A NATIONAL CODE OF CONDUCT FOR HEALTH CARE WORKERS

RESPONSE TO THE AUSTRALIAN HEALTH MINISTERS’ ADVISORY COUNCIL CONSULTATION PAPER OF MARCH 2014

APRIL 2014
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EXECUTIVE SUMMARY

Paramedics Australasia (PA), the peak professional body representing paramedics in Australia and New Zealand, strongly supports the introduction of a National Code of Conduct for health care workers (the Code). PA welcomes this opportunity to comment on the draft Code.

PA has put forward a case for national registration of paramedics which is currently being considered by government. Until paramedics are registered they will be covered by the Code. Other out-of-hospital care workers in ambulance services and in industrial, defence, mining and event settings are not part of the registration proposal and will be covered by the Code. From the 2011 census PA estimates that there are around 12,000 ambulance officers and paramedics in Australia.

PA largely supports the terms of the Code as presented. Our main points of comment are as follows:

- volunteer health care workers should be included in the coverage of the Code
- the Code should not apply to members of the public providing first aid or life saving interventions in emergencies. Rather it should only apply to people who are engaged as volunteers, employees or contractors to provide first aid services in defined roles
- the Code should apply to health care students and health care teachers/trainers when these people provide health services to members of the public
- some elements in the Code are drafted so that they apply less well to or create potentially unworkable impacts on employed health care workers compared to those in independent practice
- PA suggests modification to the draft clauses relating to safe and ethical conduct, informed consent, adverse events, infection control, claims to cure, mental or physical impairments, records and insurance so that they can apply to employed health care workers, and
- PA recommends the removal of clauses relating to financial exploitation and displaying the Code and other information because they cannot be reasonably applied to employed health care workers. Alternatively these clauses could be modified to apply only to self-employed health care workers.
In terms of priorities for national consistency, PA places a higher priority on elements of the scheme which are critical to the protection of the public and fairness across jurisdictions to health care workers (whose livelihoods are at stake) than on other elements of the arrangements.

For the protection of the public, PA considers national consistency should be a high priority in a fit and proper person test, publication of statements on prohibition orders, and the application of orders issued in other States and Territories. For fair treatment of health care workers, PA places a high priority on national consistency in interim prohibition orders, the grounds for issuing prohibition orders, and penalties for breach of a prohibition order.

PA supports a single national register of prohibition orders rather than multiple separate registers.
1. PARAMEDICS AUSTRALASIA

Paramedics Australasia is the peak professional body representing paramedics engaged in the delivery of out-of-hospital clinical care services to the community. PA’s primary role is to provide leadership in professional matters. PA provides an Australasian platform for the development and promulgation of policies and service standards that will enhance the quality of patient care.

PA provides a program of continuing professional development and publishes a monthly electronic Newsletter Rapid Response; a quarterly general interest journal Response and the peer-reviewed electronic Australasian Journal of Paramedicine. PA provides information through a website and other media; holds scientific conferences and symposia, and sponsors and fosters evidence-based research. PA has a Code of Conduct for members. PA also represents the profession by preparing submissions to government and engaging in discussions with government and other stakeholders on matters that affect the future of the paramedicine profession.

Work undertaken by PA has included holding a national forum on minimum standards for continuing professional development, consideration of competence and fitness to practice, education, accreditation of training jointly with the Council of Ambulance Authorities (CAA), setting of professional practice standards, promoting ethical practice, and processes for dealing with poor performance and misconduct.

In addition to membership based activities, PA supports the development of the profession in the public interest and advocates the profession’s policies and views on health care issues to governments and other external stakeholders.

PA is a company limited by guarantee and registered under the Corporations Act 2001.

PA welcomes the opportunity to provide its views on the Draft National Code of Conduct for health care workers and associated matters. PA stands ready to assist governments in any way it can to improve the quality and safety of the services provided to the Australian community.

2. NATIONAL REGISTRATION OF PARAMEDICS

PA is strongly of the view that paramedics should be included in the National Registration and Accreditation Scheme which operates in all States and Territories of Australia. Our earlier submission to the Australian Health Ministers’ Advisory Council refers (PA 2012a) to this position. The question of paramedic registration is currently under active consideration by governments in Australia and New Zealand.

