

**IN THE EMPLOYMENT RELATIONS AUTHORITY
AUCKLAND**

AA339/09
5124957

BETWEEN DEBBIE COOMBES
 Applicant

AND WAIKATO DISTRICT
 HEALTH BOARD
 Respondent

Member of Authority: Alastair Dumbleton

Representatives: Alan Taylor, advocate for Applicant
 Greg Peplow, advocate for Respondent

Investigation Meeting: 6 and 7 April 2009

Submissions Received 20 April, 1 and 7 May 2009

Determination: 17 September 2009

DETERMINATION OF THE AUTHORITY

Employment relationship problem

[1] The employment relationship problem which has been investigated by the Authority arose from differences that emerged during the employment of Ms Debbie Coombes by the Waikato District Health Board and that even after mediation have remained unresolved.

[2] The disagreement was about whether Ms Coombes position with the Board required her to perform nursing work.

[3] Ms Coombes was employed from January 2005 until March 2008 as a Quality Assurance/Clinical Auditor with Breast Screen Midland, which provides services for the Board. An individual employment agreement was entered into for the position.

[4] The Board maintained that Ms Coombes work was not nursing, whereas Ms Coombes considered it was and that she therefore needed to retain a nursing Annual Practising Certificate (APC).

[5] Ms Coombes also considered that because she was working as a nurse she was eligible to be employed under the Multi - Employer Collective Agreement (MECA) to which the Board was a party with the New Zealand Nurses Organisation, a union representing nurses.

[6] Ms Coombes and the Board remained in disagreement about these issues during much of their employment relationship, which ended when Ms Coombes resigned in March 2008.

Personal grievance, or dispute?

[7] The type of matter brought to the Authority for investigation was described by Ms Coombes in her application as a personal grievance. In particular she claimed that she had been disadvantaged unjustifiably by various actions of the Board in connection with the issues she had with it. She also claimed that her resignation was a constructive dismissal by the Board.

[8] The Board in its response to the application contended that Ms Coombes was barred from bringing grievance claims, for two reasons. The first was that her claim of unjustifiable action related to actions deriving solely from the interpretation, application or operation of a provision of Ms Coombes' employment agreement and therefore, under s 103(3) of the Employment Relations Act 2000, is excluded from becoming a personal grievance claim. The second reason was that if Ms Coombes did have any personal grievance claim it could not be resolved by the Authority as she had not raised a grievance with the Board within 90 days of the action complained of being taken, as required by s 114(1) of the Act.

[9] I have approached the investigation and this determination on the basis permitted by s 160(3) of the Act, under which the Authority is not bound to treat a matter as being a matter of the type described by the parties. Instead, in investigating the matter, the Authority may concentrate on resolving the employment relationship problem, however it has been described.

[10] The employment relationship problem in this case will best be resolved by the Authority making a determination principally as to whether there was any requirement for Ms Coombes' position of employment to be performed by a nurse, and also by making findings about the way the Board acted towards Ms Coombes during the employment when trying to resolve the issues she had.

[11] In maintaining to the Board her view that she was required to be employed as a nurse, Ms Coombes relied heavily on the Position Description given to her when she was recruited as Quality Assurance/Clinical Auditor. In particular she relied on a section in the document headed "*Person Specifications,*" which provides:

Credentials/Qualifications/Training

Essential: o *NZ Registered Health Professional*

Experience

Essential: o *Recent experience working in health related field*
 o *Experience and demonstrated ability in the*
 o *implementation of quality and audit systems*

Desirable: o

[12] In 2005 when she was appointed Ms Coombes was a registered nurse, although she did not then hold a current APC.

[13] The Nursing Council of New Zealand became involved in Ms Coombes' issues with the Board and in November 2007 advised her of its view that the work she was doing was nursing practise. In February 2008, shortly before Ms Coombes resigned, the Council wrote again to her confirming its earlier advice. The Council said it was based on the Board's written description of her job.

[14] The Council applied a definition of practising in relation to nursing, as follows:

Nursing practice is using nursing knowledge in a direct relationship with clients or working in nursing management, nursing administration, nursing education, nursing research, nursing professional advice or nursing policy development roles, which impact on public safety.

