Paramedics Australasia
Consultation response
On
Health professionals prescribing pathway
for
HEALTH WORKFORCE AUSTRALIA

PO Box 345W
Ballarat West
Victoria 3350

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Note: This is a modified version of the original HWA Submission with the addition of a covering page, vision statement and preamble to provide background - the submission content is unchanged.
The Paramedics Australasia Vision

Paramedics Australasia (PA) places a focus on forward-looking aspects in the delivery of Emergency Medical Services (EMS) and the facilitation of the paramedic’s healthcare role. PA’s vision is for EMS to be integrated with other health services so as to create a seamless system of care beginning at the point of need - the patient.

The paramedic practitioners and EMS systems of the future should ensure a rapid response providing appropriate levels of care to each patient presentation, and contribute a vital community resource for prevention, evaluation, care, triage, referral and advice.

Access to paramedic practice should form an integral part of the care regime available to patients in an inter-professional model of healthcare practice founded on the contributions from a dynamic mixture of professional and related staff at all stages of the patient journey.
Paramedics Australasia (PA)

*Paramedics Australasia* (PA) is the learned society representing the professional interests of paramedics within the region. Its primary objective is to lead and develop the paramedic profession. PA does this through a range of activities designed to enhance the standards of delivery of Paramedic Services (PS) (aka Emergency Medical Services or Ambulance Services) that will protect the health and safety of the community.

PA is concerned with a wide range of functions that collectively assure the competence and fitness to practise of paramedics. These include standards of entry into the profession, education, clinical training, setting of professional practice standards, promoting ethical good practice, providing continuing education, and the processes for dealing with poor performance and misconduct.

In addition to direct membership-based activities, PA has an abiding interest in policy matters that affect the access, equity, quality and effectiveness of patient care. It supports the development of the profession in the public interest and advocates the profession's policies and views on healthcare issues to government and other stakeholders.

Through its expert practitioner membership, PA is able to capture and express the views of the most significant group of practitioners engaged in PS delivery throughout Australasia. PA is thus uniquely positioned to provide insights into the role of paramedic practice in the continuum of care.

PA endorses the basic principles for healthcare espoused by the National Health and Hospitals Reform Commission (NHHRC).¹ In keeping with these principles, PA has articulated a vision for the delivery of PS. The focus of this vision is that PS should be provided in a manner that will optimise community healthcare outcomes through inter-professional practice and the integration of PS with other healthcare delivery mechanisms.

Regulatory matters are of significant concern to the paramedic profession with the current absence of a national regulatory framework within Australia. Paramedic practice holds significant risks and the profession is concerned not only with practitioner regulation but also in regulatory matters likely to affect the delivery of support services through infrastructure service providers as well as the interactions with other registered and unregistered health providers.

PA has responded to this consultation principally in the context of the proposals in the discussion paper and their potential impact on paramedics, while acknowledging that there are fundamental regulatory issues that overlap substantially with related areas or fields of practice.

PA believes that healthcare policy, including prescribing rights, should:

- incorporate PS overtly into the national healthcare reform agenda;
- recognise the benefits of holistic care delivered by health professionals operating in a multidisciplinary / inter-professional practice environment;

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• ensure an equitable health system by providing PS according to need and regardless of race, creed, gender, location or economic circumstances;

• establish funding and regulatory arrangements at Federal, State and Territory levels that facilitate the delivery of integrated healthcare services and optimise the use of available physical and human resources;

• ensure responsiveness, quality and high service standards through appropriate governance structures, with practitioner and community engagement that recognises the legitimate role of stakeholders in the planning and delivery of healthcare;

• provide adequate educational opportunities for the recruitment, training and professional development of practitioners that will ensure a competent and sustainable workforce; and

• provide a national regulatory regime for the accreditation of service providers and the independent registration of paramedics that together will ensure consistent service standards and public safety.

The prescribing principles outlined in the Health Professionals Prescribing Pathway (HPPP) and discussion papers are considered to be laudable and are supported. In many ways they mirror the aspirations and recommendations for improved healthcare advanced regularly by PA.

