AHPRA:

Consultation on common guidelines and policy

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Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.

The Australian Nursing Federation (Victorian Branch) represents more than 67,000 nurses, midwives and personal care workers (the latter predominantly in the private residential aged care sector). The Australian Nursing Federation nationally represents in excess of 230,000 members and we are the largest union in Australia representing workers in the health sector. Our members are employed in a wide range of enterprises in urban, rural and community care locations in both the public and private health and aged care sectors.

The Australian Nursing Federation participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The core business for the Australian Nursing Federation is the representation of the professional and industrial interests of our members and the professions of nursing and midwifery. Additionally, the Australian Nursing Federation (Victorian Branch) is a registered training organisation and contributes to vocational education and training of enrolled nurses, and professional development for registered and enrolled nurses and registered midwives.

The Australian Nursing Federation (Victorian Branch) represents the interests of nurses, midwives and maternal and child health nurses that are employed in a range of health care enterprises and therefore has an interest in any reform to the role and function of nursing, nurse retention and productivity which may potentially effect nursing practice in the future, either in Victoria, or nationally. Registered and enrolled nurses and registered midwives form the largest health profession in Australia, providing care to people throughout their lifespan and across all geographical localities nationally.

The depth and breadth of nursing and midwifery practice reaches into people's homes, schools, general practice, local councils and communities, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional organisations.

The Australian Nursing Federation (Victorian Branch) is pleased to provide comment into the revisions to the guidelines for advertising regulated health services, revisions to the guidelines for mandatory notifications, and the draft new policy on social media which are common to all National health boards.

1. Guidelines for mandatory notifications

The Australian Nursing Federation (Victorian Branch) provides comments to the revised paper and specifically responds to the questions as identified

The Australian Nursing Federation (Victorian Branch) acknowledges this guideline aims to assist *practitioners, employers, and education providers to understand whether and when they must make a notification about a practitioner's conduct, and whether to make a notification about an impaired student and that this is an important policy initiative for public protection.*

A. How are the current guidelines working?

The current guidelines were a welcome development at the time as there was considerable confusion amongst nurses and midwives in relation to the then new obligation for mandatory reporting under the National Law. The Australian Nursing Federation (Victorian Branch) was concerned that the application of the mandatory reporting process could be misused or misunderstood in particular by employers. We are aware of instances where the motivation for such reporting was not the protection of the public, but rather a mechanism to remove individual employees, in circumstances where the report does not meet the minimum threshold for mandatory reporting. Specifically these cases may involve one off performance issues that are not managed at the workplace, for example, one medication mistake, or new graduates being reported for time management concerns eight weeks into their graduate year.

The current and the revised guidelines, whilst correctly focussing on the mandatory requirement, do not clearly enough differentiate between voluntary and mandatory notifications. As this is the only guideline available regarding notifications, we are concerned that it could promote an unreasonable expectation that the only notification available is a mandatory one.

B. Is the content of the revised guidelines helpful, clear and relevant?

In general terms the revised guidelines are better presented presuming the layout of the revised guidelines remains the same as presented (content all on one page width rather than divided into two sections).Particularly we appreciate the

clarification to the section 'Practice while intoxicated by alcohol or drugs' (section 140(a)). We are aware of notifications made to AHPRA which suggested that a practitioner may have practiced whilst intoxicated, while the evidence supporting this was only that the practitioner may have attended the workplace the day following being observed at a private social function at which alcohol was consumed. This notification was provided in circumstaces where the notifier had no knowledge of whether the practitioner was even rostered to work. The situation creates enormous stress and anxiety for the health practitioner who has been reported even if the resolution is relatively simple.

The other welcome addition to the guidelines is the reference to potential risk already being managed through treatment and that the practitioner is fully compliant with that treatment. This is particularly welcome in light of the number of health practitioners who have conditions/illnesses that are controlled through various ways including medication. The perceived stigma of mental illness is not assisted by an assumption that all practitioners with a mental illness pose a risk to the public. In addition it is important to recognise that practitioners who are unwell or their condition is not controlled at a particular point in time do have access to personal leave and if they are taking this leave then they are not posing a risk to the public in their practice.

C. Is there any content that needs to be changed, deleted or added in the revised guidelines?

In the first instance the Australian Nursing Federation (Victorian Branch) has concerns in relation to the following new wording

Where a practitioner is told about a notifiable conduct that another practitioner or patient has directly experienced or observed, the person with the most direct knowledge about the notifiable conduct should be encouraged to make a notification themselves.

For many nurses and midwives working in health services there are processes in place for the reporting of issues/behaviours of concern. Clearly there are different levels that lead to reporting within the workplace but often the individual may suspect there is something amiss but not be sure. In this situation the report of the suspicion would go to the next level supervisor or the one above that if the behaviour raising concern is the direct supervisor.

In this situation it would be reasonable for the practitioner to believe that management will investigate and, if appropriate, make a notification to AHPRA and thus they could reasonably believe they are covered by the exceptions to the requirement of practitioners to make a mandatory notification (section 141(4)).

While this process does not prevent an individual from feeling obliged to make a subjective report to AHPRA in relation to a matter that, once investigated, was found to be without foundation.

Suggested additional words could include "*or the practitioner that has been informed about the notifiable conduct, having investigated the concern, should make the notification*"

Secondly there is a typo in the draft guidelines in relation to the heading of point 5. In this draft the heading for point 4 and point 5 are the same, whereas point 5 should reflect mandatory notifications by education providers and practitioners in relation to impaired students.

