Submission by the Australasian Sonographers Association to the National Registration and Accreditation Scheme Review

Executive Summary

The purpose of the Australasian Sonographers Association (ASA) is to guide the advancement of the profession to ensure the community has access to quality sonographic services. With a voluntary membership representing over 72% of the diagnostic medical sonographers practicing in Australia, the ASA is the leading voice for sonography in Australia and New Zealand.

Sonography has evolved as a self-regulating profession with practitioner accreditation enforced through the Australian Government's Diagnostic Imaging Accreditation Scheme (DIAS) and the Medicare Benefits Scheme (MBS). These mechanisms have enabled the requirement for a sonographer to achieve registration through entry to profession requirements, as determined through the Australian Sonographer Accreditation Registry (ASAR), and maintain this registration through accredited continuing professional development (CPD). Currently, however, a sonographer’s ‘fitness for practice’ is not governed by any existing mandatory regulations, other than the professional’s obligations as described through voluntary membership with professional associations such as the ASA.

Since its implementation the National Regulation and Accreditation Scheme (NRAS) has made significant steps toward the establishment of a nationally consistent framework to protect the health and safety of those who access health services. Unfortunately this progress has been limited to the health professions described under the NRAS to date.

There is a need for nationally consistent robust and enforceable regulation with respect to all users of ultrasound technology, with the highest priority placed on strengthening regulation for the acknowledged leaders in this area of health service delivery – diagnostic medical sonographers.

The ASA maintains that it is crucial that the sonography profession be included under the NRAS. This is important to assure protection of the public and ensure that all sonographers meet nationally consistent and enforceable regulatory requirements. This subsequently would respond to the community expectation that all Australian healthcare services meet governed standards, with established public protection processes in place.

The medical application of ultrasound and sonographers scope of practice has continued grow since the implementation of the NRAS. In private practice and rural and remote areas of Australia sonographers take on increasing responsibility in diagnostic reporting, and state governments have begun trailing expanded practice projects which include sonographers providing ultrasound guided therapeutic musculoskeletal injections and other higher risk ultrasound assisted practise. Not regulating diagnostic medical sonographers under the NRAS continues to unnecessarily expose the public to increasing risk.

Ultrasound systems are becoming more affordable which, in turn, is leading to a growth in the unregulated use by a wider range of health professions, and in non-medical practise. Notably, in the context of the spectrum of diagnostic imaging professions, sonography is the only profession not currently included under the NRAS.
This presents unique challenges in terms of achieving and maintaining standards in a significant field of diagnostic imaging. The current situation is contrary to public expectation that a formal regulation structure exists. Such regulation would provide recognition of qualifications, minimum entry standards, assurance of practice standards, a code of conduct and ethics, and a single avenue for complaints for diagnostic ultrasound services.

Recommendation

1. The ASA strongly recommends the diagnostic medical sonographer profession is included under the NRAS. It believes that this is the most efficient and effective mechanism for achieving adequate nationally consistent professional standards and regulatory processes, to assuring the health and safety of those who access diagnostic ultrasound services.

2. Including diagnostic medical sonography under the NRAS could be achieved either through defining the professional title in the NRAS legislation or amending the legislation to include a definition of self-regulating health professionals, including sonography. ASA supports both arrangements as the critical element long-term is providing nationally consistent regulation for all health professionals.

The later arrangement would see a nationally consistent model of authorised self-regulation for all health professionals currently ‘self-regulating’, such as sonographers. This change would remove the two tier regulatory system currently in place and, importantly, would respond to the community expectation that all Australian health professions meet a governed standard with nationally consistent public protection processes in place.

Unintended consequences following the implementation of the NRAS

The confined application of the NRAS has resulted in the evolution of a two tier regulatory system (NRAS regulated vs self-regulated) with a number of unintended consequences. Below are some examples to demonstrate the breadth of these unintended consequences. Additional examples can be provided if required.

Examples:

1. Health Workforce Australia’s decision to only include registered professions in the Health Professionals Prescribing Project. It is understandable that when considering a policy to extend prescribing of pharmaceutical products, the government needs to ensure there are appropriate standards and adequate complaints system in place to protect the public. However, this decision meant that self-regulated professions, many of which have a clear role in formal extension of prescribing rights, were not included in this project. This is a curious and awkward consequence and is contrary both to the intent of the project and the NRAS to the detriment of the effective delivery of healthcare.
2. A small but significant number of Medicare Locals indicate that only registered professionals can be ‘members’ of the company, with many determining that only registered professionals can provide services under some of the programs. The funding guidelines for Medicare Locals expect that they listen to their communities and have Community Advisory Committees etc representative for the full spectrum of health services in the area. The exclusion of professions not registered under the NRAS is contrary to this intention.

