannot make or communicate their preferences and decisions (See Advance Care Planning Australia).

Bullying and harassment is 'when people repeatedly and intentionally use words or actions against someone or a group of people to cause distress and risk to their wellbeing. These actions are usually done by people who have more influence or power over someone else, or who want to make someone else feel less powerful or helpless'.[3]

Competence is the possession of required skills, knowledge, education and capacity.

Cultural safety concept was developed in a First Nations' context and is the preferred term for nursing and midwifery. Cultural safety is endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the "presence or absence of cultural safety is determined by the recipient of care; it is not defined by the caregiver" (CATSINaM, 2014, p. 9[4]). Cultural safety is a philosophy of practice that is about how a health professional does something, not [just] what they do. It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM, 2017b, p. 11[5]). In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues (CATSINaM, 2017a[6]).

Delegation is the relationship that exists when a nurse devolves aspects of nursing practice to another person. Delegations are made to meet the person's health needs. The nurse who is delegating retains accountability for the decision to delegate. The nurse is also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the competence and risks. For further details see the NMBA National framework for the development of decision-making tools for nursing and midwifery practice.

Discrimination is the unjust treatment of one or more person/s based on factors such as race, religion, sex, disability or other grounds specified in anti-discrimination legislation.[7]

Handover is the process of transferring all responsibility for the care of one or more people to another health practitioner or person.

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[3] Australian Human Rights Commission, '*What is bullying*?' https://www.humanrights.gov.au/what-bullying-violence-harassment-and-bullying-fact-sheet

[4] CATSINaM, 2014, *Towards a shared understanding of terms and concepts: strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander peoples*, CATSINaM, Canberra.

[5] CATSINaM, 2017b, *The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (Version 1.0)*, CATSINaM, Canberra.

[6] CATSINaM, 2017a, *Position statement: Embedding cultural safety across Australian nursing and midwifery*, CATSINaM, Canberra.

[7] Australian Human Rights Commission, '*Discrimination'* www.humanrights.gov.au/quick-guide/12030

Health literacy 'is about how people understand information about health and healthcare, how they apply that information to their lives, use it to make decisions and act on it'.[8]

Local policy refers to the policies that apply to decision-making, relevant to the specific location and/or organisation where practice is being undertaken.

Mandatory notification is the requirement under the National Law for registered health practitioners, employers and education providers to report certain conduct (see Guidelines for mandatory notifications).

Mandatory reporting is a state and territory legislative requirement imposed to protect at risk groups such as the aged, children and young people.

National law means the Health Practitioner Regulation National Law that is in force in each state and territory in Australia and applies to those professions regulated under that law (see Australian Health Practitioner Regulation Agency).

Nominated partners, family and friends include people in consensual relationships with the person, as identified by the person receiving care.

Nurse refers to a registered nurse, enrolled nurse or nurse practitioner. The term is reserved in Australia, under law, for a person who has completed the prescribed training, demonstrates competence to practise, and is registered as a nurse under the National Law.

Open disclosure 'is an open and honest discussion with a person about any incident(s) that caused them harm while they were receiving healthcare. It includes an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to describe their experience, and an explanation of the steps being taken to manage the event and prevent recurrence'[9] (Australian Commission on Safety and Quality in Health Care).

Over-involvement is when the nurse confuses their needs with the needs of the person in their care and crosses the boundary of a professional relationship. Behaviour may include favouritism, gifts, intimacy or inappropriate relationships with the partner or family member of a person in the nurse's care.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the nurse's scope and context of practice.

Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a nurse. Practice is not restricted to the provision of direct clinical care. It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Professional boundaries allow a nurse and a person to engage safely and effectively in a therapeutic and/or professional relationship. Professional boundaries refers to the clear separation that should exist between professional conduct aimed at meeting the health needs of people, and behaviour which serves a nurse's own personal views, feelings and relationships that are not relevant to the professional relationship.

[8] Australian Commission on Safety and Quality in Health Care, *Health literacy:* https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy/

[9] Australian Commission on Safety and Quality in Health Care, *Australian Open Disclosure Framework:* https://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf

Professional misconduct includes conduct by a health practitioner that is substantially below the expected standard, and which, whether connected to practice or not, is inconsistent with being a fit and proper person to be registered in the profession.

Professional relationship is an ongoing interaction that observes a set of established boundaries or limits deemed appropriate under governing standards. The nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills with respect, compassion and kindness. In the relationship, the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power.

Referral involves a nurse sending a person to obtain an opinion or treatment from another health professional or entity. Referral usually involves the transfer (all or in part) of responsibility for the care of the person, usually for a defined time and for a particular purpose, such as care that is outside the referring practitioner's expertise or scope of practice.

Social media describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips. It includes websites and applications used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), WOMO, True Local, microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards.

Substitute decision-maker is a general term for a person who is either a legally appointed decision-maker for a person, or has been nominated to make healthcare decisions on behalf of a person whose decision-making capacity is impaired.

Supervision includes managerial supervision, professional supervision and clinically focused supervision as part of delegation. For details see the NMBA Supervision guidelines for nursing and midwifery.

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power.

Unprofessional conduct includes conduct of a lesser standard that might reasonably be expected by the public or professional peers.

Bibliography

The Australian Commission on Safety and Quality in Health Care website www.safetyandquality.gov.au provides relevant guidance on a range of safety and quality issues. Information of particular relevance to nurses includes:

- end-of-life care
- hand hygiene
- healthcare rights
- health literacy
- medication administration, and
- open disclosure and incident management

The Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with the NMBA to regulate nurses and midwives in Australia.

The Australian Human Rights Commission also provides resources that promote and protect human rights. Resources on workplace bullying include a fact sheet and a 'get help' section at https://www.humanrights.gov.au

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) website (http://catsinam.org.au/) 'promotes, supports and advocates for Aboriginal and Torres Strait Islander nurses and midwives and to close the gap in health for Aboriginal and Torres Strait Islander peoples'.

The National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 provides an evidence-based framework for a coordinated approach to improving Aboriginal and/or Torres Strait Islander people's health. For additional information go to www.health.gov.au/NATSIHP.

The National Health and Medical Research Council website www.nhmrc.gov.au provides relevant information on informed consent and research issues.

The national Nurse & Midwife Support service provides 24 hour access to health support anywhere in Australia.

The Therapeutic Goods Administration website www.tga.gov.au provides relevant information on therapeutic goods.

Registered nurse standards for practice

Effective date 1 June 2016

Introduction

Registered nurse (RN) practice is person-centred and evidence-based with preventative, curative, formative, supportive, restorative and palliative elements. RNs work in therapeutic and professional relationships with individuals, as well as with families, groups and communities. These people may be healthy and with a range of abilities, or have health issues related to physical or mental illness and/or health challenges. These challenges may be posed by physical, psychiatric, developmental and/or intellectual disabilities.

The Australian community has a rich mixture of cultural and linguistic diversity, and the *Registered nurse standards for practice* are to be read in this context. RNs recognise the importance of history and culture to health and wellbeing. This practice reflects particular understanding of the impact of colonisation on the cultural, social and spiritual lives of Aboriginal and Torres Strait Islander peoples, which has contributed to significant health inequity in Australia.

As regulated health professionals, RNs are responsible and accountable to the Nursing and Midwifery Board of Australia (NMBA). These are the national *Registered nurse standards for practice* for all RNs. Together with NMBA standards, codes and guidelines, these *Registered nurse standards for practice* should be evident in current practice, and inform the development of the scopes of practice and aspirations of RNs.

RN practice, as a professional endeavour, requires continuous thinking and analysis in the context of thoughtful development and maintenance of constructive relationships. To engage in this work, RNs need to continue to develop professionally and maintain their capability for professional practice. RNs determine, coordinate and provide safe, quality nursing. This practice includes comprehensive assessment, development of a plan, implementation and evaluation of outcomes. As part of practice, RNs are responsible and accountable for supervision and the delegation of nursing activity to enrolled nurses (ENs) and others.

Practice is not restricted to the provision of direct clinical care. Nursing practice extends to any paid or unpaid role where the nurse uses their nursing skills and knowledge. This practice includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills. RNs are responsible for autonomous practice within dynamic systems, and in relationships with other health care professionals.

How to use these standards

The *Registered nurse standards for practice* consist of the following seven standards:

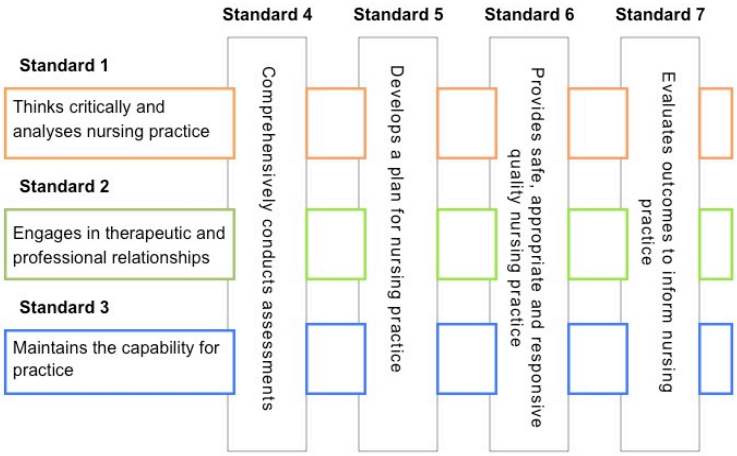
1. Thinks critically and analyses nursing practice.
2. Engages in therapeutic and professional relationships.
3. Maintains the capability for practice.
4. Comprehensively conducts assessments.
5. Develops a plan for nursing practice.

6. Provides safe, appropriate and responsive quality nursing practice.

7. Evaluates outcomes to inform nursing practice.

The above standards are all interconnected (see Figure 1). Standards one, two and three relate to each other, as well as to each dimension of practice in standards four, five, six and seven.

Figure 1: Registered nurse standards



Each standard has criteria that specify how that standard is demonstrated. The criteria are to be interpreted in the context of each RN's practice. For example, all RNs will, at various times, work in partnerships and delegate responsibilities, however not every RN will delegate clinical practice to enrolled nurses. The criteria are not exhaustive and enable rather than limit the development of individual registered nurse scopes of practice.

The *Registered nurse standards for practice* are for all RNs across all areas of practice. They are to be read in conjunction with the applicable NMBA standards, codes and guidelines, including the *Code of conduct for nurses*, *National framework for the development of decision-making tools for nursing and midwifery practice, Supervision guidelines for nursing and midwifery*, and *Guidelines for mandatory notifications*. The glossary is also important for understanding how key terms are used in these standards.

Registered nurse standards for practice

Standard 1: Thinks critically and analyses nursing practice

RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.

The registered nurse:

1.1 accesses, analyses, and uses the best available evidence, that includes research findings, for safe, quality practice

1.2 develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice

1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures

1.4 complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions

1.5 uses ethical frameworks when making decisions

1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations, and

1.7 contributes to quality improvement and relevant research.

Standard 2: Engages in therapeutic and professional relationships

RN practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships.

The registered nurse:

2.1 establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships

2.2 communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights

2.3 recognises that people are the experts in the experience of their life

2.4 provides support and directs people to resources to optimise health-related decisions

2.5 advocates on behalf of people in a manner that respects the person's autonomy and legal capacity

2.6 uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes

2.7 actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care

2.8 participates in and/or leads collaborative practice, and

2.9 reports notifiable conduct of health professionals, health workers and others.

Standard 3: Maintains the capability for practice

RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe, and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals' capability for practice. RNs are responsible for their professional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health.

The registered nurse:

3.1 considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice

3.2 provides the information and education required to enhance people's control over health

3.3 uses a lifelong learning approach for continuing professional development of self and others

3.4 accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role, and for the actions of others to whom they have delegated responsibilities

3.5 seeks and responds to practice review and feedback

3.6 actively engages with the profession, and

3.7 identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people.

Standard 4: Comprehensively conducts assessments

RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice.

The registered nurse:

4.1 conducts assessments that are holistic as well as culturally appropriate

4.2 uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice

4.3 works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/ or for referral, and

4.4 assesses the resources available to inform planning.

Standard 5: Develops a plan for nursing practice

RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the RNs appraisal of comprehensive, relevant information, and evidence that is documented and communicated.

The registered nurse:

5.1 uses assessment data and best available evidence to develop a plan

5.2 collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and timeframes are agreed with the relevant persons

5.3 documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes

5.4 plans and negotiates how practice will be evaluated and the time frame of engagement, and

5.5 coordinates resources effectively and efficiently for planned actions.

Standard 6: Provides safe, appropriate and responsive quality nursing practice

RNs provide and may delegate, quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment, and the best available evidence to achieve planned and agreed outcomes.

The registered nurse:

6.1 provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people

6.2 practises within their scope of practice

6.3 appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse's scope of practice or others' clinical or non-clinical roles

6.4 provides effective timely direction and supervision to ensure that delegated practice is safe and correct

6.5 practises in accordance with relevant policies, guidelines, standards, regulations and legislation, and

6.6 uses the appropriate processes to identify and report potential and actual risk related system issues and where practice may be below the expected standards.

Standard 7: Evaluates outcomes to inform nursing practice

RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly.

The registered nurse:

7.1 evaluates and monitors progress towards the expected goals and outcomes

7.2 revises the plan based on the evaluation, and

7.3 determines, documents and communicates further priorities, goals and outcomes with the relevant persons.

Glossary

These definitions relate to the use of terms in the *Registered nurse standards for practice*.

Accountability means that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated. The registered nurse who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated (Nursing and Midwifery Board of Australia 2013). See below for the related definition of 'Delegation'.

Criteria in this document means the actions and behaviours of the RN that demonstrate these standards for practice.

Delegation is the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a person who is not a nurse. Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service. The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment. For further details see the NMBA's National framework for the development of decision-making tools for nursing and midwifery practice (2013).

Enrolled nurse is a person who provides nursing care under the direct or indirect supervision of a registered nurse. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse for the delegated care.

Evidence-based practice is accessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings into practice.

Person or people is used in these standards to refer to those individuals who have entered into a therapeutic and/or professional relationship with a registered nurse. These individuals will sometimes be health care consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities that are within the registered nurse scope and context of practice. The registered nurse has professional relationships in health care related teams.

Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Registered nurse is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia.

Scope of practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

Standards for practice in this document are the expectations of registered nurse practice. They inform the education standards for registered nurses, the regulation of nurses and determination of the nurse's capability for practice, and guide consumers, employers and other stakeholders on what to reasonably expect from a registered nurse regardless of the area of nursing practice or years of nursing experience. They replace the previous *National competency standards for the registered nurse* (2010).

Supervision includes managerial supervision, professional supervision and clinically focused supervision. For further details see the NMBA's, Supervision guidelines for nursing and midwifery (2015).

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the NMBA's Code of conduct for nurses.

References

Nursing and Midwifery Board of Australia (2010) ‘A nurse’s guide to professional boundaries’. Retrieved 05 January 2015, www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

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Enrolled nurse standards for practice

1 January 2016

Introduction

The *Enrolled nurse standards for practice* are the core practice standards that provide the framework for assessing enrolled nurse (EN) practice. They communicate to the general public the standards that can be expected from ENs and can be used in a number of ways including:

- development of nursing curricula by education providers
- assessment of students and new graduates
- to assess nurses educated overseas seeking to work in Australia, and
- to assess ENs returning to work after breaks in service.

