Toolkit on

Complaints Management

developed by

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for the International Council of Nurses

ISBN: 978-92-95094-86-4

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About the authors

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Introduction

Since its inception, the International Council of Nurses (ICN) has held a clear position about the importance of regulation in assuring safe and competent nursing practice in order to protect the public. One of the key responsibilities of those involved in nursing regulation is to deal with incidences of unacceptable practice. It is vital that the profession is able to clearly articulate to the public that it will take action when a nurse's practice puts the public at risk.

An objective forum is needed for resolving complaints against nurses and taking action when practice or behaviours are unsafe, incompetent or unethical. It is necessary to investigate the complaint including its validity, take any appropriate action and, if deemed necessary, impose a sanction or discipline. This process is fundamental in protecting the public from registrants whose professional practice falls below the standards required of them.

This Toolkit is part of a learning package that describes the policy framework, relevant concepts, key stakeholders and the processes fundamental to a complaints management process. The process of dealing with complaints and concern about individual nurse's practice is referred to differently around the world. Some examples are discipline, professional conduct review and complaints management. For the purpose of this Toolkit it will be referred to as a complaints management process.

Throughout this Toolkit a standard approach is used to help you navigate around the resources that are available. Text that explains the issue appears in the main column.

Questions or exercises appear in a box next to the symbol: **?**

Key points to consider appear in a box next to the symbol: **!**

Structure of the Toolkit

There are two parts to the Toolkit: (1) this workbook; and (2) an accompanying PPT presentation.

The Module content

There are 13 chapters covering the following:

1. Purpose of regulation and complaints management
2. Evolution of legislative and regulatory approaches to the management of complaints against nurses
3. Role of the regulator
4. Overview of complaints management process
5. Differentiation from employer based complaint systems
6. Governance structure for regulators
7. Definitions of key terms and concepts
8. Types of complaints
9. Assessment of complaints
10. Investigation of complaints
11. Actions by regulators
12. Roles and responsibilities of stakeholders in complaints systems
13. Future work and conclusion

Providing feedback

ICN believes that regulation is extremely important in terms of the care and services that nurses deliver to the public and the way nurses practise. Health and social systems are constantly changing and, as a result, regulation and regulatory practices must also change. ICN welcomes feedback on how useful you find this material and any suggestions you may have for improvement.

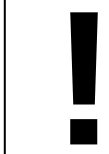
Chapter 1: Purpose of regulation and complaints management

> "Registration is a responsibility and not a right. Registration must be held in the most serious and high regard with those to whom it is granted."[1]
>
> The public needs to be protected from delinquents and wrong-doers within professions. It also needs to be protected from seriously incompetent professional people who are ignorant of basic rules or indifferent as to rudimentary professional requirements. Such people should be removed from the register or from the relevant roll of practitioners, at least until they can demonstrate that their disqualifying imperfections have been removed."[2]
>
> Professional regulation must create a framework that maintains the justified confidence of patients in those who care for them as the bedrock of safe and effective clinical practice and the foundation for effective relationships between patients and health professionals[3].

The purpose of the regulation of health professionals is to serve and to protect the public. Laws governing nursing practice are put in place by governments and enforced by regulators to provide mechanisms to ensure, as much as possible, that practitioners are fit and competent to practice.

Regulatory frameworks

In a well-developed regulatory framework, a nurse regulatory authority[4] can be expected to fulfil a number of core functions which are outlined below and will be elaborated on further in Chapter 3.



Core functions of the regulator:

- Issuing licences to practice the profession for those educated within or outside the jurisdiction;
- Periodic renewal (e.g. annual, bi-annual, etc.) of licences often with specific requirements to be eligible for renewal;
- Establishing standards for education and practice;
- Upholding professional standards and maintaining public confidence in the profession and the integrity of the register through responding to, assessing and investigating complaints, and taking appropriate action.

This Toolkit will focus on the last of the core functions by seeking to identify the general features of a modern, effective, transparent and fair complaints management system for regulators in the nursing profession. It is important to note from the onset that the percentage of nurses who end up in the complaints review process is quite small and that the vast majority

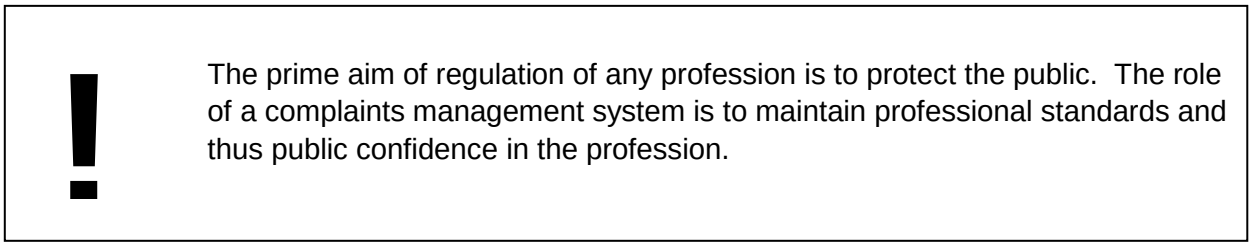
[1] Health Care Complaints Commission v Powell (2008) NSWNMT 19 @ [73]

[2] Kirby J (later Kirby J of the High Court of Australia) in Pillai v Messiter (No.2) (1989) 16 NSWLR 197 at 201.

[3] The Secretary of State for Health, United Kingdom (2007) Trust, Assurance and Safety –The Regulation of Health Professionals in the 21st Century.

[4] The term 'nurse regulatory authority', 'regulatory authority' or 'regulator' will be used to describe the body with responsibility for licensing of nurses.

of practitioners are never the subject of complaints to the regulatory authority. Nonetheless, it is essential that such a process be in place for protection of the public from the small number of unsafe, incompetent or unethical practitioners.



The object of such a system is not to punish the practitioner, although the outcome of a review may be a restriction on the scope of practice or revoking of the licence to practice in the public interest. Professional regulation is about fairness to both sides of the partnership between patients and professionals.

Because of regulation in the early stages of development, inadequate legislative frameworks, funding issues or limited financial and human resources, a number of important features of the system for complaints management described in this Toolkit may not be in place in some countries. However, this Toolkit is designed to provide information and promote discussion and self assessment. It is meant to provide a foundation for those starting to develop a complaints management system and to facilitate improvement in all regulators by seeking to identify well functioning models for complaints resolution.

A number of the concepts discussed in this paper have their origins in common law which is the governing law in countries such as the United Kingdom, United States, Canada (except Quebec), Australia and New Zealand. Different laws in other parts of the world include civil law (common in most European countries) and Sharia or Islamic law. The governing law of a country will have an influence on professional regulatory frameworks including the approach to complaints management. Differences in legal systems can translate into differences into how a complaint is investigated, how confidentiality of information is maintained during the investigation process, the standard of proof required for decisions, how decisions about discipline are made, what actions can be imposed and the degree of sharing of information on disciplinary decisions.

Regulators as they develop, establish and maintain regulatory structures will need to be familiar with the legal system in place in their country and establish their structure including a complaints management system within that system.

Chapter 2: Evolution of legislative and regulatory approaches to the management of complaints against nurses

As noted, regulation of health practitioners through a system of registration was introduced to protect the public. In many countries some form of regulation has been in place since the early 1900s. Nursing regulation is in place in much of the world although not in all countries or regions. In some countries, there is no regulation of professional practice; some have only minimal regulatory structures and others are just commencing creating regulatory mechanisms.

Regulatory frameworks have evolved over time and have been influenced by the social, cultural and legal context in which they take place. Many factors have influenced the evolution of regulatory frameworks around the world. Some examples of more recent influences are:

- A more aware and informed public;
- Increasingly complex workplaces with heightened risk of human error;
- Rapidly increasing technology and worldwide connectivity as well as the increase in use of social media;
- Globalisation and trade agreements with the resulting push from governments to allow for ease of mobility or mutual recognition in regulatory frameworks;
- Increased government intervention in and oversight of regulation with a demand for greater accountability;
- Highly publicised cases in some countries of professional misconduct which although localised have had a ripple effect on regulation in many parts of the world.

In early regulatory frameworks, registration to practice was granted simply upon proof of attainment of relevant qualifications or completion of recognised education programmes. Registration may have provided for the protection of title but generally did not define scope of practice or competence (Sheets 1996). In part, the introduction of such systems was to prevent non-qualified persons from inferring a level of skill or education that they did not possess.

In ICN's *Model Nursing Act* (2007) published as part of the ICN Regulation series, it is observed on page 16:

> 'Registration and qualification should not be synonymous. The qualification achieved at the end of a programme of nursing education should be considered as part of the route to entry on to the professional register. Possession of the nursing qualification alone should not mean that the individual is registered *to practice* in the country concerned. Qualifications are for life, whereas registration may well lapse for a number of reasons – keeping the two separate is important, particularly from a public protection perspective.'