3. Changes to Victorian legislation in August 2014 to improve safety and security measures for emergency workers in Victoria were implemented specifically for the fourteen registered health practitioner groups under the NRAS (the letter from the Honourable David Davis MP, Victorian Minister for Health, is at Attachment 1).

4. AHPRA registration is a mandatory criteria for health professionals applying for Doctoral Scholarships offered by the Windermere Foundation to support the professional development of ‘Victorian health practitioners who will become future leaders in their profession’.

5. It has been reported that the Research Advisory Board for the Australian Primary Health Care Research Institute is considering restricting new grant applications to the NRAS registered health professionals.

Establishment of the NRAS has raised the expectations of the community, health professionals and broader stakeholders that all health professions across the Australian healthcare system continuum meet a governed standard, with established public protection processes and regulation in place.

As represented by the examples above, this expectation has led to the exclusion of health professions not included under the NRAS from important health system changes and opportunities, impacting on the development of these professions, and to the detriment of positive improvements which could have been achieved to the delivery of healthcare services in Australia.

The ASA raises these issues with the relevant bodies however often there is limited opportunity (as with legislation that has just been amended) to effect timely change.

Amending the NRAS legislation to include diagnostic medical sonographers, either as a described profession or a self-regulating health profession, would respond to both the consumer protection expectations of people accessing health services, as well as addressing many of the unintended consequences of the two tier regulatory system currently in place.

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Questions from the Review of the NRAS for health professions consultation paper

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

Yes. ASA strongly support both of these.

The present regulatory model for sonographers has provided satisfactory support during the growth of sonography in Australia to this point; however it has become apparent that it does not satisfactorily cater for the increasing use and application of ultrasound technology in medical diagnostics.

The importance of including the sonographer profession and the practice of ultrasound under legislation is recognised internationally (e.g. in New Zealand through the New Zealand Medical Radiation Technologists Boards

The quality of the sonographic examination is intrinsically linked to the skill of the sonographer who tailors the examination and interprets the sonographic findings by selectively recording anatomical images, physical data and real-time physiological information.

The final diagnostic report produced by the medical specialist is inherently reliant on the technical and intellectual clinical skills of the sonographer. Sonographers require excellent communication and negotiation skills in order to work within a multi-disciplinary team, as well as high levels of emotional intelligence to work with patients who may require empathy and patience. Sonography is acknowledged by the broader diagnostic imaging community as much more than a purely technical role.

Diagnostic medical sonographers in Australia are accredited through the ASAR. Accreditation of practitioners is based on meeting minimum entry-level requirements and fulfilling the requirement for continuing professional development (CPD). The ASAR sets the standards for CPD and oversees the operations of the approved CPD programs. However, currently there is no provision for the ASAR to establish a sonographer’s ‘fitness for practice’ prior to admission onto the register of sonographers, nor is there any capacity to counsel, discipline or remove sonographers. The ASAR can only remove sonographers from the register for failure to complete the necessary CPD requirements and/or failure to pay their annual fee.

This is compounded by the current fragmentation of aspects of sonographer regulation through a complex system of co-regulation. Co-regulation is widely accepted as being more expensive than a coordinated single regulatory entity in its administration, and for the profession and patients through the flow on of these costs.

No national regulations currently exist that allow for individuals who do not meet required standards to have their scope of practice limited. While the practice of sonography and the provision of ultrasound services are controlled through the Australian Government’s DIAS and the MBS, this regulation does not extend to ‘fitness to practise’ requirements. Regulating sonographers and other health practitioners who use ultrasound technology under the NRAS legislation would allow recourse for complainants who receive inappropriate or incompetent services.

2 http://www.mrtboard.org.nz/registration-information
Currently, patients and health consumers are able to make complaints through healthcare complaints entities, such as the Victorian Health Services Commission, however these entities have limited jurisdiction. New South Wales, South Australia and Queensland have enacted state legislation which confers powers on health commissioners to impose sanctions on unsafe or unethical health care workers. However health professionals subject to sanctions in these states are currently still able to practise in other states or territories.

The ASA contend that the potential for harm to the public undergoing ultrasound procedures is such that, even if this type of regulation was extended across Australia, as proposed under the National Code of Conduct for unregistered health practitioners, the more stringent processes available under NRAS provide a more appropriate regulatory regime for sonographers and other health practitioners using ultrasound technology.

