

Towards Consistent Regulation of Nursing and Midwifery in Australia

**A select analysis of the legislation and
professional regulation of nursing and
midwifery in Australia**

Final Report

**Prepared for
The National Nursing and Nursing Education
Taskforce**

**by
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June 2006

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Suggested citation: National Nursing & Nursing Education Taskforce (2006) Towards Consistent Regulation of Nursing and Midwifery Practice in Australia: A select analysis of the legislation and professional regulation of nursing and midwifery in Australia. A report prepared by Amanda Adrian and Associates for the National Nursing and Nursing Education Taskforce.

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Contents

Abbreviations.....	5
Executive Summary	6
1 Introduction and background	9
1.1 Background to the mapping exercise	9
1.2 The regulation of nursing and midwifery.....	11
1.3 The Productivity Commission and the regulation of the health workforce.....	12
1.4 Mapping the enablers and disablers of nursing and midwifery practice	14
2 Methodology and Focus of the Regulatory Mapping Project	17
2.1 Scope of the mapping.....	17
2.2 Data sources.....	17
2.3 The analytical framework and criteria for review.....	18
2.4 Validation of the data	20
2.5 The principal legislation and delegated legislation	20
3 Rational Regulatory Frameworks – or Regulatory Mayhem?	22
3.1 Purposes and or objects of the legislation	22
3.2 The functions and powers of nursing and midwifery regulatory authorities.....	23
3.3 The constituency of the regulatory authorities.....	26
3.4 Governance and accountability of the regulatory authorities.....	27
3.5 Regulation of practice in nursing and midwifery.....	30
3.6 The registers and rolls	34
4 Safeguarding the community - competence, conduct, health and suitability to practice	39
4.1 Entry to practice as a nurse or midwife	39
4.2 Returning to practice as a nurse and/or a midwife	41
4.3 Renewing the right to practice as a nurse and/or midwife	42
4.4 Working in a specific or specialised area of practice as a nurse or midwife.....	44
4.5 In summary - getting on, staying on and getting back on to the registers and rolls as a nurse and/or midwife in Australia.....	46
5 Educational Preparation and Qualifications Leading to Registration, Enrolment or Authorisation	48
6 Mobility of the Nursing and Midwifery Workforces.....	51
6.1 Mutual recognition schemes – intent and application	51
6.2 Mutual recognition and the nursing and midwifery workforce in Australia	51
7 Towards more rational regulation of nursing and midwifery in Australia.....	54
7.1 Regulatory reform and the challenges in a federation	55
7.2 Models of harmonisation and achieving uniformity	55
7.3 Australian Nursing and Midwifery Council	57
7.4 Establishing the means for reform	58
7.5 Postscript 1 – collection of workforce data	58
7.6 Postscript 2 – accessibility to information	58
8 Conclusion	60

APPENDIX A - Key Elements in Map 1 – the legislation, the regulatory authority and professional standards	61
APPENDIX B - Key Elements in Map 2 – The registers and or rolls of nurses and midwives	63
APPENDIX C - Key Elements in Map 3 – Original or initial entry to practice requirements as a registered nurse, registered midwife or enrolled nurse	65
APPENDIX D - Key Elements in Map 5 – Application for restoration to register or roll – not currently registered or enrolled in any other jurisdiction	67
APPENDIX E - Key Elements in Map 6 – Application for registration or enrolment under mutual recognition	68
APPENDIX F - Key Elements in Map 7 – Renewal of registration or enrolment.....	70
APPENDIX G - Key Elements in Map 8 – Safe practice in specialised and specific practice areas of nursing and midwifery.....	72
APPENDIX H - Key Elements in Map 9 – Setting and reviewing educational standards	74
APPENDIX I – Summary of treatment of the different categories of nurses and midwives on the registers and rolls in each jurisdiction (from Map 2 – section 2.1) .	78
APPENDIX J – Obligation to make registers and rolls available to the public (from Map 2 – section 2.7)	82
APPENDIX K – Where information other than that publicly available will be shared with other relevant agencies such as health professional regulatory authorities in the same or other jurisdictions (from Map 2 – section 2.10).....	84
References	86

Abbreviations

ACT	Australian Capital Territory
AIN	assistant in nursing
ACTNMB	Australian Capital Territory Nursing and Midwifery Board
AHMAC	Australian Health Ministers Advisory Committee
ANCI	Australian Nursing Council Incorporated (now the Australian Nursing and Midwifery Council)
ANMC	Australian Nursing and Midwifery Council
CNO	chief nursing officer, chief nursing and midwifery officer, principal nursing and midwifery adviser
COAG	Council of Australian Governments
CWTH	Commonwealth
EN	enrolled nurse (Division 2 registered nurse in Victoria)
EP	education provider
ICN	International Council of Nurses
MP	midwifery practitioner
MR	mutual recognition
NBSA	Nurses Board of South Australia
NBT	Nursing Board of Tasmania
NBV	Nurses Board of Victoria
NBWA	Nurses Board of Western Australia
N ³ ET	National Nursing and Nursing Education Taskforce
NMB	Nurses and Midwives Board (NSW)
NP	nurse practitioner
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
QLD	Queensland
QNC	Queensland Nursing Council
RA	regulatory authority
RM	registered midwife
RN	registered nurse
RTO	registered training authority
SA	South Australia
TAFE	Technical and Further Education
TAS	Tasmania
UTAS	University of Tasmania
VIC	Victoria
WA	Western Australia
WHO	World Health Organisation

Executive Summary

The National Nursing and Nursing Education Taskforce (N³ET or the Taskforce) was established in mid-2004 to monitor and implement 22 of 36 recommendations from the *National Review of Nursing Education 2002: Our Duty of Care* Report (National Review of Nursing Education 2002).

The Legislation and Professional Regulation of Nursing and Midwifery in Australia Project was commissioned by the Taskforce in November 2005 as a crucial piece of work required to inform the broader program of work being undertaken by the Taskforce. The outcome of the Project provides a detailed and contemporary snapshot of the similarities and differences in legislation and policy that supports particular aspects of the professional regulation of nurses and midwives in each of the jurisdictions in Australia. This in turn, is intended to prompt and promote consideration of opportunities for achieving greater national consistency in these matters, both through legislation reform and through a national approach to professional regulation by nursing and midwifery regulatory authorities (RAs). There is little doubt that there are already many similarities, however the differences clearly matter and this Report primarily concentrates on those differences.

The release of the Productivity Commission Report on *Australia's Health Workforce* (Productivity Commission 2005d) has further fuelled the push for a more-uniform approach to the regulation of health professionals.

The mapping for this project is not a comprehensive review of the full range of the regulatory framework governing the practice and conduct of nurses. It is purposefully selective, cutting across the material from two specific and key angles:

- *The quality and safety of healthcare for the community:* that is a nurse or midwife's competence¹ and suitability to practice safely. This links it to the extensive work being conducted around the regulation of practice, which has developed a life of its own as the problematic notion of 'scope of practice'; the foundation of which is about defining the level of skills, knowledge, attitudes and experience needed to practice within the various areas of nursing and midwifery.
- *The portals of entry and the mobility and flexibility of the nursing and midwifery workforce across jurisdictions, specifically within Australia.* This links the work to the current acute focus on the health workforce, exemplified in the work of the Productivity Commission in 2006 (Productivity Commission 2005a; 2005b; 2005d).

How these two primary filters for the information obtained in the mapping sit with the subject areas identified in the Taskforce's *Blueprint for National Action*, is illustrated in the table below.

¹ **Competence** - the combination of skills, knowledge, values and abilities that underpin effective and/or superior performance in a profession/occupational area. Continuing professional competence is the ability of nurses (and midwives) to demonstrate that they have maintained their competence in their current area of practice (ANMC).

Table 1 - Summary of key N³ET foci and relationship with the primary heads of examination in mapping project

IMPACTS	QUALITY AND SAFETY	MOBILITY
Mutual recognition	Establishing equivalence of educational preparation, competence and suitability to practice	Capacity to move across jurisdictional boundaries with no or minimal impediments
Powers of regulatory authorities to determine scopes of practice	Functions and powers to: <ul style="list-style-type: none"> develop, adopt, review and monitor educational and practice standards enable or limit nursing and midwifery practice by regulatory mechanisms impose sanctions where standards are not met 	Functions and powers that enable nursing and midwifery registration authorities (RAs) to be gatekeepers by setting and enforcing the entry and transfer requirements across jurisdictions within Australia, as well as nurses and midwives seeking to come from overseas.
Standards for courses leading to registration and recognition	The preparation of appropriately-educated nurses and midwives who meet the competency standards and other entry requirements for registration, enrolment or authorisation as a nurse or midwife to provide safe, high-quality nursing and midwifery care to the community.	Recognition of educational standards and requirements on a national basis that enable a nurse or midwife educated in one jurisdiction to register initially for entry into practice in another jurisdiction; and for nurses and midwives to be able to have surety that their qualifications gained in one jurisdiction will be recognised without difficulty in another in Australia.
Registration requirements	The community can be confident that there are universal standards for professional practice that are designed to ensure the competence, health and conduct, that are used by RAs in establishing the fitness of nurses and midwives to practice: <ul style="list-style-type: none"> at initial entry to practice on an ongoing basis at re-entry to practice on gaining additional qualifications and practice privileges on transfer from another jurisdiction. 	Universal standards of registration, enrolment and authorisation as a nurse and midwife enable the seamless transition for a nurse or midwife registered, enrolled and/or authorised in one jurisdiction to move to another jurisdiction.
Accountability of regulatory authorities	Nursing and midwifery RAs have robust governance arrangements in place that provide confidence to the community that they are primarily there to protect the public, have an appropriate constituency and operate in a manner that provides: <ul style="list-style-type: none"> Accountability Transparency and openness Integrity Stewardship Leadership Efficiency Effectiveness Fairness Flexibility Consistency. 	RAs also have a responsibility to nurses and midwives to have these governance arrangements in place to ensure appropriate decision making that minimises the barriers to practice in different geographic locations as well as enabling recognition for requisite skills, knowledge judgement and care to enable them have flexibility to work in different areas of practice.
Competencies for initial and ongoing registration	Universal standards of professional practice and monitoring processes that are suitable measures to assess the fitness of a person to practice nursing and midwifery from entry to retirement that are accessible and well understood by the community, nurses and midwives, and employers.	Universal standards of professional practice and monitoring processes that are recognised across jurisdictions so that a registered or enrolled nurse or midwife is able to take their current credentials and standing from their 'home' jurisdiction and have them accepted as equivalent without further requirements.
Nurse practitioners	National standards for education and practice that ensure these 'expert' practitioners are adequately prepared for their role in providing safe high quality care, ensuring they maintain and build upon their skills, knowledge and experience.	Universal standards of professional practice and monitoring processes that are recognised across jurisdictions so that a nurse practitioner is able to take their current credentials and standing from their 'home' jurisdiction and have them accepted as equivalent without further requirements.
Re-entry to the professions of nursing and midwifery.	Universal standards of professional practice and assessment processes that are suitable measures to assess the fitness of a person to return to practice nursing and midwifery after a period away from practice that are accessible and well understood by the community, nurses and midwives, and employers. Appropriately-tailored refresher and re-entry courses or periods of supervised practice to enable a return to a safe level of competence.	That once re-registered or enrolled a nurse or midwife is able to move freely across jurisdictions having the same rights and obligations as any registered or enrolled nurse or midwife.

Eight 'maps' were developed² and compiled into an Atlas for the Legislation and Professional Regulation of Nursing and Midwifery in Australia (2006f):

Map 1 The legislation, the regulatory authority and professional standards

Map 2 The registers and or rolls of nurses and midwives

Map 3 Original or initial entry to practice requirements as a registered nurse, registered midwife or enrolled nurse³

Map 5 Application for restoration to register or roll – not currently registered or enrolled in any other jurisdiction⁴

Map 6 Application for registration or enrolment under mutual recognition⁵

Map 7 Renewal of registration or enrolment

Map 8 Safe practice in specialised and specific practice areas of nursing and midwifery

Map 9 Setting and reviewing educational standards

It is important that this Report is read in conjunction with the Atlas. These are available at: http://www.nnnet.gov.au/downloads/rec4_atlascomplete.pdf. It should be noted that the examples and case studies used in the Report are illustrations only and there are further examples in the mapping.

This area is not static and there was change and progress even during the course of the Report which may make some of the information in the maps out of date. With the validation provided by each of the RAs in the eight jurisdictions, it can only be claimed that they were as representative of the situation as at the middle of May 2006.

Part 2 of this Report provides a more thorough introduction to the Project and outlines the background and other contemporary drivers that have influenced the findings and conclusions in this Report, such as the Productivity Commission Report (2005d) and the identification of some of the 'enablers' and 'disablers' of nursing and midwifery practice.

Part 3 outlines the methodology used for the mapping: the scope of the mapping; the various data sources; the analytical framework used for the mapping and the criteria used for review; the validation process for the data that was used in the maps; and provides an overview of the principal legislation and delegated legislation that provided the platform for the mapping.

Part 4 discusses the primacy of the role of nursing and midwifery RAs in being: the community's gatekeepers in relation to ensuring that registered or enrolled nurses and midwives are competent and suitable to practice nursing and midwifery; and, the professions' gatekeepers in controlling the mobility and flexibility of nurses and midwives to move seamlessly across jurisdictions and meet workforce needs. It looks at the purpose, powers and functions of the RAs; the constituency and governance arrangements; the mechanisms for licensing through the register and rolls; and the RAs' key role in setting educational, practice and professional standards for nurses and midwives.

Part 5 examines more closely the mechanisms for safeguarding the community by monitoring the competence, conduct, health and suitability to practice of nurses and midwives at the checkpoints of: initial entry to practice; returning to practice after a period away from practice; renewal of the right to practice on a periodic basis; and working in specific or specialised areas of practice.

Part 6 examines the regulatory frameworks around the RA's control of the educational preparation for initial entry into practice and subsequent attainment of qualifications to practice in specialised areas of nursing and midwifery.

² NOTE: there is no Map 4. Map 4 was commenced but deemed non-essential for the purposes of the work and the very tight timeline.

³ Does not include authorisation of nurse or midwife practitioners.

⁴ Where the original removal of the person from the register or roll was for non-payment of fees or by request of the applicant.

⁵ Either under the *Mutual Recognition Act 1992* (Cwth) or the *Trans-Tasman Mutual Recognition Act 1997* (Cwth).

Part 7 reviews the issues around mutual recognition of equivalent qualifications in nursing and midwifery and any barriers to nurses and midwives moving freely across borders in Australia with their Australian qualifications.

Part 8 looks at some of the issues that might enable a more rational and uniform approach to nursing and midwifery and eliminates some of the structural impediments that are created by eight different RAs in the jurisdictions 'doing their own thing', although this may be in good faith and with the very best of intentions.

The inescapable conclusion from the mapping and the limited analysis that this Report has undertaken in relation to the data that was collected in the maps, is that there is an imperative to develop a more-transparent and uniform approach to the regulation of nurses and midwives in Australia.

There are significant community and professional benefits in ensuring: the quality and safety of care provided by appropriately educated, skilled and experienced nurses and midwives; flexibility and freedom of movement of the nursing and midwifery workforce; a reduction in the duplication of systems and processes all designed to achieve the same ends. These would be enhanced significantly by working towards national uniformity in the areas discussed throughout the course of this report, including:

- Educational standards for entry to practice and graduation into areas of practice specialisation in nursing and midwifery.
- Practice standards for nurses and midwives.
- Regulatory standards for the governance, structure, membership and functions of the RAs.
- The structure of the register and rolls of nurses and midwives.
- Uniform processes for initial entry to practice; periodic renewal of licence to practice; re-entry to practice; mutual recognition; and recognition of specialised practice qualifications.
- A strong shared emphasis on transparency and procedural fairness.
- The sharing of information with each other.

1. Introduction and Background

The fickleness of Federation in Australia plays out unequivocally in the regulation of nurses and midwives. There is scant evidence to suggest that there is a cogent, cooperative and consistent arrangement for the regulation of nurses and midwives across Australia. The statutory and policy regulatory framework for each nursing and midwifery regulatory authority (RA) is as different from each other as one can possibly imagine. While there is obvious mirroring of features of other models across some States or Territories, this is selective and idiosyncratic.

This Project, commissioned by the National Nursing and Nursing Education Taskforce (N³ET or the Taskforce) has been an opportunity to review the regulation of nurses and midwives across Australia at a time when there is increasing pressure across the Federation to ensure more-uniform, accountable, transparent and fair, effective, efficient and flexible regulation of the health professions generally, as well as within the nursing and midwifery professions more specifically.

1.1 Background to the mapping exercise

The Taskforce was established in mid-2004 to monitor and implement 22 of 36 recommendations from the *National Review of Nursing Education 2002: Our Duty of Care Report* (National Review of Nursing Education 2002), as well as recommendations from critical care, midwifery and mental health workforce reports (Australian Health Workforce Advisory Committee 2002; 2002; 2003), and a piece of work on specialisation (to develop an agreed definition of specialist nursing and an agreed framework for nursing specialisation and the development and attainment of postgraduate qualifications)(Moyes 2006: p 1).

The Legislation and Professional Regulation of Nursing and Midwifery in Australia Project was commissioned by the National Nursing and Nursing Education Taskforce in November

2005 as a crucial piece of work required to inform the broader program of work being undertaken by the Taskforce. The outcome of the Project provides a detailed and contemporary snapshot of the similarities and differences in legislation and policy that supports particular aspects of the professional regulation of nurses and midwives in each of the jurisdictions in Australia. This in turn, is intended to prompt and promote consideration of opportunities for achieving greater national consistency in these matters both through legislation reform and through a national approach to professional regulation by nursing and midwifery RAs.

Although understanding the regulatory foundations of nursing and midwifery is necessary for much of the work of the Taskforce, the recommendations from the *Our Duty of Care* Report specifically relevant to this report are Recommendations 4, 5 and 6.

Recommendation 4 - Nationally consistent scope of practice

To promote a professional scope of practice for nurses and greater consistency across Australia:

- a) *A nationally-consistent framework should be developed that allows all nurses to work within a professional scope of practice, including the administration of medications by enrolled nurses.*
- b) *To facilitate this development, all Commonwealth, State and Territory legislation and regulations that impact on nursing should be reviewed and reformed as required* (National Review of Nursing Education 2002: p 118).

This report does not deal with the other influences on nursing and midwifery practice eg the industrial, workplace culture and other issues. The Taskforce Scope of Practice Commentary Paper has a discussion on some of these issues (National Nursing and Nursing Education Taskforce 2005c).

The maps that have been produced highlight the areas of regulation that are pivotal to influencing the practice of nurses and midwives. The quality and safety of nursing and midwifery practice relates directly to the standards and mechanisms usually and primarily within the functions and powers of nursing and midwifery RAs. In most cases the functions and powers of the nursing and midwifery RA's in Australia are broad and provide significant scope for strong professional controls to be placed upon the educational preparation and the ongoing practice of nurses and midwives. The obvious inconsistencies in relation to each nursing and midwifery RAs dealing with enrolled nurses (or Division 2 registered nurses in Victoria) (ENs), and the administration of medications were clear in 2002 at the time of the *Our Duty of Care* Report.

A second area that exposes the anachronisms of colonial imperialism that remain in Australia today is in the development of the nurse practitioner (NP) role. Hence, the crafting of Recommendation 5 from the *Our Duty of Care* Report:

Recommendation 5 - National standards for nurse practitioners

To promote a consistent national approach, the Australian Nursing Council Incorporated (ANCI)⁶ should be commissioned to establish national standards for nurse practitioners (National Review of Nursing Education 2002: p 119).

The jurisdiction-specific evolution of the nurse practitioner (NP) role and regulation in Australia provides vivid examples of the enormity of the structural barriers that have confronted NPs since the first formal steps were taken in relation to establishing the role in New South Wales (NSW) in 1990 (NSW Department of Health 1995: p 2). The ongoing, very vocal critique of some sectors of the medical profession in relation to this role, have continued unabated and have been seen as a significant source of political influence and interference in the rational development of the role (Australian Medical Association 2005). However, it could be argued that the hotch-potch of onerous educational, experiential requirements and limitations to practice that have been put in place by the different RAs before a registered nurse (RN) or registered midwife (RM) can hope to become an NP are evident in a number of the maps prepared as part of this Project as well as the mapping done as part of the Taskforce Project on *Nurse Practitioners in Australia* (National Nursing and Nursing Education Taskforce 2005b; 2006d).

⁶ Now the Australian Nursing and Midwifery Council (ANMC)

Other structural influences that have shaped the evolution of the nurse practitioner role include the legislative restrictions around the supply and prescription of drugs and therapeutic goods, the legislated requirements around the scope of practice and development of clinical practice guidelines as in NSW and the Australian Capital Territory (ACT) – some of which reflect historical systems, while others are clearly the product of sector interests.

These structural impediments to the flexibility of the area of nursing and midwifery practice are also evident in other areas, such as in the practice of ENs and others.

The lack of uniformity in the educational, practice and regulatory standards that make up the regulatory frameworks for nurses and midwives in Australia plays out in significant ways in relation to the safety and quality of nursing and midwifery care and in the flexibility and mobility of the nursing and midwifery workforce. This was identified in the *Our Duty of Care* Report, generating the following recommendation:

Recommendation 6 - National ANCI principles to underpin nursing legislation and regulation

To ensure a more-nationally consistent approach to nursing, State and Territory nursing legislation and regulations should be underpinned by nationally-agreed principles. These principles should include requirements for:

- a) assessment against the ANCI competencies for initial registration of registered nurses and enrolled nurses; and*
- b) audited self-reporting for continuing registration of registered nurses and enrolled nurses using indicators that demonstrate currency of competence including ongoing education (National Review of Nursing Education 2002: 120).*

The recommendations from the *Our Duty of Care* Report have provided a focus for the mapping in conjunction with a few specific and key angles. These are:

- the quality and safety of healthcare for the community - a nurse or midwife's competence to practice safely;
- portals of entry and the mobility of the nursing and midwifery workforce across jurisdictions, specifically within Australia.

1.2 The regulation of nursing and midwifery

Restrictions on entry into the health professions serve an important purpose of protecting consumers from unqualified health care practitioners. However, at times the actual restrictions go too far. The need to protect consumers from charlatans has led to professional licensure in the health care professions, often endorsed in varying degrees by the government. The restrictions inherent in obtaining and maintaining professional licensure both serve as a means of ensuring quality of care and, at the same time, as a limit on competition. Evaluating the impact of apparently anti-competitive behaviour in the health professions thus requires careful balancing: the existence of health professions and professional associations serves many beneficial purposes for patients. Nonetheless, at times the actions of health care practitioners, professional associations and even government regulations have effects that appear to be less related to enhancing quality for consumers than with ensuring high reimbursement for practitioners or limited choice for consumers (Organisation for Economic Cooperation and Development 2005: p 9).

Why regulate the professions of nursing and midwifery at all? The Organisation for Economic Cooperation and Development (OECD) tend to suggest that nurses and midwives internationally fit into a para-professional group as *they are typically not trained in the same way as the "higher-level" professional, but at times may actually have superior training for certain types of care* (Organisation for Economic Cooperation and Development 2005: p 10). While it is arguable that the former point is true across the board for nurses and midwives in Australia, nurses and midwives care for people, often at their most vulnerable and needful times in their lives. Their work, *brings them into sustained and intimate contact with people who need help* (Lawler 1991: p 1). Nurses (and midwives) *also help people with the experience of living with and through what is happening to their bodies during illness, recovery and dying* (Lawler 1991: p 29), as well as during childbirth and in health prevention and health promotion.

What nurses and midwives do has inherent risks of physical and or psychological harm if not done with the necessary knowledge, skill, judgement and care. There is little doubt that their practice is increasing in complexity and diversity within contemporary health and aged care settings. This complexity is due to a number of sources. In Australia today, the array of technology, the range of therapeutic goods and substances, the availability of sensitive and personal information, the increasing quest to ensure practice is based upon the best scientific evidence available and the acuity of the health conditions of people that are now being managed in the health system, as well as the community's expectations of safe, high-quality health care are provided by skilled and knowledgeable health professionals. The practice of nursing and midwifery requires an expert body of knowledge that is built upon by practical skills and experience over time. This has been acknowledged over time and both nursing and midwifery have been regulated in Australia for many years.

Nursing and midwifery RAs play an important role in protecting the public and affording the community the confidence that registered nurses and midwives are well qualified to do the difficult jobs they do. In the event of poor performance or unprofessional conduct, RAs have responsibility for investigating, imposing sanctions and assisting the nurse or midwife to obtain the professional development opportunities they require or address any difficulties affecting their ability to practice (Department of Human Services Victoria 2003: p 3).

The operation of any regulatory system should be accountable, transparent and fair, effective, efficient and flexible. In 2006, any regulation must also pass the competition test, ie. the legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition (Department of Human Services Victoria 2003: p 3).

The introduction of the national competition policy in the 1990s and the attendant requirement for each jurisdiction to review all legislation to minimise the anti-competitive elements that did not have strong public interest foundations, meant that the legislation regulating the conduct of nurses and midwives, as well as most health professionals, did undergo significant reform. That reform continues today with a move towards more rational and consistent regulatory regimes being instituted on a state-by-state-by-territory basis. But these are intra-jurisdictional initiatives and are adding to, rather than reducing the complexity and diversity between jurisdictions.

1.3 The Productivity Commission and regulation of the health workforce

A major finding of the Productivity Commission after reviewing the operations of the more than 90 health professional RAs was:

Diversity in these state-based systems leads to variations in standards across the country, results in administrative duplication and can impede the movement of health workers across jurisdictions notwithstanding the operation of mutual recognition (Productivity Commission 2005d: p xxv).