Until such time as paramedics are nationally registered, paramedics would be included within the scope of any Code of Conduct legislated in each State and Territory.

PA has developed a set of paramedicine role descriptors which distinguish between the different levels of practice in the out-of-hospital health care sector (PA 2012c).
The role descriptors are as follows:

PROFESSIONAL STREAM (PARAMEDICS):
- Paramedic
- Intensive Care Paramedic
- Retrieval Paramedic
- General Care Paramedic

TECHNICAL STREAM:
- First Responder
- Patient Transport Attendant - Level 1
- Patient Transport Attendant - Level 2
- Basic Life Support Medic

AMBULANCE COMMUNICATIONS STREAM:
- Emergency Medical Dispatch Support Officer
- Emergency Medical Dispatcher

If paramedics become registered health practitioners, everyone in the Professional Stream would have to be registered. Those in the technical and ambulance communications streams would remain outside the registration system and would be covered by the Code of Conduct.

3. ESTIMATES OF THE NUMBERS OF HEALTH CARE WORKERS IN OUR PROFESSION OR FIELD

PA has undertaken work on the 2011 Australian census to arrive at estimates of the numbers of ambulance officers and paramedics in Australia in that year across both the public and the private sectors (PA 2012b).

There were 11,940 ambulance officers and paramedics in the 2011 Australian census. There were a further 818 paramedics in the Australian Defence Force (ADF) who did not identify themselves as paramedics in the census. This gives a total in the category of ambulance officers and paramedics of 12,758 if ADF paramedics are included.

The number of ambulance officers and paramedics grew between the 2006 Australian census and the 2011 census by 31 per cent.

9729 or 82 per cent of all ambulance officers and paramedics in Code 4111 were employed by State and territory governments, and 2148 or 18 per cent worked in the private sector. Of those working in the private sector, 722 or 34 per cent worked in ambulance services in Western Australia and Northern Territory where private providers have contracts with governments to supply public ambulance services.
Of all the ambulance officers and paramedics recorded in the 2011 Australian census, 93 per cent were recorded as working in ambulance services of one kind or another. Over 99 per cent of ambulance officers and paramedics were employed rather than self-employed.

**Employed paramedics working in second jobs and as volunteers**

Other interesting features of the paramedic labour market relevant to the development of the Code are that a large number of employed paramedics have secondary engagement as paramedics and/or are volunteers.

In July and August 2012 PA undertook a survey of paramedics with 3841 complete responses received (PA 2012a: Attachment B). The survey revealed that 33 per cent of the paramedics responding to the survey had a second professional engagement in addition to their main role, with most of those being second jobs being as paramedics.

Excluding those who did not state whether they volunteered or not, the 2011 census showed that 29 per cent of ambulance officers and paramedics undertook volunteer work. Based on the PA survey, PA believes that a considerable amount of this volunteering work is as paramedics.

**Reliance on volunteers in the ambulance services**

There is a heavy reliance on volunteers to provide ambulance services in Australia. In the 2011-12 Annual Report of the CAA, there were “1,131 ambulance response locations Australia wide, 63% with paid staff only, 7% combination of paid and volunteer staff and 29% fully volunteer supported. The distribution varies between states and territories, with Western Australia, South Australia and Tasmania heavily relying on volunteer based response locations in rural and remote areas” (CAA 2013: 80).

The staffing numbers for the Australian ambulance services covered by the CAA were: 14,788 full time equivalent salaried ambulance operatives and 6,012 individual volunteer ambulance operatives (CAA 2013: 78). In some cases volunteers are performing the same or similar roles as salaried staff in different (or even the same) locations.

4. APPROACH TO QUESTIONS ASKED

PA strongly supports the introduction of the Code of Conduct as a means of improving the safety and quality of health services provided to the public. It complements the national registration of health practitioners in providing additional protection to the public.

Our responses largely support the proposals as presented. Where we do not fully support the proposals our responses cover the following four main issues:

- the coverage of the Code of Conduct, particularly in relation to what are described in the consultation paper as “first aid providers”
• coverage for volunteers, health care teachers and health care students
• differences between the emergency out-of hospital care sector and other settings in which health care workers operate
• the need to distinguish between what a health care worker can be held accountable for and what his or her employer might have legal responsibility for where the health care worker is in employment or otherwise engaged by a third party (for example as a volunteer).

