Draft *Code of Conduct*

Analysis of submissions

May 2012
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Introduction

The Nursing Council consulted on the Draft Code of Conduct between November 2011 and February 2012. Feedback was sought from across the health sector, Māori Advisors, consumer organisations and through focus groups with nurses. This paper summarises the written submissions received.

The Draft Code is a substantial change from the existing Code of Conduct for Nurses (Nursing Council of New Zealand, 2010). The principles framing the Code were changed and extended to allow a change in emphasis towards the needs and rights of the health consumer and to make more explicit the values of respect and trust as the foundations of ethical relationships and behavior. More information was included on privacy and confidentiality, health consumer rights and documentation of care. New areas were included e.g. working with others in the health care team and professional boundaries. A consultation document was developed to assist submitters to identify and feedback on the changes and new areas within the Draft Code.

Analysis of submissions

A total of 74 written submissions were received. There were 40 submissions from organisations or groups and 34 individual submissions. A list of the organisations and groups making submissions is on page 48.

Table 1: Types of Submitter

<table>
<thead>
<tr>
<th>Type of Submitter</th>
<th>Number</th>
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<tbody>
<tr>
<td>District Health Boards</td>
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<tr>
<td>Professional organisations</td>
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<td>Consumer groups</td>
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<td>Education providers</td>
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<td>Aged care providers</td>
<td>4</td>
</tr>
<tr>
<td>Group of nurses</td>
<td>3</td>
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<tr>
<td>Student nurses</td>
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<tr>
<td>Individual Nurses</td>
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</tr>
<tr>
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<td><strong>Total number of submissions</strong></td>
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A quantitative analysis of the responses from the 48 submitters who completed yes/no answers to the consultation questions is included in the table on the next page.
Table 2: Responses to Yes/No questions

<table>
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<tr>
<th>Question #</th>
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Almost all submitters who completed the consultation document agreed with all consultation questions. A small number disagreed with some questions. The comments and suggestions for improvement to the content and wording of the Draft Code made by submitters are presented in themes under the 13 questions topics in the consultation document. A list of submitting organisations and abbreviations can be found on page 48. Other changes suggested by submitters are discussed in the last section and comments of individual standards are included in the table on pages 38 to 47.

The majority of submissions were positive about the substantial changes to the Code seeing it as a relevant and more useful document. Many submitters agreed that standards of professional behaviour need to be more explicit.

*I support the arrangement of the Code of Conduct around the values of respect, trust, partnership and integrity, and the seven principles which form the framework for the Code. These values and principles are well correlated to the underlying values and principles of the Code of Health and Disability Services Consumers’ Rights 1996 (the Code of Rights), and I believe that this consistency between the two Codes is not only helpful, but also very important.*

(HDC)
This document clearly sets out expected behaviour of nurses both at work and in their personal lives carefully aligning expectations to relevant legislation and competencies. It is very helpful to have this level of consistency and alignment between various documents. The revised Code of Conduct continues to compliment the Professional Boundaries Guideline.

The inclusion of ‘Guidance’, where relevant, provides added guidance that is useful focusing where improved behaviour will have greatest impact on patient outcomes and the profession.

Overall the Code is set out well, has good readability the glossary provides clarity of terms used and the values provide all nurses with a common point of understanding.

(DHB DONs)

I base all of my comments in this document on my considerable experiences using the existing Code of Conduct. These experiences include several years teaching student nurses how to use and interpret the Code, and perhaps even more pertinently, as an expert witness for the Council/Tribunal in cases involving nurses' misconduct. I feel that I should emphasis that in both instances, the existing Code, although well meant and slightly improved over the years, was often vague and imprecise. In both cases, this vagueness and lack of adequate detail seemed to me to detract from the ethical importance and legal relevance of the Code.

Overall, I think that the revisions and additions to the Code are timely and a significant improvement on the existing Code of Conduct, and that the writer(s) of the new Code are to be commended. I offer my suggestions and additions in the hope that they will be of value to the final production of the new Code.

(Individual nurse)

1) Values

Question 1: Do you agree with (the use of) these values to underpin professional conduct or behaviour? (Trust, respect, partnership, integrity)

Most submitters supported the inclusion of the values.

The four core values are fundamental to the overall integrity of the profession and set the platform for public confidence.

(DHB DONs)

One member, herself a former matron of the ‘old school’, commented that when she was a young nurse, these values were intrinsic to the profession.

Other members were pleased to see these values were openly stated as integral to a nurse’s daily work.

(National Council of Women)
Two submitters raised questions about whether values should be in the Code of Conduct.

_This draft document is a significant improvement on the 2009 Code. However, a Code is about professional conduct and there is conflict here between conduct and values and or virtue ethics. It is our opinion that values should be embedded in a code of ethics which focuses in a person’s character. In saying that, the values listed are useful._

(VUW)

_Pg 4 – Prefer the use of principles or standards versus values and replace ethical with professional._

Remove 1st paragraph on trust – it blurs with the code of ethics i.e. doing no harm, beneficence. Council needs to consider the blurring of boundaries around conduct and behaviour verses ethics. These are two completely different concepts in terms of this document. We strongly recommend that wherever there is the word ethical that this be replaced with professional behaviour and that the word values be replaced with principles. It is really important that the Code of Ethics is not confused or undermined by this document.

(WDHB)

**Trust**

One submitter thought that the use of “trustworthiness” was more appropriate than “trust” and that integrity was not a separate value.

_The section on trust should be titled ‘trustworthiness’. As stated, it is health consumers who need to be able to trust, and nurses who need to be trustworthy._

_Trustworthiness and integrity are closely linked. Integrity (honesty, adherence to a moral or ethical code) would seem to be a part of trustworthiness, which, as described here, encompasses other concepts such as competence, beneficence and non-maleficence._

_The close relationship between trustworthiness and integrity may explain why the first sentence in the paragraph under the heading ‘Integrity’ repeats the idea already stated under ‘Trust’ that nurses need to deliver safe and competent care in order to be trustworthy._

(Age Concern)

Two submitters suggested the wording under trust was repetitious.

_I suggest there is a problem with using respect, trust and integrity as separate values because acting with integrity earns respect and trust from others and demonstrates respect for others._

(Individual Nurse)
In addition, it has been noted that while trust is an essential value, the establishment of ‘immediate’ trust as suggested in the Code is unrealistic for many working in mental health settings. The very nature of many psychiatric illnesses predisposes consumers to paranoia and very high levels of suspicion. Trust in many cases can take a long time to establish. NZNO recommend removal or modification of the term ‘immediate’.

(NZNO)

**Respect**

One submitter suggested adding engagement to the descriptor of respect.

*Under respect we would like to add engagement. Respect is not just about treating with respect it is treating and engaging with health consumers, families/whānau and colleagues respectfully.*

(VUW)

The HDC suggested rewording this descriptor of respect to align with The Code of Rights.

*I note that “treating” a consumer, family member or colleague with respect requires more than “valuing” that person’s worth, dignity and uniqueness. Respect is as much about a manner of behaving, as well as an attitude. As you are aware, Right 1(1) of the Code of Rights provides that “Every consumer has the right to be treated with respect”. I suggest you consider rewording the explanation of the value of “respect” as follows:*

“Treating consumers, families and colleagues with respect enables nursing relationships that support health consumers’ health and wellbeing. Treating someone with respect means behaving towards that person in a way that values their worth, dignity, and uniqueness. It is a fundamental requirement of professional nursing relationships and ethical conduct.”

(HDC)

**Partnership**

A number of submitters commented that it was not appropriate to include partnership as a value or to place the word “Māori” at the end of the partnership descriptor. Others stated that equity did not belong with this value but it could be included in the Code as another value.

*Equity is an important ethical value in its own right, and ‘equity of access’ is quite distinct from partnership. The sentence about equity tacked on the end of the paragraph describing partnership is out of place. Adding ‘including Māori’ to the end of the sentence makes it seem like a throwaway nod to the Treaty of Waitangi. If the intent is that nurses should work in partnership with Māori consumers and their whānau to achieve positive health outcomes, then this is what should be stated here.*

(Age Concern)

*We think that the value of equity should be added and those concepts related to equity should be removed from other values and placed here.*

(VUW)
The heading ‘Partnership’, I disagree with the statement: Nurses support equity of access for all including Māori. It is not necessary to refer to Māori in this context. It would be better to state: Nurses support equity for access for all. At this point in the document, the values are high level and it is not necessary to mention Māori at this stage. And it is not only equity of access that is vital to Māori it is equity of outcomes and this is very well addressed later in the document.

(Individual nurse)

Finally we suggest that you use the term ‘equity’ rather than ‘equality’ in the section regarding working with Māori patients. Whereas ‘equality’ denotes a description of ‘sameness,’ ‘equity’ denotes an ethical principle concerning the absence of systematic disparities between groups with different levels of underlying social advantage/disadvantage.

(NZMA)

HDC suggested rewording partnership in line with the Code of Rights.

I suggest you reword this sentence so it is consistent with the Code of Rights, for example:

“Partnership occurs when consumers are given sufficient information, in a manner they can understand, in order to make an informed choice about their care and treatment, and are fully involved in their care and treatment …”

(HDC)

A few submitters wanted to see the Council’s Strategic values in the Code or the inclusion of the Treaty of Waitangi or Treaty principles as values. One submitter wanted to see the values and principles in Te Reo.

Although as a principle of the Treaty partnership must be included in our Code it is misplaced being stated as a value.

(Individual nurse)

However, there is no mention of Te Tiriti o Waitangi, which underpins the principles of bicultural partnership, in either the values or the principles of the Code. We believe that explicit reference to Te Tiriti o Waitangi is necessary to encompass bicultural partnership more solidly throughout the document and to provide a benchmark for measuring outcomes.

(NZNO)

Five submitters each suggested adding new values: professionalism, privacy and confidentiality, advocacy, innovation and self determination.

Addressing the health needs of vulnerable people: Whilst Pg 8 (2.8) and Pg 14 (6.2) speak to the need for nurses to promote and protect the needs of vulnerable people, it is suggested that a section could be included within principle 2 that expresses the requirement of nurses to be advocates and promoters of social justice.

(CONA)
I agree with the stated values but suggest a fifth one, namely ‘professionalism’. This value, which is also noted in the NZNO Code of ethics, incorporates such elements as personal ethics, quality of work, an appropriate attitude, acceptance of responsibility and accountability, expertise, good communicating skills, sound judgment and an ability to maintain high standards.

(Individual nurse)

I definitely agree with the four core values however, I feel that privacy and confidentiality needs to be clearly highlighted in the core values such as trust and integrity even though it is also in the seven new principles.

(Individual nurse)

Yes, however, we would consider advocacy as an underlying professional value.

(NorthTec)

Other comments were made about the wording of the guidance box.

The first bullet point is expressed as a requirement, not as guidance. It doesn’t answer the question ‘How do I do this?’

