ICN Regulation Series

Model Nursing Act

Developed by Maggy Wallace

for the **International Council of Nurses**

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INTRODUCTION

This material looks in detail at the preparation of a Nursing Act and is designed to offer guidance on the process of turning policy change in nursing into meaningful and effective legislation. A Nursing Act is required to establish an effective statutory regulatory system (i.e. a system underpinned by legislation) for nursing. This document has been prepared primarily to assist countries/jurisdictions who are either preparing legislation relating to nursing for the first time, or revising their existing legislation. It is intended to be used, in the main, by nursing professionals who may not be familiar with the process of making or changing legislation.

The document has two main sections. The first section looks at how policy change can be turned into effective legislation, which fulfils its intended policy outcomes. The second section offers a template for a model Nursing Act. This model could be used as a basis for legislation, or adapted to suit particular circumstances. **To gain maximum benefit from the model legislation in Section Two, it is important to first work through Section One.** *Please use the glossary to be clear about the use of terms in this document.*

The material relates specifically to nurses and nursing. It is recognised that in many countries the role of the nurse also encompasses that of the midwife and this would need to be accommodated in the preparation of any relevant legislation.

How to Use this Document

Section One should be worked through by representatives of three groups of people:

a) those involved in making policy;
b) those who will be working to prepare the necessary legislation in order to put that policy into effect; and
c) those who will be instrumental in putting the legislation into practice in the workplace.

Some people may wear more than one 'hat', as long as there is no actual or potential conflict of interest. While the detail will vary from place to place, it is likely to involve, at least, representatives from professional practice, professional management and professional education. Representatives will also be needed from professional nursing organisations/trade unions, government, higher education and other key healthcare professionals who are involved with nursing and the delivery of healthcare**.** Checklists are provided in Annex 1 to assist in the choice of those who will form the Policy Steering Group and the Legislation Steering Group.

The advice contained in the document is designed to help decide what is needed for a jurisdiction's own particular circumstances. It is *not* intended as a rigid prescription of what to do. Please feel free to adapt the material, as appropriate.

Undertaking the Preliminary Work

One effective way to start the necessary work would be to hold a facilitated workshop of the key players to discuss the issues to be addressed. In this way, participants in the process can have the time and space to explore the key issues together before commencing the preparation of legislation. A proposed workshop outline is included as Annexes 2 and 3. Key questions or prompts are set out on a variety of key issues in Annex 4 to assist those working through the policy issues. There are no absolute right or wrong answers. While the answers may vary from country to country, they should not vary significantly *within* a country.

SECTION ONE – GETTING STARTED

This section is designed as a framework to work through before considering the detail of the model legislation in Section Two. It considers:

a) the preparation of legislation;
b) the scope of nursing practice;
c) the role of nursing and nurses;
d) the principles underpinning any effective system of regulation; and
e) the various aspects of policy which need translating into legislation.

Preparing Legislation

The use of legislation
Legislation can be used as a means to empower or constrain nursing practice. An understanding of how legislation is prepared and how long the process will take, is vital in order to have real influence over its outcome. Preparation of legislation is a lengthy and expensive process. It needs to be planned and managed. Processes and legal terminology vary and it is important to be familiar with the system used in your own country/state. Understanding the process will determine how and at what points effective lobbying needs to take place to influence the outcome of the legislation. Lobbying will need to occur from within and from outside the profession itself. Compromises may have to be made *en route*. A clear understanding of those issues which are *essential*, and those on which compromises could be made, needs to be identified early in the overall process.

The role of government
The role of government in the preparation of legislation relating to professional practice will vary considerably. In Canada, for example: 'Placing the regulatory function for nursing under significant government control, as is done is some professions and some provinces, is not consistent with the values of either the public or nurses in British Columbia.' (RNABC 2000). At the other extreme, in some Eastern European countries it has been the case that the government will prepare and implement legislation relating to nursing, with no input from the nursing profession at all.

Making policy
A clear policy objective first needs to be established, following discussion and agreement by the interested parties. This can be a protracted process but is important in realising effective legislative outcomes. This is discussed in more detail below.

How is legislation prepared?
It is necessary to have a clear understanding of the way in which legislation is prepared in the country concerned. Preparing legislation is a time-consuming and expensive business. It can, at times, be extraordinarily difficult to put good policy objectives into legislation. Being fully *au-fait* with the process will ensure that opportunities for

influencing the outcome are effectively exploited. Who will be responsible for turning the policy objective into the necessary legislation? It is likely to be the lawyer(s) representing the health department of government who will actually draft the proposed legislation. It is essential, however, that identified representatives of the nursing profession work with the legal drafters to ensure that the end result actually meets its original policy objectives.

The types of legislation

Legislation broadly comes in three types: primary legislation, secondary legislation and case law.

a) *Primary legislation:* sets out the overall structure and shape of the legislative powers and requires an Act of Parliament or equivalent. This means that it will need to have dedicated parliamentary/legislature time and can therefore take a long time to be put into effect. Any change to primary legislation is likely to be slow and expensive. During the preparation stage of primary legislation before the draft legislation comes into effect, it is known as a Bill. Once in effect, the Bill becomes an Act.

b) *Secondary legislation:* (also known as delegated or subordinate legislation and sometimes known as 'orders', 'rules', 'regulations,' or 'directives') adds the detail to the primary legislation on which it is based. A frequently used catch-all phrase for secondary legislation is Statutory Instrument (SI) – a form of legislation which allows the provisions of an Act to be subsequently brought into force or altered without Parliament having to pass a new Act. Secondary legislation is easier and quicker to change and should be used for those aspects of legislation that are more likely to be changed over time.

c) *Case law: includes legal judgements, which may affect practice but are not based on explicit written statute.*

d) *International, national, local legislation:* cognizance must be taken of any relevant international or national legislation, which may affect the legislation being drafted. For example, within the European Union, there is specific legislation relating to the hours of nursing education and associated clinical experience. (77/452/EEC). This will need to be taken into consideration when preparing national legislation on the same subjects within EU countries.

e) *Uni-professional or umbrella legislation.* Any discussion on legislation should also explore whether that legislation would be most effective if it applied to one profession only, such as nursing, or whether it should be umbrella legislation in the form of a broad single Act, which incorporates a number of Practice Acts from different professions, such as nursing, medicine or allied heath professionals. In the latter case nursing representatives should ensure that they are closely involved in the preparation of the sections relating to or having implications for nursing.

Time-frames
Preparing legislation is normally a time-consuming and expensive process. From the initial establishment of a policy intent (which may take a long time in its own right) to the point when the legislation is on the statute books, is likely to be, at the very least, a minimum of one calendar year, unless there is an urgent reason to speed up the process. Factors influencing progress include:

a) the clarity of the purpose behind the legislation;
b) the professional commitment to the legislation;
c) the political commitment to the legislation;
d) the public commitment to the legislation;
e) the quality of the legal drafters;
f) the quality of the professional support;
g) the support of the legislators;
h) any objections which may be made, and by whom;
i) the amount of legislature time given to the legislation.

