

30 October 2008

Ms Amanda Hammer
National Agenda - Workforce Planning and Coordination Branch
Submitted electronically to: nraip@dhs.vic.gov.au
Attention: Practitioner Regulation Subcommittee

Dear Practitioner Regulation Subcommittee

Re: Registration Arrangements Submission

The Sisters of Charity Health Service (SCHS) welcomes the opportunity to provide feedback on the proposed Intergovernmental Agreement (IGA) for the National Registration and Accreditation Scheme for Health Professionals and trust the consultative process of engaging all of healthcare will continue. Sisters of Charity Health Service, together with its partners, are one of Australia's leading Catholic not-for-profit diversified healthcare providers. Our health service is founded on a firm commitment to Mission and Values, based on the Gospel and Catholic social teaching in the spirit of Mary Aikenhead, founder of the Sisters of Charity. Our broad ranging health services span across the public, private and aged care health sectors in New South Wales, Queensland and Victoria.

A consultative process was undertaken to review the "Registration Arrangements Consultation Paper" with feedback sought from Quality & Risk committees, National Nursing Executive and Executive responsible for Clinical Services. Through the consultation process it was identified that SCHS is in favour of the creation of a national registration and accreditation system with the intentions set out in IGA.

In particular SCHS supports the objectives to develop legislation that will:

- Improve safety and quality by ensuring only suitably qualified and trained practitioners are registered;
- Improve the sustainability and flexibility of the workforce through the reduction in red tape; and
- Facilitate the provision of high quality education and training, including rigorous assessment of overseas trained practitioners.

SCHS believe that if the proposed legislation meets the stated objectives and principles espoused in the IGA the following general issues will need to be considered:

- Significant resources will need to be devoted to the establishment of systems to assist "boards" across all health professional categories and jurisdictions to meet the implementation date of July 2010. Without resources, goodwill and support from the existing stakeholders the 2010 date is unrealistic.
- Registration should primarily attempt to consolidate consistent classifications within health professions which in turn would assist in national recognition. However within such broad classifications there should be allowance for the

distinguishing between Divisions. (i.e Div 1 RN's, Div 2 EN's, Div 3 Midwives, etc)

- Boards responsible for registration should be familiar with the contemporary education and competency requirements.
- The administrative and bureaucratic processes involved in registration and accreditation should be efficient and timely to ensure that they don't compound labour shortages in healthcare. Efficiency outcomes in the processing of registration and accreditation will be warmly welcomed by the industry.
- The level of responsiveness of registration boards. The structure and functionality of the boards will need to balance the effectiveness of a local versus federal management approach. Communication processes and responsibilities need to be spelt out for organisations.
- The IGA needs to consider the dichotomy in healthcare cultures. Nursing culture is historically regulatory whilst the medical culture has been highly autonomous in its approach. Provision of the proposed legislation needs to be conscious that a "broad brush" approach may not suit all professions.
- Greater clarity surrounding issues of privacy and confidentiality will assist organisations in their involvement with the registration and accreditation process.
- For ease of administration at an organisational level a centralised registration date/s, should be considered. At the very least different dates for each speciality.

The attached table provides direct responses pertaining to the specific topic area in the IGA paper gained through the consultative process. If you have an queries in relation to the comments please contact Mr Allan Wilson (National Risk Manager) on 0417 765 634.

Yours sincerely

Associate Professor Deborah Green
National Chief Executive Officer
Sisters of Charity Health Service Limited