On P.4, the only mention of privacy issues comes in the phrase ‘using personal information’ under the heading ‘Trust’. In bullet point two here, it is included as part of ‘Respect’. This muddles the points being made.

It would be good to include respect for culture and individuality in the second bullet point.

The third point is garbled. ‘The information and respecting their right to reach decisions’ should be replaced with ‘relevant information so that they are able to make decisions’.

The fourth point further muddles trust and integrity.

Risk (bullet point 4) is part of life, and cannot be prevented, only reduced and managed, whilst respecting the wishes of each individual.

(Age Concern)

The HDC also suggested some wording changes to the guidance box.

Guidance: Establishing relationships of trust with health consumers. The Guidance includes the following statement:

“Working in partnership includes listening to them and responding to their concerns and preferences and giving them the information and respecting their right to reach decisions about their care and treatment.”

I note that, while it is important to listen to and respect a consumer’s concerns and preferences, it may not always be practicable to respond favourably to a consumer’s preferences. There is a risk that the current wording could be read as imposing that obligation. Right 7(8) of the Code of Rights caveat the right of consumers to express a preference as to who will provide services and the right to have that preference met with the condition “where practicable”. I suggest you consider whether similar wording should be used in this guidance
statement in order to avoid creating a standard that may, at times, be unachievable. This comment also applies to standard 1.2 under Principle 1 “Respect the dignity and individuality of health consumers”.

I also note in regards to this guidance statement that the reference to “the information” is rather vague. Elsewhere in the document, reference is made to giving consumers the information they need or want. The guidance statement may be more useful if it provides greater detail here about what it means by “the information”, and I suggest consideration be given to wording that is consistent with Right 6 of the Code, being “the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive”.

I also suggest the guidance statement note that the information should be provided in a form and manner appropriate to the particular health consumer. The right to effective communication is an important aspect of the provider/consumer partnership and of the right of a consumer to be fully informed and give informed consent. The right to effective communication is currently not specifically reflected in this guidance statement.

Some submitters commented on the lack of alignment between the order of the principles and the values.

Align the order of the Principles to match the Guidance: Establishing relationships of trust with health consumers in the shaded box (p. 5) for example, respect, partnership, trust and integrity.

(CPIT)

Whilst there is agreement with the principles, reading these against the values is challenging. It would be preferred to have the principles directly aligned to the values in order for nurses to be able to articulate and fulfill the values that underpin their conduct.

(PHO)

2) Principles

Question 2: Do you agree with the principles that form the framework for the Code of Conduct?

Most submitters supported the new principles.

The moving from 4 principles to 7 principles provide a better, more comprehensive framework to work from and maintain our professionals standards.

(CDH B - CNS Group)

There was a real sense of the importance of thoroughly reinforcing these values and principles to get the message through loud and clear.

(National Council of Women)

Particularly like the “work with colleagues” which would include nurses in other organisations also providing care for consumer but maybe this needs to be specifically stated as ‘silos’ still exist.

(Individual nurse)
The rights of health consumers: re-focus on their rights and needs, aligns nicely with HDC code of rights. 

(Individual nurse)

One submitter suggested adding more principles.

I agree with the use of the seven new principles, but suggest the addition of another three, namely ‘being accountable’, ‘pursuing individual and social justice’, and ‘promoting health and well-being’.

(Individual nurse)

One submitter wanted to return to principles in the existing Code.

See comment above. These are not stated as principles – more like goals. I think the principles in the 2004 edition of the code are clearer and could be reworded and added to e.g.:

Compliance with legislative/statutory requirements:

Respect and advocacy for the rights of health consumers (this includes privacy, confidentiality, dignity, individuality – all the rights included in the Code so these would be better detailed in the standards or criteria of each principle rather than used as principles themselves).

Collegiality/Partnership (same comment as above – working with other health professionals as well as with health consumers and whanau would be appropriately detailed as standards/criteria under this principle).

(Individual nurse)

There were a number of comments on the wording of principle 2.

In point 2. ‘interests’ might be better replaced with ‘well-being’. 

(Age Concern)

Consider adding the word Rights in the Principles Statement of promoting and protecting consumer’s rights and interests.

(CMDHB)

Principle 2: sounds more of an ‘advocacy role’ as opposed to working in partnership.

(CPIT)

Other wording changes suggested were:

In principle 5, ‘serve’ and ‘interests’ might be better replaced with ‘meet’ and ‘needs’. The word ‘Interests’ has financial connotations and makes the therapeutic relationship sound like a commercial transaction when used with the word ‘consumers’. The language used here doesn’t capture the warmth and empathy that characterize successful therapeutic relationships between nurses and those in their care.

(Age Concern)

I would like to see a bit more emphasis placed on respecting colleagues and other members of the multidisciplinary team ( Civility). An expectation that nurses will have high standards of personal respect for others.

(Individual Nurse)
'Maintains health consumers’ privacy and confidentiality'.

(NorthTec)

Principle 7: to have an explicit link to professional boundaries to capture that the code also applies/links to non work conduct.

(CPIT)

A few submitters comments that the order could better align between the values and the principles.

I agree with all of these principles. However, I think the order of priority should be different. I feel that “Provide safe and competent care” needs to head the list at no 1, as to me, that is what the core of nursing is about.

(Individual nurse)

Council agrees with the stated principles; however Council recommends that practitioners and the public understand that the principles are equally important and are listed in no particular order, if indeed this is the case.

(Pharmacy Council)

Align the order of the Principles to match the Guidance: Establishing relationships of trust with health consumers in the shaded box (p. 5) for example, respect, partnership, trust and integrity.

(CPIT)

3) Rights of health consumers

Question 3: Do you agree with the focus on the rights and needs of the health consumer?

Many comments from submitters supported the focus on the rights and needs of the health consumer.

Links clearly to the HDC code which is what we are measured against during a complaint and investigation process. So it makes sense.

(Individual nurse)

Absolutely; indeed as a document that is supposed to stand up to examination in settings such as a tribunal or court of law etc, the emphasis on the Council’s main role in protecting the public’s interests should be emphasised in such a fashion.

(Individual nurse)

Agreed – need to be explicit in our expectations of health professionals in their delivery of health care that protects the rights and addresses the needs of the Health consumer.

(CCDHB & WDHB)
Absolutely - there remain areas of nursing that philosophically are not as patient centered as others. Ensuring all documents that relate to nursing care must be client centered. Failure to recognize and engage in meaningful relationships that facilitate and promote individual health could potentially result in issues of confidence about the nursing profession.

(Group of nurses)

The overarching opinion was that a benchmark is really necessary. And that they need to be enshrined, written down, in a Code of Conduct such as your Council is undertaking.

(National Council of Women)

Two submitters wanted support for consumer cultural beliefs included.

Respect health consumers’ this is a double up with Code of Ethics. We think there needs to be a principle here about respecting and upholding consumers’ cultural needs and beliefs (this will ensure link with Pg 7, 8 and 9).

(WDHB PDU)

One individual nurse thought the document emphasised the needs of the consumer at exclusion of others such as employers.

The document reads like a midwifery document where the focus is absolutely on the consumer and their preferences. In my experience working with midwives who are experiencing “difficulties” this can be to the exclusion of awareness of the rights of a number of other stakeholders.

The influence of the medical profession is also readily apparent in the references to colleagues and services rendered and failure to reference the employer and their role and expectations.

Suggest the words from HDC Code of Rights be mirrored where possible to reinforce the messages.

I agree that the proposed values and principles form the basis of the Code of Conduct.

The document would be strengthened by ensuring that there is at least one reference (preferably more) to the relationship with the employer, not just the health consumer and their colleagues. This could be covered off in a number of sections (especially Escalating Concerns) and could be as simple as saying they must follow employer’s Code of Conduct and policies/procedures.

(Individual nurse)
4) Cultural Safety

Question 4: Do you agree with the standard and guidance box on cultural safety?

Submitters were generally supportive of cultural safety within the Draft Code.

1.4 The point that it is the consumer who should decide what is culturally safe care for them is well-made here.

(Age Concern)

All guidance around understanding oneself and the impact this has on the care delivered to individuals and their families is critical to the individuals overall experience. The more understanding the nursing profession has around the effects of ethnocentrism the more attuned we will become to individual consumer needs and ultimately leading to a better health experience

(Te Ao Māramatanga/NZCMHN)

I liked that you included Pacific Island people in the cultural safety part.

(Individual nurse)

There were some comments on the wording within the guidance box.

Guidance cultural safety:
Not sure what is meant by “the culture of nursing and endeavouring to protect within this culture”?

Dot point 4 repeats point 3 in intent and is superfluous.

The last dot point I suggest could read ‘Avoid imposing your own beliefs on others and intervene if you see other health professionals doing this’.

I think this would be clearer as most often this is about people with particular religious affiliations wanting to “save” their consumers.

(Enliven PSC)

Guidance: cultural safety:
This guidance provides, among other things, that nurses must “avoid imposing prejudice on others and provide advocacy when prejudice is apparent”. To “provide advocacy” is a rather broad obligation which may be difficult to apply. Standard 2.7 also requires nurses to “advocate for” consumers. I suggest the Code of Conduct provide some guidance as to what is expected from a nurse when a nurse is required to “provide advocacy” or “advocate for” consumers.

(HDC)

Add ‘first language’ after ‘culture’ in the third bullet point.

(Age Concern)
Bullet 6; ‘Reflect on your own practice and values that impact on nursing care in relation to the health consumer’s age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability’.

Could be re-worded, to better describe the aim e.g. is ‘reflect’ the correct word? May be ‘review and address’ would be better? This would indicate an action rather than just reflection.

(Individual nurse)

The wording of the last two bullet points in CULTURAL SAFETY is too ambiguous, i.e. ‘reflect on your own practice and values that impact on nursing care in relation to the health consumer’s age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability’.

(CCDHB & WDHB)

Suggest that an explicit link is made to the Guidelines for Cultural Safety, Treaty of Waitangi and Māori health in the Guidance: Cultural Safety shaded box (p. 7).

(CPIT)

We suggest the importance of whanau involvement is added to the guidance box.

(SCDHB)

Two submitters suggested the Council include the definition of cultural safety or Kawa Whakaruruhau.

I think it would be useful to have the following definition in this document. If not this then a reference or link to Council’s Guideline document.

Council’s definition of cultural safety is: The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

(Individual nurse)

Kawa Whakaruruhau should be a key component of this section.

(Individual nurse)

One submitter thought the guidance on cultural safety was not needed and it was better to integrate throughout the document.

Does cultural safety need to be separate or should we be moving towards integration throughout the document.

(Individual nurse)

Two non nurse submitters raised the term cultural competence. One submitter suggested a link to the Treaty of Waitangi be made here. Several submitters suggested a link be made to the Nursing Council Guidelines on Cultural Safety, the Treaty of Waitangi, and Māori health (2011) in Nursing Education and Practice.
One person thought the guidance box should be standards rather than guidance.