D. Is there anything missing that needs to be added to the guidelines?

The Australian Nursing Federation (Victorian Branch) would like to see the guideline title to be Guidelines for notifications, and that the content commence with the identification of both voluntary and mandatory notifications. This could then be further developed to clarify the differences between both, specifically in the definition and threshold requirements.

In both the current and revised documents the flow chart for the decision guide for notifying intoxication identifies that even if you answer:

'no' to *Did you see the health practitioner practice his or her profession while intoxicated by alcohol or drugs?* and

'no' to *While not in a position to observe the practitioner in the course of practice, do you have a reasonable belief the practitioner went into practice while intoxicated?*

The next line states *No notification is required.* However the *Note* section underneath this states *Voluntary notification can still be made.*
The same confusion can be seen in the Decision guide – notifying sexual misconduct insofar as if you do not believe that another practitioner has engaged in sexual misconduct the flow chart indicates you are not required to make a notification but the *Note* directly underneath it states *Voluntary notifications can be made.*

It may be better expressed as 'notification is not mandatory', distinguishing between voluntary and mandatory reports.

We believe there needs to be clarification as to what would, in these instances, present a risk but not meet the threshold for notifiable conduct.

2. Guidelines for advertising regulated health services

The Australian Nursing Federation (Victorian Branch) provides comments on the revised paper and specifically responds to the questions:

A. How are the existing guidelines working?

We have no examples to demonstrate that the current guidelines are not functioning well.

B. Is the content of the revised guidelines helpful, clear and relevant?

The set out and content of the revised document seems to provide clarity to the issue in its entirety, however we believe there may be confusion in relation to advertising and advertisements.

The box identifying 'information commonly included in health services advertisements' is extensive however not all of this information may be included in the initial advertisement, but rather in follow up documentation provided at a later date. While there is a definition for 'advertiser' and 'advertising' there is no definition of 'advertisement'. References to advertising and advertisement is made in the document as having different definitions under other legislation. Aside from the lack of definition for advertisement the document states "*In particular the definition of "advertisement" in the Therapeutic Goods Act 1989 should be noted".* We believe it would be appropriate to provide a definition of advertisement in the document.

C. Is there any content that needs to be changed, deleted, or added in the revised guidelines?

The following information in the document may benefit from additional clarity -

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 definition of testimonials in advertising states

Testimonials in advertising include:-

(i) Using or quoting testimonials on a website, such as patients posting comments about a practitioner on the practitioner's business website, particularly where the website encourages patients to post comments and /or selectively publishes patient comments

(ii) Self-testimonials , such as in a newsletter or on a website, and

(iii) The use of patient stories

We are concerned as to how this would apply to health services involved in fund raising, for example, the use of children and their stories in the Royal Children's Hospital Good Friday Appeal. The whole appeal is aimed at advertising the health service with a clear objective of receiving donations to enable the provision of research and buying of equipment. It is suggested that a distinction be made between advertising a health service for business purposes and advertising a health service for fundraising. While we recognise that this is open to misuse, a carefully considered definition could be developed exclusively for benevolent institutions.

D. Is there anything missing that should be added?

E.

No additions to be suggested

F. Any other comments

G.

The only other issue of concern relates to the National Law definition of 'regulated health service' meaning 'a service provided by, or usually provided by, a health practitioner' (133(4)). This definition would arguably not include residential or community aged care, as the service is not necessarily provided by a health practitioner directly. If this section is supposed to include aged care service, which we submit that it should, there should be a clear recognition of this as there are instances of advertising that could be misleading, for example, the provision of 24 hour nursing care, without the recquisite nurses on duty.

<u>3 Social Media Policy</u>

The Australian Nursing Federation (Victorian Branch) provides comments to the draft policy and specifically responds to the questions

A. Do you support the approach of including general guidance in the draft policy and the *Guidelines for advertising* , with appropriate cross referencing

We support cross referencing all documents that can assist health practitioners to better understand their obligations. In this case it may be more appropriate to identify the "relevant National Board's code of ethics and professional conduct/practice (the Code of conduct) as the first dot point, and the information on the Guidelines on advertising of regulated health services as the second dot point

B. Does the guidance in these documents reflect the National Boards' regulatory role.

Yes. Any information and/or education that assists in protection of the public must by definition fall within the National Boards regulatory role

C. **Do you agree with the approach of referring practitioners to other sources for guidance on social media that goes beyond the National Boards' regulatory role**

Yes, where it provides clear and transparent information that can assist the health practitioner to better understand their obligations. However it's not clear how this is achieved in this document as the only references are to other AHPRA or National Board documents

D. Is the content of the draft Social media policy helpful

This document, unlike the guidelines provided for review, provides only very limited information. The ANF submits that the National Boards consider providing guidelines for the use of Social media, or provide more examples/explanations in the policy istelf.

For example it important to note that some social media sites allow or even invite you to note your employer in your publically available details. A generalised statement about your working day, when coupled with other publically available information, could result in an inadvertant breach.

E. Is there any content that needs to be changed, added or deleted in the draft policy?

The ANF submits that the Policy could contain more detailed examples of professional misconduct on social media.

F. Other comments

It is noted that the review for this policy is annual – given other documents are reviewed on a three yearly basis ANF submits there should be consistency unless a specific reason exists to do otherwise.