Review of the *Non-Emergency Patient Transport Act 2003* and Regulation and Licencing of First Aid providers

Discussion Paper

VICTORIA State Government | Health and Human Services

Review of the Non-Emergency Patient Transport Act 2003 and,

Regulation and Licencing of First Aid providers

Discussion Paper

To receive this publication in an accessible format phone 03 9096 2722, using the National Relay Service 13 36 77 if required, or email privatehospitals@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN/ISSN 978-1-76069-998-7

Available at https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/ambulance-and-nept/non-emergency-transport

Contents

Introduction

Executive Summary

Prior to the last State election, the Victorian Government made an election commitment to review the *Non-Emergency Patient Transport Act 2003* (the Act). The review is now underway. The government's commitment was to strengthen compliance with, and enforcement of, the non-emergency patient transport (NEPT) legislation and ensure the highest quality of care for patients.

Specific commitments that were made by the government are to:

- Investigate the extent to which penalties need to be increased
- Conduct snap audits of vehicles
- Ensure vehicles are fit for use
- Require the use of power lift stretchers and lifting cushions.

The review of the Act will be comprehensive which will also necessitate rewriting the *Non-Emergency Patient Transport Regulations 2016* (the NEPT Regulations). As part of the review, it is intended to regulate the commercial first aid sector for the first time and this will include a licencing system for first aid providers.

This discussion paper has been prepared to inform the NEPT and first aid sectors, and other stakeholders of the likely direction of the Regulations and the thinking that has informed that direction. Feedback and further information is sought from stakeholders and the public. To that end, the discussion paper includes a number for questions. Submitters are requested to answer only those questions that are relevant. Submitters are not expected to respond to all questions.

The discussion paper does not canvas potential amendments to the Act other than those that have already been announced by the government. The only exception is the flagging of the proposal to licence first aid providers under the Act.

Feedback received from this consultation paper will inform the framing of the NEPT Regulations and the development of new First Aid Regulations.

Once both sets of draft Regulations are prepared, there will be a second round of public consultation. Should the costs imposed by either set of Regulations exceed $2 million per annum for the life of the Regulations (10 years), a Regulatory Impact Statement (RIS) is required to accompany the release of the draft Regulations. A RIS is a cost benefit and risk benefit analysis of the proposed Regulations.

Licencing and regulation of the first aid sector will replace stand-by accreditation of NEPT licencees.

The Regulations will be drafted to provide for the licencing scheme for NEPT and first aid providers as required by the Act. The Regulations will set minimum standards and will be drafted to ensure they are outcome-based where possible, rather than being prescriptive.

The Regulations will have patient centred care, and patient safety and quality of care, as their objectives. The Regulations will set the minimum standards required to achieve these objectives.

Background

NEPT

NEPT plays a critical role in the provision of timely health care to Victorians. NEPT provides road and air transport to and from medical services. This includes transfers from home, between health care facilities and back to home.

NEPT is currently provided by Ambulance Victoria (AV), and nineteen licenced private providers. All private providers of NEPT are required by the Act to be licenced by the department in order to operate. All providers of NEPT must comply with the requirements of the NEPT Regulations.

NEPT services are provided for patients who require clinical monitoring or medical supervision but who do not require time-critical transport. Patients may be seriously ill but are considered stable and therefore not in need of an emergency vehicle for transport.

NEPT is provided in stretcher vehicles, using road and air services, for patients who require monitoring and are unable to be transported in a seated position. NEPT is also provided in cars and hoist vehicles for patients who require clinical monitoring and can sit upright.

AV contracts a number of licenced NEPT providers to operate NEPT services on its behalf. There are also a number of licenced NEPT providers who operate independently of AV and have contracts with public and private health services (hospitals), and there are some licenced NEPT services that provide stand-by first aid services at public events.

It is anticipated that with the removal of stand-by accreditation from the Act, some current NEPT providers, who transport minimal numbers of patients, will choose to be licenced as first aid providers instead of continuing with NEPT licences.

In 2017-18, AV private NEPT contractors provided approximately 115,000 NEPT transports[1]. In addition, in 2017-18 private NEPT providers transported 89,000 non AV patients.

The number of NEPT vehicles operated by NEPT licencees in 2017-18 was 371 comprising:

311 stretcher vehicles

30 hoist/wheelchair vehicles

30 passenger vehicles and six aeroplanes

In 2017-18 there were 1,411 clinical staff employed by NEPT licencees comprising:

763 Patient Transport Officers

565 Ambulance Transport Attendants

63 Critical Care Registered Nurses

20 Paramedics (NB: Paramedics are not recognised under the existing NEPT legislation and must work to the scope of practice of Ambulance Transport Attendants) [1].

In 2017-18 3,771 stand-by events were attended by NEPT licencees with 2,355 people being treated of which 289 resulted in calls to 000[1].

[1] Source: 2017-18 annual data reporting to DHHS by licenced NEPT providers

NEPT Regulatory Arrangements by other States and Territories

Interstate NEPT arrangements are summarised in Table 1 below.

Table 1

State or Territory	NEPT arrangements
NSW	**Not regulated**
Queensland	**Regulated** **Primarily provided by Ambulance Queensland** **One private provider**
Tasmania	**Regulated** **Private providers must be licenced**
South Australia	**Regulated** **Private providers must be licenced**
Western Australia	**Not regulated**
ACT	**Not regulated**
Northern Territory	**Not regulated**

First Aid

First aid provision is not currently regulated in any Australian State or Territory. It is proposed to licence commercial first aid providers in Victoria and regulate them to provide for minimum standards in the provision of first aid.

Due to the increasing number of public events, particularly large public events, the prevalence of drug overdoses at some large music events, the use of intravenous sedation and general anaesthesia, and the lack of mandatory standards, it is now considered timely to regulate the commercial first aid sector to provide minimum standards for patient safety and quality of care.

Public events can range from small scale short duration events, to large single day events, large multi-day live-in events, and events that traverse the state over a number of days. The legislation must cover first aid provision to all of these scenarios and in doing so, must be proportionate to the risk to participants and patrons.

Setting minimum standards through regulation will increase trust in the sector, provide public confidence through enforcement and licencing of the sector, and increase the transparency of the sector (reduce information asymmetry) through the provision of increased public information.

The Victorian Government does not know how many commercial first aid providers are currently operating in Victoria. Submitters are requested to provide data or estimates of the number of providers as part of their submission. This information is necessary to enable the department to accurately cost the impacts of the legislative proposals discussed in this paper.

The government also does not know how many patients are treated at public events, nor how many are transported to hospital. This information is crucial to assist with ongoing state-wide health planning to accommodate future public health needs.

While the government intends to licence first aid providers who provide their services for a fee, it is mindful of not creating unintended consequences. The department is aware that many individual first aid volunteers may be paid petrol money or be provided with lunch to assist them in providing the service. It is not intended to include these people in the licencing requirements. To do so may result in a significant withdrawal of volunteer first aid services across state sporting and community events.

This paper discusses a range of proposals for first aid regulation. The general themes are:

- a scaled licencing system according to the complexity of the first aid service provided
- escalating requirements of clinical governance according to the complexity of the first aid service provided
- escalating drugs permissions according to the complexity of the first aid service provided
- minimum equipment requirements
- infection control requirements
- training and skills maintenance requirements
- data reporting requirements.

Apart from the requirement to be licenced, all of the proposals relating to first aid discussed in this paper may be modified if submissions provide sufficient justification and there is general support by stakeholders.

Purpose of the Act

The NEPT Act, as it is currently written, is essentially a licencing scheme. It does not directly address patient safety and quality of care or staff safety and therefore, in this day and age is considered no longer fit for purpose.

It is proposed to rewrite the purpose and objectives of the Act to make clear that the Act exists to ensure patient safety and quality of care whenever attended by NEPT crews or first aid providers, and to ensure the safety of staff attending to those patients (without encroaching on the provisions of the *Workers Compensation Act 1958*).

Purpose

The Act currently lists three purposes. They are to establish a licencing scheme for NEPT services, to regulate licenced providers of NEPT services, and to establish an accreditation system for licenced NEPT providers to provider stand by services (to stabilise patients prior to transport to hospital).

It is proposed to replace these three purposes with new purposes that address patient safety and quality of care. Licencing of providers will be the means to an end (i.e., patient safety) not the end itself.

With the introduction of licencing of first aid providers, accreditation of licenced NEPT providers to provide stand-by services will be removed from the Act as it will no longer be required.

Non-Emergency Patient Transport

Licencing

All NEPT providers are required to be licenced.

The proprietor of the business must be a natural person or a corporation. Trusts will not be permitted to be the licence holder.

The criteria for licencing are set out in the Act and include:

- The fitness and propriety of the applicant for the licence (including directors of companies)
- The suitability of vehicles and equipment to be used
- The suitability of the management and staffing arrangements
- The ability of the applicant to provide and maintain patient safety and quality of service
- The suitability of arrangements to ensure continuous improvement of the service.

Much of the detail of how to meet these requirements will be set out in the Regulations.