Regulatory systems evolved to establishing other criteria beyond the academic qualification to be met before a licence to practice was granted. An academic qualification became only one pre-requisite for licensure. Other common criteria included:

- That the person's state of health is such that the person is capable of carrying out the duties entrusted to them by a licence to practice without endangering any patient the person may attend;
- That the person has sufficient command, both oral and written, of the language of the country in which they seek to be licensed to ensure that the safety and well being of patients whom they may attend is maintained;
- That the person is fit to practice the profession.

As nurses became more mobile, licensing systems became more sophisticated out of necessity. The equivalence of academic qualifications from other countries needed to be assessed, language competence needed to be established and the status of the licence in the country of origin needed to be checked to ensure it was in good standing.

With increased recognition of the regulatory role in maintaining public safety, many systems moved from not just requiring initial licensure but also establishing requirements for periodic renewal of licensure. Periodic renewal of licensure provided a mechanism to ensure that not only had foundation education been completed but ongoing competence was being maintained.

In order to do this, some jurisdictions moved to requiring such mechanisms as a minimum number of hours of practice and/or a minimum amount of professional development within a specific time period to maintain a licence to practice. Re-entry courses for those who had not had recent practice were developed by educational institutions usually in conjunction with the regulator. Requirements to address continuing competence continued to evolve with the introduction in some jurisdictions of other mechanisms such as requiring self-assessment, peer review, maintenance of professional portfolios, clinical evaluations, examinations and/or multi-source feedback (e.g. nursing and non-nursing colleagues, employer and patients) to name just a few.

The best approach to verify the ongoing competence of nurses continues to challenge regulators. As yet, there is no clear evidence-based picture of what is the best mechanism for doing so. It is the focus of much current work in regulation.

Also, as part of recognition that the role of regulators included addressing not just requirements for entry on the register but also when there was a concern about the practice of professionals, many regulatory authorities established by legislation were given wide ranging powers to investigate the fitness of registrants to practice the profession, including referring registrants for health assessments.

In many countries this work was and still continues to be carried out by members of the profession through the regulatory board or council, or with committees established by the regulatory authority hearing evidence and determining what action should be taken. This is done on the basis that the profession itself is uniquely equipped to identify the standards for practice of the profession and recognise and take action when those standards are not being met.

However, more recently with high profile cases of extremely grave misconduct leading to concerns being expressed about accountability and the potential of members of the profession

"to protect their own", there has been a call for greater independence of this process. In some countries, independent tribunals have been established to hear complaints against registrants to determine whether those persons should be subject to action taken against their licence to practice. These independent tribunals were seen as important to ensure fairness to the nurse and also in establishing transparency in the system to maintain public confidence by requiring the separation of the roles of complaints assessment, investigation of complaints and determination of guilt and actions.

Some of these bodies initially only had power to suspend or cancel the licence of registrants. This power was clearly inadequate and more sophisticated powers developed such as the power to impose conditions on licences in a wide range of matters. Some conditions might restrict the scope of practice of nursing such as a condition prohibiting practice in certain settings, requiring practice to be supervised or prohibiting access to narcotics. Other conditions might not restrict the scope of practice such as conditions requiring completion of education modules or compliance with a treatment regime prescribed by a medical practitioner.

This move to independent tribunals, although prevalent in some jurisdictions such as Australia and New Zealand, has not occurred throughout the world. As previously noted, in many jurisdictions including those with well-developed regulatory structures, this important aspect of the regulatory role continues to be carried out by committees and councils of the regulatory authority with independent decision-making authority and legal support. In all cases, whether it be by an independent tribunal or under the auspices of the regulatory authority, the process needs to be transparent, consistent and fair with a focus on public protection. It is critical that the decision makers are seen as independent and impartial.

Another more recent shift has been the introduction of a greater range of options for dealing with complaints. Some regulators are introducing negotiated outcomes in less serious situations and when appropriate. These are referred to by a variety of names such as alternative to discipline, alternative dispute resolution, and consensual complaints resolutions. In these cases agreements are reached between the nurse and the regulator often in consultation with the complainant outlining precisely what the nurse commits to do. These processes provide for protection of the public and maintenance of standards without the requirement of a formal hearing.

Reflect on how your regulatory system has evolved.

- What have been the drivers of change?
- What was the impact of these drivers on your process for handling complaints?
- Do you see recent or upcoming influences that will result in further changes? If you do, what do you anticipate will occur?
- Are there any actions you should take now to successfully negotiate the change process?

Chapter 3: Role of the regulator

The principle aim of regulation of any profession is public protection. In both Chapters 1 and 2, there has been some discussion of the role and function of the regulator. This chapter will elaborate further on this issue before focusing in on complaints management in the remaining chapters.

The key roles of a regulator are:

- **Issuing licences to practice the profession to qualified individuals**: This involves establishing a process to assess eligibility to be placed on a register of qualified individuals including both those educated within the jurisdiction and those educated in other jurisdictions. Requirements may address education, good character or fitness to practice and for those educated in other jurisdictions such issues as licensure in good standing, recency of practice and language competency.[5]
- **Requiring periodic renewal (e.g. annual, bi-annual, etc.) of licences to ensure registrants are maintaining competence and are otherwise fit to practice**: There can be specific requirements to be eligible for renewal (e.g. recency of practice, completion of continuing education and/or demonstration of continuing competence). Registrants can also be required to disclose any other circumstance which might be relevant to their fitness to practice such as any health concerns or criminal convictions.
- **Establishing standards for education**: Education standards are necessary to ensure that nurses entering the workforce are adequately prepared to provide safe, competent and ethical care. This frequently includes approving or recognising nursing education programmes for entry to practice the profession with periodic re-approval. This re-approval process is in place to ensure standards are continuing to be met by the programme and to ensure that the education is keeping up with the needs of the ever-changing context of practice.
- **Establishing standards of practice including codes of conduct and/or ethics**: Practice standards represent the criteria against which the practice of nurses is measured by the public, clients, employers, colleagues and themselves and therefore are key documents to inform complaints management.
- **Establishing and articulating the scope of practice**: Nurses, other health care practitioners and the public need to be able to clearly understand what is or what is not within the scope of practice of the nurse. This is often defined in legislation. However, the context of practice and health care is constantly evolving so scopes of practice need to be periodically reviewed to determine if they are best meeting the needs of the public.
- **Managing complaints**: Upholding professional standards and maintaining public confidence in the profession and the integrity of the register by responding to, assessing and investigating complaints; and taking appropriate action.
- **Maintenance of the public register**: This register is a representation to the public at large by the regulator that any person holding a licence is competent and fit to practice. It is critical that this register be updated regularly to ensure its accuracy as the public, employers and other stakeholders in the profession should be able to place reliance on the register. Information in the register must be in a format that is, as much as possible, easily accessible (e.g. web-based information or by telephone).

[5] Requiring demonstration of language competency, although common, is not universally in place. In some situations it is the employer that establishes the capacity to deliver care in the language of the country. This is particularly the case in situations where multi-country trade agreements have prohibited language requirements to be embedded in regulation such as within the European Union.

Beyond the core functions of the regulatory authority, there are also other functions which support their work to promote patient safety and public protection. These include:

- Advocating for quality health care and healthy public policy in the public interest;
- Responding to consultations and working in partnership with the public, government and a range of other groups at the sub-regional, national and international levels;
- Supporting a stable supply of nurses by informing health human resource planning with data collected through licensure;
- Representing the profession of nurses nationally and internationally on regulatory or patient safety issues.

Identify the regulators' powers available in your country.

- What are the key roles of the regulator?
- What is regulated?
- What are the actions being taken by the regulator to uphold professional standards and maintain public confidence in the profession?

Chapter 4: Overview of complaints management process

A complaints management system is essential to ensuring the key roles of a regulatory authority are fulfilled. Without an efficient system the regulator will not be able to identify those registrants who are no longer competent or fit to practice. Even though complaints are submitted on only a very small percentage of the overall population of nurses, a complaints management system can be one of the more costly aspects of regulation. This is due to the high costs related to investigations, legal advisors, witnesses and experts in cases of hearing, responding to appeals, etc. That is why having a system that is responsive, thorough, fair, transparent, but also proportional, efficient and effective is essential.

Such a complaints management system must have a mechanism to receive complaints, an assessment process for dealing with complaints, the authority to investigate complaints, and the capability to act on the findings of investigations in order to protect the public from unsafe, incompetent or unethical practitioners. There are many steps involved in an efficient and effective complaints management process. This chapter will provide a broad overview of these steps however it needs to be recognised that approaches to address complaints management will vary around the world and the content in this chapter is subject to that proviso. Some steps, such as assessing complaints, investigating complaints and deciding on action, are more complex than others and merit further exploration so will be further elaborated on in the remaining chapters of this Toolkit.

Informing the public and others regarding the complaints management process

There are many stakeholders involved in professional complaints management. These include the registrant about whom the complaint is being made, the complainant and their family, the employer, co-workers, trade unions, professional associations, lawyers, consumer groups and government.