While there are other legal avenues that a complainant may try, such as various Crimes Acts, the Competition and Consumer Act 2010, the Therapeutic Goods Act 1989 or ‘fair trading’ laws in the states and territories, none of this legislation has the ability to prevent a sonographer working in the field.

If, for example, the sonographer is an employee of a health service in Western Australia, a patient has no recourse except to complain to the employer or, in some cases, to pursue a suit under criminal or tort law. Additionally, the employer may fire an incompetent sonographer, but that will not prevent that person from securing employment in another service and continuing to practise.

This creates an imbalance in regulation, particularly when compared with other health practitioners conducting the same inappropriate examination who - because they are regulated - would be subject to potential deregistration. Section 55 of the National Law identifies the situations in which an individual may not be registered as a health professional, including criminal history, competency, communication skills and recency of practice. Currently, sonographers are not required to meet any of these criteria.

Notably the medical application of ultrasound and sonographer scope of practice continues to advance and expand. In private practice and rural and remote areas of Australia sonographers take on increasing responsibility in diagnostic reporting. This is acknowledged through the rural and remote exceptions described for ultrasound practice under the Medicare Benefits Schedule.

Additionally, state governments are investigating alternative and innovative models of diagnostic imaging and ultrasound guided medical practice. Significantly the Queensland Government, through the 'Ministerial Taskforce on health practitioner expanded scope of practice'\(^3\), are progressing projects which expanded the practice the sonographers in public hospitals to include direct reporting, ultrasound guided therapeutic musculoskeletal injections and other higher risk ultrasound assisted practice. Not regulating diagnostic medical sonographers under the NRAS continues to unnecessarily expose the public to increasing risk.

Furthermore, with the evolution of ultrasound technology, particularly the capacity for 3D and 4D studies, there has been an increase in the provision of commercially oriented ultrasound services used specifically for non-diagnostic ‘entertainment’ purposes such as services which are performed for the sole purpose of providing the consumer with 3D images of a fetus in utero.

Businesses dedicated to offering these services would fit within commercial law and therefore not within the purview of the Minister for Health. However, this raises issues as to what protection is

provided to people accessing these services, and the level of patient safety and assurance that should be provided to patients accessing these services. This is particularly relevant in instances where they are being provided by sonographers or other qualified health practitioners.

The ASA contend that this practice requires similar regulation under the NRAS framework. It would provide for the protection of mothers and their babies and meet the expectations of the public who, in these cases, would reasonably expect the operator to be a skilled professional who can provide a level of care which matches the requirements of each situation.

Lastly is the confusion caused for sonographers who are also practitioners under a profession registered under the NRAS (e.g. radiographers). There is a significant population of sonographers who are also practising radiographers who provide both medical imaging practices in their workplaces. This causes many issues for these professional both in-terms of cost, as they need to pay for and maintain multiple registrations, but also in complaints and notifications handling, as they are being regulated under both sides of the two tier regulatory system caused by the confined application of the NRAS.

From a complaints and notifications perspective, this causes a lot of confusion and duplication of administration. When a complaint or notification is made regarding the a registered professional in their capacity as a sonographer undertaking an ultrasound examination, the NRAS complaint and notification must still be enacted for the NRAS registered professional, even though it relates to the provision health services outside of the current legal framework. This results in significant unnecessary administration and cost, frustration and concern for the health professional, and arguably more importantly it causes unnecessary delays to the complaints and notifications process, possibly exposing members of the public to unnecessary risk.

Inclusion of the diagnostic medical sonographer profession under the NRAS responds to all of the issues described above, and is the most efficient and effective solution for an aligned regulatory system that assures patient safety in the provision of diagnostic medical sonography.
11. Should there be a single entry point for complaints and notifications in each State and Territory?

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

The ASA agrees in principle with this providing that, more importantly, there is nationally consistent single entry point for complaints and notifications regarding sonographers.

A significant achievement of the NRAS is the establishment of a nationally centralised point for receiving and responding to complaints and notifications regarding health professionals. Although in its infancy, this embraces a right-touch regulatory methodology focused on patient and consumer safety and quality healthcare delivery.

The ASA strongly supports the retention of a nationally centralised point for receiving and responding to complaints and notifications. We advocate for it to be expanded to include all health professions, either through the individual inclusion of all health professions under the NRAS or the establishment of an authorised self-regulation model under the legislation.

