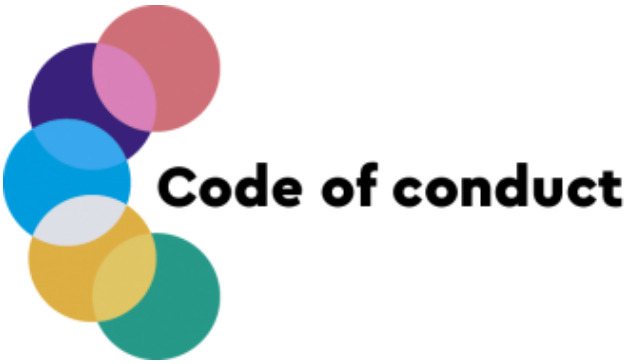

Shared code of conduct: public consultation

Introduction

The Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Chiropractic, Dental, Medical Radiation Practice, Occupational Therapy, Optometry, Osteopathy, Paramedicine, Pharmacy, Physiotherapy and Podiatry Boards of Australia (National Boards) have a shared code of conduct (shared code), most in the same form and some with minor variations.

The National Boards and the Australian Health Practitioner Regulation Agency (Ahpra) are seeking feedback about a proposed revised shared code (revised shared code).

Please ensure you have read the public consultation papers before answering this survey, as the questions are specific to the revised shared code.

Publication of responses

The National Boards and Ahpra publish submissions at their discretion. We generally publish submissions on our websites to encourage discussion and inform the community and stakeholders. Please advise us if you do not want your submission published.

We will not place on our websites, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally identifying information from submissions, including contact details.

The National Boards and Ahpra can accept submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the Freedom of Information Act 1982 (Cth), which has provisions designed to protect personal information and information given in confidence. Please let us know if you do not want us to publish your submission or want us to treat all or part of it as confidential.

Published submissions will include the names (if provided) of the individuals and/or the organisations that made the response unless confidentiality is requested.

Please select the box below if you do **not** want your responses to be published.

- [ ] Please do **not** publish my responses

About your responses

Are you responding on behalf of an organisation?

- (●) Yes
- ( ) No

Please provide the name of the organisation.

Victorian Early Career Pharmacists Working Group

Which of the following best describes your organisation?

- ( ) Health services provider
- ( ) Professional indemnity insurer
- ( ) Legal services provider
- ( ) Professional body (e.g. College or Association)
- ( ) Education provider
- ( ) Regulator
- ( ) Government
- ( ) Ombudsman
- (●) Other

Please describe your organisation.

Interest group

Your contact details

First name:

[redacted]

Last name:

[redacted]

Email address:

[redacted]

Which of the following best describes you?

This question was not displayed to the respondent

Q45. Please describe.

This question was not displayed to the respondent

Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

This question was not displayed to the respondent

Q46. Please describe.

This question was not displayed to the respondent

The following questions will help us to gather information about the revised shared Code of conduct.

Please ensure you have read the public consultation papers before responding, as the questions are specific to the revised shared code.

The revised shared code includes high-level principles to provide more guidance to practitioners especially when specific issues are not addressed in the content of the code.

Are shorter, more concise principles that support the detail in the revised shared Code preferable or are longer, more comprehensive principles a better option? Why?

Shorter, more concise principles are preferred as an overarching guide. Principles that are short and concise are easier to read and comprehend, and for practitioners to keep in mind in daily practice. More comprehensive examples and case studies that demonstrate how the principles are applied can be explained through other forums rather than being explicitly documented in the code.

In the revised shared code, the term ‘patient’ is used to refer to a person receiving healthcare and is defined as including patients, clients, consumers, families, carers, groups and/or communities’. This is proposed in order to improve readability of the code and to support consistency for the public.

Do you support the use of the term ‘patient’ as defined for the revised shared code or do you think another term should be used, for example ‘client’ or ‘consumer’? Why or why not?

In general, the use of the term ‘patient’ in the revised shared code is appropriate. This term is more specific to healthcare settings and so emphasises the primary role of health practitioners as health providers.

The revised shared code includes amended and expanded content on Aboriginal and Torres Strait Islander health and cultural safety that uses the agreed definition of cultural safety for use within the National Registration and Accreditation Scheme. (Section 2 Aboriginal and Torres Strait Islander health and cultural safety).

Is this content on cultural safety clear? Why or why not?

The content on cultural safety is clear. The inclusion of specific aspects of cultural safety is useful for health practitioners and the public.

Q49.
Sections 3.1 Respectful and culturally safe practice, 4.1 Partnership, 4.9 Professional boundaries and 5.3 Bullying and harassment include guidance about respectful professional practice and patient safety.

Does this content clearly set the expectation that practitioners must contribute to a culture of respect and safety for all? e.g. women, those with a disability, religious groups, ethnic groups.

The content clearly sets out the expectation that practitioners must contribute to a culture of respect and safety for all (colleagues, other health professionals, patients and their families, friends, and/or carers). Including a link to the Australian Human Rights Commission for further information supports readers to find more context if needed. Section 5.3 deals with discrimination, bullying and harassment, as set out in the explanatory paragraph. The heading should be edited to reflect this. Adding a definition of discrimination, which encompasses a list such as women, those with a disability, sexuality, etc would also be useful to make this explicit.