This is why it is essential that the regulatory authority make available clear and detailed information about the process for complaints management. Regulators have a responsibility to provide consumers and the profession with education and information about complaints systems. For example; when complaints should be made, to whom complaints should be made, how to differentiate between complaints about service or practitioner deficits, how complaints will be received, investigated and managed and what the potential outcomes may be. The information on how to make a complaint needs to be easily accessible, such as in a brochure, on a website and through accessible staff. Accessible regulatory authority staff is important as information on a website will often not assist those in the community without access to a computer or those lacking computer or literacy skills. If possible, it is valuable to have a designated staff person to receive complaints and answer any queries.

Many regulatory authorities have made publicly available on their websites comprehensive information on how to make a complaint and the complaints management process. Some examples from nursing and other professions are:

An Bord Altranais, Ireland: This site provides information on how to make a complaint, the complaint process, the powers of the regulator and how to apply for restoration to the register: www.nursingboard.ie/en/how_to_make_a_complaint.aspx

Nursing and Midwifery Council, United Kingdom: This site provides information on how to express a concern about a nurse, information on hearings and also additional information for employers. www.nmc-uk.org/General-public/Reporting-a-nurse-or-midwife-to-the-NMC/

Nursing Council of New Zealand: This site provides information on how to complain, the types of complaints, a link to a detailed brochure and information on the disciplinary tribunal process. www.nursingcouncil.org.nz/index.cfm/1,92,0,0,html/Complaints-about-a-nurse

Health Professions Council, United Kingdom: On this site, information is provided on how to raise a complaint, what the process is for review, what happens in a fitness to practice hearing and a video on the hearing process. www.hpc-uk.org/complaints/

In addition to providing information to the public, information should also be easily accessible to the person about whom the complaint is being made regarding what happens if a concern is raised regarding their practice. It should indicate the process, timelines, what will be expected of them, their right to seek legal assistance and assistance from their trade union or professional association as applicable.

A checklist of questions to ask when reviewing your system for informing about the process:

- Do you have readily accessible information for the public, employers and the nursing community about the complaints management process?
- Is the information about how to complain and the process written in plain language?
- Do the frontline staff who answer the phones or receive in-person visitors have clear written instructions on how to handle/refer a complaint?

Submitting a complaint

Complaints related to nursing practice may originate from multiple sources (the patient, their family, the employer, other nursing and non-nursing colleagues, as a result of a legal process etc.) and could be addressed to the nurse, the employer or to the regulatory authority. As there can be much confusion on which complaints can and should be addressed at the employer level and which should be referred to the regulatory authority, the next chapter, Chapter 5, will focus on this issue.

Although many complaints of a less serious nature are appropriately addressed by the employer with the nurse, others require review and action by the regulatory authority. The regulatory authority needs to have a mechanism in place to receive complaints. Some regulators, in order to increase accessibility and to provide clear guidance on the information required, have put in place online forms to facilitate complaint submission. Some examples are: the Health Professions Council, United Kingdom (www.hpc-uk.org/assets/documents/10003295raisingaconcernform-memberofthepublic.doc) and the Nursing and Midwifery Council, United Kingdom (www.nmc-uk.org/General-public/Reporting-a-nurse-or-midwife-to-the-NMC/).

The complainant should receive acknowledgement that the complaint has been received. It is also useful to establish a timeline for at least the initial response. Providing information on

timelines for the process as far as possible is also beneficial, noting that the time period may vary depending on the complexity of the matter.

Also, if the process is likely to be lengthy it is important to communicate on a regular basis with the complainant.

Initial screening or review of complaint

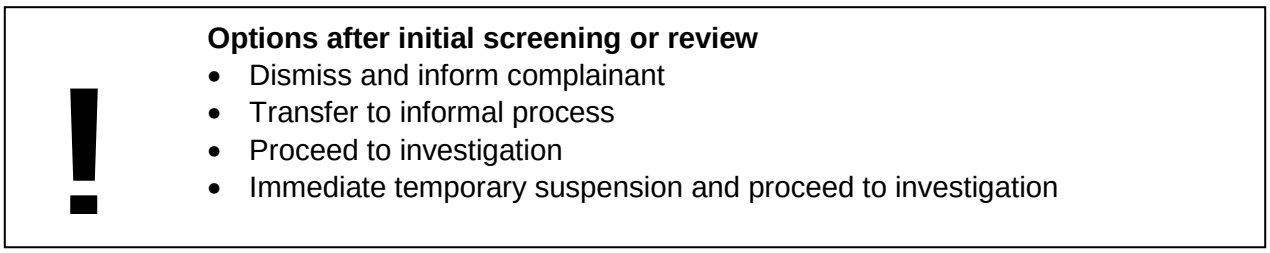
In most cases regulators put in place a mechanism for internal review of the complaint to determine if there is sufficient information or concern to indicate if investigation is required and if the matter falls within their power. This initial screening benefits the registrant by ensuring they do not, unless justified, face the expense, anxiety and risk of an investigation and a possible disciplinary hearing.

The screening process acts as a gate keeper and may help to control the nature and number of investigations and hearings. This screening is simply a preliminary assessment of the information at hand to determine if an investigation is required or justified. This can be done by staff, a committee or council. It is usually at this stage that the registrant is informed of the complaint and provided with information about the process and what to expect.

This initial screening process is required by legislation in some jurisdictions. For example, see section 149 of the legislation governing the regulation of all health practitioners in Australia[6] www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx

Two additional actions may be taken by the regulator at this time. One may be to refer a complaint of a less serious nature to an informal process to determine if there is the possibility of a negotiated outcome without proceeding to a formal investigation.

The other is the option of immediate temporary suspension of the licence in a situation where there is evidence of serious and immediate risk to the public if the nurse is allowed to continue to practice. The regulator may have the legislative mandate to immediately suspend the licence of the nurse until the risk has been mitigated (e.g. health issue addressed) or until the outcome of any disciplinary charge brought before a hearing or tribunal has occurred. This action is only used in very limited circumstances and is further explored in Chapter 11.



Options after initial screening or review

- Dismiss and inform complainant
- Transfer to informal process
- Proceed to investigation
- Immediate temporary suspension and proceed to investigation

Investigation

If the initial screening determines that a formal investigation is required or justified, the complaint proceeds to the investigation phase. The investigation of the complaint is a key piece of the regulator's work and needs to be carried out in a fair, impartial, unbiased and thorough manner. It will likely involve the gathering of data from multiple sources such as the individual who is the subject of the complaint, supervisory personnel, the patient and the

[6] Health Practitioner Regulation National Law Act (2009).

patient's family, nursing and non-nursing colleagues, documentation, etc. The investigation process is explored in more detail in Chapter 10.

Consideration of results of investigation

The investigator should submit a formal report to the regulatory authority once the investigation has been completed. The report is reviewed and a decision is made, often by a committee, on what further action (if any) should occur. The decision can be to dismiss the case, send to a formal hearing, or address the issue through a more informal process to seek a negotiated outcome. The potential actions by the regulatory authority are explored further in Chapter 11.

Hearing of complaint

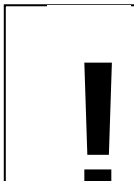
This is a hearing before the body which has power to hear the evidence of witnesses, submissions of the parties, deliver a decision and provide reasons for its decision. In some jurisdictions such hearings may be undertaken in the absence of the involved parties and witnesses in circumstances where the involved parties jointly propose an order and provide written submissions in support of that order. Hearings can be conducted by an independent tribunal or by a committee put in place by the regulator. Those involved in hearings will have training regarding their role and the hearing process. Hearings are further explored in Chapter 6. In addition, many of the websites as noted above include detailed information on hearing processes in their jurisdictions.

Recording on the register and publication

A key piece of the regulator's work is to maintain the public register. If an action has been taken against a nurse's licence this should be recorded on the public register either at the time the decision is made or after any appeal process is completed. Some jurisdictions also publish their decisions and/or post them on a website. If this is the case, clear policies need to be put in place regarding publication, such as what to publish (name, licence number, decision and reasons).

The degree of detail in published decisions varies from jurisdiction to jurisdiction. The published information may be just registration numbers or names, registration numbers and the status of the licence or it could be short statements of key findings. In some cases, full transcripts of the hearing are published.

The publication of disciplinary decisions is seen as a mechanism to promote public protection. It informs the public, employers and others that there has been action taken against a nurse's licence. Published decisions are also seen as an educational tool for other nurses to inform them of practice that is considered below the acceptable standard.



The transparency and openness in the functioning and decision making of the regulatory body is strengthened by the publication of both the decision and reasons for disciplinary judgements. Providing reasons for decisions is fundamental to ensuring the consistency and quality of decision making and to promoting the public's confidence in the delivery of justice to both the registrant and the recipient of services (ICN 2009).