[15] The Council considered that Ms Coombes was practising as a nurse because she was working for the Board in a nurse management role that impacted on public safety. In its letter to Ms Coombes of 8 February 2008, the Council explained the basis for its decision as being:

... We assess your role as requiring clinical judgement (in the clinical auditing), which requires you to use your nursing knowledge and the role also impacts on public safety. You are therefore required to hold a practising certificate in order to practise in this role.

[16] For these reasons the Council concluded that Ms Coombes was required to hold a practising certificate in order to perform the position of Quality Assurance/Clinical Auditor.

[17] In trying to resolve this dispute the Board, principally through its Service Manager for Breast Care and Screening Services, Ms Clare Coles, on many occasions orally and in writing engaged with Ms Coombes over the different views they had.

[18] The Board advised Ms Coombes that although it considered she was not required in her job to be a registered nurse and therefore did not need to have an APC, it supported her wish to hold a current certificate an APC and would reimburse her for the cost of renewing it. The Board also offered its assistance to Ms Coombes in meeting the requirements of the Nursing Council for holding an APC.

[19] The Board remained firm in its view however that Ms Coombes' position of employment itself was not covered by the MECA, as it was not a nursing position requiring a nurse to perform it.

[20] Ms Coombes and the Board attended mediation during the employment in an attempt to resolve their differences. They reached an understanding about how they would continue to work together. This was recorded in writing and signed by the mediator on 10 December 2007. Their expressed understanding was:

1. *A triangular conversation will be organised between the WDHB [the Board], the Nursing Council and BSA [Breast Screening Aotearoa]/Ministry of Health.*
2. *The purpose of the above conversation is to review Debbie Coombes' current Job Description (September 2004) with a view to determining whether it meets the new definition of nursing practice developed by the NZ Nursing Council in 2006.*
3. *Greg Peploe [the Board's advocate] agrees to initiate this action on behalf of WDHB. The goal is to have a response by 7 February 2008.*
4. *WDHB will consider the implications of the answers received to the above issue and will convey the outcome of the review discussions and the employer's response to Debbie Coombes as soon as possible after 7 February 2008.*

5. *Debbie Coombes and the WDHB will then meet to consider options available to her in light of 4 above.*
6. *Meantime, Debbie will return to work on 7 January 2008 under her existing terms and conditions (30 hours per week, etc) until this matter is clarified and resolved.*
7. *Belinda [Macfie – Clinical Nurse Director of the Board] is willing to meet with Debbie if she wishes to discuss the HPCA Act [Health Practitioners Competence Assurance Act], the implications for nurses and the competencies required.*

[21] In compliance with the mediated understanding the Board scheduled a meeting to take place with Ms Coombes on 18 February 2008, but she did not attend. Ms Coombes told the Board she saw no need for a meeting since the Nursing Council had recently confirmed its view that she was working as a nurse. A little over one month later Ms Coombes resigned, on 27 March 2008.

[22] In her resignation letter to Ms Coles she referred to the prolonged dispute regarding her position description and to a lack of support and recognition from the Board regarding the clinical component of her position. She referred to the advice of the Nursing Council that her position was in fact a nursing management position. She also referred to the Board's continuing strong opposition to her "*right*" to join the MECA. She concluded:

At present I feel I am being advised to work in unsafe conditions that could compromise public safety by being advised on numerous occasions by senior management that I do not require to hold an annual practising certificate, even though under the new definition of nursing I am clearly required to do so, as governed by the Health Practitioners Competence Assurance Act 2003.

This prolonged, drawn out process has brought about unnecessary stress and humiliation both in my work and personal life that has left me with no other option but to tender my resignation with effect from one month today as per my employment agreement.

The employment agreement and Position Description

[23] As a matter of construction of the employment agreement I find that the reference in its Position Description to "*NZ Registered Health Professional*" by itself did not determine that the position held by Ms Coombes and performed by her was that of a nurse. Registration as a health professional was expressly a requirement of the 'person' to be appointed to the position, rather than it being an identifier of the precise 'work' to be performed by that person.