In addition, they may also be used by the Nursing and Midwifery Board of Australia (NMBA) and relevant tribunals or courts to assess professional conduct or matters relating to notifications.

The *Enrolled nurse standards for practice* replace the *National competency standards for the enrolled nurse* (2002).

These contemporary standards reflect the role of the EN within the health environment. The standards for practice remain broad and principle-based so that they are sufficiently dynamic for practising nurses to use as a benchmark to assess competence to practise in a range of settings.

The EN works with the registered nurse (RN) as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice generally requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the EN to have a named and accessible RN at all times and in all contexts of care for support and guidance is critical to patient safety.

Although the scope of practice for each EN will vary according to context and education, the EN has a responsibility for ongoing self and professional development to maintain their knowledge base through life-long learning, and continue to demonstrate the types of core nursing activities that an EN would be expected to undertake on entry to practice. Therefore the core standards in this document are the *minimum* standards that are applicable across diverse practice settings and health care populations for both beginning and experienced ENs. They are based on the Diploma of Nursing being the education standard.

ENs engage in analytical thinking; use information and/or evidence; and skilfully and empathetically communicate with all involved in the provision of care, including the person receiving care and their family and community, and health professional colleagues.

The EN standards are clinically focused and they reflect the ENs capability to:

- provide direct and indirect care
- engage in reflective and analytical practice, and
- demonstrate professional and collaborative practice. ENs, where appropriate, educate and support other (unregulated) health care workers (however titled) related to the provision of care.

ENs collaborate and consult with health care recipients, their families and community as well as RNs and other health professionals, to plan, implement and evaluate integrated care that optimises outcomes for recipients and the systems of care. They are responsible for the delegated care they provide and self-monitor their work.

How to use these standards

The EN standards for practice are intended to be easily accessible to a variety of groups, including ENs, governments, regulatory agencies, educators, health care professionals and the community. It should be noted that the 'indicators' (refer to glossary) written below the statements are indicative of EN behaviours, they are not intended to be exhaustive. Rather, they are examples of activities that demonstrate the specific standard.

The standards should be read in conjunction with the following relevant documentation, including, but not limited to:

- Decision-making framework (NMBA 2013),
- Nursing practice decisions summary guide (NMBA 2010),
- Nursing practice decision flowchart (NMBA 2013), and
- Code of conduct for nurses (NMBA 2017),

They should also be read in conjunction with the attached glossary, which describes the way in which key terms are used in the standards.

There are three domains, namely:

- professional and collaborative practice
- provision of care, and
- reflective and analytical practice.

The indicators are expressed through knowledge (capabilities)[1], skills[2], and attitudes[3] inherent within these clinically focused domains. All are variable according to the context of practice.

[1] *Knowledge (capabilities)* refers to information and the understanding of that information to guide practice.

[2] *Skills* refers to technical procedures and competencies

[3] *Attitudes* refers to ways for thinking and behaving

Domains

Professional and collaborative practice

The professional and collaborative practice domain relates to the legal, ethical and professional foundations from which all competent ENs respond to their environment. The domain reflects the responsibilities of the EN to maintain currency and to demonstrate best practice. The standards are:

- functions in accordance with the law, policies and procedures affecting EN practice
- practises nursing in a way that ensures the rights, confidentiality, dignity and respect of people are upheld, and
- accepts accountability and responsibility for own actions.

Provision of care

The provision of care domain relates to the intrinsic care of individuals or groups entrusted to the EN. It encompasses all aspects of care from assessment to engaging in care, and includes health education and evaluation of outcomes. The standards are:

- interprets information from a range of sources in order to contribute to planning appropriate care
- collaborates with the RN, the person receiving care and the healthcare team when developing plans of care
- provides skilled and timely care to people receiving care and others whilst promoting their independence and involvement in care decision–making, and
- communicates and uses documentation to inform and report care.

Reflective and analytical practice

The reflective and analytical practice domain relates to the ability of the EN to reflect on evidence-based practice and ensure currency of essential knowledge and skills, to care for the personal, physical and psychological needs of themselves and others. The standards are:

- provides nursing care that is informed by research evidence
- practises within safety and quality improvement guidelines and standards, and
- engages in ongoing development of self as a professional.

Professional and collaborative practice

Standard 1: Functions in accordance with the law, policies and procedures affecting EN practice

Indicators:

1.1. Demonstrates knowledge and understanding of commonwealth, state and /or territory legislation and common law pertinent to nursing practice.
1.2. Fulfils the duty of care in the undertaking of EN practice.
1.3. Demonstrates knowledge of and implications for the NMBA standards, codes and guidelines, workplace policies and procedural guidelines applicable to enrolled nursing practice.
1.4. Provides nursing care according to the agreed plan of care, professional standards, workplace policies and procedural guidelines.
1.5. Identifies and clarifies EN responsibilities for aspects of delegated care working in collaboration with the RN and multidisciplinary health care team.
1.6. Recognises own limitations in practice and competence and seeks guidance from the RN and help as necessary.
1.7. Refrains from undertaking activities where competence has not been demonstrated and appropriate education, training and experience has not been undertaken.
1.8. Acts to ensure safe outcomes for others by recognising the need to protect people and reporting the risk of potential for harm.
1.9. When incidents of unsafe practice occur, reports immediately to the RN and other persons in authority and, where appropriate, explores ways to prevent recurrence.
1.10. Liaises and negotiates with the RN and other appropriate personnel to ensure that needs and rights of people in receipt of care are addressed and upheld.

Standard 2: Practises nursing in a way that ensures the rights, confidentiality, dignity and respect of people are upheld.

Indicators:

2.1. Places the people receiving care at the centre of care and supports them to make informed choices.
2.2. Practises in accordance with the NMBA standards codes and guidelines.
2.3. Demonstrates respect for others to whom care is provided regardless of ethnicity, culture, religion, age, gender, sexual preference, physical or mental state, differing values and beliefs.
2.4. Practises culturally safe care for (i) Aboriginal and Torres Strait Islander peoples; and (ii) people from all other cultures.
2.5. Forms therapeutic relationships with people receiving care and others recognising professional boundaries.
2.6. Maintains equitable care when addressing people's differing values and beliefs.
2.7. Ensures privacy, dignity and confidentiality when providing care.
2.8. Clarifies with the RN and relevant members of the multi-disciplinary healthcare team when interventions or treatments appear unclear or inappropriate.

2.9. Reports incidents of unethical behaviour immediately to the person in authority and, where appropriate, explores ways to prevent recurrence.

2.10. Acknowledges and accommodates, wherever possible, preferences of people receiving nursing care.

Standard 3: Accepts accountability and responsibility for own actions.

Indicators:

3.1. Practises within the EN scope of practice relevant to the context of practice, legislation, own educational preparation and experience.

3.2. Demonstrates responsibility and accountability for nursing care provided.

3.3. Recognises the RN[4] as the person responsible to assist EN decision-making and provision of nursing care.

3.4. Collaborates with the RN to ensure delegated responsibilities are commensurate with own scope of practice.

3.5. Clarifies own role and responsibilities with supervising RN in the context of the healthcare setting within which they practice.

3.6. Consults with the RN and other members of the multidisciplinary healthcare team to facilitate the provision of accurate information, and enable informed decisions by others.

3.7. Provides care within scope of practice as part of multidisciplinary healthcare team, and with supervision of a RN.

3.8. Provides support and supervision to assistants in nursing (however titled) and to others providing care, such as EN students, to ensure care is provided as outlined within the plan of care and according to institutional policies, protocols and guidelines.

3.9. Promotes the safety of self and others in all aspects of nursing practice.

Provision of care

Standard 4: Interprets information from a range of sources in order to contribute to planning appropriate care

Indicators:

4.1. Uses a range of skills and data gathering techniques including observation, interview, physical examination and measurement.

4.2. Accurately collects, interprets, utilises, monitors and reports information regarding the health and functional status of people receiving care to achieve identified health and care outcomes.

4.3. Develops, monitors and maintains a plan of care in collaboration with the RN, multidisciplinary team and others.

4.4. Uses health care technology appropriately according to workplace guidelines.

[4] Where an enrolled nurse is working in maternity services setting it is expected that they will be supervised by a midwife.

Standard 5: Collaborates with the RN, the person receiving care and the healthcare team when developing plans of care

Indicators:

5.1. Develops and promotes positive professional working relationships with members of the multi-disciplinary team.

5.2. Collaborates with members of the multi-disciplinary healthcare team in the provision of nursing care.

5.3. Contributes to the development of care plans in conjunction with the multidisciplinary healthcare team, the person receiving care and appropriate others[5].

5.4. Manages and prioritises workload in accordance with people's care plans.

5.5. Clarifies orders for nursing care with the RN when unclear.

5.6. Contributes to and collaborates in decision-making through participation in multidisciplinary healthcare team meetings and case conferences.

Standard 6: Provides skilled and timely care to people whilst promoting their independence and involvement in care decision–making

Indicators:

6.1. Provides care to people who are unable to meet their own physical and/or mental health needs.

6.2. Participates with the RN in evaluation of the person's progress toward expected outcomes and the reformulation of plans of care.

6.3. Promotes active engagement and the independence of people receiving care within the health care setting by involving them as active participants in care, where appropriate.

6.4. Demonstrates currency and competency in the safe use of healthcare technology.

6.5. Exercises time management and workload prioritisation.

6.6. Recognises when the physical or mental health of a person receiving care is deteriorating, reports, documents and seeks appropriate assistance.

Standard 7: Communicates and uses documentation to inform and report care

Indicators:

7.1. Collects data, reviews and documents the health and functional status of the person receiving care accurately and clearly.

7.2. Interprets and reports the health and functional status of people receiving care to the RN and appropriate members of the multidisciplinary healthcare team as soon as practicable.

7.3. Uses a variety of communication methods to engage appropriately with others and documents accordingly.

7.4. Prepares and delivers written and verbal care reports such as clinical handover, as a part of the multidisciplinary healthcare team.

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[5] Appropriate others include those in direct association with the person receiving care (with his/her consent) such as family, unpaid and paid carers, volunteers and clergy.

7.5. Provides accurate and appropriate information to enable informed decision making by others.

Reflective and analytical practice

Standard 8: Provides nursing care that is informed by research evidence

Indicators:

8.1. Refers to the RN to guide decision-making.
8.2. Seeks additional knowledge/information when presented with unfamiliar situations.
8.3. Incorporates evidence for best practice as guided by the RN or other appropriate health professionals.
8.4. Uses problem-solving incorporating logic, analysis and a sound argument when planning and providing care.
8.5. Demonstrates analytical skills through accessing and evaluating healthcare information and quality improvement activities.
8.6. Consults with the RN and other relevant health professionals and resources to improve current practice.

Standard 9: Practises within safety and quality improvement guidelines and standards

Indicators:

9.1. Participates in quality improvement programs and accreditation standards activities as relevant to the context of practice.
9.2. Within the multi-disciplinary team, contributes and consults in analysing risk and implementing strategies to minimise risk.
9.3. Reports and documents safety breaches and hazards according to legislative requirements and institutional policies and procedures.
9.4. Practises safely within legislative requirements, safety policies, protocols and guidelines.

Standard 10: Engages in ongoing development of self as a professional

Indicators:

10.1. Uses EN standards for practice to assess own performance.
10.2. Recognises the need for, and participates in, continuing professional and skills development in accordance with the NMBA's *Continuous professional development* registration standard.
10.3. Identifies learning needs through critical reflection and consideration of evidence-based practice in consultation with the RNs and the multidisciplinary healthcare team.
10.4. Contributes to and supports the professional development of others.
10.5. Uses professional supports and resources such as clinical supervision that facilitate professional development and personal wellbeing.
10.6. Promotes a positive professional image.

Glossary

Accountability/accountable: Nurses and midwives must be prepared to answer to others, such as people in receipt of healthcare, their nursing and midwifery regulatory authority, employers and the public for their decisions, actions, behaviours and the responsibilities that are inherent in their roles. Accountability cannot be delegated. The registered nurse or midwife who delegates an activity to another person is accountable, not only for their delegation decision, but also for monitoring the standard of performance of the activity by the other person, and for evaluating the outcomes of the delegation. However, they are not accountable for the performance of the delegated activity.

Best practice: A technique, method, process, activity or incentive which has been proven by evidence to be most effective in providing a certain outcome.

Core practice: The day-to-day or regular activities or policies of a health service provider that fundamentally guide the service as a whole.

Decision-making framework: The NMBA expects all nurses and midwives to practise within the relevant standards for practice and decision-making frameworks.

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

Duty of care/standard of care: A responsibility or relationship recognised in law. For example, it may exist between health professionals and their clients. Associated with this duty is an expectation that the health professional will behave or act in a particular way. This is called the standard of care, which requires that a person act toward others and the public with watchfulness, attention, caution and the prudence that would be made by a reasonable person in those circumstances. If a person's actions do not meet this standard of care, whereby they fall below the acceptable standards, any damages resulting may be pursued in a lawsuit for negligence.

Enrolled nurse (EN, Division 2): A person with appropriate educational preparation and competence for practice, who is registered under the Health Practitioner Regulation National Law.

Evidence-based practice: Assessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings and the individuality of situations and personal preferences as the basis for practice decisions.

Indicators: Key generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist the assessor when using their professional judgement in assessing nursing practice. They further assist curriculum development.

Midwife/midwifery practice: A midwife is a person with appropriate educational preparation and competence for practice who is registered by the NMBA. This term includes endorsed midwives for the purposes of this document. The NMBA has endorsed the ICM definition of a midwife (that includes the statement below on scope of practice) and applied it to the Australian context.

The International Confederation of Midwives (ICM) defines a midwife as follows:

> *A midwife is a person who has successfully completed a midwifery education programme that is duly recognised in the country where it is located and that is based on the ICM essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.*

Scope of practice[6]

> *The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.*

A midwife may practise in any setting including the home, community, hospitals, clinics or health units (ICM international definition of the midwife 2012). www.internationalmidwives.org

Nursing and Midwifery Board of Australia (NMBA): The national body responsible for the regulation of nurses and midwives in Australia.

Person/people: Refers to those individuals who have entered into a relationship with an enrolled nurse. Person/people encompass patients, clients, consumers and families that fall within the enrolled nurse scope and context of practice.

Person-centred practice: A collaborative and respectful partnership built on mutual trust and understanding. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Plan of care: Outlines the care to be provided to an individual/ family/ community and includes the nursing component. It is a set of actions the nurse will implement to resolve/ support nursing diagnoses identified by nursing assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care.

Professional boundaries: Refers to the clear separation that should exist between professional conduct aimed at meeting the health needs of people, and behaviour which serves a nurse's own personal views, feelings and relationships that are not relevant to the professional relationship.

Quality: Refers to characteristics and grades with respect to excellence.

Refer/referral: Referral is the transfer of primary health care responsibility to another qualified health service provider/health professional. However, the nurse or midwife referring the person for care by another professional or service may need to continue to provide their professional services collaboratively in this period.

Registered nurse (RN, Division 1): A person who has completed the prescribed educational preparation, demonstrated competence to practise, and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia. For the purposes of this document the term also includes nurse practitioners.

Risk assessment/risk management: An effective risk management system is one incorporating strategies to:

- identify risks/hazards
- assess the likelihood of the risks occurring and the severity of the consequences if the risks do occur, and
- prevent the occurrence of the risks, or minimise their impact.

[6] Scope of practice forms a part of the ICM definition of a midwife.