Some examples of published decisions are available on the following sites:
An Bord Altranais, Ireland:
www.nursingboard.ie/en/fitness_to_practise_findings_and_decisions.aspx
College of Nurses of Ontario, Canada: www.cno.org/en/protect-public/discipline-decisions/

Appeal

Those nurses subject to complaints review and action should be given the right to appeal within specified timelines and informed of on the process to submit the appeal. The appeal would normally be to a different committee or group than made the original decision. In an appeal, the decision can be upheld, varied or referred back to the original decision maker.

Restoration or reinstatement

If a licence has been revoked or cancelled, the nurse will often have the right to apply for restoration or reinstatement of the licence after a certain period of time (e.g. five years). Again, the nurse should be informed of this right and the process.

Policies

In general, clear and comprehensive policies and procedures regarding the complaints management process need to be put in place. The issue of dealing with complaints is a challenging and often sensitive and emotional one for both the nurse and the complainant and therefore the process needs to be consistent, open and transparent.

Key components of a professional complaints policy include[7]:

- Who can bring the complaint,
- The maximum time permitted between the occurrence of the event and when the complaint can be made;
- Where (to whom) the complaint can be made, how to lodge a complaint, who receives the complaint and the processes for initial acceptance or rejection of the complaint;
- The process to be followed for complaints that are to be investigated;
- The options for action (e.g. alternatives to a formal disciplinary hearing);
- The time frame for recipients to respond;
- What happens after the response is received;
- The type of hearings that can be held;
- The composition of the hearings panel;
- What sanctions are available;
- How results are notified;
- What is the appeals process;
- Whether adverse findings are published and, if so, in what format;
- Process and timeline for application to restore licence.

Evaluation and statistical analysis

In order to ensure the system is efficient, effective, fair, transparent and thorough, it is important that regulatory authorities regularly evaluate their complaints management system. Are the

[7] Adapted from Best Practice Self-Regulation Model for Psychotherapy and Counselling in Australia: Final Report, Psychotherapy and Counselling Federation of Australia, February 2008.

right resources and processes in place? What are the outcomes and timeliness of the system? Issues that can be looked at in conducting an evaluation include:

- Knowledge of stakeholders regarding reporting of complaints and performance against targets;
- Timeliness of handling complaints;
- Clarity of policies;
- Whether the subjects of the complaints were treated with respect and in a non-punitive manner;
- Consistency in decisions;
- Stakeholder satisfaction with communications regarding status of complaints process including outcomes;
- Costing of process; and
- Number of decisions overturned upon appeal.

In addition to evaluating the process it is also extremely valuable to examine the rich data made available through the complaints management process. These data can help further inform the evaluation. For example, the relationship between type of case and length of investigation can be explored. The data also can allow for the identification of best-practices and efficiencies as well as systemic problems. Aggregate data also can be examined for evidence of patterns and trends in practice or fitness issues, patterns in the demographics of those involved in discipline such as age, sex, practice area, location of practice setting (rural, urban, private, public), education, time since graduation, etc. These data can then help to focus and inform the work of employers, educational institutions and regulators in terms of priorities and actions needed to counteract negative trends with respect to nursing practice.

Benchmark your system against the system described.

- Do you have similar components?
- Are there any gaps or areas for improvement?
- If so, outline what actions should you take to address gaps or introduce improvements?

Chapter 5: Differentiation from employer-based complaints systems

As noted in the previous chapter, complaints related to nursing practice may originate from multiple sources (the patient, their family, other nursing and non-nursing colleagues, etc.) and could be addressed to the nurse, the employer or to the regulatory authority. Perhaps the most common recipient of complaints would be the employer[8] or institution providing care as they are the most visible and may come first to mind when it comes to a complaint. In addition, a complaint may involve multiple parties including other members of the health care team so it is likely that the health care institution will be the initial recipient of the complaint.

With respect to nursing practice, it is the individual nurse's responsibility to practice safely and within the scope of their own knowledge and skill. Employers, who are often governed by other legislation such as Health Systems Acts, also have a responsibility to ensure that each nurse is appropriately orientated and inducted into an area of practice and to provide essential support systems including human resources so that the practice environment is one in which nurses are able to meet their standards of practice. Nevertheless, situations will arise when there is concern about the quality or safety of care provided, including nursing care.

Most modern workplaces will have a complaints system whether the complaint emanates from the employer, other employees, or users of the service (patients or their families). An employer of nurses should appreciate that complaints should only be referred to a nurse regulatory authority if the complaint raises a serious issue about the ethics, conduct, performance/competence or health of a nurse. Employers must assess complaints objectively and should not refer complaints for a collateral purpose, such as to gain leverage in an employment dispute with a nurse.

An employer should generally seek to deal with issues of performance, including competence, itself. However if the management of that issue proves ineffective, particularly if there is concern about the safety of the nurse's practice if the nurse was to move to another practice environment, then the employer should refer the complaint to the nurse regulatory authority.

Moreover, because a nurse regulatory authority's mandate is to act in the public interest, an employer should refer a complaint if it is in any doubt. Complaints which demonstrate a significant departure from accepted standards of conduct or competence or a serious health concern should be referred.

Employers may need assistance deciding what should or should not be referred to a regulatory authority. The decision regarding when to refer complaints to a regulatory authority can be challenging so it is often helpful for regulatory authorities to provide direction regarding this matter.

[8] In some countries where regulation is carried out through the Ministry of Health, the government may be both the regulator and the employer when the nurse is employed in a public institution.

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Some key questions for an employer to ask are:

- Is the complaint of a very serious nature (e.g. sexual misconduct)?
- Is this a significant public protection issue?
- Has there been a criminal action (e.g. theft, fraud, drug trafficking, sexual offences)?
- Is this a one time problem or a pattern of behaviour?
- If this person was to resign and go to another employer, would there be a public safety concern?
- Is there evidence of a serious health issue that may impair practice (untreated alcohol dependence, drug dependence, unmanaged serious mental illness?)

However, in some situations and jurisdictions some of this decision making is taken out of the employer's hands as legislation has been put in place requiring mandatory reporting of certain instances such as in the case of terminations, sexual misconduct in connection with the practice of the profession, or when there may be an immediate concern for public safety. In addition, nursing colleagues and others may be required by legislation to report fitness to practice issues or unsafe practice of a colleague. This "duty to report" is becoming more common in regulatory frameworks.

Chapter 6: Governance structures

Depending on the specific context of each country, the nurse regulatory authority may take different forms with multiple models in existence. The models exist along a spectrum from those that are profession driven and organised to others that are state-embedded or controlled (ICN 2009). There are countries where there is little or no regulation; others where the regulatory function is administered fully within the Ministry of Health; some where regulation is carried our within the auspices of the national nurses' association; and still others where there are arms length bodies enabled by government legislation (e.g. nursing councils). Also, more recently we are seeing regulation occurring under multi-profession or umbrella legislation. In this situation the nursing regulatory authority may remain as an independent entity or be part of an umbrella agency of multiple professions sharing regulatory functions including investigations and action on complaints.

Whatever its form, it is desirable for a nurse regulatory authority to be established under legislation so that it has appropriate powers available to it, particularly in respect of investigations of complaints (see Chapter 10) and power to take action against the licences of nurses (see Chapter 11).

In addition, it is desirable that the regulator is self-funded through the collection of periodic licence fees from nurses. Such a funding model may minimise any risks of unwanted government interference, enhance the profession's independence and provide a basis for impartiality. Nevertheless, if needed, the regulator can also benefit from grants from the state in recognition of its public mission. This method of funding is used by many countries as they develop their regulatory systems and work toward a self-funding model.

Whatever system is adopted for a complaints management system, it is important that the system incorporates a timely, transparent, cost-effective and fair process. It must satisfy the primary purpose of disciplinary proceedings which is to provide public protection by:

- Maintaining professional standards;
- Protecting the public from unsafe or incompetent practitioners;
- Maintaining confidence in the profession;
- Maintaining the reputation of the profession.

In order to properly fulfil this public protection role, a complaints management system must operate as both a specific deterrent to individual nurses as well as a general deterrent to the nursing profession as a whole. Publication of the outcome of individual cases or collation of general trends is seen to assist in fulfilling this role.

In this system it must be recognised by both the regulator and nurses that the licence to practice in a profession is a privilege and not a right.

It is often expedient and effective for a nurse regulatory authority to deal with complaints against nurses on a less formal basis through direct dialogue with the nurse to seek agreement on an outcome such as remediation of knowledge and skill deficits (competence) or engaging in appropriate therapeutic interventions (health). This not only conserves valuable resources but is also less time consuming and is less stressful for nurses and for any aggrieved patients or family. Regulatory authorities have a number of different approaches to this informal

process. They may have a committee review or a senior member of the regulator staff with delegated power to resolve complaints by agreement. Whatever the process, it is essential that the best interests of the public are observed. Whenever there is any doubt, a formal process should be adopted.

