



**Occupational Therapy
Board of New Zealand**

Kaihaumanu Tūroto o Aotearoa

19 December 2011

Dr Mary Russell
Chair
Occupational Therapy Board of Australia

Dear Mary,

- 1. Advertising guidelines**
- 2. Code of conduct for registered health practitioners**
- 3. Guidelines for mandatory notifications**

Thank you for allowing the Occupational Board of New Zealand (the Board) to comment on the above documents.

We find the documents comprehensive in providing information and guidance to practitioners. There are a number of points within the documents that would have application in New Zealand. I think it important that we continue to share our policy development in the hope that we can start to harmonise our policies on standards of practice. This may be something our respective Boards may wish to discuss in the near future.

We have responded to each of the codes and guidelines as presented. You will note that some of our comments are general while others are specific.

1. Advertising guidelines

The Board presently has no guidelines covering this area. The Board will consider the application of advertising guidelines for the New Zealand context at its meeting in February 2012. We may approach you in the near future asking permission to utilize your guidelines in this area.

General

We found the guidelines to be very thorough and provided good guidance to practitioners. We found section 6.4 – *Advertising of qualifications and titles* of interest, particularly the use of the title 'Dr'.

Specific

We have one specific comment in relation to 4. *What is acceptable advertising?* We would suggest that mention is made of the requirement to obtain informed consent both implied and explicit. Also that any research used in advertising comes from a reputable source and that practice is evidence based.

2. Code of conduct for registered health practitioners

General

We found this to be an extensive piece of work which covered a wide and important range of practice and ethical issues. This is in contrast to our own Code of Ethics which revolves around a number of principle statements. The Board is reviewing its Code of Ethics next year and it may be at this point that we look at adopting more of a Trans Tasman approach and start to harmonise some of our codes and guidelines.

Specific

Section 1.2 *Professional values and qualities* – Suggest the term non-discrimination appears in this section.

Section 2.2 *Good care* – Suggest mention is made of the need for practitioners to be reflective in practice. We would also point out the need to observe issues around practitioner/patient boundaries and the need to manage these with respect. Many of our complaints relate to the 'breaking' of boundaries, having clear expectations in a code would identify good professional standards and expectations.

Section 3.5 *Informed consent* – Suggest you include that consent is still required even if the client has repeated visits, making clear that consent is a continuous process and not something that happens at initial contact.

Section 3.6 *Children and young people* – The need to have clear documentary evidence of the decision processes used.

Section 3.8 *Patients who may have additional needs* – Suggest the need for clear documentation around this area.

Section 3.10 *Adverse events and open disclosure* – Suggest the need for clear documentation.

Section 3.12 *End of life care* - Unsure what is meant by the word '*community*' in the opening paragraph of this section.

Suggest mention is made of the importance of inter-professional working and communication and multi-disciplinary team involvement in decision making processes. This would mitigate issues and dangers of practitioners working in isolation.

Section 3.16 *Closing a practice* – Suggest mention is made of the need to obtain consent from clients for the transfer of their information to another practice if applicable. Or what happens to records once the practice has closed.

Section 4.3 *Delegation, referral and handover* – Suggest an addition under *good practice involves* – informing the client of such actions.

Section 4.4 *Teamwork* – Suggest something is included which identifies an expectation to support students within the team and that role modelling examples of good interprofessional practice is important.

Section 6.2 *Risk management* – Interesting to see the connection of risk with the Code of practice

Section 10.1 *Introduction* – Suggest you look at defining the terms teaching, supervising and mentoring. There can be general misunderstanding with these terms which tend to be used interchangeably which only adds to the confusion.

3. Guidelines for mandatory notifications

General

Very good section, we particularly like the decision algorithm which makes actions very clear. The Health Regulatory Authorities New Zealand (HRANZ) has produced a document for employers which are attached for your information. Employers have found this useful particularly around advice about the threshold to be applied to reporting.

Specific

Section 2 – *General obligations* - Suggest a section for employers and the guidance around staff they may have on performance improvement plans, or where practitioners have resigned following a conduct or competence issue. We have found that employers often struggle with decisions around reporting to regulatory authorities and believe there is under reporting in this area.

Top page 42 first para second line 'p' missing in practitioner.

Section 5 – *Mandatory notifications by education providers and practitioners in relation to impaired students* – Suggest distinction is made that the qualification is both an academic one and a requirement to register and practice. Therefore in the decision guide (first box) include 'which leads to eligibility to register' after the word study.