Resources – human and financial
Any activity related to establishing a regulatory body and associated legislation must be adequately resourced if it is to succeed. Resources need to be both human and financial. Funding for the regulatory body itself is likely to come mainly from the profession itself and associated registration fees, although government funding may also be available in whole or in part. Governments may be prepared to pump-prime activity – either by means of a loan or possibly a gift - and then gradually hand over to the profession once registration fees and other income is available. Whatever the income source, a regulatory body will need effective and knowledgeable staff in the form of a Registrar/Chief Executive, together with sufficient executive staff, with both professional and administrative backgrounds, to support the Council/Board members in their work. The Council/Board and its committees will also need effective servicing. The full extent of the staffing and associated resources will be dependent upon the role and function of the body itself.

Scope of Nursing Practice

All activity relating to the preparation of legislation should start with a very clear sense of purpose of the role of nursing and nurses within the healthcare framework. The contribution that nurses and nursing can bring to the organisation and delivery of health care in the society concerned must be clearly articulated. Any legislation supporting nursing and its activities needs to be preceded and underpinned by a philosophical and conceptual discussion about the nature of nursing practice and the role of the nurse in the country/state in question. Defining the scope of nursing practice may well vary from place to place, and will be influenced by a number of factors. These factors include: the historical/traditional role of the nurse; the role of women in the country concerned; the relationship between nursing and other health care professions, particularly medicine; and the amount of exposure to international nursing/health care activity.

The ICN statement on Scope of Nursing Practice states, *'The scope of practice is not limited to specific tasks, functions or responsibilities but includes direct care giving and evaluation of its impact, advocating for patients and for health, supervising and delegating to others, leading, managing, teaching, undertaking research and developing policy for health care systems. Furthermore, as the scope of practice is dynamic and responsive to health needs, development of knowledge and technological advances, periodic review is required to ensure that it continues to be consistent with current health needs and supports improved health outcomes.'* (ICN 1998, rev 2004).

Protection of the Title 'Nurse'

One of the most significant advantages of a statutory regulatory system is that it can offer protection to the title of 'nurse'. Providing the legislation is appropriately drafted, the title 'nurse' can be protected by law and therefore used only by those legally authorised to practise the full scope of nursing.

> 'Persons receiving health care and those who are employing them have the right to know whether they are dealing with a legally qualified nurse. Reserving the title 'Nurse' for those who meet the legal standard allows the public to distinguish legally qualified nurses from other nursing care providers. …The unlawful use of the title' Nurse' should result in criminal, civil and/or administrative action against the person and anyone who assists them in using the title 'Nurse''. (ICN 1998).

In some jurisdictions, it is, potentially confusingly, only the title 'registered nurse' which is protected by law.

Principles of Regulation

ICN has set out 12 principles, which should underpin effective professional regulation. The principles were originally set out in 1986 (ICN 1986) and were re-examined and reaffirmed in 1997 (ICN 1997). They provide an excellent base from which to frame discussions about the nature and purpose of the regulatory system that is needed within your own country. They need to be discussed by the Steering Group, which is leading this work, and agreement needs to be reached on the style and approach appropriate to the country/state concerned. It is suggested that this discussion form a significant part of the workshop activity referred to above and in Annexes 2 and 3.

The principles relate to purposefulness, relevance, definition, professional ultimacy, multiple interests and responsibilities, representational balance, professional optimacy, flexibility, efficiency and congruence, universality, fairness and inter-professional equality and compatibility. A brief summary of the key points in relation to each principle and its application to a Nursing Act is set out below. For a detailed exposition of the principles, please refer to the relevant ICN documents (*ICN on Regulation*: *Towards 21st Century Models,* 1996, Styles MM & Affara FA, Geneva).

Anyone considering setting up new systems of regulation – whether whole or partial – is strongly advised to keep these principles firmly and explicitly in mind at each stage of the process and to regularly measure all activity against these benchmarks.

***Principle of purposefulness*: regulation should be directed towards a specific purpose.** *The over-riding purpose of the statutory regulation of nursing is that of service to and protection of the public.*

Effective regulation is about providing the public with assurances that the profession has effective standards in place in relation to professional education, practice, registration and professional conduct. Systems should also be in place to ensure that those who are not competent or do not practise to a satisfactory standard can be identified and supported in improving their practice, or, where appropriate, be removed from practice if it is in the public interest. Regular, critical appraisal of any regulatory system should be undertaken to ensure that it continues to meet effectively its public protection role.

***Principle of relevance*: regulation should be designed to achieve the stated purpose.** *Since the over-riding purpose of statutory regulation is service to and protection of the public, the regulatory system should be designed to satisfy this intent in a comprehensive manner.*

It is very easy to put too much detail into regulatory systems, which can have the effect of impeding change, reducing flexibility or even minimising the intended effect of the policy. Each aspect of policy should be examined to ensure that it is relevant to the overall purpose. Each aspect of policy should also be examined to see whether it needs to be supported by legislation or legislative change, or whether the purpose could be equally well served by non-statutory means, such as advice or recommendations. Such alternatives could be quicker, cheaper and just as effective. Policy should be regularly reviewed to ensure it continues to meet its objectives in terms of relevance.

***Principle of definition*: regulatory standards should be based upon clear definitions of professional scope and accountability.** *A definition of nursing and nurses should be at the heart of every system for regulation of the profession.*

Professional scope and lines of accountability may vary from country to country. The issues should be discussed and debated by policy makers and to be effective, need to be fully understood by practitioners. The role and function of the nurse and their relationships with other health care professionals, particularly doctors, should be clear and unambiguous. Any legislation should be drafted so that it can accommodate changes in professional practice without the need to resort to costly and time-consuming legislative change.

***Principle of professional ultimacy*: regulatory definition and standards should promote the fullest development of the professional commensurate with its potential social contribution.** *Since the function of a profession is, by definition, to serve society, nursing in common with other health professions, should be encouraged to serve to its maximum capability.*

Nurses are a key resource in any health care system. Any legislation should allow for the maximum development of nurses and nursing in order for them to use their knowledge and skills to best advantage in the delivery of effective health care. The role of the nurse in any society will change over time, in response to factors such as: the role of women in the society concerned; how that society views nurses; the relationships with other health care professions, particularly medicine; and the education and training of the nurse. Nursing education must prepare practitioners to function at the highest level possible to achieve these aims.

***Principle of multiple interest and responsibilities*: regulatory systems should recognise and incorporate the legitimate roles and responsibilities of interested parties, the public, the profession and its members, government, employers and other professions in various aspects of standard setting and administration.** *It is the responsibility of the profession to take the leading role in its professional governance.*

While it is indubitably the role of the nursing profession to drive policy in its own affairs, this must be done in conjunction with other key players in order to achieve maximum effectiveness. Nursing does not exist in a vacuum and there will be many others who have a legitimate role in its activity, in relation to the organisation and delivery of nursing care. For example, at different times, representatives from government, professional organisations, the law, employers, other professions and education will all have a legitimate interest in various aspects of nursing regulation. Increasingly important is the view of the consumers of health care – both patients and potential patients. Visible and transparent systems should be in place to ensure that there is an opportunity for all these voices to be heard at various stages.