Our responses are set out according to the Quick Response Form provided. We have provided recommendations in bold throughout the text.

5. SECTION 2.2 - PROPOSED TERMS OF CODE

Definitions

Volunteers: In the out-of-hospital sector, as described above, there are a large number of volunteers providing regular and in some cases the only ambulance or paramedical services available in an area. PA considers that these volunteers, an essential part of our Australian ambulance system, should be covered by the Code.

PA also considers that when people employed as health care workers provide their services on a volunteer basis outside their regular work situation they should also be covered by the Code.

PA notes that in a number of the State and Territory acts which define health services, ambulance services are specifically referenced. It is our view that this would mean that volunteers as well as employed persons in those services were covered by the term.

PA recommends that the Code cover volunteers who provide health care services.

Application to “first aid providers”: PA is strongly of the view that the Code should not apply to the provision of first aid by members of the public who may be required or feel obliged to provide emergency health care assistance as a humanitarian undertaking regardless of whether they have had any specific first aid training.

PA supports the Australian Resuscitation’s Council (ARC) commitment to encourage increased uptake of early cardiopulmonary resuscitation (CPR) even where those attempting it are not trained. The ARC has developed the slogan “Any attempt at resuscitation is better than no attempt” (ARC 2014). PA does not want to see the public’s willingness to provide first aid including CPR in emergencies in any way diminished by coverage of the Code. To do so would be to risk lives and undermine these efforts.

Ambulance services also provide telephone advice on first aid to members of the public before ambulance personnel reach the patient. Here, as elsewhere, it is essential that there be no disincentive to providing immediate first aid services which in some cases are life-saving.
Care also needs to be taken not to override any existing legislation on rendering first aid. For example, in some jurisdictions motorists are required to stop and render assistance at a collision. The Code should not create a conflict or concern with or override this and other similar requirements in law.

PA considers that the scope of the Code in relation to first aid should be limited to those who are:

1. trained in first aid and.
2. formally engaged or recognised as volunteers, employees or contractors to provide first aid services in defined roles.

PA recommends that the term “first aid providers” not be used. In its place the term “first aid workers” could be used to cover people who are engaged or recognised as volunteers, employees or contractors to provide first aid services in defined roles.

For the removal of doubt, the Code should also specifically state that it does not apply to members of the public providing first aid in emergencies.

**Application to health care students and health care teachers/trainers:** The application of the Code to health care students and health care teachers/trainers needs to be clearly articulated. PA considers that the approach adopted in the National Registration and Accreditation Scheme should be followed. Where a person provides a health service to a member of the public they should be covered by the Code. Thus health care students should be covered by the Code when they are providing services to members of the public, for example during clinical placements and intern development. Health care teachers or trainers likewise should be covered by the Code - not as teachers and trainers - but as and when they provide health services to members of the public.

PA recommends that the Code apply to health care students and health care teachers/trainers when these people provide health services to members of the public.

**Health care worker:** PA supports the use of this phrase in the Code in preference to the terms “unregistered health practitioner” or “health practitioner”. PA considers that the term “worker” describes more accurately the wide range of skills and training in the population to be covered. PA notes that this is consistent with the approach taken in the recently harmonised Workplace Health and Safety legislation which now covers those who provide their services as a volunteer.

**Application of the Code**

PA supports the approach proposed in the Consultation Paper. PA agrees that the Code should not apply to registered health practitioners unless they are engaged in the provision of health care that is not ‘covered’ by the scope or nature of their registration. The main reason is that the Code includes matters which are covered in different ways in the national
registration system. Each profession under the registration system has its own code of conduct which is pitched at the level of good practice rather than a minimum standard.

The draft Code as proposed has tried to address two partially inconsistent objectives. It tries both to provide a code which applies to all health care workers and a code which addresses poor practices in a sub-set of health care workers, largely those in independent practice. As a result a number of features of the draft Code do not apply well to health care workers who are in employment and the roles of employer and health care worker are sometimes confused.

It is important that the roles of employers and employees are clearly delineated and that the Code cover what can reasonably be expected of employees given the nature of this relationship both from a legislative and common law perspective. It should not be an unintended consequence of the Code to provide an avenue for the transfer of legal responsibilities from employers to employees.