In reviewing the legislation and other regulatory mechanisms used to regulate the nursing and midwifery professions in Australia across the eight State and Territory jurisdictions, this Project has inevitably reached the same conclusion.

The Productivity Commission's solution is a radical one. The Commission makes the recommendation that a single national registration board for all currently-registered health workers should be established. They dismiss the notions of *seeking to achieve greater uniformity within the current regime, or to introduce profession-by-profession registration at the national level, outside of an overarching registration framework* (Productivity Commission 2005d: p xxv). The role of the professions would be significantly curtailed in relation to the full range of functions and powers currently vested in each RA, but the single national registration board mooted by the Commission, *would have a series of supporting professional panels to advise on specific requirements, monitor codes of practice and take disciplinary action* (Productivity Commission 2005d: p xxv).

A discrete but related recommendation relates to the creation of a national accreditation board which would be charged with setting uniform national standards for health workforce education and training, which would have also the effect of reducing the scope of functions and powers currently held by the nursing and midwifery RAs (Productivity Commission 2005d: p 134).

Recommendation 6 of the *Our Duty of Care* Report outlined above is not far removed from Recommendation 7.1 of the Productivity Commission's Research Report, *Australia's Health Workforce* in 2005:

When a health professional is required to be registered to practice, that should be on the basis of uniform national standards for that profession:

- *Education and training qualifications recognised by the national accreditation board should provide the basis for these national registration standards.*
- *Any additional registration requirements should also be standardised nationally.*
- *Flexibility to cater for areas of special need, or to extend scopes of practice in particular workplaces, could be met through such means as placing conditions on registration, and by delegation and credentialing* (Productivity Commission 2005d: pp 140-142).

These recommendations are currently being considered by the Council of Australian Governments (COAG):

COAG recognises the challenges facing Australia regarding the health workforce and the need for national systemic reform to workforce and health education structures. COAG welcomes the Productivity Commission's report on Health Workforce released in January 2006 and supports its key directions. COAG has endorsed the National Health Workforce Strategic Framework. Given the significance of the recommendations of the Productivity Commission's Report, COAG has asked senior officials to undertake further work on the recommendations and related issues and report to it in mid-2006. This work will include, but not be limited to, the number and distribution of training places, the organisation of clinical education and training, and accreditation and registration (Council of Australian Governments 2006: p 13).

At a more general level, the COAG National Reform Agenda is also focusing on reducing the regulatory burden imposed by the three levels of government, which sits compatibly with the Productivity Commission's recommendations and will undoubtedly have resonance in their consideration of possible reforms in relation to the regulation of health professionals:

COAG agreed that all governments will:

- *establish and maintain effective arrangements to maximise the efficiency of new and amended regulation and avoid unnecessary compliance costs and restrictions on competition;*
- *undertake targeted public annual reviews of existing regulation to identify priority areas where regulatory reform would provide significant net benefits to business and the community;*
- *identify further reforms that enhance regulatory consistency across jurisdictions or reduce duplication and overlap in regulation and in the role and operation of regulatory bodies; and*
- *in-principle, aim to adopt a common framework for benchmarking, measuring and reporting on the regulatory burden* (Council of Australian Governments 2006: p 9).

The centralisation or harmonisation of regulatory frameworks and establishing national instrumentalities that have power to execute their roles is no easy feat. It is controversial and complex in a federated nation. Constitutional barriers and the vigorous resolve of most States in maintaining their sovereign authority pose significant challenges. Opeskin argues that the:

...many methods of cooperative harmonisation can be both time-consuming and cumbersome. The need to reach agreement in up to nine jurisdictions (the Commonwealth, the six States and the two Territories) may be labour intensive and slow. In the absence of strong political imperatives, many negotiations continue over many years (Opeskin 1999: p 23).

The Productivity Commission Report and the COAG response and agenda (Productivity Commission 2005d; Council of Australian Governments 2006) reflect the general

community and health system's dissatisfaction about the way that the health workforce has been educated, organised and regulated in Australia, largely due to our colonial heritage and the fierce determination of States to maintain their independence and autonomy. The Productivity Commission Report boldly and clearly puts a strong case for the imperative for change.

1.4 Mapping enablers and disablers of nursing and midwifery practice

The regulatory mapping exercise undertaken with this Project highlights the inconsistencies that exist within the current regulatory frameworks for nurses and midwives wishing to practice in Australia. The inconsistency is not merely in the legislation, but also in the myriad of instruments that make up such regulatory frameworks. *Health work is heavily regulated compared to many other sectors. The regulatory framework within which health workers operate is not only extensive but complex* (Australian Health Ministers Advisory Council 2005: p 5). For example, the practice of a registered nurse and/or midwife is subject to:

- Primary and delegated legislation (registration/enrolment, poisons and therapeutic goods, public health, radiation, etc) – this is outlined more fully in part 3.3;
- Nursing and midwifery RA codes, standards, guidelines and policies;
- Australian Nursing and Midwifery Council (ANMC) Codes and Standards;
- Professional association policies, codes and guidelines (including those relating to supervision, delegation and support/assistant roles);
- Industrial organisation policies (including those relating to supervision, delegation and support/assistant roles);
- Institutional credentialing; and
- State and Federal industrial awards and Enterprise Bargaining Agreements (Australian Health Ministers Advisory Council 2005: p 5; National Nursing and Nursing Education Taskforce 2005c).

This mapping focused only on several of these areas, those being the primary and delegated legislation relating to the registration of nurses and midwives, the RA codes, guidelines and policies and to some extent, the ANMC Codes and Standards. However, the impact of the other influences is unmistakable and adds further dimensions to an already disparate landscape that confronts employers wishing to employ nurses, nurses and midwives who may wish to cross a border and ply their professions in a jurisdiction where they did not obtain their qualifications and the community more generally, interested in the protections afforded to them in controlling the health workforce that provides nursing and midwifery care.

This mapping is not a comprehensive review of the full range of the regulatory framework governing the practice and conduct of nurses. It is purposefully selective, cutting across the material from a few specific and key angles:

- **The quality and safety of healthcare for the community** - a nurse or midwife's competence⁷ and suitability to practice safely. This links it to the extensive work being conducted around the regulation of practice, which has developed a life of its own as the problematic notion of 'scope of practice'; the foundation of which is about defining the level of skills, knowledge, attitudes and experience needed to practice within the various areas of nursing and midwifery.
- **The portals of entry and the mobility and flexibility of the nursing and midwifery workforce across jurisdictions**, specifically within Australia. This links the work to the current acute focus on the health workforce, exemplified in the work of the Productivity Commission in 2006 (Productivity Commission 2005a; 2005b; 2005d).

A great deal more work needs to be done in adding to these maps to turn them into a comprehensive atlas of the field. Nevertheless, these initial maps are an important beginning, giving a very clear picture of the lack of uniformity and consistency in these

⁷ **Competence** - the combination of skills, knowledge, values and abilities that underpin effective and/or superior performance in a profession/occupational area. Continuing professional competence is the ability of nurses (and midwives) to demonstrate that they have maintained their competence in their current area of practice (ANMC).

important areas for health consumers, nursing and midwifery professionals, employers, policy makers, regulators and educators.

The term 'a dog's breakfast' was used recently by the current Health Minister in the Australian Government in describing the health system generally (Australian Broadcasting Corporation 2006). The regulation of nursing and midwifery is a microcosm of this state of affairs and the community, employers and nurses and midwives would significantly benefit from a cooperative and bold effort to bring together the energies, wisdom, innovations and ideals of each of the nursing and midwifery RAs in developing a more rational approach to the way that the eight nursing and midwifery RAs conduct their business. It is essential that any such approach demonstrates that the RA's primary responsibility is to protect the public by ensuring that evidence-based professional educational, practice and regulatory standards are applied, monitored and reviewed. The functions and powers of nursing and midwifery RA's have discernible impacts on the quality and safety of nursing and midwifery practice and their flexibility as part of the health workforce to meet the contemporary health care needs of the communities across Australia.

In interviewing the executive officers, board/council chairpersons/presidents, key RA officers, nursing and midwifery leaders and chief nursing and midwifery officers and advisors (CNOs) in each jurisdiction as part of this Project, there was universal agreement that much-stronger uniformity in the way that nursing and midwifery RAs operate was needed.

Acknowledgement must be made of the high level of cooperation and assistance that all the RA officers and board and council members, CNOs and nursing and midwifery leaders provided throughout the course of this Project. The Project timeline was short and the turnaround time for provision of information and validation of the mapped information was preposterous. However, the goodwill and productivity was exceptional. It went well beyond expectations.

The possibility of moving towards a more consistent and rational approach to the regulation of nurses and midwives in Australia as recommended in *Our Duty of Care* (National Review of Nursing Education 2002: p 19) does not seem out of reach with this prevailing attitude, but will clearly require:

- A strong commitment and action in relation to this as a commonly shared goal;
- Returning to first principles of regulation as a means to protect the public and minimise the potential for harm to establish the foundation;
- A great deal of good will, collaboration and tolerance to enable the realities of differing histories, ideas and current local political imperatives;
- A capacity to be responsive and innovative in a landscape that is constantly changing.

Opeskin, a commentator on the changing face of Federation and the push to a more-unified infrastructure, writes that:

It is little surprise that the Australian States and Territories have been drawn closer together as a legal community over a century of Federation. That possibility was foreseen and welcomed from the outset. In 1903, Alfred Deakin wrote that: "Some day ...the real unity of the six little streams of public affairs will become obvious as they are more and more brought together. Reciprocal relations will be fostered under the growing pressure of (common) ideals, needs, activities, and the mutual understandings begotten of mutual interests".

The increased permeability of State and national borders, nourished by globalisation of the world economy and culture, has hastened the processes of harmonisation in the Australian Federation. It seems inevitable that these processes will continue in one form or another - it is a challenge to ensure that the processes are harnessed to achieve high standards of ...health in Australia, while simultaneously accommodating other values at the core of Australia's federal system of government (Opeskin 1999: p 30).

This Report will analyse the findings of the mapping exercise conducted for the purposes of this Project and discuss some of the opportunities for more national consistency if not uniformity in three key areas: those of regulatory standards, professional educational

standards and practice standards. Each of these areas impacts directly upon nursing and midwifery practice, the quality and safety of care provided by nurses and midwives and the mobility and flexibility of the nursing and midwifery workforces.

2. Methodology and Focus of the Regulatory Mapping Project

2.1 Scope of the mapping

The scope of the maps was developed from the considerable thought already invested by the Taskforce in relation to the priority action areas arising from the *Blueprint for National Action*, with the key heads of investigation identified as:

- Mutual recognition;
- Powers of RAs to determine scopes of practice;
- Standards for courses leading to registration and recognition;
- Registration requirements;
- Accountability of RAs;
- Competencies for initial and ongoing registration;
- Nurse practitioners;
- Re-entry to the professions of nursing and midwifery.

While not a comprehensive review of the full range of the regulatory framework governing the practice and conduct of nurses and midwives the work that has been done is nevertheless very revealing.

Eight 'Maps' were developed⁸:

- Map 1** The legislation, the regulatory authority and professional standards
- Map 2** The registers and/or rolls of nurses and midwives
- Map 3** Original or initial entry to practice requirements as a registered nurse, registered midwife or enrolled nurse⁹
- Map 5** Application for restoration to register or roll – not currently registered or enrolled in any other jurisdiction¹⁰
- Map 6** Application for registration or enrolment under mutual recognition¹¹
- Map 7** Renewal of registration or enrolment
- Map 8** Safe practice in specialised and specific practice areas of nursing and midwifery
- Map 9** Setting and reviewing educational standards.

The key elements or criteria that provide the points for examination for each of these Maps are listed in **Appendices A to H**.

2.2 Data sources

While the specific legislation and delegated legislation for the registration of nurses and midwives were primary sources of evidence for the maps, other critical sources included:

- Interviews with the executive officers, board/council chairpersons/presidents and key officers of the nursing and midwifery RAs in the eight jurisdictions;
- Interviews with each of the chief nursing officers, chief nursing and midwifery officers, principal nursing and midwifery advisers (CNOs), responsible for providing advice to governments on nursing and midwife in their jurisdiction;
- Interviews with a range of nursing and midwifery leaders selected by the RAs and CNOs;
- Policy, guideline and information documents published by the RAs, available either in paper form or electronically on the RA's website.
- Policy, guideline and information documents published by the State and Territory Governments available either in paper form or electronically on the Government's website

⁸ NOTE: there is no Map 4. Map 4 was commenced, but deemed non-essential for the purposes of the work and the very tight timeline.

⁹ Does not include authorisation of nurse or midwife practitioners.

¹⁰ Where the original removal of the person from the register or roll was for non-payment of fees or by request of the applicant.

¹¹ Either under the *Mutual Recognition Act 1992* (Cwth) or the *Trans-Tasman Mutual Recognition Act 1997* (Cwth).

- Policy, guideline and information documents published by education providers (EPs) - the universities or registered training authorities (RTOs) providing education and training courses for nurses and midwives, available either in paper form or electronically on the EPs website.
- The N³ET research and reports on the issues listed above (National Nursing and Nursing Education Taskforce 2005a; 2005b; 2005c; 2006a; 2006b; 2006c; 2006d).

The scope, scale and sources of information available were not uniform across the jurisdictions, which impacted on the level of analysis that could be undertaken. A significant finding of this Project, somewhat tangential to the original purpose, was the critical role that well-designed, well-organised, current and comprehensive electronic sources of information are becoming to all in the community. This holds true for access to current statutory instruments, current government and nursing and midwifery RA policy and information, as well as information about educational opportunities.

While each of the websites had significant strengths, it was their weaknesses that led to a sense of frustration in obtaining the data required for this Project. Some of the websites had a great deal of information available but how to get to it was not always intuitive. Others had remarkable photographs of nurses and midwives but had minimal policy, guidelines, useful information or application forms. Some had a list of links to other important sites, but not all of them had a link to their government's legislation site where one could access the critical information from which the powers and functions of the RA were vested. Other RA websites had obviously out-of-date information. Some gave no clue as to when the information was posted on the website. The availability of accessible comprehensive information is primary evidence of good governance. The accountability, transparency and openness, as well as integrity and leadership (Australian National Audit Office 2003: p 8) of the regulatory processes can be effectively demonstrated through the provision of high quality, accessible information for all RA audiences; nurses and midwives, the community, employers, policy makers, researchers, educators and others.

2.3 The analytical framework and criteria for review

Diagram 1 below is a diagrammatic representation of the sources of data and how these have been interpreted and utilised for the Project. There is also acknowledgement of the inevitable influences that the other forces, such as other legislation and rights and obligations, impose on nurses and midwives and on nursing and midwifery practice.

At level one is legislation¹². For the purposes of this Project, these are the principal acts that are administered by the nursing and midwifery RAs and discussed in the next section of this Report.

The second level in the diagram, that of delegated legislation¹³, includes the regulations, rules and statutory codes administered by the RAs. These are also discussed further in the next section.

Policy in this context is intended to describe the standards and requirements, which while not specifically enshrined as legislated instruments, would generally be regarded as obligatory for nurses and midwives to follow. These are often enshrined in codes of professional conduct, codes of ethics and statements of competency standards. These have been separated out from guidelines, procedures and information, while the other three sources of information tend to be provided as guidance for action. However, a court or

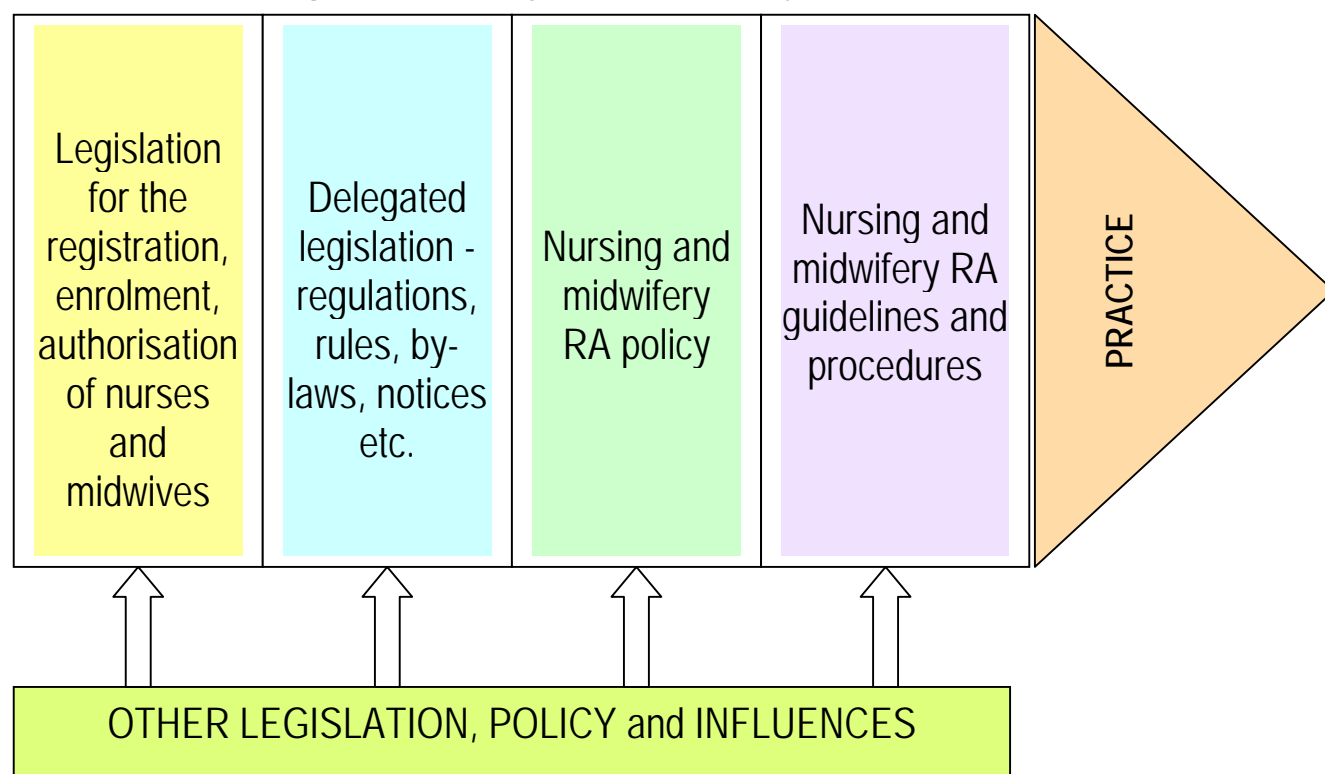
¹² A law or body of laws formally made or enacted. The term is often confined to those laws promulgated by a legislature (statute law or Acts of Parliament)
Butt P, Ed (2004) *Butterworths Concise Australian Legal Dictionary* Chatswood (NSW), LexisNexis Butterworths.

¹³ Legislation made by a person or body other than Parliament, under authority granted to that person or body by an Act of Parliament. Individually, delegated legislation is given a variety of names such as 'regulations', 'by-laws', 'rules', 'ordinances', and 'orders-in-council'. Collectively, they are variously referred to as 'subordinate legislation', 'statutory rules', 'legislative instruments', or 'subsidiary legislation'
Ibid.

tribunal may seek guidance from any of these sources when making decisions about the appropriateness of a nurse or midwife's professional conduct and practice.

The maps provide a synthesis of these four types of information and the sources of information can be identified to some extent by the colour coding used in the maps themselves. The four layers of: legislation, delegated legislation, policy, guidelines and procedure are all key informants of nursing and midwifery practice.

Diagram 1 – Scope of the Legislation and Professional Regulation of Nursing and Midwifery in Australia Project



The analytical framework and the criteria or 'key elements' that provided the infrastructure for the maps were largely drawn from the heads of information identified as required by the Taskforce, and were informed by the work done by Chiarella in 2001 for the National Review of Nursing Education (Chiarella 2001/03), and the work of Tarrant & Associates in their recent work *Literature Review of Nurse Practitioner Legislation and Regulation* (Tarrant and Associates 2005), as well as the N³ET work on the regulation of nursing and midwifery practice (National Nursing and Nursing Education Taskforce 2005c).

Two jurisdictions were selected as 'pilots' to test the key elements prior to commencing the very demanding review across all eight jurisdictions. The ACT and NSW data was entered initially and the key elements adjusted and adapted prior to entering the data from the other jurisdictions. There were several reasons for choosing the ACT and NSW. Using the map design developed, the ACT and NSW were the first two jurisdictions in the alphabetical sequence. The ACT had new model legislation, while NSW had some of the oldest (although significantly reviewed and amended relatively recently) legislation, and they were very different legislative models on which to test the robustness of the key elements.

The information gleaned from these sources was then processed through the two primary filters already identified above, these being: the quality and safety of healthcare for the community - a nurse or midwife's competence and suitability to practice safely, the portals of entry and the mobility and flexibility of the nursing and midwifery workforce across jurisdictions, specifically within Australia.

2.4 Validation of the data

As each map was completed, it was sent to the CNO and executive officer at each RA in each jurisdiction to consult with relevant RA board and council members and staff in order to test the veracity of the data and where necessary fill gaps where data had not been located in the first instance. The cooperation of each jurisdiction was extraordinary given the very short turn-around time, and feedback was received from every jurisdiction. A 100% return rate must be acknowledged and ensures that the data in each of the maps is as accurate as possible at May 2006, given the constant flux in the development and amendment of statutory instruments, policy and guidelines.

2.5 The principal legislation and delegated legislation

Table 1 below outlines the specific statutory instruments establishing and governing the registration and enrolment frameworks for nurses and midwives in Australia. It should be noted that each of the principal statutes (marked with an *) has been drafted since 1990. While there have been significant amendments during that period, principally due to the review required under the National Competition Policy, it is the emergence of the intra-jurisdictional omnibus or template-style legislation that is a feature of the more recent legislative reforms. For example, the Northern Territory (NT) and the ACT have relatively-new 'omnibus style' legislation, the *Health Practitioners Act 2004* (NT) and the *Health Professionals Act 2004* (2004), which governs the regulation of all registered health professionals in the jurisdictions – an apparent 'clean slate' approach. Victoria is moving towards that model with the *Health Professions Registration Act 2005* passed by the parliament, but not yet commenced (due to commence in July 2007). It is also interesting to observe that the scope of the Victorian legislation is not as generic as that in the Northern Territory, retaining as it does many of the features of the *Nurses Act 1993*. The Western Australian Parliament is currently working through the parliamentary processes in relation to the *Nurses and Midwives Bill 2005*, 'template-style' legislation, based on the *Osteopaths Act 1997* (the most recent of the health professional registration Acts in Western Australia to be enacted).

Table 2 – Specific statutory instruments governing the registration and enrolment frameworks for nurses and midwives in Australia

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
* <i>Health Professionals Act 2004</i>	* <i>Nurses and Midwives Act 1991</i>	* <i>Health Practitioners Act 2004</i>	* <i>Nursing Act 1992</i>	* <i>Nurses Act 1999</i>	* <i>Nursing Act 1995</i>	* <i>Nurses Act 1993</i>	* <i>Nurses Act 1992</i>
<i>Health Professionals Regulation 2004</i>	<i>Health Care Complaints Act 1993</i>		<i>Nursing Regulation 2005</i>	<i>Nurses Regulations 1999</i>	<i>Nursing (Fees) Regulations 1998</i>	<i>Nurses Regulations 2004</i>	<i>Nurses Rules 1993</i>
<i>Health Act 1993</i>	<i>Nurses and Midwives Regulation 2003</i>			<i>Nurses (Electoral) Regulations 1999</i>		<i>Health Professions Registration Act 2005 (HPRAct)¹⁴</i>	<i>Nurses Code of Practice 2000</i>
	<i>Nurses and Midwives Amendment (Performance Assessment) Act 2004</i>						<i>Nurse Practitioners Code of Practice 2004</i>
							<i>Nurses and Midwives Bill 2005¹⁵</i>

Source: Section 1.1 of Map 1.

The following parts of the Report are organised around the main foci of quality and safety for the community and the mobility and flexibility of the nursing and midwifery workforce.

¹⁴ The legislation has been enacted but is not yet commenced.

¹⁵ The Bill is currently being debated in Parliament – second reading speech has been given by the minister.

Part 4 discusses the primacy of the role of nursing and midwifery RAs in being: the community's gatekeepers in relation to ensuring that registered or enrolled nurses and midwives are competent and suitable to practice nursing and midwifery; and, the professions' gatekeepers in controlling the mobility and flexibility of nurses and midwives to move seamlessly across jurisdictions and meet workforce needs. It looks at the purpose, powers and functions of the RAs; the constituency and governance arrangements; the mechanisms for licensing through the register and rolls; and the RAs' key role in setting educational, practice and professional standards for nurses and midwives.

Part 5 examines more closely the mechanisms for safeguarding the community by monitoring the competence, conduct, health and suitability to practice of nurses and midwives at the checkpoints of: initial entry to practice; returning to practice after a period away from practice; renewal of the right to practice on a periodic basis; working in specific or specialised areas of practice.

Part 6 examines the regulatory frameworks around the RA's control of the educational preparation for initial entry into practice and subsequent attainment of qualifications to practice in specialised areas of nursing and midwifery.

Part 7 reviews the issues around mutual recognition of equivalent qualifications in nursing and midwifery and any barriers to nurses and midwives moving freely across borders in Australia with their Australian qualifications.

Part 8 looks at some of the issues that might enable a more rational and uniform approach to nursing and midwifery, and eliminates some of the structural impediments that are created by eight different RAs in the jurisdictions 'doing their own thing', although this may be in good faith and with the very best of intentions.