The statements in the guidance box are standards related to culturally safe care and should be listed as standards rather than put in a guidance box as if they are an “optional extra” rather than a component of safe care for any health consumer.

(Individual nurse)

The Pharmacy Council suggest the wording should be more action orientated.

Council understands cultural safety to be action-oriented, and should take the practitioner beyond cultural awareness and the acknowledgement of differences. Cultural safety should also help practitioners understand the limitations of cultural competence. Since the Nursing Council has historically been an advocate of cultural safety, the Pharmacy Council believes these points should be made more strongly in the guidance.

(Pharmacy Council)

5) Working with Māori

Question 5: Do you agree with the standard (2.9) and guidance box on working in partnership with Māori to improve health outcomes?

Most submitters were supportive of this approach.

Clear and explicit around reducing Māori health disparities and improving health outcomes. Compliance with the Treaty left too much room for interpretation.

(DHB DONs)

Happy with this section. Agree with change from compliance to work in partnership.

(CMDHB)

Four submitters did not agree with the omission of the Treaty of Waitangi from the Draft Code.

There is no reference to the Treaty of Waitangi, a reference to this and the basic principles of partnership, participation and protection in the guidance box on page 9 could be inserted.

(Individual nurse)

My opinion, compliance with the Treaty should continue to be emphasized.

(Individual nurse)

We believe that this standard should continue to have reference to the Treaty of Waitangi as a core foundation to Māori health outcomes and a founding document for Māori/Crown relationships.

(BOPDHB)
Moving away from ‘the Treaty’ to working in partnership to improve health outcomes of our indigenous people is the removal of an important part of the bicultural themes of the country. Not to mention the founding document of this country is not acceptable.

(CCDHB & WDHB)

Some commented on guidance points.

Is it the intent that each practitioner incorporates Māori models of health into their practice?? Last 2 dot points is it equity rather than equality??

(Enliven PSC)

Guidance: Working with Māori to improve health outcomes:
This guidance requires nurses to “incorporate models of Māori health”, “facilitate equality of access and opportunities for Māori and non-Māori” and “pursue equality in health outcomes”. It is difficult to give effective meaning to these broadly expressed requirements when considering an individual nurse’s obligations, and I suspect that maintaining these ideals may often be outside the control of an individual nurse. I suggest Council give thought to expressing these requirements in a way that is perhaps more relevant to individual nursing practice.

(HDC)

The fifth bullet point is problematic. Where health status is unequal for different population groups, working towards equality in health outcomes is likely to require different levels or types of access and opportunity for different groups.

(Age Concern)

My suggestions for some wording changes are: Integrate models of Māori health into everyday practice as an alternative to “Incorporate models of Māori Health”. I would also ask you to consider: Understand Māori health inequalities and pay particular attention to those relating to the area you nurse in. Actively work with colleagues and Māori health consumers towards improving Māori health outcomes instead of “pursue equality in health outcomes”

(Individual nurse)

I support your comment that Māori are a diverse population and a foundational understanding of Māori identity, beliefs, values and practices including the use of Te Reo Māori is required in order to safely practice within Aotearoa/NZ. In addition to this is knowledge of Māori networks to facilitate equality of access and opportunities for Māori and non-Māori alike.

(Individual nurse)

We think that it is important to include a statement recognising that within the Māori population there is also diversity.

(VUW)

Suggest that the following is added to the shaded Guidance: working with Māori to improve health care. Contact the identified organisational Māori health support person.

(CPIT)
6) **Vulnerable groups**

**Question 6:** Do you agree with the standards (2.8 and 6.2) on advocating for and protecting vulnerable groups?

Several submitters made comments agreeing with this question.

> This aspect is a vital part of our work and training and should remain paramount and this standard clearly highlights this.  
> (CCDHB & WDHB)

Some questioned whether both standards 2.8 and 6.2 were necessary.

> 6.2 provides one list of vulnerable people however is not exclusive – question as to whether this statement should be examples such as but not limited to? This could be consolidated into 2.8 rather than repeated in 6.2.  
> (BOPDHB)

Some suggested wording changes.

> Change 6.2 to read “protect all people from exploitation and harm”. My rationale for this is that it is not uncommon for people receiving health care to be out of their area of comfort which could be argued implies vulnerability and a power imbalance in the relationship.  
> (Individual nurse)

> 6.2 ? the use of the word protect - we can only protect within our interactions and referral processes etc.  
> (Individual nurse)

> Standard 2.8 should not be about protection its focus must be about advocacy. Protection is a paternalistic view and the preferred focus is about being there for the person. We also ask you to reconsider using the word vulnerable and rewording standard 6.2 to ‘Advocate for people or groups in need of advocacy e.g. children, those with disability, the homeless, frail older people.’  
> (VUW)

> Standard 2.8: insert professional i.e. use your expertise and professional influence…  
> (CPIT))

The word influence in the statement “The Code requires nurses to use their expertise and influence to protect the health and wellbeing of vulnerable health consumers, communities and population groups (2.8, 6.2)” may need further explaining or fleshing out. Words such as ‘influence’ and the context in which it has been used could be misinterpreted.  
> (DHB DONs)
Our vulnerable groups are those most at risk of exploitation or of receiving less than optimal care and treatment. The word ‘influence’ in the statement “The Code requires nurses to use their expertise and influence to protect the health and wellbeing of vulnerable health consumers, communities and population groups (2.8, 6.2).” may need further explaining or fleshing out. Words such as influence and the context it has been used in may be misinterpreted.

(Te Ao Māramatanga/NZCMHN)

One submitter made the point that all health consumers are vulnerable.

I do agree, however surely as RNs and ENs, any patient by virtue of their needs can become vulnerable within the health system. So it is about patient advocacy and, as nurses, we are but part of the whole team that need to be mindful of this.

(Individual nurse)

Others suggested adding groups or defining vulnerable groups e.g. children, lower socioeconomic, English as a second language.

Add after vulnerable people “inclusive but not limited to”.

(CMDHB)

Identifying a population group by nationality is contentious and could be infinite. Somalia people would be equally eligible. Would it be easier to say people not originating from New Zealand or where English/Te Reo/Sign is their second language. In terms of health determinants and outcomes may be useful to recognise people from low socio-economic circumstances.

(WDHB PDU)

7) Conflicts of interest

Question 7: Do you agree with the standards (3.11, 6.4, 6.6, 7.3, 7.5, 7.8, and 7.9) in the Code on conflicts of interest?

Many submitters agreed with the standards.

Agree. Potential for conflicts of interest are becoming more common in our society with increased diversification of roles and professions. New Zealand is a small country, which increases the chances for such conflict.

(DHB DONs)

Think the inclusion of this within the standards is hugely important. It has not been well understood by some, and having it articulated clearly and threaded through the whole document will be hugely helpful for the whole profession.

(Individual nurse)

…and about time too (I feel like saying!). The previous Code was rather obscure about such matters and this really revealed itself as an issue during Tribunal hearings and the like because the existing Code was rather vague about such matters.

(Individual nurse)
A few suggested “clarify health products” and some thought the standards were repetitions and could be put in a guidance box.

There is repetition in these standards – could they be refined or collated to one standard statement?

(BOPDHB)

I agree that the information should be included but none of these is a “standard” and all would be better included in a guidance box on conflicts of interest – which could also include the research currently in 6.10.

(Individual nurse)

One submitter raised the issue of conflict of interest in relation to cultural practice.

Yes, I agree that conflicts of interest can arise and I note that the major concern seems to be specific to professional position to promote their own or others commercial or personal interests. Yes, I support this however I am also mindful of cultural practices of whakawhanaungatanga, manaakitanga, koha, whai korero whereby one makes connections, welcome manuhiri/guests, offer putea/money, food, time and knowledge to make connections/promote personal interests in a way. Therefore some clear examples of conflicts of interest vs. cultural practices need to be spelt out further.

(Individual nurse)

Standard 6.4 ‘decline gifts’ this wording should be changed to reflect the reality of practice. This could include the nurse accepting gifts transparently for public use. Standard 7.3 should be removed because as nurses we are focused on the health and wellbeing of a community and society. The definition of health is too narrow. What is the rationale for this standard? Standard 7.9 if a nurse is an independent practitioner they have the right to promote their service. Consider rephrasing ‘do not use’ to ‘do not misuse’. This standard is also reflected in principle 3. We recommend the Council develop a guideline for complementary or alternative therapies like the United Kingdom Nursing and Midwifery Council which states “You must ensure that the use of complementary or alternative therapies is safe and in the best interests of those in your care”. Standard 23 of the Standards for medicines management states: “Registrants must have successfully undertaken training and be competent to practise the administration of complementary and alternative therapies.”

(VUW)

One submitter commented specifically on gifts.

That said, we are ‘conflicted’ over gifts. Some of us say nurses must always refuse gifts or favours, but another group felt if patients and their families want to say a special ‘thank you’ with a gift, then maybe there needs to be some policy, perhaps involving checking its appropriateness with senior staff or the Council itself, and that would allay concerns.

(National Council of Women)
One submitter suggested changes to the wording.

_Suggest adding ....‘and is not influenced by your own or those known to you interests’. To make it explicit to nurses who may be influenced by those with whom they have a close affiliation for example, family and friends._

(CPIT)

8) Social media

Question 8: Do you agree with standard (4.1) and guidance on social media?

Submitters were generally very supportive of inclusion of this guidance.

_This is a necessary development in an age of rapid changes in social communication._

(Individual nurse)

_It’s really good to have some guidance for nurses regarding social media. Some nurses do not see the link with colleagues and health consumers engaging in a social media relationship as potentially inappropriate or breaching privacy._

(Individual nurse)

Some submitters thought 4.1 should include public spaces not just social media.

_Yes, but the focus on social media may obscure the fact that simply gossiping face to face, even with colleagues, is a significant risk to patient confidentiality._

(Age Concern)

_We feel that standard is not strong enough on general disclosure in other public spaces. For example ‘maintain health 7 consumers’ confidentiality and do not discuss practice issues or colleagues in any public space or on social networking sites e.g. Facebook’_

(VUW)

Some submitters suggested wording changes to the guidance on social media.

_In the Guidance box: social media bullet point 2: ‘In general avoid social networking relationships with current or former patients’. Concern over the use of ‘general’._

(DHB DONs)

_Dot point 2 in guidance is too vague i.e. (in general avoid social networking relationships with current or former patients). There needs to be much stronger wording._

(WDHB)
The opposite view expressed by an individual submitter.

In general the guidance is a good outline however the statement on avoiding social networking with former patients needs to be carefully detailed in the further advice that is being developed, because social networking has become a social norm it is unrealistic to expect that nurses will not network with former patients or family members of former patients. Instances where social networking has occurred between a nurse and someone who becomes a patient at some future time are likely to become increasingly common. The guidance rather than inferring a prohibition needs to be clear that nurses in this situation must be careful and maintain a professional relationship with people with whom they have previously networked and where this is not possible seek advice and if appropriate refer care to another colleague. Good criteria need to be developed to guide nurses on maintaining safe boundaries in social networking particularly with former patients and their families.