In its response PA has tried to identify those areas where the Code as drafted does not apply easily to employed health care workers and to suggest how the difficulties may be addressed. PA has operated on the principle that a Code of Conduct for all health care workers is desirable and has focused its suggestions on what is necessary to achieve that end.

PA notes that in terms of the numbers of health care workers to be covered by the Code, the number for employed workers in the aged care, disability, hospital and out-of-hospital sectors may well outweigh the numbers who are engaged in private practice by a substantial margin.

1. Health care workers to provide services in a safe and ethical manner

PA supports this clause of the draft Code but notes that employed health care workers can only be held accountable for matters over which they have some control. Employers have responsibilities in relation to equipment, premises and other working environments such as ambulance vehicles, training, supervision, treatment guidelines/protocols and procedures. Furthermore the ‘junior’ roles played by many employed health care workers as members of multidisciplinary health care teams would not necessarily mean that they carried what are described as “professional responsibilities” for example for determining a course of treatment or being aware of adverse interactions between therapies.

**PA recommends that this clause be modified to reflect the shared responsibilities between employers and the health care workers they employ and between health care workers and more senior members of health care teams.**

2. Health care workers to obtain informed consent

PA strongly supports the principle of informed consent. However as currently drafted PA does not support this clause because it mandates consent in all circumstances. As the Consultation Paper notes this is a complex area in relation to emergency treatment, treatment of individuals with impairment e.g. unconscious, minors etc. These issues are
already addressed in ambulance services, emergency departments and health care practice more generally.

PA’s Code of Conduct (PA n.d.) reads as follows “Wherever possible, members shall be committed to ensuring that they receive informed consent from their clients prior to instigating treatment at the highest standard of contemporary care” [underlining is only for the purposes of this paper].

Some may feel that “Wherever possible” is too weak for a minimum standard. However it may have the benefit of placing the onus on the health care worker to demonstrate why it was not possible if a complaint were made. This would be manageable in the context of health services (including ambulance, aged care, disability and hospital services) where they are already laws, regulations or guidelines which govern the absence of informed consent and which could inform the handling of any complaint. These laws, guidelines etc. would protect the health care worker if he or she had complied with the requirements.

An alternative is to provide explicit definitions for informed, implied and emergency consent and descriptive advice regarding the applicability of each such as may be found in some medical consent legislation in Australia.

PA is not clear how this clause might apply to health care workers who work in teams under the supervision of other health care workers or registered practitioners, for example in hospitals, aged care facilities and disability services facilities. It could be that local or employer protocols assign others in the team the responsibility for obtaining informed consent to treatment.

PA suggests that the relationship of this clause in the Code to other State and Territory legislation governing consent to treatment needs to be explored, for example legislation covering mental health and substituted decision-making. It should not be the intention of the Code to override this other legislation and where possible the wording should be consistent with any used in this legislation.

PA recommends that

- only a general informed consent requirement be retained moderated by a phrase such as “Wherever possible” or “Wherever practicable”
- this clause be modified to reflect, recognise and incorporate the different roles health care workers are assigned in health care teams
- it should be explicit that this part of the Code does not override other legislation relating to consent in a State or Territory e.g. mental health legislation.

3. Appropriate conduct in relation to treatment advice

PA supports this clause of the draft Code.

4. Health care workers to report concerns about treatment or care provided by other health care workers
PA supports this clause of the draft Code.

5. Health care workers to take appropriate action in response to adverse events
PA understands the concern that some health care workers may not move quickly enough to get assistance when a medical emergency arises and supports the inclusion of the first sub clause about appropriate action in response to an adverse event during the course of treatment.

However PA has some difficulty applying the second sub clause about having first aid to hand and calling the emergency services to ambulance officers and paramedics since these health care workers are the suppliers of such emergency services. PA considers that the provision of first aid facilities in a workplace is the responsibility of the employer not the individual employed health care worker.

One solution would be to remove the second sub clause as being too detailed. However if the clause were to be retained it should not apply to those working in ambulance services and sub-clause 2(a) should be removed.