3. Rational Regulatory Frameworks – or Regulatory Mayhem?

The primary purpose of the legislation regulating the practice of nurses and midwives is to protect the public, not to protect the interests of the professions – this form of regulatory regime is known as a ‘protective jurisdiction’ and provides:

- a barrier to entry to the professions by untrained persons;
- a mechanism for standards of training and practice to be established and enforced;
- an avenue for consumers to have complaints against practitioners addressed (Department of Human Services Victoria 2003: p 17).

3.1 Purposes or objects of the legislation

It is useful to note that the statements of objects or purposes at the front end of legislation are recognised as setting the philosophical foundations or ‘tone’ of the legislation – an executive summary. While these are spelt out in more detail in the functions and powers and other parts of the legislation, it is in the purpose or objects statement where it is usually spelt out that the establishment of the regulatory regime is a protective jurisdiction.

Chiarella identified that it is agreed by both the International Council of Nurses (ICN) and the World Health Organisation (WHO) that the main objective of the statutory regulation of nursing is the protection of the public (Chiarella 2001/03: p 2). Map 1 identifies a variety of approaches to outlining the objects or purposes of the Act. Currently, all States and Territories except South Australia (SA), clearly establish that the purpose of the legislation is to protect the community. How this is done differs from jurisdiction to jurisdiction - see **Appendix A** for the key elements of Map 1.

The following are the specific key elements that appear in the statements of objects or purpose in the legislation of the different jurisdictions:

Protect the health and safety of the community by having a registration system for nurses and midwives that enables the following:

- *Developing, promoting, applying and reviewing standards of professional practice and conduct;*
- *Ensuring nurses and midwives who provide health services are fit and competent to practice;*
- *Ensuring nurses and midwives who provide health services maintain the required levels of competence and fitness to practice;*
- *Providing a standard system of reporting, investigating and dealing with issues of professional conduct, professional performance and the ability to practice of nurses and midwives;*
- *Providing mechanisms to enable the public and employers to readily identify nurses and midwives who are registered or enrolled;*
- *Establishing an RA responsible for the regulation of nurses and midwives and administering the registration system;*
- *Having a registration system for students of nursing and midwifery that enables the investigation into the suitability of students to undertake clinical training;*
- *Other (Section 1.2 of Map 1).*

It is interesting to note that the South Australian *Nurses Act 1999* and the new Bill in Western Australia (WA) have no statement of purpose or objects.

Even if not explicit in a statement of objects or purposes, the connection between the protection of the public and having a system of registration for nurses and midwives is discernable in all the Acts with the identification of mechanisms to ensure that nurses and midwives who provide health services are fit and competent to practice according to professional standards, and hence protect the community.

3.2 The functions and powers of nursing and midwifery regulatory authorities

Protecting the public requires: a licensing process for those who meet the requirements to practice as nurses and midwives, and a substantial infrastructure to manage: compliance with that licensing process; developing and monitoring educational and practice standards; and the complaint system. The nursing and midwifery RAs in each State and Territory have been established to undertake these functions. However, inherent in these roles and functions are significant powers that can be seen, on the one hand as safeguarding the community; while on the other hand as being unnecessarily restrictive, coercive and protective of their own institutional interests to the detriment of the community, nurses and midwives and employers. This tension is evident in the innate dichotomy that is posed by the mandate of protection of the public and having a flexible and mobile health workforce.

How the legislation and the internal policy making of the RAs shape the professions is evident in the maps prepared as part of this Project.

The table below sets out the specific RAs in each jurisdiction in Australia. There is a clear trend to include midwifery in the titles of these authorities in the last few years. Victoria is out of synchronisation with the general trend of reform from 2000. The RA in the as-yet uncommenced Act retains the name, the Nurses Board of Victoria. The ACT, NSW, the Northern Territory and Western Australia (the latter in the current Bill) have all given midwifery explicit titular recognition in their last rounds of legislative reform. Queensland, South Australia and Tasmania have not yet changed the name of the RA responsible for nursing and midwifery, but each of the RA officials interviewed expressed an opinion that it would be inevitable in any forthcoming legislative amendments.

Table 3 – the RAs in Australia

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
ACT Nursing and Midwifery Board	Nurses and Midwives Board	Nursing and Midwifery Board of the Northern Territory	Queensland Nursing Council	Nurses Board of South Australia	Nursing Board of Tasmania	Nurses Board of Victoria Nurses Board of Victoria ¹⁶	Nurses Board of Western Australia Nurses and Midwives Board of Western Australia ¹⁷

There is no doubt that RAs already share a core set of objectives, roles and functions that require specific powers under legislation. This can be seen in Table 4. These are described differently and the scope varies across jurisdictions, making comparability and application challenging for the community, employers and nurses and midwives.

The functions and powers of the RAs are the foundations of the legislative infrastructure. It is these that enable the nursing and midwifery RAs to be able to do what they do. They were identified as part of the mapping and the jurisdictions that have listed them specifically in their regime of functions and powers are listed in the table below:

Table 4 – Summary of functions and powers of nursing and midwifery RAs

Functions and Powers	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
1. Education of nurses and midwives and educational programs relating to nursing and midwifery – approval of courses, setting standards for courses and course providers	✓	✓	✓	✓	✓	✓	✓	✓
2. Advising the Minister	✓	✓	✓	✓	✓	✓	✓	✓

¹⁶ The legislation has been enacted but is not yet commenced.

¹⁷ The Bill which will amend the RA's title is currently being debated in Parliament – second reading speech has been given by the Minister.

Functions and Powers	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
3. <i>Administering the scheme of registration, enrolment, authorisation/endorsement of qualified nurses and midwives, and exercising discretions granted under Act in relation to the registration or enrolment of nurses and midwives</i>	✓	✓	✓	✓	✓	✓	✓	✓
4. <i>Developing, promoting, maintaining and reviewing professional practice standards and professional development standards of nursing and midwifery practice</i>	✓	✓	✓	✓	✓	✓	✓	
5. <i>Reviewing and monitoring the entry, re-entry and continuing competence, professional development conduct and health or registered or enrolled nurses and midwives</i>	✓	✓	✓	✓	✓		✓	
6. <i>Provision of information about and promotion of nursing and midwifery</i>	✓	✓	✓			✓		✓
7. <i>Taking action in relation to breaches of standards, reports or complaints about nurses and midwives</i>			✓	✓	✓	✓	✓	
8. <i>Providing information concerning nurses and midwives for lawful purposes</i>	✓		✓		✓	✓	✓	
9. <i>Consulting with and developing relationships with other organisations and participating in activities relevant to RA's functions and powers</i>	✓		✓	✓		✓	New	
10. <i>Cancelling or suspending any registration, authorisation or enrolment in accordance with requirements outlined in the Act</i>	✓	✓						
11. <i>Refusing or imposing conditions on registration or enrolment; terminating or varying registration, enrolment, authorisation or endorsement; withdrawing or varying conditions of, any recognition or exemption in relation to registration, enrolment, authorisation/endorsement</i>		✓						
12. <i>Other functions, exercising powers and obligations of the RA</i>		✓	✓	✓	✓	✓	✓	✓

Source: Section 1.9 of Map 1.

There is a fair degree of consistency, although some of the functions and powers were not necessarily clearly articulated in the specific statements of functions and powers in the Acts and had to be sought out in other areas of the legislation or implied from other provisions. A number of powers were not specifically identified in the section outlining the powers that form critical regulatory community safeguards in some of the Acts but are clearly evident in other areas of the legislation. For example, the RA's role in taking action in relation to breaches of standards, reports and complaints about nurses and midwives (1.9.10) is a significant power, but is not specifically listed as a function or power of the RA in the ACT, NSW or Western Australia. However, there is a comprehensive framework for the RAs to exercise these powers in the legislation.

Another important area is the sharing of information between RAs concerning applicants for registration or enrolment (1.9.6). Given the now stringent privacy protection in Australia, the capacity for RAs to be able to identify nurses and midwives applying for registration or enrolment who have been registered and enrolled in another jurisdiction and have come to the attention of that RA because of issues of competence and fitness to practice, is substantially proscribed, unless there are specific exemptions under the privacy legislation and attendant powers in the parent RA legislation. The sharing of this information is seen as an important mechanism for protecting the community from nurses and midwives whose conduct, health or practice does not meet the contemporary standards of the professions.

NSW, Queensland and WA do not list this power specifically, although each has some capacity to share information in certain circumstances. The scope of this power varies across jurisdictions which causes considerable tension and comment between the RAs. For example, the ACT, Northern Territory (NT), SA and Tasmania have quite broad powers to share information with other RAs, whereas the other RAs have significant limitations on their powers, such as NSW, where the power is narrowly prescribed.

A third anomalous area is in the RA's explicit role and powers in relation to reviewing and monitoring the entry, re-entry and continuing competence, professional development, conduct and health of nurses and midwives (1.9.3). Each principal piece of legislation establishes an RA to administer a scheme of registration, enrolment, authorisation, etc. for qualified nurses and midwives. Less explicit are all the RA's functions and powers to assess

the suitability/fitness or competence for these nurses and midwives to practice at these checkpoints of registration and enrolment. For example, Tasmania and WA do not specifically identify this function although it can be implied. However, in NSW and WA this function is limited as the boards must renew the practicing rights of a nurse or midwife who completes the required documentation and pays the prescribed fee at renewal time even if they self identify as actually or potentially unfit to practice. This is a source of concern to both RAs who then have to rely on a complaint or a report to be able to instigate action. This raises significant questions about the potential risks to the community and gaps in the powers of the RAs to take appropriate action for nurses and midwives who remain registered, but do not meet current professional standards.

In each of the legislative regimes except the ACT, there are a number of 'other' specifically-listed functions, powers and obligations on RAs. These can be broken down into two groups and are outlined in the table below. Group 1 is a collection of 'catch-all' provisions which are intended to enable the RAs to carry out the functions and exercise their powers: that may not be listed explicitly in the specific legislation, but are clearly outlined in other parts of the legislation; or where the source of certain functions and powers may be located in other legislation or delegated legislation. These 'catch-all' provisions are potential sources of a significant extension of powers if given a liberal legal interpretation by RAs. This is manifest in some of the discretions exercised by the nursing and midwifery RAs in conducting their day-to-day business where there is no apparent source of power.

Table 5 – the 'other' functions, powers and obligations of RAs

GROUP 1 - The 'catch-all' provisions:

- Generally, to do any other act or to exercise any other functions necessary for carrying the provisions of the Act into effect – NSW.
- The Board has those functions that are imposed on it by this or any other Act or that are prescribed – NT.
- The Board has power to do all things necessary or convenient to be done in connection with the performance of its functions – NT
- Carrying out other functions conferred on it by this or another Act – QLD.
- The council has power to do all things necessary or convenient to be done for, or in connection with, the performance of its functions – QLD.
- Carrying out other functions assigned to the board by or under this Act, or by the Minister – SA.
- Undertaking such other functions as may be imposed on the board by this or any other Act or as may be prescribed – TAS.
- The board has power to do all things necessary or convenient to be done in connection with the performance of its functions – TAS.
- Doing anything incidental to any of its powers – TAS.
- Undertaking any other functions conferred on the responsible board by this or any other Act – new VIC.
- A responsible board has all the powers necessary to enable it to perform its functions – new Vic.
- Performing the other functions that are vested in the board by this Act – WA.
- The board may do all things that are necessary or convenient to be done for, or in connection with, its functions – WA.
- To perform other functions that are conferred on the board under this Act or any other Act – WA Bill.

GROUP 2 - Other functions and powers:

- Establishing and maintaining other records in relation to nurse education and nursing practice – QLD.
- Conducting research into matters relevant to the council's functions – QLD.
- Giving the Minister a report of the board's work and activities and those of its committees during each financial year – QLD.
- The council has, for or in connection with the performance of its functions, all the powers of an individual and may eg:
 - enter into contracts.
 - acquire, hold, dispose of and deal with property.
 - appoint committees to assist it to perform its functions.
 - exploit commercially any resources of the council, including any study, research or knowledge, or the practical application of any study, research or knowledge, developed by or within the council or belonging to the council (whether alone or jointly with another person or body) – QLD.
- The board has the powers necessary or expedient for, or incidental to, the performance of its functions eg:
 - engage experts or consultants, appoint agents, or engage contractors.
 - enter into any form of contract or arrangement.
 - acquire, hold, deal with and dispose of real and personal property.
 - acquire or incur other rights or liabilities – SA.
- Issuing and publishing guidelines about the minimum terms and conditions of professional indemnity insurance for registered nurses – VIC.
- When so requested by the Minister, giving to the Minister any information reasonably required by the Minister – VIC.
- Undertaking any other functions conferred on the board by this Act – VIC.
- The board has all the powers necessary to enable it to perform its functions – VIC.
- The board must consult with the Minister and have regard to the Minister's advice in carrying out its functions and exercising its powers

– VIC.

- Issuing and publishing guidelines about the minimum terms and conditions of professional indemnity insurance for registered health practitioners regulated by the board – new VIC.
- When so requested by the Minister, giving to the Minister any information reasonably required by the Minister – new VIC.

Source: Section 1.9.12 of Map 1.

Group 2 of the 'other' functions, powers and obligations are an eclectic group that have little commonality across the jurisdictions.

There are clear benefits of reaching agreement across the RAs at a policy level in relation to a core set of principle-based objects, functions and powers that could inform future legislative review and provide policy guidance for the present time in providing the foundations for regulation of nursing and midwifery in Australia. It would assist clarity for the community in what protections exist to protect its health and safety in relation to the RA's capacity to ensure the fitness of nurses and midwives to practice safely, identify those that do not, and take action in those cases. Secondly, the RA's role in the development, monitoring and review of practice standards would be significantly enhanced by having a universal set of principles and definitions reflected in the functions and powers as a platform that goes to ensuring consistency of application of the legislation, policy and practices across all jurisdictions.

3.3 The constituency of the regulatory authorities

The size of the boards/council of each of the nursing and midwifery RAs ranges from 7 to 16 members, with the smaller jurisdictions having the smaller number of members. For example, the ACT, NT and Tasmania have 9, 7 and 7 members respectively, whereas NSW and Victoria have 16 and 12 members.

It is worthy of note that despite the fact that this area of regulation is known as a protective jurisdiction, there are still some significant indicators of self regulation remaining. Community members remain a notable minority on all RAs with Queensland and Western Australia having only one community member each. ACT, Northern Territory, Tasmania and currently Victoria have two community members, while NSW and South Australia have three community members.

The current models of regulation have been described as being based upon peer review and known as 'statutory self regulation' or 'professional self regulation' (Department of Human Services Victoria 2003: p 4). The model is based upon the essentially paternalistic notion that a professional's peers are in the best position to decide what is appropriate professional practice and conduct and how to ensure the protection of the public. Carlton says:

Although registration legislation in every Australian jurisdiction now makes provision for community and legal members on registration boards, there are questions about the extent of influence a few non-practitioner members can have on boards that are made up primarily of practitioners, whether the community interest is afforded sufficient weight, and whether community members may be 'subject to capture' by the professions. In addition, practitioner members bring essential professional and clinical expertise, but may be ill-prepared for a role that requires an understanding of the principles of natural justice and procedural fairness, and they may, at times, lack insight where professional interests conflict with the broader public interest (Carlton 2006: p 4).

There is increasing international and national pressure to ensure that the protective jurisdiction is indeed for the protection of the public and has an appropriate level of community oversight (Carlton 2006: p 4). This would mean a more equal distribution of community members to nursing and midwifery professional members to reflect genuine community participation in transparent governance in the public interest. The as yet uncommenced *Health Professions Registration Act 2005* in Victoria does enable the Minister for Health to:

...recommend for appointment up to half the members of a registration board who are not practitioners from the profession concerned and to appoint non-practitioners in office bearing roles on registration boards, where this is necessary for the effective operation of a board. These reforms 'are designed to ensure a proper balance is struck

between the rights and interests of consumers and those of the practitioners who deliver health services' (Carlton 2006: p 5).

Currently, the primary membership of the RAs is nurses and midwives. How these are selected or elected and distributed across the different practice areas of nursing and midwifery varies considerably. Table 1 – 1.5 demonstrates this diversity of approach. For example, Tasmania has five nurses who hold current practicing certificates and have demonstrated an ability to assist in the fulfilment of the board's objectives, nominated by the Minister. Whereas NSW has very specific categories of RNs, RMs, mental health nurses, ENs and nurses and/or midwives from the education sector. These are both elected and nominated, with some nominated by the Minister and others by nursing and midwifery professional and industrial organisations.

The Minister's power to control the constituency on a number of RAs is noteworthy. For example, the members of the boards in Tasmania, Victoria and WA are all nominated and appointed by the Minister. Unless there is clear policy for advising the Minister in a transparent and rational way on appropriate nursing and midwifery professional representation on the board/council, there is some risk of idiosyncratic and perhaps political nominations that may not be seen as serving the interests of the community, or secondarily, the professions of nursing and midwifery. An appropriate skill mix and balance of interests of the members is as important on a nursing and midwifery RA board as in any governing body. With the important functions and the significant powers vested in an RA, it is critical that these powers are exercised fairly, transparently and with community protection remaining paramount.

In discussion with RAs who have minimal legislated prescription in this area, it appears that there is policy to ensure that there is a representative mix of the different practice areas of nursing and midwifery or a very deliberate policy to coopt appropriate expertise to ensure a balanced approach: to the collective's decision making; the setting of educational and practice standards; and in the exercise of the other RA functions. For example, the ACT has a policy to ensure that a senior nurse or midwife representing the academic sector is always a member of the board. Given the RAs' roles in setting educational standards, it is essential that the RA receives relevant and timely advice from an education provider's perspective.

Which legislative regime is preferable is debatable as both have their benefits and burdens. What is obvious is that where RA policy is the means of ensuring appropriate membership of nursing and midwifery interests, this policy was not freely available to the public or the professions.

There are considerable opportunities and benefits at this time for reaching agreement around a uniform set of principles guiding the constituency of RAs that promote a higher level of transparency, strong community participation and balanced involvement of the key practice areas of nursing and midwifery. These may be used in the review of legislation, to advise Ministers and to enable the promulgation of a nationally-consistent and collectively-agreed approach to the membership of RAs or a nursing and midwifery panel if the Productivity Commission's recommendation comes into effect.

3.4 Governance and accountability of the regulatory authorities

As the regulators of the nursing and midwifery professions, the RAs have high legal and ethical obligations to ensure their processes for making decisions are accessible, transparent and fair. These decisions will affect: the quality of nursing and midwifery care provided to the community; the professional practice of nurses and midwives; employers' decisions in relation to the recruitment and selection of nurses and midwives who are competent and suitable to employ; and the confidence of the community in the professions of nursing and midwifery.

The governance of RAs differs in each jurisdiction. Map 1 – section 1.14 outlines the legal status of the RAs and their reporting requirements to the Parliament or Minister for Health in each jurisdiction.

Except for NSW, where the Nurses and Midwives Board is a statutory authority that is dependent upon the health bureaucracy for employment of staff and for the conduct of its corporate functions, each of the RAs is established as a statutory corporation. This gives the RAs a level of independence in the conduct of their business and in the exercise of their functions and powers. That said, as organisations created under legislation they do have a level of accountability to the community, usually via Parliament, the Minister of the government responsible for the health portfolio or the bureaucracy.

The RA's relationships with the Parliament, the government of the day, the ministers and government departments responsible for the health portfolio, differ from jurisdiction to jurisdiction. Some are explicitly under the control and direction of the Minister for Health, such as the Nurses and Midwives Board in NSW and the ACT Nursing and Midwifery Board. Others appear to have increasing degrees of independence. For example, the Queensland Nursing Council *advises and reports to the Minister on the functions of the Council* - s 7(a) *Nursing Act 1992*. This latter relationship implies an advisory, passive reporting role to the Minister and a non-interventionist approach by the Minister in relation to the conduct of the council's business. In Western Australia:

The Minister may, after consulting with the Board, give directions in writing to the Board with respect to the performance of its functions either generally or in relation to a particular matter, and the Board shall give effect to any such direction, except in relation to directing the Board with respect to the performance of its functions in regard to:

- *a particular person; or*
- *a particular application, complaint or proceeding – s 10 Nurses Act 1992.*

This clearly gives the Minister or their delegate (such as the head of the Department of Health) the power to actively intervene in the board's policy development role, or in other functions of the board, except in relation to its dealings with individual nurses and midwives, individual applications, complaints or disciplinary proceedings. This provision significantly curtails the independence of the RA and the relationship between the Minister of the day and the officials and members of the board will be critical to the smooth functioning of the regulatory system in WA.

In Victoria, *when so requested by the Minister*, (the board is required to give) *to the Minister any information reasonably required by the Minister – s 66(1)(k) Nurses Act 1993*.

As a form of control, a number of the RAs, such as the ACT, NSW, SA, Tasmania under the new legislation in Victoria, and WA have very specific legislated requirements around the development, approval and notice to be given in relation to codes, standards, policies or guidelines, though each differs in their approach. This is discussed in the following section of this Report – part 4.5.

There are innate tensions in the RAs not being vulnerable to the influences of current political exigencies, but at the same time having robust accountability frameworks which ensure that they conduct their business in a way that meets all the requirements of effective and efficient public sector governance:

- **Accountability** - RAs should be accountable to the community for their decisions and operations by submitting themselves to appropriate scrutiny.
- **Transparency and openness** - the decision-making processes of RAs should be open, clear and understandable and have the confidence of consumers, nurses, midwives, employers, policy makers and government.
- **Integrity** – involves straightforward dealing based upon honesty, objectivity and high standards of propriety and probity in the conduct of the RAs' functions and in the exercise of powers.
- **Stewardship** – RA officials, staff and members exercise their powers on behalf of the community. The resources that they have are held in trust and not privately owned; hence they are stewards of these resources and have the concomitant obligations that go with that privilege.
- **Leadership** – the functions and powers given to RAs bestow them with influence and authority within the professions, which bring responsibilities to provide conscientious leadership across nursing and midwifery for the primary purpose of protecting the public while at the same time showing fairness and even-handedness.

- **Efficiency** - the resources expended and the administrative burden imposed by the health profession's regulatory system should be justified in terms of the benefits to the community with a commitment to evidence-based strategies for improvement (Australian National Audit Office, 2003 #862: p 8; Department of Human Services Victoria, 2003 #865: p 10).

The following explicit principles have also been added to those of the Australian National Audit Office:

- **Effectiveness** - the regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high quality care.
- **Fairness** - RAs should maintain an acceptable balance between protecting the rights and interests of health consumers and those of nurses and midwives.
- **Flexibility** - the regulatory system should be able to respond to emerging issues in a timely manner as the health care system evolves and the roles and functions of nurses and midwives change.
- **Consistency** - as far as possible, there should be consistency across Australian States and Territories in the regulatory arrangements for the health professions (Department of Human Services Victoria 2003: p 10).

Areas where there appears to be considerable variation in RA openness, policy and practice is in the variation in the use of appropriate experts in order to conduct its functions and exercise its powers. For example, each of the RA's processes, standards and requirements for the accreditation or approval or education courses for entry to nursing and midwifery, which is a primary function of each of the RAs, differs recognisably where that information is available. This is discussed further in the discussion on the RA's roles in setting and reviewing nursing and midwifery educational standards in Part 7 of this Report. However, the capacity of the community, nurses and midwives, employers, educators and health policy makers to have an understanding of how each RA undertakes its required functions and exercises its powers is critical to their obligations as public sector instrumentalities. The access to information on the RA websites (discussed above) is an important mechanism for evidence of all these principles of good practice in public sector governance to be displayed. As lamented above, information is currently not always available or accessible.

Each nursing and midwifery RA has an explicit obligation to advise the Minister in some way or other (see Map 1 – 1.9.5). Some, such as the legislation in the ACT, require the board to give advice about matters relevant to nursing and midwifery. In Queensland, the council are required to advise and report on developments in nursing education and nursing practice, as well as the needs of the State in relation to nurse education and nursing practice. In NSW, the board is required to advise the Minister on matters relating to the registration or enrolment of nurses and midwives. In SA, the board is required to provide advice to the Minister as may be appropriate.

The annual reports that most RAs are obliged to furnish to the Parliament or Minister in their jurisdiction do not have and cannot have all current policies and guidelines alongside the financial and statistical information that they provide. However, there would be benefits in having some uniform reporting standards in relation to the core activities and functions of RAs, as well as registration and enrolment data that could enable benchmarking across RAs for the purposes of quality improvement, reducing the barriers to the mobility of nurses and midwives and for sharing of information, as well as identifying opportunities to reduce the duplication of intellectual and financial resources across each of the jurisdictions.

It would also be useful in the important work that each of the nursing and midwifery RAs undertakes to have a set of uniform regulatory standards that clearly articulate the common principles of governance outlined above. This would be beneficial whether the RA is a national registration authority of health professionals or individual RAs in each jurisdiction.

3.5 Regulation of practice in nursing and midwifery

One of the RA functions of greatest consequence is their central role in the development, monitoring and review of educational, practice and professional standards for nurses and midwives. It is these standards that influence the quality of care provided to health consumers by nurses and midwives and dictate the ease or barriers that nurses and midwives face in moving across jurisdictional boundaries because of their similarities or differences.

Map 1 – 1.10 demonstrates that each of the RAs has a very clear legislated mandate for the development of codes, standards and policies relating to nursing and midwifery practice. It is notable that only the ACT, NT and WA Boards have the statutory capacity to specifically recognise that the standards, codes or policies may have been created by another entity (such as the ANMC).

A number of the RAs have requirements to act at the behest of the Minister in the development of codes, standards, policies or guidelines. As noted above, a number of the RAs have very specific legislative requirements on the consultation and circulation processes for any codes, policies and standards developed and/or approved or endorsed by the RA. Some RAs require ministerial sign-off before they can introduce any standards, codes, etc.

For example, in the ACT, any standards statement must be in writing and is a 'notifiable instrument' requiring its existence to be notified in the Government Gazette.