Scope of practice: Is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice of individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

Standards for practice: Set the expectations of enrolled nurse practice. They inform the education standards for enrolled nurses; the regulation of nurses and determination of nurses' fitness for practice; and guide consumers, employers and other stakeholders on what to reasonably expect from an enrolled nurse regardless of the area of nursing practice or years of nursing experience. They replace the previous *National competency standards for the enrolled nurse*.

Supervision/supervise: Supervision can be either direct or indirect:

- **Direct supervision** is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised.
- **Indirect supervision** is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the person receiving care and the needs of the person who is being supervised.

For the purpose of this document, supervision includes access, in all contexts of care, at all times, either directly or indirectly to professional and clinically focussed supervision to a named and accessible registered nurse for support and guidance of the practice of an enrolled nurse.

Nurse practitioner standards for practice – Effective from 1 January 2014

Updated March 2018

Orientating statements

Nurse practitioners have the capability to provide high levels of clinically focused nursing care in a variety of contexts in Australia. Nurse practitioners care for people and communities with problems of varying complexity.

The nurse practitioner (NP) scope of practice is built on the platform of the registered nurse (RN) scope of practice, and must meet the regulatory and professional requirements for Australia including the *Registered nurse standards for practice* and *Code of conduct for nurses*.

The nurse practitioner standards (Standards) build on, and expand upon, those required of a registered nurse. When assuming the title and scope of practice of a nurse practitioner, the NP understands the changes in the scope of practice from that of a registered nurse, and the ways that these changes affect responsibilities and accountabilities. Fundamentally, a nurse practitioner provides nursing care within their regulated scope.

The core Standards in this document are the minimal Standards that are applicable across diverse practice settings and patient/client populations for both beginning and experienced NPs.

Nurse practitioner attributes are consciously cultivated through formal learning that includes a work based component. The educational requirement for endorsement of NPs in Australia is a Masters degree. This formal learning builds on demonstrable advanced practice within the RN scope.

The nurse practitioner has a high degree of systems literacy and can manage care across a variety of health systems to maximise outcomes; NPs engage in complex and critical thinking; integrate information and/or evidence; judiciously use clinical investigations; and skilfully and empathetically communicate with all involved in the care episode, including the person receiving care and their family and community, and health professional colleagues.

NP attributes are clinically focused, and NPs are capable in research, education and leadership as applied to clinical care (Refer Figure 1). Research includes processes to support reflective practice, evidence-based care and quality management. The NP has the capability to educate others related to the focus of, and available options, of care. Nurse practitioners are leaders and have an ability to lead care and care teams. Nurse practitioners engage in reflective practice and support others in this process through clinical supervision or mentoring.

Nurse practitioners are capable of managing episodes of care, including wellness focused care. Nurse practitioners may be the primary provider of care or part of a care team. They collaborate and consult with health consumers, their families and community, other professionals, including health personnel, to plan, implement and evaluate integrated care that optimises outcomes for recipients and the systems of care.

As part of providing care, NPs can order and interpret investigations to facilitate diagnosis and care planning. Care may include nursing interventions that involve initiation, titration or cessation of medications. Nurse practitioners take responsibility for following-up on any components of care initiated. They are accountable for care provided and self-monitor their work.

How to use these Standards

The Standards have been written so as to be easily accessible to a variety of groups, including nurse practitioners, governments, regulatory agencies, health care professionals and the community. It should be noted that the *Cues* (refer to Glossary) written below the *Statements* are indicative of nurse practitioner behaviours, they are not intended to be exhaustive. Rather, the cues are examples of activities that demonstrate the *Statement for that standard*.

These Standards should be read in conjunction with other relevant NMBA documentation, including: the *Registered nurse standards for practice* andthe *Code of conduct for nurses.* They should also be read in conjunction with the attached Glossary, which clearly stipulates the way in which key terms are used in the Standards.

In Figure 1, the *Nurse practitioners standards framework* is illustrated. There are four domains, namely:

- clinical
- education
- research, and
- leadership.

The education, research and leadership domains are couched within the clinically focused standards. The knowledge and skills contained within the three domains of education, research and leadership, are integrated in their expression in the clinical role or work.

Collectively, these attributes expressed in nurse practitioners' knowledge, skills and affect, are applied in the education domain through educating those receiving care, peers and colleagues. The use of knowledge in the research domain is evidenced through the judicious application of research evidence in formulating practice decisions, self- regulation and the development of new systems of care. The domain of leadership, initially evident in clinical work, increases in capacity to include community and political engagement.

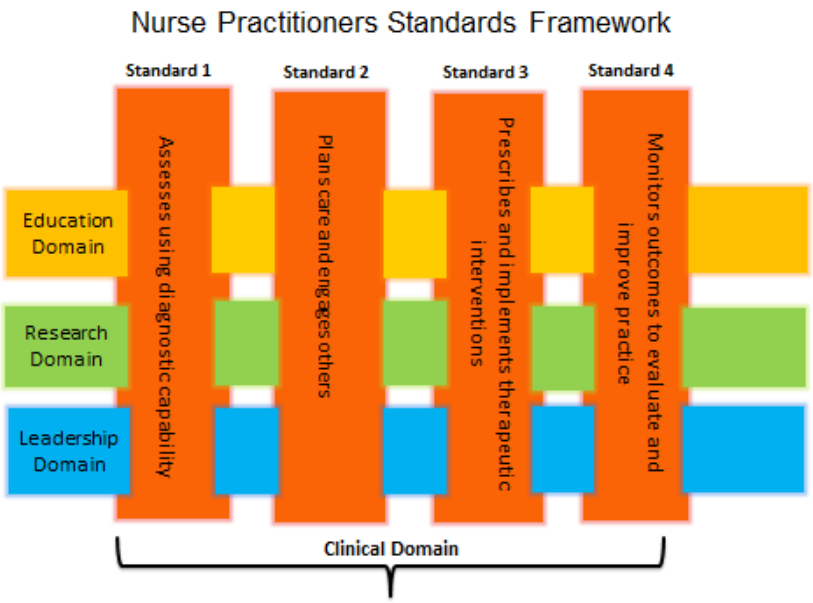

Figure 1: Representation of how the education, research and leadership domains are couched within the clinically focused standards

Nurse practitioner standards

Standard 1: Assesses using diagnostic capability

Statement 1.1: Conducts comprehensive, relevant and holistic health assessment

Cues:

- Demonstrates extensive knowledge of human sciences and health assessment
- Demonstrates comprehensive and systematic skill in obtaining relevant, appropriate and accurate data that inform differential diagnoses
- Assesses the complex and/or unstable health care needs of the person receiving care through synthesis and prioritisation of historical and available data
- Assesses the impact of comorbidities, including the effects of co-existing, multiple pathologies and prior treatments in the assessment of the person receiving care
- Demonstrates comprehensive skill in clinical examination including physical, mental health, social, ethnic and cultural dimensions
- Consistently and accurately synthesises and interprets assessment information specifically history, including prior treatment outcomes, physical findings and diagnostic data to identify normal, at risk and abnormal states of health
- Critically evaluates the impact of social determinants on the person and population.

Statement 1.2: Demonstrates timely and considered use of diagnostic investigations to inform clinical decision making

Cues:

- Makes decisions about the use of person-focused diagnostic investigations that are informed by clinical findings and research evidence
- Demonstrates accountability in considering access, cost, clinical efficacy and the informed decision of the person receiving care when ordering diagnostic investigations
- Orders and/or performs selected screening and diagnostic investigations
- Is responsible and accountable for the interpretation of results and for following-up the appropriate course of action
- Uses effective communication strategies to inform the person receiving care and relevant health professionals of the health assessment findings and diagnoses.

Statement 1.3: Applies diagnostic reasoning to formulate diagnoses

Cues:

- Synthesises knowledge of developmental and life stages, epidemiology, pathophysiology, behavioural sciences, psychopathology, environmental risks, demographics and societal processes when making a diagnosis

- Considers the person's expectations of assessment, diagnosis and cost of health care
- Acts to prevent and/or diagnose urgent and emergent and life threatening situations
- Determines clinical significance in the formulation of an accurate diagnosis from an informed set of differential diagnoses through the integration of the person's history and best available evidence.

Standard 2: Plans care and engages others

Statement 2.1: Translates and integrates evidence into planning care

Cues:

- Takes personal responsibility to critically evaluate and integrate relevant research findings into decision making about health care management and interventions
- Ethically explores therapeutic options considering implications for care through the integration of assessment information, the person's informed decision and best available evidence
- Is proactive and analytical in acquiring new knowledge related to nurse practitioner practice.

Statement 2.2: Educates and supports others to enable their active participation in care

Cues:

- Respects the rights of the person to make informed decisions throughout their health/illness experience or episode, whilst ensuring access to accurate and appropriately interpreted information
- Uses appropriate teaching/learning strategies to provide diagnostic information that is relevant, theory-based and evidence-informed
- Communicates about health assessment findings and/or diagnoses, including outcomes and prognosis
- Works to meet identified needs for educating others regarding clinical and ongoing care.

Statement 2.3: Considers quality use of medicines and therapeutic interventions in planning care

Cues:

- Develops an individual plan of care and communicates this to appropriate members of the healthcare team and relevant agencies
- Exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to nurse practitioner scope of practice
- Works in partnership with the person receiving care to determine therapeutic goals and options
- Verifies the suitability of evidence-based treatment options including medicines, in regard to commencing, maintaining/titrating or ceasing interventions
- Demonstrates accountability in considering access, cost and clinical efficacy when planning treatment.

Statement 2.4: Refers and consults for care decisions to obtain optimal outcomes for the person receiving care

Cues:

- Collaborates with other health professionals to make and accept referrals as appropriate
- Consults with and/or refers to other health services, disability services, aged-care providers and community agencies at any point in the care continuum.

Standard 3: Prescribes and implements therapeutic interventions

Statement 3.1: Prescribes indicated non-pharmacological and pharmacological interventions

Cues:

- Contributes to health literacy by sharing knowledge with the person receiving care to achieve evidence-informed management plan
- Safely prescribes therapeutic interventions based on accurate knowledge of the characteristics and concurrent therapies of the person receiving care
- Demonstrates professional integrity and ethical conduct in relation to therapeutic product manufacturers and pharmaceutical organisations
- Safely and effectively performs evidence-informed invasive/non-invasive interventions for the clinical management and/or prevention of illness, disease, injuries, disorders or conditions
- Interprets and follows-up the findings of screening and diagnostic investigations in an appropriate time frame during the implementation of care.

Statement 3.2: Maintains relationships with people at the centre of care

Cues:

- Supports, educates, coaches and counsels the person receiving care regarding diagnoses, prognoses and self-management, including their personal responses to illness, injuries, risk factors and therapeutic interventions
- Advises the person receiving care on therapeutic interventions including benefits, potential side effects, unexpected effects, interactions, importance of compliance and recommended follow-up
- Shares information with others in consultation with the person receiving care
- Coordinates care with other health, disability and aged-care providers, agencies and community resources
- Discloses the facts of adverse events to the person receiving care and other health professionals; mitigates harm, and reports adverse events to appropriate authorities in keeping with relevant legislation and organisational policy
- Advocates for improved access to health care, the health care system and policy decisions that affect health and quality of life.

Statement 3.3: Practises in accordance with federal, state and territorial legislation and professional regulation governing nurse practitioner practice

Cues:

- Defines duty of care in accordance with relevant legislation and regulation
- Remains informed of changes to legislation and professional regulations, and implements appropriate alterations to practice in response to such changes
- Contributes to the development of policy and procedures appropriate to context and specialty.

Standard 4: Evaluates outcomes and improves practice

Statement 4.1: Evaluates the outcomes of own practice

Cues:

- Monitors, evaluates and documents treatments/interventions in accordance with person- determined goals and health care system outcomes
- Considers a plan for appropriately ceasing and/or modifying treatment in consultation with the person receiving care and other members of the health care team
- Applies the best available evidence to identify and select appropriate outcomes measures of practice
- Uses indicators to monitor and measure the effectiveness of strategies, services and interventions to promote safe practice
- Participates in clinical supervision and review
- Implements research-based innovations for improving care
- Contributes to research that addresses identified gaps in the provision of care and/or services.

Statement 4.2: Advocates for, participates in, or leads systems that support safe care, partnership and professional growth

Cues:

- Advocates and provides evidence for expansion to nurse practitioner service where it is believed that such an expansion will improve access to quality and cost-effective health care for specific populations
- Demonstrates clinical leadership in the design and evaluation of services for health promotion, health protection or the prevention of injury and/or illness
- Articulates and promotes the nurse practitioner role in clinical, political and professional contexts
- Acts as an educator and/or mentor to nursing colleagues and others in the healthcare team
- Critiques health care policies for their implications on the nurse practitioner role and the populations for whom they care
- Influences health, disability and aged-care policy and practice through leadership and active participation in workplace and professional organisations.

Glossary

Advanced nursing practice (ANP): ANP is a continuum along which nurses develop their professional knowledge, clinical reasoning and judgement, skills and behaviours to higher levels of capability (that is recognisable). Nurses practising at an advanced level incorporate professional leadership, education and research into their clinically based practice. Their practice is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex health care requirements.

Advanced nursing practice is a level of practice and not a role. It is acknowledged that advanced nursing practice is individually attributed within a regulated nursing scope (enrolled nurse, registered nurse or nurse practitioner).

Advanced practice nursing (APN): APN in the Australian nursing context identifies the additional legislative functions of an endorsed nurse practitioner that are outside the contemporary registered nurse scope of practice.

Advanced practice nursing as a nurse practitioner is a qualitatively different level of advanced nursing practice to that of the registered nurse due to the additional legislative functions and the regulatory requirements. The requirements include a prescribed educational level, a specified advanced nursing practice experience; and continuing professional development.

Advanced practice nursing should not be confused with the term 'practice nurse' that is used colloquially to describe nurses working in the general practice setting.

Attributes: Are characteristics that underpin competent performance. Refer to the NMBA's Registered nurse standards for practice

Competence: The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in a profession/occupational area. Refer to the NMBA's Registered nurse standards for practice

Cues: Key generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist the assessor when using their professional judgement in assessing nursing practice. They further assist curriculum development. Refer to the NMBA's Registered nurse standards for practice

Nurse Practitioner: A nurse practitioner is an advanced practice nurse endorsed by the Nursing and Midwifery Board of Australia (NMBA) to practise within their scope under the legislatively protected title 'nurse practitioner'.

Person/people: In these Standards, person/people is used to refer to those individuals who have entered into a relationship with a nurse practitioner. Person/people encompass patients, clients, consumers and families that fall within the NP scope and context of practice.

Prescribing: is defined as the steps of information gathering, clinical decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine.

Scope of practice: The scope of nursing practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice of individual practitioners is influenced by the settings in which they practise, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider

A national framework for the development of decision-making tools for nursing and midwifery practice

Nursing and Midwifery Board of Australia

Introduction

The Nursing and Midwifery Board of Australia

The Nursing and Midwifery Board of Australia (the National Board) undertakes functions as set by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The National Board regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public by making sure that only nurses and/or midwives who are suitably qualified to practise in a competent and ethical manner are registered.

The National Board sets the registration standards as well as professional codes, standards and guidelines that underpin safe and competent practice. They also help to clarify the National Board's expectations on a range of matters.

In order to become registered, nurses and/or midwives must meet the National Board's mandatory registration standards.

The National Board expects registered nurses and midwives to practise within the relevant competency standards and decision-making frameworks.