[24] Nursing, in which Ms Coombes was qualified, is one of a number of health professions for which registration is available and may be required under the Health Practitioners Competence Assurance Act 2003. Others include dietitians, occupational therapists, physiotherapists, podiatrists, and of course doctors.

[25] On that basis the “*Person Specification*” found in the job description would have been met by the appointment of a registered optometrist, for example, although there is no suggestion that Ms Coombes’ job required the practice of optometry.

[26] The real issue then is whether Ms Coombes, in the work she was employed to do as Quality Assurance/Clinical Auditor, was required to practise as a registered health professional of a particular kind under the 2003 Act. If she was then it was a requirement of the Act for Ms Coombes to hold a current practising certificate issued by the authority appointed in respect of that particular health profession, whether nursing, optometry or other.

[27] The Nursing Council is one of several separate authorities that exist under the 2003 Act. There is for example a Physiotherapy Board which is the statutory authority in respect of that profession, and there is an Optometrists and Dispensing Opticians Board.

[28] This employment relationship problem is therefore to be resolved by determining whether or not Ms Coombes was appointed to a position requiring her to substantially perform the work of a nurse, or was engaged in nursing practice.

[29] The Position Description expressed her role to be;

.....pivotal in ensuring the overall quality and consistency of information recorded and forwarded to the national monitoring database.

a. The incumbent needs to understand each phase of Breast Screen Aotearoa from the identification, screening, assessment, treatment and follow-up of women identified as having breast cancer.

[30] The acquisition of such an understanding was not something a nurse alone was capable of, as other registered health professionals, doctors for example, obviously were equally capable of gaining that understanding. An understanding of treatment is not the same thing as giving that treatment.

[31] The Position description also required the incumbent to implement “*an effective clinical risk minimisation programme*” within Breast Screen Midland. It

has not been suggested to the contrary that other registered health professionals could undertake the work of implementing a programme, just as much as a nurse.

[32] Various witnesses gave evidence for Ms Coombes or for the Board of their knowledge or understanding of what Ms Coombes was required to do in her position.

Ms Hoeberechts evidence

[33] Ms Catherine Hoeberechts gave evidence in support of Ms Coombes. Ms Hoeberechts acknowledged she did not have a clinical background but was an IT professional. She had been a member of the panel that interviewed Ms Coombes for the job in January 2005. She confirmed that Ms Coombes' registration as a nurse was a factor taken into consideration when the decision was made to appoint her to the position.

[34] Ms Hoeberechts referred to the problem of errors and omissions of data on clinical files. These mistakes had previously been corrected by administrative staff transcribing information from doctors' letters and pathology reports. She said this posed a medico-legal risk and that a new Data Audit form had been developed to reduce this risk. She said it was vitally important for the safeguarding of the information in the system, to have someone with a clinical background who was able to pick up any discrepancies with clinical data and to also understand all of the clinical abbreviations and terminology documented.

[35] As this information had previously been entered into the system by non-clinical personnel, the appointment of Ms Coombes had given Ms Hoeberechts some reassurance that the system would be safer and more secure.

[36] The question for the Authority is whether the credentials, qualifications and training that Ms Coombes had as a registered nurse, and which undoubtedly were of use to the Board in the role she was employed in, defined or indentified the role itself as a nursing role.

[37] Ms Hoeberechts gave her understanding of "*clinical audit*," a term used in the Position Description, as being a process that was to do with the clinical pathway of treatment for a patient. Clinical audit she said is the reviewing of clinical decisions that have been made for the patient, to assess whether the decisions were correct. Ms Hoeberechts confirmed that it was not Ms Coombes' job to conduct such audits.

Her job, she said, had been to control the accuracy of data transcription from a form, on which it was written, to a computer. Her job had been to check that the data was correctly input to the computer.

[38] This was ‘data’ audit rather than ‘clinical’ audit, as made clear by the reference in the Position Description to “*Clinical Audit*” as being the auditing of “*the quality of clinical data entry*,” and also the reference to the checking of hard copy information from clinical files against data in the IT system.

[39] Ms Hoeberechts agreed that a qualified person was required to interpret the data and that the role of the auditor was not to do that but to confirm that the information fed into the computer had been correctly transcribed from forms on which it had been written by the clinician. Ms Hoeberechts did not go so far as to express the opinion that the auditor role required a clinician to perform it.