***Principle of representational balance*: the design of the regulatory system should acknowledge and appropriately balance interdependent interests.** *It is not in the best interests of any profession to be unchallenged in its regulatory standards and processes.*

Linked to the previous principle, this principle seeks a balance between those with legitimate interests in the regulatory system being established. All professions need increasing external scrutiny and comment on their affairs to ensure that the public protection role is effectively met. Representation will need to be sought from a selection of different groups, including those outlined in principle 5 above. Regulatory Boards increasingly have greater public/consumer representation – sometimes, indeed, more 'lay' than professional representatives. This approach should also be adopted throughout the whole regulatory system – for example, on committees and working groups.

***Principle of professional optimacy*: regulatory systems should provide and be limited to those controls and restrictions necessary to achieve their objectives.** *The purpose of statutory regulation is to ensure that competent and accessible care is available from accountable professionals and this should be done using efficient effective and economic processes.*

A constant theme in applying the principles should be to ensure that all systems put into place are fit for purpose and that they do not impose unnecessary burdens on those trying to implement the system, either immediately the legislation comes into effect or in the future. Controls and restrictions should be kept to a minimum. This will be a significant challenge and require a clear understanding of those issues which need to be placed into legislation and those where the means can be achieved through other routes. Focus should be on the important issues such as mandatory credentialing and continuing professional development, the accreditation of those with additional qualifications, the effective management of those who support nurses, the positive management of poor practice and effective disciplinary processes.

***Principle of flexibility*: standards and processes of regulation should be sufficiently broad and flexible to achieve their objective and at the same time permit freedom for innovation, growth and change.** *Regulation should be neither too general nor too specific. Scope of practice definitions and educational standards should give broad guidance to practitioners and employers through general statements of nursing function.*

Definitions will need to address the roles and relationship between the varying categories of nurse, for example the registered (qualified) nurse, the specialist nurse, the advanced practice nurse and the nurses' assistant/aide (known as Unlicensed Assistive Personnel [UAP] in some jurisdictions). There should be no ambiguity in respect of the various roles and functions. However, as professional practice will change over time, any professional definitions need to be able to accommodate a reasonable degree of change without frequently resorting to expensive and time-consuming legislative change.

***Principle of efficiency and congruence*: regulatory systems should operate in the most efficient manner ensuring coherence and coordination among their parts.** *Regulatory activity on behalf of all interested parties should be coordinated to accomplish the purpose of regulation in a streamlined and uniform manner.*

Ensuring congruence between all parts of a regulatory system can be difficult unless you are starting with a blank sheet of paper – which is rarely the case. More frequently, legislation is changed over time in incremental fashion. It will be extremely important to ensure that all the parts of the system do not duplicate or contradict each other. This emphasizes the importance of legislation being prepared jointly by those who fully understand the policy intent from a professional perspective, as well as those who have an understanding of the legal process of preparing legislation.

***Principle of universality*: regulatory systems should promote universal standards of performance and foster professional identity and mobility to the fullest extent compatible with local need and circumstances.** *Although some recognition must be given to local needs and cultural differences, substantial inconsistency is antithetical to the achievement of broad and uniform development of the profession and free movement of practitioners.*

Nurses are increasingly mobile as practitioners and frequently cross local, national and international boundaries for work, either temporarily or on a more permanent basis.

The more similarity there is between standards of education and practice, the less likelihood there is of any misunderstanding of the role of the nurse. As a result, the contribution of nursing to the delivery of effective healthcare is maximised. A jurisdiction should be cautious about implementing unique and restrictive entry requirements, which it will then need to constantly defend from challenges by immigrating nurses denied the right to practise their profession.

***Principle of fairness*: processes should provide honest and just treatment for those parties regulated.** *Honest and just systems of regulation must be visible, open and objective with explicit routes for appeal.*

Everyone involved in any part of a regulatory system – either as a nurse, patient, a member of the public or another member of a healthcare profession – needs to know that the system has explicit standards in all aspects of its work. The way in which those standards have been set and how they will be monitored should be a matter for public scrutiny and examination by a variety of means.

***Principle of inter-professional equality and compatibility*: in standards and processes, regulatory systems should recognise the equality and interdependence of professions offering essential services.** *For professions to develop and work collaboratively on the public behalf, education and practice standards need to be comparable and regulatory processes complementary.*

In order for nursing and nurses to take their place as equal but interdependent partners in the delivery of health care, their systems of regulation should match those of other health care providers. Education and practice standards must be robust and visible and complementary to other health care providers. Approaches to professional discipline should also be similar amongst all health care professionals.

Policy Issues

Any enabling legislation, primary and /or secondary, will usually address the following issues, as a minimum:

- description of the purpose and scope of the regulatory body;
- the establishment, composition and function of the regulatory body;
- a definition of nursing, the nursing role and the categories/types of nurse (e.g. nursing aide, registered nurse, advanced practice nurse, etc.);
- licensure requirements/standards for practice;
- standards for registration/licensure;
- standards for maintaining registration/licensure;
- the position of those not covered by the Act, e.g. Nursing Assistants.

Legislation can vary significantly in terms of length, detail and presentation according to the country concerned. Generally, the enabling legislation, whether that is a Nurses' Act or part of a broader multi-professional legislation with a different name, will provide a broad framework on which to 'hang' more detail. The enabling legislation will give the regulatory body concerned the power to make Rules which elaborate the detail of the requirements. The following issues will usually appear in Rules:

Education
Entry criteria

a) Age of entry
   This may vary from country to country depending on the general education system in place. Ideally, it should be the same entry age for all higher education in the country concerned. This would ensure parity for nursing education with other health care professional education. Legislation on age discrimination may mean that some countries do not specify age of entry.

b) Academic level/qualifications
   General education qualifications may be specified here, in terms of the qualifications and the levels of attainment to be reached before being eligible to apply for a place at a nursing college. Attention will also need to be given to alternative forms of entry for those who do not hold the relevant certification. Some form of assessment of prior (experiential) learning (AP(E)L) will be necessary. Such criteria will need to be synchronised with the general entry requirements of the higher education institution providing nursing education. The requirements for nursing should broadly match those for other professional entry requirements.

c) Length of schooling
   A minimum length of general schooling in years is often expressed as an additional entry criterion. This can be used instead of stating a minimum age of entry into programmes of nursing education. Nursing students should have the same minimum length of schooling as other students entering higher education.

The programmes of nursing education
Some form of specification is likely to be made in relation to:

a) Length/balance of theory and practice
   Details of the programme in respect of the balance of theory and clinical practice are important for a practice-based profession. There needs to be sufficient clinical components to ensure clinical safety before registration/licensure, supported by sufficient theoretical input to provide evidence-based support for effective nursing care in practice.

b) Level
   The academic qualification to be obtained before registration or licensure – whether a degree, diploma or certificate – will need to be specified in the legislation. Such decisions will depend on the general education system and the value attached to nursing education in the country concerned. Many countries are now requiring the final nursing qualification at graduation to be at first degree level.

c) Specialist/advanced practice nursing
Requirements will also need to be made in relation to the additional qualifications to be obtained following initial registration. Second entries on the professional register in the specialist or advanced practice nursing category will need explicit criteria. Education/training criteria for specialist/advanced practice will need to be matched by employment roles that 'fit' the preparation offered. Credentialing for additional qualifications may be the responsibility of a body other than the regulatory body, for example, the professional nursing association.