PA recommends that either the second sub clause about having first aid to hand and calling emergency services is removed or this sub clause be amended to exclude those working in ambulance services from coverage of the second sub clause. If sub-clause 2 is retained 2(a) should not apply to employed health care workers.

6. Health care workers to adopt standard precautions for infection control
PA supports this clause of the draft Code but notes that employers also have responsibilities in this area, for example in relation to personal protective equipment, the method for disposal of sharps, routine environmental cleaning, reprocessing of reusable medical equipment and instruments, waste managements and appropriate handling of linen.

PA recommends that this clause be modified to reflect the shared responsibilities between employers and the health care workers they employ.

7. Health care workers diagnosed with infectious medical conditions
PA supports this clause of the draft Code.

8. Health care workers not to make claims to cure certain illnesses
PA supports this clause of the draft Code but notes that employed health care workers cannot be held responsible for advertising or other material making claims to cure certain illnesses.

PA recommends that this clause be modified to reflect the shared responsibilities between employers and the health care workers they employ.
9. Health care workers not to misinform their clients
PA supports this clause of the draft Code.

10. Health care workers not to practise under the influence of alcohol or drugs
PA supports this clause of the draft Code.

11. Health care workers with certain mental or physical impairment
PA supports the first sub clause of this clause of the draft Code. However, PA considers that the second sub clause which requires the health care worker to take specific action on their own account and stop practice of their own volition, should apply only to those health care workers in independent private practice. However, sub-clause 2 does not apply comfortably to employed health care workers where the decision as to whether and how a worker continues to perform their duties needs to be made with their employer.

**PA recommends that sub-clause 2 be removed because it does not apply to employed health care workers.**

12. Health care workers not to financially exploit clients
Whilst in principle PA supports the intention of this clause, we have significant concerns regarding the inclusion in the Code of this provision because it is often the case that financial arrangements surrounding the provision of services are the responsibility of employers not of health care workers in employment. In ambulance services, for example, the charging regime is determined by the government/employer not the paramedic or ambulance officer. There is unlikely to be any shared responsibility in most cases.

**PA recommends the removal of this clause because it is not applicable to employed health care workers. Alternatively the clause should be reworded to apply only to self-employed workers.**

13. Health care workers not to engage in sexual misconduct
PA supports this clause of the draft Code.

14. Health care workers to comply with relevant privacy laws
PA supports this clause of the draft Code.

15. Health care workers to keep appropriate records
This clause as currently drafted is not applicable to health care workers who are employed working in an agency framework. In these cases, the responsibility to make appropriate records, hold these securely, make them secure from unauthorized access, make them
accessible to clients and transfer records as appropriate will lie with or be directed by the employer or agency rather than the individual health care worker.

Even the creation of records is difficult because in an emergency care team environment, it is common that only one health care worker or health care professional has the responsibility for creating the record. For example, in an ambulance team, the primary treating or senior clinician in the team attending usually has the responsibility for creating the record.

PA also notes that the use of the words “client” and “consultation” do not easily encompass all possible service provision contexts. It is hard, for example, to describe an emergency call-out to an unconscious person as a consultation.

**PA recommends that this clause be modified to reflect the shared responsibilities between employers and the health care workers they employ and between health care workers and more senior members of health care teams.**

16. Health care workers to be covered by appropriate insurance

PA supports this clause in principle especially where this relates to self-employed health care workers. The consultation paper acknowledges that for employed health care workers insurance is the responsibility of employers. It is difficult to argue that it is necessary for compliance that employees have to check with their employers that they are insured to comply with the Code. Such checks will also be costly for employers. PA would prefer that the Code make it clear that employed health care workers can rely on their employers to provide appropriate insurance for them while they are exercising their duties as employees without making any checks.

PA also suggests that a check needs to be made of State and Territory “Good Samaritan” legislation. Where such legislation exists, the Code should not be able to override such legislative protection for health workers or other persons from civil liability on the basis of providing emergency or first aid in good faith.

**PA recommends that this clause be modified so that employed health care workers do not have to make any checks with their employer about insurance cover and to ensure that it does not override Good Samaritan legislation where it exists.**

17. Health care workers to display Code and other information

PA acknowledges the importance of public accountability and transparency. However, this clause can only apply to an independent self employed health care worker. The employed health care worker is not in a position to insist that the Code and other information be displayed on the premises of their employer or agency. The display of material in workplaces is a matter for the owner/operator of the workplace not the employee/volunteer.