[40] The opinion given by Dr Madeleine Wall, the Clinical Director of Breast Screen Aotearoa, was that “*clinical*” refers to the clinician performing a procedure or who generally performs a procedure, such as a pathologist, surgeon or radiologist. In that sense clinician does not mean a nurse. The clinician provides a report from which a trained person interprets the data onto forms. The interpretation is signed off by a clinician and then the information written on the form can be entered into a computer by data entry personnel. The transcription from the written form to the computer is not required to be checked for accuracy by a clinician or a nurse practising as such, but by an auditor. Dr Wall’s view was discussed by Ms Coles with Ms Coombes.

Evidence for the Board

[41] Advice was also sought by the Board from the Chief Nursing Adviser to the Minister of Health, whose view was that Ms Coombes’ role did not require a nurse or any other registered health professional to perform it.

[42] The Board considered that Ms Coombes was not required to have any “*clinical responsibility*” or to make recommendations regarding clinical practice, as a health professional such as a nurse might.

[43] The view of Ms Barbara Garbutt, the Board’s Group Manager for Population Health Services, was that the position Ms Coombes was appointed to was not a

nursing position and did not require her to have an APC. She confirmed the Board's policy was to support employees who wished to retain their APC, and this support had extended to reimbursement of the fees and releasing employees from duties to allow them to undertake clinical work in hospital wards to meet competency standards.

[44] Ms Garbutt's view was that the position held by Ms Coombes was essentially an administrative function of providing assistance to clinicians with their work.

[45] The evidence of Ms Belinda Macfie, the Board's Clinical Nurse Director, was that Ms Coombes' position did not require clinical judgement to be exercised but was concerned with providing access to information that had come out of a clinical environment. The role entailed, Ms Macfie said, the analysis of audit data but did not require the assessment or evaluation of the treatment administered by the relevant clinician. In that sense, there was no exercise of clinical judgement as there might be by a nurse performing nursing work.

[46] The evidence of Ms Bernadette McKeany, the Board's Human Resource consultant (who is registered both as a nurse and midwife), was that Ms Coombes' position was not a nursing position and therefore she was not required to maintain an APC and was not covered by the nursing MECA. Ms McKeany accepted that the position had an impact on patient and therefore public safety.

[47] To varying degrees that must be so with most if not all positions of employment within a District Health Board, given the functions of Boards as public health providers. Clearly though across the spectrum of positions there will be great differences between them as to the degree to positions may have an impact on public safety.

[48] I accept from the evidence of Ms McKeany that Ms Coombes had acknowledged to her that when she had been appointed to her position, in 2005, that it had been made clear that she did not have to be a nurse to perform the work and that consequently she had not renewed her APC. Later however Ms Coombes considered that she was required to perform her position as a nurse and therefore needed to have an APC.

[49] I find that the specification in the job description for a NZ Registered Health Professional, expressed as "*essential*," did not create any contractual obligation on the part of the Board to employ Ms Coombes as a registered health professional in the

position of Quality Assurance/Clinical Auditor, particularly as a registered nurse holding an APC.

[50] The importance of professional health registration, in my view, related to the understandable desire of the Board to employ a person who had some commitment or affinity to, or some empathy with, the environment in which the auditing work was being done, which was public health.

[51] In any event, if registration as a health professional was essential to the appointment, Ms Coombes had satisfied that requirement because she was registered, as a nurse. But it was the work that she performed that determined whether the MECA applied to her position, not her qualifications.

[52] I find that although undoubtedly there was a significant advantage to the Board in having Ms Coombes as a registered nurse perform the position, it gave her no control or input over the information itself collected by the Board. Her role was to ensure the integrity of a process which saw clinicians gather the information, make decisions about it and communicate it in paper form from which it could be transposed to computerised form.

[53] A particular problem encountered by Ms Coombes was that clinicians were not filling in the forms, but because the information that was needed on the form was a matter for clinicians and not Ms Coombes her role was to send the forms back to the clinicians for them to fully complete.

[54] Ms Coombes accepted that the essence of her role was to focus on “*system and process.*” She accepted that as being the focus of most quality assurance positions.