The national decision-making framework, developed in the context of national workforce strategies promoting diversity, flexibility and responsiveness in the workforce, reflects a whole-of-health workforce perspective.

The national decision-making framework

The national framework consists of two parts.

The first is a set of principles that form the foundation for the development and evaluation of decision-making tools.

The second contains two templates for decision-making tools, one for nursing (registered and enrolled nurses) and one for midwifery, in recognition of the differences between the two professions. Terms that are underlined in the text are expanded on in the 'Explanations of terms' used in the 'Template tools' section of this document.

National decision-making framework

National principles for the development of decision-making tools

Templates for tools for nursing and midwifery practice decisions

Guide for nursing practice decisions	Guide for midwifery practice decisions
Nursing practice decision flowchart and narrative	Midwifery practice decision flowchart and narrative
Nursing practice decision-making summary diagram	Midwifery practice decision-making summary diagram

Explanations of terms used in the template tools

Purpose of the framework

The purpose of the framework is to foster consistency across jurisdictions by:

- identifying the agreed foundation principles for decision-making tools
- demonstrating the application of the principles and concepts in the two professions.

Professions are regulated in the public interest. Regulation contributes to public safety by ensuring that those who are authorised to make decisions, for which professional knowledge and experience are needed, are competent to do so. Use of the national principles for the development and evaluation of decision-making tools will therefore contribute to safety and quality in nursing and midwifery practice. Use of the template tools will facilitate flexibility in practice and enable reflection on current practice and practice change.

Scope of practice of a profession

A profession's scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform.

Some functions within the scope of practice of any profession may be shared with other professions or other individuals or groups. The scope of practice of all health professions is influenced by the wider environment, the specific setting,

legislation, policy, education, standards and the health needs of the population.

Scope of practice of an individual

The scope of practice of an individual is that which the individual is educated, authorised and competent to perform. The scope of practice of an individual nurse or midwife may be more specifically defined than the scope of practice of their profession. To practise within the full scope of practice of the profession may require individuals to update or increase their knowledge, skills or competence.

Decisions about both the individual's and the profession's practice can be guided by the use of decision-making tools. When making these decisions, nurses and midwives need to consider their individual and their respective profession's scope of practice.

National principles for the development of decision-making tools

These nationally-agreed principles guide the development and evaluation of decision-making tools in Australia. Through the principles, and tools based on them, health consumers, regulators, governments, employers, professional groups and workforce planners can be confident that nurses and midwives, irrespective of their category of registration or where they practice, are supported to make decisions in a consistent way.

The national principles

Decision-making tools:

1 guide nurses and midwives in making decisions about everyday practice and changes to practice over time to meet the health needs of the community

2 facilitate planning, negotiation and implementation of practice change for individuals or groups of nurses and midwives to meet the health needs of the community

3 acknowledge that the promotion and provision of quality health services for individual consumers and for the broader community are the drivers for change in practice

4 enhance safety and quality when integrated with a comprehensive approach to managing risk

5 recognise and apply to all domains and contexts of practice

6 facilitate responsiveness to consumers' needs by health workers through changes to the repertoire of skills of individuals or groups by:

- evolution of new practice areas/capabilities
- negotiation among health workers and between health workers and employers
- making or accepting delegations.

7 acknowledge the following determinants of practice and how they may limit or enable practice change:

- legislated authority or restrictions on professional practice
- professional standards of practice
- evidence for practice
- individual capability (knowledge, skill and competence) for practice
- contextual/organisational support for practice

8 that are a part of the professional practice frameworks used by the National Board and in the self assessment of practice, state explicitly and transparently the role of the tools in circumstances where a nurse or midwife may be called to account for their practice decisions.

Template tools for decision-making in nursing or midwifery practice

Preface

In a dynamic health care environment such as Australia's, where change is a constant feature, nurses and midwives are expected to be flexible and to respond to change in ways that benefit health consumers.

A nursing or midwifery practice decision-making tool is part of the National Board professional practice framework ensuring that nursing and midwifery care are provided in the public interest. Decisions[1] about nursing or midwifery practice using these template tools are therefore made by those who are best qualified and competent to do so — registered nurses[2] and midwives.

Because the template tools are principle based, they are sustainable over time. Decisions made using these template tools are grounded in informed professional discretion, guided by principles. Differences in the education, experience and competence of the individual, and in the context in which they practise, are considered in using the template tools.

Registered nurses and midwives have a key role in the coordination and supervision of others who may assist them in the provision of care to consumers. The template tools therefore provide guidance not only for individual practice decisions by registered and enrolled nurses and midwives, but also for decisions about if, and when, it is appropriate for registered nurses or midwives to delegate aspects of consumer care to others, such as support workers. Organisations in which nurses and midwives work are responsible for ensuring there are sufficient resources to enable safe and competent care for the consumers for whom health care services are provided. This includes policies and practices that support the development of nursing and midwifery practice to meet the needs and expectations of consumers, within a risk management framework.

These template tools establish a framework for decision-making that is based in competence. They do not condone or authorise the substitution of less qualified health workers for nurses or midwives when the knowledge and skills of nurses or midwives are needed. No nurse or midwife may be directed, pressured or compelled by an employer, or other person, to engage in any practice that falls short of, or is in breach of, any professional standard, guidelines and/or code of conduct, ethics or practice for their profession.

1 This type of decision, depending on assessment of dynamic contextual factors, must be made by the accountable registered nurse or midwife at the time. Such decisions cannot be made in advance. However, an organisation can prepare certain groups of workers to be capable of performing the activity when the registered nurse or midwife determines that it is appropriate for a specific health consumer in a specific context.

2 The National Competency Standards for Nursing currently reserve decision-making about the planning and coordination of nursing care to registered nurses.

Use of the template tools

The template tools promote a consistent approach to decisions about nursing or midwifery practice across all areas of practice. The template tools are most relevant for the clinical practice setting, but may be modified or adapted for decision-making in other areas of nursing or midwifery practice such as education, research and management.

Decision-making is complex and dependent on a range of inter-related factors. Use of the template tools assists nurses, midwives, employers and policy-makers in understanding and considering these factors in decisions and discussions about practice. The template tools do not define activities or procedures.

The template tools provide a mechanism for:

- nurses or midwives to use when considering, determining and self-assessing their individual practice
- dialogue with employers, managers and policy-makers in interpreting, planning for and changing practice
- stimulating discussion regarding professional issues and raising awareness in relation to scope of practice and decision-making
- educators in embedding the principles and concepts underpinning the template tools within educational programs that prepare nurses or midwives for practice
- the National Board to use in identifying practice that falls outside the accepted scope of nursing or midwifery practice, or decision-making processes that are not congruent with the statements of principle in the tools.

The template tools are to be used in conjunction with other professional practice tools and standards such as competency standards, policies, regulations and legislation related to nursing or midwifery, to resolve practice issues.

If conflict arises over application of the guide from practice decisions, and this conflict cannot be resolved by the parties, advice may need to be obtained from more senior management, the National Board or a professional/industrial organisation to assist in conflict resolution.

Rationale for developing the template tools

Decisions about nursing or midwifery practice in response to the rapid and dynamic changes that are occurring within nursing, midwifery and the environment of practice need to be planned rather than ad hoc. Unplanned responses could result in wide variation in practice between individuals of similar background and experience and between similar settings. Effective decision-making tools provide a framework where quality and safety are central considerations in decisions about nursing or midwifery practice, allowing:

- new services/practices to be introduced safely and in an orderly way
- everyday practice to be undertaken confidently and competently
- delegation decisions to be safe.

These tools have been developed to assist in rational decision-making about nursing or midwifery practice and practice changes. Influences for change in nursing or midwifery practice may arise from, among other factors:

- legislative or technological change
- community expectations, including an increased emphasis on the safety and quality of health care
- professional developments
- work practice changes including:
- changes in the model of care initiated by organisations or professional groups
- changes in other health professions
- the emergence of new health care roles
- changes in the structure and funding of education
- resource changes including changes in the numbers of available health care workers, including nurses and midwives, and an ageing workforce.

The Board-approved *National competency standards for nurses* and the *Competency standards for the midwife* set clear standards of practice regarding scope of practice and delegation.

Guide for nursing practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables nurses to work to their full and potential scope of practice. The Statements of principle set out below provide guidance to nurses and others about processes that will help to ensure that safety is not compromised when making decisions about nursing practice and about whether to delegate activities to others.

Statements of principle	Explanatory statements
1. The primary motivation for any decision about a care activity is to meet clients' health needs or to enhance health outcomes.	Decisions about activities are made in a planned and careful fashion and: • whenever possible, in partnership with the client, their families and support network and in collaboration with other members of the multidisciplinary health care team • based on a comprehensive assessment of the client and the client's needs • only where there is a justifiable, evidence-based reason to perform the activity • after identifying the potential risks/hazards associated with the care • activity, and strategies to avoid them.
2. Nurses are accountable for making professional judgements about when an activity is beyond their own capacity or scope of practice and for initiating consultation with, or referral to, other members of the health care team.	Judgements are made in a collaborative way, through consultation and negotiation with other members of the health care team, and are based on considerations of: • lawfulness (legislation and common law) • compliance with evidence, professional standards, and regulatory standards, policies and guidelines • which is the most appropriate discipline to provide the education and competence assessment for the activity • context of practice and the service provider/employer's policies and protocols • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice. Nurses wishing to integrate into their own practice activities not currently part of the accepted, contemporary scope of nursing practice must ensure that: • they have the necessary educational preparation and experience to do so safely • their competence has been assessed by a qualified, competent health professional or provider (who may be a more experienced/qualified registered nurse) • they are confident of their ability to perform the activity safely • they have any necessary authorisations or certifications and organisational support.

Statements of principle	Explanatory statements
3. Registered nurses are accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care.	Decisions about nursing practice are made, in partnership with the client whenever possible, to ensure that the right person (nurse or non-nurse) is in the right place to provide the right service for the client at the right time. Decisions are based on, justified and supported by, considerations of whether: • there is legislative or professional requirement for the activity to be performed by a particular category of health professional or health care worker • the registered nurse has completed a comprehensive health assessment of the client's needs • there is an organisational requirement for an authority/certification/credential to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the person who will perform an activity that has been delegated to them by a registered nurse from a nursing plan of care has been ascertained by a registered nurse • the person is competent, confident of their ability to perform the activity safely, or is ready to accept the delegation, and understands their level of accountability for performing the activity • the appropriate level of clinically-focussed supervision can be provided by a registered nurse for a person performing an activity delegated to them by a registered nurse • the organisation in which the nurse works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the person performing the activity, and to support the decision-maker in providing support and clinically-focussed supervision.
4. Nursing practice decisions are best made in a collaborative context of planning, risk management, and evaluation.	Organisational employers/managers, other health workers and nurses share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent,evidence-based practice to the full extent of the scope of nursing practice • processes for providing continuing education, skill development and appropriate clinically-focussed supervision • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and nursing practice decisions.

The nursing practice decision flowchart illustrates the processes that a registered nurse would follow in making decisions about nursing practice, taking account of the guiding principles set out above. A summary guide for nursing practice decisions is also provided.

Nursing practice decision flowchart narrative

Any activity intended to achieve desired/beneficial client outcomes is based on a comprehensive assessment of the client by a registered nurse and is determined, whenever possible, in partnership with the client. Practice changes may also arise from evaluations of services and a desire to improve access to or efficiency of services to groups of clients. The first decision that will need to be made is whether the activity is within the current contemporary scope of nursing practice as envisaged in professional practice standards and legislation.

If the **activity IS within the current contemporary scope of nursing practice**, the registered nurse would need to consider the organisation's quality and risk management framework as well as its capacity in terms of staffing, resources and access to other health professionals.

If the organisational capacity is not sufficient to support the activity, further planning and consultation should be undertaken before proceeding and referral may be necessary in the meantime.

If the activity **is NOT within the current contemporary scope of nursing practice**, the registered nurse[3] will need to consider whether she/he (or another nurse) wishes to integrate the activity into their own nursing practice and/or whether the employer wishes to initiate a change within the organisation.

If not, then the client will need to be referred to an appropriate health professional or health service provider, and the registered nurse will need to establish a collaborative relationship with that person/service to ensure the provision of ongoing nursing care for the client.

3 Current professional standards, such as the competency standards for the RN and EN, clearly give certain responsibilities exclusively to registered nurses, including making professional judgements about the scope of nursing practice and delegation of activities in a nursing plan to others.

The registered nurse will need to conduct a risk assessment to determine the appropriate person to perform the activity.

Factors to be considered by the registered nurse in making this decision include whether a nurse should perform the activity because:

- the client's health status is such that the activity should be performed by a nurse
- the complexity of care required by the client indicates that a nurse should perform the activity, because specific knowledge or skill is needed
- professional standards for nurses indicate that the activity should be performed by either a registered or enrolled nurse
- any state/territory or Commonwealth legislation specifies that a nurse should perform the activity
- any local or organisational policy, guideline or protocol requires a registered or enrolled nurse to perform the activity
- the model of care mandates that the activity should be performed by a nurse
- there is evidence that the activity is best performed by a nurse.

If a nurse wishes to integrate the activity into their nursing practice, or an organisation wishes to initiate practice change, they will need to consider a number of factors, such as lawful authority, professional consensus, risk management, organisational support and the preparation and experience of the registered nurse, before proceeding.

These factors include whether:

- the activity can legally be performed by a nurse, with due consideration given to the need for the client to consent to the activity being performed by a nurse if at all possible
- professional standards would support a nurse performing the activity
- a risk assessment has found no risks indicating that the activity should be performed by another qualified person/service
- consultation and planning with all relevant stakeholders[4] has occurred
- the organisation in which the activity is to be performed is prepared to support the nurse in performing the activity
- the nurse has the education, authorisation, experience, capacity, competence and confidence to safely perform the activity.

4 The identification of which stakeholders are relevant is dependent on the context, and may include other health professionals, other service providers or educational institutions.

If the registered nurse decides, on the basis of **any one** of the above factors, that the activity needs to be performed by a nurse, the competence and confidence of that registered or enrolled nurse will need to be determined, as will their understanding of their level of accountability in performing the activity. Whether further education, clinically-focussed supervision and support from a registered nurse is required will also need to be established, based on consideration of the support, education and competence assessment that may be needed and is available.

Before new activities can be integrated into a nurse's practice, changes to legislation, community opinion, professional standards, public health policy, local/organisational policies, educational opportunities, resource provision, levels of supervision, roles and responsibilities, and/or the individual's educational preparation and competence may be required. Nurses may need to identify whether there are any professional or industry standards or expectations for education and training to prepare for the new role, including accredited education programs leading to formal qualifications, and if not, may need to collaborate in the development of appropriate education and assessment pathways.

If **all** of these factors are positive, the activity may be performed by a nurse and the outcomes evaluated.

If no competent nurse is available, or the desired education, level of supervision or support cannot be provided, the decision maker will need to refer the activity to a more experienced nurse to perform.

If **all** of these factors are found to be positive, then a nurse can perform the activity. However, if at any of the decision points a negative response occurs, the nurse would need to undertake further education, consultation or planning before proceeding, and/or refer the client to another health professional or service provider. In the latter case, the nurse would continue to collaborate to ensure provision of any ongoing nursing care.