In particular PA supports the concepts of inter-professional involvement and participative engagement from all relevant stakeholders as fundamental to achieving change.
WRITTEN SUBMISSION
to
HEALTH WORKFORCE AUSTRALIA
to provide comment on the
HEALTH PROFESSIONALS PRESCRIBING PATHWAY (HPPP)
in Australia

Name of stakeholder/organisation: Paramedics Australasia
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The observations and recommendations in this submission have been provided from the perspective of the peak professional body representing the paramedics of Australasia. They are the distillation of the practical experience of paramedic practitioners and the input received from a national request for practitioner engagement.
1. A nationally consistent health professionals prescribing pathway - need, impact and acceptability

1a) What principles should underpin a national approach to health professionals prescribing? Examples could include the importance of safety and quality, or the maintenance of practitioner competence.

All prescribing must be patient centred. The key consideration in any national approach must be a focus on achieving the best outcome for the patient/client given the contemporary Australian health care environment. Professional discipline interest (whilst needing to be respected), should not be the sole or principal driver of this change agenda.

1. Prescribing should be undertaken within a collaborative professional context. The prescribing of medications also must take into account the role of the patient/client’s primary health care practitioner in decision making and reporting.

3. Identification and codification of a nationally consistent health care practitioner scope of practice (which would need to include a medication formulary) must be achieved within each professional group seeking prescribing privileges.

4. Practitioners providing clinical services to patient/client groups must be regulated in regard to their prescribing level and medication formulary by the defined range of clinical practice with which they are familiar and are trained to perform. Where necessary, they may be credentialled according to profession. Operation within their scope of practice needs to include the recognition of the need for referral when appropriate.

5. The prescribing rights and operating parameters that currently apply to the ambulance officer, paramedic and specialist/advanced paramedic roles, are poorly defined and highly variable according to jurisdiction and service provider. This variability will be addressed should the proposal for national paramedic registration be supported by AHMAC.

6. Access to prescribing privileges requires a robust educational and practical grounding in clinical assessment, pathophysiology, pharmacology and systems administration. Health professionals prescribing medications therefore must be adequately trained, in relation to the relevant prescribing levels, in their own professional practice and must carry the competencies required to safely prescribe. This training must be nationally consistent, independently accredited and meet the minimum competency standards.

7. Individual practitioners must be able to demonstrate initial and ongoing competency in compliance with these standards through their initial training, continuing professional development and later monitoring audit. In the case of paramedic or ambulance officer prescribing this professional development should be achieved as part of the undergraduate training programs that would be required for recognition or registration as a paramedic. Standalone courses will likely be required initially to enable familiarisation training for existing practitioners who will be operating at any level other than level 1 in the prescribing competency standards.
8. In the case of specialist/advanced paramedics (e.g. extended/community care paramedics) the professional development (according to the prescribing competencies framework) to achieve Level 4 prescribing should be included as part of the requisite post graduate studies/development for credentialing at this level with a standalone training program for existing practitioners.

9. The issues of individual practitioner accountability and fitness-to-practice are core considerations in the safe prescribing of medication at all levels. These criteria should be assured through Independent practitioner standards of professional conduct, fitness to practice and accountability. Health practitioners operating at levels 2, 3 & 4 must be nationally registered to ensure the independent monitoring of standards, fitness and quality of individual practice within the prescribing framework. To ensure public safety, other health practitioners operating at level 1 should be either nationally registered or covered by a code of practice for non-registered health care providers (e.g. based on the NSW Code model) - or other national regulatory provisions determined under NRAS.

10. National consistency in policy and uniform implementation across jurisdictions are important factors to ensure effective patient/client management. Variations in jurisdictional approaches have been identified as a significant issue by mobile practitioners like paramedics and ambulance officers who often work across jurisdictional boundaries on a daily basis. These variations present serious risks and hindrances to the delivery of effective care which would be considerably reduced by a uniform national approach to prescribing (see further below).

1b) Will a nationally consistent approach to health professionals prescribing, covering important principles such as those listed above, support improved access to health services, efficiency of the health system and help address health workforce issues within the Australian health system?

Please provide further explanation and, if possible, practical examples to support your view.

The following answers illustrate generic issues, but are oriented primarily towards examples found in paramedic practice.