In a number of countries such as Australia, the United Kingdom and New Zealand, it is believed that a robust complaints management system should enable a nurse regulatory authority to refer more serious complaints (particularly those that are likely to result in either the cancellation or suspension of a nurse's licence) to an independent arbitrator to hear and determine charges.[9] This arbitrator will ideally take the form of a tribunal chaired by a member of the judiciary, assisted by members of the nursing profession and a representative of consumers of nursing services.

A disciplinary tribunal can only be truly independent if it is established by legislation. However, if legislation does not provide for a tribunal, the regulator can establish its own tribunal or committee to hear complaints. This approach is taken by many countries where the regulatory authority convenes a panel to undertake the formal process of hearing complaints.

Whatever, the process, fairness and transparency is necessary to avoid the perception by a respondent nurse that any outcome has been prejudged. Just as critical, it is necessary to avoid any perception by the public that the regulator is seeking to protect members of the profession. Independence and the *perception* of independence are important in maintaining public confidence in the system.

Some key distinguishing features of systems that use independent tribunals for the purpose of achieving the objective of independence are:

- Appointments to the tribunal are not made by the nurse regulatory authority (although the regulator may be asked for recommendations).
- The tribunal is not funded by the nurse regulatory authority.
- The tribunal does not sit in the same premises as the nurse regulatory authority.

It is contended that the best composition of an independent tribunal is a member of the judiciary or otherwise someone with legal training supported by at least one member of the nursing profession to ensure that the decision of the tribunal reflects contemporary nursing practice. In some systems a consumer representative is also represented on the tribunal to ensure the perspective of users of nursing services is considered. The lawyer member is important to ensure due process is followed.

In a system where the disciplinary tribunal stands apart from the nurse regulatory authority, it is important that the power of the regulator to refer a complaint to the tribunal is clearly defined. This power should not be too restrictive. For example, it should not be a precondition of a referral to a disciplinary tribunal that each complaint must be investigated as there will be complaints that are well supported by documentary evidence which will not require an investigation by the regulator such as a conviction for a criminal offence. It should be enough for the power of referral to be exercisable if the regulator forms a reasonable belief that a ground exists to take disciplinary action.

[9] In civil law jurisdictions the role of the independent arbitrator may also include an investigation function.

Act honestly and in good faith
This duty requires a member of a regulatory authority to act in the best interests of the authority having regard to the authority's objectives which invariably will be to protect the public and maintain the good standing of the profession. The duty also requires that the member act honestly at all times.

Exercise powers for proper purpose
Members must exercise the powers of the nurse regulatory authority for the purpose intended by the enabling legislation or the constitution of the authority and not be motivated by any ulterior purpose.

Do not misuse information or position
Members must not misuse their position, nor make improper use of information acquired in the capacity as a representative of the regulatory authority to gain, either directly or indirectly, an advantage for themselves or any other person or to take away from the authority achieving its stated objectives.

Exercise care and diligence
Members must exercise the degree of care and diligence that a reasonable person in a like position would exercise with a view to achieving the authority's objectives. This requires each member to become familiar with the powers and functions of the authority including all policies publicly put forward by the authority.

Disclose conflicts of interest
A member of a nurse regulatory authority should be vigilant in ensuring that any decision in which they participate is one in which they do not have either a direct or indirect interest, whether financial or otherwise, or may be perceived to have such a conflict of interest. If any such conflict arises, the member should disclose the nature of the interest, absent themselves during any deliberation and not take part in any decision in relation to the matter. The minutes of meeting of the nurse regulatory authority should reflect this process.

A member of a nurse regulatory authority may be appointed through a nursing organisation of which they are also a member. A policy should clearly state that a member of a nurse regulatory authority has an overriding and predominate duty to serve, on every occasion upon which a conflict may arise, the interest of the authority and not the organisation which nominated the member. If the member considers they are unable to properly fulfil this duty in relation to any matter that comes before the nurse regulatory authority, then the member should disqualify themselves from any participation in the decision making process regarding that matter.

A member should also disclose any approach, either in person or by other forms of communication, by a person who is the subject of a complaint to the authority. A member should avoid engaging in any discussion to the person making the approach.

Chapter 7: Definition of key terms and concepts

An important aspect of an effective and consistent complaints management system is to provide a clear definition of terms used in the process.

However, the precise definition of terms, such as *unprofessional conduct*, *unsatisfactory conduct* and *professional misconduct*, may vary from jurisdiction to jurisdiction as often terms such as these will be defined in enabling legislation or by professional or societal norms. This chapter should be read subject to that proviso.

Unprofessional conduct

The term '*unprofessional conduct*' or '*unsatisfactory professional conduct'* generally connotes a departure from accepted professional standards which is not as serious as conduct which would constitute professional misconduct or infamous conduct of a professional nature.

In judging the standard of the profession, a definition should state whether that standard is to be judged by the public, the person's professional peers, or both of them.

In Australia, in its recent legislation to introduce a national registration system for health professionals, the relevant legislation defines '*unprofessional conduct*' prescriptively and in a way which enables nurses to better understand what type of conduct could result in disciplinary action. That definition is as follows:

Unprofessional conduct "means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes:

a) a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention; and
b) a contravention by the practitioner of:
   i) a condition to which the practitioner's registration was subject; or
   ii) an undertaking given by the practitioner to the National Board that registers the practitioner; and
c) the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practice the profession; and
d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being; and
e) influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care; and
f) accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider; and
g) offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner; and
h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the

nature of that interest to the person before or at the time of giving the referral or recommendation."[10]

The term *professional misconduct* will only be satisfied if the conduct represents a serious or significant departure from professional standards as judged either by the profession or the public.

This test will not be satisfied by mere professional incompetence nor by deficiencies in the practice of the profession. What must be shown is a deliberate departure from accepted standards or such serious negligence as, although not deliberate, would portray indifference and an abuse of the privileges which accompany registration in the profession.

This term is defined in the national law in Australia to include:

a) "unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and
c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession." [11]

Examples of conduct which would amount to professional misconduct include:

- assaulting a patient
- stealing from a patient
- engaging in a sexual relationship with a patient where there is a power imbalance in the relationship.

Fitness to practice

Many systems of registration as a professional person require a number of qualifications such as attainment of academic qualifications and language qualifications in the relevant jurisdiction. In addition, it is imperative for a 'catchall' qualification to ensure that those persons who do not meet the minimum standards of the profession are not allowed to practice the profession or can be made subject to conditions under which they may practice. There are a number of different descriptions of this catchall qualification, such as:

- Fit to practice;
- Fit and proper person;
- Good repute and character.

Such a qualification for registration recognises that a licence to practice in a profession is a privilege and not a right. Abuse of any privilege attached to a profession may result in a loss or restriction of that privilege.

In determining fitness to practice, each case must be judged on its own merits and preconceived notions or rigid ideals should not be applied. For example, the commission of a crime by a nurse should not of itself be determinative of fitness to practice. Depending on the

[10] Health Practitioner Regulation National Law Act 2009, section 5, p.39
[11] Health Practitioner Regulation National Law Act 2009, section 5, p.36

seriousness of the behaviour, a one-off isolated event may or may not result in a determination that a person is unfit to practice.

Fitness to practice must be determined *at the time of the decision* and may have regard to past behaviour however remote, although the longer ago the behaviour occurred, the less relevance should be attached to it. However access to information on past behaviour will vary, as in some countries, once a sentence has been served, information on the criminal conviction cannot be considered in decision making.

Personal misconduct

The behaviour of a nurse when not practising as a nurse may display an absence or presence of qualities which are essential for, or incompatible with, the conduct of nursing practice. As such, *personal misconduct* may amount to professional misconduct. However personal misconduct must have a more direct bearing on the question of fitness to practice in order for any adverse action to be taken against a nurse's licence to practice.

The most obvious example of personal misconduct would be the commission of a serious criminal offence. By allowing a nurse to remain registered, the nurse regulatory authority affirms the nurse as a fit and proper person to practice the profession. The commission of a criminal offence, even though unconnected with the nurse's profession, will demonstrate unfitness to practice if the conduct demonstrates a lack of qualities essential for the conduct of the nursing profession or if the public could not be expected to put complete trust in the practitioner. Given the often vulnerable nature of the health care recipient at the time they are receiving care, it is essential that the public's belief in the honesty and the integrity of the profession be maintained.

Another example is a nurse engaging in the manufacture of and/or selling of illicit drugs where the deleterious effects on health and social fabric are in direct conflict with the concepts of health promotion and disease prevention.

Impairment

Impairment is often a ground for disciplinary action by itself, although some countries do not currently recognise this concept in their legislation. The term should have a very wide definition to include any physical or mental incapacity which may adversely affect the capacity of a nurse to safely and proficiently practice the profession. The following definition provides a balanced approach:

> "a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect … the person's capacity to practice the profession."[12]

An example would be a nurse with a drug addiction or serious psychiatric disorder which has proved resistant to treatment.

[12] Health Practitioner Regulation National Law Act 2009, section 5, p.34.