Registration

The following issues will need consideration:

a) Qualifications
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. The possession of a nursing qualification alone should not mean that the individual is registered *to practise* 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.

b) Levels/grades of nurse
The various levels/grades of nurse need to be explored in detail – will there be one standard for all registered nurse for initial entry on to the register or will there be more than one? From a public protection perspective, one standard is less confusing than many and makes for a clearer career pathway. If there are to be different levels of nursing qualification, then this should be made clear in the legislation, in order to avoid duplication and confusion of roles.

c) Scope of practice
As mentioned above, whatever decision is made about levels/grades of nurse there needs to be clarity about the various roles and responsibilities to avoid duplication, overlap and confusion. This applies both to initial and subsequent entries on the professional register.

d) Registration periods
Registration periods can vary from annual, biennial or triennial renewal to life (now an unusual approach). Registration fees will also vary according to the frequency of registration.

e) Criteria for maintaining registration
Specific criteria will usually be required for the maintenance of registration. Payment of a fee alone is not sufficient to confirm competency in practice, which should be the key objective of the registration process. Such requirements will usually be in the form of some kind of continuing professional development (CPD). This may be stated in a number of ways, for example, in terms of the number of hours of CPD to be achieved over a given registration period. Whatever the requirement, it will need to be made clear to all registrants, so that they know what they have to achieve in order to maintain or renew their registration.

Practice
The following issues will need consideration:

a) Code of Conduct/Ethics as a baseline for practice
All regulatory bodies will need an explicit Code of Ethics or Practice, in order to provide practitioners with a template against which they can measure their professional 'behaviour', and against which any allegations of misconduct/lack of competence could be judged.

b) Scope of Practice – flexible/limited
The scope of practice for registered practitioners may be set out in greater or lesser detail depending upon the approach used for all professions in the country concerned. Some legislation will give very specific guidance on the tasks which may be performed by certain member(s) of the health care team; other approaches may adopt more general guidance linked to professional accountability and autonomy.

c) Role of those who assist nurses
The position of those who assist nurses should be made quite clear in the legislation in order to prevent confusion, role conflict and potential. For example, the following extract addresses in detail the role and function of nursing assistants in California:

Functions performed by unlicensed personnel (from the California Board of Registered Nursing, Article 2725.3)

a) A health facility licensed pursuant to subdivision (a), (b) or (f) of Section 1250 of the Health and Safety Code shall not assign unlicensed personnel to perform nursing functions in lieu of a registered nurse and may not allow unlicensed personnel to perform functions under the direct clinical supervision of a registered nurse that require a substantial amount of scientific knowledge and technical skills, including, but not limited to, any of the following:

1) administration of medication;
2) venipuncture of intravenous therapy;
3) parenteral of tube feedings;
4) invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning;
5) assessment of patient condition;
6) educating patients and their families concerning the patient's health care problems, including post discharge care;
7) moderate complexity laboratory tests.

b) This section shall not preclude any person from performing any act of function that he or she is authorized to perform pursuant to Division 2 (commencing with Section 500) or pursuant to existing statute or regulation as of July 1, 1999.

(Added Stats 1999 ch 945 § 2 [AB 394])

Education following qualification
The following issues will need consideration:

a) Additional qualifications/credentialing.
   Decisions will need to be made about the additional qualification(s) to be placed against a practitioner's name on the professional register. Such qualifications may relate to specialist or advanced professional practice, education, research or teaching qualifications. The criteria for achieving the qualifications will need to be made explicit, as will the expansion in the individuals' role and responsibilities.

b) Continuing professional development requirements for maintaining registration.
   Most regulatory bodies now expect registrants to undertake some form of CPD, which will be monitored in some way at the point of renewal of registration. Such requirements may include a specific educational/training activity, which may be defined in legislation.

Fitness to practise
The way in which professional conduct or competence to practise is usually measured will be according to the professional code being used by the body concerned. Where compatible and consistent with their public protection role, regulatory bodies will wish to take a positive, rehabilitative approach to fitness to practise issues. All registrants must be fully aware of their professional Code of Conduct /Ethics and understand their professional accountability. The following systems will need to be established:

a) mechanism for investigation – visible, fair, with appeal mechanisms;
b) sanctions – e.g. caution, suspension, removal from register/right to practise;
c) re-instatement process.

These are dealt with in more detail in the draft legislation in Part II of Section Two.

Funding

Many jurisdictions are limited by resources and this must be taken into account. The legislation must contemplate the practical ability to enforce that legislation. If, for example, it is anticipated that the nursing profession alone will pay for the cost of a self regulating system and there simply are not enough nurses to pay for those costs, then the legislation should consider including three or four professions to be regulated by a single system. This would provide economies of scale and drive costs down.

Liability

The obligation for professionals to have liability protection is sometimes viewed as a necessary component of registration for the protection of the public. Whether this is included in the legislation or promulgated as a mandatory requirement of the regulatory body will depend on the importance attached to it in the particular jurisdiction.

Exemptions/Exclusions

In some jurisdictions the legislation may need to allow for certain limited circumstances where an individual may nurse without licensure, e.g. student nurses, or emergency situations.

Transitional Arrangements

Consideration should also be given to any necessary transitional arrangements, which might affect those who are already part of a system which is being changed, to ensure that individuals are not disadvantaged. Where legislation replaces existing law, the transitional arrangements may also need to be specified as part of the new legislation.

Conclusion to Section One

It is essential that each of the above issues is subject to detailed discussion and debate in policy terms by those involved, before the process of legislation preparation can commence. Each element is now looked at in more detail under the relevant section of the draft legislation in Section Two.

SECTION TWO – THE MODEL LEGISLATION

This part of the document sets out material, which would serve as a suitable framework for a Nurses' Act. It is not intended to be complete in all detail because the scope and purpose of regulatory bodies will vary, as will their detailed functions. It is intended to offer broad headings, which need to be addressed, plus some discussion on the key issues for consideration.

The legislation, which is eventually prepared, may be primary legislation in its own right – that is, an Act that relates only to nursing. If so, it will also need to have supporting secondary legislation in the form of more detailed rules, which can be amended more quickly than primary legislation, if necessary. Alternatively, the powers to create the necessary legislation relating to nursing may stem from a more general Act of Parliament. Such an Act may deal with wider health organisation and delivery issues and include the practice-based professions as part of that primary legislation. If this is the case, the specific issues relating to nursing will need to be drafted in some form of secondary legislation (rules, Statutory Instruments).

The final form of the legislation will lie with the law makers, government civil servants and the legal system within the country concerned. While the detail and presentation of the legislation will vary from country to country, the content should be broadly the same, if nursing is to take its proper place in the organisation and delivery of effective health care. It is *essential* that nurses play a significant role in the preparation of the actual legislation, ensuring that the final law meets its intended professional policy outcomes.