In Tasmania:

The Board may make by-laws for the purpose of providing practical guidance to nurses in general practice and in restricted practice areas. By-laws made may be referred to, collectively, as the Nursing Code and the Board must:

- *make a copy of the Nursing Code available at its office to be inspected by any person on request free of charge.*
- *ensure that any person who wishes to do so may obtain a copy of the Nursing Code from the Board – s 11 Nursing Act 1995.*

In WA, the prescription is the most obvious. Here:

The Board may, with the approval of the Governor, by publication in the Gazette, issue codes of practice with respect to:

- *the practice of nursing and the conduct of nurses.*
- *the practice of any nursing speciality and the conduct of nurses practicing that speciality.*
- *nurse practitioners.*

The Board may, with the approval of the Governor, by publication in the Gazette:

- *amend;*
- *revoke; or*
- *revoke and replace, a code of practice.*

A code of practice is to contain only information recommended by the Commissioner of Health with respect to the functions of nurse practitioners, including:

- *the possession, use, supply or prescription of poisons, as defined in the Poisons Act 1964, by a nurse practitioner*
- *the requesting, or undertaking, of diagnostic testing or therapies*
- *the undertaking of treatments by a nurse practitioner*
- *such other functions as are necessary or convenient with respect to the practice of nursing as a nurse practitioner and the conduct of nurse practitioners, and anything incidental or conducive to those functions.*

A code of practice may adopt wholly or partly any standards, rules, code, or other provisions published by some other body and may adopt them:

- *with or without any amendment or modification*
- *as in force at the time of adoption or as amended from time to time – s 9 Nurses Act 1992.*

A significant challenge in mapping this area of RA responsibility is the lack of clarity around the definitions and almost no uniformity in what these 'things' are. The language of codes, standards, policies and guidelines (among others) is used almost interchangeably, yet there is no clear definition in any of the statutory instruments or indeed in the RA documents that spells out clearly what the meaning of 'code', 'standard', or the other names for what are clearly mandatory or guiding statements that relate to the practice of nurses and midwives. The NT is the only jurisdiction that has a definition of a 'code', circular though it may be, indicating that it *means the policy and guidelines adopted by the Board (s 4) for the purpose of providing practical guidance to health practitioners...* (s 12(1)). The ACT legislation specifically discusses standards in the context of standards for the maintenance of competence (Clause 13 of the *Health Professionals Regulation 2004*) and standards statements. The former outlines the requirements of the standards as: *the requirements for maintaining professional competence and professional development; and how the requirements are satisfied and demonstrated* (Clause 131(6)). The Regulation defines a standard statement as:

... a statement designed to raise awareness of the standard of practice required from a health professional for the professional to be competent to practice, or to help the professional to improve his or her suitability to practice Clause 134(1).

The example of a 'standard' given in the ACT Regulation is a 'code' of professional conduct. The Codes of Practice for Nurses and Nurse Practitioners in WA are specific statements of key features of what is expected of nursing (including midwifery) or nurse practitioner practice. On the other hand, the use in other jurisdictions of the concept of a 'code' varies greatly. The 'codes' in Tasmania and the NT are collections of policy statements and guidelines across disparate areas of behaviour, practice requirements and other guidelines, but with little uniformity on what is the 'whole' of what a complete policy framework might look like to guide the practice of nurses and midwives.

This lack of consistency and clarity in the definitions makes it very difficult to compare and contrast the RAs approach to setting policy and standards within their jurisdictions. Only SA appears to be taking a higher-level view and is in the early stages of working on the development of a policy framework to inform the priorities and scope of the standards, policies, guidelines and information of where the board should be concentrating resources. The lists of standards, codes, guidelines and information brochures on most RAs websites are idiosyncratic and difficult to compare. One can speculate that many were drafted in response to an event, incident, complaint, tribunal decision or political imperative at one time. This reactive and ad hoc approach to policy making, while serving the exigencies of the moment do not enable the systematic development of a comprehensive policy infrastructure to be built from the ground up.

The lack of definitional clarity as to the status of standards, codes and other policies and guidelines presumably also gives RAs some discretions in deciding which of those must undergo the onerous, resource-intensive and time-consuming statutory consultation, approval and notification processes outlined in the legislation in those jurisdictions discussed above.

The growing general acceptance across jurisdictions of the ANMC Codes of Conduct and Ethics for Nurses (sic) in Australia and the competency standards for RNs, midwives, ENs and nurse practitioners (NPs) is noteworthy though not yet universal (Australian Nursing and Midwifery Council Inc 2000; Australian Nursing and Midwifery Council 2002; Australian Nursing and Midwifery Council Inc 2002; Australian Nursing and Midwifery Council 2003; Australian Nursing and Midwifery Council Inc 2005; 2006) – see Table 1 – 1.13. For example NSW has not adopted the national Codes of Ethics or Conduct, or the National Competency Standards for Nurse Practitioners at the time of writing, although it was reported that the adoption of these latter standards was imminent.

Map 1 – 1.12 indicates that there remains a proliferation of local standards, guidelines and other information available through RA websites and as printed material that is at times inconsistent with those national codes and standards, and very confusing to the nurse, midwife, employer, community member or researcher attempting to understand what are the requirements to practice as a nurse or midwife in Australia.

A cogent uniform national policy framework is clearly needed to hang each of these mechanisms (ie. codes, standards, policies, etc.) from. A common lexicon with clear definitions that makes it is clear what their intent is and what their standing is as mandatory requirements or advisory information, will make the requirements for the education and practice of nurses and midwives much more transparent. Clarity in their purpose and impact and how the RAs should use them should translate into better understanding by nurses and midwives at the coal face in relation to the standards of professional practice expected of them and reduce some of the challenges that confront nurses and midwives seeking to move across jurisdictions.

Evident from an examination of the regulatory frameworks of each of the RAs is the energy and focus in the area of establishing a decision-making framework relating to the scope of practice for nurses and midwives. Stemming from research commissioned in Queensland, commenced in 1995 and published in 1998 (Queensland Nursing Council 1998; 1998), the 'scope of practice movement' has gained national interest. Queensland and SA have a legislated obligation to determine scopes of practice and Victoria has the responsibility to determine the core functions of the different divisions of nurses and midwives, while most of the other jurisdictions have devoted considerable resources to the development of guidelines and decision-making frameworks (Nursing Board of Tasmania 2001; Nurses Board of Western Australia 2004; Nurses Board of Victoria 2005; Queensland Nursing Council 2005; Nurses Board of South Australia 2006). The ANMC has undertaken consultation from January to April 2006, with a view to proposing a *National Framework for Decision Making by Nurses and Midwives about Scopes of Practice* (Australian Nursing and Midwifery Council 2006; 2006).

One cannot help but celebrate this national initiative, given the challenges in getting national agreement on any of the work commissioned by the ANMC. However, the problems associated with setting boundaries to professional practice deserve some consideration. Where does this work sit within a broader framework of nursing and midwifery standards and policy? The ambit of nursing is flexible, expanding to meet consumer needs where needs are left unmet. Any mechanism to restrict the practice is fraught. Strong principles around adequate competency and the currency of skills, knowledge, judgement and care required to provide nursing or midwifery care are critical. The risks associated with the developments in regulating the limits of nursing and midwifery practice make it predictable that a level of rigidity will develop around tasks and roles that will ultimately constrain the capacity for the professions to meet consumer needs. There is already evidence of this in two areas of nursing practice. That is, in the domain of ENs and NPs. Here, it can be argued that what set out to be enabling principles are developing into constraining rules.

Box 1 - Example of an RA specifying the actual tasks that can be undertaken by a level of nurse or midwife

From a recently-published report from the Nurses Board of Victoria *Report from Questionnaire – Guidelines:*

Determining Scope of Nursing and Midwifery Practice when discussing 'expanded registered nurse practice':

In terms of the Division 2 registered nurse (RND2), they have not been included here. In Victoria, the role of the RND2 has been limited in practice. In other states for example it may be the usual practice for RND2s to: insert a NGT; IDC; care for tracheostomy tubes; suctioning, but this is not the case in Victoria. The NBV would state that instead of being an advancement to usual practice this would be an expansion for this level of nurse. Even though these are considered usual practice for nursing – it is not the case for the RND2 in Victoria (Nurses Board of Victoria 2006)¹⁸.

It should be noted that these limits to practice are not outlined in any other Nursing Board of Victoria's (NBV) documents, policies and standards. However, the seed may be planted.

¹⁸ Different processes apply to 'advancing' and 'expanding' practice in the NBV consultation document.

The rigidities that are emerging for NPs in their evolving roles in the requirements to define their scope of practice, the areas of practice and the requirements around their use of clinical protocols and guidelines, are easy to predict. Map 8 outlines some of the requirements for registration, authorisation etc of NPs. They are not nationally consistent which makes mobility across State and Territory borders tricky in establishing equivalence. They are not all principle-based and place stringent boundaries around the role evolving to meet changing consumer and organisational workforce needs.

The other area where the debate continues is in the discussions around what midwifery practice is, and where the overlaps are with nursing practice. In some jurisdictions, the statutory instruments are totally silent in relation to midwifery, choosing to encapsulate it totally within the profession of nursing, eg. in Tasmania. With the emergence of the direct entry Bachelor of Midwifery programs that have been approved or accredited by the RAs as meeting EP requirements for midwifery practice that are being established in three of the States (NSW, SA and Victoria), and the increasing demands for more overt recognition by some groups of midwives, it is likely that some agreement will be required on how this potentially-divisive conflict can be resolved.

ENs are also being squeezed as part of this role-scoping in some jurisdictions. The variation in requirements for preparation for entry in each jurisdiction evident from the data in Map 9 – 9.18 and the extraordinary variation in dealing with ENs in relation to the administration of medications is also a source of significant concern. The aged care sector is a particularly good example of where the consequence of this plays out vividly. Assistants in nursing (AINs) with no educational preparation, or prepared at Certificate III or IV level, are able to distribute medications from Webster Packs, but depending upon what the medication is or their educational preparation, an EN may not be able to undertake the same task in some jurisdictions. The variations are well documented as part of the ongoing national debate. However it is apparent that the restrictions which exist that limit the potential practice capabilities of ENs is a significant structural barrier for ENs moving easily across jurisdictions in Australia.

While the work being done around the national decision-making framework about scopes of practice, national competency standards and codes of ethics and conduct has some claim on being founded upon an evidence base, it is of some concern that many of the policy statements and information issued by the nursing and midwifery RAs in Australia do not come well supported by clear and contemporary evidence.

The work on decision-making frameworks and scopes of practice needs to be looked at as part of the development of a broader policy infrastructure. The early work done by the Taskforce and published in the *Scopes of Practice Commentary Paper* highlights the challenges in regulating the practice of nursing and midwifery (National Nursing and Nursing Education Taskforce 2005c). The Paper points out very clearly the double-edged sword that this level of specificity in the regulation of the practice of nurses and midwives can create:

It is clear that scopes of practice may serve more than one purpose at any given time, reflecting a range of stakeholder interest. A scope of practice can enable practices by providing authorisation, or indeed limit practice by articulating boundaries (National Nursing and Nursing Education Taskforce 2005c: p 25).

The limitations around the practice of NPs and ENs provide salient cautions around the limitation of practice that goes far beyond ensuring the safety of the community. The restrictions suggest the existence of intra-professional turf battles in the case of ENs and inter-professional turf battles in the case of NPs, with little rational evidence to support the stringency and efficacy of the limitations. The work in this area in Western Australia, particularly relating to EN practice, demonstrates that there is the capacity to have a more flexible approach.

Given the health workforce challenges that currently exist and are looming in the future, 'enabling' practice should be the focus of the initiatives to provide safe, high-quality care to meet people's needs by appropriately educated and skilled health professionals.

The Taskforce Paper goes on to state:

The enablers of practice for nurses and midwives are numerous, complex and inter-related.

A nationally-consistent framework for scopes of practice would need to consider how to accommodate the numerous enablers that:

- *integrate the complexity without losing diversity;*
- *build responsiveness and diversity;*
- *acknowledge and harness the reciprocal nature of these elements* (National Nursing and Nursing Education Taskforce 2005c: p 39).

There are benefits in and opportunities for agreement to be reached around uniform principle-based definitions of codes, standards, policy, guidelines, etc. and their standing as mandatory or advisory instruments in relation to the practice of nurses and midwives. Also, agreement on the development of a uniform national policy framework for each jurisdiction that clearly identifies areas of national evidence-based codification and standard setting would be a significant step forward. Added to that, areas where local policy formulation and information is required to meet the unique needs that may prevail in a specific jurisdiction would also enhance the capacity of the community, nurses and midwives, educators and employers to understand and navigate this area.

3.6 The registers and rolls

A review of the very differing ways that nurses and midwives are regulated in each jurisdiction is evident from the data in Map 2. The table below outlines the registers and rolls which exist in each of the jurisdictions.

Table 6 – the Registers and rolls in each jurisdiction:

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
<ul style="list-style-type: none"> • Register of Nurses • Register of Midwives 	<ul style="list-style-type: none"> • Register of Nurses • Register of Midwives • Roll of Nurses <ul style="list-style-type: none"> ○ List A – ENs ○ List B – ENs (Mothercraft) 	<ul style="list-style-type: none"> • Register of Nurses • Register of Midwives (DEM only) • Roll of Nurses 	<ul style="list-style-type: none"> • Register of Nurses • Roll of Enrolled Nurses 	<ul style="list-style-type: none"> • Register <ul style="list-style-type: none"> ○ Register of General Nurses ○ Register of Midwives ○ Register of Mental Health Nurses ○ Register of Nurse Practitioners ○ Other parts (or 'registers') • Roll <ul style="list-style-type: none"> ○ Roll of Nurses 	<ul style="list-style-type: none"> • Register of Nurses • Roll of Nurses 	<ul style="list-style-type: none"> • Register of Nurses • Register of Health Practitioners 	<ul style="list-style-type: none"> • Register of Nurses • Register of Nurses and Midwives

Source: Section 2.1 of Map 2.

In **Appendix I** there is a summary of treatment of the different categories of nurses and midwives on the registers and rolls in each jurisdiction taken from Map 2 – section 2.1. This summary table and the other data in Map 2 paint a very clear picture of the lack of consistency across the States and Territories in:

- The naming and title definitions of the different categories of nurses and midwives. For example, Victoria and WA use divisions of the register and do not have a roll of nurses (although in WA the Division 2 nurses will be registered as enrolled nurses under the current Bill that is before the Parliament).
- Whether title, or title and practice are protected, eg. The ACT, NT, Tasmania and WA specifically protect both title and practice. This has implications for students of nursing and midwifery undertaking their clinical placements in their pre-entry courses when they are 'practising' nursing or midwifery in a clinical setting.
- The way that the registers and rolls are constructed, ie. one register, multiple divisions; multiple registers; registers and rolls; registration or enrolment, and authorisation or endorsement with almost no correlation between the methodologies of

each RA. This makes it difficult to compare like qualifications and titles easily on the public rolls and registers across the jurisdictions as a member of the public, a nurse or a midwife, an employer, researcher or policy maker.

- The recognition of midwives who have undertaken a Bachelor of Midwifery and do not have a nursing qualification, eg. there will be Specific Registration as a midwife under the new Act in the Victoria for midwives who have no nursing qualification. RNs with a midwifery qualification will be registered in Division 1 of the Register and endorsed as a midwife. In the ACT, NSW and SA, an RN who is also a midwife is registered on the Register of Nurses and registered on the Register of Midwives. For midwives who have no nursing qualification, they will be registered on the Register of Midwives only in those three jurisdictions.
- The recognition of nurses who have a mental health qualification, be it a post-graduate nursing qualification or a mental health nurse who has no general nursing qualification. SA registers mental health nurses on a discrete register of mental health nurses (those with general nursing qualifications will also be registered on the Register of General Nurses), whereas Queensland and Tasmania authorise RNs with post-registration qualifications in mental health nursing. For mental health nurses who have no general nursing qualification, the treatment is even more idiosyncratic, with these mental health nurses registered on the Register of Nurses with no limitations on their practice in the ACT, NSW, Queensland, Tasmania or Western Australia. Currently in Victoria, they are registered in Division 3 or the Register of Nurses and will be given Specific Registration under the new Act after commencement.

Map 2 and the summary table in **Appendix I** also highlight the variation and anomalies in:

- The way that NPs and (MPs in NSW) are treated on the register (or registers), eg. in ACT they are registered as a NP on the Register of Nurses, whereas in NSW they are authorised as an NP on the Register of Nurses.
- The recognition of mothercraft or maternal and child health qualifications.
- The recognition of an EN with preparation in the administration of medications (or not) eg. The ACT enrolls the nurse in the specialty area as an EN (medications). In NSW, NT, SA and currently in WA, these nurses are not specifically recognised, nor are any limitations or conditions placed upon their practice if they do not have expertise in this area. Queensland and Victoria endorse ENs for medication administration; and Tasmania authorises ENs to practice in the restricted practice area as an authorised EN.
- The recognition of other areas of nursing practice from past regulatory schemes and from nurses and midwives who gained their qualifications overseas.
- The recognition of qualifications additional to qualifications gained on entry to nursing or midwifery.
- The different means and scope of registration, enrolment or authorisation – full, limited, provisional, temporary, interim, short term, conditional, specific, honorary, body corporate, non-practicing or student.
- How documentary evidence of registration or enrolment is provided to the nurse or midwife.
- Whether a nurse and midwife can be registered and enrolled in the same jurisdiction.
- The obligation to make information available to the public, the information that is made available to the public and potential employers, and what information is shared between RAs in the different jurisdictions.

The Obligation to make the registers and rolls available to the public is outlined in **Appendix J** – in an extract from Map 2 – section 2.7. Despite the obligation in each jurisdiction to make certain information available to the public, there are significant differences in how this occurs. The public in Queensland, SA, Tasmania, Victoria, WA, and since Map 2 was completed, NSW, have the capacity for access to the registers and rolls via the internet. The NT has web -ased access, but the site is not 'live'. It is updated weekly. ACT is the only jurisdiction with no internet access to its registers and roll. While the information available to the public is limited, its availability to the public and employers via the internet is a significant improvement to the bureaucratic requirements of past processes for a search to be conducted. The benefits for protection of the community are undeniable. Employers wishing to establish the registration or enrolment status of any nurse or midwife in their employ or seeking employment has a timely, free and accessible means of doing this.

The sharing of information between RAs is one flagged earlier in this Report as being one of some contention across the jurisdictions. **Appendix K** – an extract from Map 2 – section 2.10, outlines any further information to that available to the public that the RAs will share with other RAs and the issues associated with that sharing. There is considerable variation in the capacity and willingness to share information across RAs. For example, NSW is seen by many of the other RAs as being unduly cautious in providing information on its registrants and enrollees. The Nurses and Midwives Board (NMB) in NSW:

...is authorised to inform any body, which under the law of another State or Territory, is responsible for the registration, enrolment or authorisation to practice of nurses or midwives of a determination of the Tribunal – s 70 Nurses and Midwives Act 1992.

However, the NSW NMB has no express provisions and therefore argues that it cannot provide information in relation to current investigations of serious matters or any determinations from Professional Standards Committees or Impairment Panels. This may mean that the NMB cannot provide any information to the RA in another jurisdiction about a nurse or midwife registered in NSW who applies for registration or enrolment in that jurisdiction while under investigation by the Health Care Complaints Commission for a serious matter, such as the alleged assault of a resident of an aged-care facility, until the Tribunal has made a determination on the matter.

The NSW NMB reported that it does not provide information to other jurisdictions, other than where legislative power exists or the information is part of the public registers or roll. Even information in the registers and roll are not necessarily made public (eg. details of any conditions).

Section 33(1) of the *Mutual Recognition Act* (Commonwealth) has been interpreted by the NSW NMB as providing for information about disciplinary conditions to be advised to other jurisdictions participating in mutual recognition (MR) arrangements even though a person's initial application for registration was not made MR.

The NSW NMB also report that there are a number of instances in which it would be desirable to share additional information about registrants or applicants for registration or enrolment, if permitted by legislation, including privacy legislation and the *Health Records and Information Privacy Act 2002* (NSW). For example, the RA has recently sought legal advice regarding the ability to share information about a registered nurse who has a serious mental health problem and who is also registered with another health professional RAs in NSW.

On the other hand, the Nursing and Midwifery Board of the Northern Territory and the Nursing Board of Tasmania have broad powers to share information with other health practitioner RAs and with other persons and bodies (whether within Australia or elsewhere) - s 11(2)(a) *Health Practitioners Act 2004* (NT) and s 8(1)(a) *Nursing Act 1995* (Tas).

At interview, one person observed that Queensland is also not recognised for its liberal approach to the provision of information to RAs, although its legislation is silent on the issue - a claim that the RA disputes.

The Nurses Board of Western Australia:

...may notify any finding, reason or decision of the board or the professional standards committee to any board or authority outside the State charged with regulating the registration and supervision of nursing or any officer, employee or agent thereof. No action, claim or demand lies against a person in respect of the communication or publication in good faith – s 79 Nurses Act 1992.

In Victoria and SA, it is an explicit function of the boards to exchange information with the nursing and midwifery registration authorities – s 66(i) *Nurses Act 1993* and s 161 *Health Professionals Registration Act 2005* (Vic); and s 16(1)(j) *Nurses Act 1999* (SA).

The legislation in the ACT is silent on this issue, but the ACT Nursing and Midwifery Board takes the view that information which goes to the community's health and safety about the conduct, competence or health of a nurse or midwife registered in the ACT should be shared with another RA if requested, although there is no written policy in relation to this matter.

The capacity to share information about nurses and midwives seeking to register or enrol in another jurisdiction, has been an important means of identifying nurses and midwives who have come to the attention of their 'home' RA for sometimes serious breaches of professional conduct or health problems, that bring into question their competence or suitability to practice. It does occur that in an attempt to escape the action or censure in relation to that matter, these nurses and midwives do seek registration or enrolment elsewhere, hence placing the community in that other jurisdiction at risk.

An alternative means of the board obtaining information is by requiring the applicant or registrant/enrollee to provide it. Most of the principal Acts have penalty or offence provisions if a person fails to provide information or provides false information to the RA. Some RAs, such as NSW and SA, are required to prescribe the information required, while others have a much-broader provision that enables the board to obtain other information or material, such as in Victoria and Queensland where the discretion to require information is relatively wide, with penalties prevailing if it is not provided without reasonable excuse.

Other powers to require information are also evident in some of the legislation. For example, in SA and the NT, there are obligations on treating health professionals to provide the RA with the information if they reach the conclusion that a person does not have the physical or mental capacity due to illness, injury or other causes to practice nursing, and the obligations on employers to report misconduct or incompetence to the RAs.

In NSW, the courts have an obligation to provide the NMB with information when they record a conviction in relation to a registered or enrolled nurse or midwife.

These provisions reduce the risk that an RA will not have all the relevant information that it requires for the determination of an application for registration or enrolment or the ongoing competence and suitability of a nurse or midwife to continue practicing. This in turn reduces the risk to the public of nurses and midwives continuing to practice freely, when clearly this may not be appropriate due to competence, health or conduct reasons.

All of these differences in the statutory requirements make comparability and mobility across State and Territory borders extraordinarily challenging. Real structural impediments exist in some of the legislation, especially around the construction of the registers and rolls and the availability of information to the public, employers and other RAs. Underneath these statutory requirements are a plethora of administrative policies and procedures that further diversify each jurisdiction's handling of their regulatory responsibilities.

While there may not be a need to have absolute conformity in all areas of regulation and administrative processes across RAs, there are significant drawbacks to the lack of transparency and inconsistency in approach. It serves to complicate and confuse. For nurses and midwives moving across jurisdictions the burden of having to provide different information and evidence to the different RAs can be significant. For employers, educators and the public, the purpose of these differences is not clear and provides substantial scope for misinterpretation, if not obfuscation. Some level of research and agreement reached now in these areas of the lexicon and classifications for nurses and midwives and how they are recorded on the registering system, especially as there is a clear movement towards adoption of national competency standards for RNs, ENs, midwives and NPs, would assist the community, nurses and midwives, employers and others to understand the licensing processes across jurisdictions. It is tricky enough to navigate the regulatory frameworks in each jurisdiction, even for those who are reasonably familiar with them. Serious thought should be given to the development of:

- a uniform national lexicon for the naming of each classification of nurses and midwives;
- national principles for the way that entry and subsequently-obtained qualifications are recorded on the registering systems, for which groups of nurses and midwives, and which qualifications should be recorded;
- a consistent set of principles for dealing with registration that is limited in any way, eg. by time, classification or practice;

- consistent principles and practice around the provision of information to the public, employers, other RAs and others that balance the need to protect the public and the need to protect the privacy of individual nurses' and midwives' personal information;
- transparency in the criteria and processes used for determining equivalence with a commitment to movement to developing common criteria.

4. Safeguarding the community - competence, conduct, health and suitability to practice

This section of the Report looks at the checkpoints where an RA has the capacity to assess the suitability of a person to practice as a nurse or midwife. The RA's responsibilities for assessing a nurse or midwife's competence to practice, professional conduct, health and capacity to practice are increasingly being recognised. While the evidence for how the RAs can effectively assess this is scant, much effort and energy is clearly being invested by the RAs in order to improve the robustness of their processes. Self declarations of competence in the area of current practice, good health, ethical practice, good character, recency of practice and, increasingly, ongoing professional development, are being coupled with random and semi-random audits by the RAs to test the veracity of these self declarations. As yet there is little evidence to support the current measures of suitability and competence to practice. However, those selected do have strong face validity and increasing support. Research is required to test their validity and reliability for the purpose.