If **the registered nurse decides that the activity can be performed by a non-nurse**[5], the registered nurse will need to consider, within a risk management framework, who the most appropriate person (eg nursing student[6], Aboriginal or Torres Strait Islander Health Worker[7], support worker, volunteer, family member, carer, other) is to perform the activity. In making this decision, the registered nurse will need to decide whether:

- performance of the activity by a non-nurse will achieve the desired client outcomes, and the client consents, if at all possible, to the activity being performed by a non-nurse
- there is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a non-nurse (for students, support from the educational institution for this activity to be delegated to students should also be established)
- there is professional consensus (ie support from the nursing profession or other experienced nurses) and evidence for the performance of this activity by a non-nurse
- the non-nurse is competent (ie, has the necessary education, experience and skill) to perform the activity safely
- the non-nurse's competence has been assessed by a registered nurse
- the non-nurse is ready (confident) to perform the activity and understands their level of accountability for the activity
- there is a registered nurse available to provide the required level of supervision and support, including education.

5 A non-nurse is any person who is not registered to practise as a registered or enrolled nurse

6 For students, the decision to delegate an activity to them to perform should be congruent with the educational goals in their registered nurse or enrolled nurse program of study, and demonstrated level of their individual knowledge and skill.

7 The relationships between Aboriginal and Torres Strait Islander health workers and nurses vary according to context. They may work autonomously or be accountable to a registered nurse for activities the registered nurse has delegated to them.

If all of these factors are positive, then the registered nurse can delegate[8] the activity and ensure that the appropriate level of supervision is provided. If any of these factors is negative, the activity should not be delegated. In the absence of another competent non-nurse, or if necessary additional support (education, competence assessment, supervision etc) cannot be provided, the activity should either be performed by a nurse or referred to another service provider. In the latter case, the registered nurse would continue to collaborate to ensure the provision of any ongoing nursing care required by the client. Further consultation and planning may be necessary to achieve changes at the organisational or professional level to permit delegation in future, if this is considered appropriate.

Whatever the decision, documentation and evaluation of the outcomes of the decision must be completed. All parties to the decision, including the client, the registered nurse, the person performing the activity, and other health care team members, should participate in the evaluation, if at all possible. The employer may also be involved in evaluation of an organisational change. The evaluation should consider outcomes for the client, for the person performing the activity, for the person delegating the activity and for any others affected by the decision.

8 A delegation can only be made by a person who is competent to perform the activity they are delegating.

Guide for midwifery practice decisions

Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables midwives to work to their full and potential scope of practice. The statements of principle set out below provide guidance to midwives and others about the factors to be considered to ensure that safety is not compromised when making decisions about midwifery practice and about whether to delegate activities to others.

Statements of principle	Explanatory statements
1. The primary motivation for any decision about a care activity is to meet women's or babies' health needs or to enhance health outcomes.	Decisions about activities are made in a planned and careful fashion and: • in partnership with the woman, and in collaboration with other members of the multidisciplinary health care team • by a midwife, based on a comprehensive assessment of the woman/newborn and their needs • only where there is a justifiable, evidence-based reason to perform the activity • after identifying the potential risks/hazards associated with the care activity, and strategies to avoid them.
2. Midwives are accountable for making professional judgements about when an activity is beyond their own capacity or scope of practice and for initiating consultation with, or referral to, other members of the health care team.	Judgements are made in a collaborative way, through consultation and negotiation with women and other members of the health care team, and are based on considerations of: • lawfulness (legislation and common law) • compliance with evidence, professional standards, policies and guidelines • which discipline should provide the education and competence assessment for the activity • the context of practice and the service provider/employer's policies and protocols • whether there is organisational support, including sufficient staffing levels and appropriate skill mix, for the practice. Midwives wishing to integrate activities that are not currently part of the accepted contemporary scope of midwifery practice into their own practice ensure that: • they have the necessary educational preparation and experience to do so safely • their competence has been assessed by a qualified, competent health professional or health service provider (who may be a more experienced midwife) • they are confident of their ability to perform the activity safely • they have any necessary authorisations or certifications and organisational support.

Statements of principle	Explanatory statements
3. Midwives are accountable for making decisions about who is the most appropriate person to perform an activity that is in the midwifery plan of care and would currently normally be performed by a midwife.	Decisions about midwifery practice are made by midwives in partnership with the woman to ensure that the right person (midwife or non-midwife) is in the right place to provide the right service for the woman/newborn at the right time. Decisions are based on, justified and supported by, considerations of whether: • there is a legislative or professional requirement for the activity to be performed by a particular category of health professional or health care worker • the midwife has assessed the woman's or newborn's needs and determined with the woman that the activity should be performed by a particular category of health professional or health care worker • there is an organisational requirement for an authority/certification/credential to perform the activity • the level of education, knowledge, experience, skill and assessed competence of the person who will perform an activity that has been delegated to them by a midwife from a midwifery plan of care, has been ascertained by a midwife to ensure the activity will be performed safely • the person is competent and confident of their ability to perform the activity safely, or is ready to accept delegation, and understands their level of accountability in performing the activity • the appropriate level of clinically-focussed supervision can be provided by a midwife for a person performing an activity delegated to them by a midwife • the organisation in which the midwife works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the person performing the activity, and to support the decision maker in providing support and clinically-focussed supervision.
4. Midwifery practice decisions are best made in a collaborative context of planning, risk management, and evaluation	Organisational employers/managers, other health workers and midwives share a joint responsibility to create and maintain: • environments (including resources, education, policy, evaluation and competence assessment) that support safe decisions and competent, evidence-based practice to the full extent of the scope of midwifery practice • processes for providing continuing education, skill development and appropriate clinically-focussed supervision • infrastructure that supports and promotes autonomous and interdependent practice, transparent accountability, and ongoing evaluation of the outcomes of care and practice decisions.

The midwifery practice decision flowchart illustrates the processes that a midwife would follow in making decisions about midwifery practice, taking account of the guiding principles set out above. A summary guide for midwifery practice decisions is also provided.

Midwifery practice decision flowchart narrative

Any activity intended to achieve desired/beneficial outcomes for the woman or newborn is based on a comprehensive health assessment by a midwife and is determined in partnership with the woman. Practice changes may also arise from evaluations of services and a desire to improve access to or efficiency of services to groups of clients. The first decision that the midwife will need to make is whether the activity is within the current, contemporary scope of midwifery practice as envisaged in professional practice standards and legislation.

If the midwife decides on the basis of **any one** of the above factors that the activity needs to be performed by a midwife, the competence and confidence of the midwife will need to be determined, as will their understanding of their level of accountability. Whether education, competence assessment, support or clinically-focussed supervision from a more experienced midwife is required will also need to be established, based on consideration of what may be needed and is available.

The midwife will also need to conduct a risk assessment to determine the appropriate person to perform the activity. Factors to be considered in making this decision include whether a midwife should perform the activity because:

- the woman or newborn's health status is such that the activity should be performed by a midwife
- the complexity of care required by the woman or newborn indicates that a midwife should perform the activity, because specific knowledge or skills are required
- professional standards for midwives indicate that the activity should be performed by a midwife
- there is evidence that the activity is best performed by a midwife
- any state/territory or Commonwealth legislation requires a midwife to perform the activity
- any local or organisational policy, guideline or protocol requires the activity to be performed by a midwife
- the model of care mandates that the activity should be performed by a midwife.

If the **activity is NOT within the current, contemporary scope of midwifery practice**, the midwife will need to consider whether she/he (or another midwife) wishes to integrate the activity into their own practice, and/or the employer wishes to initiate practice change. If not, then the woman or newborn will need to be referred to an appropriate health professional or health service provider, and the midwife will need to establish a collaborative relationship with that person/service to ensure the provision of ongoing midwifery care for the woman and her newborn.

If a midwife wishes to integrate the activity into their midwifery practice, or the organisation wishes to initiate practice change, they will need to consider a number of factors such as lawful authority, professional consensus, risk management, organisational support and the preparation and experience of the midwife before proceeding. These factors include whether:

- the activity can legally be performed by a midwife, with due consideration given to the need for the woman to consent to the activity being performed by a midwife
- professional standards would support a midwife performing the activity
- a risk assessment has found no risks indicating that the activity should be performed by another qualified person/service
- the organisation in which the activity is to be performed is prepared to support the midwife in performing the activity
- consultation and planning with all relevant stakeholders[9] have occurred
- the midwife has the education, authorisation, experience, competence and confidence to safely perform the activity.

9 The identification of which stakeholders are relevant is dependent on the context, and may include other health professionals, other service providers or educational institutions.

If the midwife decides on the basis of **any one** of the above factors that the activity needs to be performed by a midwife, the competence and confidence of the midwife will need to be determined, as will their understanding of their level of accountability. Whether education, competence assessment, support or clinically-focussed supervision from a more experienced midwife is required will also need to be established, based on consideration of what may be needed and is available.	Before new activities can be integrated into a midwife's practice, changes to legislation, community expectations, professional standards, public health policy, local/organisational policies, educational opportunities, resource provision, levels of supervision, roles and responsibilities, and/or the individual's competence may be required. Midwives may need to identify whether there are any professional or industry standards or expectations for education and training to prepare for the new role, including accredited education programs leading to formal qualifications, and, if not, may need to collaborate in the development of appropriate education and assessment pathways.
If **all** of these factors are positive, the activity can be performed by a midwife, and the outcomes evaluated. If the desired education, level of supervision or support is not available, the decision maker will need to refer the activity to a more experienced midwife to perform.	If **all** of these factors are found to be positive, then the midwife can perform the activity. However, if at any of the decision points a negative response occurs, the midwife would need to undertake further education or consultation and planning before proceeding, and/or refer the woman or newborn to another health professional or service provider. In the latter case, the midwife would need to continue to collaborate to ensure the provision of any ongoing midwifery care.

If the midwife decides that the activity can be performed by a non-midwife[10], the midwife will need to consider, within a risk management framework, who the most appropriate person (midwifery student[11], nurse, Aboriginal or Torres Strait Islander Health Worker[12], support worker, volunteer, family member, carer, other) is to perform the activity. In making this decision, the midwife will need to decide whether:

- performance of the activity by a non-midwife would achieve the desired outcomes for the woman or newborn, and the woman consents to the activity being performed by a non-midwife
- there is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a non-midwife (for students, support from the educational institution for this activity to be delegated to students should be established)
- there is consensus in the midwifery profession regarding the performance of this activity by a non-midwife
- the non-midwife is competent (has the necessary education, experience and skill) to perform the activity safely
- the non-midwife's competence has been assessed by a midwife
- the non-midwife is ready (confident) to perform the activity and understands their level of accountability for the activity
- there is a midwife available to provide the required level of supervision and support, including education.

10 A non-midwife is any person who is not registered to practise as a midwife

11 For students, the decision to delegate an activity to them to perform should be congruent with their educational goals in their midwifery program of study and demonstrated level of individual knowledge and skill.

12 The relationships between Aboriginal and Torres Strait Islander health workers and midwives vary according to context.

If **all** of these factors are positive, then the midwife can delegate[13] the activity and ensure that the appropriate level of supervision is provided. If any of these factors is negative, the activity should not be delegated. In the absence of another competent non-midwife, or if necessary additional support (education, competence assessment, supervision etc) cannot be provided, the activity should either be performed by a midwife or referred to another service provider. In the latter case, the midwife would continue to collaborate to ensure the provision of any ongoing midwifery care that was required by the woman or newborn. Further consultation and planning may be necessary to achieve changes at the organisational or professional level to permit delegation in future, if this is considered appropriate.

Whatever the decision, documentation and evaluation of the outcomes of the decision must be completed. All parties to the decision, including the woman, the midwife, the person performing the activity, and other health care team members, should participate in the evaluation, if at all possible. The employer may also be involved in the evaluation of an organisational change. The evaluation should consider outcomes for the woman/newborn, for the person performing the activity, for the person delegating an activity and for any others affected by the decision.

13 A delegation can only be made by a person who is competent to perform the activity they are delegating.

Glossary

A number of terms used in the template tools are defined in a variety of ways in the health industry and elsewhere. For the purposes of this framework, the following definitions have been adopted.

Accountability/accountable

Accountability means that nurses and midwives must be prepared to answer to others, such as health care consumers, their nursing and midwifery regulatory authority, employers and the public for their decisions, actions, behaviours and the responsibilities that are inherent in their roles. Accountability cannot be delegated. The registered nurse or midwife who delegates an activity to another person is accountable, not only for their delegation decision, but also for monitoring the standard of performance of the activity by the other person, and for evaluating the outcomes of the delegation.

Activity/activities

An activity is a service provided to consumers as part of a nursing or midwifery plan of care. Activities may be clearly defined individual tasks, or more comprehensive care. The term can also refer to interventions, or actions taken by a health worker to produce a beneficial outcome for a health consumer. These actions may include, but are not limited to, direct care, monitoring, teaching, counselling, facilitating and advocating. In some jurisdictions, legislation specifically prohibits the delegation of nursing care to non-nurses, and mandates that only midwives can care for a woman in childbirth.

Collaboration/collaborate

Collaboration refers to all members of the health care team working in partnership with consumers and each other to provide the highest standard of, and access to, health care. Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe health care.

Competence/competent

Competence is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession. It encompasses confidence and capability.

Competence assessment

Assessment of an individual's competence may occur through structured educational programs or a peer review process. Evidence of a person's competence may include:

- written transcripts of the skills/knowledge they have obtained in a formal course
- their in-service education session records
- direct observation of their skill
- questioning of their knowledge base
- assessment from the consumer's perspective using agreed criteria
- self assessment through reflection on performance in comparison with professional standards.

Comprehensive (health) assessment

A comprehensive health assessment is the assessment of a consumer's health status for the purposes of planning or evaluating care. Data are collected through multiple sources, including, but not limited to, communication with the consumer, and where appropriate their significant others, reports from others involved in providing care to the consumer, health care records, direct observation, examination and measurement, and diagnostic tests. The interpretation of the data involves the application of nursing or midwifery knowledge and judgement. Health assessment also involves the continuous monitoring and reviewing of assessment findings to detect changes in the consumer's health status.

Consultation/consult

Consultation is the seeking of professional advice from a qualified, competent source and making decisions about shared responsibilities for care provision. It is dependent on the existence of collaborative relationships, and open communication, with others in the multidisciplinary health care team.

Consumer

The term consumer is used generically to refer to client (nursing) and to woman (midwifery). Advising consumers of their right to make informed choices in relation to their care, and obtaining their consent, are key responsibilities of all health care personnel.

Client Clients are individuals, groups or communities of health care consumers who work in partnership with nurses to plan and receive nursing care. The term client includes patients, residents and/or their families/representatives/significant others.

Woman The term 'woman' includes the woman, her baby (born and unborn), and, as negotiated with the woman, her partner, significant others and community.

Context

Context refers to the environment in which nursing or midwifery is practised, and which in turn influences that practice. It includes:

- the characteristics of the consumer and the complexity of care required by them
- the model of care, type of service or health facility and physical setting
- the amount of clinical support and/or supervision that is available
- the resources that are available, including the staff skill mix and level of access to other health care professionals.

Delegation/delegate

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

- transfer of authority to a competent person to perform a specific activity in a specific context or
- conferring of authority to perform a specific activity in a specific context on a competent person who does not have autonomous authority to perform the activity.

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

Responsibilities when delegating

To maintain a high standard of care when delegating activities, the professional's responsibilities include:

- teaching (although this may be undertaken by another competent person, and teaching alone is not delegation)
- competence assessment
- providing guidance, assistance, support and clinically-focussed supervision
- ensuring that the person to whom the delegation is being made understands their accountability and is willing to accept the delegation
- evaluation of outcomes
- reflection on practice.