It is proposed that the updated Regulations will also require NEPT licencees to hold $20 million of insurance in order to be licenced, a change from the current requirement for them to hold $10 million. It is the department's understanding that the premiums paid for a $10 million and a $20 million policy are very close. Members of the sector have recommended that it is advantageous to have the $20 million policy for a minimal increase in premiums.

Q. 1 Is a requirement for a NEPT licencee to hold $20 million of insurance reasonable? If not, why not?

Maintaining an NEPT Licence

The department is considering introducing a requirement that any person who holds an NEPT licence must transport NEPT patients. If no transports are undertaken within 12 months the NEPT licence would automatically be cancelled.

If less than a specified number of transports is undertaken during a 12 month period, the licencee would be required to justify to the department why they should continue to be licenced. The licencee would need to demonstrate how all staff were maintaining their competence and skills if they were not transporting patients under the licencee's clinical governance arrangements. It has been suggested that a minimum of 400 patient transports per annum would be necessary for staff to maintain skills and competencies.

Q 2. What would be a suitable number of NEPT transports per annum to allow NEPT crews to maintain their skills and competencies within the licencees clinical governance framework?

Variation of Licences

For any application for a new NEPT licence, or when an existing NEPT licencee wishes to add additional vehicles to their fleet, a licence variation can only be issued when the nominated vehicles have been purchased, modified, and the current regulation 47 has been complied with. The Act and the schedules in the NEPT Regulations will be amended to clarify this.

Stand-by Accreditation

There is currently a problem with commercial providers of first aid obtaining a NEPT licence to transport patients solely in order to access the expanded range of drugs that are available to NEPT providers. This was never the intent of the stand-by accreditation provisions in the Act and therefore, it is proposed to remove stand-by accreditation.

Applicants will be required to apply for a NEPT licence or a first aid licence or both depending on the services they provide.

Q. 3 What detrimental impacts might replacing stand-by accreditation with the licencing of first aid providers have?

Vehicle Licencing

It is proposed to introduce a separate licencing system for each NEPT vehicle. In addition, increased oversight and enforcement including mandatory annual inspections of each vehicle is proposed.

To date, the department has had no oversight of licencees' NEPT vehicles apart from the few that are present when the licencee's depots are inspected. This has resulted in most NEPT vehicles not being inspected. Without each vehicle being inspected, it is not possible for the department to assure itself that the Regulations are being adhered to in all cases.

It is proposed to amend the Act to require a separate patient transport licence for each NEPT vehicle. Each vehicle will be required to be licensed by the department and relicensed every two years at the same time as the NEPT business licence is renewed. Each vehicle will be identified by its registration plate and VIN number on the application for a licence.

It is proposed that the department will provide two days per annum (more if needed) at pre-determined locations where vehicles may be brought for inspection. Any vehicle that is unable to attend the locations will be required to be brought to the department's city offices for inspection. Any vehicle that is not inspected annually will have its licence cancelled. This proposal is modelled on the Primesafe legislation and operational processes. Primesafe is a Victorian Statutory Authority with responsibility for the regulation of the Victorian meat and seafood industry. It licences all meat and seafood transport vehicles and inspects each vehicle annually.

In addition, the department proposes to institute spot inspections when vehicles are on the road at locations such as hospital emergency departments. This was an election commitment of the current Victorian Government.

Driver Licences

It is proposed to amend the Regulations to require that only staff that have a full drivers licence may drive NEPT vehicles. Probationary drivers would no longer be permitted to drive NEPT vehicles. This change would align the NEPT Regulations with the taxi industry and Uber. The department is concerned that probationary drivers are not sufficiently experienced to be entrusted with driving vulnerable patients and that there is increased patient safety risk as a result.

The change is for patient safety reasons as patients are vulnerable and are not in a position to choose their driver or choose to travel or not travel with a probationary driver. Both Commercial Passenger Vehicles Victoria and Uber require drivers to have a full licence. Given NEPT patients are not as healthy or mobile as general taxi customers and cannot choose their driver, it is not consistent nor considered appropriate to allow probationary licence holders to drive an NEPT vehicle.

Q. 4 What costs would result from a requirement for all NEPT vehicle drivers to hold a full licence?

A further issue that has been brought to the attention of the department is that of loss of licence, suspension of licence and demerit points on licences of staff. It is essential that NEPT licencees know when NEPT staff who drive vehicles have had their licence cancelled, suspended, have been convicted of driving offences, or have received demerit points. While NEPT licencees should have policies that require disclosure of such matters, the Regulations have not addressed this issue.

Permitting staff who have had their licence suspended or cancelled to drive, knowingly or unknowingly, may invalidate insurance of the NEPT company and put patients at risk.

Further, if a person who is employed, or wishes to be employed, to drive a NEPT vehicle incurs any convictions relating to driving offences or fails to provide information, or provides incorrect information to authorised officers, the police or the courts, this must be declared to the NEPT licencee. Otherwise, the NEPT licencee may not be able to meet the statutory obligation to ensure the safety of patients.

It is proposed to require NEPT licencees to review the licences of all staff who drive vehicles (whether employed, contracted, or volunteer) annually. Further, the department wishes to explore options for requiring staff to disclose such information to NEPT licencees noting that the Act does not currently provide a power to create offences for staff of licence holders.

The department will explore whether it is possible to make regulations to require employees to disclose to licencees driving offences, suspensions and cancellations.

It is proposed to require that any staff who may drive an NEPT vehicle must provide a police check to the licencee prior to driving the vehicle.

Q. 5 How do NEPT licencees currently keep informed of licence suspensions, cancellations or convictions for driving offences by staff? If so how do NEPT licencees currently act on such information?

Clinical Governance

It is proposed to introduce clinical governance requirements into the Regulations for NEPT licencees. Clinical Governance is the process whereby a licencee establishes procedures and protocols to manage, review and improve clinical activities over time. This should include:

- setting the scope of practice of clinical staff
- setting the clinical scope of practice of the business
- credentialing medical practitioners
- setting up a medical advisory committee to review all clinical activities of their business
- establishing procedures for clinical matters.

It is proposed to require all NEPT licencees to establish a medical advisory committee (MAC) to oversight and review all clinical practice of the business. It is proposed that the MAC should contain at least three members of which one is a registered medical practitioner.

The MAC should have responsibility for:

- oversighting processes to set the scope of clinical practice of all clinical staff (whether employees, contractors or volunteers)
- oversighting processes to set the scope of practice of the business to ensure it does not provide services beyond its competencies and ability
- oversighting the credentialing and three-yearly re-credentialing of all registered medical practitioners engaged by the business in any capacity
- reviewing matters of clinical concern including each critical incident

- oversighting the auditing of patient care records
- maintaining records of its meetings including decisions taken and the rationale for those decisions
- reviewing patient satisfaction survey and staff safety survey data
- reviewing clinical practice protocols and guidelines of the business
- oversighting processes to continually assess the capacity of the business to provide safe, patient centred care.

It is proposed that the MAC should meet at least once every three months and keep written minutes that can be made available to the department on request.

It is also proposed that every NEPT licencee must nominate a person who is responsible for all clinical matters for the business and the name of this person and business contact details (phone, email) be provided to the department within 28 days of appointment.

Q. 6 Should a registered medical practitioner be required to be a member of the MAC?

Q. 7 What cost impacts would introducing clinical governance requirement have?

Q. 8 Are there additional clinical governance matters that should be included?

Patient Surveys

Public and private hospitals undertake patient surveys and staff satisfaction surveys to obtain feedback about the safety and quality of their services.

Patient Satisfaction Surveys focus on the patient's perception of the safety and quality of the service they have received while in the hospital. At times this feedback may be quite different to the hospital's perception of the safety and quality of service they are providing.

These surveys are treated seriously by hospital management as they can uncover systemic problems and they provide an opportunity for the hospital to improve the standards of the services they provide.

It has been suggested that tailored patient surveys be required to be undertaken by NEPT licencees and that the information received be used by the licencee to address identified issues and improve the standard of the service provided. This approach is a continuous improvement model.

There would be a limited set of questions that would be used. From the department's point of view, it would be helpful if there were a short standard set of questions used by all NEPT providers. The surveys could be conducted post transport, perhaps via email.

Staff Safety Survey

Victorian hospitals also conduct staff safety surveys to gauge levels of engagement, and whether staff feel safe and supported to report problems they observe or encounter. Where staff report that they do not feel safe to report problems (i.e., it may jeopardise their job) this is an indication of cultural failings at the hospital that need to be addressed as patients may be at risk.

Again, it was suggested that the NEPT sector would benefit from introducing similar surveys. Where staff members do not report problems to management, particularly those relating to treatment of patients, then future patients of that service are at risk and there is a lost opportunity for the service to improve.

Reporting

If a requirement to conduct the above surveys was introduced, the department, during its inspections, would request to see the survey reports and outcome assessments and see written records of how the feedback has been addressed. The licencee's management of the survey process and its response to the survey outcomes would also form part of the clinical governance of the business.

Initially, the department would not require the survey outcomes to be reported to the department. This could be considered down the track if there was a clear benefit in doing so.