For clarity and consistency, the material which follows is based broadly on a specific piece of legislation – the enabling legislation used in the UK, Statutory Instrument 2002 No 253 The Nursing and Midwifery Order (HMSO 2001), which established the roles and powers of the Nursing and Midwifery Council. Italics are used where the legislation is quoted directly. The Order (secondary legislation) was made in accordance with The Health Act 1999, which is the enabling primary legislation. As different terminology will be used in different places, depending upon the legislative processes in place, countries will wish to adapt the framework to their own specific circumstances. The most important thing is that the various issues identified should be addressed.

The Model Legislation – Broad Outline

As explained above, there is no definitive format for a Nurses' Act. However, whatever the format, one would expect to see the following sections included within any model legislation relating to nursing (whether primary or secondary legislation, practice specific or part of wider umbrella legislation). Discussion of the issues is in ordinary type, direct quotes from the legislation are in italics and the relevant article of legislation is referenced (*Source: The Nursing and Midwifery Order 2001*).

Name/type of the legislation
Arrangement of articles
General information
The Board/Council and its committees
Registration
Education and Training
Fitness to Practise
Appeals
Midwifery
Offences
Miscellaneous
Schedules
Council

- Tenure of members
- Procedure of Council & Committees
- Powers of the Council
- Powers of the Committees

Committees
Transitional provision
Interpretation
Consequential changes to primary legislation
Explanatory Notes

The requirement of the body concerned to consult with those who will be affected by the legislation should appear throughout the text of the legislation. Similarly, the body will be required throughout to publish its agreed standards/requirements in all areas of its work.

The Model Legislation – Detailed Information

The following numbering relates to this document and not to the actual legislation. Where the legislation is directly quoted, the quote and its following references are in italics.

Explanatory Notes
A.1. This section, which does not form an official part of the legislation and may appear at the beginning or the end of the actual legislation itself, will provide a brief synopsis (3-4 paragraphs) of the powers of the legislation and an explanation of its overall purpose. It would be a good place to start for those who are using the legislation for the first time and who wish to ascertain its broad powers in a quick and simple fashion.

Name/type of the legislation
A.2. The name of the legislation should be unambiguous and describe as accurately as possible what the legislation contains. It must also give the date when the legislation was made (which may not be the same date as when it comes into effect). The type of legislation should also be made explicit both for legal purposes and ease of reference. For example:

Primary legislation will refer to the Act of Parliament/Senate/Assembly (whatever is the name of the legislature) and its date; for example:

The Nurses, Midwives and Health Visitors Act 1997

The Health Act 1999

Secondary legislation will give the title of the legislation, its date and a Statutory Instrument (SI) number, for example:

The Nurses, Midwives and Health Visitors (Periodic Registration Rules) Amendment Order 1995 Statutory Instrument No. 979

Statutory Instrument 2002 No. 253 The Nursing and Midwifery Order 2001

Arrangement of articles
A.3. This, in effect, constitutes the table of contents of the legislation. Legislation is normally divided into Sections or Parts, which relate to each other, and then is further sub-divided into individual articles or clauses which each relate to a specific issue relevant to that section. When referencing legislation for any purpose, one would refer to *the title* of the legislation itself, its *date,* the *article/clause number* and the *publisher* of the legislation.

Part I – General

General information
A.4. General information will include:

a) *Citation and Commencement*
The citation and commencement will give the name of the piece of legislation (its citation) and the date the legislation comes into force (commencement). The legislation may come into force the day the Order is made, or it may be delayed until a specific commencement date, which would be specified in the text.

b) *Interpretation*
Interpretation is, in effect, is a glossary of the terms used in the legislation and also gives details of associated legislation referred to in the text. One of the explanatory schedules will give further details.

Part II – The Council and its Committees

The Council and its committees
A.5. This section will set out the detail of the body, which may be known as a Board or a Council (but for clarity will henceforth be known as 'The Council' in this text) regulating the profession and its committees. It will include:

The name of the Council:
A.6. The name of the Council will be given here:
'There shall be a body corporate known as…' [3 – (1)].
The body will be known as a 'corporate body singular'.

The principal functions of the Council:
A.7. This section details the principal functions of the Council:

'The principal functions of the Council shall be to establish from time to time standards of education, training and conduct and performance for nurses and midwives and to ensure the maintenance of those standards…' [3. – (2)].

The additional/supplementary functions of the Council:
A.8. The Council will also need its supplementary functions to be detailed, e.g. *The Council shall have such other functions as are conferred on it by this Order… [3. – (3)].*

A statement about the public interest role of the Council:
A.9. As the principle function of any good regulatory system is public protection, this must be made explicit in the legislation.

'The main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or need in the services of registrants.' [3. – (4)]

In the exercise of its functions:
A.10. This section deals with all those people and places of which the Council needs to be mindful in undertaking its work. It might specify:

a) places, such as the states or countries, covered by the legislation;
b) those who should be involved, such as representatives from:
    - education/training providers;
    - funding bodies;
    - other professions within health or social care;
    - others who may use/be affected by nurses or nursing;
    - those who employ nurses.

Depending on the wording of the legislation, the Council may need to 'consult' or 'seek the views' or 'co-operate'. Different words will have different meanings in law and should be ascertained at the time of preparation, as the links with other bodies will play a significant role in the Council's activities, affecting both outcome and, importantly, resources, particularly financial.

The committees of the Council:
A.11. This section will give the powers for the establishment of the statutory committees of the Council. It will name those committees which must, by law, be set up. Should the statutory committees ever need changing, then new legislation will be necessary. The statutory committees are likely to include, as a minimum, those committees dealing with the body's public interest role, such as:

a) investigations;
b) conduct and competence;
c) health

The legislation may also include committees dealing with the affairs of separate elements of the profession such as community nursing, mental health or midwifery. These may not be statutory (see 12 below). The role and functions of the committees, their membership, etc. will be given more detail in the explanatory schedules to the main legislation.

Other committees
A.12. In addition to the establishment of statutory committees, the legislation needs to provide for '…*such other committees as it considers appropriate in connection with the discharge of its functions…' [3. – (12)].*

This will give the Council powers to set up a variety of committees/sub-committees which it considers necessary. The advantage of such an approach is that the committees can be changed as necessary, to reflect changing priorities, without seeking further legislative change. The type of committees, which may be formed under this section of the legislation, could include:

a) education/training;
b) registration;
c) continuing professional development;
d) specialist credentialing.

Other functions of the Council:
A.13. The additional functions of the Council need to be made explicit. These may include:

a) giving advice to registrants/the public;
b) consultation;
c) setting and publishing standards.

Part III – Registration

A.14. The register in an effective regulatory system must be designed to be as dynamic and flexible as possible, capable of quick access and containing up-to-date and accurate information. The responsibility for the management of the register will lie with the role of Registrar, a role which may be combined with that of Chief Executive. The following sections are likely to be included in any legislation:

Registrar
A.15. The legislation would include:

a) tenure of office of the Registrar;
b) the functions of the registrar;
c) any payments which are allowed;
d) the role of any deputy.

Establishment and maintenance of the register

A.16. This section gives the powers to establish a register:

'In accordance with this Order, the Council shall establish and maintain a register of qualified nurses and midwives' [5 – (1)].