1. Cross-jurisdictional issues are constant factors in the delivery of paramedic care. Currently paramedics and service providers in each State and Territory not only have their own standing orders, protocols and/or medication formulary but also differing legislation covering the prescribing of medications. This causes significant issues in relation to medication supply, administration and prescribing when practitioners operate across jurisdictional boundaries. Canberra/ACT and NSW provide a good example where paramedics work across separate jurisdictions on almost a daily basis providing care both inwards (from NSW) and outwards (medivac retrieval) across jurisdictional boundaries.

2. A nationally consistent approach to prescribing would undoubtedly address some of the operational issues created by the current legislative environment and provide more flexible
deployment of the paramedic workforce to deliver optimal care, especially for rural patients who are serviced by paramedics operating from within another jurisdiction.

3. Paramedics and ambulance officers are often consulted by patients/clients as they are recognised as having expertise in health care and there are often no other health care providers readily available due to local workforce shortage, service availability, geographical distance or time of day.

4. Contemporary paramedic practice encompasses not only the traditionally recognised roles of assessment and management of acute life threatening incidents (for which specific medications may be administered) but also the management of sub acute presentations via alternate non-hospital care management pathways. The role of the paramedic in the defence force and the private sector sees practitioners working in isolation in remote environments and in many cases providing a range of primary health care services in addition to the traditional emergency response function.

5. The evolution of the extended care/community paramedic in the statutory ambulance services has seen the creation of a role where the aim is to optimise care for a variety of complex clinical issues and to avoid hospital admission by managing subacute patients in their own environment e.g. palliative care patients. The use of medications within this context is currently determined on a jurisdictional basis with significant variability in terms of education, practice legislation, practitioner monitoring and formulary.

6. A nationally consistent approach to prescribing will assist with the timely, consistent and collaborative provision of health care to patients/clients seeking the services of paramedics especially where other health practitioners may not be available e.g. in rural and remote communities and out of normal business hours.

7. The provision of prescribing rights for paramedics would allow more timely access by patient/clients to a range of acute treatment modalities, such as analgesics (simple and narcotic), anti-emetics, anti-inflammatories and antibiotics. This could allow for future expansion to facilitate repeat prescriptions for medications used in chronic conditions such as antihypertensives and antidepressants to support the primary medical prescriber.

8. Regularly, paramedics are able to make a definitive diagnosis, yet under current legislative restrictions patients must be referred to a medical prescriber simply for a prescription for a specific medication not available over the counter, but for which the paramedic may be competent to prescribe and/or administer. Empowering paramedics to prescribe a regulated number of medications from a specific formulary would help to reduce inappropriate presentations to hospital Emergency Departments (EDs) and reduce the load of short notice appointment demand for GPs. The provision of paramedic prescribing rights thus should be able to improve the availability of other providers to service more relevant needs whilst maintaining the primary health care provider at the centre of the patient's health care team.

9. The current regulatory framework for paramedics (which is largely determined by individual jurisdictional statutory or private providers or health departments) creates a number of administrative and legal barriers to effective health care delivery. The anomalies become more
apparent. In cases of disaster response commonly attended by paramedics (where Sovereign/State/Territory borders are required to be crossed) or where a paramedic is not acting under a direct employment contract by a statutory provider e.g. has part time employment in the private or defence sector. In such cases the prescribing scope is not usually legally transferable and separate privileging is required, with potentially a unique scope of practice, protocol or formulary. This leads to a decreased ability to provide best practice clinical care using the prescribing competencies and clinical experience of the paramedic; it potentially introduces critical time delays; and limits both workforce portability and effective utilisation of this professional group in delivering desirable health outcomes.

(For a better appreciation of some of the legal issues faced by paramedic practitioners in disaster operations and jurisdictional issues that create operational problems, see the blog article "Use of medication and procedures as a paramedic outside of employment" by Michael Eburn and his various linked articles here: http://emergencylaw.wordpress.com/category/ambulance/)

2. Potential prescribing models for a health professionals prescribing pathway

2a) Should a health professionals prescribing pathway in Australia have graded levels of prescribing autonomy? Are there other options that should be considered? If so, what are they?

1. Paramedics Australasia supports the concept of graded or tiered levels of prescribing autonomy as a practical measure to capture the myriad of potential practice settings and different practitioner groups. One size will not fit all and a nationally consistent framework should be introduced to guide the prescribing of medication and ensure optimal patient outcomes according to patient need, the practitioner role and relevant risks.