Q. 9 Is there enough benefit to NEPT businesses to justify conducting patient experience and staff safety surveys?

Q. 10 What percentage of patients should be surveyed to give meaningful information to the NEPT service?

Patient Transport

A number of changes are proposed to the current Regulations governing patient acuity and patient transport.

The Victorian Government election commitment was that all NEPT vehicles must have power lift stretchers and lifting cushions. These two pieces of equipment have different purposes. Stretchers are potentially required for every transport as the patient may not be capable of sitting in an upright position. Lifting cushions are used to help to lift patients who have fallen so they can be manoeuvred onto a stretcher. Typically, NEPT crews will only attend to fallen patients in their own home as patient care and transfers from hospitals or aged care facilities are managed by the facility staff.

It is therefore proposed that all NEPT vehicles must be fitted with power lift stretchers and NEPT vehicles attending patients' homes must carry lifting cushions.

Patient Loading

It is proposed to require all medium and high acuity patients to be single loaded. This mirrors contracted Ambulance Victoria transports, provides more space for NEPT crews to work, and is more dignified for patients.

The department is also considering whether to mandate that low acuity patients should be single loaded. One reason for this is that the modern design of vehicles, particularly if power lift stretchers are required, does not provide sufficient space for crew to move between double loaded patients. It is not considered appropriate that staff have to lean over the heads of patients to attend to them, nor is such a posture safe as it places staff at risk of injuries. Patients may also find being treated in this manner unsatisfactory.

There is a design solution for double loading of patients using power lift stretchers that is used in the UK and Queensland. It uses a cab chassis with a fitted box on the back that has sufficient width for two power lift stretchers and a movable chair on rails between the stretchers. If this design was adopted universally, it may be suitable to continue with double stretcher vehicles. Otherwise, the compromises are considered to be too great and potentially unsafe for patients and crews.

At a minimum, if double loading of low acuity patients is to continue, the department is of the view that there must be sufficient space for a crew member to walk unimpeded between the stretchers. The department considers a minimum width of 460mm (18 inches) would be required. If double loading of patients is to continue the Regulations will set a minimum width to be maintained at all times between stretchers.

Requiring the sector to use single stretcher loading for all patient transport will affect the capacity for services individually and the sector as a whole. It is anticipated that this would have the greatest impact on rural areas with few vehicles and longer distances, and may also impact on disaster responses (e.g., a mass casualty event, evacuation of a hospital, etc.).

Q. 11 Should all patients requiring a stretcher be single loaded?

Q. 12 What would be the cost implications of either requiring all stretcher patients to be single loaded or requiring the cab chassis box arrangement for double loading of patients?

Q. 13 What would be the system capacity implications for requiring single loading?

Q. 14 What minimum distance should be required between double loaded stretchers?

Patient Acuity

The department is considering clarifying what is meant by the phrase "active management" in the definitions of medium, and high acuity.

It is proposed that "*active management"* be defined as "a patient who requires treatment from the commencement of transport to maintain a stable clinical condition".

Q. 15 Would the clarification of "active management" provide a benefit to NEPT licencees?

Vehicle Equipment

Power Lift Stretchers

Power lift stretchers are designed to raise and lower electronically rather than manually. They are easier and safer to use than manual stretchers and can be lowered to allow for easier loading of patients. They also prevent staff injuries and Worksafe claims potentially leading to a reduction in Worksafe premiums for NEPT providers.

Historically, sixty per cent of paramedic injuries (in Ambulance Victoria) have been manual handling injuries[2]. The introduction of power-lift stretchers and lifting cushions is expected to result in a significant decrease in back injuries of NEPT crews.

It is proposed to require all NEPT vehicles to be equipped with power lift stretchers with the requirement to be phased in over three years. After that time, any vehicle without power lifters will not be permitted to be used for NEPT. Each stretcher costs approximately $40,000 and has a five to seven year lifespan.

The department understands that this requirement will mean that most NEPT vehicles will only be able to carry one patient at a time. This will result in more vehicles being required to be purchased and fitted out at significant cost (up to $140,000 per additional vehicle).

There are two schools of thought about the impact these changes will have on rural service access. One thought is that with vehicles being reduced to single patient transport there will be less capacity in rural areas as a result. The alternative thought is that double load vehicles currently are often away transporting a single patient so the changes will not make any material impact, and conversely, may lead to more single stretcher vehicles being deployed, thus improving the current availability levels in rural areas.

Some providers have voiced that putting a power-lift stretcher in every vehicle would be too expensive to be able to recover from financially within a reasonable amount of time. It is therefore proposed that this measure would have a transition period of three years.

It is noted that Ambulance Victoria has introduced a contractual requirement that all of their contracted NEPT providers must introduce power-lift stretchers and lifting cushions within the three-year life of the current contract that commenced on 1 July 2019. The regulatory requirements will therefore only impact on licencees and vehicles not subject to an Ambulance Victoria NEPT contract.

Q. 16 Is the introduction of power lift stretchers likely to lead to a reduction or increase in rural NEPT services? Why?

[2] *New Powered Stretchers Lower Paramedic Injuries,* Minister for Ambulance Services, 17 August 2017.

Lifting Cushions

Lifting cushions are used where a person, usually in their own home, has fallen and is unable to get up but is not badly injured. The patient is placed on the cushion which is then inflated until the person is able to stand up and walk to the vehicle for transport or be placed onto a stretcher.

It is proposed to require every truck that is used to collect patients from their homes must carry a lifting cushion. Lifting cushions are not required for hospital to hospital transfers and hospital to home transfers as patients are not lying on the floor when collected in hospitals (or aged care facilities).

NEPT vehicles that do not attend patients' homes will not be required to carry lifting cushions.

Q. 17 Will the cost of power lift stretchers and lifting cushions cause any current NEPT providers to exit the market?

Vehicle Emergency Warning Lights

A number of NEPT licencees have recommended that all vehicles be required to install red and blue lights on top of the vehicles.

Lights would enable vehicles to:

- isolate a place in a public area should the NEPT come across an emergency, e.g., a motor-vehicle accident
- indicate an emergency patient transport
- be able to drive down one-way streets if required.

The current requirement is for all vehicles to carry warning lights without specifying the type of lights. The intent was to allow those vehicles that did not have red and blue emergency lights installed to carry an amber warning light in case they need to protect an accident scene to alert passing traffic. The department is advised that this requirement has not been adhered to and so it is considering strengthening the requirement. If so the amended regulation would have a caveat that the emergency lights can only be activated at the direction of Victoria Police or AV.

Q. 18 Should all NEPT vehicles be required to install red and blue emergency lights, and if so, why?

Q. 19 What is the likely cost per vehicle?

Patient Care

Clinical Review

When medium and high acuity patients are transported it is a requirement of the AV contract with their contractors that:

- there is a patient care record for every transport
- the patient care records are reviewed by clinical staff
- clinical audits are undertaken by AV for a specified number of patient care records per Ambulance Transport attendant.

AV also audit the practice of each staff member by reviewing patients' clinical case sheets. A proportion of low acuity patients are also reviewed.

The purpose of creating patient care records (PCR) and reviewing them is to ensure that patients are receiving appropriate care each journey and that management has clear oversight of the patient care standards provided by the AV contractor.

It is proposed to introduce this concept into the NEPT Regulations. Such an approach fits well with the continuous improvement model already mandated through the use of accredited quality assurance plans. Indeed, this approach can be incorporated into the NEPT licencee's quality assurance plan.

Every PCR for medium and high acuity patient transports by NEPT contractors for AV is audited to review the clinical care of the patient. This allows AV to identify systematic issues across their service and put in place necessary improvement measures.

The requirement may not mirror the AV requirements but may require that all medium and high acuity patients must have their case sheets reviewed and that staff transporting medium and high acuity patients also be reviewed via the PCRs. The purpose of the reviews is to look for systemic issues that may not otherwise be identified in isolation. Should patient care issues be uncovered, they would be expected to be addressed through the quality assurance plan to ensure no repetition and continuous improvement in care of the patients. Should concerns regarding an individual staff member be uncovered, it would be expected that the staff member be provided with additional training and clinical supervision until the licencee is satisfied the staff member is competent to carry out his or her tasks. The use of PCRs should not be seen or used as a punitive exercise.

The outcomes of the reviews and audits would be required to be documented and any actions taken as a result documented as part of the quality assurance process – to drive improvement in patient care.

It is proposed to require all NEPT medium and high acuity patients' PCRs be reviewed by a nominated clinical person within the licencee's organisation. If AV undertake an audit of a PCR under their contract arrangement, the licencee will not be required to also undertake a review, however the audit outcome will be required to be recorded by the licencee (this could be in the form of a report from AV). The PCR reviews and audits should form part of the NEPT licencee's quality assurance plan and be used to drive improvement over time.

Q. 20 What cost impacts would the proposal to record and review PCRs for medium and high acuity patients place on NEPT licencees?

Q. 21 Is the review of PCRs to monitor NEPT practice considered worthwhile?

Q. 22 If so, what proportion of PCRs, for both patients and staff, should be reviewed and who should do the reviewing?

Staff Training and Competence

Training

The department proposes to maintain and strengthen the requirements for 400 hours of supervised training for Ambulance Transport Attendants (ATA).