Additional powers will be given in respect of:

a) any additional requirements which are thought to be necessary, for example, relating to good health and good character;
b) the details of what information will be held against the individual's name on the register (which might include, for example, additional qualifications, whether the individual was suspended from practice or whether their practice had any limitations imposed upon it).

The Register

A.17. This section deals with the types and parts of the register which may be established. Each part may relate to the possession of qualifications or competence in a particular field of care. Parts of the register may be sub-divided. Individuals may be registered in more than one part of the register if they meet the necessary requirements.

Any changes to this section of the legislation would require consultation with those who may be affected by the change.

The Register: supplemental provisions

A.18. This section should include issues such as:

a) fees to be paid for registration, readmission, additional entries, lapsing of registration;
b) how entries should be made, altered or deleted.

Access to the Register

A.19. Public access should be available for the register and the register should also be published, in a manner to be agreed.

Registration

A.20. This paragraph sets out the criteria for entry to the register:

'A person seeking admission to part of the register must apply to the Council and, subject to the provisions of this Order, if he satisfies the conditions mentioned in … he shall be entitled to be registered in that part'. [9. – 1)]

Evidence will be required of the relevant certification/qualification/experience. Should an application be rejected for any reasons the individual must be informed of their right to appeal.

Renewal of registration and re-admission
A.21. A policy decision will need to be made as to the frequency and nature of renewal of registration. Most registration systems are subject to periodic renewal, and renewal periods can range from 1- 5 years. Most renewals are also subject to some additional requirement, such as a minimum number of practice hours, or completion of some form of continuing professional development (CPD). Where these requirements are not met, after a specific period, the individual's registration will lapse.

Lapse of registration
A.22. The body will need powers to ensure that an individual cannot let their registration lapse in order to avoid any professional conduct, competence or fitness to practise proceedings.

Approved qualifications
A.23. It will be for the body concerned to agree what are acceptable qualifications for registration *'…as attesting to the standard of proficiency it requires for admission to the part of the register in which he is applying'. [13. – (1) (a)].* These powers also should extend to qualifications gained outside the host country.

Specific areas
A.24. Some countries will be required to have specific requirements in place in respect of other country/states with whom they have formal or informal arrangements, for example, across the European Economic Area (EEA) (formal statutory systems) or the Gulf States (informal voluntary systems).

Part IV – Education and Training

A.25. The body concerned may have varying powers in respect of education and training. It is likely to be charged with establishing and maintaining standards for pre and post registration education of all kinds. How those standards are put into effect may vary and delivery is likely to be delegated to higher education institutions. Some form of monitoring/inspection/audit will be required to link the standards and their delivery and this needs a legislative base.

Education and training
A.26. The body will be required to establish the standards of education and training that it considers necessary for meeting its proficiency criteria for entry on to the professional register. Such standards may be described in a number of ways - increasingly in the form of competencies. The detail of such standards would normally be made in rules, or secondary legislation, in order to achieve maximum flexibility.

Standards are likely to be needed for:

a) pre-registration or pre-qualifying education/training;
b) continuing professional development (CPD);
c) specialist education/training (credentialing);
d) advanced education/training.

Visitors
A.27. The Council is likely to need some form of audit for its standards of education. This can be done by a variety of means, such as visitors, inspectors, assessors. The powers of the Council in this regard need to be enshrined in law, in order to ensure that the respective roles of the Council and the institutions delivering the education are clearly delineated.

Information to be given by institutions
A.28. This is one element of the relationship between the Council, which sets the standards and the institution, which delivers the education to meet the standards. It is intended to avoid ambiguity and overlapping, by clarifying what may be reasonably expected of the education provider institutions.

Refusal or withdrawal of approval of courses, qualifications and institutions
A.29. The standard-setting body must have the power in law to withdraw its approval from any educational institution that does not meet its criteria, providing due notice has been given.

Post registration training
A.30. The Council needs the powers to set standards in all aspects of education and training – the details being set out in secondary not primary legislation. For example:

> *The Council may make rules requiring registrants to undertake such continuing professional development as it shall specify in standards' [19 – (1)].*
>
> *'In respect of additional qualifications which may be recorded in the register the Council may establish standards of education and training… [19 – (6)].*

The detail of these standards is considered further in the schedules below.

Part V – Fitness to Practise

A.31. Given the increasing emphasis on the public protection role of the regulatory bodies, the fitness to practise requirements (which used to be known as professional conduct or professional discipline requirements) have been subject to increasing scrutiny from within and from outside the profession. There is a growing public expectation that the professions are seen to be establishing and maintaining clear and visible controls over practice. Appropriate checks and balances must be in place to effectively manage issues of competence, conduct and ethics. Fitness to practise legislation must be meticulously detailed, not least to avoid any potential challenge through the courts. This is especially important where an individual's professional livelihood may be at stake. The detail of such legislation will depend on the judicial system in place in the country/state concerned. A broad outline only is given here.

Functions in respect of fitness to practise, ethics and other matters
A.32. The Council will need to have the powers to issue advice on conduct, performance and ethics both to registrants and employees. In that way, a template of appropriate behaviour can be established for practitioners to use and against which practitioners can be measured, and if necessary, judged.

> *'The Council shall…establish and keep under review the standards of conduct, performance and ethics expected of registrants and prospective registrant and give them such guidance on these matters as it sees fit'…[21 – (1)].*

Allegations
A.33. This section will need to set out the grounds on which allegations can be made against registrants in relation to the impairment of their fitness to practise. For example:

a) misconduct;
b) lack of competence;
c) conviction or caution for a criminal offence;
d) physical or mental health problems;
e) fraudulent entry on the register;
f) other

A.34. The legislation will also need to specify who can make an allegation against a registrant. This usually includes as wide a range of people as possible. The legislation also needs to make it explicit as to whether allegations can be made about practice outside the country where the legislation is made. In terms of public protection and the increasing mobility of the professions, this would be desirable.

A.35. Detailed clauses will be needed on how allegations are dealt with in the first instance ─ for example by screeners, an Investigating Committee or a Practice Committee. The nature of the Committee/s hearing the allegations, their powers, the relevant time-frames for managing the allegation, and so on, must be made explicit.

A.36. Detailed clauses will also be needed on the role and nature of those who will be involved in the process of considering allegations, to ensure that they are:

a) chosen fairly against agreed criteria;
b) have no previous links with the registrant or allegation concerned;
c) have no other conflict of interest.

There will usually be at least two stages to the process. First, there will be some form of screening during which it is decided whether there is a case to answer in respect of the allegation, or not. Second will be the process of consideration of the offence.

Screeners
A.37. The legislation will need to provide explicit information about who can fulfil the screening role; their role and function; their legislative powers; and their reimbursement.

Lay and registrant members should be considered.

Council's powers to require disclosure of information
A.38. This section gives the Council the powers to request the necessary information to prepare a case.