Statements about bullying and harassment have been included in the revised shared code (Section 5.3 Bullying and harassment).

Do these statements make the National Boards'/Ahpra's role clear? Why or why not?

Section 5.3 statement (g) regarding the National Boards'/Ahpra's role in bullying and harassment is not clear when read on its own. Within the context of the revised shared care, this statement reads as discrimination, bullying or harassment that is harming patients, students, trainees, colleagues or healthcare teams is reportable – with no mention of risk to public safety. The case study provided in the consultation draft on page 7 (under 'new content') makes this explicit.

The revised shared code explains the potential risks and issues of practitioners providing care to people with whom they have a close personal relationship (Section 4.8 Personal relationships).

Is this section clear? Why or why not?

This section is clear. It could be improved by separating it out into two sections: • 4.8.a-c are practices that apply to all patients regardless of personal relationships (i.e. treat them the same as any other patient), and • 4.8.d-f are practices that apply specifically to providing care to a person you have a personal relationship with.

Is the language and structure of the revised shared code helpful, clear and relevant? Why or why not?

Yes, but acknowledging that members of the public may not have the same levels of literacy.

The aim is that the revised shared code is clear, relevant and helpful. Do you have any comments on the content of the revised shared code?

• Vexatious complaints or notifications case studies – it was not clear that case study 1 (Sam) is from the patient's point of view and case study 2 (Felicity) is from a health practitioner's point of view. Defining this at the start would be clearer, such as in the Bullying and harassment case study and Risk management and clinical governance case studies (e.g. 'Joanne is an occupational therapist…'). • Principle 6 should include safety • Principle 9, statement f is concerning. Including the 'try to work safe hours whenever possible' is concerning. If working safe hours is not possible, then the implication is that health practitioners will work unsafe hours. This is not an acceptable risk. This wording also puts the onus on the practitioner, who may be an employee with limited power to act on this. • Substitute decision-makers - use of 'patients' includes substitute decision-makers for people who do not have the capacity to make their own decisions. It should be made clear that is only the case when patients do not have the capacity, and that even in these cases, the patient should participate in decision-making up to their capacity. For example, people living with dementia often do have capacity, and should be included and empowered in decision-making at all opportunities possible.

Do you have any other feedback about the revised shared code?

The National Boards are also interested in your views on the following questions about the potential impacts of the proposed revisions to the shared Code of conduct.

Would the proposed changes to the revised shared Code result in any adverse cost implications for practitioners, patients/clients/consumers or other stakeholders? If yes, please describe.

There may be some implications for health practitioners who will need to undertake continuing professional development to meet the new culturally safe and respectful practice inclusions.

Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.

Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for vulnerable members of the community? If so, please describe them.

Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.

The next two questions are about the Chiropractic Board and its changes to the revised shared code of conduct. They are not relevant to all stakeholders but you are welcome to give feedback if you are interested.

Do you wish to read the questions and provide feedback about the Chiropractic version of the revised shared code?

- (●) No
- ( ) Yes

The Chiropractic Board's (the Board) current code of conduct is common to many of the National Boards with the exception that the Board's current code of conduct has minor edits, extra content in its Appendices and additional content relating to modalities.

Many of these expectations relating to the Appendices are referred to more broadly in the revised shared code and/or are largely replicated in other relevant board documents such as the recently revised Guidelines for advertising a regulated health service (Appendix 1) and the FAQ: chiropractic diagnostic imaging (Appendix 2). It is proposed that the appendices and section on modalities be removed and additional guidance on these areas be presented in additional guidelines or similar.

Noting that the principles and expectations in the current appendices and modalities section are addressed broadly in the revised shared code and other relevant documents do you think it is necessary to keep the additional information in the Appendices and modalities section? Why or why not?

This question was not displayed to the respondent

If you think keeping the extra information is necessary, do you support that the information be presented as a guideline, or similar, rather than as an appendix to the revised shared code? Why or why not?

This question was not displayed to the respondent

The next question is about the Medical Radiation Practice Board and its current version of the revised shared code of conduct. It is not relevant to all stakeholders but you are welcome to give provide feedback if you are interested. Do you wish to read the questions and provide feedback about the Medical Radiation Practice version of the revised shared code?

- (●) No
- ( ) Yes

The Medical Radiation Practice Board's (the Board) current code of conduct is common to many of the National Boards with the exception that the Board's current code has extra content in its Appendix A. Appendix A includes expectations specific to medical radiation practitioners about providing good care, effective communication and radiation protection. Many of these expectations are referred to in the Professional capabilities for medical radiation practice (the capabilities), which set out the minimum skills and professional attributes needed for safe, independent practice in diagnostic radiography, nuclear medicine technology and radiation therapy. The Board is proposing to remove Appendix A from the revised code as the content duplicates content included in other documents such as the capabilities.

Do you think the extra information in Appendix A should be presented in a guideline or similar, noting that the expectations specific to medical radiation practitioners are referred to in the

capabilities? Why or why not?

This question was not displayed to the respondent

Q24.

Thank you!

Thank you for participating in the public consultation.

Your answers will be used by the National Boards and Ahpra to improve the proposed revised shared Code of conduct.