(Individual)

One submitter questioned the advice regarding uploading photos of colleagues to social media.

Bullet 3 difficult to maintain – example– photograph uploaded on your secure internet site– cannot be responsible for others sites.

(Individual nurse)

The advice on texting was questioned.

Bullet 6 Texting often used for appointment reminder etc - difficult to keep track.

(Individual nurse)

Principle 4: Respect health consumer’s privacy and confidentiality under the guidance social media, this could be more specific as regards texting, and the use of a private phone and phone for the purpose of messaging clients, making appointments and so on. As texting is a convenient and inexpensive way of communication. Also protecting resources and environment.

(Student nurses)
The Medical Council suggested the aligning the advice with the appropriate Standards throughout the document and not detracting from the standards for all conduct.

We suggest that the standards that relate to the use of social media might be better addressed in other parts of the document. For example, the statement that nurses should avoid social networking relationships (such as those on Facebook) might better sit under the heading “Professional boundaries”. Similarly, the advice not to upload photos of patients might better be incorporated into the advice on “Respect health consumers’ privacy and confidentiality”. While it may be useful to draw nurses’ attention to risks in the use of social media, there is a danger that establishing separate standards on this subject might lead to an assumption that online relationships are subject to different rules to those in real life. In our view, information disclosed online should be subject to the same rules as information disclosed in other settings, and there does not appear to be any real ethical difference between uploading a photo of a patient onto a social networking site, and showing your friends that photo on your cell-phone.  

(Medical Council of New Zealand)

One submitter raised the issue of organisational networks, not just social ones.

Some DHBs/EDs have facebook sites: should there be a point in this part about organisational networks as well as personal ones?  

(College of Emergency Nurses New Zealand - NZNO)

Other submitters suggested some changes to 4.5.

Standard 4.5 refers to only accessing records for the purpose of providing care, where does access to records for research purposes fit within this standard?

(CDHB - CNS Group)

Just a suggestion for a slight wording change to 4.5. I would take out “not removed except” and put “only accessed” instead. This reflects that more and more health records are now in an electronic format and before too much longer there won’t be anything to physically remove.

(Individual nurse)

Submitters wanted more advice and suggested more areas be included e.g. email, work computers, use of smart phones and cameras in the workplace.

Members have also suggested that principle 4 needs to provide guidance on the misuse of computers in the workplace, for example non-work related use, personal emails, pornography, child exploitation.  

(NZNO)

Could also make mention of the judicious use of smartphones/cameras etc to record events in the workplace – impacts on breach of privacy/confidentiality for staff and consumer. This is an area of concern in the electronic era.  

(Neonatal Nurses College of Aotearoa – NZNO)
9) Escalating concerns

Question 9: Do you agree with the standards (1.10, 5.9, 7.6 & 7.7) and guidance on advocating for health consumers at risk of harm and escalating concerns?

Submitter’s comments were generally supportive of this advice.

Historically nurses are loathe to report colleagues for unbecoming behaviour/practise, but we agree with the standards to support nurses to act appropriately.

(Neonatal Nurses College of Aotearoa – NZNO)

We feel that the above standards and guidance send a clear message that health consumer well-being takes precedence over other loyalties.

(Age Concern)

This drew a resounding yes from our members. They say the patient/health consumer’s needs must come first and be paramount over loyalty to one’s colleagues.

(National Council of Women)

One submitter disagreed.

Open to abuse, e.g. vindictive behaviour from one nurse to another due to e.g. jealousy, poor understanding of the situation or role, Authoritarian attitude.

(Individual nurse)

Some suggested wording changes were that all health colleagues should put concerns in writing, emphasise correct channels in the workplace and document in the notes.

Point 1.10 could be made more explicit regarding documenting the incident. For example: “Explain fully and promptly to the health consumer and family affected, what has happened and the likely effects, and document this in the health consumer’s notes”.

(NZNO)

The guidance box states “clinical environment” this should be replaced with practice setting to cover all areas of nursing practice.

(Individual nurse)

Suggest it commences with ‘Formally report to your employer’...

(CPIT)

Guidance: Escalating concerns shaded box (p.18) should read …‘that could endanger others to encompass all personal within the health care setting i.e. family, visitors, staff…’

(CPIT)

NZNO emphasise culture of open disclosure: There is also a need to articulate the culture of open disclosure that is becoming embedded in many health workplaces, and that nurses should participate in investigations and quality improvement strategies.

(NZNO)
Guidance - Escalating concerns - we suggest the first step is to raise the issue with the other party, this is consistent with 5.1 and 5.3.  
(Waipuna Hospice)

Guidance escalating concerns:

3 rather than internally say within your employing organisation.

Last dot point add at the beginning Only and use the term employer as people make all kinds of attempts at issues with colleagues but never let their manager know until there is a crisis or sometimes go straight to an external organization without speaking with their employer.  
(Enliven PSC)

10) Teamwork

Question 10: Do you agree with the standards (5.1-5.10 and 3.5 and 3.6) on how nurses should work with colleagues?

Many submitters were supportive of this section.

Team work is vital to ensure patients’ care is not compromised and critical reflection is a vital part of practice also respect of colleagues knowledge and practice.  
(CCDHB & WDHB)

I think this is very important and worded well. For some teams, collegiality or lack there of has the potential to directly impact on patient safety.  
(Individual nurse)

In the rapidly evolving healthcare environment, the Pharmacy Council believes effective teamwork and communication amongst healthcare professionals is critical to improving health outcomes for all health consumers.

The Council noted that the revised Code of Conduct has a strong focus on collegiality and teamwork, and we support that in recent years the health sector has shifted towards service provision from a team environment, and it is important that standards for health practitioners reflect this and ensure the co-operation necessary for the quality and continuity of health care delivery. This subject is also a major focus of our ‘Good medical practice’.  
(Medical Council of New Zealand)

There is also little about working with other health professionals. Refer to the NZMA Code of Ethics, paragraph 32.

When working in a team environment, doctors have a responsibility to behave co-operatively and respectfully towards team members.  
(NZMA)
Some suggested wording changes.

5.5 I believe this statement should be changed to: Do not make malicious or unfounded criticisms of colleagues or employers that may undermine health consumer’s trust in their care.

(Individual nurse)

I would like to see a bit more emphasis placed on respecting colleagues and other members of the multidisciplinary team (civility). An expectation that nurses will have high standards of personal respect for others.

(Individual nurse)

Page 13
…? Include standard – recognise that others have the right to hold views that may differ from our own – respect.

5.8 report findings and ask assistance.
5.9 at the earliest opportunity (after appropriate person).
5.10 only comment related to ethics.

(Individual nurse)

5.7 Those who are new? new to what. Suggest maybe beginner practitioner here instead of new.

(Individual nurse)

3.5 would be more supportive of collegiality if it were added to 3.4 instead of implying that advice and assistance needs to be sought only if care is compromised by lack of knowledge and skill.

It also uses “client” instead of health consumer.

5.1 to 5.6 – the content may be acceptable but the wording is poor. These are not stated as standards but as instructions, (dos and don’ts)! Perhaps a guidance box on teamwork is a more appropriate place for this sort of information.

(Individual nurse)

Some submitters wanted guidelines on direction and delegation referenced in this section.

11) Professional boundaries

Question 11: Do you agree with the standards (6.11 and 6.12) and the guidance on professional boundaries in the new draft Code?

Some submitters were supportive of the standards and guidance.

Absolutely and about time. Always amazed that it was not clearly articulated before.

(Individual nurse)

Extremely important to have this clarified as it does seem to be a “grey” area that some nurses appear to have difficulty with, especially with regard to partners of health consumers.

(EIT)
The use of the words “do not” in 6.12 is clear and definitive.  

(SCDHB)

Other submitters thought the advice was not clear and/or inadequate.

We believe more work is needed here: for sexual relationships it says “do not” in the standard and “in most circumstances” in the guidance: the statements conflict with each other. Also, in some cases the nature of the professional relationship is not such that it would be a breach of conduct principles (notably thinking of brief encounters such as in a minor injury situation where the nurse-consumer encounter has been less than 10 minutes and no approach of any kind has been made during that time - what if they subsequently meet up months later as a matter of chance? (which is not altogether unlikely in the small communities of Aotearoa).

(College of Emergency Nurses New Zealand - NZNO)

Rural nurses in particular are often challenged by this as they may be the only nurses for the area without the option of the client being reassigned to another health professional.

(New Zealand Institute of Rural Health)

6.10 The meaning of “recognized boundaries” is open to interpretation and needs to be clarified.

(SDHB)

There is still a grey area with regard to relationships after the care episode has ended. This is especially relevant for nurses in rural settings. Yes, we treat patients when they are at their most vulnerable state and this professional boundary should never be crossed as outcomes can be compromised and standards breached.

(CCDHB & WDHB)

The word ‘appropriate’ is inadequate. The guidance will need to understand the differences that nurses working in smaller and rural communities face compared to their city colleagues and also will need to encompass the choice Māori (and other cultures) make that their preference is to be cared for by their own.

(Southern Regional Council NZNO)

More guidance was requested by some submitters.

I recommend the addition of a great deal more about professional boundaries in the new Code, even though it has a useful reference to the NCNZ’s Draft Guidelines within it. This is because it is very clear to me that some nurses are vague and unsure about this topic, and both they and large numbers of nursing students are confused about exactly which specific situations these boundaries cover in practice settings. I therefore strongly suggest that the statements on pages 10-11 of the 2009 Code of Conduct [Conduct in question] be reviewed and re-inserted into the new Code (as an appendix at least?).

(Individual nurse)
There is still a grey area with regard to relationships after the care episode has ended. This is especially relevant for nurses in rural settings. (DHB DONs)

Sexual boundaries need to be carefully and explicitly addressed both under the guidance and in more detail within the further document “Professional Boundaries”. In keeping with similar documents from the Medical Council of NZ the Code needs to have reference to the criteria by which nurses, consumers and others can evaluate situations where a sexual boundary has been crossed. This is important because as stated in previous documents the Code cannot specify all circumstances of crossing sexual boundaries or when the crossing of that boundary may become professional misconduct.

Criteria to evaluate sexual boundaries have been outlined in MCNZ publications and these could be considered and adapted within the Code or guidance on boundaries.

Examples of criteria from the MCNZ includes:

11. A former nurse-consumer professional relationship:
   The relationship was minor, short or temporary.

   The nature (type) of therapeutic relationship:
   There is evidence that the power imbalance, knowledge or influence was used for initiating or maintaining that relationship.

2. Relationship with family members of a former professional nurse consumer relationship:
   That power imbalance, knowledge or influence has not been used in initiating or maintaining the relationship.

(Reference: Sexual boundaries in the doctor patient relationship MCNZ)

6.12 could be reworded to state:
You should not engage in sexual behaviour or relationships with health consumers in (under) your care or those close to them while a health consumer is under your care.