The Investigating/Conduct and Competence/Health Committees
A.39. These sections set out the powers for each of the Committees, which are to be established under the Fitness to Practise legislation. The powers should include the way in which the Committees can obtain the necessary data; the powers they have to refer and to act or decide there is no case to answer. Other specific powers may be allowed, for example:

a) mediation through the Screeners (Investigating Committee);
b) make a 'striking-off' order (Health Committee/Conduct and Competence Committee);
c) make suspension order (Health Committee/Conduct and Competence Committee);
d) make a conditions of practice order (Health Committee/Conduct and Competence Committee);
e) make a 'caution' order (Health Committee/Conduct and Competence Committee).

Review of orders by the Health Committee and the Conduct and Competence Committee
A.40. The committees will need powers to extend, further extend, reduce or replace orders due to expire. A condition of practice order may also be made for a practitioner returning after a period of suspension. Time limits will need to be placed upon the orders in line with the legislation, e.g. one year, three years.

Interim orders by a Practice Committee
(i.e. Health Committee or Conduct and Competence Committee)
A.41. These may include 'interim suspension' orders or 'interim conditions of practice' orders.

Investigations of allegations: procedural rules
A.42. *'The Council shall make rules as to the procedures to be followed by the Health and the Conduct and Competence Committee in considering any allegation and before making an order under… [32. – (1)].*

Such rules would include:

a) making referral to other committees;
b) allowing for preliminary meetings;
c) informing the person concerned of the allegation(s) and allowing them to make a written response within a specific period;
d) holding hearings in public;
e) empowering the committee to require people to give evidence or produce documents;
f) the admissibility of evidence.

Restoration to the register of persons who have been struck off
A.43. This section sets out the means by which an individual may apply for restoration to the register. It will put limits on the time during which an individual may apply and gives them the opportunity for a hearing to argue their case. Restoration may be accompanied by specific requirements relating to additional education/training and experience and/or a condition of practice order. There must be an appeal process for those whose applications for restoration are refused.

Legal assessors
A.44. The work of the body in relation to fitness to practise needs to be supported, on a part-time basis, by those who are legally qualified to work in the country concerned. Legal assessors will be experienced lawyers who will have a variety of roles, based on giving advice on the legislation to screeners, practice committees and the body in general

Medical assessors
A.45. The Council also needs powers to appoint medical assessors whose advice will be sought '*on matters within their professional competence in connection with any matter which any of those persons is considering'. [35. – (2)].* This is likely to include opinions on the physical or mental health of those under consideration.

Registrant assessors
A.46. As with legal and medical assessors, the Council may also appoint assessors from within the nursing profession to advise on any matters concerning professional practice, which may be referred to them.

A.47. Arrangement must also be made for:

a) the payment of fees and allowances;
b) reimbursement of expenses for all the above assessors.

Part VI – Appeals

Appeals against the Registrar's decision
A.48. Individuals will have the right to appeal against the decisions of the body as given to them by the Registrar. This could include refusal of an application for registration; re-admissions; renewal or inclusion of an additional entry. An individual can also appeal against a decision to remove their name from the register for not meeting the specified CPD requirements. Details of the panel to consider the appeal need to be made explicit – to ensure that a balance of lay and professional persons is included. Such persons cannot have been involved in the original decisions in any way. The decision may be to dismiss the appeal; allow the appeal and quash the decision; or change the decision.

Appeals
A.49. Appeals in respect of the fitness to practise legislation may also be made externally to an appropriate court, in which case the body is considered to be the Respondent.

Part VII – European Economic Area

A.50. Where the body concerned is part of the European Economic Area (EEA), or a similar grouping of countries having shared legislative requirements, there may be the need for a specific section pertaining to those requirements. Such requirements are likely to relate to the necessary qualifications for education/training and practice across the area concerned and the documentation to be provided.

Part VIII – Midwifery

A.51. Arrangements for midwifery will vary according to how midwives and midwifery are considered in the country concerned. If midwifery is considered as a separate profession to nursing, there may well be entirely separate legislation relating to midwifery. More commonly, legislation pertaining to nursing will include specific sections on midwifery, designed to protect the unique nature of midwifery practice. Where obstetric nursing is considered to be a form of specialist nursing practice it will be dealt with in the same way as any other nursing specialty. Where midwifery is considered as an integral part of the nursing role, then no specific differentiation will be made in legislation.

Where there is specific legislation relating to midwifery, it is likely to provide for:

a) a separate Midwifery committee to advise the body on all matters pertaining to midwifery;
b) specific midwifery practice rules;
c) some form of supervision arrangements for midwives;
d) stipulations as to who can attend women in childbirth.

Part IX – Offences

Offences

A.52. A range of offences relating to the register need to be made explicit. For example, a person will be considered to have committed an offence if:

- *'…he falsely represents himself to be registered in the register';*
- *'uses a title…to which he is not entitled'; or*
- *'falsely represents himself to possess qualifications in nursing or midwifery'. [44 – (1) (a) (b) (c)].*

Part X – Miscellaneous

A.53. This section will include all those items which do not fit into the previous categories and can encompass a range of issues relating to the making and approval of the rules; the need to consult those affected by any rules; and the powers of the person or legislative body under whose jurisdiction the regulatory body works (which might be the Secretary of State for Health, the Privy Council, or some other body). '*If it appears to the Privy Council that the Council, has failed to perform any functions which, in the opinion of the Privy Council, should have been performed, the Privy Council may notify the Council of its opinion and require the Council to make representations to it*.' [49 – (1)].

A.54. Also included will be requirements in respect of:

a) the body's finances;
b) the charging of fees;
c) the keeping, inspection and publication of accounts;
d) the production of annual reports.

Schedules

Schedules are an integral part of the legislation and offer an elaboration of many of the issues set out above.

Schedule 1: The Council and its Committees
A.55. This schedule will address the detail of the make-up of the Council which will form the key part of the regulatory structure. It would make provision for:

Membership
A.56. Membership should be as small as is commensurate with undertaking the role and function of the Board/Council.

Membership should include various representatives from a range of constituencies, for example:

a) nursing practice;
b) nursing management;
c) consumer interests;
d) higher education;
e) medicine;
f) finance;
g) government;
h) the law.

A.57. The proportion of professional (i.e. nursing) to lay (which may be interpreted as non-nursing *or* non-health related) members should be carefully considered. Increasingly, it is considered that the public interest is best served by a higher proportion of lay to professional members than has been the case in the past, in some cases now up to 50:50.

Tenure of members
A.58. Agreement should be reached on how long members will serve. Periods of two-four years are common. Consideration will also need to be given to rotating time-scales, as it is not desirable that all members change over at the same time. Arrangements will also be needed for replacing members who resign.

The President
A.59. Powers will need to be in place for the choice of a Chair or President, ideally by election from within the Council. Public appointment may be used in some countries, or this approach may be used when the Council is in 'shadow' or 'transitional' form before elections can take place.

Procedure of Council & Committees
A.60. This section of the legislation includes:

a) detail about quorums;
b) procedures;
c) establishing standards;
d) the composition of any committee/sub-committee;
e) the choice of the Chair of each committee;
f) the way people may be removed from office;
g) the role of officers;
h) whether meetings should be held in public or private;
i) voting powers.