Four primary areas have been selected because of their importance as review hubs:

- Entry to practice as a nurse or midwife – Map 3.
- Application for restoration to the register or roll – when not currently registered or enrolled in any other jurisdiction, where the person's removal was for non-payment of fees or by request – Map 5.
- Renewal of registration or enrolment – Map 7.
- Safe practice in specialised and specific areas of nursing and midwifery – Map 8.

Each of the maps reviews the legislated requirements, as well as the standards, criteria and processes of application and requirements for the presentation of evidence or declarations for nurses and midwives to establish their competence, good conduct, health and general suitability or fitness to practice.

4.1 Entry to practice as a nurse or midwife

Entry to practice is the first point of intervention that the RA has with any nurse or midwife currently. With the commencement of the *Health Professionals Registration Act 2005* in Victoria, students of nursing and midwifery will also be registered and a review process to establish their suitability to undertake clinical education where they will have direct contact with health consumers is currently being developed.

Appendix C outlines the key elements that were used to review the legislation and other regulatory instruments and guidelines which make up the legislative and policy requirements as well as the application process requirements for nurses and midwives entering the practice of nursing and/or midwifery, either for the first time, or if they have had to undertake another entry course of study because their previous registration or enrolment was outside the recency of practice requirements for refresher or re-entry courses in the jurisdiction.

Reviewing Map 2, there is reasonable consistency in the legislative requirements (although not absolute), with key indicators for suitability being:

- Appropriate qualifications and educational preparation for the area of practice where registration or enrolment is sought (although there is no national accreditation system for the recognition of courses).
- Competence in that area of practice (usually provided through the successful completion of an approved entry to practice educational course and/or a declaration by an education provider (EP)).
- Mental and physical health and capacity.
- Being of good character, including in most cases not having a significant criminal history (though how this is established is varied).
- An adequate command of the English language.

Requirements or other indicators, such as adequate communication skills, having no addictions to substances, such as alcohol or narcotics (which can be identified as under

the more generic rubric of mental and physical health and capacity), professional indemnity arrangements and the requirement that the educational qualification was completed in the last five years, are less consistent across the jurisdictions.

As already indicated, processes are not established to enable a person to obtain their entry to practice qualifications in one jurisdiction in Australia and seek initial registration or enrolment in another. The Northern Territory, Queensland, Victoria and Western Australia require a nurse or midwife to register or enrol in the jurisdiction where they obtained their qualifications, even if they have no intention to practice there, thus increasing the bureaucratic, time and cost burden to the applicant. NSW is not so definitive, requiring full details so that it can establish equivalence, yet suggesting at the same time that it is not customary to do so. The ACT is the only jurisdiction where it is clear that the board will recognise another RA's approval of a nursing or midwifery program, thus enabling a nurse or midwife to register in the ACT in the first instance, even if they had not obtained their qualification in the ACT. The issue of RA's accreditation or recognition of courses will be dealt with further in Section 8 of this Report.

The requirements for establishing educational preparation in an RA-accredited or recognised course is at its easiest at original entry in most jurisdictions as information is transferred directly from the EP of the course directly to the RA, so all that an applicant is required to establish is proof of their identity and to provide some basic details of where they undertook their course. In the ACT, a transcript showing that the applicant has successfully completed all components of the course is required.

The primary source of evidence of competence for entry to practice is through the meeting of all requirements to graduate from the accredited or recognised course. The NT requires a written reference from a lecturer at the university where the entry course was completed attesting to the applicant's competence to practice, or if an EN is applying for registration as an RN, then a certificate of good standing is required if the RA enrolling the nurse is not the Northern Territory Board (Health Professions Licensing Authority - Northern Territory Undated). The ACTNMB plans to undertake a random audit of applications received. The ACT also requires on its generic application form an original or certified copy of professional reference that is less than five years old, from a nurse or midwife manager or immediate supervisor with:

- Dates of employment;
- Areas of experience;
- A statement of professional competence as a nurse and/or a midwife; and
- Name, signature and position of a professional referee (ACT Nurses and Midwives Board 2006).

This seems an unusual requirement for a beginning practitioner in nursing or midwifery, as they would not necessarily be able to meet the requirements for the reference. However, it may merely reflect the limitations of the generic application form.

The EP's obligation to give assurances around an applicant's competence as a beginning practitioner is sometimes a source of tension between employers and the EPs, with the RAs seemingly caught in the cross fire in their role of accrediting or recognising courses. This is sometimes related to differences in expectations. However, it is suggested that some EPs are not attuned to the needs of the health system and are not adequately preparing their students, although they do meet the RA's requirements. The ANMC has recently undertaken a consultation in relation to the national competency standards that resulted in those for RNs and ENs being amended only minimally. As these are pivotal mechanisms used to assess the competence and suitability of a student being ready to practice as a beginning practitioner, perhaps the consultation did not involve the employers and other stakeholders adequately to ensure a commonality of what is expected of the newly registered or enrolled practitioner.

As gatekeepers to entry into and maintenance in the professions of nursing and midwifery, the RAs have significant obligations to protect the health and safety of the community. Therefore, the emphasis that RAs place in this area needs to be carefully considered and founded upon good evidence. It is a fine balance between inadequate safeguards and requirements that are too onerous.

NSW and the NT are the only RAs to require character references. Otherwise the establishment of good character and lack of criminal record are made as self declarations in a statutory declaration under the relevant jurisdiction's oath instrument.

ACT, NSW, the NT, Queensland and Tasmania seek consent to approach relevant persons, institutions and organisations to obtain information about an applicant. This ranges from obtaining information from other RAs as in the ACT (ACT Nurses and Midwives Board 2006) to a very broad power in Queensland for the Council to:

- Exchange information with authorities in any country, State or Territory on practice as a nurse or midwife, or any other matters that are relevant to the application.
- Seek a national criminal history check through the Queensland Police Service, and for the Queensland Police Service and the Australian Police Service to disclose any criminal history information, including charges laid against the applicant awaiting determination (Queensland Nursing Council 2004).

Ensuring that a beginning practitioner is adequately prepared and safe to practice (as a beginning practitioner) is vital. There is variation in the requirements for entry to practice across the jurisdictions and real opportunities exist to negotiate around universal requirements that could provide benefits for applicants, employers and RAs, and more certainty for the community around the safeguards that reduce known risks in the provision of health care by nurses and midwives.

4.2 Returning to practice as a nurse and/or a midwife

Map 5 indicates that the variations in the way that each jurisdiction deals with nurses and midwives seeking to return to practice after a period out of the professions is quite profound. **Appendix D** outlines the key elements that were used as criteria to review the legislation, policies and practices of RAs in this area. Most jurisdictions will enable a nurse or midwife who can establish their competence through recency of practice or other means of establishing their suitability to practice to be re-registered or re-enrolled or restored to the register or roll when their name has been removed at their request or for non-payment of the renewal fee. The NT has a short period of grace at renewal time, after which the person seeking to return to the register or roll has to make a complete application for registration or enrolment.

Each RA has the power to exercise discretion in assessing the applicant's competence through recency of practice or other means of establishing their suitability to practice. Some are obliged to restore a person to the register or roll if it is within the recency of practice time period (eg. in Queensland - <5 years, in Victoria <2 years with the commencement of the new Act). For others, such as SA and Tasmania, there is the clear power to establish the person's competence and suitability to practice prior to restoring their name to the register or roll.

Recency of practice is the primary indicator for competency that is routinely used in applications for re-entry to practice. While it has beguiling face validity, it is difficult to source the evidence for such dependence on this temporal requirement. NSW is the only jurisdiction that does not have broad-reaching recency of practice requirements, although they attest to reviewing the person's last date of practice as giving them an indication as to whether they will require a competency assessment as part of the requirements for restoration. Map 5 – 5.6 outlines the different approaches that each RA takes to applicants if they have not practiced or maintained their competence to practice over a specified period. For example, the ACT and Tasmania take a hard line and require the applicant to undertake further education (some differentiating between the need for refresher courses and re-entry to practice courses). Others, such as Queensland and SA, require formal competency assessment, while others, such as the NT and NSW, require the RA to be satisfied that the applicant is competent to practice using a variety of other means, not always obvious. Some RAs, such as the ACT, NT, SA, Tasmania and WA, place conditions on practice around supervision, education and locations and times of practice until the applicant is able to satisfy the RA that they are competent and fit to practice with full registration or enrolment.

The Queensland Council is the only jurisdiction that requires a self declaration as to adequate ongoing professional development, although the ACT Board has power under the

Health Professionals Act 2004 to require at least 30 hours in a three-year period – Schedules 3 and 4, paras 3.8 and 4.6.

The Taskforce review of the legislative requirements and funding support for re-entry programs for nurses and midwives (National Nursing and Nursing Education Taskforce 2005d) found considerable inconsistency in the leadership and guidance provided by the RAs in relation to those nurses and midwives wishing to re-enter the health workforce after a period away. The differences in requirements and whether there is a robust assessment process to establish the level of supervised practice, refresher course or re-entry course that an individual would require in order to practice safely varied widely. Some RAs, such as the NT, exercise broad discretions and the assessments look at the specific needs of the individuals and attempt to tailor an appropriate approach or program that will meet the person's requirements to ensure they are able to practice competently and safely. Others, such as the ACT, appear to have a much less sensitive approach and have a standard time-related requirement which means that if a person hasn't practiced for between five and ten years, they are obliged to undertake a refresher course. If the time since they practiced is more than ten years, then the ACT Nursing and Midwifery Board (ACTNMB) requirement is that the person must undertake a re-entry program. This approach fails to make any differentiation for what the person has done in the meantime and what relevant professional development they may have undertaken. There is an issue of fairness, as well as ensuring that those nurses and midwives who want to return to practice are expedited to do so in times of workforce shortages.

There is certainly room for some negotiation around principles for nurses and consistency in the area of re-entry to practice. As indicated above, the Taskforce has been examining the issue of re-entry to the professions through another project and has found:

A number of State and Territory reports which have examined the reasons why nurses/midwives have left the profession and quote the high cost of maintaining professional competency and skills and undertaking formal specialist postgraduate education as key factors. These factors have formed the basis for governments providing scholarship funding to nurses/midwives wishing to specialise in clinical areas with recognised shortages and to encourage nurses/midwives to return to the workforce. However, the approach to scholarship funding is fragmented, inequitable and variable. It was also noted that the financial burden placed upon nurses/midwives wishing to regain registration was a deterrent to returning to the workforce.

In an attempt to address funding support and quality issues identified as part of the Review deliberations in relation to specialist nursing/midwifery practice and re-entry programs, a more cooperative and coordinated approach was recommended (National Nursing and Nursing Education Taskforce 2006e).

The idiosyncratic and sometimes hard-line approach evident in the RA's treatment of people previously registered or enrolled as nurses and midwives in Map 5 highlights the impediments that exist for nurses and midwives wishing to re-enter the workforce, while not always clearly justifying the RAs position of community protection. There is obviously room for a clear articulation of transparent and uniform principles governing RA policy in this area. The CNOs are leading some work in this area to develop some high-level principles to guide the jurisdictions, which should be the start of a more-consistent and rational approach in this area.

4.3 Renewing the right to practice as a nurse and/or midwife

Map 7 outlines the requirements of each jurisdiction for the renewal of a nurse's and midwife's rights to practice. **Appendix F** lists the key elements that were used to review the legislation, policy and practice in each jurisdiction.

Increasingly, the renewal process is being recognised as an important checkpoint for establishing a nurse or midwife's ongoing competence and suitability to practice. Once merely treated as a revenue collection process and an opportunity to collect data from people who had changed names and addresses, the renewal of practicing certificates, annual licence certificates and the reissue of certificates of registration or enrolment is an important and regular opportunity to test the ongoing competence, professional conduct, health and capacity to practice nursing and midwifery.

On receipt of the data on a person's annual return, the boards in NSW and WA are the only RAs that do not have any express power to take action if a nurse or midwife is unable to satisfy the boards of their ongoing competence and/or suitability to practice. Both boards report that they do not have an 'own motion power' and hence are unable to take action at this point unless they receive a report or complaint about the person's competence, conduct or health from another party. This is contrasted, for example, to the NT's explicit power:

...on its own motion, may at any time review the registration or enrolment of a health practitioner and may

- a) vary the conditions to which the registration or enrolment is subject; or*
- b) impose conditions to which the registration or enrolment is subject – s 30(3).*

Each jurisdiction except Western Australia has an annual renewal process (WA offers an alternative of annual or triennial renewal). This means that there is a different standard in WA for establishing competence, where the nurse or midwife elects to renew their registration every three years. Instead of the annual review checkpoint or renewal, in WA this may be annual or three yearly. NSW is also out of step here as there is no review of competence at renewal. However, WA is one of the only jurisdictions that have created a toolkit to enable individual nurses and midwives to self assess and demonstrate their ongoing competence (Nurses Board of Western Australia 2004). This is seen as a fundamental responsibility of the professional nurse and midwife and is explicit in the *Code of Professional Conduct for Nurses in Australia* (Australian Nursing and Midwifery Council 2003).

All but NSW have a set date on the calendar for the renewal process to be completed. NSW uses the anniversary of a person's original registration or enrolment as the renewal point.

The primary mechanism for testing competence to practice at renewal is recency of practice. However there is a growing propensity to require information around a person's ongoing professional development. ACT has the power to require thirty hours of ongoing professional development in a three-year period, and Queensland and Victoria require self declarations that the person continues to improve their knowledge, skill and judgement or has been undertaking professional development activities in the past twelve months. While this latter self declaration is not a specific requirement under legislation, like many of the questions asked in the RAs' annual returns and application forms, they have selected particular indicators that they believe will test the health, competency and suitability to practice of nurses and midwives. As indicated, there is still much work to be done in relation to establishing the evidence to support these criteria that appear to have strong face validity.

The NT requires a self declaration that the nurse and/or midwife practices in accordance with the ANMC Competency Standards and they note that the domain of critical thinking and analysis requires the nurse or midwife to participate in ongoing professional development of self and others.

Five of the eight jurisdictions (all but NSW, Victoria and SA) have, or are introducing, systems for random and semi-random audits of the annual returns at renewal point as a means of testing the validity of evidence provided to support the applicant's claim that they are competent and meet the RAs requirements for being suitable to practice nursing and/or midwifery on an on-going basis – see Map 7 – 7.16. For Tasmanian nurses and midwives, this means being audited every five years. A person selected for audit is required to provide adequate evidence of their ongoing competence and suitability to practice. The evidence required varies across jurisdictions, but ranges from statements from employers and supervisors, to portfolios of evidence of ongoing professional development and practice in the areas where registration or authorisation is sought. Several jurisdictions have developed guidance tools for nurses and midwives to put together the requisite evidence to satisfy the RA as to their ongoing competence, health and suitability to practice, such as WA and the ACT.

It is interesting to note that the declarations made on the annual return are not in the form of a statutory declaration in any of the jurisdictions. Statutory declarations are required for most other applications for registration and enrolment. A person's character

and credibility would certainly be brought into question, should they furnish the RA with incorrect information. As discussed, many of the jurisdictions have offence or penalty provisions if a person furnishes the RA with false or misleading information, that give the RA power to take action should it come to their attention that a person had not been completely honest on their annual return or application forms, which make a statutory declaration non-essential.

As well as being gatekeeper to the considerably-lesser numbers of applicants for registration and enrolment as new graduates and people seeking to re-enter the professions and move from one jurisdiction to another, renewal of registration or enrolment entitlements is the point where an RA has the most systematic opportunity to conduct a formal risk assessment of the majority of the nursing and midwifery workforce in that jurisdiction. There is no doubt that this is a costly exercise to do properly. Robust review of each self declaration, random or semi-random audit and follow-up are labour-intensive and time-consuming exercises. While there is yet to be conclusive evidence to support the best indicators of competence and suitability to practice, there is a need to take what steps are necessary to protect the community and ensure the benefits outweigh the burdens. The data collected at renewal and the audit processes are ideal opportunities for research to be conducted that may contribute to building that evidence base.

Map 7 demonstrates once again that there is a wide range of subtle and overt differences in the renewal processes in each jurisdiction that would benefit from agreement around a common set of principles and requirements. Clearly there is a balance that has to be struck in relation to obtaining the best information for the RA to make a determination as to the competence, health and suitability of a person to continue to practice nursing or midwifery in that jurisdiction, while at the same time ensuring that the information they require is appropriate, fair and not unnecessarily burdensome for the person to provide. Renewal is an important checkpoint for effective risk management strategies to be put in place to protect the public from nurses and midwives whose competence and suitability to practice may not meet required standards.

Research is warranted into the existing flags used as indicators for competence and suitability to practice, in order to establish a suite of evidence-based indicators. This may improve an RA's opportunity to identify those nurses and midwives practicing, or with the right to practice, who may pose a risk to health consumers due to deficits in their competence, health or other determinants on suitability to practice.

4.4 Working in a specific or specialised area of practice as a nurse or midwife

Map 8 clearly demonstrates the complex array of snakes and ladders that awaits the nurse or midwife who is working in a specific or specialised area of practice, especially if they wish to cross a border within Australia. **Appendix G** lists the key elements used as criteria to examine these issues. The discussion above in part 3.6 of this Report about the register and rolls also highlights this. Each jurisdiction deals with any registration of a nurse and/or midwife, other than a generalist RN, in differing ways. The differences relate to variations in the education preparation required, the way that the registers or rolls are constructed and whether or not the area of practice is treated as a limitation of practice or an 'add-on' authorisation or endorsement.

The challenges that exist for NPs and ENs (for the latter, highlighted in relation to the administration of medications) particularly emphasise the extreme tensions that have arisen in attempting to balance flexibility and mobility of practice and the safeguards that have been adopted in the attempt to protect the community from harm. However, there appear to be other interests evident in these two areas that muddy the waters somewhat. These are the intra-professional and cross-sector professional interests who have brokered, often at high-level government, other layers of anti-competitive and burdensome requirements over and above the quality and safety and flexibility and mobility of practice that should be paramount. The Taskforce has several projects on foot in relation to these two particular areas and has recently issued a position statement on *Nurse Practitioners and Clinical Practice Guidelines* (National Nursing and Nursing Education Taskforce 2006d) in response to recognition from the evidence gathered from the NP mapping project of the unrealistic and intrusive requirements being imposed upon

nurses seeking registration or authorisation as NPs and subsequent employment in a NP position in a health service.

Carlton notes that:

...workforce reform is unnecessarily contested and slow. In Victoria for example, it has taken more than 10 years to develop and implement the role of nurse practitioner, and the same length of time to implement changes to the scope of practice of division 2 (state enrolled) nurses to allow them to administer medication to patients in Victorian aged-care facilities. Discipline-specific registration Boards dominated by a single professional voice, in concert with their respective professional associations, can operate to limit scopes of practice, block task transfer and fuel rather than resolve demarcation disputes (Carlton 2006)¹⁹.

This is well illustrated in the following case study.

Box 2 – Case Study - EN from one jurisdiction seeking recognition of medication capability and endorsement in another

The EN undertook an approved 30-hour medications course in their 'home' jurisdiction 15 years ago and has been working as an EN administering medications up to and including Schedule 4 poisons by oral, enteral, topical and parenteral administration routes. In their 'home' jurisdiction, medication administration is considered part of the ENs scope of practice and there is no additional recognition process/endorsement by the RA of this dimension of practice.

In the jurisdiction they moved to ENs are required to undertake additional approved post-registration training in medication administration and must apply for endorsement of their registration to be authorised to administer medications including Schedule 4, 8 and 9 poisons (although practice is restricted by the RA to oral, enteral and topical administration routes).

Despite a demonstrated record of competency and safe practice in the area of medication administration, the RA was initially proposing to refuse the application for endorsement and was going to advise the EN that they had to undertake a Board examination at a significant cost of to the EN. If the EN were to fail the examination, successful completion of an approved training program would have been required to qualify for endorsement in the future.

It is noted that in a recent decision *Renton and Medical Board of Queensland* [2005] AATA 600 (24 June 2005) by the Administrative Appeals Tribunal, the Tribunal found that a medical practitioner with a recent demonstrated record of safe practice in a specialist area of practice (intensive care) in a state where recognition of specialist status is not a function of the regulatory authority was entitled to this recognition on the register (as an intensivists) pursuant to the *Mutual Recognition Act 1992* (Cwth), and that registration may be subject to conditions²⁰.

While this is an individual matter, it is one that is likely to reoccur as more ENs with medication capability seek endorsement in States and Territories where endorsement over and above a basic qualification is required for the administration of medications.

The Taskforce's work on developing a national specialisation framework for nursing and midwifery and the definition and identification of specialty areas of practice in Australia is a critical piece of work that identifies the significant structural impediments that exist currently:

Categorising and naming specialties or areas of practice, within nursing and midwifery have been identified as a complex issue for many years. In Australia, the evolution of a plethora of 'specialties' has occurred in an ad hoc way with no coherent structure or classification system to guide the process.

This work is far from complete and the information below is not intended to suggest that any specific classification system for managing or regulating the developments around specialisation in nursing or midwifery. However, it is important to understand the complexities that confront the community, governments and the professions in attempting to regulate in a way that achieves balance between the quality and safety of nursing and midwifery care and the flexibility and mobility of the nursing and midwifery workforces.

¹⁹ At page 8.

²⁰ Available at: <http://www.austlii.edu.au/au/cases/cth/aat/2005/600.html>

For example, specialty areas of practice are described in many ways including:

- *Body systems, eg. cardiology, respiratory*
- *Diseases, eg. dementia, mental health*
- *Service or settings, eg. residential care, operating theatre*
- *Interventions/therapy, eg. chemotherapy, continence, palliative care*
- *Client/population, eg. women's health, aged care*
- *Combinations, eg. rural and remote mental health.*

Unlike medicine, there has been no agreement about what constitutes a specialty or an area of sub-specialisation within nursing and midwifery in Australia and a proliferation of educational courses and special areas of practice have developed in response to changing health needs, health policy decisions, consumer demand and advancing technologies.

This work alone identified over 100 areas of both nursing and midwifery 'special practice' currently in use in workforce documentation nationally. Without an agreed process to identify what a specialty is, the expansion in the number of areas declaring specialty status and the attendant issues will continue unchecked (National Nursing and Nursing Education Taskforce 2006c: p 2).

The consultation draft specialisation framework Paper demonstrates a mindfulness of the:
...highly-complex interplay of service setting, industrial, regulatory, professional and education factors in the specialisation debate, any framework is likely to resonate more with some sectors than others. In particular, the framework needs to reflect the relationship between the nursing and midwifery disciplines and to assist with workforce planning for both disciplines collectively, as well as individually. The focus of this specialisation framework is on the identification of the level at which it is practical and effective to focus workforce policy and planning (National Nursing and Nursing Education Taskforce 2006c: p 2).

The Paper goes on to say that the:
...national importance of workforce planning to meet the health needs of the Australian community throughout this decade are articulated in the National Health Workforce Strategic Framework. A specialisation framework for nursing and midwifery will assist in this work (National Nursing and Nursing Education Taskforce 2006c: p 2).

This is also true of the Productivity Commission's report on the health workforce which relies significantly on the National Health Workforce Strategic Framework (Australian Health Ministers' Conference 2004; Productivity Commission 2005d).

The development of a national policy framework and principles is the first step. The framework should provide the infrastructure for the rational development of transparent and consistent regulatory, educational and practice standards for nurses and midwives in specialty areas of practice in Australia. This should go a long way to addressing the anomalous and often anti-competitive mechanisms that have emerged in a number of the jurisdictions in order to accommodate the political pressures, the turf battles and over-zealous introduction of so-called safeguards when an area of nursing and midwifery practice has developed into a discrete and specialty area.

4.5 In summary - getting on, staying on and getting back on to the registers and rolls as a nurse and/or midwife in Australia

On reviewing the multiple application forms for each of the jurisdictions for the purposes of this Project, the differences in language, layout, descriptions of requirements and order of information are both varied and confusing. Issues of fairness and the burdensomeness of processes arise over and over again. This work and the work that was undertaken by the Taskforce in mapping of the models, legislation and authorisation processes for nurse practitioners (National Nursing and Nursing Education Taskforce 2005b) identify there are clear differences in the educational preparation required, the processes, evidentiary requirements for application, preparation of clinical practice guidelines etc confronting a nurse or midwife wishing to practice as a nurse practitioner (or midwife practitioner in NSW). Their scope of practice has to be defined and both the process and areas of practice

can differ from jurisdiction to jurisdiction. In a nation with at-risk populations who lack access to any health service at all, the over-zealous construction of so-called 'safeguards' can have the effect of further denying these communities of the opportunities that having nurse practitioners could provide. Once again, it is critical to separate what are reasonable safeguards from what are anti-competitive and burdensome requirements that effectively act as structural impediments to appropriately-skilled, knowledgeable and experienced nurses and midwives.

There would be significant benefits for nurses and midwives in Australia if each RA had uniform application and renewal requirements for each of the portals and checkpoints of entry or re-entry to practice, renewal of rights to practice, or advancement to a specialised area of practice. These should be founded upon sound, evidence-based principles that balance the need for a flexible mobile workforce and the need for high-quality, safe, competent nursing and midwifery care for the community. In some instances, the differences in requirements are subtle, whereas in other areas they are much more substantial.

The anomalies and inconsistencies and the impact that these have for nurses, midwives and employers that are evident from the maps strongly suggest the necessity for the development of:

- National evidence-based principles around the requirements for entry or re-entry to practice, or advancement to a specialised area of practice that balance the need for a flexible mobile workforce and the need for high-quality, safe, competent nursing and midwifery care for the community.
- Uniform application and renewal requirements for each of the portals and checkpoints of entry or re-entry to practice, renewal of rights to practice and recognition of advancement to a specialised area of practice.

5. Educational Preparation and Qualifications Leading to Registration, Enrolment or Authorisation

Map 9 deals with RA responsibilities in setting the standards for education for nurses and midwives. **Appendix H** lists the key elements that were used to examine this issue.