2. The proposed level 1 prescribing privileges nominated for "Ambulance Paramedics" must be reviewed because it is not representative of the contemporary clinical education standards and practice diversity of this workforce within Australia.(and internationally) - see item 3.

3. Prescribing privileges should be assigned in accordance with the role of the individual health care practitioner in the context of patient centred care and practitioner capacity and not according to the employment status of the practitioner which may be independent practice, with a private organisation or a government agency/service. Generic descriptors should be used and where applicable, the registered title for the professional practitioner. In this regard the proposed terminology is considered inappropriate and any categorisation might be better described in terms of a 'Paramedic' (which stands alone in any context) and 'Ambulance Officer'.

4. The past omission of paramedic practice and emergency medical services from the mainstream of health care policy considerations also has resulted in the clinical roles of paramedics and ambulance officers being overlooked in the context of prescribing and administration of medications. One also commonly finds a poor understanding of the exponential rate of development
that has occurred within this field of practice and the level of clinical practice and interventions now undertaken by these practitioners. External perceptions are often driven by an historical image of ambulance transport rather than the present reality of highly skilled but forgotten health professionals. In ad hoc surveys in shopping centres and ED waiting areas there is astonishment expressed by members of the community when told that paramedics remain unregistered health providers - the assumption is that they are registered and can provide medications within their formulary at any time.

5. Paramedics are now qualified primarily (80-85%) through university course programs at undergraduate level. Postgraduate courses are available and utilised by statutory and private service providers to train individuals in advanced practice and develop their autonomous clinical practice and independent decision making.

6. Based on our assessment of patient needs under typical practice settings and the level of education and competencies carried by today’s practitioners, our analysis indicates that paramedics and ambulance officers* should fall within at least levels 1*, 2 & 4 of the proposed prescribing structure. As a group, ambulance officers (or other similar title) are typically educated under the Australian VET system to a Certificate III or IV level and operate under a more structured clinical care approach that would align with the suggested prescribing level 1.

7. Paramedic prescribing and administration of medications is currently regulated through the mechanism of “Clinical Practice Guidelines”. These set down the prescription of medication based on the principle of a standing order (as the only legal method by which paramedics can administer medications). Within this prescribing/administration framework, there is considerable latitude to vary the defined instructions according to individual patient need and the clinical judgement of the attending practitioner. This may result in the medication prescription described in the guideline being modified (by increase or decrease) or withheld depending upon local circumstances and training.

8. This terminology currently appears to be missing from the proposed prescribing pathway and should be considered either as a component of level 2 prescribing or through the creation of a special category or level to accommodate this approach. Clinical Protocols are a safe and effective method of regulating medication use in most cases of typical, single morbidity presentation whereas Clinical Guidelines provide for the management of cases where the patient's condition does not 'fit' the protocol or has a complex, interacting clinical presentation.

2b) How will the health professionals prescribing pathway need to accommodate the variations of clinical settings and team environments (e.g. hospital, residential, community and private practice settings).

1. The prescribing pathway needs to take account of the contemporary scope of practice of the particular practitioner and the inter-professional practice setting. For example, in the case of paramedics and ambulance officers there is a fundamental distinction between the two groups based on their education and the level of autonomous clinical decision-making and judgement applied. Ambulance officers (who include volunteers and patient transport officers) normally work on the basis of achieving
clinical outcomes within a range of known and often predictable clinical conditions or presentations using an algorithmic and predetermined approach e.g. protocol, which in some circumstances may require medical authorisation and control. This situation appears to be currently articulated within the scope of Level 1 prescribing. Paramedic practice on the other hand, is focussed on achieving clinical outcomes based on individual patient assessment, diagnosis and the implementation of unique patient management strategies within the practitioner’s scope of practice and without the requirement for medical authorisation or control.