Negligence (or harm by omission or commission)

Negligence is a civil wrong which enables a person suffering damage as a consequence of another's breach of duty to seek damages. A person is *negligent* if the person does something, or omits to do something, which a prudent and reasonable person would not do. Negligence does not require proof of an intention to harm.

Negligence, of itself, will not usually amount to professional misconduct. Whilst the civil tort of negligence requires proof of damage (that is the consequences flowing from the relevant act or omission), such proof is not necessary to prove in disciplinary proceedings. Disciplinary proceedings are more concerned with exposure to risk rather than the actual consequences. In other words, it is the *potential* of the actions or omissions of a nurse to cause adverse consequences rather than proof of adverse consequences which is the focus of disciplinary action. For example, a nurse who recklessly commences an infusion of blood that has not been cross-matched for the patient will be liable to disciplinary action irrespective of any adverse patient outcome.

Many systems of regulation now require nurses to notify their nurse regulatory authority when the nurse was named as a party to civil proceedings alleging negligence in the practice of the profession and those proceedings resulted in a court judgment or a settlement.

Gross carelessness or gross negligence

Care or treatment provided by a nurse which falls significantly short of the standard patients are entitled to expect may amount to gross carelessness or gross negligence. Such conduct will often result in a finding of professional misconduct even though the conduct was not morally blameworthy.

Such conduct represents such a significant or marked departure from the normal standard of conduct of a professional person as to infer a lack of ordinary care which a person of ordinary skill would display.

Natural justice

Natural justice is a legal doctrine which requires that a person's rights or expectations cannot be adversely affected without first providing a reasonable opportunity to be heard before a decision against the person is made and that the decision maker is not biased. This legal doctrine is also known as *procedural fairness*. It would be expected that a disciplinary committee or tribunal would comply with the rules of natural justice in conducting a hearing.

The operation of this doctrine can be excluded by legislation but only if the legislation makes it clear that the doctrine has no application. The most likely occasion when this doctrine would be excluded would be those circumstances requiring urgent action by a nurse regulatory authority because the nurse posed a serious and imminent risk to patient health and safety. A suspension of a licence to practice in these circumstances might be permitted by legislation without first notifying the nurse.

Regulatory offences

This term is used in this Toolkit to describe the conduct of persons who are not licensed as nurses in the jurisdiction in which they are practicing (whether or not they are qualified to be licensed) which constitutes a contravention of a legislative provision. What constitutes an offence will depend on the relevant legislation although it is common for offences to include:

practicing the nursing profession when not licensed to do so; taking or using a title or description which suggests that the person is licensed to practice as a nurse; holding out another person as a nurse when that other person is not licensed to practice; or practicing the nursing profession when that person's licence was cancelled in another country or jurisdiction.

Undertaking

An undertaking is a promise. A written undertaking provided by a nurse to a nurse regulatory authority is often a very useful way of satisfying concerns of the authority arising from a complaint against the nurse because it is simple and effective. A breach of an undertaking is considered a very serious contravention of a nurse's professional obligations. More information on undertakings will be provided in Chapter 10.

The above definitions have their basis in new legalisation governing health care professions in Australia. Additional definitions of these and other terms can be found in regulatory legislation in other jurisdictions which is often made available on regulatory authorities' websites. ICN provides a global database of nursing regulators from around the world which includes contact information and, where available, websites of regulators. The database can be accessed at: www.icn.ch/pillarsprograms/global-database/

In addition ICN provides a summary of regulation terminology which can be accessed at: www.icn.ch/images/stories/documents/pillars/regulation/Regulation_Terminology.pdf

Also the Council of Licensure, Enforcement and Regulation (CLEAR), an international regulatory resource organisation, provides definitions of regulatory terms many of which are used in complaints management processes on its website. These can be accessed at: www.clearhq.org/resources/Glossary_General.pdf

Compile a list of defined terms for your jurisdiction.
Compare and contrast with those listed here.

Chapter 8: Types of complaints

It is desirable for a regulator to seek to categorise complaints as this will assist in how each complaint is dealt with and lead to more consistent complaint management. This promotes consistency which is essential for maintaining confidence in the regulation system. Although there will be variations in categorisations used by regulators, a basic categorisation of complaints might consist of the following: health; conduct; performance/competence; and regulatory offences.

Health

This category deals with those complaints where a nurse's state of health may result in an *impairment* which may compromise patient health and safety.

Conduct

Complaints about conduct can include a wide variety of behaviour and will include conduct not only in a professional capacity but also personal conduct. Such complaints can include:

- Boundary violations, such as forming an intimate relationship with a patient or taking an inappropriate gift or loan from a patient or from the patient's relatives or family;
- Physical or verbal abuse of patients;
- Theft from patients;
- Misuse of confidential patient information;
- Dishonesty (for example social security fraud or falsifying patient records);
- Failing to comply with a condition of practice;
- Breach of an undertaking;
- Failing to disclose a matter to the nurse regulatory authority which may be relevant in a determination of fitness to practice (for example, the commission of a criminal offence).

Performance/competence

A complaint about performance will generally relate to an allegation of lack of competence; that is, an absence of the knowledge or skills necessary to practice the profession to a standard acceptable to the public or to professional colleagues.

It is expected that employers of nurses will generally seek to address issues of performance or competence either through education, supervision or mentoring. If, however, these interventions prove unworkable or unfulfilling, or should the nurse choose to change employers to avoid these interventions, it would be prudent for a complaint to be made to the nurse regulatory authority.

Regulatory offences

Complaints alleging a regulatory offence will often be dealt with as part of a complaints management process even though the complaint itself cannot lead to disciplinary proceedings.[13] An example would be when the legislation includes protection of the title *nurse*

[13] The power to take disciplinary action will often only be available under the regulator's enabling legislation where the person was registered as a nurse at the time when the matter complained of arose, even if the person was not registered at the time disciplinary action was commenced.

and an individual uses the title *nurse* when not legally authorised by the regulatory authority to do so. As this person is not licensed with the regulatory body no action can be taken against the nursing licence. Such offences will be prosecuted by regulators through the legal system as opposed to the disciplinary process. The result of a successful prosecution will usually be imposition of monetary fines.

There must necessarily be some overlap in any categorisation of complaints. For example, it might be alleged that a nurse has been stealing medications from their place of employment. At the same time it might be alleged that the nurse is impaired. Whether the regulator deals with such a complaint as a *health* matter or a *conduct* matter will often depend on what action the regulator wishes to take (see Chapter 11).

Chapter 9: Assessment and screening of complaints

Chapter 4 provided an overview of the steps involved in the complaint management process and a brief overview of each of these steps. However, as noted some steps, such as the assessment of complaints which is explored in this chapter, merit more in-depth exploration.

The assessment or screening of a complaint is to determine whether the nurse regulatory authority should accept the complaint for action.

It is important for a nurse regulatory authority to have in place written policies about how complaints can be made. For example, will the authority accept complaints that are not in writing? Will it accept those made anonymously? It is suggested the answer to both these questions should be in the affirmative although greater scrutiny of a complaint would be required in those circumstances. A policy should also provide for the nurse regulatory authority to make a complaint to itself, such as in the case of a criminal offence by the nurse or where a newspaper report describes abhorrent conduct of a nurse and the regulator wants to investigate further but has not received a formal complaint. Ideally an authority should have capacity to receive any type of complaint which may bear upon the fitness of a nurse to practice the profession.

Once a complaint is received, the nurse regularity authority must scrutinize the complaint to determine whether the complaint falls within their powers and if so the strength of the evidence available to support the complaint. This assessment requires a determination whether there may be other information that is necessary for the authority to consider before making a decision on the complaint. That information might include medical opinion about the state of health of the nurse or a formal assessment of a nurse's competence. This assessment will determine whether an investigation is required (see Chapter 10). This phase can be carried out by regulatory authority staff or a committee.

Complaints that are deemed to be trivial or vexatious must be rejected. Such complaints would not, even if proved, lead to any disciplinary action. An example of a vexatious complaint is one made for an ulterior purpose and where the complaint has no merit, such as where an employer makes a complaint simply to gain an advantage in an industrial dispute with the nurse.

In this assessment phase it is useful to seek the consent of the complainant to authorise the release of their name to the nurse and to provide a copy of any written complaint to the nurse. In this way it is easier for the regulator to comply with rules of natural justice if it is determined it would be appropriate to take some action without an oral hearing, such as the imposition of conditions. However, such consent should not be a pre-condition to acceptance of the complaint.

Chapter 10: Investigation of complaints

Investigations may be undertaken in respect of any type of complaint. The purpose of an investigation is to establish and document the relevant facts and provide sufficient information to decide on next steps. Depending on the nature of the complaint the investigation may entail an independent assessment of the health or clinical competence of a nurse.