It is in this area that the territoriality of the RAs and the structural barriers to mobility, innovation and flexibility of the nursing and midwifery workforce are most evident.

As indicated above, it is only the ACT that specifically recognises nursing and midwifery courses that have been recognised by other nursing and midwifery RAs. While there has been some cross-border accreditation of courses, it is far from the norm and is regarded by the 'home jurisdiction' as poaching if another RA enters its jurisdiction to review a course and/or EP.

Standards for the accreditation of educational courses and programs should not prevent, limit or act as disincentives to innovations to nursing and midwifery practice, nor should they do the same to innovation in education.

The data in Map 9 make a strong case for a streamlined approach to recognition of qualifications leading to registration across the jurisdictions in Australia. Among many other aspects, the diversity in curriculum standards and requirements, the unevenness in the mix of clinical and theoretical requirements and the differing processes and expertise used for reviewing the courses and settings make recognition across jurisdictions in the current circumstances unlikely. Yet the status quo is counter-intuitive and clearly places significant structural impediments in the way of:

- Nurses and midwives having freedom of choice in their place of education without having to register in multiple jurisdictions, because there is very little approval or recognition of cross-border education courses.
- Employers and RAs having certainty about the educational standards for the preparation of nurses and midwives in the areas in which they practice, because of the multiplicity of approaches by each jurisdiction.
- EPs having certainty about the educational standards required of the nursing and midwifery professions, also because of the diversity of approaches.
- EPs making rational, needs-based and economic decisions to facilitate delivery of and access to educational programs.

In Map 9, sections 9.3 – Educational advisory committees or panels established by the RA and functions; 9.4 – Membership of educational advisory committees or panels; 9.5 – conduct and ethical requirements of educational advisory committees; 9.10 – Principles underpinning RA review and approval for education courses and providers; and 9.11 – RA processes for review and approval of education courses, demonstrate the extent of variation in both the processes and the level and breadth of expertise used for this process. For example, WA and Queensland have minimalist statutory requirements, but detailed and available policy, on the accreditation of courses and clearly-outlined processes for setting up specific peer review panels with a range of coopted listed stakeholders and experts for each of the categories of courses it is required to approve, making recommendations to a specific board and Council Committee that provides advice to the board and council (Nurses Board of Western Australia 2004). This is in contrast to the processes in NSW where there are two statutory committees of the Nurses and Midwives Board; the Nurses Practice Committee and the Midwives Practice Committee and the NP and Midwife Practitioner (MP) Accreditation Committees established under policy to provide the board with advice on applications for approval of courses. The information available for the approval processes and use of experts and stakeholders in the ACT, the NT, SA and Tasmania is minimal, though each reports that they do co-opt expertise as needed. Victoria differs again. Having recently dissolved their Accreditation Advisory Committee, it has now built up a bank of more than fifty experts and relevant reviewers, and constitutes a review panel from that bank with a Board staff member as the case manager for the application, at the time that a submission for the accreditation of a course is received.

Because there is no centralised or national approach to the accreditation of educational courses, the variation in processes creates barriers to EPs seeking to obtain accreditation or approval for courses in more than one jurisdiction. Hence, it is not surprising that very

few EPs have sought to do so, although clearly many would regard their market for most courses as wider than their 'home' jurisdiction. It also makes it difficult for people wishing to undertake pre-entry nursing and midwifery courses in a jurisdiction other than the one in which they wish to work on completion of the course. Currently, except in the ACT or where individual courses have been accredited by the RAs in another jurisdiction, a nurse or midwife wishing to register or enrol on completion of their pre-entry course must enrol in the jurisdiction where that course was conducted and once registered seek registration in the jurisdiction of their choice under the mutual recognition scheme. This is an unnaturally-cumbersome process with extra fees and additional bureaucratic red tape to be navigated, which increases the disincentives for nurses and midwives to move freely around Australia. The following examples show that despite these disincentives there is an increasing global market for sound educational programs and these will benefit greatly from having a more-rational, consistent and transparent approach to the approval or education courses for nurses and midwives across Australia.

Box 3 – Educational providers moving across jurisdictional boundaries

Commencing in 2006, the University of Tasmania (UTAS) School of Nursing and Midwifery offers a Bachelor of Nursing program in partnership with St Vincents and Mater Health, Sydney. The Nurses Board of Tasmania (NBT) has accredited the program; graduates will be entitled to apply for registration with the NBT and can apply for registration in other States, including NSW, through mutual recognition, although additional registration costs apply.

The UTAS delivers the entire course at their Sydney campus located at St Vincents and Mater Health Service. The campus has its own qualified teaching staff but academics based in Tasmania also teach in the program. Students do most of their clinical practicum in NSW; however there are also opportunities to undertake clinical practicum in Tasmania and Sweden.

Similarly, Charles Darwin University runs a Bachelor of Nursing program via external or internal modes of study. The university currently has campuses in Darwin and Alice Springs and satellite centres in Geraldton and Fremantle in Western Australia, and the Royal Melbourne Hospital in Victoria. External students are required to attend a one week intensive clinical teaching block held at the university (or associated satellite centres) in the first and second years of study, and must also attend the one-week clinical teaching block and one-week intensive workshop at the university (or associated satellite centres) prior to placements. Satellite centres are utilised for second and third-year teaching blocks only, while the Darwin and Alice Springs campuses run the first-year teaching blocks. This program is accredited by Northern Territory Nursing and Midwifery Board, and graduates are eligible to apply for registration in NT and in other jurisdictions through mutual recognition.

The lack of current transparency about the processes and the use of appropriate expertise to undertake this technically-complex and specialised process in some of the jurisdictions is another concern. This undoubtedly fuelled the criticism that was levelled at a number of the RAs during the course of the interviews for this Project about the lack of openness and inappropriate exercise of their powers without due processes to support their decision making. It is also notable that the EPs already have burdensome quality and governance requirements imposed by the education sector that are often duplicated by the RAs. The following example highlights EP's frustrations with the current system.

Box 4 – An education provider's perspective on the course accreditation requirements in one jurisdiction

One university remarked on a number of anomalies in the course accreditation process and the excessive and prescriptive documentation requirements of the RA:

The requirements of the RA in terms of documentation required for accreditation standards are excessive. It would appear that the standards for accreditation have been developed to apply to all education and training providers, including universities, TAFEs and other registered training organisations. Yet there are processes in place in TAFEs and universities, which govern standards of course delivery including such aspects as information transparency, student grievances processes, resources including computers and library services, etc. that must be available for students, and are outside the remit of RA. Despite this, universities are required to provide detailed information about these matters.

It is not clear on what evidence the course accreditation standards are based. For example, comments by RA officers regarding teaching and learning strategies indicate a lack of contemporary knowledge about student

learning and the use of a range of teaching and learning strategies including computer-mediated learning strategies. RA officers have voiced the view that unless students are actually sitting in lecture theatres/tutorial rooms, etc. they are not learning, and there is a requirement to demonstrate that students are indeed attending scheduled lectures. This is out of step with contemporary program objectives that focus on student outcomes and recognise that students learn in a variety of ways. Similarly, for accreditation the university is required to specify hours of simulated practice as distinct from actual clinical hours. Whilst on one hand clinical tools must specify competency standards for students, there is a requirement that students must complete all clinical hours specified in the curriculum document.

For accreditation, the university must submit course timetables/planners and assessment schedules and clinical learning programs, yet timetables change from one year to another. There is also a requirement to document in detail units offered each year of the program with specific content theory/clinical, eg. aged care in the third year of the undergraduate course. This limits program flexibility in planning the clinical practicum component of the program.

If there was a centralised or national approach to the accreditation of educational courses, a course accredited in one State or Territory would be recognised in all others. This will require the development of a set of national principles for a common approach to recognition of educational courses, curricula and settings in nursing and midwifery, and it will need an effective system to support this, ie. a central registry of accredited and recognised courses. This would significantly reduce the impediments to the mobility of nurses and midwives in Australia wishing to work in other jurisdictions. It would also yield significant cost savings and efficiencies having a 'one-stop shop' or national acceptance of common standards and requirements for educational courses.

The work being done as part of the project for the development of a national framework for the accreditation of nursing and midwifery courses leading to initial registration and enrolment within Australia under the auspices of the ANMC is an important initiative to reduce both the variation in the principles, processes (including the use of appropriate experts) and standards for accreditation of these courses across Australia (Australian Nursing and Midwifery Council 2006). This is only the first step. The next step is for automatic recognition and a central register of accredited courses, with the final step being national accreditation of any nursing and midwifery course.

6. Mobility of the Nursing and Midwifery Workforces

6.1 Mutual recognition schemes – intent and application

The mutual recognition schemes under the *Mutual Recognition Act 1992* (Cwth) and the *Trans-Tasman Mutual Recognition Act 1997* (Cwth)²¹ were formulated in response to frustration about the extent of regulatory differences across Australia and the resultant adverse impacts on industry of operating in the multiple regulatory environments of the States and Territories. Prior to its inception, different regulatory standards for the registration of occupations across Australian jurisdictions were seen as inappropriately inhibiting the movement of skilled people (Productivity Commission 2003).

The Productivity Commission undertook a review of the mutual recognition schemes in 2003 and came up with the following conclusions in relation to the implementation of the policy for registered occupations:

An inadequate awareness of mutual recognition obligations is impeding the implementation of mutual recognition for both registered occupations and goods. For occupations, there is inadequate awareness among regulators and professional associations of some procedures and obligations of mutual recognition. For instance, there are cases where registrants are not granted their full rights under mutual recognition and this inhibits occupational mobility...

...While mutual recognition has, in general, reduced impediments to occupational mobility, several problems in the day-to-day operation of the schemes could be dealt with by:

- *enhancing the information exchange systems and procedures among registration boards (for example, in relation to incomplete disciplinary actions) by greater use of electronic database registration systems with capacity for access by counter-part registration boards;*
- *improving the capacity of registration systems to accommodate short-notice applications for registration to allow short-term service provision across jurisdictions;*
- *encouraging Australian occupational registration authorities to develop national registration systems where the benefits justify the costs; and*
- *encouraging jurisdictions to continue to work on reducing differences in registration requirements to address concerns that the entry of professionals through the 'easiest jurisdiction' might lower overall competencies.*

The Commission considers other concerns raised in relation to 'local knowledge' requirements, the length of time allowable for checking applications, capacity to delay teachers from teaching until it is established they are 'fit and proper', and discrepancies across jurisdictions over 'recency of practice' can be addressed within the existing arrangements (Productivity Commission 2003: p xviii).

6.2 Mutual recognition and the nursing and midwifery workforce in Australia

Under the mutual recognition scheme, an individual registered to practice an occupation in one jurisdiction is able to obtain registration to practice in a substantially-equivalent occupation in another participating jurisdiction. To do this, a nurse or a midwife should be able to simply forwards details of their registration in their 'home' jurisdiction to the RA in the second jurisdiction and sign a consent form enabling the authority to undertake reasonable inquiries relating to their application. Contingent on the outcomes of these inquires which should be finalised within a month, during which they are able to practice, registration is granted by the second jurisdiction's RA. This means that nurses and midwives should not need to demonstrate that they satisfy the requirements of the other jurisdictions regarding qualifications and experience in order to be registered in an

²¹ Registration is granted under the *Mutual Recognition Act 1992 (Commonwealth)* and *Trans Tasman Mutual Recognition Act 1997 (Commonwealth)*. The state legislation enables the Commonwealth legislation to have effect, but it is the Commonwealth legislation under which registration is granted.

equivalent occupation. However, there is a need to make a separate application and pay a fee. They also need to comply with the local laws applying in each jurisdiction in which they practice (Carlton 2006)²².

For most nurses and midwives, the process is relatively easy and deemed registration can be achieved in a matter of hours with the correct documentation being presented and fee paid. Others report a difficult and convoluted process. Map 6 suggests that some of the structural impediments identified by the Productivity Commission remain a challenge for some nurses and midwives wishing to use the provisions of mutual recognition to move across borders in Australia in 2006. **Appendix E** lists the key elements that were examined in Map 6. While it would appear from most of the published information from the RAs that the process is straight forward, there is anecdotal evidence that unless equivalence of occupation is comfortably established that nurses and midwives can find themselves in a limbo position for some time. This is not surprising given the lack of consistency across the jurisdictions around the variety of specialised and specific practice areas in nursing and midwifery.

It was the area of mutual recognition that elicited most comment in the interviews with RA board and council members, staff, RAs and nursing and midwifery leaders. Section 6.24 of Map 6 outlines some of the issues raised.

A number of CNOs and board officers interviewed raised concerns about the fact that NSW has no recency of practice requirements, which means that some applicants under mutual recognition from that State may remain registered or enrolled, but not have practiced for considerable periods of time. Concerns were also expressed that competency and suitability to practice could not be tested in an application under mutual recognition.

That said, most of the evidence and real case studies came from the structural barriers that confront individual nurses and midwives and employers attempting to have some flexibility to be able to move across borders to provide nursing and midwifery care, such as the case studies below.

Box 5 - Case study - Nurses and midwives working for employment agencies across jurisdictions

A company that owns nursing and midwifery employment agencies in a number of States and Territories reports the complexities and costs associated with ensuring that the nurses and midwives in their employ are registered and enrolled across the jurisdictional boundaries in which they are likely to work.

These agencies are critical to supporting the workforce needs of health and aged-care services and can be called upon at often very short notice to provide nurses and midwives with generalist and specific competencies to fill an urgent workforce need, as well as for planned periods on a temporary basis where permanent staff are taking leave. In specialised areas of practice or smaller jurisdictions where there may be only a limited number of adequately skilled nurses or midwives, the flexibility of being able to deploy staff across borders is important, especially where the staffing need is in a rural and remote area and there are few alternatives available for an employer to call upon.

The agencies concerned will reimburse the registration costs for nurses and midwives in jurisdictions other than their 'home' jurisdiction but report that the application process, the differences in the regulatory systems and the time to register or enrol in other jurisdictions limits their capacity to easily deploy staff across borders to meet workforce needs.

Box 6 – Case study – Nurse practitioner seeking authorisation under the Mutual Recognition Scheme

²² At page 2.

A nurse practitioner who is endorsed in one jurisdiction reported that they had been trying to get recognition in NSW since November 2005. At first they were told that they didn't recognise nurse practitioners under the mutual recognition scheme. They obtained external advice and were told to pursue the issue. However, they were now being asked to provide extensive documentation and had still not been advised of the outcome in March 2006. Even allowing for Christmas/New Year that is still four months. A number of people commented that this was a well-recognised 'problem' with respect to NSW and transparency in process was particularly affected.

There is a necessity for better transparency of mutual recognition processes and for agreed processes and guidelines to be developed at a national level around mutual recognition, especially in relation to NPs, midwives, mental health nurses and ENs around medications, as well as in other new areas of qualifications. A common approach to the level or waiving of fees for applicants using the mutual recognition scheme as the means of moving to employment in other jurisdictions or employment across jurisdictions in Australia is also required.

7. Towards more rational regulation of nursing and midwifery in Australia

The Productivity Commission identified a range of structural impediments to efficient, responsive and sustainable health workforce arrangements, including:

- fragmented roles and responsibilities, with health workforce policy 'compartmentalised' by profession, even in circumstances when an integrated 'cross-profession' approach is clearly called for;
- inadequate co-ordination mechanisms, inflexible and inconsistent regulation, with a lack of collaborative policy efforts to improve co-ordination across the various parts of the system;
- inflexible and inconsistent regulation that is subject to considerable influence from the professional groups concerned, and widely perceived as inhibiting changes to scopes of practice and the development of new competencies that could help to better meet changing health care needs;
- perverse funding and payment incentives that may result in patients seeking treatment from a doctor, when (unsubsidised) treatment from another health professional may be more appropriate, and limited incentives for medical practitioners to delegate less-complex service provision to other suitably-skilled, but more cost-effective health professionals; and
- entrenched workforce behaviours that are heavily influenced by 'custom and practice' (Productivity Commission 2005b: pp xxvii-xxviii; Carlton 2006: p 5).

The work of the Productivity Commission in relation to the health workforce and operation of mutual recognition (Productivity Commission 2003; 2005a; 2005b; 2005d), the work outlined in the National Health Workforce Strategic Framework (Australian Health Ministers Advisory Council 2005), the individual opinions of people interviewed in the course of this Project and the evidence provided as part of this mapping of the wide diversity of approaches to the regulation of nurses and midwives in Australia are all strong grounds for looking to a more-uniform and rational approach, as well as greater transparency around all aspects of the policy and processes. This is in the interests of the community and the quality and safety of nursing and midwifery care available to them, as well as in the interests of achieving a more-flexible and mobile nursing and midwifery workforce.

So how does this push for national uniformity and consistency in legislation and policy occur? The ANMC is a peak body established in 1992 to facilitate a national approach to nursing and midwifery regulation. The ANMC works with State and Territory nursing and midwifery RAs in evolving standards for statutory nursing and midwifery regulation. These standards are flexible, effective and responsive to the health care requirements of the Australian population.

The ANMC's core activities are to:

- Identify matters which impact on, or are relevant to, statutory nursing and midwifery regulation;
- Establish, review and promote a national standards framework for nursing and midwifery practice in Australia;
- Undertake assessments of internationally-qualified nurses and midwives consistent with the registration and/or enrolment requirements of the Australian nursing and midwifery RAs;
- Initiate and participate in relevant projects on regulation that aid the future growth and development of the nursing and midwifery professions;
- Ensure nursing and midwifery standards reflect the contemporary needs of the Australian community;
- Develop and be guided by a strategic view of statutory nursing and midwifery regulation in the national and international contexts; and
- Foster cooperation, consult with and provide advice to government bodies, professional and other organisations, and international nursing and midwifery RAs (Australian Nursing and Midwifery Council 2006).

To date, the success of the ANMC acting as the facilitator for these initiatives has at best been patchy. It has been argued that the current governance arrangements and its lack of

an effective statutory power base have rendered it a toothless tiger. Nevertheless, the successes that it has brokered must be recognised, given the limitations in the means with which it had to achieve these. Further discussion around the future role and structure of ANMC is canvassed in part 8.3 of this Report.

In relation to the broad intent of the suggestions made for reform in this Report, they all rely on improving the transparency of the policy and processes and brokering national agreement of a broad range of principles around the uniformity of regulation of nurses and midwives across Australia. For these purposes, there have already been significant research and moves towards the harmonisation of legislation and policy across this Federation that can be drawn upon and learnt from (Opeskin 1999; Carlton 2006). The Productivity Commission Report also provides a sound blueprint. However, even that requires some unpicking of the statutory and other structural impediments to achieving those goals.

7.1 Regulatory reform and the challenges in a Federation

In discussing the diversity of views that is likely to arise about reforms mooted by the Productivity Commission, Carlton succinctly outlines the policy issues that underpin the rationale for reform, observing that *the proposals for reform appear designed, in general terms, to overcome the barriers created by Commonwealth/State boundaries and/or the boundaries between the health professions* (Carlton 2006: pp 9 -10).

Table 7 – Policy questions identified by Carlton as requiring resolution in order to pave the way for rational reform

<p><i>In relation to Commonwealth/State boundaries:</i></p> <ul style="list-style-type: none"> <i>Is consistency in regulatory arrangements desirable across states and territories and if so, how much consistency and for what purpose?</i> <i>Are structural solutions necessary or is it possible to achieve the policy objectives through better cooperation, communication and information sharing between state-based regulatory authorities?</i> <i>Is structural reform, to establish one or a number of national authorities for registration and/or accreditation likely to contribute to an improvement in standards of care, or will it simply dilute the professional input that is critical to ensuring standards are well articulated, applied and maintained?</i> <i>What is the preferred model, if any, for reform?</i> <i>If a national regulatory and/or accreditation authority is to be established, then what is the legislative mechanism/s through which this is to be achieved and how are the best elements of the current system to be preserved?</i> <p><i>In relation to the boundaries between professions:</i></p> <ul style="list-style-type: none"> <i>What are the strengths and weaknesses of professionalisation, professionalism and the existence of strong and distinct professional identities, in terms of standards of care and the effective operation of the health care system?</i> <i>What are the opportunities and threats associated with more flexible work roles, achieved, for example, through multi-skilling, task transfer and trans-disciplinary approaches to service delivery?</i> <i>Will a 'flexible and responsive' health workforce necessarily result in better quality care for patients - what are the potential risks and benefits, and how is it to be achieved in ways that protect consumers and safeguard standards of care?</i> <i>What is the nature of the relationship between regulatory structures and functions and ensuring a 'flexible and responsive' health workforce? What should be the role, if any, of registration boards in facilitating or supporting workforce reform? (Carlton 2006: pp 9 - 10)</i>
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The debate and discourse in relation to these seminal policy issues is an important segue into any discussion on how reform such as this can be achieved.

7.2 Models of harmonisation and achieving uniformity

The Productivity Commission Report is silent on how the creation of a single health professional registration authority and accreditation authority could be created. There are some considerable impediments to achieving these goals, not the least of which is the

Constitution and Australia's system of Federation. That said, there has been some careful thought given to these issues over time.

Some of the more cogent work in this area has been distilled by Opeskin in his paper on models of harmonisation of law. Although the specific focus of this paper was on the harmonisation of public health law, it has strong resonance for the regulation of health professionals, and specifically for achieving a more-uniform and rational approach to the regulation of nurses and midwives in Australia. The table below is very skeletal summary of Opeskin's meta-analysis of the literature and law on harmonisation across jurisdictions.

Table 8 - Opeskin's models of harmonisation of law in a federal system
(Opeskin 1999)

MODELS OF HARMONISATION	BRIEF DESCRIPTION	EXAMPLES
UNILATERAL APPROACHES		
1. Unilateral Federal action	Use of centralised power	
i. Federal legislation	Australian <i>Constitution</i> specifically assigns certain powers to the federal legislature, particularly Section 51 eg the corporations power, the communications power, the external affairs power, the trade and commerce power.	Used in the <i>Dams</i> case to prevent the damming of the Franklin River
ii. Fiscal coercion	Although the states have a level of independence in other areas of government they are increasingly dependent upon the Federal Government for financial support. The introduction of GST has further curtailed that fiscal independence. Under Section 96 of the Constitution the Federal Government has the power to grant financial assistance to the States on terms and conditions it deems appropriate. Three types of grants have traditionally been made with the latter of the 3 relevant for the purposes of harmonisation: <ul style="list-style-type: none"> • Special assistance grants - one off grants for immediate relief • General revenue grants - Provided to States by the Federal Government as part of their general budget to compensate the States for the taxes that are collected centrally such as income tax and GST- usually these grants are untied and can be used for any purpose. • Specific purpose grants - Federal government gives financial assistance to states on condition that it is used for specific purposes eg health, or that the states implement specific policies. This category of grants has potential for driving reform in many areas of administration, not least of which is the regulation of health professionals. 	The Australian Health Care Agreements often have very specific areas of reforms required by the Federal Government for the States to receive their full revenue allocation - quality and safety initiatives have been a feature of recent Agreements.
2. Unilateral State action	Borrowing of legislative arrangements from other jurisdictions as models for developing new legislation or improving existing legislation. This is not an interactive process but where one jurisdiction ' <i>observes, interprets and copies</i> ' the legislative model or another. This tends to lead to ' <i>common behaviour without identical outcomes</i> '.	Many of the current health professional statutory regulatory frameworks reflect their borrowings from other jurisdictions.
MULTILATERAL APPROACHES - based upon inter-governmental cooperation		
3. Reciprocal schemes	A low level form of harmonisation that permits variations in the laws of participating jurisdictions while enabling one jurisdiction to recognise, on a reciprocal basis, a status conferred by another jurisdiction. The difference between this process and unification is: unification is about the definition of uniform standards; schemes like the mutual recognition scheme are about recognising possibly divergent standards.	The mutual recognition scheme.
4. Mirror legislation	Ministerial agreement on a detailed draft piece of legislation, which is then enacted by separate legislation in each jurisdiction. This produces virtual uniformity in the beginning, but this diminishes over time as local legislators respond to home based political pressures and issues, and introduce amendments that are not extrapolated in the same legislation in the other jurisdictions.	Hire purchase and company law schemes from the 1950s and 1960s.
5. Application of laws	Enactment of legislation in one jurisdiction (the host jurisdiction), and the application of that law in other participating jurisdictions. The host legislation contains all the substantive provisions that are to be enacted with the precise terms being agreed to by the relevant Ministerial Council prior to enactment by the host.	Australian and New Zealand food standards.