[55] The Authority heard various views from the different witnesses as to whether Ms Coombes’ position required the exercise of “*clinical judgement.*”

[56] I find that undoubtedly Ms Coombes’ role required the exercise of judgement, as do most jobs to greater or lesser degree, and in exercising her judgement Ms Coombes would have been assisted by her qualifications, training and experience as a nurse. I do not accept however that this added up to her exercising clinical judgement. Her judgement was exercised in relation to the presence or absence of

data provided by clinicians, and the need for that data to be obtained, to ensure the computer records were complete and accurate.

[57] Ms Coombes, in her evidence (at para.52) listed about eight separate actions of the Board which she claimed had unjustifiably disadvantaged her in her employment. Mr Peplow, the Board's advocate, has argued, correctly in my view, that a personal grievance was not raised by her within 90 days in relation to any of these actions, most of which would seem to have arisen in 2006.

[58] Ms Coombes' evidence was that, as a result of the stress these issues were causing her, she considered she had no choice other than to resign from her position and seek employment elsewhere. She contends that the actions of the Board in causing the situation constituted a constructive dismissal. She resigned on one month's notice given on 27 March 2008.

[59] Upon receipt of that resignation the Board wrote to Ms Coombes and said it had been working through the implementation of the understandings reached with mediation for resolving outstanding issues. The Board offered Ms Coombes a week in which to reconsider her resignation decision, although it maintained to her its stance that the position did not require her to be a nurse and that it was not therefore covered by the MECA

[60] Ms Coombes' response was to advise that she would reconsider her resignation if the Board agreed to her joining the MECA, backdated according to whenever it was she should have been offered the option of joining it.

[61] The Authority finds that the differences between Ms Coombes and the Board arose partly from the reference in the position description to the "essential" specification for the job incumbent to be a registered health professional, but also from the report from an audit carried out by the Breast Screening Association of New Zealand of Breastscreen Midland Service. That report had recommended:

A clinician needs to be designated to check all assessment and treatment forms. Error logs should be kept so that issues can be identified and addressed. The designated person should be at a minimum a registered nurse with a current practising certificate.

[62] The report and recommendation in it were made after Ms Coombes had been appointed to her position, which had been created prior to the audit.

[63] Ms Coombes could see some financial attraction in being employed under the MECA instead of her individual employment agreement and this, to some extent, became the focus of her disagreement, rather than the real nature of the position to which she had been appointed. A further dimension was added to the parties' differences when the Nursing Council expressed its opinion that Ms Coombes had been employed in a position requiring a nurse.

[64] In my view, the Board had reasonably reached the conclusion that Ms Coombes' position was not that of a nurse. It also acted reasonably in engaging with her and her representatives in trying to resolve the differences. The Board was communicative and responsive. It clearly wished to retain her in the employment and asked her to reconsider her resignation. Further, the Board acted reasonably in participating in the mediation from which the Memorandum of Understanding was produced. The Board had been prepared to carry out its part of the arrangements agreed to.

[65] I find that Ms Coombes resigned because she had a different view to the Board as to the operation of her employment agreement. It was her free choice to go and I do not consider she was in any way forced by the Board to leave in the circumstances.

[66] In my view, the Board is correct in its submissions that underlying the differences between the parties there was a dispute about the operation of the employment agreement and on that basis therefore the personal grievance remedy was not available to Ms Coombes under the Act.

Determination

[67] The determination of the Authority is that this employment relationship problem is to be resolved by upholding the Board's contention that Ms Coombes' position did not require her to perform nursing work. I find that the Board did not act unreasonably, unfairly or in breach of the employment agreement with regard to Ms Coombes. Although an issue could potentially have arisen if the proposal it made had been carried through to unilaterally re-write the contentious part of the job description, that action had not been taken when Ms Coombes resigned.

Costs

[68] Costs are reserved. Mr Peplow and Mr Taylor are to try and resolve any issue about costs between themselves on behalf of the parties. If that cannot be done the Board may file a memorandum in the Authority and serve a copy on Mr Taylor who will have 14 days in which to reply from the date of service.

A Dumbleton

Member of the Employment Relations Authority