The department will also amend the Regulations to clarify that clinical supervision of ATAs may only be conducted by Clinical Supervisors as defined by the Regulations.

The department is also considering introducing a minimum 100 hours of clinically supervised training for Patient transport Officers (PTOs). This should occur within 12 months of employment. PTO's are often the most highly trained staff member on a vehicle when low acuity patients are being transported. It is necessary for the licencee and department to have confidence that PTOs are clinically competent when they work without the supervision of an ATA or higher qualified staff member. Clinical supervision would

be able to be provided by an ATA (who had completed his or her own clinical supervision) or by a clinical instructor.

Further, the department is considering whether to require that clinical training in any recognised course and in refresher training should be face to face. Online training only for some clinical competencies and driving components is not considered suitable as the trainer has no ability to determine the physical competence of the person being trained. Examples are ALS, BLS and airway management.

The purpose of clinically supervised training is to ensure that ATA's and PTO's are competent to make clinical decisions within their scope of practice independently of any other advice or assistance. The ATA may be the senior clinician on board when clinical decision making is required.

It is proposed to strengthen the requirements around the 400 hours of clinically supervised training over two years to require:

- The ATA qualification must be obtained before clinically supervised training commences
- All clinically supervised training must be hands on. Observational shifts will not count towards the 400 hours.
- A clinical instructor must be in the passenger compartment of the vehicle with the person undergoing clinical instruction
- All clinical supervision of ATAs must be provided by a clinical instructor (as defined by the Regulations).

Similarly, if PTOs are required to undergo 100 hours of clinically supervised training over 12 months, the following will be required:

- The PTO qualification must be obtained before clinically supervised training commences
- All clinically supervised training must be hands on. Observational shifts will not count towards the 100 hours.
- A clinical instructor or ATA must be in the passenger compartment of the vehicle with the person undergoing clinical instruction
- All clinical supervision must be provided by a clinical instructor (as defined by the Regulations) or an ATA.

Q. 23 Are there any negative consequences of requiring certain clinical competencies to be taught and assessed face to face?

Q. 24 Is there any reason why PTOs should not be required to undergo a period of clinical supervision?

Q. 25 Is 100 hours of clinically supervised practice within 12 months sufficient for a PTO to be clinically competent when working without a higher qualified crew member?

Q. 26 What additional costs would be incurred as a result of introducing the clinical supervision requirement for PTOs?

Clinical Instructors

The department is considering whether to keep a register of all clinical instructors. To do this, licencees would be required to provide names, qualifications and a CV for each clinical instructor to the department. The department would review the information and determine whether the person met the requirements to be a clinical instructor.

Once the register was established, licencees who were employing ATA staff from another licencee could contact the department to confirm that the clinical instructor who had signed off the ATA 400 hours was

on the department's register. This would provide certainty of compliance with the legislative requirements and remove some risk from licencees.

Q. 27 Should the department maintain a register of clinical instructors?

Leave Considerations

The Regulations need to accommodate staff who take maternity, parental or carers leave while undertaking clinical supervision. The two-year limit for completing the clinically supervised training for ATAs and the 12 month limit for PTOs may be problematic in this situation. However, if too much time is spent on maternity, parental or carers leave, will the clinical skills already obtained be lost or reduced?

Q. 28 How should the Regulations provide for maternity, parental or carers leave in regard to the requirement for ATAs to complete 400 hours of clinically supervised training over two years, and PTOs to complete 100 hours within 12 months?

Ongoing Training

The department has been advised that a number of NEPT licencees have reduced the ongoing training of staff required to introduce new skills and equipment, or maintain existing skills, to reduce costs. It is reported that this is due in part to the downward pressure exerted by the Health Purchasing Victoria (HPV) contracting process where NEPT licencees contract with public health services to provide NEPT services outside of the Ambulance Victoria process. Reducing training has the potential to compromise patient care and is therefore of concern to the department.

Ongoing training will incorporate refresher training but may also include upskilling as technology and equipment change.

In order to address this issue, it is proposed to introduce minimum annual refresher training requirements. These requirements may be modelled on AV contractual requirements. They would be expected to include matters such as basic life support, CPR, defibrillation, airway management, and possibly infection control. A minimum number of hours of annual training would be stipulated. The department will also consider whether to require that a nominated person be required to sign off that the person being trained has demonstrated the necessary competencies.

The training requirements would apply to all employed clinical staff, all contracted clinical staff, and all volunteer clinical staff. Clinical training would be required to be hands on for certain matters such as ALS, BLS, defibrillation, and airway management, as the department does not consider all clinical knowledge can be adequately refreshed using an online process as there is no ability for the trainer to assess competence.

Q. 29 What should ongoing training cover?

Q. 30 What should the minimum hours of training considered necessary to maintain competence and which training should be face to face and practical hands on training?

The department is also considering requiring applicants for NEPT licences and renewal of a licences to submit their staff training plan for the next two years. This would assist the department in assessing ongoing quality and safety and maintenance of staff skills and competencies prior to issuing or reissuing a NEPT licence.

Additional Training

Mental health training has been proposed to the department as necessary additional training for those NEPT crew who transport mental health patients. The premise is that with appropriate training, staff can provide more appropriate care during the NEPT journey.

If the proposal was adopted, the Regulations would require that before any NEPT crew member could transport a patient with a diagnosed mental health issue, the NEPT crew member must have completed an approved mental health training course.

Q. 31 What are the merits of requiring mental health training?

Employment of Clinical Staff

It has been reported that some NEPT providers do not employ clinical staff (permanent full time, permanent part time, or casual) but engage them as contractors and then pay them as a business. In addition some NEPT businesses may use volunteer staff.

This is considered to be problematic as the Regulations are written on the basis that clinical staff are employed by the licencee. If clinical staff are not employed by the licencee but are engaged as contractors or volunteers, it raises questions about the enforceability of any regulation that relates to licencee's staff. This applies to matters such as training, 400 clinical hours requirement, etc.

To address this issue and to ensure there is no ambiguity in the application of the Regulations, the department is considering amending the Regulations to make clear that the Regulations apply irrespective of whether staff are employed, contracted or are volunteers.

Further Discussion

The department is also considering including a requirement in the Regulations that the licencee must verify the qualifications, competence, work history and clinical supervision of each clinical staff member they engage, whether via direct employment, contracting, or volunteering. It is the intention of the department to ensure licencees are responsible for the clinical competence of any clinical staff member they employ or engage, including medical practitioners.

Paramedics

It has been proposed to the department is that the use of the term "paramedic" in a company name should be prohibited. This approach would mirror the *Ambulance Services Act 1986* that prohibits the use of the words "ambulance service" on vehicles and in company names. It would also help to remove patient confusion or misunderstanding about when a paramedic is actually attending to them. It would be reasonable for a member of the public to assume that if a company name includes the word "Paramedic" in its business name and the vehicle has that name written on it that they will be attended by a paramedic. Such misunderstandings are unhelpful and potentially undermine paramedic practice.

A number of currently licenced NEPT providers use the word "Paramedic" in their company name and display that name on the sides of their vehicles despite the fact that the service is not a paramedic service.

Q. 32 Should the use of the word "Paramedic" be prohibited from NEPT company names?

Occupational Health and Safety

NEPT vehicle crew occupational health and safety is generally covered under the Worker's Compensation Act 1958. This Act provides general protections across all sectors of the workforce.

NEPT has particular staff safety risks due to the nature of the work which involves lifting and manoeuvring patients. The Victorian Government made election commitments to introduce power lift stretchers and lifting cushions as mandatory equipment.

There are also risks associated with attending and transporting patients who are mentally unwell (unforeseen events that may be a potential threat to staff safety), including patients with Alzheimer's or dementia (occupational violence).

The other risk associated with the sector is the risk of staff exposure to infectious disease from patients being transported.

Occupational Health and Safety Plans

There is a current Australian Standard for Health and Safety (AS 4801) and International Standards Organisation standard (ISO 45001) available for use by companies who wish to improve their staff health and safety outcomes and reduce their Workcover premiums.

In the NEPT industry, injuries acquired by vehicle transport staff, apart from the distress caused to the individual staff member, can interfere with crew rostering, and increase Worksafe premiums.

The Standards above are suitable for any organization that wishes to:

(a) implement, maintain and improve an Occupational Health and Safety Management System)OHSMS

(b) assure itself of its conformance with its stated Occupational Health and Safety (OHS) policy

(c) demonstrate such conformance to others

(d) seek certification/registration of its OHSMS by an external organization

(e) make a self-determination and declaration of conformance with the Standard

The standards cover matters such as a safety plan, policies, processes, and procedures, training and induction, monitoring, supervision, records keeping and reporting.

It is proposed to introduce a regulation to require all NEPT licences to have an occupational health and safety plan that is audited and accredited by a JAS-ANZ accredited third party.

The Regulation will specify the minimum elements that must be included in the occupational health and safety plan. Proposed inclusions are:

- maintenance of a hazard register
- incident reporting and management
- data sheets
- risk evaluation
- risk management
- staff qualifications and training
- recording of incidents and resulting actions.