MODELS OF HARMONISATION	BRIEF DESCRIPTION	EXAMPLES
	Each participating jurisdiction then passes legislation giving the host legislation the force of law within that jurisdiction. Later amendments then require legislative change in only the host jurisdiction.	
6. Agreed policies: separately drafted laws	<p>Ministerial Councils agree to detailed policies rather than specific legislation. These policies must then be implemented by appropriate legislation in each State.</p> <p>This method is less prescriptive than other methods of cooperative harmonisation as each jurisdiction has some flexibility in deciding the precise manner in which the agreed policies are implemented. The more detailed the agreed policies, the greater the degree of harmonisation but the less autonomy of the States in drafting their own legislation.</p>	The introduction of 'uniform' gun laws introduced following the Port Arthur massacre.
7. Complementary schemes	Used when no jurisdiction can achieve a desired objective alone. Complementary legislation must be enacted cooperatively in several jurisdictions if the intended aim is to be achieved.	Therapeutic goods – where the Federal constitutional power does not extend to regulating unincorporated bodies engaged in purely interstate trade. State legislation was required to fill in the gaps.
8. Joint Federal-State bodies	The establishment of a permanent Federal-State body with the responsibility of joint administration in a specific area. Usually, the body is established by federal legislation and given specified powers by other participating governments.	Murray River Commission.
9. Reference of power to the Commonwealth	<p>Section 51 (xxxii) of the <i>Constitution</i> provides a mechanism by which State and Federal governments may cooperate to solve problems that arise because of the limitations of the federal legislative power. This can occur in 2 ways: a State can refer power to the Commonwealth for the Commonwealth to cover the field; or a State can later adopt a Commonwealth law that has been made after the reference of power from another State. A reference of power is limited to the subject matter and duration of the reference.</p> <p>A matter referred to the Commonwealth by a State:</p> <ul style="list-style-type: none"> • can be in either specific or general terms. If made on general terms, then the Commonwealth has discretion in relation to the legislation it passes in response to the reference • the legislative power over the referred matter is not exclusive to the Federal Parliament – the power can be exercised concurrently • may be made for a limited period • may be conditional eg on the occurrence of a particular event or dependent upon other States making a similar reference of power. 	Aged care services

A number of these models may have some application in achieving the changes required to achieve the reforms envisaged by the Productivity Commission, as well as in the more-limited area of nursing and midwifery regulation. By focusing on the latter, a number of the components of the Productivity Commission's reforms are achieved, ie. in the development and agreement around national uniformity in the standards for education, practice and regulation, as well as streamlined administrative processes (Carlton 2006).

7.3 Australian Nursing and Midwifery Council

There is a strong view across the professions of nursing and midwifery that the ANMC does not currently have the governance structures, resources and powers to be able to lead and achieve an important reform agenda. It is argued that it will require significant realignment of the relationships between the ANMC and the RAs and a balancing of tensions between the national agenda and state responsibilities for the organisation to be able to be the flagship. While it does have runs on the board as far as development of the Codes of Professional Conduct and Ethics and the National Competency Standards for Registered Nurses, Enrolled Nurses, Midwives and Nurse Practitioners, these have been hard won and each have taken an inordinate length of time in their development and then in achieving consensus from each of the jurisdictions.

The governance principles outlined in Part 4.4 of this Report in respect to RAs also need to underpin the structure and the conduct of the ANMC.

7.4 Establishing the means for reform

For an organisation or group to be the appropriate vehicle for driving the reform that is mooted in this Report, it must have power, influence and authority, and be recognised as the primary conduit for change by the nursing and midwifery professions. To achieve this, strong coalitions must be built with governments through the Chief Nursing Officers, the Australian Health Ministers' Advisory Council (AHMAC) and any subcommittee or working group for health practitioner regulation reform; as well as the Council of Deans of Nursing and Midwifery-ANZ, nursing and midwifery professional organisations and the RAs.

It remains to be seen what the appropriate vehicle might be for brokering the significant reform this Report has mooted in relation to the regulation of nurses and midwives in Australia. What *is* urgently needed is some national debate as a means of achieving agreement on this reform and a path forward. The leadership, drivers and supporting functions and powers must be in place. Some of the thrust for this initiative must come from within the nursing and midwifery professions. The rest will necessarily come from the government and bureaucratic sectors in each of the State and Territory jurisdictions as well as from the Australian Government and Australian Health Ministers Council and the Australian Health Ministers Advisory Committee (AHMAC).

7.5 Postscript 1 – collection of workforce data

Map 7 – section 7.7 shows that the collection of data about the nursing and midwifery national workforce data, conducted by RAs as the conduit for the Australian Institute for Health and Welfare is idiosyncratic. The role of RAs in the collection and reporting of registration data as a means to obtaining a realistic census of the nursing and midwifery workforce is controversial. However, it is reasonable to argue that this conduit is probably the most-effective means to understand the work choices of nurses and midwives and what sectors of the workforce they occupy. Competent workforce planning requires good data. Good data come from clarity around the following:

- The period of collection, eg. annually at x point;
- Having a core and common data set;
- Uniformity in the method of counting/calculating;
- Uniformity in the format for reporting;
- Strong incentives if not mandating the completion of the survey form.

It is difficult to identify any other means of accessing practicing (and some non-practicing) nurses and midwives. There are already systems in each jurisdiction for contacting each and every registrant and enrollee renewal time, although in WA this may be a triennial process and the anniversary for renewal varies across jurisdictions. Some tweaking of the process in agreement with Health Ministers and the health bureaucracies in each jurisdiction, and the Institute of Health and Welfare has the potential to deliver significantly-improved workforce data for workforce planning.

7.6 Postscript 2 – accessibility to information

It was notable during the course of the mapping that the scope, scale and sources of information available were not uniform across the jurisdictions, which impacted upon the level of analysis that could be undertaken. A significant finding of this Project, somewhat tangential to the original purpose, was the critical role that well-designed, well-organised, current and comprehensive electronic sources of information are becoming to all in the community. This holds true for access to current statutory instruments, current government and nursing and midwifery RA policy and information, as well as information about educational opportunities. RAs should not underestimate the importance that their websites play in providing important, contemporary information to their multiple audiences, ie. the local, national and international community, nurses and midwives, researchers, educators, other health professionals and government policy makers. Accountability, transparency and openness and integrity for governments, the nursing and midwifery professions, the health system and the community generally, are important principles of good governance in the public sector. The opportunities that RA websites

provide as vehicles for attesting to each of these principles while demonstrating professional leadership are increasingly essential (Australian National Audit Office 2003: p 8).

8. Conclusion

The mapping exercise undertaken as part of this Project is an important key to understanding why there should be a strong push to achieving a level of national consistency across the jurisdictions in a number of areas, as well as improved transparency around policy and processes in the regulation of nurses and midwives in Australia. The idiosyncratic and non-uniform approaches to the regulation of nurses and midwives across the eight jurisdictions create much confusion and a number of structural challenges and economic disincentives for nursing and midwifery professionals, employers, educators, policy makers, researchers and the community.

The reforms that have been occurring in each jurisdiction in relation to the regulation of nursing and midwifery are lauded. However, it is clear that many of the quirks of the colourful patchwork arrangement that reflects the political imperatives of the period since enactment (a feature of 'mature' legislation), need to be neutralised. This intra-jurisdictional approach does not auger well for national consistency around professional regulatory, professional practice and educational standards, which is a goal of both the *Our Duty of Care* Report and the Productivity Commission Report (National Review of Nursing Education 2002; Productivity Commission 2005d). Despite the fact that some of the outcomes of the Productivity Commission recommendation for a single consolidated registration board (Productivity Commission 2005d: pp 141 - 145) may be achievable, the push for consistency in the particular skills, knowledge, experience and practice that constitute nursing and midwifery, is at risk of adding another layer of complexity to the task.

The governments in each of the States and Territories will undoubtedly continue their push for achieving greater consistency in the regulation of health professionals locally. However, it is important that the Health Ministers and governments through the CNOs in each jurisdiction, the AHMAC, the ANMC, the RAs, the Council of Deans of Nursing and Midwifery and the nursing and midwifery professional and industrial organisations, continue to drive the vital concomitant agenda of ensuring uniform standards of regulation, practice and educational preparation for the discrete health professions. The need for this clearly comes from the inconsistencies that emerge from the mapping and the attendant confusion and frustrations that this creates for nurses and midwives, employers, educators and national policy makers around the less-than-optimal utilisation of the nursing and midwifery workforces. This is due to the structural impediments created by the various layers of regulation from legislation to the policy guidance and processes of each of the RAs that do not always intuitively go to the protection of the health and safety of the community.

There are significant community and professional benefits in ensuring: the quality and safety of care provided by appropriately-educated, skilled and experienced nurses and midwives; flexibility and freedom of movement of the nursing and midwifery workforce; a reduction in the differences in standards and requirements that go to the fairness, safety and confidence in both the process and its outcomes and economies in reducing the duplication of systems and processes all designed to achieve the same ends. These would be enhanced significantly by working towards national uniformity in the areas discussed throughout the course of this report, including:

- Educational standards for entry to practice and graduation into areas of practice specialisation in nursing and midwifery.
- Practice standards for nurses and midwives.
- Regulatory standards for the governance, structure, membership and functions of the RAs.
- The structure of the register and rolls of nurses and midwives.
- Uniform processes for initial entry to practice; periodic renewal of licence to practice; re-entry to practice; mutual recognition; and recognition of specialised practice qualifications.
- The sharing of information with each other.

What is urgently needed is national debate to broker agreement on a path to move this reform agenda forward.

APPENDIX A - Key elements in Map 1 – the legislation, the regulatory authority and professional standards

Key Elements	
1.1	Health Professional Regulatory Regime Specific to Nursing and Midwifery
1.2	Legislated Purpose or Objects of Act
1.2.1	Protect the health and safety of the community by having a registration system for nurses and midwives that enables the following:
1.2.2	Developing, promoting, applying and reviewing standards of professional practice and conduct
1.2.3	Ensuring nurse and midwives who provide health services are fit and competent to practice
1.2.4	Ensuring nurses and midwives who provide health services maintain the required levels of competence and fitness to practice
1.2.5	Provide a standard system of reporting, investigating and dealing with issues of professional conduct, professional performance and the ability to practice of nurses and midwives
1.2.6	Provide mechanisms to enable the public and employers to readily identify nurses and midwives who are registered or enrolled
1.2.7	Establish a RA responsible for the regulation of nurses and midwives and administering the registration system
	Protect the health and safety of the community by having a registration system for students of nursing and midwifery and enables the investigation into the suitability of students to undertake clinical training
	Others
1.3	Regulatory authority responsible
1.4	Number on RA board or council
1.5	Regulatory authority membership and method of appointment
1.5.1	Community members
1.5.2	RNs
1.5.3	Midwives
1.5.4	ENs
1.5.5	Mental health nurse
1.5.6	Nurses - classification mixed or unspecified
1.5.7	Nurse and/or midwives from education sector
1.5.8	Nurse administrators or managers
1.5.9	Executive officer of the RA
1.5.10	Other specific classes of professional or occupation
1.6	Term of RA appointment
1.7	Chairperson of the RA
1.8	Appointment of executive officer
1.8.1	Selected and appointed by
1.8.2	Role
1.8.3	Duration of appointment
1.8.4	Removal
1.8.5	Other provisions of note
1.9	Legislated functions powers and obligations of the authority

1.9.1	Provision of information about and promotion of nursing and midwifery
1.9.2	Developing, promoting, maintaining and reviewing professional practice standards and professional development standards of nursing and midwifery practice
1.9.3	Reviewing and monitoring the entry, re-entry and continuing competence, professional development conduct and health of registered or enrolled nurses and midwives
1.9.4	Education of nurses and midwives and educational programs relating to nursing and midwifery - See Table 9
1.9.5	Advising the Minister
1.9.6	Providing information concerning nurses and midwives for lawful purposes
1.9.7	Administering the scheme of registration, enrolment, authorisation/ endorsement of qualified nurses and midwives, and exercising discretions granted under Act in relation to the registration or enrolment of nurses and midwives
1.9.8	Refusing or imposing conditions on registration or enrolment; terminating or varying registration, enrolment, authorisation or endorsement; withdrawing or varying conditions of, any recognition or exemption in relation to registration, enrolment, authorisation/ endorsement
1.9.9	Cancelling or suspending any registration, authorisation or enrolment in accordance with requirements outlined the Act
1.9.10	Taking action in relation to breaches of standards, reports or complaints about nurses and midwives - See Table 10.
1.9.11	Consulting with and developing relationships with other organisations and participating in activities relevant to RA's functions and powers
1.9.12	Other functions, exercising powers and obligations of the RA
1.10	RA role in professional and practice standards of nursing and midwifery practice
1.11	RAs codes of conduct and ethics to guide their work and decision making
1.12	Key codes of conduct, ethics and statements of standards and guidelines developed by RA
1.13	RA adoption of national standards
1.13.1	Code of Ethics for Nurses in Australia (ANMC 2002)
1.13.2	Code of Professional Conduct for Nurses in Australia (ANMC 2003)
1.13.3	National Competency Standards for the Registered Nurse (ANMC 2000)
1.13.4	National Competency Standards for the Enrolled Nurse (ANMC 2002)
1.13.5	National Competency Standards for the Midwife (ANMC 2006)
1.13.6	National Competency Standards for the Nurse Practitioner (ANMC 2005)
1.14	Accountability of RA
1.15	Delegation by RA

APPENDIX B - Key elements in Map 2 – The registers and/or rolls of nurses and midwives

Key Elements
2.1 Registers and rolls
2.1.1 RNs or Division 1 registered nurse
2.1.2 ENs or Division 2 registered nurse
2.1.3 Midwife/RN (post registration qualifications)
2.1.4 Direct Entry Midwife
2.1.5 Nurse Practitioner
2.1.6 Midwife Practitioner
2.1.7 Mothercraft nurse
2.1.8 Mental Health Nurse (post registration qualifications)
2.1.8 Direct Entry Mental Health Nurse (pre registration qualifications)
2.1.9 ENs with recognised medication expertise
2.1.10 Maternal and child health nurses
2.1.11 Other
2.2 Effect of registration, authorisation, endorsement or enrolment
2.3 Protection of practice and/or title
2.3.1 Practice
2.3.2 Title
2.4 Registration, authorisation, endorsement and other recognition of specific or higher level qualifications on the registers and rolls
2.5 Registration, enrolment, authorisation or endorsement other than full registration
2.6 Information on database/ register or roll
2.6.1 Name
2.6.2 Address and other contact details
2.6.3 Date of birth
2.6.4 Gender
2.6.5 Country of birth
2.6.6 Date of initial registration /enrolment
Date of last renewal/ expiry date of registration or enrolment period
2.6.7 Registration number
2.6.8 Qualifications
2.6.9 Authorisations, endorsements etc
2.6.9 Any conditions upon registration or enrolment
2.6.10 Registration or enrolment refused, suspended or cancelled
2.6.11 Other information
2.7 Obligation to make registers and rolls available to the public
2.8 Information available to the public
2.9 Fee to inspect the register or roll
2.10 Where other information will be shared with other relevant agencies such as health

professional regulatory authorities in the same or other jurisdictions

2.11 Certificates of registration, authorisation, endorsement and/or enrolment

2.11.1 Certificate of registration or enrolment

2.11.2 Annual (or other period) practicing certificates

2.12 A person can be on more than one register in jurisdiction

2.13 A person can be registered and enrolled at same time in a jurisdiction

APPENDIX C - Key elements in Map 3 – Original or initial entry to practice requirements as a registered nurse, registered midwife or enrolled nurse

Key Elements:

- 3.1 Registration or enrolment in jurisdiction required to practice nursing or midwifery
- 3.2 Before application will be considered
- 3.3 Suitability to practice, general competence, character and personal - legislative requirements for entry
 - 3.3.1 Qualifications
 - 3.3.2 Required educational preparation
 - 3.3.3 Competence to practice at the level for which application is made
 - 3.3.4 Adequate communication skills
 - 3.3.5 Adequate command of the English language
 - 3.3.6 Mental and physical health and capacity
 - 3.3.7 No addictions to substances
 - 3.3.8 Be of good character
 - 3.3.9 Have appropriate professional indemnity arrangements
 - 3.3.10 Other
- 3.4 Educational requirements for registration as a nurse – RN - See also Table 9
- 3.5 Educational requirements for registration as a midwife – RM - See also Table 9
- 3.6 Educational requirements for enrolment as an enrolled nurse - EN
- 3.7 Evidence of qualifications required
- 3.8 Evidence of successful completion of education program required
- 3.9 Pre-Registration or Pre-Enrolment qualification completed within last 5 years
- 3.10 Accreditation or approval of education programs for entry into practice required - See Table 9
- 3.11 Recognises another nursing and midwifery regulatory authority in Australia or NZ approval of a nursing or midwifery program
- 3.12 Scope for RA to establish equivalence
- 3.13 Examination distinct from education program
- 3.14 Competency requirements – in areas in which they practice
- 3.15 Mental and physical health requirements
- 3.16 Addiction to alcohol, other drug or substance that may affect ability to practice
- 3.17 Communication skills requirement
- 3.18 Adequate written and spoken English to practice nursing
- 3.19 Criminal convictions or record
- 3.20 Academic conduct requirements
- 3.21 Competence assessment distinct from education program required

- 3.22 Ever had name suspended or removed from a Register/Roll or been refused registration or enrolment in this or another jurisdiction
- 3.23 Ever had conditions imposed on registration or enrolment in this or another jurisdiction
- 3.24 Practice hour requirements (internship)
- 3.25 Proof of identity
- 3.26 Commitment to follow codes of conduct and ethics
- 3.27 References required for registration or enrolment
- 3.28 Consent for RA to approach and request information from relevant persons, institutions and organisations appropriate to determine eligibility for registration or enrolment in a jurisdiction
- 3.29 Professional indemnity requirements
- 3.30 Other requirements for lodging registration or enrolment application
- 3.31 Self-declarations are made according to jurisdiction's oath instrument
- 3.32 Temporary and/or restricted permits for entry to practice applicants
- 3.33 Refusal of an application for registration or enrolment
- 3.34 Imposition of conditions on registration or enrolment
- 3.35 Fees

APPENDIX D - Key elements in Map 5 – Application for restoration to register or roll – not currently registered or enrolled in any other jurisdiction

Key Elements:

- 5.1 Registration or enrolment in jurisdiction required to practice
- 5.2 Before application will be considered
- 5.3 Application for restoration to the register or re-registration if previously registered or enrolled in that jurisdiction
- 5.4 Registered or enrolled in other jurisdiction(s)
- 5.5 Qualifications and education
- 5.6 Recency of practice requirements
- 5.7 Suitability to practice and competency requirements – in areas of practice
- 5.8 Requirements for a nurse or midwife undertaking a re-entry or refresher course or requiring assessment of competence prior to full registration or enrolment
- 5.9 Ever refused registration or enrolment in any jurisdiction
- 5.10 Ever had registration or enrolment suspended or cancelled in any jurisdiction
- 5.11 Any conditions or restrictions placed upon practice in any jurisdiction
- 5.12 Adequate professional development
- 5.13 Mental and physical health requirements
- 5.14 Addiction to alcohol, other drug or substance that may affect ability to practice
- 5.15 Communication skills requirement
- 5.16 Adequate written and spoken English to practice nursing
- 5.17 Criminal charges, convictions or record
- 5.18 Professional indemnity requirements
- 5.19 Proof of identity
- 5.20 Commitment to follow codes of conduct and ethics
- 5.21 Details of previous employment
- 5.22 References
- 5.23 Consent for RA to approach and request information from relevant persons, institutions and organisations appropriate to determine eligibility for registration or enrolment in a jurisdiction
- 5.24 Any self-declarations are made according to the jurisdiction's oath instrument
- 5.25 Refusal of restoration or re-registration
- 5.26 Fees

APPENDIX E - Key elements in Map 6 – Application for registration or enrolment under mutual recognition

Key Elements	
6.1	Registration or enrolment in jurisdiction required to practice
6.2	Legislation in jurisdiction ²³
6.3	Mutual recognition - within Australia and between Australian and NZ
6.4	Requirements for registration under the <i>Mutual Recognition Act 1992</i> (Cwth) – s19 and the <i>Trans-Tasman Mutual Recognition Act 1997</i> (Cwth) – s18
6.4.1	Lodgement of a written notice (application) with the Board seeking registration or enrolment as a nurse and/or a midwife in accordance with the mutual recognition principle
6.4.2	State the specific area of nursing and/or midwifery that the person is registered or enrolled for in: the first State and specify that State; or NZ
6.4.3	State the area of nursing and/or midwifery that for which registration is sought
6.4.4	Specify all the participating jurisdictions in which the person has substantive registration for equivalent occupations
6.4.5	State that the person is not the subject of disciplinary proceedings in any participating jurisdiction (including any preliminary investigations or action that might lead to disciplinary proceedings) in relation to nursing and/or midwifery
6.4.6	State that the person's registration in any participating jurisdiction is not cancelled or currently suspended as a result of disciplinary action
6.4.7	State that the person is not otherwise personally prohibited from carrying on nursing and or midwifery in any participating jurisdiction, and is not subject to any special conditions in carrying on that occupation, as a result of criminal, civil or disciplinary proceedings in any State
6.4.8	Specify any special conditions to which the person is subject in carrying on any such occupation in any participating jurisdiction
6.4.9	Give consent to the making of inquiries of, and the exchange of information with, the authorities of any participating jurisdiction regarding the person's activities in nursing and/or midwifery or occupations or otherwise regarding matters relevant to the notice.
6.4.10	The notice must be accompanied by a document that is either the original or a copy of the instrument evidencing the person's existing registration (or, if there is no such instrument, by sufficient information to identify the person and the person's registration).
6.4.11	The instrument evidencing the person's existing registration, the person must certify in the notice that the accompanying document is the original or a complete and accurate copy of the original.
6.5	Effect of mutual recognition
6.6	Registration Authority's capacity to inquire further into a person's suitability to practice nursing or midwifery prior to granting full, unconditional registration or enrolment
6.7	Evidence of qualifications
6.8	Evidence of successful completion of education programs
6.9	Approval of education programs by Authority required

²³ Registration is granted under the *Mutual Recognition Act 1992 (Commonwealth)* and *Trans Tasman Mutual Recognition Act 1997 (Commonwealth)*. The state legislation enables the Commonwealth legislation to have effect, but it is the Commonwealth legislation under which registration is granted.

- 6.10 Recency of practice
- 6.11 Competency requirements – in areas in which they practice
- 6.12 Adequate written and spoken English to practice nursing
- 6.13 Mental and physical health requirements
- 6.14 Addiction to alcohol, other drug or substance that may affect ability to practice
- 6.15 Communication skills requirement
- 6.16 Proof of identity
- 6.17 Commitment to follow codes of conduct and ethics
- 6.18 Details of previous employment
- 6.19 References
- 6.20 Professional indemnity requirements
- 6.21 Other requirements
- 6.22 Fee waiver
- 6.23 Fees
- 6.24 Issues in relation to the application of mutual recognition policy
 - 6.24.1 General
 - 6.24.2 RNs
 - 6.24.3 ENs
 - 6.24.4 Midwives
 - 6.24.5 Mental health nurses
 - 6.24.6 NPs/MPs
 - 6.24.7 Others

APPENDIX F - Key elements in Map 7 – Renewal of registration or enrolment

Key Elements:

- 7.1 Registration or enrolment in jurisdiction required to practice
- 7.2 Period of registration or enrolment
- 7.3 Renewal date(s)
- 7.4 Recognition of renewal
- 7.5 Failure to renew and grace period prior to removal for non-payment of fees
- 7.6 Before renewal will be considered
- 7.7 Workforce data collected
- 7.8 Obligations on nurses and midwives to ensure their competence and ongoing suitability to practice nursing and/or midwifery
- 7.9 RA's obligations in relation to ensuring the ongoing competence and suitability to practice nursing and/or midwifery
- 7.10 Policy and/or guidelines issued by RA in relation to competence, conduct and ethics
- 7.11 National standards endorsed by RA in relation to competence, conduct and ethics
- 7.12 Recency of practice requirement at renewal
- 7.13 Competency and performance requirements
- 7.14 If competency and recency of practice requirements are not met
- 7.15 Recognition of competencies for nurses and midwives working in non-traditional nursing and midwifery roles
- 7.16 Audit of currency of practice and competency
 - 7.16.1 Audit Process
 - 7.16.2 Mandatory or voluntary
 - 7.16.3 Options to demonstrate maintaining competence and ongoing professional development
 - 7.16.4 Exemptions from audit
 - 7.16.5 Audit process evaluated
- 7.17 Ongoing professional development requirements
- 7.18 Adequate written and spoken English to practice nursing
- 7.19 Commitment to follow codes of conduct and ethics and adhere to competency standards
- 7.20 Refused registration or enrolment in another jurisdiction
- 7.21 Any conditions or restrictions placed upon practice in any other jurisdiction
- 7.22 Information re registration or enrolment in any other jurisdiction at time of renewal requested
- 7.23 Mental and physical health requirements
- 7.24 Addiction to alcohol, other drug or substance that may affect ability to practice

- 7.25 Criminal convictions and/or record
- 7.26 Professional indemnity requirements
- 7.27 Any self-declarations are made according to the jurisdiction's oath instrument
- 7.28 Annual (or other period) renewal fees

APPENDIX G - Key elements in Map 8 – Safe practice in specialised and specific practice areas of nursing and midwifery

Key Elements:	
8.1	Specific or specialised areas of nursing and/or midwifery
8.2	Means of recognition
8.2.1	Midwives
8.2.2	Mental Health Nurses
8.2.3	Nurse Practitioners and Midwife Practitioners
8.2.4	ENs - Medications
8.2.5	Other
8.2.6	Protection of title and or practice
8.3	Conditions precedent for registration, enrolment, authorisation /endorsement etc
8.3.1	Midwives
8.3.2	Mental Health Nurses
8.3.3	Nurse Practitioners and Midwife Practitioners
8.3.4	ENs - Medications
8.3.5	Other
8.4	Legislated requirements for specialty recognition
8.4.1	Midwives
8.4.2	Mental Health Nurses
8.4.3	Nurse Practitioners and Midwife Practitioners
8.4.4	ENs - Medications
8.4.5	Other
8.5	RA pathways available leading to specialty recognition
8.5.1	Midwives
8.5.2	Nurse Practitioners
8.5.3	Mental Health Nurses
8.5.4	Enrolled nurses – medication administration
8.5.5	Other
8.6	Adoption of national practice standards
8.7	Adoption of national educational standards
8.8	Approval of education programs for entry into practice required
8.9	Educational requirements for registration, authorisation or endorsement
8.9.1	Midwives
8.9.2	Mental Health Nurses
8.9.3	Nurse Practitioners and Midwife Practitioners
8.9.4	ENs - Medications
8.9.5	Other
8.10	Evidence of successful completion of education program required
8.11	Experiential requirements for registration, authorisation or endorsement