An efficient complaints management system will allocate resources where they are best used. Therefore it is important that a regulator only initiate a formal investigation of a complaint if there is some purpose in doing so. For example, there may be a material witness to interview or certain documents to obtain. If the complainant, such as the employer, has already investigated a complaint then the regulator should only initiate its own investigation if there is good reason to do so. In this case, however, it is essential that the regulator is confident that the previous investigation has been fair, transparent, un-biased and thorough.

Regulators may collaborate with other legislative agencies in an investigation, for example police or other health practitioner regulators, where the complaint involves criminal activity or multiple health care providers. A decision to initiate a formal investigation should often await the outcome of any coronial inquiry or criminal prosecution.

Investigator's powers

When determining whether an investigation should be initiated, the regulator must consider the powers available to investigators. Regulators operating within a legislative framework will often have at their disposal investigators with compulsive powers, such as a power to compel an individual to answer questions or produce documents. Also, in some cases, investigators may have power to obtain search warrants enabling them to enter premises and seize certain documents or items.

Investigators may be members of the regulator's staff or independent contractors provided with terms of reference and scope of investigation instructions. It is important that investigators are appropriately trained on how to carry out, document and report on an investigation. It is also essential that no one with an actual or a potentially perceived conflict of interest, such as someone with direct involvement with either the complainant or the subject of the complaint, carry out the investigation of the complaint.

The investigator should keep a complete record of the investigation documenting each step including the discussions, phone calls, interviews and any conclusions made during the investigation. It is essential that any records (paper and electronic) be securely stored to prevent unauthorised access, damage or alteration and to maintain confidentiality (New South Wales Ombudsman 2004).

An investigation must be conducted in compliance with any legislative framework which governs its progress. For example, legislation may stipulate that the nurse under investigation must be provided with details of the allegations being investigated and also be afforded an opportunity to respond to those allegations during the course of the investigation.

Irrespective of what legislative framework may exist, it would be common for an investigator to advise the nurse under investigation of the nature of the allegations forming the basis of the complaint and seek the nurse's response to those allegations. The nurse should be provided

the opportunity to deny the complaint and/or provide additional information, explanations or information on any mitigating circumstances. A response from the nurse could then be put to other witnesses for comment. In this way the evidence of various witnesses can be tested.

Nurses should be advised before the commencement of the investigation process that it is advisable to seek advice and support from their professional association, union and/or legal advisor.

It must be recognised that an investigation of a complaint about possible contraventions by a person of their professional duties and obligations, and any subsequent tribunal hearing, is not criminal in nature. It is a process directed towards the protection of the public by considering adherence to professional standards. This gives rise to a duty on the nurse to co-operate reasonably in that process by ensuring that any disclosure to the investigator is a full and frank disclosure.

However, it must also be recognised that, subject to any express legislative provision or any necessary implication arising from legislation, this general duty of candour is overridden in many jurisdictions by a general law privilege against self-incrimination (that is, a right to silence). What this means is that *if* a nurse does provide any statement or documents to an investigator, that disclosure must be truthful and not misleading in any way.

Interviewing witnesses

It is important for the regulatory framework to provide that any person who provides information or documents to an investigator relating to a person under investigation does not incur any civil liability. Often the defamation laws of a country will provide a complete defence to any action in defamation to any person who supplies documents or information to an investigator in good faith. However, an express provision to that effect in the enabling legislation is important so prospective witnesses can feel at ease when communicating with an investigator.

It is desirable that interviews with witnesses be on a face to face basis, although that will not be possible in many situations. Where the credibility of a witness is central to the substance of a complaint, every effort should be made to conduct a face to face interview.

Very often it will be necessary to speak to witnesses on more than one occasion as a witness' statement may have to be put to another witness for comment. This is an important step in any investigation to properly test the veracity and reliability of the evidence of witnesses.

Investigation report

Once the investigation has been completed a report should be submitted to the regulatory authority. There may be a legislative requirement for such a report and the legislation may prescribe the contents of the report (e.g. findings of fact and opinions based on those findings).

The regulator should have in place detailed policies about what matters should and should not be included in the report. For example, if a report is subject to disclosure, it may be desirable to de-identify witnesses and to exclude their personal details, such as address and telephone numbers.

To ensure consistency, a policy about investigation reports should detail the format of the report and how any attachments to the report are to be collated and presented.

Health assessment

An investigation may comprise or include a health assessment. A regulator will often have power to require a nurse to be assessed by a health practitioner of its choosing, such as a psychiatrist, addiction medicine specialist, occupational physician or neuro-psychologist. Such a power may include the right to require the nurse to pay for the assessment if the regulator determines it appropriate to do so.

It would be advisable that any health assessment be carefully controlled by the regulator including any written instructions. The assessor should also be informed of any formal requirements for the report.

Competence assessment

In a well-developed regulatory system, there will be provision for a regulator to assess the knowledge and skills of nurses through an independent assessor. In any assessment of competence, clear standards of practice must be available to enable an objective and reliable assessment. The standards and competencies expected of a beginning practitioner which lead to initial registration should, at a minimum, be the standards applied to an assessment of competence in the setting of the complaint. However, an assessment of competence should also consider the context of the practice setting and be based on an understanding and application of accepted principles underpinning practice rather than specific technical skills or tasks.

Some questions to ask for consideration in an investigation (adapted from New South Wales Ombudsmen 2004)

- Were all relevant witnesses interviewed?
- Was all relevant information collected and assessed?
- Was proper documentation carried out including the recording of witness statements?
- Could there be any perceived conflict of interest/bias with respect to the investigator?
- Was there any inappropriate storing of documentation and potential or real breach of confidentiality?
- Are all decisions and rationales documented?
- Does the investigative report meet regulator and legislative requirements?

Decision by the nurse regulatory authority

The nurse regulatory authority will be in a position to make a decision on what action, if any, should be taken on a complaint once an investigation report, health assessor report, or competence assessment report is made available. The actions that might be taken by the regulator after the investigation has been completed are dealt with in Chapter 11.

Chapter 11: Actions by the regulator

The comments in this chapter are of a general nature only as the powers available to a nurse regulatory authority, and the circumstances in which those powers may be exercised, will vary from jurisdiction to jurisdiction.

The primary function of a nurse regulatory authority is to issue licences and maintain a public register of those persons to whom licences to practice have been issued. The register is very important as it amounts to a representation by the nurse regulatory authority to the public that a person with a licence is fit to practice the profession. It is therefore imperative that a regulator is vested with such powers as will enable it to take whatever action is necessary to ensure that the public register is accurate. Whenever these powers are exercised by the regulator, an important action is to immediately update the public register.

These powers therefore must be in addition to the power to refer a matter to an independent tribunal or hearing or carry out the investigation and decision making regarding a course of action.

It is imperative that a regulator have sufficient powers to be able to take whatever action is necessary to protect the public in response to complaints made about nurses whether those complaints relate to their conduct, competence or performance, or their state of health. Policies should be put in place to deal with how those powers should be exercised in order to ensure consistency.

In Chapter 6 there was discussion about professional conduct hearings. However, not all complaints that are assessed as having substance will require a formal hearing.

The powers of the regulator to act without referral to a hearing will often include the power to cancel a licence, suspend a licence, or impose conditions on a licence. These powers should be available to be exercised based on written material before the regulator and without any oral hearing.

By contrast, a tribunal with the right to hear and determine disciplinary charges referred by the regulator would be expected to have the ability to summon witnesses and hear oral evidence. As a result many complaints relating to the *conduct* of a nurse must be referred to for a formal hearing if there is any dispute about the culpability of the nurse.

In order to ensure consistency and maintenance of the confidence of the profession and the public, it is vital that there is a clear delineation between those disciplinary matters that are referred to a formal hearing and those that are dealt with by the regulator without a hearing process. Legislation may specify the circumstances in which the regulator *must* refer a complaint to a tribunal or hearing. Those circumstances may be if the regulator reasonably forms the view that the conduct may constitute professional misconduct or if the conduct may result in the cancellation or suspension of a nurse's licence. If there is no legislative provision it is important to adopt a written policy on this issue.

This chapter will focus on those matters where the regulator does not refer a disciplinary matter to a formal hearing.

The powers of cancellation, suspension and imposition of conditions will invariably, unless the relevant legislation states otherwise, only be exercisable by a regulator when it has accorded procedural fairness. Procedural fairness requires that the nurse is fully appraised of the allegations made against them (ideally the nurse is given a copy of the material to be considered by the regulator) and given an opportunity to make a submission or provide any other evidence in support of their position. It is in this context that it can be seen why it is desirable that the consent of a complainant is obtained in order to enable the regulator to provide a copy of any written complaint to the nurse.

Cancellation

It is likely that a nurse regulatory authority would only be able to exercise such a power in the very clearest of cases, such as:

- When the licence to practice of a nurse has been cancelled in another jurisdiction and the legal and regulatory framework of the regulators are substantially the same;

- When the nurse procured the licence to practice by making a false or misleading statement or representation in connection with their application for licensure.