We often have calls from students and lectures wanting advice about passed convictions which they feel may affect their eligibility to practice following successful completion of the programme.

We hope you find these comments useful. Please contact us if you require any further information.

Yours sincerely,



Andrew Charnock
Chief Executive/Registrar
Occupational therapy Board of New Zealand

HRANZ / DHB

AGREED GUIDELINES FOR

COMPETENCY REFERRALS

July 2010

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Table 1 - Regulatory Authority Contact Details as at July 2010

Chiropractic Board Ph 04 474 0703 www.chiropracticboard.org.nz	Dental Council Ph 04 499 4820 www.dcnz.org.nz or www.dcnz.health.nz	Dietitians Board Ph 04 474 0746 www.dietitiansboard.org.nz
Medical Council of New Zealand Ph 04 384 7635 www.mcnz.org.nz	Medical Laboratory Science Board Ph 04 801 6250 www.mlsboard.org.nz	Medical Radiation Technologists Board Ph 04 801 6250 www.mrtboard.org.nz
Midwifery Council Ph 04 499 5040 www.midwiferycouncil.org.nz or www.midwiferycouncil.health.nz	Nursing Council of New Zealand Ph 04 385 9589 www.nursingcouncil.org.nz	Occupational Therapy Board Ph 04 918 4740 www.otboard.org.nz
Osteopathic Council Ph 04 474 0747 www.osteopathiccouncil.org.nz	Optometrists and Dispensing Opticians Board Ph 04 474 0705 www.optometristsboard.org.nz or www.odob.health.nz	Pharmacy Council Ph 04 495 0330 www.pharmacycouncil.org.nz
Physiotherapy Board Ph 04 471 2610 www.physioboard.org.nz	Podiatrists Board Ph 04 474 0706 www.podiatristsboard.org.nz	Psychologists Board Ph 04 471 4580 www.psychologistsboard.org.nz
Psychotherapists Board Ph 04 918 4727 www.pbanz.org.nz		

Context

These guidelines were established to help District Health Boards (DHBs) and the 16 Regulatory Authorities (RAs)¹ that make up Health Regulatory Authorities of New Zealand (HRANZ) manage competency notification processes. They have been developed from collated DHB and RA feedback about competency notification at both DHB and regulatory level, with the aim of streamlining these processes.

Introduction

- The competence review process was introduced for all registered health practitioners under Sections 34-44 of the HPCAA 2003².
- It does not replace employers' existing mechanisms for addressing competence concerns.
- It is a remedial process aimed at helping the health practitioner to achieve competent practice.
- The focus of the inquiry and review is on assessing whether there is a competence concern and whether the practitioner is currently competent to practise.
- Each RA has developed different processes for conducting a competence review based on what methods of assessment are appropriate for the professions for which it is responsible.
- This document deals with the competence review process involving RAs only.

¹ Refer Table 1

² Health Practitioners Competence Assurance Act 2003 accessed from http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html?search=ts_act_health_rese&p=1&sr=1

Goals of Guidelines

- Create understanding of DHB/RA expectations about the competency notification process.
- Clarify the rights and obligations of DHBs and RAs under the current legislation.
- Provide guidance on how this process could better work within the current environment.
- Clarify each party's (DHB and RA) ongoing responsibility and involvement.
Specifically:
 1. What can and should an employer do in regards to a competency notification?
 2. What can and should an RA do in regards to a competency notification?
 3. Employment and professional roles – what is the crossover?

1. COMPETENCE CONCERNS

1.1 Points for DHBs to consider when deciding whether to refer a practitioner to an RA for competence concerns:

- If a registered health practitioner has resigned or been dismissed for reasons related to competence you **must** make a notification under Section 34 (3) of the Act.

- A competence concern is indicated when over time, the practitioner makes continuous/frequent errors (note: this is not limited to constant errors over time, this could also apply if error was a significant one off error i.e. due to sickness, concern for health of practitioner) or demonstrates inadequate practice (e.g. lack of skill or knowledge, inadequate understanding of concepts and procedures, or poor judgement). Depending on the severity of the concern, a DHB may wish to consider putting the practitioner on a performance management process to rectify the problem. The main concern of the HPCAA 2003 is public health and safety. If the DHB considers the practitioner's practice may pose a risk to public health and safety, it should notify the RA immediately. The most appropriate pathway may be via Section 34(1) which would rely on a health practitioner making the notification.