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

Overseas-trained sonographers are currently assessed through the Australian Institute of Radiography (AIR). This is a legacy arrangement. The Department of Education and Department of Immigration and Border Protection share the responsibility to approve organisations to undertake assessment of overseas health professionals. In 1999, AIR was determined as the appropriate national body to assess both overseas trained radiographers and sonographers.

Under the NRAS provisions is expected that the assessment of overseas trained radiographers will transition to the Medical Radiation Practice Board of Australia. Besides this, and considering the significant maturing of sonography as a profession since 1999, arguably AIR is no longer the most appropriate entity to undertake this function, as their primary professional focus is radiographers.

Inclusion of diagnostic medical sonography under the NRAS, either as a defined profession under legislation or as a self-regulating health profession, would empower the alignment of all regulatory functions. This would eliminate the current fragmentation, better support transparency of processes and ensure national consistency in the regulation of Australian sonographers for safety and quality in the provision of ultrasound services.
Dear CEO

Improving safety and security for Victorian health practitioners

Preventing violence and aggression in Victorian health services is critically important. Health practitioners should not fear for their safety or that of patients and their loved ones. That is why the Victorian Coalition Government is honouring our election commitment to improve safety and security in Victorian health services.

Ministerial Advisory Committee for improving hospital safety and security

In seeking to fulfill our commitment, in early 2013, I established the Ministerial Advisory Committee for improving hospital safety and security to provide advice on implementing the Inquiry’s recommendations. Actions undertaken by the Government as a result of that advice have had and will have real impact.

Increased penalties for perpetrators of violence

The Justice Legislation Amendment (Confiscation and Other Matters) Bill 2014 was introduced into Parliament on Wednesday 20th August, 2014. This bill will amend the Summary Offences Act 1966 and builds on the Sentencing Amendment (Emergency Workers) Bill 2014, which focuses on sentences for assaults against emergency workers such as paramedics providing emergency care, to create an offence of assaulting a registered health practitioner in the course of providing care or treatment, including all 14 registered health practitioner groups.

The new offence will not be limited to a hospital or health setting, which will mean that all registered health practitioners will be covered by the offence, regardless of where they are conducting their professional duties.

For those health practitioners who work in a hospital the offence will also cover any incident that occurs in hospital premises including car parks, foyers and forecourts.

The offence of assaulting a registered health practitioner in the course of providing care or treatment will be punishable by six months imprisonment or sixty penalty units.

Funding

In related action, the Government has committed well over $40 million over the forward estimates in safety and security related initiatives, including:

- $11.4 million to directly address the issue by upgrading duress and security systems and supporting organizational responses to clinical aggression, including staff training and capital improvements.

- A further $38.9 million to enhance the management of population groups that pose a known risk to safety and security, in particular, those where mental health and alcohol and other drugs are an issue.
Standardised health service response to clinical aggression

Standards for organizational responses to clinical aggression (Code Grey) have also been released. The Standards for Code Grey reflect best-practice and have been transmitted to metropolitan and rural health services for adoption and implementation.

A review of the literature and evidence surrounding clinical aggression by Melbourne Health underpinned the development of best practice principles and minimum practice standards for Code Grey. This work has provided the foundations for the Standards which have then been drafted more broadly to include organisational responses to all forms of aggression including on the part of patients, visitors, staff, volunteers or indeed anybody on the premises.

Under the conditions of funding set out in the annual Victorian Health Policy and Funding Guidelines, all health services are required to report to the Victorian Health Incident Management System (VHIMS). Reporting captures all incident types including both clinical and non-clinical violence and aggression in health services.

Effective duress alarms and other security measures

Since coming to government, the Coalition has undertaken an audit of security devices in our health services including emergency departments. This audit found that:

- 22 health services reported having both fixed trigger point and personal duress alarms for staff in emergency departments and mental health facilities.
- 9 remaining health services reported having duress alarms in place, however they noted having only fixed trigger point duress alarms available to staff.

In 2012-13, we invested in upgrading duress alarms in 30 Victorian hospitals previously neglected by Labor.

Our smaller rural and regional services have also received funding to improve safety and security. Examples include external lighting to car parks, CCTV and additional duress alarms.

Unlike the previous state Labor Government, who refused point blank to satisfactorily increase penalties for assaults against emergency and health care workers over eleven years, the Napthine Government has in its first term demonstrated no tolerance for violence or aggression against health professionals. The caring role of our health care workers needs to be respected and hospitals should be safe for patients and staff alike.

Yours sincerely

Hon David Davis MP
Minister for Health

20/08/2014