Adherence to an occupational health and safety plan will encourage a health and safety culture for employers and employees and may potentially reduce the number of WorkSafe claims and premiums.

At this stage, the department does not propose mandating which standard should be used.

Q. 33 Are there other items that should be mandated in an occupational health and safety plan? Are the items listed above appropriate?

Accreditation of Occupational Health and Safety Plans

It is proposed to mirror the current requirements in the Regulations for Quality and Safety Plans and require that they be accredited by an independent third party accreditation service annually.

External oversight of the occupational health and safety plan, which includes verification that the plan, is appropriate and is being followed will provide users of the service with confidence that staff safety, and by extension patient safety, is being appropriately managed.

Q. 34 Do you agree that all NEPT licencees should have an accredited occupational health and safety plan?

Q. 35 What would be the initial costs of developing an occupational health and safety plan and what would be the ongoing costs to maintain accreditation?

Quality Assurance

Currently, Regulation 29 of the Regulations sets out the minimum requirements that must be included in the Quality Assurance Plan of a NEPT licencee. There is no specific requirement for NEPT vehicles to be cleaned after transporting an infectious patient. It is proposed to add cleaning requirements to be applied after every transport of an infectious patient to the legislation, perhaps under Regulation 29.

The department has received advice that deep cleans of vehicles to manage infection risks to patients are not routinely or uniformly undertaken across the industry. This is also the UK experience. To address this concern, the department will look at adopting the National Health and Medical research Council (NH&MRC) Australian Guidelines for the Prevention and Control of Infection in Healthcare. Disinfection is integral to any infection control program.

Q. 36 Is there any reason why the NH&MRC Australian Guidelines for the Prevention and Control of Infection in Healthcare should not be adopted?

Regulation 32 contains an error that will be fixed through this review. Where regulation 32 refers to a "quality assurance plan" this will be replaced with "certificate of accreditation of a quality assurance plan".

Reporting

Critical Incidents

Currently, NEPT licencees are required to report critical incidents to the department. NEPT providers are not always reporting critical incidents according to the department's data. Critical incidents are defined in the Regulations as: (a) the death of a patient; or (b) an adverse event; or (c) an event that results in a risk of a high probability of harm or injury to a patient. (NB: adverse event means an event that results in harm or injury to a patient.)

The department considers it important that critical incidents be reported so it can review patient deterioration during transport, and other unanticipated matters or errors (e.g., medication errors). This is important in identifying systemic issues and driving improvements on sector performance.

000 Call Outs

It is proposed that whenever a NEPT crew calls out a 000 emergency ambulance, it should be reported to the department. Emergency ambulances should be called by NEPT crews when any job they attend is beyond their scope of practice and requires an emergency response, or when a patient has deteriorated during transport to such an extent that an emergency vehicle is called to meet the NEPT vehicle.

Through these notifications the department has the opportunity to review and monitor for systemic issues.

Q. 37 Should 000 call outs by NEPT crews be reported to the department as they occur or should they be included in the annual report?

First Aid

The purpose of first aid is twofold:

- to address minor injuries, so the patient can continue on with his or her activity
- to stabilise patients until an emergency ambulance arrives to transport the patient to hospital.

Licencing

It is proposed to regulate providers of first aid services for the first time. First aid provision by commercial providers has been identified by the department as an area of potential patient safety risk.

At the moment, the department has no oversight of the size, nature and scope of the commercial first aid sector. Consequently, it does not know what treatment is being provided, what drugs are being administered to whom, who they are being administered by, what the level of training is of those who are providing first aid, or how many people are transferred to hospital by emergency ambulance.

First aid providers can operate in short term, single-site environments, to large-site, multi-day, live-in environments, and multi-site environments. The first aid provided can vary from basic first aid to high level trauma care and stabilisation.

It is proposed that each commercial provider of first aid will be required to obtain a licence from the department. A fee will be charged for the application that will cover the cost of assessing the licence application and providing the required regulatory oversight and inspections.

Matters to be assessed in considering a licence application will be fitness and propriety of the proposed proprietor of the business, clinical capacity, clinical governance, staff training and competence (initial and ongoing maintenance), management processes, patient escalation processes, infection control, complaints handling, and the types of events to which the applicant wishes to provide services.

The department is considering whether or not to include an application for Approval in Principle, whereby a person submits an application that sets out a how a range of matters will be addressed in the proposed business.

Matters such as the fitness and propriety of the proposed licence holder, business management arrangements, clinical governance arrangements, and financial capacity could be assessed at this stage. Once the department was satisfied that these elements were in place, then an application for licence could be lodged.

Once the department understands the size of the sector and the regulatory oversight work that will be required, it will be able to calculate licence fees. Draft licence fees will be circulated for comment with the draft regulations early next year.

The requirements to be licenced will be limited to commercial providers of first aid at public events (to be defined). It will exclude volunteers who provide first aid based on our current understanding that these are local events that do not attract large crowds. The requirements are not intended to capture small community events where first aid is provided by community members on a voluntary basis. The legislation is expected to apply to suppliers of first aid to events where there is a recognised risk of injury to participants or patrons.

If the department finds that there are large scale events or events where there is risk of significant injury to participants or patrons, and first aid is provided solely by volunteers (even if they are medical practitioners), the department will reconsider its approach as it is of the view that first aid providers to these sorts of events should be licenced and regulated.

All licencees will be required to have current public and professional indemnity insurance. It is proposed that for intermediate and advanced first aid providers $20 million of insurance will be required. This is the amount of insurance recommended to the department by existing first aid providers. We are advised that there is little difference in the premiums charged for $10 million and $20 million.

The department is conscious of not pricing basic first aid providers out of the market. Advice is sought on what level of insurance should be required to be held by basic first aid providers.

The department will consider a three tier licencing system for first aid providers. Suggested terminology for the tiers is:

Basic Care

Intermediate Care

Advanced Care

Basic Care would be for those providers who only use over-the-counter medications and provide basic first aid. The purpose of this service will be to provide care that will allow patients to continue on with their day after their first-aid visit. Over-the-counter medications are suitable for this purpose.

This tier of first aid provision would potentially have fewer clinical governance and training requirements.

Intermediate Care would be for more complex first aid provision. The purpose of Intermediate Care includes the stabilisation of patients until emergency ambulance arrives to transport the patient to hospital, or for a friend or family member to drive them to the nearest emergency department. At times, schedule 4 medicines will be appropriate for this purpose. In order to administer a schedule 4 medicine, the licencee would be required to hold a health service permit. It is proposed to align the medicine permissions with the current NEPT permissions of specific schedule 4 medicines. Schedule 8 medicines would not be permitted to be administered unless it was under the direction of, or by, a registered medical practitioner.

Intermediate Care will require a moderate amount of clinical governance.

Advanced Care would cover complex and emergency first aid provision. Administration of schedule 8 medicines is an issue to be considered for the Advanced Care tier. Emergency stabilisation may well be required to be provided by Advanced Care first aid providers and limiting schedule 8 medicine administration to only being under a medical practitioner's supervision may be detrimental to the quality of patient care. An alternative view is that the first aid sector has no compliance record having not been previously regulated. Until a record of compliance with the legislation is established it is considered to be premature to allow first aid licencees access to schedule 8 medicines via health service permits and it would be prudent initially to require schedule 8 medications to only be provided under the direction of a registered medical practitioner.

Significant clinical governance requirements will apply and they would be expected to be similar to those of a day procedure centre (day hospital).

Q. 1 How many commercial providers of first aid currently operate in Victoria?

Q. 2 What amount of public liability and professional indemnity insurance should be held by basic first aid providers.

Q. 3 Is a three-tier licencing process for first aid providers appropriate? If so what should be the determinants for each tier?

Q. 4 Should schedule 8 medications be administered under the direction of a registered medical practitioner or should appropriately qualified and skilled health practitioners such as paramedics and registered nurses be permitted to administer Schedule 8 medicines?

Linking First Aid Licencing with Council Event Permit Systems

It is intended that once the First Aid Regulations are made and are operational that they will be used to support the event permit systems used by councils. An up-to-date list of all licenced first aid providers will be maintained on the department's website for councils to access.

The department will liaise with local councils with the intention of seeking their cooperation to incorporate licencing of first aid providers as part of the process to issue permits for public events.

For all major public and many smaller events, councils require a medical risk assessment to be provided by the event organiser with its application for a permit to run the event.

Councils will be asked to require the event organiser to provide the details of the licenced first aid provider that will be used. The purpose is to allow councils to check whether nominated first aid provider is licenced by the department, and to review whether the proposed first aid provider is licenced at the required level to meet the risks identified in the medical risk assessment.

Council participation will be voluntary. However, it is anticipated most would choose to utilise the licencing system to provide improved risk mitigation.

It is anticipated that this increased level of oversight by councils will help drive all event organisers to ensure they have adequate and suitable first aid coverage for their events.