2. Taking as an example the clinical practice of paramedics and ambulance officers, the prescribing pathways should recognise the diversity of operating environments which may include:
   - the traditionally recognised role as community emergency health care providers delivering a range of clinical care based on an authorised scope of practice
   - the transfer of critically injured or unwell patients between health facilities
   - a disaster or declared emergency
   - private sector operations (nationally and internationally) undertaking a variety of roles from emergency response to supporting primary health care
   - the defence force
   - across State and Territory boundaries
   - the provision of sub-acute care in residential, community and rural settings where other health care assistance is either not present or available - both from a generalist (paramedic) and specialist (Extended/Community Care paramedic) perspective.
   - the provision of acute and subacute care within hospital EDs e.g. small rural hospitals with no or limited access to a medical practitioner
   - the provision of vaccinations.

3. Any proposed pathway will need to ensure the flexibility and adaptability to enable practice in the above environments and operational settings whilst maintaining patient safety.

4. Consideration also must be given to the identification of appropriate patient/client referral pathways and communication mechanisms to enable practitioners who commonly operate in a mobile environment (like paramedics) to communicate with the patient's primary health care provider regarding any prescribing decisions or treatment outcomes.

3. Scope of Practice Considerations

3a) How could professional practice and development and professional boundaries between professions be best addressed in a health professionals prescribing pathway?

1. From the perspective of the Paramedic profession one of the most effective mechanisms to diminish inter-professional barriers would be for paramedic practice and the Emergency Medical Services sector to be recognised as integral components of the health care system at a national and policy level together with the national registration of paramedics. That integration of
infrastructure services and practitioners would immediately create a climate of enhanced communication and better inter-professional practice. For an outline of the ways that systemic change may be introduced that will have positive knock-on effects in prescribing pathways, see the PA publication *The forgotten health profession* available here: http://bit.ly/rKFaRx.

2. Currently there is no nationally consistent regulation of the scope of practice or maintenance of professional competence requirements in relation to paramedics or ambulance officers within Australia. The practices vary across jurisdictions, with differing standards and legislative requirements for practitioners operating within statutory and private providers and the defence force. The first step must be to ensure a harmonised and nationally consistent scope of practice incorporating the maintenance of professional competence requirements. This may be achieved via a national regulatory framework and practitioner registration that encompasses the diversity in contemporary practice for this sector of the health workforce. A regulatory review of the paramedic profession is the subject of a separate study being spearheaded by the WA Department of Health and the HPPP should consider the implications of a registered professional cohort for paramedics. For further information go here: http://www.paramedics.org.au/category/registration-2/

3. The prescribing pathway should support the principles of inter-professional practice and interactions between prescribers that are focussed on the patient/client (outcome and safety), inter-professional respect, team work and collaboration whilst recognising the legitimate scope of professional autonomy.

4. The introduction of enhanced inter-professional practice and prescribing pathways will require some changes in educational pathways as well, and it is here that some of the greatest gains can be made through creating opportunities for inter-professional learning both during initial qualification and later in continuing professional development. Outreach and extension programs will be needed to implement change (and maintain competency) and to foster interaction, these should be not be conducted in isolation but be organised as truly inter-professional activities when discussing principles and practices. Only when it comes to particular practice-specific matters should these activities be hived off into goal-directed programs oriented towards the particular practitioner scope of practice and medication formulary.

5. Professional boundaries in relation to the prescribing of medicines should be set by the regulatory agency following advice from the professions (in our case from paramedics). This should take the form of a schedule of prescribed medicines, which should be publicly available to inform all prescribers and health care professionals.

### 4. Registration and Accreditation Considerations

4a) **What changes to registration and accreditation practices might be needed to implement a national health professionals prescribing pathway?**

1. Paramedics Australasia believes that health practitioners holding prescribing privileges should be registered under a national regulatory framework such as AHPRA. For paramedics to be provided with level 2, 3 or 4 prescribing privileges which is consistent with their practice and patient needs, national registration should apply (for the reasons discussed above) with recognition for
advanced/specialist modes of practice requiring specific consideration to complement the proposed prescribing framework. Following registration of the profession, subsequent changes to State and Territory controlled substances legislation will be required to enable implementation by this practitioner group outside of level 1 (which is the only method currently supported by legislation).

2. Undergraduate and post graduate paramedic education programs will need to be independently accredited against agreed national benchmarks for content and practices that support the development of the prescribing competencies to the level of privileging being sought.