- Notification should be made where attempts at education, mentoring and support have been offered to address the concern and have not worked, or where the concern is of sufficient magnitude, in the DHB's view, to involve the RA.

1.2 General principles applied by RAs when considering concerns about competence (some or all may apply, depending on the RA):

- Evidence indicates that following employer-managed training or supervised support the practitioner is unable to sustain improvements in practice.
- Lack of evidence to show that the practitioner has insight into his/her lack of competence. Problems with assessment, analysis or decision-making, inability to work as part of a team and difficulty in communicating with colleagues, patients or clients.
- Evidence indicates that the practitioner accepts responsibility for activities, knowing these are beyond his/her skill level.
- Lack of evidence of ongoing professional development by the practitioner.
- Lack of evidence that current practice meets standards, or evidence that current practice does not meet standards.
- Evidence of professional isolation.
- Evidence that the practitioner does not respect professional boundaries. This may also be cause for disciplinary action, so DHBs are advised to contact the relevant RA to discuss the situation before deciding how to proceed.
- There is an expectation for full and prompt (early) compliance with the requirements of the Act. RAs prefer to work with a DHB to manage any active concerns. That may mean the RA simply steps back and monitors the progress/effectiveness of whatever performance management process already instituted. If concerns remain, an RA can assist by applying mechanisms under the Act (e.g. conditions on scope).
- RAs should be notified at other times if there are patient safety concerns that cannot be managed by the employer or performance management processes are unsuccessful. Employers can seek advice from the RA if unsure when to notify.

- If you are making a notification under Section 34, it is very helpful to include a letter to the Registrar outlining the area(s) of concern. It is helpful to send all information pertaining to the initial notification at once. However, if only a letter has been sent, you will be asked to provide more information in the inquiry phase, for example:
 - Detail of the specific incident(s) giving rise to concern and the reasons it may appear to be a competence issue.
 - Any education and action plan set up, and the timeframe for meeting the outcomes of this process.
 - Copies of professional development undertaken.
 - Copies of performance appraisals or competence assessments done in the past three years.
 - Details of any systems in place to protect public health and safety (e.g. supervision, limited practice rights, suspension).

2. MANDATORY COMPETENCY REPORTING

2.1 Points for DHBs to consider regarding mandatory reporting of competence concerns:

- Mandatory reporting is required if a health practitioner resigns or is dismissed from his or her employment for reasons related to competence.
- A DHB should contact an RA for advice regarding a possible concern.
- Each DHB should develop a framework for notification, including a clear internal system with delegated authorities to report to RAs (e.g., CMO, DON, DAH. As enabled by Section 34.1).
- In the interests of transparency and to meet natural justice obligations, the practitioner involved should be notified of a DHB's decision to refer the matter to the Regulatory Authority.

3. RISK OF HARM

3.1 RA guidelines of risk of harm and thresholds DHB should be cognisant of when considering and referring for serious risk of harm under Section 35:

Section 35 of the Act requires an RA to notify certain persons when it has reason to believe that the practice of a health practitioner it regulates may pose a risk of harm to the public. When making an assessment under section 35, RAs will usually consider the three key features of section 35(1), as follows:

- 1) The RA is only obliged to notify when it has **reason to believe** there is a risk of harm. The RA must have reasonable grounds for its belief, and be able to identify the circumstances giving rise to that belief.
- 2) The RA's belief must relate to **a risk of harm**. The nature of providing health care is such that merely engaging in practice presents a risk of harm. The RA cannot be obliged to notify of a risk that arises merely by reason of a practitioner practising. The risk must be one which exists over and above the risk of harm that is a necessary incident of practice.
- 3) The risk must be **to the public**. The provision does not apply to risks to the practitioner. Nor is it likely to apply to risks to a practitioner's colleague or business associate. The risk must be to a member of the public, i.e. patients/clients, or potential patients/clients.

3.2 Test for risk of harm:

Against the background of this analysis of section 35(1), the question of whether, in any particular case, an RA is obliged to notify will be tested by asking questions including but not limited to:

- Has the RA formed a genuine belief that a practitioner's practice may pose a risk of harm (i.e. the risk is not unlikely) Risk of harm may be indicated by a recognised factor including but not limited to:
 - A pattern of practice over a period of time that suggests the practitioner's practice may not meet the required standards of competence, or;
 - A one-off incident that demonstrates a significant departure from accepted standards, or;
 - Recognised poor performance where previous recommendations from a competence review have failed – this does not exclude notifications of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern, or;
 - Relevant criminal offending, or;
 - Professional isolation with apparent declining standards.