Clinical Governance

Some event organisers do not wish to pay for a first aid provider to use a doctor or do not wish to pay for an appropriate level of first aid coverage. This has resulted in a lower level of first aid coverage and less medicines being provided at many events than is desirable. This creates a situation where an emergency ambulance may be called more often that may have been the case if an appropriate level of first aid was available in the first instance.

It is proposed to introduce clinical governance requirements into the Regulations for first aid licencees. One of the purposes of clinical governance is to establish whether the business service provision is adequate to manage the risks at the event and if not, how the risks are addressed.

Clinical governance is the process whereby a licencee establishes procedures and protocols to manage, review and improve clinical activities over time. This may include:

- setting the scope of practice of clinical staff
- setting the clinical scope of practice of the business
- credentialing medical practitioners
- setting up a medical advisory committee to review all clinical activities of their business
- establishing procedures for clinical matters
- determining whether the services provided are commensurate with the risk profile of the prospective patients.

All first aid providers will be required to have a level of clinical governance and patient review in order to obtain a licence. Each tier will have an its own set of requirements with the Advanced Care level having a clinical governance model similar to a day procedure centre. This would entail rules (by-laws), a clinical governance review committee (similar to a medical advisory committee), credentialing and scope of practice setting arrangements, patient review arrangements, and reporting to the department.

It is proposed that all clinical staff must have their scope of practice defined for all tiers. The more advanced the tier of first aid provision, the more scope will be assigned to staff, noting that they must work within their clinical competence and only to the level that the first aid licencee can support.

It is proposed to require all first aid licencees with a licence to provide **intermediate** or **advanced** first aid to establish a medical advisory committee (MAC) to oversight and review all clinical practice of the business. It is proposed that the MAC should contain at least three members of which one is a registered medical practitioner.

The MAC should have responsibility for:

- oversighting processes to set the scope of clinical practice of all clinical staff (whether employees, contractors or volunteers)
- oversighting the scope of clinical practice for the business
- oversighting the credentialing, and three-yearly re-credentialing, of all registered medical practitioners engaged by the business in any capacity
- reviewing matters of clinical concern including each adverse event and each sentinel event
- oversighting the auditing of patient care records
- maintaining records of its meetings including decisions taken and the rationale for those decisions
- reviewing patient satisfaction survey and staff safety survey data
- reviewing clinical practice protocols and guidelines of the business
- oversighting processes to continually assess the capacity of the business to provide safe, patient centred care.

It is proposed that the MAC should meet at least once every three months and keep written minutes that can be made available to the department on request.

Licencees with a licence to provide **basic first aid** will be required to:

- set the scope of clinical practice of all clinical staff (whether employees, contractors or volunteers)
- set the scope of clinical practice for the business
- review each matter of clinical concern including each adverse event and each sentinel event
- maintain records of clinical reviews including decisions taken and the rationale for those decisions
- setting clinical practice protocols and guidelines of the business
- have processes to continually assess the capacity of the business to provide safe, patient centred care.

Licencees and their MACs will develop the required processes according to the type and range of first aid services they provide.

It is also proposed that every first aid licencee must nominate a person who is responsible for all clinical matters for the business and the name of this person and business contact details (phone, email) be provided to the department within 28 days of appointment.

Q. 5 What are cost impacts of the clinical governance proposal?

Q. 6 Are there additional clinical governance matters that should be included?

Q. 7 Should a registered medical practitioner be required to be a member of the MAC?

The department will give consideration to mandating minimum requirements for first aid posts. Matters such as infection control, suitability of environment, storage and disposal of waste, flooring, tent materials, and furniture must all be considered.

Q. 8 What minimum requirements should be mandated for first aid posts in relation to materials and fit-out?

Patient Surveys

Public and private hospitals undertake patient surveys and staff satisfaction surveys to obtain feedback about the safety and quality of their services.

Patient Satisfaction Surveys focus on patients' perceptions of the safety and quality of the service they have received while in the hospital. At times, this feedback may be quite different to the hospital's perception of the safety and quality of service it is providing.

These surveys are treated seriously by hospital management as they can uncover systemic problems and they provide an opportunity for the hospital to improve the standards of the services it provides.

It has been suggested that tailored patient surveys be required to be undertaken by first aid licencees and that the information received be used by the licencee to address identified issues and improve the standard of the service provided. This approach is a continuous improvement model.

There would be a limited set of questions that would be used. From the department's point of view, it would be helpful if there were a short standard set of questions used by all first aid providers.

Staff Safety Survey

Victorian hospitals also conduct staff safety surveys to gauge levels of engagement and whether staff feel safe and supported to report problems they observe or encounter. Where staff report that they do not feel safe to report problems (i.e., it may jeopardise their job), this is an indication of cultural failings at the hospital that need to be addressed as patients may be at risk.

It was suggested that the first aid sector would benefit from introducing similar surveys. Where staff members do not report problems, particularly those relating to treatment of patients, future patients of that service are at risk and there is a lost opportunity for the service to improve.

Reporting

If a requirement to conduct the above surveys was introduced, the department in its inspections, would want to see the survey reports and outcome assessments and see written records of how issues reported have been addressed. The licencee's management of the survey process and its response to the survey outcomes would also form part of the clinical governance of the business.

Initially, the department would not require the survey outcomes to be reported to the department. This could be considered down the track if there was a clear benefit in doing so.

Q. 9 Is there enough benefit to first aid businesses to justify conducting patient experience and staff safety surveys?

Q. 10 What percentage of patients should be surveyed to give meaningful information to the first aid business?

Q11. Should the department develop a short standard set of questions for all licencees to use?

Patient Care

Clinical Reviews

As with the NEPT sector, it is proposed to require that Advanced first aid providers and Intermediate first aid providers undertake and audit Patient Care Records (PCR) for every patient transported out of the event by an emergency ambulance, whenever intravenous sedation or general anaesthesia is used, and when trauma injuries require stabilisation.

All such PCRs should be audited to review the clinical care of the patient. This would allow the first aid licencee to identify systematic issues and staff training issues across the service and put in place necessary improvement measures.

It is proposed to require the PCRs to be reviewed by a nominated clinical person within the licencees organisation.

Q. 12 Which patients should have their PCR reviewed?

Q. 13 What cost impacts would this proposal place on first aid licencees?

Q. 14 Is there any reason why the proposal should not be implemented?

Patient Extraction

There are times when first aid providers will be requested by Ambulance Victoria to extract a patient from an off-road site and meet an emergency or non-emergency ambulance at a public road rendezvous. Under the current NEPT regulations, movement of patients off public roads does not constitute NEPT transport. It is intended to continue with this exclusion. The effect of this is that licenced first aid providers will be permitted to move patients under AV direction if the patient is in an off-road setting.

The First Aid Regulations will require that in such situations patient safety and quality of care is maintained as far as is reasonably practical, given the circumstances of the patient condition and terrain over which they must be moved to rendezvous with an ambulance.

Staff Training and Competence

Staff Training

First aid licence holders will be responsible for ensuring all clinical staff they engage (employees, contractors, and volunteers) are clinically competent to perform their duties.

To satisfy this requirement, licencees will need to verify the information provided to them by clinical staff about qualifications, recency of practice, competence, etc.

New graduates will be required to undergo clinical supervision before they can practice alone. Advice is sought on how much clinical supervision for each qualification is required and who should be the clinical supervisor for each first aid qualification ranging from Certificate 2 to paramedic degree, for example.

Q. 15 What amount of clinical supervision should be required for new graduates of the Certificate II, Certificate III, Diploma and Degree in Paramedical Science, etc.?

Ongoing Training

The department proposes to require refresher training of all first aid clinical staff to cover matters such as basic life support, defibrillator operation, oxygen management, airway management, medicines use, manual handling, etc. The department is considering whether to require annual refresher advanced life support (ALS) training for clinical staff of advanced first aid licencees.

These requirements would include registered medical practitioners and registered nurses and midwives. It is understood that doctors and nurses who work in hospitals may undergo refresher training as part of their continuous professional development but that that training may not be not provided by a registered training organisation. However the refresher training is provided it will need to be documented with verifications of competencies included.

The department has received reports of online courses offering clinical qualifications for matters that include hands-on clinical practice. It is not clear how competence in some hands-on clinical matters such as BLS, ALS, defibrillation, and airway management can be assessed online. It is proposed these elements not be accepted as meeting requirements for first aid qualifications.

Refresher training requirements would apply to all employed clinical staff, all contracted clinical staff, and all volunteer clinical staff.

Q. 16 Is ALS refresher training required and if so, who for?

Q 17 How many hours of refresher training should be required per annum? What should it encompass?

Q. 18 What should the minimum hours of training considered necessary to maintain competence and what elements of this training should be face to face and practical hands on training?

The department is also considering requiring applicants for a first aid licence and renewal of a licence to submit their staff training plan for the next two years. This would assist the department in assessing ongoing quality and safety and maintenance of staff skills and competencies prior to issuing a first aid licence or a renewal of licence.

Scope of Practice

A process for setting the scope of practice of first aid staff, whether employees, sub-contractors or volunteers, would be required. The scope of practice would encompass both clinical staff competencies and the ability of the first aid business to support their practice.