3. Continuing Professional Development programs required to maintain registration should take into account the need for the updating of individual practitioner understanding and compliance with the prescribing competencies and outcome review of patients. See also item 4 under Section 3a.

4b) **What strategies could be utilised in a nationally consistent health professionals prescribing pathway to ensure the safety and quality of prescribing by health professionals?**

1. Accreditation processes which form part of the normal professional registration functions should provide for assessment of courses leading to the qualification requirements granting entry to the related profession (see above).

2. Credentialling should be applied to professional development programs to ensure their course content and outcomes result in the required prescribing competency standards being attained for the relevant professional scope of practice.

3. The implementation of prescribing risk management and complaint mechanisms would allow for the reporting of issues relating to a prescriber and their practice where reporting to a regulatory body may not be indicated. This, possibly confidential, process should be focussed on professional development needs and not disciplinary action. It may be complementary to the normal risk management, monitoring and reporting provisions for registered professions under the AHPRA (NRAS) framework.

4. Practitioners with prescribing privileges should be required to undertake a reflective review and evaluation of their prescribing practices at regular intervals. This may form part of the regulatory requirements for the maintenance of full or partial registration.

5. Professional bodies representing the interests of professional groups should be encouraged (through a variety of incentives - which may range from quite simple support and publication initiatives) to extend their professional activities to encompass the content and implementation of prescribing pathways relevant to their profession.

6. International regulatory best practice espouses the transparency principle and this should apply to the operations of the HPPP. Almost all regulators now maintain open Web sites and publish annual reports with information about the regulator, the regulated persons or entities, and the regulatory outcomes and decisions made in each year. Allied with transparency is the notion of appropriate feedback that will better inform practice. The nature and content of reporting varies
substantially, reflecting the wide range of requirements for information disclosure. The work undertaken under any prescribing framework thus also might be considered for inclusion to some degree within the remit of the Australian Institute of Health and Welfare (AIHW).
(http://www.aihw.gov.au/)

4c) What accreditation requirements and considerations might exist in a national health prescribing pathway? How might these requirements best be managed?

1. Academic programs (for new entrants to a profession) should be accredited against national benchmarks to ensure the attainment of the relevant prescribing competencies for the prescribing level applicable to the graduate (see above). This process should be integrated into the educational program accreditation functions currently facilitated by the NRAS.

2. Existing practitioners who require prescribing privileges should be assessed against current practice and the prescribing competency standards to identify any developmental requirements which need to be addressed prior to privileging. Existing practitioners who have a requirement for level 2, 3 or 4 prescribing should be individually accredited as part of their professional registration. This might be managed as an endorsement to a registration or as a new minimum standard for professional registration (depending upon clinical role requirements). In the case of paramedics, this mapping and, if required, competency development could be undertaken as part of the transition process to national registration so that current practice can continue uninterrupted.

4d) Given the National Law establishes consistent processes for accreditation of programs of study, would a consistent approach to the accreditation of prescribing education across health professions be an effective strategy?

1. Yes, aiming for consistency will provide a more standardised approach across the disciplines and ensure that the clinical interface between individual prescribers when managing a patient is approached from a common basis of understanding. Significantly, entry qualifications and education programs form only part of an effective regulatory regime. The competencies framework and the maintenance of professional competence are other key factors, and while educational accreditation is a crucial element, it is only one piece of the jigsaw comprising the fabric of regulation.

2. Internationally, the impact of regulatory activities on the health professions has become part of the public policy agenda and the realisation has grown that the underlying principles and practices of regulation are founded on common principles that should form the primary determinants governing the regulation of any health profession and the elements of their professional practice. Put another way, one may say that equality of regulatory obligations among health care professions is considered to be in the public interest. The legislative objective of equality then is achieved through the application of a common regulatory framework to all
professions, despite their differences in scope of practice. The practical outcome is to treat all regulated health professions essentially the same by adherence to common regulatory purposes, processes and procedures.

3. The approach to accreditation must focus on the outcomes of the prescribing education and not the pedagogy. This will allow individual disciplines and providers the flexibility to optimise the development and integration of these competencies into their course programs.

5. Quality and Safety

1. All practitioners seeking privileging rights outside of level 1 (basic) should be nationally registered to ensure a codified scope of practice and an independent process for the monitoring and assessment of individual fitness to practice. Prescriber privileging also should be prefaced on holding currency of registration. These aspects should be facilitated by the national regulatory board.