Topic Area	SCHS Comments
Criminal History Checks	
<p><i>Proposal 4.3.1: There are a number of options available on or relating to requirements for criminal history checking of applicants for registration and renewal of registration:</i></p> <p>Option 1: That the legislation require criminal history checks be applied to all new applicants for registration from 1 July 2010, but not to existing registrants renewing their registration.</p> <p>Option 2: That the legislation require criminal history checks on all new applicants and at renewal of registration, but these requirements be phased in over time from 1 July 2010.</p> <p>Option 3: The legislation require criminal history checks on all new applicants for registration, with a discretionary power for boards to require checks at annual renewal, and self-declaration obligations imposed on registrants both at annual renewal and during the registration period.</p> <p>Option 4: That the legislation provide the power to require criminal history checks on applicants at the discretion of the relevant board, while not making checks mandatory for all applicants.</p>	<p>Option 3 is considered the most practical for healthcare organisations.</p> <p>Comment: Aim should be that Criminal History Checks (CHC) are administered at the registration board level and that the criminal history check is provided to health facilities along with other registration certification (or available on the public register) for consideration with employment and credentialing applications.</p> <p>For initial registration: CHC supported and should be handled at the registration level by the Board, with self disclosure at renewal time. However there is interest in what criteria will be used to evaluate CHC's, with consideration of privacy, timespan between convictions and registration, as well as IR legislation need to be considered.</p> <p>In addition it is acknowledged that organisation will need to consider other factors when making appointment i.e. the area being employed e.g. Aged Care, Children.</p> <p>It is also unclear will be for students in relation to the screening process?</p>
6.1.1 Powers of boards before deciding applications for registration	
<p>The organisation supports the proposal that the legislation provide for responsible boards at their discretion to exercise the following powers:</p> <ol style="list-style-type: none"> a. investigate the applicant b. require the applicant to attend before the board to answer questions about their application c. require the applicant to provide further information or any documents considered necessary by the board to decide the application d. require the applicant to undergo a written, oral or practical examination to assess the applicant's competence to practice e. require the applicant to undertake a health assessment to assess the applicant's capacity to practice. 	<p>With regard to d., it is suggested that for overseas applicants where English is not the native language, the ability for Boards to require an English fluency assessment should be specifically expressed in the legislation.</p> <p>The question of discretion may need clarification or conditions, it is suggested that in the cases of overseas applicants that an "aural" and/ or practical assessment should be mandatory.</p>

Who Makes Registration Decisions

Proposal 6.2.1: It is proposed that when a committee makes registration decisions the responsible board would otherwise be empowered to make, it is constituted appropriately. In order to achieve this, the legislation would require provisions that:

- a. require a committee, when exercising registration functions, to comprise at least the following:
 - i. a chair appointed by the responsible board who may be a registrant (from the profession regulated by the responsible board), or a non-registrant
 - ii. at least two members who are registrants from the profession concerned
 - iii. at least one lawyer
 - iv. at least one community member who is not and has never been a registered practitioner in that profession, and
 - v. no more than two thirds of members being registrants from the profession concerned
- b. allow a committee to regulate its own proceedings, while requiring it to observe the principles of natural justice and procedural fairness, and
- c. allow members appointed to committees to be paid the sitting fees and allowances approved by the Ministerial Council.

This proposal appears consistent with most legislative committee constitutions.

Looking for a degree of balance in the constitution of the committee. There is not a “no less than” requirement for members of the profession. Expertise required strongly depends on the case before the Board, there may need to be a co-opting powers to engage specialists to assist with decisions in complex issues.

Proposal 6.2.2: It is proposed that the legislation include powers for a responsible board to delegate, in writing, to a member of the responsible board or a member of a committee, a person employed by the National Agency, or a person engaged by the National Agency to provide services to the board, its registration powers and functions under the legislation, other than its powers to:

- a. refuse to grant, or refuse to renew a registration or an endorsement of registration
- b. impose conditions on a registration or endorsement of registration
- c. impose conditions on a registration renewal or endorsement renewal
- d. amend, vary or revoke conditions on a registration or endorsement, and
- e. remove a person's name from the register where the person no longer meets the requirements for registration (see section '12.5 Removal from the register' of this paper).

The powers noted would remain part of existing tribunal / disciplinary functions within the board structure.

Professional Indemnity Insurance (PII)

Proposal 6.3.1: It is proposed that the legislation require registrants (except for non-practising registrants if any) to be covered by PII arrangements at all times during the registration period, as a condition of registration, and to require registrants demonstrate coverage to the satisfaction of the responsible board, at the time registration is granted for the first time, and annually on renewal of registration.

The legislation concerning PII must allow registrants to meet the requirements if they are covered by an employer's PII, their university's PII, or the PII of a health facility where they are a student, as well as when a registrant purchases their own PII cover.

Proposal 6.3.2: It is proposed that each national board have the power to issue a guideline about what constitutes acceptable arrangements for PII for registrants.

Clarify whether PII arrangements that is currently provided with union membership for nurses / midwives would meet the legislative requirements. Example: in the private sector where nurses are performing roles that are outside the general realm of nursing function such as a surgical assistant

Further details about what is adequate PII for the registrants is required, with a lot of onus on the organisations to provide certificate of currency, with different timeframes for registration and PII renewals.

Consider, when cancel registration / renewal for PII that they notify the organisation.

We would suggest that applicants should be required to not only provide evidence of their current professional indemnity cover, but also be required to disclose whether any indemnity insurer had ever placed any conditions on their cover or refused to provide cover, and the circumstances surrounding this.

