Australian Nursing & Midwifery Federation

Submission to the public consultation by the Nursing and Midwifery Board of Australia on the revised Code of conduct for nurses and revised Code of conduct for midwives

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Lee Thomas

Federal Secretary

Annie Butler

Assistant Federal Secretary

Australian Nursing & Midwifery Federation

PO Box 4239 Kingston ACT 2604

T: 02 6232 6533

F: 02 6232 6610

E: anmfcanberra@anmf.org.au

W: www.anmf.org.au

Introduction

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership which now stands at over 258,000 nurses, midwives and assistants in nursing, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

Currently, the ANMF represents the largest number of midwives in the country, with over 20,000 members registered as midwives. This is almost two thirds of all registered midwives in Australia, according to the total number of 32,817 shown in the December 2016 statistics for the Nursing and Midwifery Board of Australia (NMBA)[i].

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANMF welcomes the opportunity to provide response to this consultation on the revised Code of conduct for nurses and Code of conduct for midwives. Our feedback is provided against the questions posed in the consultation document for both the Code of conduct for Nurses and for the Code of conduct for Midwives.

Questions for consideration

1. Do the seven principles and the content of the Codes reflect the conduct required of nurses/midwives?

The ANMF supports the seven principles presented within the Codes of conduct, however we do have a number of additions and adjustments which are outlined below.

While the ANMF supports the identified principles for the Codes of conduct as presented in the consultation document, we would like the NMBA to consider combining the Codes of Conduct and the Codes of Ethics for the professions into one document, just as the Professional Boundaries document has been incorporated within the Codes of Conduct document. There is an extensive number of regulatory documents that nurses and midwives need to read and consider in order to safely undertake their day to day practice. It thereby makes sense to streamline their professional reference material by combining the Codes into one document.[ii]. Should this recommendation be supported, the ANMF is happy to work with the NMBA and the other professional bodies holding co-copyright of the Code of Ethics to combine the co-badged Code of Ethics and the Code of Conduct documents.

i http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx
ii https://www.nmc.org.uk/standards/code/read-the-code-online/

2. Is information in the Code/s presented clearly?

Overall the information provided in the Code/s is presented clearly and is easy to understand. The ANMF provides the following recommendations for amendments throughout the document to improve the readability and understanding of the information presented in the Code/s:

Page	Content
P14/15 and P32	**1.2 Lawful behaviour** **Point b:** We acknowledge that sexual misconduct may be a crime, however, all other crimes are not mentioned. We suggest that the point about sexual misconduct is moved to the professional boundaries section of the document; and, that 1.2 (b) refer to criminal conduct/misconduct in general terms. **Point e:** 'complaints' needs to be defined. Is this point referring to making 'frivolous and vexatious complaints' to the regulator about other regulated health professionals? **1.3 Mandatory reporting** This section should also include the mandatory reporting requirements for making a notification against other registered health practitioners.
P15/P33	**2.1 Nursing Practice/Midwifery Practice** The following additions made in bold font should be added: **Point a:** Practice in accordance with the **NMBA** standards of the profession and broader health system (see the NMBA standards, codes and guidelines and the Australian Commission on Safety and Quality in Health Care).
P15-16/P33	**2.2 Decision-making** **Point d/e:** authorisation should be addressed in two parts – legal requirements and local policies. They are distinct requirements and do not have the same intention. For example, a particular practice may be legally permissible but not allowable under the health services policy. Where this occurs, the practice should not be undertaken.
P16/P34	**2.3 Informed consent,** **Point b:** The following additions made in bold font should be added: Give the person adequate opportunities to ask questions, make decisions and to refuse investigations and treatments, and proceed in accordance with **the person's wishes considering** local policy. **Point d:** what is the 'other valid authority'? **Point e:** *advise people of the benefit, as well as associated costs or risks, if referring the person for* **further assessment,** *investigations or treatments, which may wish to clarify before proceeding.*
P16/P34	**2.4 Adverse events and open disclosure** **Point a:** 'report the incident'- needs to be added in the mid-wifery document and should be expanded in the next point to describe to whom the incident should be reported. **Point g:** should include – 'seek advice from your professional association or the Australian Nursing and Midwifery Federation Branch'.