2. In the case of paramedics and ambulance officers operating across jurisdictional boundaries privileging must be applied consistently to ensure optimal patient outcomes and to minimise the potential service delivery disadvantages of living adjacent to jurisdictional boundaries. Clinical practice via Protocol and/or Guidelines should be harmonised across Australia i.e. adoption of National Ambulance Officer Protocols (L1) and Paramedic Guidelines (L2), to optimise patient outcomes and streamline service delivery across this sector of health care.

3. A high order of standardisation is feasible across multiple providers and has been achieved in a number of other countries e.g. UK, Ireland. In practical terms a project to create this harmonised approach should form a national project funded by government (in the public interest) and made the joint responsibility of the professional body, statutory and private providers and defence. Canada provides the model of leadership for the funding of such a significant project http://bit.ly/Kclq2x and http://bit.ly/MvSFUM

4. Measures should be taken to enhance the provision of clear instructions for patients and carers in relation to the safe use and intended and side effects of medicines in easily understood language. This is perceived as a responsibility of the medication supplier, the prescriber and to a lesser extent the service provider / employer.

4. All relevant information relating to prescribing that is performed by a practitioner who is not the patient/client's usual primary health care professional should be reported to that (primary) individual within a reasonable timeframe. This will facilitate patient/client follow up and assist with the identification and management of any adverse outcomes.
5. Practitioners must be audited regularly and made accountable for the prescribing of medication within their level of privileging to ensure that only medications and clinical conditions that they are educated in relation to are managed. This could form part of the requirements for renewal of registration.

6. All adverse events relating to the prescribing process or medication used must be reported to the appropriate agency. This may involve the TGA or local employer based mechanisms e.g. Safety Learning System, AIMS.

7. Where possible, electronic recording and documentation systems should exist to minimise the risks associated with handwritten documentation. This practice holds the potential to minimise transcription errors, allow the prescriber to share important clinical information more easily with other health care professionals involved in the patient's care and minimise the risks of drug interactions or overdose. Such records management is a matter for the practitioners and service providers and employers to facilitate.

5b) What communication strategies between health professionals should be employed to support safe prescribing?

1. The use of electronic recording and communication strategies has many safety benefits in minimising the risks associated with handwritten/abbreviated notes and the difficulties in sharing hard copy information between prescribers and other health care providers. Paramedics Australasia strongly supports the principle of a single patient electronic health care record that would minimise the risks associated with over prescribing and practitioner "shopping" by allowing prescribers access to other care management plans already or previously in place.

2. As noted previously where the prescriber is not the patient/client's usual primary health care practitioner, documented communication should occur in a timely manner with the primary provider updating them as to the immediate prescriber's assessment and actions. This process could then provide a feedback mechanism between the primary provider and prescriber in evaluating the effectiveness of the care management regime.

3. Regular multimodal communication with clinicians (e.g. communiqués, newsletters, etc) is a necessary component of information dissemination regarding updates, issues, developments etc in relation to the safe use of medicines and prescribing. Also see response 6 under Section 4b.

Every opportunity should be taken to foster inter-professional cooperation in the development of extension programs, workshops, conferences and other continuing professional development activities to broaden the audience for sessions related to common prescribing issues. Also see response 4 under Section 3a.
6. Education and training

6a) What strategies and mechanisms should be in place to ensure Australian health professionals are adequately and consistently trained in prescribing?

1. Paramedics Australasia recommends the independent accreditation of all undergraduate and postgraduate courses whose completion will lead to prescriber privileging. Accreditation should be based on assessment of the likelihood of achievement of the outcomes defined in the relevant national competency standards.

2. Clinical internship programs should involve structured supervision and development of the prescribing practices of beginning or provisionally registered practitioners.

3. Transition training for existing practitioners could consist of a core element that is not aligned to a specific discipline e.g. the current system offered by the NPS - that will provide an overview and understanding of the framework. Specific profession-based competencies or development could then be addressed by the relevant discipline or professional body. Also see response 4 under Section 3a.