Powers to Refuse to Grant Registration

Proposal 6.4.1: It is proposed that the legislation provide powers for a responsible board to refuse to grant registration on a number of grounds, including but not limited to the following:

- a. the applicant has not satisfied the board of their competence to practise in the regulated profession and this cannot be satisfactorily addressed by the imposition of conditions
- b. the applicant's character is such that it would not be in the public interest to allow the applicant to practise in the regulated profession
- c. the applicant is considered by the board to be unfit to practise because of drug or alcohol dependency or physical or mental impairment
- d. the applicant has been convicted of or made the subject of a criminal finding for an offence in any participating jurisdiction or an offence under a foreign law, and the circumstances of the offence are such as to render the applicant unfit in the public interest to practise in the regulated profession
- e. the applicant has previously been registered under this Act or a corresponding previous enactment of a participating jurisdiction, and that registration has been suspended or cancelled, or during the course of that registration, the practitioner has had proceedings brought against him or her and those proceedings have never been finalised
- f. the applicant has been deregistered or suspended under a foreign law, for any reason relating to conduct that would constitute professional misconduct under this Act, or during the course of that registration, the practitioner has had proceedings brought against him or her and those proceedings have never been finalised
- g. the applicant has had insufficient recent practice experience in the relevant profession (with the time period within which an applicant must demonstrate they have practised to be determined by the responsible board, eg two years is preferred in some professions, five years in others)
- h. the applicant's English language proficiency is not considered sufficient by the board for the applicant to practise in the relevant profession

Part h: Need to clarify the process by which proficiency of the English language is determined.

Other parts within this section appear to be reasonable

English aural and written requirements are supported

Section g time frames for recent practice should take into consideration the existing time frame for nurses of 5 years since recent clinical practice, as predominantly a female workforce.

<p>i. the applicant does not have arrangements for professional indemnity insurance that the responsible board considers sufficient, or</p> <p>j. the applicant is disqualified from applying for registration under this Act or a previous enactment of a participating jurisdiction.</p>	
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Types of Registration Granted

<p><i>Proposal 7.1: It is proposed that the legislation enable a national board to grant any one of a number of different types of registration, depending on the circumstances of the applicant, and to impose conditions on a grant of registration.</i></p> <p>The proposed types and sub-types of registration are set out in Table 2 found in Consultation Paper – National Registration and Accreditation Scheme for Health Professions. While the labels vary, most jurisdictions provide in some legislative form for the sub-types of registration listed under specific registration.</p>	<p>Further clarification on definition for ‘non practicing registrant’</p> <p>Example: Would a senior nurse in management / project roles that are administrative in function be classified as non-practicing?</p> <p>A generic list with category of equivalent positions and levels, providing clarification about what went into each classification would be welcomed.</p>
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Non-Practicing Registration

<p><i>Proposal 7.3.1: It is proposed to include in legislation the capacity for boards to adopt a non-practising category of registration if they wish, in order to:</i></p> <ul style="list-style-type: none"> • make more transparent the distinction between those registrants who are and are not in active practice • better target competency requirements, and • provide more accurate data for workforce planning purposes. <p>It may also mean some non-practising registrants maintain a connection with their profession that may facilitate their return to active practice.</p> <p>ALTERNATIVE OPTION: Boards be required to have a non-practising category of registration.</p>	<p>Further clarification is sought on definition for ‘non practicing registrant’, example provided above, defining what is meant by practicing.</p> <p>Clarification sought within each professional group, with clarity requested regarding if a non practicing registrant is required to assist in an emergency. Needs to take account of the stakeholder benefit.</p> <p>Can criteria be developed regarding the determination of registration determined by hours of clinical practice? If you answer a series of questions in one way, does that determine the type of registration granted? Medical and nursing expertise, using knowledge and skills, practice involved in advising etc Does the Board or the application determine the restriction type?</p> <p>What is the process to move from non-practicing to practicing? How this is undertaken has a large impact on recruitment, retention, self regulation and meaning of professionalism, this may impact on very subtle ways.</p>
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Proposal 7.3.2: If a non-practising registration is to be provided under the legislation, then it is proposed that those granted this type of registration registrants would be required, as a condition of their registration, not to practise at all.

This means that such registrants would be acting unprofessionally (and possibly also committing an offence), if they were to breach the conditions attached to their registration. For example, if a non-practising medical practitioner were to write a prescription this would constitute active practise in breach of their non-practising registration.