The department is considering whether to specify the scope of practice of first aid staff in the Regulations. The scope of practice would be tied to training attainment and medicines permissions, and hopefully would promote a standardised use of role titles within the sector. An example table is included below for review and comment.

Example Table

Title	Qualification	Competencies that can be performed	Medicine administration permissions
First Aid Level 1 Responder	Certificate III Emergency Medical Responses Certificate IV Healthcare (Paramedical Services) Certificate II Emergency Medical Responses	GCS Breath testing Pulse palpation Resp rate Temp Cap Refill BSL SPo2 Blood pressure (manual & automatic) Pupil assessment Neuro assessment Burns surface area Airway management: Oropharyngeal/nasopharygeal Direct pressure and application of tourniquet to control bleeding Cooling techniques AED Urinalysis Splinting fracture I/O NGT CPR Warming techniques	Schedule 2 (over-the-counter meds)
First Aid Level 2 Responder	Diploma in Paramedical Science Diploma of Nursing AHPRA registration (Division 2 RN)	All of the above, and: ECG (only performing the ECG) IV/IM/subcut/IO injections Auscultation of chest	Schedule 4
Registered nurse	Bachelor of Nursing AHPRA registration	All of the above, and: Manual defibrillation	Schedule 4 (Schedule 8 & 11 under doctors' orders only)

Paramedic	Bachelor of Paramedicine AHPRA registration	All of the above, and: Airway management (laryngeal mask) Remove airway obstruction with Macgills forceps Traction splinting Laryngoscopy Relocation of dislocation Valsalva	Schedule 4 (Schedule 8 & 11 under doctors' orders only)
Critical Care Nurse	Bachelor of Nursing + Graduate Certificate in Critical Care Nursing AHPRA registration	All of the above, and: Ventilation Cannulation Interpret blood gases Cricothyroidotomy IV fluids	Schedule 4 (Schedule 8 & 11 under doctors' orders only)

Q. 19 What changes are required to the above table to make it reasonable and representative of levels of first aid responders?

Q: 20 Who should set the scope of practice for first aid staff? Should it be the responsibility of the licencee or should the regulations set scopes of practice tied to the training and competency of the staff member?

Supervised Clinical Training

It is not enough that first aid staff have attained a qualification in order to provide first aid. It is also necessary for staff to undertake supervised clinical practice before they can work on their own. It is proposed that the Regulations will specify how many hours of supervised clinical practice is required. Advice from the sector is sought on what amount of supervised clinical practice, over what timeframe, is considered appropriate before a first aid provider can work alone. For example, it is anticipated the amount of supervised clinical practice for a Certificate 3 first aid provider would be significantly different to that of a newly graduated paramedic who has not worked with an ambulance service.

Q. 21 How much supervised clinical practice for each level of first aid provider is considered appropriate?

Q. 22 Who should supervise the clinical practice and what qualifications and competencies should they have?

Employment of Clinical Staff

In the first aid sector it will be important to frame the Regulations to make it clear that the licencee has responsibility for the actions taken and services provided by the business. Therefore, the Regulations will

make clear that the licencee is responsible for all clinical staff utilised by the business irrespective of whether they are employed, contracted, or are volunteers. This will ensure the training requirements, clinical governance requirements, etc., apply irrespective of each staff member's employment status.

If registered medical practitioners sub contract their services to a first aid business, the licencee will be responsible for the care provided as they are for all other clinical staff engaged by the business.

In addition, if the current licencing approach for NEPT is replicated in the first aid sector it would be likely to mean that any sub-contractor would require a first aid licence with the department as he or she would be engaged by the first aid licence holder on the basis that he or she can provide first aid. This may require a change to how first aid business is conducted and may reduce the pool of subcontractors.

A process to record volunteers who are working for the first aid licence holder, and to verify their qualifications and experience, will also be required

Further Discussion

In addition to how the licencing system will operate, the department is also considering including a requirement in the Regulations that the licencee must verify the qualifications, competence, work history and clinical supervision of each clinical staff member that is engaged, whether via direct employment, contracting, or volunteering. One way or another, it is the intention of the department to ensure licencees are responsible for the clinical competence of any clinical staff member they employ or engage, including medical practitioners.

Q: 23 Are there any negative impacts from requiring licencees to verify clinical qualifications and experience of staff that the department should be aware of?

Q. 24 If ABN contractors are also required to be licenced, what impact will that have on licenced first aid providers who subcontract ABN staff?

Paramedics

In December 2018, paramedics became a registered profession under the Australian Health Practitioners Regulation Agency (AHPRA).

The department is considering defining paramedics, nurses and registered medical practitioners within the First Aid Regulations. This is to ensure alignment with the national registration scheme administered by AHPRA and to provide for the setting of appropriate scope of practice for each profession. This is necessary as the department is not intending to develop first aid clinical practice protocols.

It is reported that in the first aid sector, many people who are not paramedics are wearing jackets with "paramedics" emblazoned on them. Defining paramedics in the First Aid Regulations will address this issue.

It has been proposed to the department that the use of the term "paramedic" in a company name should be prohibited. This approach would mirror the *Ambulance Services Act 1986* that prohibits the use of the words "ambulance service" on vehicles and in company names. It would also help to remove patient confusion or misunderstanding about when a paramedic is actually attending to them. It would be reasonable for a member of the public to assume that if a company name includes the word "Paramedic" and the vehicle has that name written on its side that they will be attended by a paramedic. Such misunderstandings are unhelpful and potentially undermine paramedic practice.

Q. 25 Should the use of the word "Paramedic" (or paramedical) be prohibited in first aid company names?

Reporting

It is proposed to require Advanced Care first aid providers, and potentially Intermediate Care first aid providers to report data to the department. Initially, this could take the form of an excel spreadsheet.

The data reporting proposed is:

- name and location of the event
- estimated patronage
- number and categories of treatments provided
- any 000 referrals and the reason for each one
- staffing numbers, types and qualifications for clinical staff (including sub-contractors and volunteers) used at the event
- equipment provided by the licencee and the event organiser.

If this proposal proceeds, the department could also consider requiring reporting by Basic Care first aid providers and limit it to identification of the events, numbers of people treated and referrals to 000. The purpose would be for the department to build a picture of the scale of the sector and the events in Victoria and to inform hospital emergency department planning.

Reporting for all licencees could be quarterly.

Q. 26 What data should be reported to the department and how often?

Medications

One of the principles of developing legislation is that legislation should not provide a competitive advantage to a business. Currently, Regulation 7 of the *Drugs, Poisons and Controlled Substances Regulations 2016* confers a competitive advantage for St John Ambulance by providing permission for them to access a range of Schedule 4 medications that no other commercial first aid provider is permitted to access.

It is proposed to amend Regulation 7 to allow all appropriately licenced first aid providers access to suitable schedule 4 medicines via a health service permit to create a level playing field.

If medicines other than over-the-counter medicines are to be used, a clinical governance structure will be required to ensure the first aid staff do not operate beyond their scope of practice and potentially put patients at risk.

Advanced first aid providers would possibly expect to be able to access Schedule 8 medicines due to the nature of the injuries (normally) they need to be prepared to manage. Equestrian and Motor racing in particular, have potential to incur catastrophic injuries and first aid providers need to be able to stabilise and manage patients until they can be transfer to hospital.

At this stage, it is the department's preference that schedule 8 medicines be accessed through a registered medical practitioner. This would require any first aid provider wishing to carry and administer schedule 8 medicines to engage the services of a registered medical practitioner. The department recognises this may not be the view of the first aid sector. Advice is sought from Advanced Care first aid providers on how they would prefer to access schedule 8 medicines.

Q. 27 Do advanced first aid providers prefer to engage their own registered medical practitioners, work to the direction of registered medical practitioners engaged directly by the event, or do they prefer be able to apply for schedule 8 medicines on their health service permit?

Medical Assessment of Public Events

Currently, first aid providers are engaged by the event organiser. There is no uniform assessment process to determine the level of first aid required at events. Many event organisers do not want to pay the costs that would be incurred if appropriate levels of first aid were provided. This forces the first aid providers to provide a lower level of coverage than they consider necessary. A process to appropriately determine the first aid requirements of events is needed.

A regulation could be enacted to require the first aid provider engaged by the event organiser to undertake an assessment of what is required to provide adequate first aid coverage, identify the shortfalls in what they have been engaged to do, and provide a copy of that report to the local council and the department. The council and/or department could then follow up with the event organiser. However, this would place a cost on the first aid provider.

Alternatively, if the event organiser does the risk assessment, the first aid licencee could be required to review that assessment and document any identified gaps/risks and make recommendations to the event organiser to address those issues. If the event organiser does not address the identified risks then the licencee, if they accept the job, must have a written risk management process to manage those identified risks.

Q. 28 Should first aid providers be required to determine whether the event organiser medical risk assessment is adequate or undertake the risk assessment themselves?

Q. 29 Should events with inadequate first aid provision be reported to the department website? NB: the purpose of the reporting would be to gather evidence to determine if there was a need to introduce licencing and regulation of the event sector.