The draft clause already includes some major exemptions. PA considers that it is likely that all employed health care workers would need to be exempt (not just those employed by the services so far listed), plus all volunteers working within an agency framework. PA thinks it is
likely that the number of health care workers exempt would exceed by a wide margin the number of health care workers who were not exempt.

PA recommends the removal of this clause because it is not applicable to employed health care workers. Alternatively the clause should be reworded to apply only to self-employed workers.

Overview of PA response on draft code clauses

PA responses to the 17 clauses fall into three categories:

- clause as currently drafted can be applied to all health care workers
- clause can be applied with modification to all health care workers, including employees, and
- clause cannot be modified to apply to employees and should be removed or modified to apply only to self-employed health care workers.

Our responses on each clause are summarised in Table 1 overleaf.

PA acknowledges that there may well be other ways to address the difficulties we have identified. However it is important that the outcome is a Code that can be applied to all health care workers while taking into account the different circumstances of health care workers who are operating on their own account and health care workers who are employed.
Table 1. How does the draft Code apply to health care workers (HCW) working on their own account and employed health care workers?

<table>
<thead>
<tr>
<th>Clause in draft code</th>
<th>Can apply as is to both groups</th>
<th>Can apply to both groups with modifications</th>
<th>Cannot apply to employed health care workers</th>
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<tr>
<td>1 HCW to provide services in a safe and ethical manner</td>
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<td>✓</td>
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<td>2 HCW to obtain informed consent</td>
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<td>3 Appropriate conduct in relation to treatment advice</td>
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<td>4 HCW to report concerns about treatment or care provided by other HCW</td>
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<td>5 HCW to take appropriate action in response to adverse events</td>
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<td>6 HCW to adopt standard precautions for infection control</td>
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<td>7 HCW diagnosed with infectious medical conditions</td>
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<td>8 HCW not to make claims to cure certain illnesses</td>
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<td>9 HCW not to misinform their clients</td>
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<td>10 HCW not to practise under the influence of alcohol or drugs</td>
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<td>12 HCW not to financially exploit clients</td>
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<td>14 HCW to comply with relevant privacy laws</td>
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<td>15 HCW to keep appropriate records</td>
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<td>16 HCW to be covered by appropriate insurance</td>
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<td>17 HCW to display Code and other information</td>
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6. ITEMS NOT INCLUDED IN THE DRAFT NATIONAL CODE OF CONDUCT

1. Sale and supply of optical appliances
PA supports the non-inclusion of this item.

2. Health care workers required to have a clinical basis for treatments
PA supports the use of evidence based practice in health care provision. However we understand the diversity of the workforce covered by this code and the complexities associated with enforcing this requirement across all health workers. We recommend the non-inclusion of this item because of the large variability in the use of evidence-based practice across not only the health care workers to be covered by the Code but also among the registered health professions.

An alternative may be to reword this clause along the lines of: “Health care workers are not to misrepresent or make any false claims in relation to the scientific basis for treatments. Clinical treatments must accord with the principles of beneficence and non-maleficence.”

7. SCOPE OF APPLICATION OF THE NATIONAL CODE

Definition of a health care worker See earlier discussion under definitions relating to Section 2.2.

Definition of a health service
The greatest possible national consistency is desirable to protect the effectiveness of the Code, not just in definitions but also in all matters relating to the Code such as those addressed below in Section 9.

PA supports national consistency where possible because consistency

- provides the greatest protection for the public
- makes it easier for health care workers who move between jurisdictions to understand what compliance involves
- enables employers who operate across jurisdictional boundaries to more easily assist their employees to comply with the Code, and
- provides the greatest economic benefit in terms of mobility and costs to industry.

Response from Paramedics Australasia
PA notes that ambulance officers and paramedics are a fairly mobile population. In the 2011 census 6 per cent of ambulance officers and paramedics (a total of 665 persons) had moved across State and Territory boundaries in the last five years (PA 2012b: 9,10). The proportion was much higher at 11 per cent among 20 to 29 year olds.

PA accepts that governments may feel that full national consistency is not possible in all aspects and our priorities for consistency are set out in our responses below.