Responsibilities when accepting a delegation

A key component of delegation is the readiness of the recipient of the delegation to accept the delegation. The recipient has the responsibility to:

- negotiate, in good faith, the teaching, competence assessment and level of clinically-focussed supervision needed
- notify in a timely manner if unable to perform the activity for an ethical or other reason
- be aware of the extent of the delegation and the associated monitoring and reporting requirements
- seek support and direct clinically-focussed supervision until confident of own ability to perform the activity
- perform the activity safely
- participate in evaluation of the delegation.

Activities delegated to another person by a registered nurse or midwife cannot be delegated by that person to any other individual, unless they have since obtained the autonomous authority to perform the activity. If changes in the context occur that necessitate re-delegation, a person without that autonomous authority must consult with a registered nurse or midwife.

Education

Formal education includes courses leading to a recognised qualification. Informal educational methods include, but are not limited to:

- reading professional publications
- completing self-directed learning packages
- attending in-service education sessions
- attending seminars or conferences
- individual, one-to-one education with a person competent in the subject or skill
- reflection on practice alone or with colleagues.

Practical experience and assessment of competence by a qualified person are key components of any educational preparation for the performance of a health care activity.

Enrolled nurse

An enrolled nurse is a person with appropriate educational preparation and competence for practice, who is registered under the National Law.

Evaluation/evaluate

Evaluation is the systematic collection of evidence, measurement against standards or goals, and judgement to determine merit, worth or significance. It focuses on the consumer's response to nursing or midwifery care to review the plan of care. It can also be used to determine the appropriateness of continuing to undertake an activity, or to delegate it. Relevant stakeholders who should be involved in evaluation include the consumer, and any party affected by the activity, such as other health care workers

Legislation/legislative

Legislation refers not only to National Law, but also to a diverse range of state/ territory and Commonwealth acts and regulations that may affect practice. Examples include the national Aged Care Act and Health Insurance Commission Act, and state/territory mental health acts, Radiation Safety legislation and Drugs and Poisons Regulations.

Midwife/midwifery practice

A midwife is a person with appropriate educational preparation and competence for practice who is registered with the Nursing and Midwifery Board of Australia. Includes eligible midwives and endorsed midwives.

Non-nurse, non-midwife/support workers

A non-nurse is any person who is not registered to practise as a registered or enrolled nurse.

A non-midwife is any person not registered to practise as a midwife. The category includes, but is not limited to, support workers (also known as unlicensed health care workers) such as doulas, assistants in nursing, personal care assistants, orderlies, ward attendants, receptionists.

Support workers are people whose roles include carrying out non-complex components of personal care for consumers that:

- have traditionally been within the scope of practice of regulated health professionals
- may also, or otherwise, be provided by family, volunteers or significant others.

Support workers may have a care-worker qualification or no formal education for their role. They are not professionally regulated, so are not bound by standards set by a licensing authority. Support workers are individually accountable for their own actions and accountable to the registered nurse or midwife and their employer for delegated actions.

Routine client-specific activities requiring a narrow range of skill and knowledge may be delegated to support workers. An activity is routine if the need for the activity, the consumer's response and the outcome of the activity have been established over time, and are therefore predictable.

Nurse/nursing practice

See registered nurse and enrolled nurse.

Organisation/organisational support

Employers/organisations are responsible for providing sufficient resources to enable safe and competent care for the consumers for whom they provide health care services. This includes policies and practices that support the development of nursing and midwifery practice to meet the needs and expectations of consumers, within a risk management framework.

In situations where the nurse or midwife is self employed as a sole practitioner, the nurse or midwife assumes the employer's responsibilities for developing and maintaining a policy and risk management framework.

Other health professional/service provider

Other health professionals are people who have the necessary education to qualify for registration, in their respective professions, to provide a health service for which they are individually accountable. Information about health professionals that are Nationally regulated is available from www.ahpra.gov.au.

The health professions that are licensed vary between jurisdictions. In this document, the term also refers to what are sometimes known as health practitioners or semi-regulated professions, such as paramedics, and social workers. In some contexts, the term health service provider may be used, and can refer to both individuals and organisations.

Refer/referral

Referral is the transfer of primary health care responsibility to another qualified health service provider/health professional. However, the nurse or midwife referring the consumer for care by another professional or service may need to continue to provide their professional services collaboratively in this period.

Registered nurse

A registered nurse is a person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered under the National Law as a registered nurse in that jurisdiction. The term also includes nurse practitioners.

Risk assessment/risk management

An effective risk management system is one incorporating strategies to:

- identify risks/hazards
- assess the likelihood of the risks occurring and the severity of the consequences if the risks do occur
- prevent the occurrence of the risks, or minimise their impact.

Scope of practice

A profession's scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorised to perform. The scope of professional practice is set by legislation — professional standards such as competency standards, codes of ethics, conduct and practice and public need, demand and expectation. It may therefore be broader than that of any individual within the profession. The actual scope of an individual's practice is influenced by the:

- context in which they practise
- consumers' health needs
- level of competence, education, qualifications and experience of the individual
- service provider's policy, quality and risk management framework and organisational culture.

Student

Students in courses that lead to eligibility to apply for registration as a nurse or registration or as a midwife are an integral part of the health care team in many settings. As part of their educational program, they are expected to provide care to clients under the supervision of a registered nurse, and to women and babies under the supervision of a midwife. In order to gain the necessary knowledge and skill for professional practice, they may, during their course, undertake under supervision the full range of care activities that are expected of a licensed nurse or midwife.

Decisions about what activities a student may perform will be guided by consideration of whether:

- performance of the activity is congruent with the educational goals of the program in which the student is enrolled, and with the professional role (enrolled nurse, registered nurse, midwife) that the student will undertake once they graduate
- the educational institution supports the performance of the activity by the relevant group of students
- the student is competent and confident to perform the specific activity for the consumer in the current context.

Supervision/supervise

There are three types of supervision in a practice context:

1. managerial supervision involving performance appraisal, rostering, staffing mix, orientation, induction, team leadership etc
2. professional supervision where, for example, a midwife preceptors a student undertaking a course for entry to the midwifery profession, or a registered nurse supports and supervises the practice of an enrolled nurse
3. clinically-focussed supervision, as part of delegation.

In relation to consumer care activities delegated to another person by a midwife from a midwifery plan of care or by a registered nurse from a nursing plan of care, clinically-focused supervision includes:

- providing education, guidance and support for individuals who are performing the delegated activity
- directing the individual's performance
- monitoring and evaluating outcomes, especially the consumer's response to the activity.

There is a range of clinically-focussed supervision between direct and indirect. Both parties (the delegator and the person accepting the delegation) must agree to the level of clinically-focussed supervision that will be provided.

Direct supervision is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised.

Indirect supervision is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the consumer and the needs of the person who is being supervised.

Support workers

See non-nurse, non-midwife.

Volunteers/family members

Volunteers provide service without expectation of financial reward. In some contexts they provide services similar to those provided by support workers. While they are unpaid, and may be said to participate in care rather than be delegated care activities, the accountabilities of a registered nurse or midwife who involves the volunteer/family member in the provision of care are the same as for delegation.

References

The following are sources used in the concepts and definitions within this document:

- An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework
- Australian College of Midwives Inc (2004) National Midwifery Guidelines for Consultation and Referral
- Nurses Board of South Australia (2006) A Scope of Practice Decision-Making Tool.
- Nursing Board of Tasmania (2006) Final Report on the implementation of a scope of practice decision-making framework.
- Nurses Board of Victoria (2005) Discussion Document - Guidelines Determining the Scope of Nursing and Midwifery Practice
- Nurses Board of Western Australia (2005) Report of the Scope of Nursing Practice Project Implementation (Phase 2)
- Queensland Nursing Council (2005) Scope of Practice Framework for Nurses and Midwives

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Nursing practice decisions summary guide

Nursing and Midwifery Board of Australia

NOTE: the order in which these issues are considered may vary according to context

Identify client need/benefit

Yes to all / No to any

- Has there been a comprehensive assessment by a nurse to establish the client's needs/or their need for improved access to care?
- Has there been appropriate consultation with the client/their family/significant others?
- Is the activity in the client's best interests?

Reflect on scope of practice and nursing practice standards

Yes to all / No to any

- Is this activity within the current, contemporary scope of nursing practice?
- Have legislative requirements (e.g. specific qualification needed) been met?
- If authorisation by a regulatory authority is needed to perform the activity, does the person have it or can it be obtained before the activity is performed?
- Will performance comply with nursing practice standards /evidence?
- If other health professionals should assist, supervise or perform the activity, are they available?

Consider context of practice/organisational support

Yes to all / No to any

- Is this activity/practice supported by the organisation?
- If organisational authorisation is needed, does the person have it or can it be obtained before performing the activity?
- Is the skill mix in the organisation adequate for the level of support/supervision needed to safely perform the activity?
- Have potential risks been identified and strategies to avoid or minimise them been identified and implemented?
- Is there a system for ongoing education and maintenance of competence in place?
- If this is a new practice:
  - → Are there processes in place for maintaining performance into the future?
  - → Have relevant parties been involved in planning for implementation?

Select appropriate, competent person to perform the activity

Yes to all / No to any

- Have the roles and responsibilities of registered and enrolled nurses and non-nurses been considered?
- Does the person who is to perform the activity have the knowledge, skill, authority and ability (capacity) to do so either autonomously or with education, support and supervision?
- Is the required level of education, supervision/support available?
- Have all factors associated with delegation been considered?
- Is the person confident and do they understand their accountability and reporting responsibilities in performing the activity?

YES TO ALL

ACTION

Proceed to:

- perform the activity OR
- delegate to a competent person
- document the decision and the actions

EVALUATE

NO TO ANY

ACTION

- Consult/seek advice (eg NUM, DON other health professional) OR
- Refer/collaborate OR
- Plan to enable intergration/practice changes if appropriate (including developing/implementing policies, gaining qualifications as needed)

Document and evaluate and, if change still desired, commence process again

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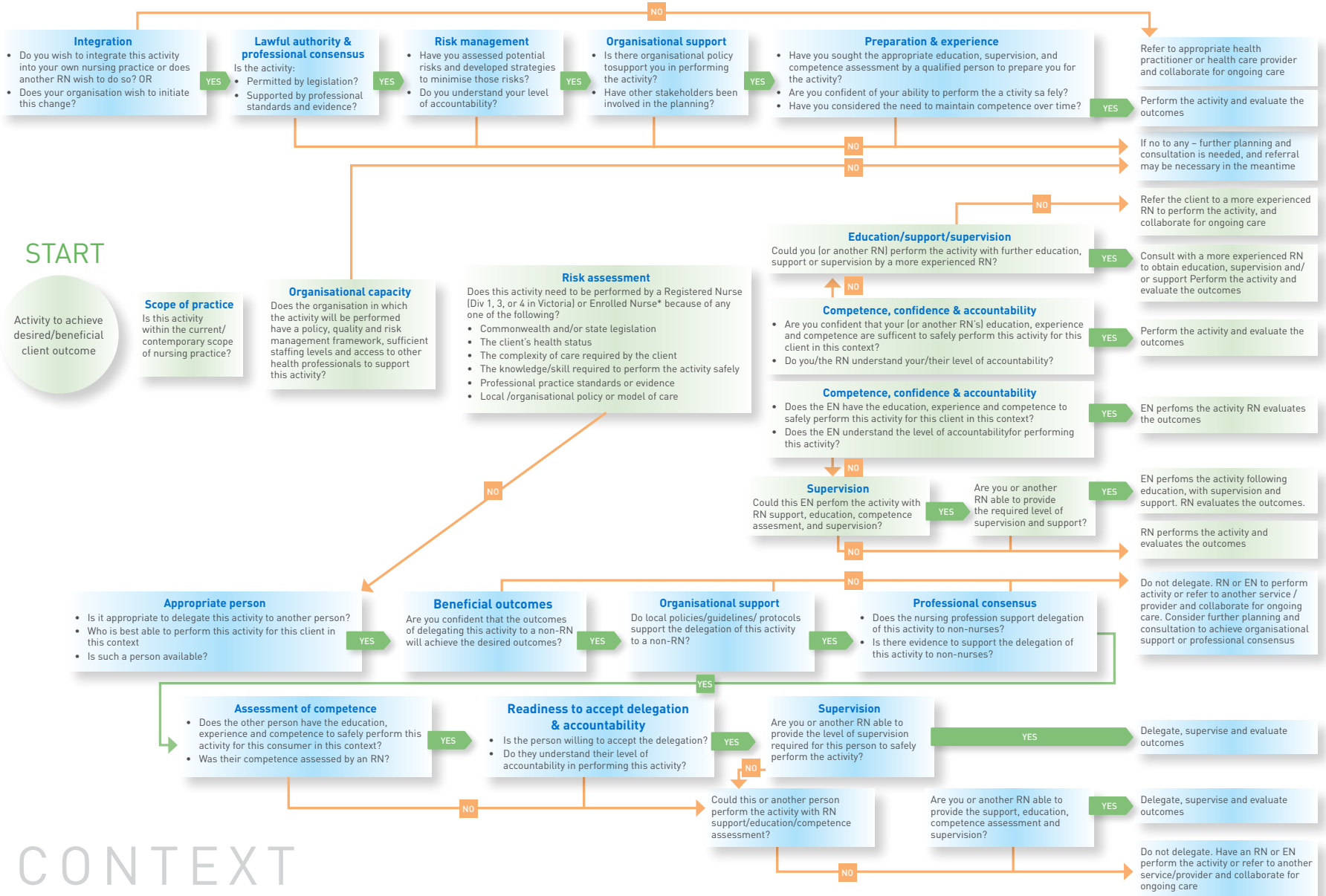
Nursing practice decision flowchart

Nursing and Midwifery Board of Australia



Civil and Administrative Tribunal
New South Wales

Case Title:	HCCC V Piper
Medium Neutral Citation:	[2014] NSWCATOD 62
Hearing Date(s):	5 May 2014
Decision Date:	12 June 2014
Jurisdiction:	Occupational Division
Before:	Mary Brennan, Principal member Catherine Sharp, nurse member Suellen Moore, nurse member Boyd Higgins, lay member
Decision:	1.Ms Piper is found guilty of unsatisfactory professional conduct and professional misconduct. 2. Rosalie Piper must pay the legal costs of the Health Care Complaints Commission of and incidental to these proceedings, such costs to be as agreed or as assessed. 3. Under Clause 7 of Schedule 5D of the National Law publication of the name, address or any other material identifying any patient to which any facts of the matter relate is prohibited.
Catchwords:	Unsatisfactory professional conduct and professional misconduct, supply and administration of S4 drugs without prescription or supervision of a medical practitioner; suspension of registration
Legislation Cited:	Health Practitioner Regulation National law (NSW) No 86a Poisons and Therapeutic Goods Act 1966 (NSW)
Cases Cited:	Rejfek v McElroy (1995)112 CLR 517) NSW Bar Association v Hamman (1999) NSWCA 404 NSW Bar Association v Meakes [2006] NSWCA 340 Currabubula Holdings Pty Ltd v State Bank of NSW [2002] NSW SC 232

	Ohn v Walton (1995) 36 NSWLR 77 Healthcare Complaints Commission v Rolleston 2013 NSWNMT 12 HCCC v Gower [2011] NSWNMT 17
Category:	Principal judgment
Parties:	The Health Care Complaints Commission (Complainant) Rosalie Piper (Respondent)
Representation	
- Counsel:	Counsel Ms H Bennett (Complainant) Ms P Robertson (Respondent)
- Solicitors:	Health Care Complaints Commission (Complainant) Rosalie Piper (Respondent in person)
File Number(s):	1420007
Publication Restriction:	Under Clause 7 of Schedule 5D of the National Law publication of the name, address or any other material identifying any patient to which any facts of the matter relate is prohibited.