Work force management issues need to be considered here. Example: if non-practising registrant is required to assist at the coal face to facilitate safe practice, does there need to be direct supervision?

Student Registration

Proposal 7.4.1: It is proposed that the legislative provisions with respect to student registration would be framed to:

- require only those students who are undertaking clinical training that involves contact with patients/clients to be registered
- empower boards to deal with students whose ability to undertake clinical training is affected by physical or mental impairment, drug or alcohol dependency, and
- give boards the discretion to include or not include a student category of registration.

Alternative options are as follows:

Option 1: The legislation includes powers to register and regulate students, but only for specified professions and boards, for example, the medical and dental professions.

Option 2: The legislation includes powers for all boards to register and regulate students, and student registration be mandatory, but only for those students who are undertaking clinical training, that is, those who are at the point in their course where they are in direct contact with patients.

Option 3: The legislation includes powers for all boards to register and regulate students, and student registration be mandatory for students in all regulated professions, at the point of enrolment and for the duration of their course.

Option 3 appears to be the simplest and secure process. This information would need to be passed on to healthcare facilities when negotiating contractual agreements with educational bodies.

Indemnity insurance for students would also need to be clearly defined (usually covered by education bodies as part of enrolment)

Clarification is sought on what is the onus on the hospitals to report to the Board on issues versus universities?
Suggest the inclusion of the English language proficiency criteria.
Student registration should not take away from the organisation's ability to determine scope of practice.

Continuing Competence Requirements

<p><i>Proposal 9.2.1: With respect to ensuring continuing practitioner competence, it is proposed that the legislation require the boards to establish requirements within each profession for registrants to demonstrate continuing competence at the time of annual renewal, with the scheme to be implemented for each profession on 1 July 2010. Since continuing competence would be a condition of registration renewal, requirements would apply to all registered health professionals, regardless of whether they work in public or private settings, and are employees or self-employed.</i></p>	<p>Support the responsibility being placed on the applicant at the point of registration in demonstrating continuing competence, as is the current process for nurse registration.</p>
<p><i>Proposal 9.2.2: It is proposed that the legislation enable the national boards to:</i></p> <ul style="list-style-type: none"> a. develop and publish minimum standards (approved by the Ministerial Council) for: <ul style="list-style-type: none"> i. the continuing competence requirements that registrants must meet in order to renew their registration in a regulated profession, and ii. the requirements that any accreditation/certification/performance appraisal scheme must meet in order for registrants who participate to be able to satisfy the board's continuing competence requirements b. oversee a system of approval of various accreditation/certification/performance appraisal providers or schemes, or approve an external body or bodies to ensure these schemes meet the board's standards c. refuse to renew the registration of a practitioner on any ground on which the board might refuse to grant registration (see section 6.4 of this paper), and on grounds that the registrant has not met the responsible board's continuing competence requirements and therefore has not demonstrated, to the satisfaction of the board, that they are competent to practise in the regulated profession, and d. impose conditions on registration at renewal in the same way conditions may be imposed at first registration, including with respect to those registrants who have not met the continuing competence requirements of the board. 	<p>Need to clarify the method by which the registration boards will determine continuing competence as this may impact directly on the healthcare provider in terms of ensuring that employees meet any requirements set.</p> <p>Example: if the registration boards require 30 hours of 'hands on' clinical time, this may impact on the healthcare provider to assist the employee in meeting the requirements set out by the registration board.</p> <p>Example: offering CPD points</p> <p>A process to appeal decisions also need to be clearly articulated. Consideration should be given to the role of the professional organisations in providing input to the development of competencies. It is assumed the Board will work in partnership with the professional bodies to develop the competency set.</p>

Annual Reporting Obligations on Registrants

<p><i>Proposal 9.3.1: It is proposed that the legislation require registrants to submit to their respective boards at the time of annual renewal various items of information required by the board in order to determine whether the practitioner is fit to practise. As part of such an annual return, the legislation might require reporting on a range of matters including:</i></p> <ul style="list-style-type: none"> a. how the board's continuing competence requirements have been met b. if charged with or convicted/subject of a finding of guilt for an offence punishable by 12 months imprisonment or more c. any medical negligence claims d. if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer, and e. any data required to be provided to the Ministerial Council for workforce planning purposes. 	<p>Are there any obligation of the employer to provide information or only the registrant?</p> <p>Will the reporting obligations of the Registrant include any medical negligence claim against the hospital where expert opinion criticise aspects of employee competence / duty of care?</p> <p>Example: a nurse administers a IV drug causing extravasation but the legal claim is against the facility and a Visiting Medical Officer not specific to the nurses involved in the medication error. Expert opinion criticise the nurses actions / duty of care</p>
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Registration Certificates