- Is that belief reasonable in the sense that it has been arrived at fairly on the basis of adequate information, or is there a need for further investigation?
- Is the risk of harm identified as a risk that is more than the acceptable risk that arises by reason simply of the carrying on of practice?
- Is the risk of harm identified as a risk to the public?
- Have the context and circumstances of the practitioner and his/her practice been taken into consideration?

3.3 Risk of serious harm:

Risk of serious harm may be indicated when:

- A patient may be seriously harmed; or
- The practitioner may pose a threat to more than one patient and as such the harm is collectively considered serious.
- There is sufficient evidence to suggest that the alleged criminal offending is of such a nature that the practitioner poses a risk of serious harm to one or more than one member of the public.

4. PATIENT SAFETY MEASURES

4.1 Measures to be put in place in regards to patient safety when waiting for a RA to respond to a notification:

The clinical adviser involved in managing the case should use his/her professional judgment to determine what measures should be put in place to protect patient safety, depending on the seriousness of the situation.

- Measures could include any or a combination of supervision, non-patient contact work, additional training, referral to an Employee Assistance Programme (EAP), competence assessment and/or suspension.
- A documented performance management plan which may include education and supervised practice by a peer that has a timeframe and concludes with a reassessment of competence.

NOTE:

There is an expectation that these measures be undertaken/considered when any competence concern is raised within a DHB, regardless of whether the DHB considers the threshold for notification to the RA has been met. If a notification is made, these measures could remain in place while the RA conducts its process.

5. EMPLOYMENT VERSUS COMPETENCE NOTIFICATION REQUIREMENTS

5.1 Distinguishing between employment processes and competence notification requirements:

- Notification of a competence concern is a separate process to any employment issues a DHB may have with an individual practitioner. It can be difficult to keep these processes separate when the practitioner is going through a performance management process.
- DHBs should involve both HR and the relevant professional leader from the beginning, to give advice and help manage employment issues.
- Employment processes and competence processes may run concurrently.

6. ALTERNATIVE EMPLOYMENT PROCESSES TO NOTIFICATION

6.1 Employment processes which can be used separate from the process of notification:

Processes include:

- Education plans, performance improvement plans, disciplinary investigations, alternative duties, referral to Occupational Health and Safety. The internal processes used will be dependent on the issues arising and any contextual information (e.g. health issues).

7. EMPLOYER EXPECTATIONS

7.1 Points for DHBs and RAs to consider during the notification process:

- A DHB can contact an RA for verbal advice without prejudice.
- DHBs should know the RA's legal limitations regarding what feedback can be given.
- RAs will acknowledge notifications within ten working days. As RAs are required to follow fair processes they may not act on a notification without notifying the health practitioner concerned and giving him/her the opportunity to respond.
- RAs are limited in the feedback they can give employers until/unless an RA determines that the practitioner poses a risk of harm under Section 35, and/or a competence review has been completed and orders have been made. In this case the authority must notify the employer of the orders under Section 38(3)(a)(ii).
- RAs will encourage, but cannot require, individual practitioners to notify their employers when they are required to undergo a competence review (unless Section 35 or 39 applies).

8. TIMEFRAMES

8.1 Details and Timeframes for RA Response:

- RAs may prioritise notifications based on the content of the notification and type of employment the health practitioner is presently engaged in that could pose an increased risk of harm to the public (e.g. practising in isolation).
- If the health practitioner is no longer employed by the notifier, no further information would be given to that employer.
- RAs will acknowledge receipt of a notification within ten working days. Within the letter of acknowledgement, the RA will advise the DHB of the likely process and probable timeframes as far as possible.
- Timeframes and processes may vary between RAs. Where orders are made under section 38 of the Act, following a competence review, the RA must provide the practitioner's current employer with a copy of those orders.

9. PRACTITIONER SUPPORT DURING THE RA PROCESS

9.1 Points for DHBs to consider before going to the RA and initiating the competency notification process:

- Both parties should encourage referral.
- Both parties should encourage information sharing and provide consistent messages.