(Individual)

I would like to see something regarding social media in relation to boundary transgressions. The increasing use of Facebook and other social media sites creates a whole new area for exposure and vulnerability. Nurse should not "befriend" patients in this forum or use "chat rooms" to discuss any information in relation to their workplace, even with a colleague.

(Individual nurse)

Suggestions were made about the wording of the guidance box.

Guidance section is clear and explicit but does it need to add something about property as well as sex!

(Enliven PSC)

Dot point 2 in guidance box is too open i.e. “in most circumstances”. Needs to be wording that reinforces a clear boundary.

(WDHB)
Insert in second bullet point in the guidance section page 15 “sexual relationships between nurses and persons and their partners …”  

(Individual nurse)

Both of the following comments relate more specifically to the draft Guideline: professional boundaries.

I am also somewhat concerned re reporting re individual perceptions of inappropriate therapeutic touch. Some nurses are averse to touch as are some patients. Those averse to touch may feel more inclined to report actions of those nurses who use touch to build a therapeutic relationship and may feel threatened that their actions may be reported. Nursing has become a very task oriented profession and those of us trying to bring back “heart centred practice” as coined by Dr Jean Watson may feel reticent about pursuing this.  

(Individual nurse)

Pg 5 Boundaries doc. Suggest rewording of the example of nurse taking consumer for a coffee as part of care plan. Suggested change for new Professional Boundaries guidelines document would be taking a health consumer out for a hot drink or meal in a local cafe or restaurant may assist the health consumer to develop their goals to improve their social skills and confidence in a public place.  

(Te Ao Māramatanga/NZCMHN)

12. Alcohol and drugs

**Question 12: Do you agree with the standard (6.7) that nurses should not compromise their care with the use of alcohol and drugs?**

Most submitters agreed with the standard.

*Again fully support. The new wording allows for a broader interpretation, which will not be based on attempting to prove that a nurse has a substance problem.*  

(Individual nurse)

*Yes, regrettably the increasing misuse of alcohol and various drugs is a factor within all of the health related professions.*  

(Individual nurse)

However a number wanted the statement modified by changing the statement to “misuse”.

*We suggest re-wording to say “mis-use” rather than “use” of alcohol and drugs- given that nurses have the same alcohol mis-use profile as the general population this standard needs expanding. Further, ‘drugs’ is a little loose - many nurses are on innocuous prescribed medication!*  

(College of Emergency Nurses NZ - NZNO)

*Possibly should read misuse of alcohol and drugs including misuse of prescription medication.*  

(Individual nurse)
Agree in principle but some ambiguity around “drugs” - should this be defined as illegal drugs or does this include prescribed medication. Guidance should also be provided given a nurses performance can be impaired by taking prescribed and un-prescribed medications as well as illegal drugs. 

(Te Ao Māramatanga/NZCMHN)

“By alcohol, recreational drugs and medication” - with our ageing workforce many nurses take medications, some of which may have impact on their practice/practice type/settings for instance using machinery, driving, immunity, effects on blood sugar and blood pressure.

(Individual nurse)

Perhaps a comment around “the use of alcohol should be limited to avoid any impairment to nurses” critical judgment and decision making. The use of illicit drugs in a crime under other statute and nurses need to be reminded of this. To use drug and alcohol in the say terms undermines the legislation around illicit drugs. Continuing on drugs nurses need to be alert where self administered or prescribed medicines may equally impede judgment and their responsibilities and accountabilities around patient safety.

(WDHB)

Many submitters commented that the wording in this standard should change from “should” to “must”.

Pg 14 Principle 6, point 6.7 states “your practice should not be compromised by the use of alcohol or drugs” this could be firmer. This represents a minimum standard being set; therefore change the word ‘should’ to ‘must’.

(DHB DONs)

Your practice must (rather than should)... much stronger wording and a clearer statement is required.

(CPIT)

Pg 14 Principle 6, point 6.7 states “Your practice should not be compromised by the use of alcohol or drugs” again this is too ambiguous, this represents a minimum standard being set by Nursing Council, therefore change the word ‘should’ to MUST.

(CCDHB & WDHB)

We feel this needs to be stronger and suggest the following amendments to standard 6.7 “do not practice at any time when your practice could be compromised by the use of alcohol or recreational drugs”.

(VUW)

Not sure that this statement will engender the expected response. Agree that alcohol / drugs influence the ability of the nurse but think the statement needs to be more assertive. “Your practice should not be compromised by the effects of alcohol or drugs in the short, medium or long term”.

(PHO)
13. **Public confidence**

**Question 13: Do you agree with the diagram and guidance box on fitness to practice and public confidence?**

There was a range of responses to this question.

Some saw the diagram and guidance box as useful.

*Useful diagram. The section gives good explanation in regard to behaviour that may impact on public trust and confidence in the profession.*

*(Individual nurse)*

Others did not understand the diagram and thought it should be removed.

*The Guidance box material is perhaps adequate, but the diagram (Figure 1?) is hopeless surely? Two circles and a couple of statements do not a good diagram make…*

*(Individual)*

*I had some trouble with the diagram after Principle 7 as I was not clear if that relates just to that principle or more widely to professional practice. Given the NCNZ role in the management of fitness to practice and misconduct I feel that some more context is required for that part of the document as it can be read as the guidelines for notification to Council. There is a relationship but I don’t think they are the same thing exactly.*

*(Individual nurse)*

A few submitters thought that nurses had a right to a private life and did not think this was any of the Council’s business.

*Discussed and generally agreed with. However there was some discussion around professional and personal boundaries. It was agreed that the examples given (making racist jokes, prostitution) would diminish public confidence in nurses but while no one supported public drunkenness, there were concerns about the right of the nurse to a private life etc.*

*(Individual nurse)*

*The Nursing Council’s use of the word ‘inappropriate’ is reflective of their goal to have unrealistic powers over a nurse’s personal life. I doubt reasonable members of the New Zealand public of 2012 would expect that nurses should come under such scrutiny in their personal lives as the Nursing Council would like to see happen.*

*(Southern Regional Council NZNO)*

There was a suggestion to expand and improve the sections.

*The guidance should be included but needs expansion to make this more explicit. The diagram adds nothing so could be deleted. What is required are examples of where personal issues become professional issues and the list of questions in the section above re alcohol and other drugs provides some of situations which could be used. The use of prohibitive statements should be avoided and the emphasis should be on promoting healthy and safe behaviour.*

*(Individual nurse)*
Other comments on this section were.

Agree in principle, but suggest the word prostitution be removed. Suggest wording ‘public drunkenness’ change to acting disorderly whilst under the influence of alcohol or drugs in a public place.

(Te Ao Māramatanga/NZCMHN)

The guidance boxes are clear however some members found the diagram less clear and commented that the ‘grey’ area is not named or given a title to explain what it signifies. NZNO also recommends changing bullet point 1 in the Fitness to Practice guidance box from ‘If you undertake unlawful or unethical actions in your personal life this may reflect adversely…’ to ‘If you undertake unlawful or unethical actions in your personal life this will reflect adversely…’.

In addition, NZNO notes that prostitution is not a behaviour as the guidance states; rather it is a form of employment covered by legislation. NZNO recommends another example be used or the wording modified.

(NZNO)

What is unethical behaviour? By whose standards? Unlawful behaviour being sited is fine, however “public drunkenness” is a sweeping statement that could then lead to a disciplinary process due to public confidence issue is not seen as supported.

(Individual nurse)

The definition of fitness to practice is narrow; it places undue emphasis on behaviour (behaving appropriately) both within and outside the professional role and omits other important parameters. Other references, such as the MCNZ define fitness to practice much more broadly and should consider including aspects such as the ability to demonstrate the level of skill and knowledge required for safe practice acts of commission and omission that may impact adversely on patient safety (The domains of clinical competence: skills, knowledge and abilities etc.).

This definition requires review to ensure that standards of behaviour are not the only parameter that is important.

I would like to comment in more detail on the boundaries document if there is a planned consultation.

In the introduction the following statement is made:

“Nurses are expected to uphold exemplary standards of conduct while undertaking their professional role. Because nurses must have the trust of the public to undertake their professional role they must have a high standard of behaviour in their personal lives.”

The first sentence is agreed however the second sentence infers an unrealistic standard in the modern society context and crosses the boundary between a professional role and a nurse’s personal life. It may be better to state that “nurses need to be aware of conduct in their personal life which may have an impact on their professional role”. This provides the message that in
some situations conduct in their personal lives may impact on their professional role (and therefore the trust of the public) and nurses should be aware of this. While a high standard of conduct in personal life is desirable insisting that nurses MUST have a high standard of behaviour in their personal lives as part of a professional code does not appear appropriate and should not dictate how nurses chose to conduct their personal life.  

(Individual nurse)

14. Other comments

Question 14: Please comment on any other standards or guidance with the Code.

Format and wording

Principle 5 colleagues and employers please in the heading and wherever colleagues are mentioned!  

(Enliven PSC)

It is a really long document which may detract from nurses using it.  

(CCDHB & WDHB)

The formats of other Council documents could be used (standards and criteria or standards and indicators) but if the use of principles and standards is persisted with then the wording needs to be adjusted so that is how it reads.

The introduction states that the Code is intended for multiple audiences and that “mandatory language is not used” but the draft is largely written in the second person, often with prohibitive statements in mandatory language, clearly directed at nurses.

Prohibitive statements could be reworded and most could be reworded positively and as standards e.g. 4.5 Records are stored securely and removed only as required for the purpose of providing care.

4.6 Health consumers’ personal and health information is accessed and disclosed only as necessary for providing care.  

(Individual nurse)

Suggest that the introduction does not clearly identify the intention of the Code. The introductory statement at the beginning of this consultation template is far more succinct and to the point.  

(PHO)

Glossary- include Māori terms.  

(MCDHB)

Pg.4: Values underpinning professional conduct/partnership. Suggest the inclusion of a statement which acknowledges the principles of Te Tiriti o Waitangi as underpinning this Code of Conduct.  

(CONA)
NZNO notes there is some overlap with other documents including the Competencies for Scopes of Practice and the Professional Boundaries guidelines released in draft format last year. While acknowledging the Code of Conduct is likely to be an overarching document that the other documents will sit under, this is not clearly outlined in the Code and NZNO recommends that a statement to this effect is included. If this is not the case then a diagram and/or explanation of how the Code sits alongside the Competencies for scopes of practice, professional boundaries guidelines etc would be helpful.

NZNO recommend that you add the terms ‘whānau’ and ‘tūroro’ to the glossary for the benefit of non-Māori speakers and those new to Aotearoa New Zealand.

(NZNO)

Suggest that throughout document add “and family/whanau” wherever health consumer is mentioned especially as we are working towards patient and family centred care.

(CMDHB)

Generally it is well worded and inclusive. Language throughout the document should be the same – mainly health consumer 3.5 client, 4.1 patient.