Powers of the Council
A.61. This section sets out the detail of the Council's powers in respect of a range of issues, including the powers to borrow money; to employ and pay staff; to establish new sub-committees; to abolish its committees (other than the statutory committees).

The Statutory Committees
A.62. This section details the composition, appointment of members; quorum; procedures and the standards for the education, training, attendance and performance of committee members for the statutory committees. The statutory committees will vary according to the body but are likely to include Midwifery and Practice Committees. Changes to a statutory committee would need amending legislation.

Schedule 2: Transitional provision

A.63. Unless the legislation is the first of its kind in a country, some arrangements will need to be established for the transitional period until the new legislation comes into force, to bridge the gap between the old arrangements and the new legislation. This may involve the establishment of 'shadow' arrangements, or may provide for the gradual introduction of the new legislation. Such transitional arrangements would need to address the tenure of members; the election scheme; the appointment of the first President; the Registrar; the function of the Council during the transitional period; the register; fitness to practise proceedings; and transfer of staff and property.

Schedule 3: The Competent Authority for EEA purposes

A.64. This schedule sets out in detail the Council's role within the context of the EEA.

Schedule 4: Interpretation

A.65. This schedule is a glossary of terms used in the legislation. It will give definitions for such terms as, for example:

a) 'alternate member';
b) 'application for restoration';
c) 'approved qualification';
d) 'competent authority';
e) 'lay member';
f) 'lay person';
g) 'licensing body';
h) 'local supervising authority';
i) 'practice committees';
j) 'screeners'.

Schedule 5: Consequential changes to primary legislation

A.66. This schedule will list the other legislation, primary or secondary, which is affected by the Nurses' Act. It may include, for example, reference to legislation relating to the organisation and delivery of health care; employment legislation; state legislation; freedom of information; or human rights legislation. In some instances, the new legislation will replace previous law; in some instances it will supplement it. It is likely to include legislation that is not directly the responsibility of the regulatory body but which impinges in some way on nurses or nursing. Such legislation might include, for example, reference to nurses or nursing in the giving of medicines; fair trading; Registered Nursing Homes; the care of children; freedom of information; or employment rights.

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Annex 1

Checklists

Policy Steering Group
This group will be the key forum for the deliberations on different elements of the policy that will eventually be translated into legislation. It is important that it is as representative as possible, in order to ensure that all those involved 'own' the finished legislation.

Think about including representation from:

- nursing practice;
- nursing management;
- nursing education;
- higher education;
- other health care professionals;
- hospital management;
- community practice;
- professional organisations/trade unions;
- lawyers;
- government.

Legislation Steering Group
This group will be considerably smaller than the Policy Group but should include those who are clear about the policy objectives. Their main role will be to assist the legal drafters, to ensure that it meets its policy objectives.

Think about including representation from:

- the regulatory body (if already in place);
- the Government Chief Nurse (if there is one);
- nursing management;
- nursing education.

Annex 2

Nursing Legislation Workshop

Scope and purpose
The workshop is designed to offer an opportunity for participants to:

- consider the current position in relation to the country's existing legislation relating to nursing;
- determine what further work needs to be done;
- explore the most effective routes for achieving the agreed goals;
- agree the roles and responsibilities of the key players;
- formulate and agree a plan of action.

The style of the workshop should be interactive and participative, with plenary presentation, plenary discussions and group work. The emphasis throughout should be on achievable action. See overleaf for supporting over-head projector slides (OHPs).

Day 1

Session 1	Introductions Agree definitive objectives for the workshop Finalise programme
Session 2	Presentation - principles of regulation Plenary Q and As
Session 3	Presentation - adopting a strategy for change Where are you now? - *is there a shared understanding?*
LUNCH	
Session 4	Presentation - what do you want in your legislation? - detail Where do you want to get to? - *agreeing a common outcome*
Session 5	What options are open to you? - *is legislation the best/only way?*

Day 2

Session 6/7	What needs to be done to achieve the goals? - *identifying activity*
Session 8	Who needs to do what? - *identifying the key players*
Session 9	What next? - *agreeing a timetable for action*
Session 10	
Conclusion	

Annex 3

Supporting Material for Workshop
(to be used as OHPs, powerpoint, handouts)

Regulatory and legislative change

- what do you want?
- why do you want it?
- when do you want it?
- where do you want it?
- how will you do it?

Where are you now?

- what mechanisms already exist - are they statutory, mandatory or permissive, national, local, guidelines, custom and practice?
- of the mechanisms in place which are most effective and why?
- of the mechanisms in place which are least effective and why?
- is the current legislation properly used?

Where do you want to get to?

- what needs to be changed and why?
- what are the options?
- legislation - advantages/disadvantages
- other - mandate, national advice or guidance, local guidance, contractual requirements

How do you get there?

- what policy changes are needed?
- what do you want/need, any compromises?
- who makes policy?
- is there consensus?
- who do you need to persuade? - informally, formally through consultation
- are your consultation processes in place and effective?

Style of change

- does it have to be legislative?
- does it need to be primary or secondary legislation?
- would advice/guidance be as effective for all/part of it?

Implementation of change

- has this been given enough attention?
- whose responsibility is it and who pays?
- who needs to know?
- how will it be done?
- when will it be done?
- what audit mechanisms will there be?

Annex 4

Questions to be considered before preparing any legislative change

These general questions should have been addressed by the time that the work on the legislation preparation is complete. Some will fall naturally into the work of the workshop, others will be addressed during the meetings of the Policy Group. There are no absolute right or wrong answers but there are issues which need to be thoroughly explored before any legislation is drafted.

What do you see as the main role of the qualified/registered nurse in your health care system?

What are the supplementary/additional roles of the qualified/registered nurse in your healthcare system?

What is the role (if any) of the nurse's aide/assistant in your health care system?

How do patients see the role of nurses – is there a difference between their view and the nurses' view? If so, why do you think that is the case? What are the implications?

How do doctors see the role of nurses – is there a difference between their view and the view of nurses? If so, why do you think that is the case? What are the implications?

What are the relationships in your country/state between medicine and nursing?

What are the relationships in your country/state between nurses and doctors?

Who is responsible for teaching nursing to nurses? If it is not nurses themselves who teach nursing, why do you think this is the case? What are the implications?

Who else should contribute to the teaching of nursing?

Who is responsible for preparing legislation relating to nursing?

Do you know how legislation is prepared in your country?

Glossary of Regulation Terminology

ICN has been working for some time on developing a document of regulation terminology (referred to as the source document). To ensure congruence and reduce misinterpretation, many words in this glossary have been taken from that source document. Other definitions, which may not have appeared in ICN material before, are offered in italics.

Definitions and words commonly used in the context of professional regulation often mean different things in different countries leading to confusion and misinterpretation. ICN identified common key terms and definitions and invited regulators and National Nurses Associations to provide alternative terms and definitions which are used in their countries, 18 responses were received. The responses have been collated and terms and definitions that were broadly similar to the ICN definition or repetitive have been excluded. Some ICN definitions have been amended in response to feedback. In order to promote understanding and facilitate dialogue, this information is available on-line at www.icn.ch/regulation_terminology.pdf. It is envisaged that this will always be 'work in progress' and therefore subject to amendment over time.