P17/P35	**3.1 Aboriginal and/or Torres Strait Islander peoples** There are a number of times within this section where Aboriginal and/or Torres Strait Islander peoples are referred to as 'Aboriginal and/or Torres Strait Islander people'. This needs to be corrected.
P17/P35	**3.2 Culturally safe and respectful practice** **Point d:** 'avoid bias' should be changed to 'be aware of bias'
P18/P36-37	**3.5 Confidentiality and privacy** **Point e:** identifying 'other online platforms' as an area to not transmit, share or post confidential information is not appropriate. This broad statement denies the fact that many digital health systems use secure online platforms for care related information management. This sentence needs to be reworded. **Point f:** this point needs to be expanded to include **'…support people to manage and control their own information in a digital platform such as the *My Health Record*'.**
P19	**3.6 End-of-life care** **Point d:** should state 'in accordance with health service/ organisation policy, and applicable legislation'. Also, point d should be added to the midwifery document.
P19/P37-38	**4.1 Professional boundaries** The ANMF supports the wording within the current code of conduct under statement 8 and recommends it is added into this section. We use this information on a regular basis with our members and believe it is clear and concise. ***Conduct Statement 8*** *Nurses promote and preserve the trust and privilege inherent in the relationship between nurses and people receiving care* *Explanation* *1. An inherent power imbalance exists within the relationship between people receiving care and nurses that may make the persons in their care vulnerable and open to exploitation. Nurses actively preserve the dignity of people through practised kindness and respect for the vulnerability and powerlessness of people in their care.* *Significant vulnerability and powerlessness can arise from the experience of illness and the need to engage with the health care system. The power relativities between a person and a nurse can be significant, particularly where the person has limited knowledge; experiences pain and illness; needs assistance with personal care; belongs to a marginalised group; or experiences an unfamiliar loss of self-determination. This vulnerability creates a power differential in the relationship between nurses and persons in their care that must be recognised and managed.*

	2. Nurses take reasonable measures to establish a sense of trust in people receiving care that their physical, psychological, emotional, social and cultural wellbeing will be protected when receiving care. Nurses recognise that vulnerable people, including children, people with disabilities, people with mental illness and frail older people in the community, must be protected from sexual exploitation and physical harm. *3. Nurses have a responsibility to maintain a professional boundary between themselves and the person being cared for, and between themselves and others, such as the person's partner and family and other people nominated by the person to be involved in their care.* *4. Nurses fulfil roles outside the professional role, including those as family members, friends and community members. Nurses are aware that dual relationships may compromise care outcomes and always conduct professional relationships with the primary intent of benefit for the person receiving care. Nurses take care when giving professional advice to people with whom they have a dual relationship (e.g. a family member or friend) and advise them to seek independent advice due to the existence of actual or potential conflicts of interest.* *5. Sexual relationships between nurses and persons with whom they have previously entered into a professional relationship are inappropriate in most circumstances* ***and could amount to unprofessional conduct or professional misconduct.*** *Such relationships automatically raise questions of integrity in relation to nurses exploiting the vulnerability of persons who are or who have been in their care. Consent is not an acceptable defence in the case of sexual or intimate behaviour within such relationships.* *6. Nurses should not be required to provide nursing care to persons with whom they have a pre-existing nonprofessional relationship, reassignment of the persons to other nurses for care should be sought where possible.* *7. Nurses take all reasonable steps to ensure the safety and security of the possessions and property of persons requiring and receiving care.*
P20/P38	**4.3 Legal, insurance and other assessments** **Point c:** 'duty of care' should be defined in the glossary.
P21/P38-39	**4.4 Conflicts of interest** **Point b:** conscientious objection should be defined in the glossary.
P21/P39	**4.5 Financial arrangements and gifts** **Point d:** The following additions made in bold font should be added: *Not become financially* ***or legally*** *involved with a person* ***for whom they have or are currently providing care****, for example through* ***the establishment of*** *bequests, powers of attorney, loans and investment schemes, and…*

P21/P39	**5.1 Teaching and supervising** Another point should be added to this section outlining the accountability and responsibilities for registered nurses and midwives in delegating to, and supervising students. The second sentence of the stem should be amended to state: 'In their teaching and supervisor roles registered nurses and midwives must:'
P22/P40-41	**7.1 You and your colleagues' health** **Point a:** Nurses and midwives must understand the principles of public health interventions. While it is ideal that nurses and midwives maintain their health it is unreasonable to include must 'maintain their health' in the code of conduct. While nurses or midwives who smoke are not enacting the principles of health promotion, smoking is not an illegal activity. **Point c:** Remove the term 'impaired', as it is a legal test defined in the National Law.

3. Is information in the Code/s applicable to clinical and non-clinical practice settings?

The ANMF supports the content presented within the draft Code of Conduct/s as being able to be applied to all practice settings. Reference to clinical and non-clinical practice should be removed from the Code's introductory paragraphs and replaced with all practice settings.

4. At this stage, the NMBA has developed separate codes for nursing and midwifery. What are your views on either a separate or a combined code of conduct for nurses and midwives?

At this time, the ANMF is unable to reach a consensus position in response to this question, as Branches' views are divided. There are strong arguments to support both the position of combining the codes of conduct and for the codes of conduct remaining separate.