(Individual nurse)

It would be helpful to have a preamble to each principle (in much the same way as for these consultation questions) to provide context.

(College of Emergency Nurses New Zealand – NZNO)

Definition of terms
The term “health consumer” is used throughout the document and, as indicated by the definition section, “is intended to represent terms such as patient, client, resident or turoro”. In my view, use of the term “health consumer” does not adequately reflect that many registered nurses are also providing services within the disability sector, where such consumers are more appropriately referred to as “disability services consumers”. I suggest you consider using an alternative term such as “consumer” to describe all consumers to whom nurses will be providing services in accordance with the Code of Conduct.

(HDC)

I think that the inclusion of statements beginning with ‘Do not’ does not fit in a Code of Conduct as I tend to think this is more about what to do than what not to do. For instance 5.4 “Nurses must not display behaviours that are dismissive, indifferent etc” rather than Do not be dismissive, indifference etc.

(Individual nurse)
In 5.8 we would like to see the Guidelines on Direction and Delegation referenced.

We would like to see the Treaty of Waitangi and Health Practitioners Competency Assurance Act referenced as Related Documents.

(SDHB)

Content

One submitter wanted a list of legislation included.

One individual nurse wanted to retain the list of Conduct in question.

I have found the current Code very satisfactory and the list of examples has been particularly helpful when helping nurses to see where and why their conduct or practice has been out of step with expectations. I would want to see a similar summary list of examples include with the revision please.

(Enliven PSC)

It would be helpful to have a preamble to each principle (in much the same way as for these consultation questions) to provide context.

(College of Emergency Nurses New Zealand – NZNO)

Include guidance for acting for a third party.

There seems to be nothing in the guidelines covering the situation where a nurse is acting for a third party. In this regard you may wish to consider preparing something similar to the following guideline which appears in the NZMA’s Code of Ethics (paragraph 32).

Where a doctor is performing an assessment on behalf of a third party, the patient must be clearly informed of who the third party is the purpose of the assessment and the limits of confidentiality. Where the assessment occurs in the context of a treating relationship, the patient should be made aware that the doctor is ethically obliged to provide a complete and professional report.

(NZMA)

More emphasis on reporting a health issue.

The Code is silent on the health of the nurse. Refer to the NZMA Code of Ethics, paragraph 26. Doctors have both a right and a responsibility to maintain their own health and well being at a standard that ensures that they are fit to practise.

(NZMA)
Provision of honest and accurate information.

I note that Principle 2 of the draft Code of Conduct does not include a specific provision relating to an obligation to provide honest and accurate information in relation to nursing care. This is a provision that is included in the Australian Nursing and Midwifery Council Code of Professional Conduct for Nurses in Australia. Right 6(3) of the Code of Rights also provides that consumers have the right to honest and accurate answers to questions relating to services. Honesty and accuracy of information are two important aspects of building a trusting relationship between nurse and consumer, and a relationship which allows both nurse and consumer to work in partnership. Accordingly, you may wish to consider including a specific standard within Principle 2 that addresses this.

(HDC)

Add standard on making false declarations on your practising certificate application.

Some nurses are applying for APCs knowing that they do not meet the competency requirements. Council was going to make this requirement and potential consequences more explicit but it does not yet appear in the draft Code of Conduct.

(DHB DONs)

Add a requirement for research.

Finally we think that there must be mention of the nurses’ responsibility to growing the discipline of nursing and engaging in research activity. These components are missing from the document.

(VUW)

Include reference to children and young people.

I note the term Health Consumer is used throughout the document, representing patients, clients etc. Although implicit within this definition, there is no explicit reference to children or young people. I invite you to consider whether the rights of children and young people should be made more prominent in the Code. This might include, for example, special consideration, around their right to information, right to be consulted and heard and a nurse’s responsibility to provide children and young people with the time and space to fully understand their situation.

I have enclosed a copy of the Code of Ethics for Youth Work in New Zealand, recently published by Ara Taiohi. Section 4 sets out some ways in which youth workers encourage youth participation and some of this section – and other parts of the Code – might be useful when thinking about how to include special consideration of children and young people in the nurse’s Code.

You may well be aware of the Charter on the rights of Tamariki Children and Rangatahi Young people in Healthcare Services in Aotearoa New Zealand, which can be downloaded from the Paediatric Society at www.paediatrics.org.nz. This might be a useful document to consider in relation to your draft Code.

(Children’s Commissioner)
Insert a provider compliance clause.

Clause 3(1) of the Code of Rights provides:

“A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.”

“The circumstances” is defined in Clause 3(3) to mean, “all the relevant circumstances, including the consumer’s clinical circumstances and the provider’s resource constraints”. This Clause recognises that, on occasion, despite the best efforts of a provider, it may not always be possible to comply with the requirements of the Code of Rights. I suggest Council consider whether a similar rider be placed on the requirements in the Code of Conduct, because there will be circumstances where compliance is simply not possible. 

(HDC)

Provide education on the Code.

The language used in these standards is easily understood and the expectations of the standards is clearly laid out. This is important both for the individual nurse and other nurses especially when concerns are raised about a nurse’s ability to practice. The Council will need to ensure that the education around the changes to the Code is robust as this could have serious repercussions for some nurses if they are unaware of the changes. Also, If one of the aims is to inform the public, how will the public be made aware? Will the Council actively advertise this to ensure public awareness?

(CDHB - CNS Group)

NZNO strongly supports the teaching of the content of the Code of Conduct in undergraduate and return to nursing education programmes and wide dissemination to practising nurses.

(NZNO)

Other issues

Screening for abuse.

I have only 1 observation to make. It is regarding screening. When I set up the Family violence initiative for the WDHB the hardest thing was the screening. Many nurses feel uncomfortable asking patients intimate questions. We are supposed to screen the elderly also for elder abuse under the FVI banner.

I think (the person) who does the audits would say this is still an area we don’t do well. With this still being a huge issue at a national level and with all the publicity I would see this as an area that the Council could support.

I think there should be a comment in one of the sections that challenges nurses and reinforces screening for abuse. Others may not have the same strength of feeling re this but having set up the programme I feel very strongly about this.

(Individual nurse)
Casualisation of the workforce.

One concern that we feel needs emphasizing is that in ‘the old days’, the nursing staff were the stable force in a hospital, around which doctors, technicians and therapists orbited.

Now, with increasing casualisation, it is vitally important that good communication and sufficient time for discussion is allowed when shifts change and patients are handed over to a fresh nursing team.

We feel this work trend may need to be addressed more fully by the Council.

(National Council of Women)

Many suggestions were made to improve the wording of individual standards. A summary of these suggestions can be found on the following table.

15. Other comments related to specific standards

Table 3: Other comments on the standards within the Code

<table>
<thead>
<tr>
<th>Standard</th>
<th>Comment</th>
<th>Submitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>A grammatical point: Principle 1, Standard 1.2 should read ‘Listen to health consumers, ask for and respect……and respond.’</td>
<td>Pharmacy Council</td>
</tr>
<tr>
<td>1.3</td>
<td>Partnering with, and involving, family members is important, particularly where family members are involved in the care of the health consumer, or where the consumer requests that their family be involved. However, it may not always be appropriate to involve family members, for example, where the consumer specifically requests the family not be involved. Currently the document does not reflect that there may be circumstances where it is not appropriate to involve family members in a health consumer’s care and treatment. Accordingly, you may wish to reword this standard to: &quot;Work in partnership with the family of a health consumer where appropriate, and be respectful of their role in the care of the health consumer&quot;.</td>
<td>HDC</td>
</tr>
<tr>
<td>1.3</td>
<td>This needs to include those with decreased mental capacity. We suggest ‘work in partnership with the family/whānau including where the health consumer has a lack of mental capacity e.g. dementia, brain injury, parents of children, learning disability’.</td>
<td>VUW</td>
</tr>
<tr>
<td>1.3</td>
<td>Re working in partnership with the family ….need to be stating “with the consumers consent” and being clear that the relationship is to be specifically with the person holding EPOA Health &amp; Welfare for consent issues where the consumer is not able to consent for themselves.</td>
<td>Enliven PSC</td>
</tr>
<tr>
<td></td>
<td>The grammar needs some attention.....seems to suggest that race, religion, sex etc are disabilities. More contemporary language would be ethnicity and gender rather than race and sex.</td>
<td>Enliven PSC</td>
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<tr>
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</tr>
<tr>
<td>1.5</td>
<td>Add ‘age’ to the list in this point.</td>
<td>Age Concern</td>
</tr>
<tr>
<td>1.6</td>
<td>Is particularly relevant and valuable to have clearly stated.</td>
<td>Waipuna Hospice</td>
</tr>
<tr>
<td>1.6 &amp; 1.7</td>
<td>It can be hard to deliver appropriate support when many services are only available during office hours (e.g. interpreters, Māori support etc) 1.6 and 1.7 are worded as directives not principles- perhaps need re-writing?</td>
<td>College of Emergency Nurses New Zealand - NZNO</td>
</tr>
<tr>
<td>1.8</td>
<td>In my view, if a nurse conscientiously objects to providing treatment to a health consumer, the nurse has an obligation to inform the consumer and advise the consumer that he or she can obtain the service from another provider. This is consistent with the High Court of New Zealand’s interpretation of section 174 of the Health Practitioners Competence Assurance Act 2003 which, although restricted to conscientious objection in relation to contraception, sterilization, or other reproductive health services, provides that a health practitioner who conscientiously objects to such services is required to inform the consumer requesting the service that the consumer can obtain the service from another health practitioner.</td>
<td>HDC</td>
</tr>
<tr>
<td>1.8</td>
<td>Should read ‘you must inform your manager’ (not colleagues).</td>
<td>Enliven PSC</td>
</tr>
<tr>
<td>1.8</td>
<td>Suggest include that the nurse should negotiate with their not only their colleagues but also their employer if they conscientiously object to involvement in care.</td>
<td>SCDHB</td>
</tr>
<tr>
<td>1.8</td>
<td>We recommend that Standard 1.8 be amended to ‘you have a right not to be involved in care to which you conscientiously object. The exercising of your right should not impede access to any legal treatment’.</td>
<td>VUW</td>
</tr>
</tbody>
</table>