8. OTHER SECTIONS

Section 3.3 Application of a ‘fit and proper person’ test
PA considers that there should be a power to issue a prohibition order on the grounds that a person is not fit and proper to provide health services where they present a serious risk to public health and safety.

PA considers that it is more important to get the prescribed offences aligned across jurisdictions than to align the technical means by which this is put in place. If the offences are not aligned, a health care worker could move to another jurisdiction and practise where the offence he or she was convicted of was not a bar to practice, whatever the prohibition register said.

PA considers that consistency in definition of prescribed offences should be a high priority.

Section 3.4 Who can make a complaint?
PA considers that while desirable, consistency in this area is not a high priority.

Section 3.5 Commissioner’s own motion powers
PA considers that while desirable, consistency in this area is not a high priority.

Section 3.6 Grounds for making a complaint
From the material in the Consultation Paper, PA cannot see that the most serious matters would escape complaints in any of the models currently used. As a result, PA considers that consistency in this area is not a high priority.

Section 3.7 Time frame for lodging a complaint
PA considers that while desirable, consistency in this area is not a high priority.

Section 3.8 Interim prohibition orders
PA strongly believes that interim prohibition orders should be included in the scheme for the protection of the public. Given the significance of these orders for a health care worker’s present and future livelihood, consistency in the time period and grounds for these orders should be a high priority.

**Section 3.9 Who is empowered to issue prohibition orders**
PA considers that while desirable, consistency in this area is not a high priority.

**Section 3.10 Grounds for issuing prohibition orders**
PA considers that relevant or prescribed offences should be included nationally in the grounds for issuing prohibition orders. See our comments at 3.3 above. PA also considers that in all cases a prohibition order must rest on a serious risk to the health or safety of members of the public not just a breach of the Code. Given the significance of these orders for a health care worker’s present and future livelihood, consistency in the grounds for these orders should be a high priority.

**Section 3.11 Publication of prohibition orders and public statements**
PA considers that public statements on prohibition orders are likely to have more effect on public alertness to problems with health care workers than the register alone. As a result PA supports consistent provisions across jurisdictions which support public statements. Consistency in this provision is also important for there to be fairness across jurisdictions between health care workers subject to prohibition orders in different jurisdictions. PA considers that consistency in this area should be a high priority.

**Section 3.12 Application of interstate prohibition orders**
PA considers it is essential for the protection of the public that prohibition orders made in one State or Territory apply in all States and Territories. This should be a high priority. PA does not have a view on what mechanism should be used to achieve this result.
AHMAC may wish to consider the implications of the Trans Tasman Mutual Recognition Agreement for these new arrangements.

**Section 3.13 Right of review of a prohibition order**
PA considers that consistency in this area is not a high priority as long as the right is available alongside the principles of transparency and natural justice. How this works out is essentially a matter for the legal and justice systems in each State and Territory just as it is in the National Registration and Accreditation Scheme.
Section 3.14 Penalties for breach of a prohibition order

There appear to be quite large differences in penalties between jurisdictions at the moment. As a matter of fairness to health care workers across jurisdictions, PA considers that consistency in penalties should be a high priority.

Section 3.15 Powers to monitor compliance with prohibition orders

It appears that breaches of prohibition orders may well come to the attention of complaints commissioners by means other than compliance monitoring. PA considers that while desirable, consistency in this area is not a high priority.

Section 3.16 Information sharing powers

As long as information sharing powers are in place, PA considers that while desirable, consistency in this area is not a high priority.

Section 4.1 Mutual recognition

PA supports a single national register for prohibition orders (options 2 and 3) rather than 8 separate registers (option 1). A single register is more user-friendly for all potential users and carries less risk of error. PA would prefer Option 3 if it were possible but considers Option 2 is also acceptable.

9. ANY OTHER COMMENTS

PA has no other comments to add.

PA would like to be informed of the outcome of the consultation and would be happy to assist with the process in any way we can.
REFERENCES CITED


ACRONYMS USED

ADF Australian Defence Force
ARC Australian Resuscitation Council
CAA The Council of Ambulance Authorities
CPR cardiopulmonary resuscitation
HCW health care worker
PA Paramedics Australasia