4. CPD requirements for each prescriber should involve a minimum participation in a review of the prescriber framework and competencies. This might involve formal refresher training in each CPD cycle e.g. via an online learning module that is developed and/or hosted by the NPS or self-directed performance/safety evaluation.

5. Prescribing competencies should be reviewed as part of the profession's CPD requirements within each accreditation cycle to ensure familiarity and currency.

7. Design and implementation of a nationally consistent health professionals prescribing pathway

7a) What are the critical implementation and design factors for a nationally consistent health professionals prescribing pathway?

1. The usual mechanisms used to implement change management will apply, especially since the implementation of non-medical prescribing will likely be subject to substantial opposition from some existing professions. The general principle of the prescribing competencies and pathways will need to be emphasised and remain uppermost in focus during this process as will considerations around patient safety.
2. Paramedics Australasia strongly believes that certain professional groups should be granted prescribing privileges on the grounds of patient need, informed practice and common sense. The prescribing privileges should be aligned with the nominated privileging levels in the proposed framework as outlined above. In that category PA submits that formal recognition should be made of the contemporary role of the paramedic and ambulance officer in health care delivery including the autonomous use of medicines by paramedics (also see response 6 section 2a).

3. Formalisation of the scope of practice and regulatory arrangements for paramedics including the prescribing and administration of medications should be included in any provisions for national registration of paramedics within the NRAS.

4. Inclusion of prescriber competency standards into course accreditation processes.

5. Development and rollout of training for existing practitioners to enable prescriber privileging.

6. Establishment of a multidisciplinary group to monitor and recommend changes as required to the implementation of the proposed prescribing framework.

7. Early engagement and ongoing interaction between the professional bodies of the various included disciplines.

8. **Current and Future Innovation**

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<th>Do you know of any health professionals prescribing trials / projects that are happening in your area / industry? If so, please briefly describe.</th>
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<tr>
<td>1.</td>
<td>No - we are not aware of any projects directly related to this area of prescribing efficacy, although there are several research studies nationally on the use of medications in emergency care and their impact on patient outcomes.</td>
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<td>2.</td>
<td>The current HWA project on Extending the Role of Paramedics is a good example of why there is a need to recognise this relatively new and rapidly developing professional role and its clinical autonomy and scope of practice. The daily exercise of clinical practice and operation within the limited provisions afforded by current prescribing and medication law, demonstrates the need to review this situation to provide full (L4) prescribing for paramedics.</td>
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9. Extra Information

9a) Please make any further comments that might assist.

1. As identified above, contemporary practice performed by paramedics and ambulance officers has highlighted the anomalies and challenges created by traditional jurisdictional and employer regulation of the emergency health care role performed by these well qualified and competent practitioners. Those limitations have inhibited the development of new pathways of care and better utilisation of the health workforce through the mobilisation of the paramedic cohort.

2. Significant changes have taken place in paramedic practice along with increasing education standards and rapid expansion in the number and type of Australian service providers employing paramedics both nationally and internationally. The expansion of practice requirements in terms of scope and practitioner autonomy embodies a need for prescribing privileges in the interests of the patient. It also mandates appropriate mechanisms for accountability and independent determination of fitness to practice. To ensure these objectives, PA is firmly committed to the national registration of paramedics under the NRAS at the earliest opportunity.

3. Paramedics Australasia strongly believes that the current proposed model in relation to paramedic practice must be reviewed and modified as it does not appear to fully encapsulate the contemporary provision of health care by this group of practitioners. That dissonance in role perception is likely the result of lingering mis-perceptions of role based on outdated practice models and common folklore depicted in the media. Paramedics and Advanced/Specialist Paramedics e.g. Intensive Care, Retrieval & Extended Care do not operate in many circumstances according to the principles of "prescribe to administer" and should be specifically considered for inclusion in the relevant prescribing levels once these are finalised.

4. The inclusion of paramedics and ambulance officers within the prescribing framework at a clinically appropriate level is strongly supported by the profession. Whilst this will require a number of legislative, procedural and professional changes to implement given the current lack of a national regulatory framework, PA submits that it is in the public interest to take this action now.

5. The outcome will be increased flexibility and access to safe and reliable care by providing the community with improved access to the health care provided by this group of highly competent health care professionals whose practice mode is often 24/7 availability in many locations where there are no other equivalent health care services.