8.11.1	Midwives
8.11.2	Mental Health Nurses
8.11.3	Nurse Practitioners and Midwife Practitioners
8.11.4	ENs - Medications
8.11.5	Other
8.12	Other requirements for registration, authorisation or endorsement
8.12.1	NPs and MPs
8.12.2	Other
8.13	Recency of education and/or practice
8.14	Summary of application for registration, authorisation or endorsement requirements
8.15	Period of registration, authorisation or endorsement in specialty area
8.16	Scope of practice defined for specialty area of practice
8.16.1	Midwifery
8.16.2	Nurse Practitioners
8.16.3	Mental health nurses
8.16.4	Enrolled nurses – medication administration
8.16.5	Other
8.17	Specific practice requirements eg content and approval of clinical practice guidelines for NPs and MPs
8.18	NP areas of practice
8.19	Professional indemnity requirements
8.20	Temporary and/or restricted permits for entry to practice applicants
8.21	Renewal requirements
8.24	Fees for original application and renewal

APPENDIX H - Key elements in Map 9 – Setting and reviewing educational standards

Key Elements

9.1 RA's legislated role in setting and reviewing standards of education

- 9.1.1 Assessing and approving educational and training courses/ curricula related to entry to practice as a nurse or midwife
- 9.1.2 Assessing and approving educational courses/ curricula for refresher and re-entry programs
- 9.1.3 Approving other educational courses/ programs related to other professional qualifications in nursing and midwifery
- 9.1.4 Holding or determining examinations determining the character, subjects and conduct of those examinations and appointing examiners
- 9.1.5 Promoting the education of nurses and midwives and educational programs relating to nursing and midwifery
- 9.1.6 Recognise, approve or accredit educational and other institutions and health services and aged care services offering courses for the education of nurses and midwives
- 9.1.7 Developing and/or endorsing standards about ongoing professional development
- 9.1.8 Support education and research in health care practice
- 9.1.9 Collaborate and/or cooperate with university, hospital or other institution or body to provide education and evaluation of nurses and midwives
- 9.1.10 Participate in programs(local and national) relating to the education or practice of nurses and midwives
- 9.1.11 Participate in the formation or, and be a member of, any body or program concerned with nurses and midwives

9.2 Educational representation on RA

- 9.2.1 Nurses and/or midwives involved in tertiary or pre-enrolment education
- 9.2.2 Other educators

9.3 Educational advisory committees or panels established by RA and functions

- 9.3.1 Nursing – for all courses leading to registration, enrolment, authorisation or endorsement and other courses approved by the RA
- 9.3.2 Midwifery – for all courses leading to registration, authorisation or endorsement and other courses approved by the RA
- 9.3.3 NPs and MPs - for all courses leading to registration, authorisation or endorsement and other courses approved by the RA

9.4 Membership of educational advisory committees or panels established by RA

- 9.4.1 RA members
- 9.4.2 Nurses or midwives engaged in the tertiary education of nurses and/or midwives
- 9.4.3 Nurses engaged in the pre-enrolment education of nurses
- 9.4.4 Nurses, midwives, NPs or MPs in clinical practice
- 9.4.5 Other nurses or midwives including administrators
- 9.4.6 Other educators
- 9.4.7 Others

9.5 Conduct and ethical requirements of educational advisory committees including disclosure of and management of conflicts of interest

9.6 Approval of specified courses

- 9.6.1 Accreditation/ approval of entry to practice programs
- 9.6.2 Accreditation/approval of re-entry to practice educational programs
- 9.6.3 Accreditation/ approval of other educational programs

9.7	Courses currently approved by RA
9.8	RA adoption of national competency standards in education for assessing eligibility to practice
9.8.1	Code of Ethics for Nurses in Australia (ANMC 2002)
9.8.2	Code of Professional Conduct for Nurses in Australia (ANMC 2003)
9.8.3	National competency Standards for the Registered Nurse (ANMC 2000 and 2005)
9.8.4	National competency Standards for the Enrolled Nurse (ANMC 2002)
9.8.5	National Competency Standards for the Midwife (ANMC 2006; ACMI 2002)
9.8.6	National Competency Standards for the Nurse Practitioner (ANMC 2005)
9.8.7	Code of Ethics (ACMI 2001)
9.8.8	Others
9.9	RA adoption of professional education standards
9.10	Principles underpinning RA's review and approval of education courses and providers
9.10.1	Approves or accredits educational providers
9.10.2	Approves or accredits educational courses
9.10.3	Programs and courses meet accepted, validated Australian competency standards which reflect professional scopes of practice
9.10.4	Programs and/or educational providers are accredited for a defined period.
9.10.5	RA retains the right and has the authority to revoke or vary accreditation status at any stage should the required nursing education standards not be met.
9.10.6	Educational institution must notify the RA of any changes occurring during the process of the course that (may) affect the outcome of the course.
9.10.7	Other
9.11	RAs processes for the review and approval of education courses
9.11.1	Timing
9.11.2	Preliminary discussions
9.11.3	Documentation requirements
9.11.4	Committee and/or expert review
9.11.5	Representatives from the education institution are invited to meet committee/ panel and provide additional information and address the issues raised.
9.11.6	Site visit to assess the standard of teaching resources, including the facilities.
9.11.7	Recommendations to Board
9.11.8	Conditions of approval
9.11.9	Fee charged for review and approval process
9.12	Summary of formal standards or requirements set to review courses and comprehensive-ness of curricula
9.13	RA's position on the cost of pre-registration courses
9.14	RN program requirements
9.14.1	RA pre-requisites for entry to RN programs
9.14.2	Evidence underpinning the standards and requirements for educational programs for nurses
9.14.3	Temporal requirements on length of course eg hours, semesters, years
9.14.4	Specific substantive connect hours, laboratory time simulator time, excluding clinical

- 9.14.5 General curriculum content
- 9.14.6 Clinical experience - hours, ratios or percentage of whole course
- 9.14.7 Clinical experience content and settings ie clinical setting, laboratory or simulation setting
- 9.14.8 Clinical experience is obtained in a supernumerary capacity
- 9.14.9 Assessment and approval of theoretical and clinical educational settings
- 9.14.10 Obligations of EP and health services providing clinical experience for RN programs
- 9.14.11 Clinical and theoretical teaching and supervision of students
- 9.14.12 Assessment – requirements and standards
- 9.14.13 Combined qualifications
- 9.14.14 Recognition of prior learning
- 9.14.15 Modalities for delivery of programs
- 9.14.16 Evaluation requirements for educational programs
- 9.14.17 Bachelor of Nursing students clinical requirements for eligibility to apply for enrolment
- 9.14.18 Specific requirements of the head of nursing or midwifery program in an EP
- 9.15 Midwifery programs accredited**
- 9.16 Midwifery program requirements**
- 9.16.1 RA pre-requisites for entry – midwifery programs
- 9.16.2 Evidence underpinning the standards and requirements for educational programs for midwives
- 9.16.3 Temporal requirements on length of course eg hours, semesters, years
- 9.16.4 Specific substantive connect hours, laboratory time simulator time, excluding clinical
- 9.16.5 General curriculum content
- 9.16.6 Clinical experience – hours, ratios or percentage of whole course
- 9.16.7 Clinical experience content
- 9.16.8 Clinical experience is obtained in a supernumerary capacity
- 9.16.9 Assessment and approval of theoretical and clinical educational settings
- 9.16.10 Obligations of health services providing clinical experience for midwifery programs
- 9.16.11 Clinical and theoretical teaching and supervision of students
- 9.16.12 Assessment - requirements and standards
- 9.16.13 Combined qualifications
- 9.16.14 Recognition of prior learning
- 9.16.15 Modalities for delivery of programs
- 9.16.16 Evaluation requirements for educational programs
- 9.16.17 Specific requirements of the head of nursing or midwifery program in an EP
- 9.17 NP and MP program requirements**
- 9.17.1 RA pre-requisites for entry NP and MP Programs
- 9.17.2 Evidence underpinning the standards and requirements for educational programs for NPs and MPs
- 9.17.3 Temporal requirements on length of course eg hours, semesters, years
- 9.17.4 Specific substantive connect hours, laboratory time simulator time, excluding clinical
- 9.17.5 General curriculum content
- 9.17.6 Clinical experience - hours, ratios or percentage of whole course
- 9.17.7 Clinical experience content
- 9.17.8 Clinical experience is obtained in a supernumerary capacity
- 9.17.9 Requirements to assess and approve theoretical and clinical educational settings
- 9.17.10 Assessment - requirements and standards

- 9.17.11 Modalities for delivery of programs
- 9.17.12 Evaluation requirements for educational programs
- 9.18 EN program requirements**
- 9.18.1 RA pre-requisites for entry - EN Programs
- 9.18.2 Evidence underpinning the standards and requirements for educational programs for NPs and MPs
- 9.18.3 Temporal requirements on length of course eg hours, semesters, years
- 9.18.4 Specific substantive connect hours, laboratory time simulator time, excluding clinical
- 9.18.5 General curriculum content
- 9.18.6 Specific curricula requirements in EN programs for medication administration
- 9.18.7 Clinical experience – hours, ratios or percentage of whole course
- 9.18.8 Clinical experience content
- 9.18.9 Clinical experience is obtained in a supernumerary capacity
- 9.18.10 Assessing and approving theoretical and clinical educational settings
- 9.18.11 Clinical and theoretical teaching and supervision of students
- 9.18.11 Assessment - requirements and standards
- 9.18.13 Bridging courses for ENs
- 9.18.14 Recognition of prior learning
- 9.18.15 Modalities for delivery of programs
- 9.18.16 Evaluation requirements for educational programs
- 9.18.17 Specific requirements of the head of nursing or midwifery program in an EP

APPENDIX I – Summary of treatment of the different categories of nurses and midwives on the registers and rolls in each jurisdiction (from Map 2 – section 2.1)

KEY:

- Entries in black in the tables are general commentary and contain questions and statements that require checking as to their veracity or information to be provided by board
- Entries in blue are where there is specific reference to the issues in the statute or subordinate legislation
- Entries in violet are where there is legislation that has been assented but has not commenced at the time of writing
- Entries in green indicate where the statute and other regulatory instruments may be silent but the regulatory authority has a policy regarding the issue
- Entries in red indicate information provided during interview with the various nursing and midwifery regulatory authorities, nursing and midwifery leaders and chief nursing officers in each state and territory.

Key Elements	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
RNs or Division 1	Registration on Register of Nurses	Registration on Register of Nurses	Registration in the category of health care practice of nursing – registered nurse	Registration on Register of Nurses	Registration on Register of General Nurses	Registration on Register of Nurses	Registration in Division 1 of the Register General Registration in Division 1 of the Register	Registration in Division 1 of the Register Registration on Register of Nurses and Midwives as a registered nurse
ENs or Division 2	Enrolment on Register of Nurses	Enrolment on List A of Roll of Nurses	Enrolment in the category of health care practice of nursing – enrolled nurse	Enrolment on the Roll of Nurses	Enrolment on the Roll of Nurses	Enrolment on the Roll of Nurses	Registration Division 2 of the Register General Registration in Division 2 of the Register	Registration Division 2 of the Register Registration on the Register of Nurses and Midwives as an enrolled nurse
Midwife/RN (post registration qualifications)	Registration on Register of Nurses and Registration on Register of Midwives	Registration on Register of Nurses and Registration on Register of Midwives	Registered in the category of health care practice of midwifery – registered nurse authorised to practice midwifery	Registration on Register of Nurses – authorised to practice midwifery	Registration on Register of Nurses and Registration on Register of Midwives	Registration on Register of Nurses - authorised to practice in the restricted practice area of midwifery	Registration Division 1 of the Register General Registration in Division 1 of the Register and endorsed as a midwife	Registration in Division 1 of the Register Registration on Register of Nurses and Midwives as a registered nurse and a midwife
Direct Entry Midwife	Registration on Register of Midwives	Registration on Register of Midwives	Registered in the category of health care practice of midwifery – midwife	No Bachelor of Midwifery authorised by the Council. DEMs entered on database as a non-nurse, midwife only	Registration on Register of Midwives	No Bachelor of Midwifery authorised by the Council.	Registration Division 1 of the Register – with a restriction only to practice midwifery Specific Registration as a midwife.	No provision under current Act but policy to grant registration in Division 1 of the Register DEMs applying under MR are registered with restrictions only to practice midwifery. Registration on Register of Nurses and Midwives as a midwife.
Nurse	Registration on	Authorisation as	Authorisation in	Registration on	Registration on	Role currently	Registration	Registration in

Key Elements	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Practitioner	the Register of Nurses	NP on the Register of Nurses	a restricted practice area of NP – on the Register of Nurses	Register of Nurses – authorised to practice as NPs under the section enabling the Council to authorise a person to practice nursing in another area of nursing.	'other parts or "registers" for other areas recognised by the Board as being special practice areas'.	still under development in Registration on Register of Nurses - s 43 Authorised to practice in the restricted practice area of nursing practice as may be prescribed. The area of nursing practice performed by an NP is prescribed as a restricted practice area.	Division 1, 3 or 4 of the Register and endorsed as NP in a specific category or categories for which the NP is qualified to use the title. General Registration in Division 1, 3 or 4 of the Register and endorsed as NP in a specific category or categories for which the NP is qualified to use the title.	Division 1of the Register as a NP. Registration on Register of Nurses and Midwives as a registered nurse and a NP.
Midwife Practitioner	No provision for category	Authorisation as an MP on Register of Midwives	No provision for category	No provision for category	No provision for category	No provision for category	No provision for category	No provision for category
Mothercraft nurse	Enrolment on the register of nurses.	Enrolled on List B of Roll of Nurses as EN(mothercraft)	No specific recognition Enrolment in the category of health care practice of nursing – EN	No specific recognition	No specific recognition	Enrolled on Roll as EN(Mothercraft)	Registration in Division 5 of the Register. General Registration in Division 5 of the Register as a mothercraft nurse. Division now closed.	Registration Division 2 of the Register – 34(b) with recognition of specialist qualifications in a mothercraft nurse. Registration on the Register of Nurses and Midwives as an EN.
Mental Health Nurse (post registration qualifications)	No specific recognition Registered on the Register of Nurses	Qualifications may be recorded on the Register of Nurses.	Not recognised Registered on the Register of Nurses	Registration on Register of Nurses – authorised to practice mental health nursing if successfully completed a recognised course	Registration on Register of General Nurses and the Register of Mental Health Nurses.	Registration on Register of Nurses - authorised to practice in the restricted practice area of psychiatric nursing.	Registration in Division 1 of the Register General Registration in Division 1 of the Register	Registration in Division 1 and 2 of the Register Registration on Register of Nurses and Midwives as a registered nurse.
Direct Entry Mental Health Nurse (pre registration qualifications)	No specific recognition Registered on the Register of Nurses	No specific recognition Registered on the Register of Nurses	Registered on the Register for Nurses and conditions placed on practice to work only in mental health facilities.	Registration on Register of Nurses.	Registered on the Register of Mental Health Nurses .	No specific recognition Registered on the Register of Nurses	Registration Division 3 of the Register. Specific Registration as a mental health nurse – s 7(1). Division now closed – not accepting any new entries though may re-enter.	No provision under current Act but policy to grant registration in Division 1of the Register. Under MR nurses with only mental health qualifications are registered with restrictions only to practice mental health nursing. Registration on Register of Nurses and Midwives.
ENs with recognised	Enrolled in specialty area	Enrolled on the Roll of Nurses	No specific recognition	Endorsement - EN	No specific recognition	Enrolled on Roll of Nurses	Registration Division 2 of the	Registration Division 2 of the

Key Elements	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
medication expertise	as an EN(medications)				Enrolled on the Roll of Nurses	Authorised to practice in the restricted practice area as an authorised enrolled nurse.	Register and endorsed for medication administration. General Registration in Division 2 of the Register and endorsed for medications.	Register. Registration on the Register of Nurses and Midwives as an EN. Conditions will be able to be imposed under the pending legislation.
Maternal and child health nurses	No specific recognition	No specific recognition	No specific recognition	No specific recognition	No specific recognition	No specific recognition	No specific recognition	Registration Division 2 of the Register with recognition of specialist qualifications in a children's nurse. Registration on the Register of Nurses and Midwives as an EN.
Other		<p>Register of Nurses: Mental retardation /developmental disability or similarly qualified</p> <p>General nurses (former NSW or equivalent courses).</p> <p>Adult nurses (UK).</p> <p>Geriatric nurses - (without conditions if registered < Aug 04, but may have conditions >Aug 04.</p> <p>Infants nurses (former NSW and equivalent courses), Sick Children's and Children's nurses (UK, Ireland, Germany, Switzerland) (without conditions if registered < Aug 04, but may have conditions > Aug 04.</p>					<p>Mental Retardation Nurses – Registered Division 4.</p> <p>Specific Registration as a mental retardation nurse.</p> <p>Division now closed</p> <p>Registration as a student.</p>	<p>Mental Health Disability Nurses – dealt with in the same way as direct entry mental health nurses – Direct entry mental health nurses will only be registered under MR if there is employment available. Disability services are provided by Social Trainers in WA.</p> <p>Registration Division 2 of the Register with recognition of specialist qualifications in a dental nurse. Dental nurses will not be registered under the new legislation. No longer recognized as a nursing role, therefore no requirement for them to be registered.</p> <p>Registration Division 2 of the Register with recognition of specialist qualifications in</p>

Key Elements	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
								<p>a tuberculosis nurse.</p> <p>Registration on the Register of Nurses and Midwives as an enrolled nurse.</p>

APPENDIX J – Obligation to make registers and rolls available to the public (from Map 2 – section 2.7)

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
<p>The registers kept by the Board must be kept in a way that allows the information about registered nurses and midwives to be readily reproduced in an easily readable form – CI 153.</p> <p>Registers must be open for inspection by the public at reasonable times – CI 155(1). Board plan to publish selected information from register >31 March 2006 when renewal process is completed.</p>	<p>The registers and rolls must be available for inspection by any person:</p> <ul style="list-style-type: none"> • In person at the office of the Board at all reasonable times • By other means and at such times that the Board determines – s 16. <p>Register and Roll currently being prepared for internet access – due mid 06.</p>	<p>A person may inspect the register or roll kept by the Board at the office of the Board or obtain a copy of or extract from the register or roll kept by the Board – s 47.</p> <p>Web-based access is now available but is not yet 'live' – is updated weekly.</p>	<p>A person may, on payment of the prescribed fee:</p> <ul style="list-style-type: none"> ▪ inspect an entry in the register or roll; or ▪ obtain a copy of, or extract from, an entry in the register or roll, certified correct by the executive officer; <p>during ordinary business hours on days on which the council's office is open – s 53(1).</p> <p>Register may be searched using the internet – available at: http://www.qnc.qld.gov.au/register/register.aspx.</p>	<p>Register may be searched using the internet – available at: http://www.nursesboard.sa.gov.au/reg.html.</p> <p>Power under legislation though with the internet access fee is not required: The Registrar must, on payment of the prescribed fee:</p> <ul style="list-style-type: none"> ▪ release the full name of a nurse whose name appears on the register or roll ▪ make any information entered on qualifications, conditions or limitations on registration or enrolment and any action taken by the Board on proceedings – s 22(11). 	<p>A person may, on payment of the prescribed fee, inspect the register or roll at the office of the Board.</p> <p>A person inspecting the register may, on payment of the prescribed fee, obtain a copy of or extract from the register or roll.</p> <p>The Board may waive the payment of all or part of the prescribed fee for inspecting or obtaining a copy of or extract from the register or roll – s 47.</p> <p>Register may be searched using the internet – available at: http://www.nursingboardtas.org.au/nbtonline.nsf/AZ?OpenForm.</p>	<p>The register may be inspected at the office of the Board by any person during ordinary office hours without charge.</p> <p>A person may obtain a copy of or an extract from the register on payment of the fee determined by the Board.</p> <p>A private address of a person whose name appears on the register must not appear on that part of the register which is open to the public for inspection, unless the person so authorises – s 17(6).</p> <p>Register may be searched using the internet – available at: http://www.nbv.org.au/nbv/nbvonline1.nsf/AZ?OpenForm.</p> <p>The Board may publish the register on a website maintained by or in the name of the responsible board on the Internet.</p> <p>The register may be inspected at the office of the Board by any person during ordinary office hours without charge.</p> <p>A person may obtain a copy of or an extract from the register on payment of the fee determined by the Board.</p> <p>The Board must not provide a</p>	<p>The register shall be kept in the office of the Registrar and they may permit any person, on payment of the prescribed fee (if any) to inspect the register – ss 35(1) and (2).</p> <p>Register may be searched using the internet – available at: http://www.nbwa.org.au/0/50/50/Home.pm.</p> <p>The register must be kept in the office of the registrar and must be available for inspection by members of the public:</p> <ul style="list-style-type: none"> ▪ during normal office hours ▪ on an internet website maintained by the Board <p>A person may, on application to the registrar in respect of the register or an entry on the register and payment of the prescribed fee (if any) obtain a certified copy of the entry – CI 39(1) – (4).</p>

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
						copy of the register to any person unless satisfied that it is in the public interest to do – ss 30(5) – (7).	

APPENDIX K – Where information other than that publicly available will be shared with other relevant agencies, such as health professional regulatory authorities in the same or other jurisdictions (from Map 2 – section 2.10)

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
<p>Legislation is silent but the Board takes the view that information that goes to the community's health and safety about the conduct, competence or health of a nurse or midwife registered in the ACT should be shared – not written policy in this respect</p> <p>Section 86 provides for mandatory consultation with the Commissioner for Community and Health Services</p> <p>Complaints and s 87 provides for information sharing with the Chief of Police where evidence of offence committed by nurse or midwife.</p>	<p>Board is authorised to inform any body, which under the law of another State or Territory, is responsible for the registration, enrolment or authorisation to practice of nurses or midwives of a determination of the Tribunal – s70.</p> <p>Board does not provide information to other jurisdictions other than where legislative power exists or the information is part of the public Registers or Roll.</p> <p>As noted, even information in Registers and Roll are not necessarily made public (eg details of any conditions)</p> <p>Section 33(1) of the <i>Mutual Recognition Act</i> (Commonwealth) has been interpreted as providing for information about disciplinary conditions to be advised to other jurisdictions participating in mutual recognition arrangements even though a person's initial application for registration was not made MR.</p> <p>There are a number of instances in which it would be desired to share additional information about registrants or applicants for</p>	<p>Board has power to share information with other health practitioner registration authorities and with other persons and bodies (whether within Australia or elsewhere) – s 11(2)(a).</p>	<p>The council may, at the request of the Australian Nursing Council Incorporated, supply that body with information about the particulars in the register or roll – s 53(3).</p> <p>Provision for notification of Commissioner for Young people and Child Guardian in certain instances – s 139A.</p> <p>Legislation is silent for other provision of information; however other RAs are able to have access through the internet to the register.</p> <p>The information available through the Nurse RA Access for each nurse includes:</p> <ul style="list-style-type: none"> ▪ name ▪ registration/enrolment number ▪ type of nurse (eg: registered/enrolled) ▪ type of registration/enrolment (eg: full/limited) ▪ current registration/enrolment status (eg: active/limited/suspended) ▪ contact QNC indicator (if a nurse is subject to disciplinary action under the provisions of the Nursing Act 1992) ▪ expiry date of licence ▪ date of initial registration/enr 	<p>It is a function of the Board to exchange information with other registering authorities for nurses – s 16(1)(j) <i>Nurses Act</i> and s 37(1) <i>Mutual Recognition Act</i>.</p>	<p>The Board has power to share information with nursing registration authorities, ANMC and other relevant bodies – s 8(1)(a).</p>	<p>Functions of the Board are to:</p> <ul style="list-style-type: none"> ▪ exchange information with registration boards in other jurisdictions about registered persons or persons who have sought to become registered in Victoria – s 66(i). ▪ provide information to the ANMC about registered persons or persons who have sought to become registered in Victoria – s 66(j). <p>The Board may disclose information relating to health practitioners or students registered by the board or to applicants for registration by the board that it collects or is given to:</p> <ul style="list-style-type: none"> ▪ another responsible board ▪ a person or body established under a law of another jurisdiction that has functions or powers that correspond to the functions or powers of a responsible board under the Act. <p>A responsible board may only disclose information in accordance with</p>	<p>The Board may notify any finding, reason or decision of the Board or the professional standards committee to any board or authority outside the State charged with regulating the registration and supervision of nursing or any officer, employee or agent thereof. No action, claim or demand lies against a person in respect of the communication or publication in good faith – s 79.</p> <p>The Board may notify any finding, reason or decision of the Board or the professional standards committee to any board or authority outside the State charged with regulating the registration and supervision of nursing or any officer, employee or agent thereof. No action, claim or demand lies against a person in respect of the communication or publication in good faith – CI 107.</p>

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
	<p>registration/enrolment, if permitted by legislation including privacy legislation and <i>Health Records and Information Privacy Act 2002</i> (NSW). Eg the Board has recently sought legal advice regarding ability to share information about a registered nurse who has a serious mental health problem and who is also registered with another RA in NSW.</p> <p>Board has no power to provide information re current investigations of serious matters or any determinations from Professional Standards Committees or Impairment Panels.</p>		<p>olment</p> <ul style="list-style-type: none"> ▪ qualification details ▪ any current endorsements on the licence ▪ any conditions on the licence (Queensland Nursing Council 2006). <p>The Council also notifies all Australian nursing and midwifery RAs about all Council and Tribunal decisions that alter the data contained in the Register or Roll.</p>			<p>this section for the purpose of:</p> <ul style="list-style-type: none"> ▪ fulfilling its functions under the Act ▪ assisting the above persons or bodies to fulfil their functions – s 161. 	

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