Equipment

Events held in remote or rural locations may have additional risks such as bushfire, snakebites, etc. The licenced first aid provider should have equipment at hand to ensure they are prepared for these eventualities. The following kits are recommended by WorkSafe for workplaces.

First Aid Kit – Minimum Requirements

A first aid kit needs to include:

- basic first aid notes
- disposable gloves
- resuscitation mask
- individually wrapped sterile adhesive dressings
- sterile eye pads (packet)
- sterile coverings for serious wounds
- triangular bandages
- safety pins
- small sterile unmedicated wound dressings
- medium sterile unmedicated wound dressings
- large sterile unmedicated wound dressings
- non-allergenic tape
- rubber thread or crepe bandage
- scissors
- tweezers
- suitable book for recording details of first aid provided

- sterile saline solution
- plastic bags for disposal.
- automatic defibrillator
- oxygen.

Additional Contents of First Aid Kits for Use in Remote Locations

Where people work in remote locations, it is likely that the first aid kit will need to include:

- emergency reference manual
- broad crepe bandages (for snake bites)
- cervical collar (for spinal/neck injuries)
- large clean sheeting (for covering burns)
- thermal blanket (for treating shock)
- whistle (for attracting attention)
- torch/flashlight
- notepad and pencil (for recording treatment given).

Q. 30 Should there be a list? If so, should the list be a guideline, or should it be a regulatory requirement?

Q. 31 Is some or all of the list of equipment to be carried appropriate?

First aid room minimum requirements

The first aid room needs to be large enough for its purpose, well-lit and well ventilated. It also needs to be easily accessible by injured people who may need to be supported or moved by stretcher or wheelchair and who need to have easy access to toilets.

The following items need to be provided in the room:

- resuscitation mask
- sink and wash basin with hot and cold water
- work bench or dressing trolley
- cupboards for storing medicaments, dressings and linen
- a container for soiled dressing
- a sharps disposal system
- electric power points
- a couch with blankets and pillows
- an upright chair
- a desk and telephone
- signage indicating emergency telephone numbers
- signage indicating emergency first aid procedures
- a stretcher
- a first aid kit appropriate for the workplace
- automatic defibrillator
- oxygen.

Where a first aid room is provided, it should not be used for any other purpose. Each first aid room (and its contents) needs to be under the control of a first aid officer who has the appropriate skills and knowledge.

Appendix 1

List of NEPT Questions

Q. 1 Is a requirement for a NEPT licencee to hold $20 million of insurance reasonable? If not, why not?

Q. 2 What would be a suitable number of NEPT transports per annum to allow NEPT crews to maintain their skills and competencies within the licencees' clinical governance framework?

Q. 3 What detrimental impacts might replacing stand-by accreditation with the licencing of first aid providers have?

Q. 4 What costs would result from a requirement for all NEPT vehicle drivers to hold a full licence?

Q. 5 How do NEPT licencees currently keep informed of licence suspensions, cancellations or convictions for driving offences by staff? If so how to NEPT licencees currently act on such information?

Q. 6 Should a registered medical practitioner be required to be a member of the MAC?

Q. 7 What cost impacts would introducing clinical governance requirement have?

Q. 8 Are there additional clinical governance matters that should be included?

Q. 9 Is there enough benefit to NEPT businesses to justify conducting patient experience and staff safety surveys?

Q. 10 What percentage of patients should be surveyed to give meaningful information to the NEPT service?

Q. 11 Should all patients requiring a stretcher be single loaded?

Q. 12 What would be the cost implications of either requiring all stretcher patients to be single loaded or requiring the cab chassis box arrangement for double loading of patients?

Q. 13 What would be the system capacity implications for requiring single loading?

Q. 14 What minimum distance should be required between double loaded stretchers?

Q. 15 Would the clarification of "active management" provide a benefit to NEPT licencees?

Q. 16 Is the introduction of power lift stretchers likely to lead to a reduction or increase in rural NEPT services? Why?

Q. 17 Will the cost of power lift stretchers and lifting cushions cause any current NEPT providers to exit the market?

Q. 18 Should all NEPT vehicles be required to install red and blue emergency lights, and if so, why?

Q. 19 What is the likely cost per vehicle?

Q. 20 What cost impacts would the proposal to record and review PCRs for medium and high acuity patients place on NEPT licencees?

Q. 21 Is the review of patient case sheets to monitor NEPT practice considered worthwhile?

Q. 22 If so, what proportion of case sheets for both patients and staff should be audited and who should do the auditing?

Q. 23 Are there any negative consequences of requiring certain clinical competencies to be taught and assessed face to face?

Q. 24 Is there any reason why PTOs should not be required to undergo a period of clinical supervision?

Q. 25 Is 100 hours of clinically supervised practice within 12 months sufficient for a PTO to be clinically competent when working without a higher qualified crew member?

Q. 26 what additional costs would be incurred as a result of introducing the clinical supervision requirement for PTOs?

Q. 27 Should the department maintain a register of clinical instructors?

Q. 28 How should the Regulations provide for maternity, parental or carers leave in regard to the requirement for ATAs to complete 400 hours of clinically supervised training over two years, and PTOs to complete 100 hours within 12 months?

Q. 29 What should ongoing training cover?

Q. 30 What should the minimum hours of training considered necessary to maintain competence and which training should be face to face and practical hands on training?

Q. 31 What are the merits of requiring mental health training?

Q. 32 Should the use of the word “Paramedic” be prohibited from NEPT company names?

Q. 33 Are there other items that should be mandated in an Occupational Health and Safety plan. Are the items listed above appropriate?

Q. 34 Do you agree that all NEPT licencees should have an accredited Occupational Health and Safety plan?

Q. 35 What would be the initial costs of developing an Occupational Health and Safety plan and obtaining and what would be the ongoing costs to maintain accreditation?

Q. 36 Is there any reason why the NH&MRC Australian Guidelines for the Prevention and Control of Infection in Healthcare should not be adopted?

Q. 37 Should 000 call outs by NEPT crews be reported to the department as they occur or should they be included in the annual report?

Appendix 2

List of First Aid Questions

Q. 1 How many commercial providers of first aid currently operate in Victoria?

Q. 2 What amount of public liability and professional indemnity insurance should be held by basic first aid providers.

Q. 3 Is a three-tier licencing process for first aid providers appropriate? If so what should be the determinants for each tier?

Q. 4 Should schedule 8 medications be administered under the direction of a registered medical practitioner or should appropriately qualified and skilled health practitioners such as paramedics and registered nurses be permitted to administer Schedule 8 medicines?

Q. 5 What are cost impacts of the clinical governance proposal?

Q. 6 Are there additional clinical governance matters that should be included?

Q. 7 Should a registered medical practitioner be required to be a member of the MAC?

Q. 8 What minimum requirements should be mandated for first aid posts in relation to materials and fit-out?

Q. 9 Is there enough benefit to first aid businesses to justify conducting patient experience and staff safety surveys?

Q. 10 What percentage of patients should be surveyed to give meaningful information to the first aid business?

Q. 11 Should the department develop a short standard set of questions for all licencees to use?

Q. 12 Which patients should have their PCR reviewed?

Q. 13 What cost impacts would this proposal place on first aid licencees?

Q. 14 Is there any reason why the proposal should not be implemented?

Q. 15 What amount of clinical supervision should be required for new graduates of the Certificate

II, Certificate III, Diploma and Degree in Paramedical Science, etc.?

Q. 16 Is ALS refresher training required and if so, who for?

Q. 17 How many hours of refresher training should be required per annum? What should it encompass?

Q. 18 What should the minimum hours of training considered necessary to maintain competence and what elements of this training should be face to face and practical hands on training?

Q. 19 What changes are required to the above table to make it reasonable and representative of levels of first aid responders?

Q: 20 Who should set the scope of practice for first aid staff? Should it be the responsibility of the licencee or should the regulations set scopes of practice tied to the training and competency of the staff member?

Q. 21 How much supervised clinical practice for each level of first aid provider is considered appropriate?

Q. 22 Who should supervise the clinical practice and what qualifications and competencies should they have?

Q: 23 Are there any negative impacts from requiring licencees to verify clinical qualifications and experience of staff that the department should be aware of?

Q. 24 If ABN contractors are also required to be licenced what impact will that have on licenced first aid providers who subcontract ABN staff?

Q. 25 Should the use of the word “Paramedic” (or paramedical) be prohibited in first aid company names?

Q. 26 What data should be reported to the department and how often?

Q. 27 Do advanced first aid providers prefer to engage their own registered medical practitioners, work to the direction of registered medical practitioners engaged directly be the event, or do they prefer be able to apply for schedule 8 medicines on their health service permit?

Q. 28 Should first aid providers be required to determine whether the event organiser medical risk assessment is adequate or undertake the risk assessment themselves?

Q. 29 Should events with inadequate first aid provision be reported to the department website? NB: the purpose of the reporting would be to gather evidence to determine if there was a need to introduce licencing and regulation of the event sector.

Q. 30 Should there be a list? If so, should the list be a guideline, or should it be a regulatory requirement?

Q. 31 Is some or all of the list of equipment to be carried appropriate?