REASONS FOR DECISION

Introduction

1 Registered nurse, Rosalie Piper (the nurse) started working in cosmetic medicine more than a decade ago. For nearly two and a half years, a medical practitioner obtained cosmetic medications for her that were restricted substances under the Poisons and Therapeutic Goods Act 1966 (NSW) (the PTGA). The nurse supplied and administered the restricted substances to patients at the medical practitioner's surgery and at a day spa 30 kilometres away.

2 The complainant was advised of the nurse's supply and administration of the restricted substances and conducted an investigation resulting in the

filing of these proceedings. The practitioner has admitted the particulars of the Complaints filed. In addition to being satisfied that the particulars of the Complaints are established, the Tribunal's task is to formulate some appropriate orders to protect the public. It is hoped that other nurses working in cosmetic medicine will carefully review their supply and administration of S4 drugs.

Background

3 In or about August 2009 the nurse entered into an arrangement with Associate Professor Haertsch, a specialist plastic surgeon who has a surgery at Epping. Dr Haertsch obtained the cosmetic injectable medications listed in Appendix A to the Complaint and provided them to the nurse. The nurse reimbursed Dr Haertsch for the cost of the medications with a sizeable share of the fee she received from the patients receiving injections from her. She worked one day per week as a nurse injector at his clinic in Epping. The nurse also took the drugs to premises in Collaroy, known as the Aroma Ki Day Spa Salon (the day spa) and supplied and administered the medications to clients of this business.

4 The seven medications detailed in Appendix A, which include Botox, are all restricted substances within section 4 of the PTGA. Section 4 of this Act provides that a restricted substance is one specified in Schedule 4 of the Poisons List. The Poisons List includes hyaluronic acid and its polymers in preparations for injection or implantation for tissue augmentation or cosmetic use. The Poisons List also includes botulinum toxins for human use. The complainant tendered material to establish that the seven medications supplied by Dr Haertsch to the nurse contained hyaluronic acid or botulinum toxins.

5 The complainant also tendered a protocol for the use of S4 drugs for cosmetic procedures by nurses. The protocol was produced in April 2005 and was a collaboration between the Australasian Society of Cosmetic Medicine (ASCM), the Australian Nurses Federation and the

Pharmaceutical Services Branch, NSW Department of Health. It is worth setting out the protocol's terms in some detail as it clearly provides the requirements for the supply and administration of S4 medication.

6 It notes that many medical products used in cosmetic procedures, such as Botox, collagen and hyaluronic acid are classified in the Poison Schedule as S4 drugs and that the use is controlled in NSW by the PTGA to protect the health and welfare of the community. The protocol further details that under the PTGA an S4 drug may only be supplied on the recent prescription of a medical practitioner and that the control, storage and dispensing of these drugs is limited to medical practitioners and pharmacists.

7 A medical practitioner may supply an S4 drug to a nurse to administer to a patient if the patient is under the direct care of the medical practitioner and a specific patient authorisation to administer the drug has been given to the nurse. A medical practitioner may not supply an S4 drug to a nurse for administration to a patient who is not under the direct care of that medical practitioner. Further, a nurse may not administer any drug to a patient unless written authorisation has been given by a medical practitioner to administer the substance to that specific patient.

8 Additionally, under the protocol, any patient receiving an S4 drug should initially be assessed by a medical practitioner, so a clinical history and record of the patient's medications and allergies can be noted. The management plan must include a discussion of potential side effects or any complications of the drugs being administered. Once the plan of management has been determined, the nurse may administer the drugs according to the medical practitioner's recent instructions. The medical practitioner should be immediately contactable to deal with any problems arising from the administration of the medication.

9 Significantly for the purposes of this case, the protocol states that medical practitioners who supply S4 drugs to nurses but have no input into the clinical management of the patient, or no physical presence on the premises at which the drugs are injected, contravene the law and are liable to prosecution. Nurses are also advised that if they function autonomously to store, prescribe and dispense S4 drugs purchased for them by medical practitioners, they contravene the PTGA. Further, this conduct is outside the nursing scope of competency and practice.

10 The document also warns nurses practising outside the protocol's terms that they may find they are not appropriately protected, professionally or industrially if a claim is made. The Tribunal was surprised, in asking the nurse about her professional indemnity insurance arrangements, to be informed by her that she had a policy which provided coverage for her work as a nurse injector, particularly at the day spa.

11 The complainant's tender bundle also includes an undated document entitled Australasian College of Cosmetic Surgery Protocol for Delegated Cosmetic S4 Injections. The Protocol notes that it is not uncommon for cosmetic injections to be administered by nurse injectors and if so, the supervising medical practitioner has ultimate responsibility for the training and skills maintenance of the nurse and for the patients' safety and overall care.

12 Suitably trained registered nurses can administer S4 medicines for cosmetic purposes after a medical practitioner has consulted the patient and formulated a written treatment plan which includes stating which medications are to be used and the maximum number of procedures and doses of medication to be administered. It is not acceptable for a medical practitioner to on-sell S4 medications to nurses to then administer these to patients.

13 From approximately 8 August 2009 to about 10 December 2011, the nurse supplied the medications obtained by Dr Haertsch to 97 patients on more

than 230 occasions at the day spa without authority or written direction from a medical practitioner. The nurse also administered the medications without a medical practitioner being involved in the consultations.

14 Further, on 90 occasions between 16 September 2009 and 8 December 2011, the nurse supplied and administered S4 medications obtained by Dr Haertsch for 29 patients at his practice at Epping without his or any other medical practitioner's involvement in the consultations.

15 In early 2011 the ASCM received a complaint regarding the nurse's alleged administration of Botox at beauty salons and at her home and informed the complainant. The Society expressed concerns that the nurse's activities were not only well outside the scope of nursing practice but were also in direct contravention of the law.

16 In response to a letter from the complainant, the NSW Nurses Association, on behalf of the nurse denied that their member had administered Botox from her home. In terms of her work at the day spa, the Association also advised the complainant that the treatment was under the supervision of Dr Haertsch and that patients' photos and records were reviewed by him. Further, since the nurse had become aware of the complaint, she had ceased administering Botox at the day spa and would only administer such treatments at the Epping clinic when Dr Haertsch was in attendance. Around this time the nurse also began working at Anti-Aging Associates, a group of cosmetic clinics providing dermal fillers and other "anti-ageing" treatment.

17 In a record of interview with an employee of the complainant, the nurse said that she did not know where the "rules" about the supply and administration of S4 drugs came from. She also was not certain if "fillers" were an S4 drug. She advised that she ceased administering Juvederm or Botox without supervision at the end of 2011. She said that she did not cease the treatment when she first became away of the complaint because

of pressing financial issues. A summary of the nurse's billing records between August 2009 and December 2011 reveal that she administered Dysport, which contains botulinum toxins, at the day spa in December 2011 and Botox, at the Epping practice in the same month.

18 In explaining her practice at the Epping clinic, the nurse detailed in a written statement dated 19 June 2011 that for every new patient seen at Dr Haertsch's surgery she would access a blank medication order form and a consent form. After seeing a patient she would notate the form for the cosmetic medication(s) to be used and the surgery would supply them. She would then administer the medication(s) and write up her medical and treatment notes. She noted that Dr Haertsch "did not sign the order form prior to but would sometimes sign the document later that day or soon after."

19 Ms Cheryl Hayward, Dr Haertsch's medical secretary, provided a statement dated 4 December 2012. She said that the nurse would obtain blank prescription and consent forms from her prior to seeing a patient. After the nurse's treatments Ms Hayward would give the prescription forms to Dr Haertsch for his signature. She said that Dr Haertsch would usually not see the Botox or dermal filler patients unless they required surgery or if the treatment required was beyond the scope of the injecting treatment.

20 In an interview with the complainant, on 8 August 2012, Dr Haertsch advised that the nurse obtained the injectable medication by asking his secretary to order them. He also noted that occasionally the nurse would ask him "something about" the patients she saw.

21 Dr Haertsch was also asked to answer some specific questions by the complainant in a letter dated 15 December 2011. In response he advised on 18 January 2012 that whilst he was "available for direct supervision and consultation if necessary" of patients the nurse had seen, he did "not usually attend the patients at the same time as she [did]." Dr Haertsch also

advised that he had no knowledge of the nurse's "arrangements in other practices."

22 The complainant filed the proceedings dated 20 September 2013 alleging the nurse was guilty of unsatisfactory professional conduct under section 139B of the Health Practitioner Regulation National Law (NSW) (the National Law) and professional misconduct under section 139E of the National Law.

23 The nurse admitted the Complaints. On 10 April 2014 the complainant amended the complaints to withdraw some of the particulars.

The hearing

24 The Tribunal heard this matter on 5 May 2014. The complainant's and nurse's evidence was tendered without objection. The nurse gave evidence. The parties' counsel addressed the Tribunal on the appropriate protective orders to be made, given the nurse's admissions. The parties also made submissions on costs. The complainant provided the Tribunal with written submissions on 5 May 2014. The nurse's counsel filed submissions with the Tribunal on 9 May 2014.

Meaning of unsatisfactory professional conduct and professional misconduct

25 Pursuant to section 139B of the National Law, unsatisfactory professional conduct of a registered health practitioner includes both of the following-

> (a) conduct significantly below reasonable standard
> Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or expertise.
> ...
> (l) other improper or unethical conduct
> Any other improper or unethical conduct relating to the practice or purported practice of the practitioner's profession.

26 Professional misconduct under section 139E of the National Law means-

> (a) unsatisfactory professional conduct of a sufficiently serious nature to justify suspension or cancellation of the practitioner's registration; or
>
> (b) more than one instance of unsatisfactory professional conduct that, when the instances are considered together, amount to conduct of a sufficiently serious nature to justify suspension or cancellation of the practitioner's registration.

The PTGA's requirements

27 Section 10(3) of the PTGA provides that a person who supplies a restricted substance otherwise than by wholesale is guilty of an offence. Section 10(4) exempts the supply by a medical practitioner if it is within the lawful practice of his/her profession.

Complaints' particulars

28 Both Complaints rely upon the same particulars.

> 1. Between around August 2009 and December 2011, the nurse supplied to patients at the Epping practice and/or at the day spa, the restricted substances contrary to section 10(3) of the PTGA.
>
> 2. Between around August 2009 and December 2011, the nurse administered the restricted substances to patients at the Epping practice and/or the day spa in the absence of any:
> (a) consultation, review or assessment of the patients by a medical practitioner;
> (b) prescription from a medical practitioner;
> (c) written instructions or written orders from a medical practitioner;
> (d) supervision by a medical practitioner.

The evidence

29 The material tendered by the complainant includes records of interview with the nurse, Dr Haertsch and his medical secretary, Ms Hayward. It also provides an expert opinion from Ms Allison Cummins received by the complainant on 6 May 2013 and Mr Bruce Battye dated 24 February 2014. The respondent's tender bundle includes statements from the nurse, Dr Haertsch and reports from Ms Robyn Barrett Roydhouse dated 29 April 2012, 5 June 2012 and 10 January 2013.

Evidence relied upon by the complainant

30 Evidence from the nurse, Dr Haertsch and Ms Hayward which establishes the complaints, has been discussed above. Ms Cummins is a registered midwife. As a lecturer in midwifery at the University of Technology, she teaches the storage and administration of medications. She opines that the nurse's prescribing and administration of Botox and dermal fillers without authority or written orders at the day spa constitutes conduct significantly below the standard of a practitioner of an equivalent level of training.

31 Further, this expert considers the nurse's conduct is outside the scope of professional practice as per the national competency standards for the registered nurse developed by the Australian Nursing and Midwifery Council (ANMC). Ms Cummins referred to the requirements in the standard that nurses must practise in accordance with legislation affecting nursing practice and health care. She notes that registered nurses are not permitted to prescribe S4 medications unless they are an endorsed nurse practitioner with prescribing rights. Under the PTGA, the nurse is also prohibited from controlling, storing and dispensing of S4 drugs.

32 In terms of the nurse's prescribing and administration of S4 drugs at the Epping clinic, the expert considers that the nurse's conduct also falls significantly below the standard of a practitioner of an equivalent level of training. Ms Cummins notes that from the statements obtained by the complainant, there is no evidence that Dr Haertsch consulted with patients, developed a care plan or prescribed the S4 medications. Finally, while noting that it is outside the scope of her report, Ms Cummins also opines that Dr Haertsch is partly responsible for the actions taken by the nurse, particularly as she worked in his rooms.

33 The Tribunal also considered a report by Mr Battye, the acting Chief Pharmacist and Associate Director of the Pharmaceutical Services Unit, NSW Ministry of Health. The complainant asked the Pharmaceutical

Services Unit to comment upon the protocol provided by the nurse governing her employment with Anti Aging Associates. The complainant highlighted to the Pharmaceutical Services Unit that the medical practitioners prescribing S4 substances for patients of the business appeared to be based in Victoria and consult with patients via Skype.

34 Mr Battye notes that the Pharmaceutical Services Unit is aware that some medical practitioners are setting up accounts with wholesale suppliers to obtain restricted substances, including botulinum toxin and hyaluronic acid, without taking personal responsibility for the storage, supply or administration of the restricted substances to patients. There is no objection to a medical practitioner authorising the administration of a restricted substance to a patient under the medical practitioner's direct supervision or allowing the administration of a restricted substance, providing that he/she takes responsibility for ensuring the person administering the substance is competent. Mr Battye considers that it is advisable for the medical practitioner to provide written, patient specific authorisation, prior to the administration of a restricted substance, to confirm the medical practitioner's intention.

35 The report ends with expressing concern that some medical practitioners are failing to adequately consult and review patients and empowering nurses or other unauthorised persons to administer and make clinical decisions about restricted substances, without authority or supervision. The use of multidose vials on more than one patient with the risks of microbial contamination and cross infection is also raised as a concern.

Evidence relied upon by the nurse

36 The nurse tendered three reports from Ms Barrett Roydhouse. Ms Barrett Roydhouse had worked in cosmetic aesthetic injecting for nine years at the time of her first report. She was briefed by the complainant to comment on the nurse's conduct at the day spa and the Epping clinic. Ms Barrett

Roydhouse refers to the protocols issued by ASCM and the Australasian College of Cosmetic Surgery. She concludes the nurse's administration of S4 drugs without standing orders from a medical practitioner for a specific patient is a departure from prevailing legislation and standard industry practice. Ms Barrett Roydhouse also considers that the nurse had disregarded industry best practice and legislation and she is strongly critical of this. The expert criticises the nurse's records, opining that she would have expected additional supporting medical records relating to specific patients.

37 In a follow-up report, Ms Barrett Roydhouse was asked by the complainant to review a number of the nurse's medical records. As a result of conducting this review, she expresses satisfaction at the level of detail provided by the nurse which she considers is in accordance with the expected standard of practitioner of an equivalent level of training or experience. Further, the expert revised her opinion in relation to the nurse's treatments of patients at Dr Haertsch's practice and said she regards the nurse's administration of S4 drugs is not a significant departure.