Rationales for each of these approaches are outlined below:

Combined Codes

The establishment of a joint or combined code of conduct for nurses and midwives provides direction for the professions and the public which unambiguously addresses the expected conduct of both a nurse and/or a midwife as a health professional. Conduct expected of nurses and midwives while practising, is not directly related to the type of practice they undertake, but rather to the standard expected of them as health professionals.

The proposed codes are the same save for the terms: 'patient or client' for nursing and 'women' for midwives. The majority of registered midwives in Australia are dual registered as nurses and midwives. Given the large number of regulatory documents that govern nursing and midwifery practice, duplication of the codes of conduct as separate codes is unnecessary.

Separate Codes

As nursing and midwifery are separate professions in Australia, there needs to be separate codes for nursing and midwifery to reflect this clear differentiation of practice. It is also recognised that nursing and midwifery have a different philosophical basis for their practise and therefore it would be inappropriate to combine the codes.

Further, the NMBA and AHPRA are clear, that whilst some aspects of practice may be consistent between the two professions, the auditing of individual practitioners regarding compliance with registration standards presumes a clear separation between the standards for practice of the two professions.

Should the Codes remain separate, they should very closely mirror one another to ensure consistency of understanding and application.

5. The NMBA wants to get the language used in the codes right and use terms applicable to as many clinical and non-clinical settings as possible. The NMBA has adopted person or people to refer to individuals who enter into professional relationship with a nurse or midwife. Do you support this approach or is there an alternative?

There should be consistency of terms used in all NMBA documents. The use of the term 'person' to refer to individuals who enter into a professional relationship with a nurse or midwife, is supported as this is an inclusive term.

The ANMF notes the importance of using terms that are inclusive for all those being cared for by a midwife. For a person who identifies himself as a man, or not as a woman, and is pregnant, it would be discriminatory to use the term woman/ women in the Code of Conduct for midwives, for this man or person. In 2014, men gave birth to fifty four babies in Australia[iii]. There is an increasing number of people who identify as a man or as intersex, having babies in this country. As such, the use of the term 'person' is more appropriate.

6. Various terms have been used previously to capture the interaction between the nurse or midwife and the person receiving care. 'Professional relationship' is used in the draft *Codes of conduct* to capture this interaction, irrespective of the nurse or midwife's context of practice. Do you support the use of the term 'professional relationship' as an appropriate description of the interaction between the nurse or midwife and the person receiving care or is there an alternative?

The ANMF supports the term 'professional relationship' to define the care relationship between a person being cared for by a nurse or midwife.

iii ihttp://www.dailytelegraph.com.au/news/nsw/pregnant-men-new-statistics-reveal-men-have-given-birth-to-54-babies-in-australia/news-story/ed8a56f4b906d20a4093c82562173c8e

7. How should the NMBA promote awareness of the new Codes to nurses, midwives, other health professionals, employers, educators and the public?

Select all that apply

- ✓ **in person at information forums at venues such as hospitals and universities**
- ✓ **via social media, e.g. Twitter, Facebook and LinkedIn**
- ✓ **on posters and flyers in hospitals and other healthcare workplaces**
- ✓ **in person at nursing and midwifery conferences and events**
- ✓ **in print and online media, e.g. newspapers, nursing and midwifery journals and health magazines**
- ✓ **in the NMBA newsletter**
- ✓ **in an email to all nurses and midwives**
- □ **on a card that nurses and midwives can carry on their lanyards at work**
- □ **other *(please list)***

The ANMF and its Branches are happy to have discussion directly with the NMBA as to how we can assist in promoting new regulatory documents to our members.

8. Do you have any other comments on the public consultation draft Code/s?

As identified earlier the ANMF believes it is reasonable to incorporate the professional boundaries within the Code of Conduct for nurses and Code of Conduct for midwives. However, one area which has not been adequately covered in the draft code documents is that of 'context of practice', including how the context of one's practice can influence the practice of a nurse or midwife. The ANMF recommends this be added to the code documents, including defining influential factors in one's practice as outlined in the previous codes.

These include:

Nursing

- the characteristics of the consumer (including their cultural background) and the complexity of care they require;
- the model of care, type of service or health facility and physical setting;
- the amount of clinical support and/or supervision that is available; and
- the resources that are available, including the staff skill mix and level of access to other health care professionals.

Midwifery

- the model of care, whether the midwife is employed in a hospital labour ward or working in private practice, home, community, hospitals, clinics or health units;
- the characteristics of the woman and the complexity of care required by her and her infant;
- whether the relationship is for only one pregnancy or for a much longer period over successive pregnancies;
- the amount of clinical support and/or supervision that is available; and
- the resources that are available, including the staff skill mix and level of access to other health care professionals.