1 Hallagan and New Zealand Health Professional Alliance Incorporated v Medical Council of New Zealand. HC WN CIV-2010-485-222, 2 December 2010.
<table>
<thead>
<tr>
<th>1.8</th>
<th>Standard 1.8 in Principle 1 provides: “You have a right not to be involved in care to which you conscientiously object. You must inform your colleagues but not impeded access to legal treatment.” Pg 6 (1.8): Conscientious objection. This term has commonly been associated with a nurses right to absolve themselves of involvement with terminations of pregnancy due to personal ethical beliefs. It is suggested that if this section is specifically referring to terminations of pregnancy, then this should be expressly written as such, thus avoiding any confusion or potential use of this clause as grounds for exemption from other nursing tasks or duties. It is also suggested that consideration should be given to a preamble to the Code of Conduct, articulating an expectation that prior to entering the nursing profession an individual would need to consider potential challenges to their personal values and beliefs, preparing to face these issues as they arise and only utilising a withdrawal from provision of care as a last resort.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8</td>
<td>One member noted that point 1.8 under Principle 1 could be clearer and suggested that the wording found in the Health Practitioners Competence Assurance (HPCA) Act Section 174 could be utilised here: ‘…to which you object on the grounds of conscience’.</td>
</tr>
<tr>
<td>1.8</td>
<td>Will allow a growing number of nurses to extract themselves from caring for men, within the colonoscopy service (particularly if patient is male), within termination services and even in ICU where very elderly complex patients have been offered and had invasive surgery. Needs to be carefully considered.</td>
</tr>
<tr>
<td>1.8</td>
<td>Standard 1.8: is potentially problematic if all nurses in a team ‘conscientiously object’. The public should be able to expect that the nursing profession as a whole will provide non-judgmental care and that they will not be discriminated against or denied care on the basis of who they are or the decisions they have made about their health care.</td>
</tr>
<tr>
<td>1.8 &amp; 1.9</td>
<td>1.8 And 1.9 might conflict with each other in an emergency if a staff member cannot be immediately replaced. The Code should make clear which takes precedence in an emergency situation.</td>
</tr>
<tr>
<td>1.9</td>
<td>Suggest including the following... take steps to minimize risk and provide care, based on evidenced based practice, that does not intentionally harm the health or safety of health consumers. To make it clear that nursing care should be centred on Evidenced Based Practice.</td>
</tr>
<tr>
<td>1.9</td>
<td>Take steps to eliminate risk or minimize known risk to ensure your care does not harm the health and safety of health consumers. Consider adding the word “rights” in the Principles Statement of promoting and protecting consumer’s rights and interests.</td>
</tr>
<tr>
<td>1.10</td>
<td>Covered by the Open Disclosure processes…</td>
</tr>
<tr>
<td>1.10</td>
<td>Explain fully ---- and document the discussions held.</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>1.10</td>
<td>Doesn’t fit in a “principle” about dignity and individuality (as don’t 1.8 and 1.9). The first sentence is appropriately included in the code (? in “principle” 2 or 3) but the second would be problematic for nurses in some “risk averse” organisations. Who discusses events causing harm with health consumers and whanau, is very controlled in some workplaces and nurses may face disciplinary action if they don’t abide by the organisation’s policies.</td>
</tr>
<tr>
<td>1.10</td>
<td>Reword to encompass a clearer guideline for an adverse event i.e. If a health consumer has suffered harm for any reason act immediately to minimize further harm and notify the appropriate senior personal (employer)…..</td>
</tr>
<tr>
<td>1.10</td>
<td>Should include advice to seek guidance prior to explaining “fully &amp; promptly” to consumer, to ensure principles of natural justice; organizational policy &amp; procedures are adhered to and NZNO or other professional support is obtained.</td>
</tr>
<tr>
<td>1.10</td>
<td>“Act immediately if a health consumer has suffered harm for any reason”. Whilst it is acknowledged that this implicitly refers to harm caused to the health consumer by a nurse, this needs to be made more explicit in this section.</td>
</tr>
<tr>
<td>1.10</td>
<td>For an employed nurse we would expect that the first conversation would be with their Manager who would then communicate with the consumer and EPOA in line with the organisational open disclosure policy. Would then expect the nurse to follow organisational requirements related to incident management and documentation and co-operating promptly with internal and external investigations….this needs to be specified. The second sentence should have a separate statement in another part of the Code …perhaps in principle 5? If you have specific concerns about the work environment that you think may put the health consumer at risk and may impact on your ability to provide care, you must raise that with your Manager. If the concern is not addressed and you think the risk remains put your concern in writing to your employer.</td>
</tr>
<tr>
<td>1.10</td>
<td>I suggest you reword the Standard to “Explain fully and promptly to the consumer affected, and where appropriate the consumer’s family, what has happened and the likely effects”. While I agree that the policy of open disclosure needs to be endorsed, Standard 1.10 does not adequately reflect that a nurse’s role in the open disclosure process may vary depending on the organisation in which they work and that organisation’s internal policies and procedures, the nurse’s role in the event that caused the harm, and the nurse’s role in the multi-disciplinary team. You may consider rewording Standard 1.10 to reflect this.</td>
</tr>
<tr>
<td>2.1</td>
<td>It is not clear what is meant by the word “affirming”, and further clarification of this standard would be useful. I also note that, to be consistent with Right 6 of the Code of Rights, the standard should be to provide consumers with information they want and/or need – the provisions are not mutually exclusive as suggested by wording the statement “want or need”. Indeed, as noted above, to be consistent with the requirements of Right 6 of the Code of Rights, it would perhaps be more accurate if the statement read: “Give consumers the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive, and that they need, in order to make an informed choice and give informed consent. Information should also be provided in a way that they can understand and enables them to ask questions, as necessary.”</td>
</tr>
<tr>
<td>2.2</td>
<td>In particular, Principle 2.2, which you may wish to consider rewording to: “Respect health consumers’ rights to participate in decisions about their care and involve them and their families, where appropriate, in planning care. The concerns, priorities and needs of the health consumer and family, where appropriate, must be elicited and respected in care planning.”</td>
</tr>
<tr>
<td>2.2</td>
<td>Refer earlier comments re consumers consent to involve family and role of and EPOA. Families have no “right” to be involved in care planning.</td>
</tr>
<tr>
<td>2.2</td>
<td>Some health consumers may misinterpret care and so the health professional should be protected against this. Perhaps the words well informed should go before health consumer.</td>
</tr>
<tr>
<td>2.2</td>
<td>In many contexts the families participate in care planning and delivery. Under 2.2 (Principle 2) we suggest the addition of “… ’and delivering’ care in the first sentence.</td>
</tr>
<tr>
<td>2.2</td>
<td>In many contexts the families participate in care planning and delivery. Under 2.2 (Principle 2) we suggest the addition of “… ’and delivering’ care in the first sentence.</td>
</tr>
<tr>
<td>2.2</td>
<td>Suggest adding… ‘and their families and where appropriate, significant others’. Suggest a definition of family, in the broadest sense, is used and provided in the Glossary. Also add… ‘in care planning and provision of health care’.</td>
</tr>
<tr>
<td>2.3</td>
<td>For Principle 2; (2.3) I believe the contribution health consumers make to their own care and will being should be safe and that they should be well informed with current best practice to enable them to make the right choice.</td>
</tr>
<tr>
<td>2.3</td>
<td>More emphasis on encouraging health consumer to self-manage, autonomy/self determination not mentioned</td>
</tr>
<tr>
<td>2.4</td>
<td>It may not always be possible to meet a consumer's language needs, despite the best endeavours of the nurse. This may happen, for example, in emergency circumstances. Right 5(1) of the Code of Rights provides that: “Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter”. Consistent with the Code of Rights, you may wish to consider including the terms “reasonably practicable” when requiring a nurse to meet a consumer’s language needs, to avoid creating a standard that may, at times, be unachievable.</td>
</tr>
<tr>
<td>2.4</td>
<td>Can’t always meet the needs but must be able to ensure that support for communication is available</td>
</tr>
<tr>
<td>2.5</td>
<td>I note that “advocate” is not defined in the draft Code of Conduct and so the requirements of this standard are somewhat unclear. Right 7(4) of the Code of Rights sets out the steps a provider must take before providing services to a consumer who is not competent to make an informed choice and give informed consent. I recommend you consider rewording Standard 2.5 to be consistent with Right 7(4) of the Code of Rights, so that the professional guidance to nurses in the Code of Conduct is consistent with their legal obligations.</td>
</tr>
<tr>
<td>2.7</td>
<td>Not sure that this is the right place for this statement or right role for the individual nurse without context? 2.8 would cover it??</td>
</tr>
<tr>
<td>2.8</td>
<td>Sometimes when a patient has dementia or mental illness, intellectual or neurological impairment, or is a child, nursing practice needs to be modified to respect these ideals, but also to meet the needs of the client.</td>
</tr>
<tr>
<td>2.8</td>
<td>Standard 2.8: insert professional i.e. use your expertise and professional influence…</td>
</tr>
<tr>
<td>2.8 &amp; 6.2</td>
<td>Addressing the health needs of vulnerable people: Whilst Pg 8 (2.8) and Pg 14 (6.2) speak to the need for nurses to promote and protect the needs of vulnerable people, it is suggested that a section could be included within Principle 2 that expresses the requirement of nurses to be advocates and promoters of social justice.</td>
</tr>
<tr>
<td>2.9</td>
<td>Whanau /family is not in the glossary.</td>
</tr>
<tr>
<td>2.9</td>
<td>NZNO agrees with the focus on the rights and needs of the health consumer. NZNO suggests that point 2.9 under Principle 2 could be reworded to be inclusive of all families/whānau and not just Māori whānau as implied.</td>
</tr>
<tr>
<td>3</td>
<td>For Principle 3 (guidance documentation) I believe that the name and designation of the person making the documentation should be clearly written or stamped which is legible so that they are accountable for their practice.</td>
</tr>
<tr>
<td>3.1</td>
<td>The use of the word appropriate is not useful as it means</td>
</tr>
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<td></td>
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<td>---</td>
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</tr>
<tr>
<td><strong>3.2</strong></td>
<td>Do we mean don’t leave the premises or tuck yourself up for a sleep?? It might be useful to be more specific about what readily available means as it will be different in different circumstances.</td>
</tr>
<tr>
<td><strong>3.5</strong></td>
<td>Add and notify ‘your manager of your development needs’.</td>
</tr>
<tr>
<td><strong>3.6</strong></td>
<td>Replace ‘openly evaluate’ (which suggests nurses don’t?) with ‘proactively contribute to peer review processes’.</td>
</tr>
<tr>
<td><strong>3.7</strong></td>
<td>Standard 3.7 of Principle 3 provides, “Deliver care based on best available evidence or best practice.&quot; Best practice is informed by evidence, and in my view, best practice should be consistent with the best available evidence – the concepts are not alternatives as suggested by use of the word “or”. Accordingly, I suggest you reword Standard 3.7 to read, “Deliver care based on best available evidence and best practice.”</td>
</tr>
<tr>
<td><strong>3.7</strong></td>
<td>Best available evidence is best practice?? Do we need to add in line with your organisations clinical policies and guidelines as that is where best practice is required to be captured (HDSS) including those related to medicine administration. I wonder why one aspect of nursing care has been singled out when it is covered in more generic statements.</td>
</tr>
<tr>
<td><strong>3.9</strong></td>
<td>We recommend that Standard 3.9 be amended to ‘administer medicines and healthcare interventions in accordance with regulation and legislation, your scope of practice and established standards or guidelines’.</td>
</tr>
<tr>
<td><strong>3.10</strong></td>
<td>Wider standards is not a helpful descriptor …suggest being very careful not to include anything beyond legislation and contemporary professional standards which is specific but allows for change.</td>
</tr>
<tr>
<td><strong>3.12</strong></td>
<td>Could be clearer …are we saying offer assistance but only to the level of your knowledge and skill….reads like it is OK to go beyond that if there are no other options available??</td>
</tr>
<tr>
<td><strong>4.3</strong></td>
<td>‘It will usually be etc’ ‘to replace may’.</td>
</tr>
<tr>
<td><strong>4.3 &amp; 4.4</strong></td>
<td>Note 4.3 and 4.4 -in respect of the Tuberculosis Act 1948 allows disclosure of names in order to identify contacts and also provisions in the current Health Act as well. What happens when police make enquiries also?</td>
</tr>
<tr>
<td><strong>4.4</strong></td>
<td>Principle 4 (4.4) It should be specified whether the consent can be oral or written as this is a grey area in health care and needs to be clearly defined.</td>
</tr>
<tr>
<td><strong>4.5</strong></td>
<td>Suggest records must be stored securely and are only accessed for the purpose of providing care or for approved audits.</td>
</tr>
<tr>
<td><strong>4.5</strong></td>
<td>Standard 4.5 refers to only accessing records for the purpose of providing care, where does access to records for research purposes fit within this standard?</td>
</tr>
<tr>
<td>Section</td>
<td>Suggestion</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>4.5</td>
<td>Just a suggestion for a slight wording change to 4.5. I would take out “not removed except” and put “only accessed” instead. This reflects that more and more health records are now in an electronic format and before too much longer there won’t be anything to physically remove.</td>
</tr>
<tr>
<td>4.5 &amp; 4.6</td>
<td>Prohibitive statements could be reworded and most could be reworded positively and as standards e.g. 4.5 Records are stored securely and removed only as required for the purpose of providing care; 4.6 Health consumers’ personal and health information is accessed and disclosed only as necessary for providing care.</td>
</tr>
<tr>
<td>4.6</td>
<td>Suggest this one need some work…sometimes disclosing of information may be required if abuse or neglect is suspected. If my suggestion is accepted for 4.5 it is covered.</td>
</tr>
<tr>
<td>5.3</td>
<td>Needs to be a separate statement about referrals and handovers.</td>
</tr>
<tr>
<td>5.4 &amp; 5.5</td>
<td>Should be written as what is to be done rather than what isn’t to be done????</td>
</tr>
<tr>
<td>5.6</td>
<td>Communicate with colleagues and employers.</td>
</tr>
<tr>
<td>5.6</td>
<td>Suggest inclusion of memos, policies and procedures, emails be explicitly stated as examples of communication and ways of keeping practice up-to-date. Quality Improvement activities are to keep practice up to date, as well as quality care; refusal to engage in these is not an option, but do not think this has permeated nursing culture.</td>
</tr>
<tr>
<td>5.6</td>
<td>This is fine in traditional hospital or community settings, but not in unique settings where no peer is available. We already need to keep a portfolio, that’s enough</td>
</tr>
<tr>
<td>5.7</td>
<td>Welcome, support etc new colleagues and students.</td>
</tr>
<tr>
<td>5.8</td>
<td>Point 5.8 is not relevant for enrolled nurses and should be reworded accordingly.</td>
</tr>
<tr>
<td>5.9</td>
<td>‘This is not just about reporting, it is about intervening and/or stopping the unsafe practice. ‘First responsibility is to intervene and stop the unsafe practice including advising and discussing the issue with those involved and report where necessary’.</td>
</tr>
<tr>
<td>5.9</td>
<td>If you are concerned about the practice or behavior of another health professional you must report it to your manager or the regulatory body. (Link to HPCA Act) and take action to safeguard health consumers.</td>
</tr>
<tr>
<td>5.10</td>
<td>Be familiar with and refer to an ethical code or framework etc.</td>
</tr>
<tr>
<td>5 &amp; 6</td>
<td>Guidance on page 5 is misplaced before any principles/standards have been mentioned. Perhaps if it is to be used at all it should be with principle 6 but it needs to be reworded.</td>
</tr>
<tr>
<td>6.1</td>
<td>Add ‘colleagues and employers’.</td>
</tr>
<tr>
<td>6.2</td>
<td>Page 14. 6.2 add after vulnerable people “inclusive but not limited to”.</td>
</tr>
<tr>
<td>6.2</td>
<td>Standard 6.2: suggest it reads ‘Protect vulnerable people from exploitation and harm, for example, children...’</td>
</tr>
<tr>
<td>6.4</td>
<td>Decline rather than refuse.</td>
</tr>
<tr>
<td>6.4</td>
<td>Who interprets whether it's an attempt to gain preferential treatment?</td>
</tr>
<tr>
<td>6.4</td>
<td>Respect for culture needs to be taken into consideration when declining gifts (No. 6.4.) This may cause a grey area for nurses as in some cultures to refuse a gift may cause offence. This has been covered in the draft professional boundaries guidelines.</td>
</tr>
<tr>
<td>6.4</td>
<td>Principle 6: Act with integrity to justify health consumer’s trust. 6.4. Refusing hospitality is too broad. Depending on the cultural beliefs of the consumer it may be insulting to refuse the hospitality offered (it may be a cup of tea).</td>
</tr>
<tr>
<td>6.7</td>
<td>I suggest Council give consideration to a more stringent standard in this regard. Council may wish to consider the wording of the Australian Nursing and Midwifery Council Code of Professional Conduct for Nurses in Australia which provides: “Nurses practise in a safe and competent manner that is not compromised by personal health limitations, including the use of alcohol or other substances that may alter a nurse’s capacity to practise safety at all times.”</td>
</tr>
<tr>
<td>6.7</td>
<td>Replace ‘should’ with ‘must not’.</td>
</tr>
<tr>
<td>6.8</td>
<td>Should this be ---- ‘ability to practice safely’?</td>
</tr>
<tr>
<td>6.8</td>
<td>If your health ‘including addictions’ impacts on your ability to practice.</td>
</tr>
<tr>
<td>6.12</td>
<td>Do we add ‘colleagues’ to this one??</td>
</tr>
<tr>
<td>7.4</td>
<td>Add including “time”.</td>
</tr>
<tr>
<td>7.5</td>
<td>Need a separate statement that says “Do not represent yourself as a practicing nurse if you are employed in a non nursing role”.</td>
</tr>
<tr>
<td>7.6</td>
<td>Add ‘document and report’.</td>
</tr>
<tr>
<td>7.6 &amp; 7.7</td>
<td>Standards 7.6 and 7.7 need to include ‘report and document’.</td>
</tr>
<tr>
<td>7.7</td>
<td>Add at end or bring disrepute on the profession.</td>
</tr>
<tr>
<td>7.8</td>
<td>To whom are they to declare??</td>
</tr>
<tr>
<td>7.9</td>
<td>It is unclear how this Standard relates to a nurse employed to sell or promote particular therapeutic products, particularly on a commission basis. Surely, the important point is not the sale or promotion of particular products; but that a nurse’s personal interests in doing so do not override the best interests of the consumer. I suggest you consider providing greater clarity on this point in Standard 7.9.</td>
</tr>
<tr>
<td>7.10</td>
<td>Do we need to be more specific and say timesheets are to accurately reflect your hours of work? Services rendered is not commonly used nursing language.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>7</td>
<td>In discussing the dignity of health consumers, and we are all, even nurses, consumers of health care at different times of our lives, emphasis was placed on how nurses must be conscious of their position of trust in the community.</td>
</tr>
</tbody>
</table>
**Table 4: List of organisations making submissions**