<p>Proposal 11.2.4: It is proposed that the legislation impose an obligation on registered practitioners to notify the responsible board of a change of contact address, within 28 days and that a penalty apply for failure to comply. ALTERNATIVE OPTION: There be no penalty for failure to notify of change of address.</p>	<p>This would be difficult to mandate and monitor.</p>
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<p>Proposal 11.2.5: It is proposed that the legislation provide a power for boards to require registrants provide details of each practice address from which they offer regulated health services. Special arrangements would be required so that the reporting obligations are manageable for locum practitioners whose practice address changes regularly. ALTERNATIVE OPTION: There be no requirement to provide a practice address.</p>	<p>It may be an option for healthcare providers (at point of employment) to provide address of facility / location to the relevant boards when employment occurs. This would ensure the relevant boards are provided with the most up to date information relating to employment location.</p>
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Failure to Renew

<p>Proposal 11.3.1: It is proposed that the legislation include provision for a 'grace' period of three months following expiry of registration, during which a practitioner is 'deemed' to be registered, but that if they fail to renew by the end of this period, then the board removes</p>	<p>There should be NO option to allow a clinician a grace period for renewal of their registration.</p> <p>However, it should be stressed that if no "grace" period is provided an</p>
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their name from the relevant register.
 ALTERNATIVE OPTION: That there is no 'grace' period and that if a practitioner fails to renew their registration on time, their name is removed immediately from the register and they may be committing an offence if they continue to practise.

adequate lead time will need to be given. Moreover the systems in place in the body administering the registration process will need to be adequately efficient to process all health professionals' registration annually in a timely manner.

It is recommended that some degree of consolidation of registration dates be sought.

The process will need to ensure it will not impose workforce restrictions on health care providers due to inability to practice for registrants that have not renewed by due date. The Registration process needs to ensure there are no disruptions to workforce.

Failure to Renew

Proposal 11.4.1: It is proposed that the legislation include provisions that allow a practitioner's name to be restored to the register, if they re-apply within a period of two years following a lapse of registration (under this Act, or a previous enactment of a participating jurisdiction), and they meet any continuing competence requirements set by the responsible board.
 ALTERNATIVE OPTION: There be no provision for restoration to the register, and practitioners who hold outdated qualifications and let their registration lapse be required to meet current registration requirements in the event that they reapply for registration, that is, they complete either an approved course of study and supervised practice, or an approved re-entry or refresher course.

Clarification surrounding the 2 years, is this a continuous period? How would the scenario of a practitioner takes 23 months off, then work for 2 weeks then take another year off?

Consideration needs to be made for maternity / paternity leave, long term illness – viral etc

Transition Arrangements

Proposal 12.1: With respect to transition arrangements, it is proposed that transitional provisions provide for:
 a. all persons who are registered on 30 June 2010 in one or more of the ten regulated health professions be automatically deemed to be registered under the new national scheme on 1 July 2010, on the register or division of the register specified in the transition

This could be onerous to achieve by 2010

provisions, and for the term specified in their registration renewal

b. all persons who have endorsements on their registration of a type available under the national scheme on 30 June 2010 be deemed to have endorsement of that type under the national scheme from 1 July 2010

c. all persons who have conditions imposed on their registration or endorsement of registration on 30 June 2010 in one jurisdiction be automatically deemed to have the same conditions imposed on their registration or endorsement of registration from 1 July 2010

d. where there are disparities between the types of registration or endorsements available under the national scheme and those conferred by existing State and Territory legislation, wherever possible registrants be migrated across to the national scheme with the widest possible scope of practice that is consistent with public safety. They would then be expected to practice within their competence, with conditions imposed only if it is considered necessary to limit their practice in order to protect the public

e. where a practitioner is registered in more than one jurisdiction and these registrations expire at different dates, then they be automatically deemed to be registered through until the latest date of registration that applies, unless they have conditions placed on their registration, in which case, they will be deemed to be registered through until the first expiration date that applies, and

f. if a practitioner holds or has held multiple registrations and has been either deregistered in one jurisdiction, or has not renewed in a jurisdiction where an investigation or disciplinary process was not finalised, then they not be automatically 'deemed' to be registered from 1 July 2010 and will be required to make a fresh application for registration with an expeditious process required