38 In a third report provided to the complainant, Ms Barrett Roydhouse states that she retracted her initial criticism of the nurse's treatment of patients at the Epping clinic in her last report as she assumed Dr Haertsch had seen the patients prior to treatment. As a result of learning this was not the case, the expert opines the nurse's conduct in administrating S4 injectable medications is a departure from the standard reasonably expected of a practitioner of an equivalent level of training or experience but not a significant departure. Ms Barrett Roydhouse maintains her opinion that the nurse's supply and administration of the S4 medications at the day spa fell significantly below the standard.

Findings

39 The nurse admits unsatisfactory professional conduct as particularised in Complaint One which reflects the definition in section 139B(1)(a) and (l) of the National Law. In light of the nurse's admissions and the overwhelming evidence before it, the Tribunal is comfortably satisfied on the balance of probabilities that the Complaint of unsatisfactory professional conduct is proven (Rejfek v McElroy (1995) 112 CLR 517).

40 The nurse also admits professional misconduct as particularised for Complaint Two, which reflects the definition in section 139E of the National Law. Again the Tribunal is satisfied that this Complaint is proven.

41 The Tribunal finds that the nurse has not met the ANMC Standard of practising in accordance with legislation affecting nursing practice and health care. The PTGA leaves little doubt that S4 medications, including those administered by the nurse, cannot be supplied and administered by a registered nurse. The protocols developed by the ASCM and the Australasian College of Cosmetic Surgery provide further guidance to practitioners who choose to work in this area and clearly set out the roles and responsibilities of medical practitioners and nurses.

42 The Tribunal notes that in a document dated 17 December 2013, Dr Haertsch states that in commencing work at his clinic, the nurse adopted the system that had been in place for the previous 18 years and that most of the clients were long-standing and had been treated by the previous nurse injector. The nurse gave evidence that she presumed, in taking over the practice of the previous nurse injector at the Epping clinic, that the practice was appropriate. She knew of Dr Haertsch's reputation as a respected medical practitioner. She said that she recognised that she should have been more assertive so that Dr Haertsch saw all the patients and wrote the scripts for the S4 medication.

43 The Tribunal has some sympathy for the nurse given the opportunities provided by Dr Haertsch. It is highly critical of his acquisition and supply of

the S4 medication for the nurse. There is no doubt that he provided the means for her to engage in the conduct found to be unsatisfactory and professional misconduct. However, this does not detract from the nurse's responsibility to ensure she was complying with the law and with the terms of her registration to practise.

44 Further, it finds that the nurse did not understand or practise within the scope of her practice. The Standard guides registrants to seek clarification if there is uncertainty about what is meant by the scope of practice and to demonstrate an accountability and responsibility for their own actions within nursing practice. The Tribunal finds the report of Ms Cummins more persuasive than the reports from Ms Barrett Roydhouse on whether the nurse had failed to meet the standard expected of a practitioner of an equivalent level of training.

45 The nurse gave evidence that as a result of Mr Battye's report she resigned from her employment with Anti Aging Associates. She said prior to commencing with the business she carefully reviewed its protocols to ensure the business met the required Standards. She was disappointed after reading the expert's report, as she believed she had been practicing appropriately but considered there were clearly grey areas, particularly with the use of Skype for patient consultations.

46 The Tribunal does not make any findings in relation to the nurse's work at Anti Aging Associates, which is not covered by the Complaints. It finds her evidence that she had reviewed the company's protocols for S4 injections, prior to starting with the company, to be credible particularly, in light of the complaint already made. Mr Battye's report highlights the risks for nurses and medical practitioners involved in the administration of S4 medication for cosmetic procedures.

47 At the end of the day, the requirements in the PTGA and the protocols developed to assist practitioners working in cosmetic medicine, leave little

ambiguity of the procedures which must be followed by nurses and medical practitioners. It is imperative nurses working in this area access and understand the requirements for the supply and administration of S4 drugs or they practise at their peril. As the subject nurse has found, assuming or hoping that her treatment of patients was within the law because it had the support of a medical practitioner does not protect her from serious consequences.

Protective orders

48 The Tribunal's power to make protective orders when a complaint is proven is set out in sections 149A-C of the National Law. The Tribunal's jurisdiction is protective rather than punitive. As such, the object of protection includes deterring the practitioner from repeating the conduct and significantly, in this case, deterring others who may consider engaging in similar conduct (NSW Bar Association v Hamman (1999) NSWCA 404. As noted by Basten JA in NSW Bar Association v Meakes [2006] NSWCA 340:

> "There are also important but indirect effects to be considered. First, the order reminds other members of the profession of the public interest in the maintenance of high professional standards. Secondly and more specifically, it may give emphasis to the unacceptability of the kind of conduct involved in the disciplinary offence. Thirdly, by speaking to the public at large, it seeks to maintain confidence in the high standards of the profession. The underlying purpose is not self-aggrandisement on the part of the profession, but a recognition of the social value in the availability of the services provided to the public, combined with an understanding the vulnerability of many who may require such services."

49 The Tribunal considers there may be a high level of vulnerability with patients seeking cosmetic services, such as those offered by the nurse, given S4 medications are still relatively new and the treatments exploratory. As the complainant submits, Botox and dermal filler injections for cosmetic purposes is a growing and financially lucrative area of healthcare where considerations of general deterrence, maintenance of high professional standards and public confidence are of particular importance.

50 The nurse's practice of supplying and administering S4 medication occurred at the day spa and Epping clinic for over 2 years. While she would not have been able to have engaged in such conduct without the restricted substances' supplied by Dr Haertsch, the Tribunal does not consider the nurse took sufficient responsibility to ensure that she was operating within the terms of the law. The Tribunal is particularly concerned about the nurse's treatment of patients at the day spa given there was not even the possibility for a medical practitioner to become involved in the management plan and treatment of those patients.

51 The nurse cooperated with the complainant's investigation and expressed remorse at various stages of the matter. While the Tribunal finds this expression of remorse and insight genuine, it is troubled by the fact that the nurse, through the NSW Nurses Association, assured the complainant that she had ceased supplying and administering Botox to patients at the day spa in May 2011, when her later evidence and billing records show this was not the case. Further, the Association advised the complainant that Dr Haertsch reviewed the day spa patients' photos and treatment records and had input into medication prescribed which is also untrue.

52 Having carefully reviewed all the evidence, the Tribunal considers it unlikely that the nurse will contravene the law or work outside her scope of practice again and our orders reflect this belief. The conditions to be placed on the nurse's registration take account of the complainant's and respondent's submissions as well as the extensive experience of the Tribunal's nursing members.

53 As noted in the decision of Medical Tribunal of NSW v Whitton No. 40027/04, "a further consideration is making orders which will deter other practitioners from similar behaviour. It must be seen by the community and the profession that the Tribunal will make orders designed to protect, to maintain standards and to give a clear indication to the profession that the conduct giving rise to such orders is unacceptable."

54 The Tribunal hopes the orders will remind and deter all nurses working in this field of cosmetic medicine to ensure they are practising within the law. The administration of Botox and dermal fillers is a medical procedure that must be medically supervised.

The orders of the Tribunal are:

(1) The nurse be reprimanded.

The Tribunal acknowledges that the nurse has admitted the subject matter of the complaint in writing to the Tribunal after the Complaints were filed. Nonetheless the Tribunal opined that the nurse, Ms Rosalie Piper, would or should have known that the administration of Schedule 4 drugs by subcutaneous injection, that were not prescribed by a medical practitioner, was putting her, and the patients she treated, at great risk. In addition the use of multi-dose vials was seen as a major concern, by the Tribunal.

The Tribunal also considered that the nurse would or should have known that the administration of Schedule 4 drugs had to be checked by a second nurse authorised to check Schedule 4 drugs and that this was not done.

Further, the Tribunal opined that, even if the nurse honestly believed she was doing the right thing for the patients she was injecting, she should have checked with the Nurses Registration Board or after 1 July 2010, AHPRA, as to whether she needed a script for each patient after the patient was reviewed by a medical practitioner and a second person to check the Schedule 4 drugs.

The Tribunal found the nurse's conduct to be well below the standard expected of someone with her level of experience and education. Her actions, putting the public at risk, are well below the accepted standard and show a significant departure and she deserves strong criticism.

The Tribunal finds the nurse guilty of unsatisfactory professional conduct and serious misconduct.

(2) The nurse's registration is suspended for three months from the date of this decision;

(3) Conditions as follows be placed all the nurse's registration :

RESTRICTIONS
1.The nurse is not to inject permanent fillers such as polylactic acid, acrylic hydrogel and polyacrylamide.
2.The nurse is not to transport S4 cosmetic injections.

PRACTICE CONDITIONS
The nurse may only administer S4 cosmetic injections when she is in compliance with the following conditions:

3.The nurse is only to administer S4 cosmetic injections:
a.within a medical practice. At all times:
i.a medical practitioner must be onsite;
ii.If there is a second enrolled nurse or registered nurse employed at the same location as the practitioner, a second person check should occur before the S4 is administered (other than the authorised prescriber) as per the best practice guidelines outlined in Medication Handling in NSW Public Health Facilities; and
iii.emergency resuscitation equipment, i.e. equipment for maintaining an airway, equipment to assist ventilation (including bag and mask), intravenous access, and emergency medicines, must be available.
b.which have been prescribed by a medical practitioner who has authorised the practitioner to administer such injections to his/her patients and that the prescription for S4 cosmetic injection/s meets the requirements outlined in Clause 35 of the Poisons and Therapeutic Goods Regulation 2008 (or its equivalent in other jurisdictions) including adequate instruction for location and volume of injection.
c.that specify the prescribed interval/s between repeat injections, if applicable.

4.The nurse must advise the Nursing and Midwifery Council of New South Wales (the Council) of the name and location of any medical practice that she will administer S4 cosmetic injections. The nurse must also advise the Council of each medical practitioner who has authorised the nurse to administer S4 cosmetic injections to his/her patients. The practitioner must:
a.provide the Council with the name, registration number and the contact details of each medical practitioner within two weeks of commencing administration of S4 cosmetic injections.
b.authorise each medical practitioner to:
i.notify the Council of any breach of the conditions or unsafe practice;
ii.exchange information with the Council related to compliance with the conditions;
iii.provide the Council with a copy of the conditions signed by the practitioner and by the medical practitioner indicating awareness of the conditions and authorisation; and

iv.provide the Council with a report, in a format to be determined by the Council, at 6 monthly intervals, which addresses the practitioner's compliance with the conditions.

5.On each occasion prior to administering S4 cosmetic injections the nurse must verify the following information from the patient's medical record:
a.That the patient has undergone prior consultation with the prescribing medical practitioner.
b.The prescription for S4 cosmetic injection/s meets the requirements outlined in Clause 35 of the Poisons and Therapeutic Goods Regulation 2008 (or its equivalent in other jurisdictions) including adequate instruction for location and volume of injection.
c.The prescribed interval/s between repeat injections, if applicable.

6.The nurse must maintain clinical records for each patient which include:
a.Details of the prior consultation including date of consultation and name of medical practitioner.
b.Details of the S4 cosmetic injection/s administered including date, time, drug/s, site/s and volume administered.
c.Details of any adverse or unexpected outcome following administration including action taken by the practitioner.
d.Confirmation, within one week, of consultation by a medical practitioner following any adverse or unexpected outcome.

AUDIT
7.The nurse will submit to an audit at her place of employment of a random selection of her clinical records by a registered nurse nominated by the Council. The audit is to occur within three months of her commencing employment and then after a further six months. The nurse is to be given seven days notice of the audits. If the nurse is employed by more than once practice, the audit will only occur at one practice. The nurse is to authorise the auditor to provide the Council with a report on his/her findings. The nurse is to meet all reasonable costs associated with the audit and the report.

EDUCATION
8.The nurse is to undertake the following courses (or an equivalent course that has been approved by the Council:
a.Basic Life Support incorporating AED as recommended by the Australian Resuscitation Council.
b.CPD Infection Prevention and Control course conducted by the Australian College of Nursing.

9.The commencement date for the courses outlined in Condition 8 should be no later than 1/12/2014 (or otherwise at a date determined by the Council) and the completion date should be no later than 1/6/2015 (or otherwise at a date determined by the Council).

10.For a minimum period of two years and thereafter as to be determined by the Council, the nurse is to undertake on an annual basis education which is approved by the Council in relation to each S4 cosmetic product she administers by injection. Prior to commencement the nurse must submit details of the education

including the proposed commencement date for consideration by the Council. This education is in addition to the requirements of her registration.

11.The nurse is to provide to the Council evidence of successful completion of the courses / education programs required by Conditions 8 and 10 signed by an individual authorised by the relevant education institution within fourteen days of completion of the course or education program.

REVIEW
12.The appropriate review body for the purposes of Division 8 Part 8 of the Health Practitioner Regulation National Law (NSW) (the National Law) is the Council.

13.The Council is to conduct a general review of the conditions imposed on the nurse's registration by the Tribunal within three years of this decision, and no earlier than within two years of this decision, to determine whether each of the conditions should remain, be varied or removed. This does not preclude the Council from varying or removing a condition at any other time as it deems appropriate.

14.Sections 125 to 127 inclusive of the National Law are to apply should the nurse's principal place of practice be anywhere in Australia other than in New South Wales, so that the appropriate review body in those circumstances is the Nursing and Midwifery Board of Australia.

(4) Under Clause 7 of Schedule 5D of the National Law, publication of the name, address or any other material identifying any patient to which any facts of the matter relate is prohibited.

Costs

55 The complainant submitted at the hearing that the nurse should pay its costs as the successful party to litigation has a reasonable expectation of being awarded costs. Fairness dictates that the unsuccessful party typically bears liability for costs unless it is demonstrated that some other order is appropriate Currabubula Holdings Pty Ltd v State Bank of NSW [2002] NSW SC 232. The presumption is based on the principle that costs are compensatory and applies to this Tribunal. (Ohn v Walton (1995) 36 NSWLR 77)

56 The nurse submitted that each party should be ordered to pay their own costs. She referred to the decision of the Medical Tribunal of NSW in Healthcare Complaints Commission v Rolleston 2013 NSWNMT 12 where

this was ordered in circumstances where the practitioner advised the complainant at an early stage of the matter that he would not be defending the proceedings and would not practise again. In that case, the medical practitioner had been imprisoned and the Tribunal accepted that it was very unlikely he would attempt to practise in the future given these circumstances coupled with his age.

57 In this case, the nurse advised the complainant at the first directions hearing that she admitted the Complaints. She also requested the matter proceed pursuant to section 165H of the National Law. This section provides that no inquiry need be conducted into a complaint if the registered health practitioner admits the subject matter of the complaint in writing to the Tribunal.

58 In a statement dated 10 January 2014 the nurse "accepted and acknowledged" that between August 2009 and December 2011 she had practised outside the accepted standards of a cosmetic nurse injector.

59 In HCCC v Gower [2011] NSWNMT 17, the practitioner was represented by counsel and admitted all the particulars of the complaint. There were detailed submissions about the appropriate protective orders to be made. In that case the Tribunal awarded costs to the complainant. In the Rolleston case, the Tribunal distinguished this decision when determining costs, given the necessity for that Tribunal to consider protective orders in some detail, as occurred in the present case. In Rolleston, the Tribunal did not need to hear the parties on this important issue because it was satisfied the practitioner would not practice in the future.

60 On balance, the Tribunal orders that the nurse pay the complainant's costs in this matter on the ordinary basis as defined in section 3 of the Civil Procedure Act 2005 (NSW) as agreed or assessed. It considers that whilst the nurse's admission resulted in a shortened period of hearing for the

Tribunal, this should be reflected in reduced costs to those which would have otherwise have been incurred.

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