<table>
<thead>
<tr>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Concern New Zealand (Age Concern)</td>
</tr>
<tr>
<td>Bay of Plenty District Health Board (BOPDHB)</td>
</tr>
<tr>
<td>Canterbury District Health Board, Clinical Nurse Specialist Group (CDHB - CNS Group)</td>
</tr>
<tr>
<td>Capital &amp; Coast District Health Board &amp; Wairarapa District Health Board (CCDHB &amp; WDHB)</td>
</tr>
<tr>
<td>Children's Commissioner</td>
</tr>
<tr>
<td>Christchurch Polytechnic Institute of Technology - School of Nursing &amp; Human Services (CPIT)</td>
</tr>
<tr>
<td>College of Emergency Nurses New Zealand- NZNO</td>
</tr>
<tr>
<td>College of Nurses Aotearoa NZ (CONA)</td>
</tr>
<tr>
<td>Counties Manukau District Health Board (CMDHB)</td>
</tr>
<tr>
<td>District Health Boards Directors of Nursing (DHB DONs)</td>
</tr>
<tr>
<td>Eastern Institute of Technology - Faculty of Health Sciences (EIT)</td>
</tr>
<tr>
<td>Enliven Presbyterian Support Central (Enliven PSC)</td>
</tr>
<tr>
<td>Health and Disability Commissioner (HDC)</td>
</tr>
<tr>
<td>Healthcare Development, MidCentral District Health Board</td>
</tr>
<tr>
<td>Health Workforce New Zealand (HWNZ)</td>
</tr>
<tr>
<td>Medical Council of New Zealand</td>
</tr>
<tr>
<td>MidCentral District Health Board (MCDHB)</td>
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<tr>
<td>National Council of Women of New Zealand (National Council of Women)</td>
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<tr>
<td>National Enrolled Nurse Section NZNO</td>
</tr>
<tr>
<td>Nurse Educators in the Tertiary Sector (NETS)</td>
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<tr>
<td>Primary Health Organisation (PHO)</td>
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<tr>
<td>Pharmacy Council of New Zealand (Pharmacy Council)</td>
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<tr>
<td>Neonatal Nurses College of Aoteaora - NZNO</td>
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<tr>
<td>New Zealand Institute of Rural Health</td>
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<tr>
<td>New Zealand Medical Association (NZMA)</td>
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<tr>
<td>New Zealand Nurses Organisation (NZNO)</td>
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<tr>
<td>NorthTec</td>
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<tr>
<td>Royal New Zealand Plunket Society (Plunket)</td>
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<tr>
<td>South Canterbury District Health Board (SCDHB)</td>
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<tr>
<td>Southern District Health Board (SDHB)</td>
</tr>
<tr>
<td>Southern Regional Council NZNO</td>
</tr>
<tr>
<td>Taranaki District Health Board (TDHB)</td>
</tr>
<tr>
<td>Te Ao Maramatanga/NZ College Mental Health Nurses (Te Ao Māramatanga/NZCMHN)</td>
</tr>
<tr>
<td>Victoria University of Wellington - Graduate School of Nursing Midwifery &amp; Health (VUW)</td>
</tr>
<tr>
<td>Waikato District Health Board (WDHB)</td>
</tr>
<tr>
<td>Waikato District Health Board Professional Development Unit (WDHB PDU)</td>
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<tr>
<td>Waipuna Hospice</td>
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</tbody>
</table>