It would be unusual if this power was used in connection with a complaint concerning the *conduct* of a nurse. As noted earlier, legislation might require a nurse regulatory authority to refer such a matter to a formal hearing in circumstances where the regulator forms a reasonable view that the conduct may either amount to misconduct or result in a cancellation or suspension of a licence. Further, it is desirable for the reasons outlined previously, that a policy be adopted in these terms so that the regulator is not seen to be usurping the functions of a formal hearing.

This power of cancellation might be available based on views expressed in a report from a health assessor or a competence assessor. However it would generally be more likely that the power of suspension would be used in those circumstances.

Suspension

Some legislation will provide for a power of *immediate* and temporary suspension which may not require the regulator to accord procedural fairness. The legislation may indicate the maximum length of such a suspension. Such a situation would usually arise in circumstances where the state of health of a nurse suddenly prevented the ability to provide safe and competent nursing care or in the case of serious and imminent risk to patient safety.

As with the exercise of any power, it is critical to ensure that the preconditions to that exercise are satisfied. The regulator may have to defend its exercise of the power in court and must be in a position to prove that the relevant statutory test was satisfied.

The power of suspension will usually be exercised in circumstances where the health or competence of a nurse is such that the nurse poses an unacceptable risk to patient health and safety. In circumstances where this power is exercised the regulator should, if possible, advise the nurse on what steps must be taken in order to have the suspension lifted.

This power may also be exercisable, subject always to satisfaction of any statutory test, as an interim public protection measure while awaiting the outcome of any disciplinary charge brought

before a formal hearing. There may be circumstances where the allegations are so serious that the regulator forms the view that there is an unacceptable risk to the public if the allegations are proved to be true, for example; an allegation of a sexual relationship with a child.

Imposition of conditions

The regulator may also impose conditions on the nurse's licence. There are two general types of conditions that might be imposed – those conditions which restrict the scope of a nurse's practice, and those that don't. For example, the following conditions restrict the scope of practice:

- A condition prohibiting a nurse from working in certain areas, e.g. in a home setting;
- A condition prohibiting a nurse from working with certain types of patients, e.g. paediatric patients;
- A condition prohibiting the handling, possession or administration of certain medications, e.g. narcotics;
- A condition prohibiting any practice unless under supervision (setting out precisely what form of supervision is required).

A condition which does *not* restrict the scope of practice could include, for example, a nurse with an alcohol abuse disorder who might be required to remain abstinent from alcohol consumption, provide breath specimens both before and at the end of each shift, and provide monthly blood tests. Subject to compliance with those conditions the nurse may be free to work without any restriction on the setting or type of patient that may be cared for.

Both categories of conditions may also include generic monitoring conditions, such as:

- A requirement to notify the regulator of the nurse's place of employment;
- A requirement to authorise the nurse's employer or treating doctor to report to the regulator at any time there is a concern about the nurse's conduct, health or competence, or whenever the regulator requests such a report to be provided.

Monitoring type conditions may also be usefully employed as an interim public protection measure awaiting the outcome of a disciplinary charge before a formal hearing.

When exercising any powers available to it, a regulator should have regard to the outcome it seeks to achieve. This consideration is best illustrated in complaints alleging impairment. Although impairment will often be a ground to initiate disciplinary action, it is preferable for the regulator to seek to deal with these types of complaints itself (that is, without referring the complaint to a formal hearing) by monitoring a nurse's health status utilising the power of suspension or by the imposition of conditions.

Undertakings

An alternative approach, and one that is more frequently being used in situations of less serious complaints, is the provision of a written undertaking, whether or not the undertaking is noted on the public register.

The focus with *health* complaints is on the rehabilitation of the nurse. This addresses fairness to the nurse; is usually at much lower cost than a tribunal hearing; and recognises that,

provided public health and safety are not compromised and there is no issue of competence or conduct, there is utility in having the nurse continue to provide health services.

If monitoring a health condition proves unworkable, or if the nurse does not comply with an undertaking or conditions of practice, then as a last resort the regulator may take disciplinary action by referring the matter to a formal hearing either on the basis of the impairment or for breach of undertaking or conditions.

An undertaking is a less formal approach to complaints management. Nevertheless, this process must be handled fairly. There should be policies and procedures to clearly describe the process to be followed in the assessment and resolution of such matters. It is not always necessary that enabling legislation recognises undertakings as a properly drafted undertaking constitutes a promise to the regulator which can have serious consequences for the nurse if it is breached.

Undertakings will not be limited to health complaints but may also extend to other types of complaints. For example, an undertaking to complete re-education in a particular area may be determined to be an appropriate outcome of a complaint, such as clinical care, professional ethics or professional boundary management.

It is imperative that the undertaking very carefully sets out precisely what the nurse promises to do. This will include the timeframe in which the promise must be completed. An undertaking should also include various acknowledgements by the nurse, such as:

- That the undertaking may be noted on the public register (if that is the approach taken by the regulator);
- That the undertaking is to be complied with at the expense of the nurse;
- That the undertaking was given voluntarily after receiving or being given the opportunity to receive independent legal advice;
- That the nurse has not relied on any representation or inducement whether written or verbal of any member, officer or agent of the regulator, except as may be disclosed in the undertaking;
- That the nurse must keep all necessary records or documents to be able to satisfy the regulator that the nurse has complied with the undertaking in all respects;
- That a breach of the undertaking in any respect may amount to unprofessional conduct or professional misconduct enabling the regulator to institute disciplinary proceedings.

An undertaking may be sought by a regulator to resolve less serious complaints concerning conduct, health or performance. Where possible, it is worthwhile for a representative of the regulator to meet with the nurse to invite the nurse to enter into a consensual undertaking. This less formal system provides protection of the public and maintenance of standards through a mediated approach rather than a formal process and is increasingly being used in complaints management.

Chapter 12: Roles and responsibilities of stakeholders in complaints system

The efficacy of a complaints management system relies on appropriate matters being reported to the nurse regulatory authority. This in turn requires that the public and the profession understand what behaviour or circumstances warrant a complaint being made. To provide that understanding, as noted previously, it is desirable that a nurse regulatory authority have a user-friendly website or publications that clearly articulate the type of complaints that may be made and how a complaint can be made.

Employers also should provide information to the public about how to make a complaint regarding care and be able to provide direction on which complaints can be handled by the employer and which need to be referred to the regulatory authority. Consumer groups may also have a role to play in educating the public on these issues.

Nurses and employers of nurses have a responsibility to the profession and to the public to report a nurse in circumstances where they consider there is good reason to believe the nurse's health, conduct or competence may pose a significant risk to patient health and safety. This obligation to take action is a shared responsibility of nurses, employers, regulatory authorities and others (CRNBC 2006). For employers, it should not be enough to terminate the employment of a troublesome nurse. Similarly nurses should not always expect such issues to be dealt with exclusively by employers. In some jurisdictions it is a legislative requirement to report certain behaviour to the regulator. This is sometimes referred to as "duty to report" or "whistle blowing". This requirement may extend to other regulated health practitioners to report nurses suspected of behaving in a way that constitutes a serious departure from accepted professional standards.

The website of nurse regulatory authorities may publish hearing decisions on their websites. They may also publish decisions in their professional journal. This information usually includes background and reasons for the decision which can serve as an educational tool regarding the type of practice that is considered below the acceptable standard for the profession. Care must be taken to ensure the names of patients, or any information that might identify a patient or their family, is not published.

Chapter 13: Future work and conclusion

As there is much variability, it would be useful for regulatory authorities at both a regional and international level to work towards the adoption of common definitions of key terms and concepts used in regulation. This will help to maximise the utility of information shared between regulators both with respect to data shared on individual registrants moving between jurisdictions and on aggregate data on complaints.

Also, to assist developing countries, regulators with more developed complaints management systems should consider the creation of an international database of disciplinary decisions to educate nurses, the public and other health practitioners worldwide about standards expected in the nursing profession. Progress in this area is being made in Europe and perhaps this work can be built upon in the broader international context.

To develop common definitions and a database would not be without challenges due to differences in legal systems with definitions of terms and actions often embedded in legislation. For example, action which would result in removal from the register in one country might not be treated in the same way in another country. Such differences may influence the utility in sharing and interpretation of data.

The objective to achieve greater consistency in professional standards and complaints management becomes more of an imperative as the nursing workforce becomes more mobile internationally. With the proliferation of trade agreements and resulting enhanced mobility of workers, nurses are frequently crossing borders. It is important when addressing discipline and safety that there is a common understanding of disciplinary terms and actions taken on nurses' licences in other jurisdictions and what the implications are for registration in the new jurisdiction. The current lack of consistency in definitions, terms and actions can impact data sharing and have implications from a patient safety and public protection perspective.

Conclusion

The nursing profession has a responsibility to ensure that the highest possible standards of care are provided to patients at all times. The use of a robust and effective complaints management system is essential to fulfil this responsibility. Effective complaints handling increases the confidence of the public, the nursing profession, employers, government and other stakeholders that the profession is addressing issues related to the practice of nursing in a fair and transparent manner.

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