Aboriginal and Torres Strait Islander Health Practice Board of Australia

Registration for Aboriginal and Torres Strait Islander health practitioners

- Frequently asked questions
- Standards, Guidelines and the Code

2013/14

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Contents

Frequently asked questions (FAQs)

Who needs to register?

The National Law[1], states that a practitioner must be registered if their employer requires them, or they wish to, use one of the protected titles in the law.

The protected titles are:

- Aboriginal and Torres Strait Islander health practitioner
- Aboriginal health practitioner, or
- Torres Strait Islander health practitioner.

A practitioner may be required to be registered as part of their employment requirements, even if the protected title is not used.

An employer may call a job anything they like, but if the employer requires the practitioner to hold registration as an Aboriginal and Torres Strait Islander health practitioner as a requirement of the job, the health worker must be registered to be employed.

I work in a role that is called 'Aboriginal Health Worker'. Do I need to register?

Aboriginal health workers who are required by their employer to use the protected titles, 'Aboriginal and Torres Strait Islander health practitioner', or 'Aboriginal health practitioner' or 'Torres Strait Islander health practitioner' need to be registered.

Aboriginal health workers who are not required by their employer to use these protected titles are not legally required to be registered, and will still be able to continue to work, using their existing titles (for example, Aboriginal Health Worker, Drug and Alcohol Worker, Mental Health Worker, and so on).

However, the Board strongly encourages employers of Aboriginal health workers in clinical roles to require them to hold registration as an 'Aboriginal and Torres Strait Islander health practitioner' (or either of the other two protected titles) as a requirement of the job, in the interest of public safety.

If I belong to a professional association do I still need to register with the National Board?

Yes. Belonging to a professional association is something you do because you want to. It is not something you do because you have to.

Being registered is a legal requirement under the National Law if you are working as an Aboriginal and Torres Strait Islander health practitioner, or under either of the other two protected titles, or are required to be registered as a requirement of your job.

[1] Health Practitioner Regulation National Law, as in force in each state and territory.

How does the Board define practice?

The Board's definition of practice is:

Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

What is non-practising registration?

Aboriginal and Torres Strait Islander health practitioners with non-practising registration cannot undertake any clinical practice but they can use the protected title. They are not permitted to treat or refer, regardless of whether they are being paid or not. There is a lower fee for non-practising registration.

This type of registration may be suitable for practitioners who:

- have retired, or
- are temporarily not practising (for example on maternity or sick leave).

What is 'recency of practice'? I haven't practiced for a few years. Will I be able to register?

To ensure health practitioners are able to practise competently and safely, all registered health practitioners must be able to demonstrate 'recency of practice' within their profession.

For Aboriginal and Torres Strait Islander health practitioners returning to practice, the specific requirement for recency of practice depends on the length of absence from the field and the length of practice prior to absence. Upon applying for initial registration, practitioners will be required to make a declaration to ensure their length of absence from the field and the length of practice prior to absence meets the Board's *Recency of practice registration standard* and the Board's *Recency of practice guidelines*.

The Board's *Recency of practice registration standard* outlines the scope, requirements and possible exemptions for practitioners who have been absent from practice.

Under the National Law, the Board may decide that an individual is not a suitable person to hold general registration as an Aboriginal and Torres Strait Islander health practitioner because, due to absences, they have not practised the profession for the length of time which the Board considers to be sufficient. They must have recent experience practising their profession and that their skills are current and up to date.

More information around the requirements in relation to recency of practice can be found in the Board's *Recency of practice registration standard* and the Board's *Recency of practice guidelines*.

When a practitioner renews their registration, they must also make a declaration that they have met the recency of practice requirements set by the Board.

How do I register with the National Board?

Registration application forms are available on the Board's website. If you do not have internet access, paper copies can be requested by phoning AHPRA on 1300 419 495.

Will I be registered for life once I am registered?

No. You must renew your registration and pay the registration renewal fee every year.

You are also required to complete and submit an annual renewal form declaring that you meet the Board's registration standards (i.e. continuing professional development, criminal history, professional indemnity insurance arrangements, and recency of practice).

How do I renew my registration under the National Scheme?

AHPRA emails all practitioners a notice to renew when their registration renewal is due as well as reminders to renew. It is important to provide AHPRA with your most up to date email address.

What happens if I don't renew my registration by the due date?

You have a one-month late period after the registration expiry date during which you can apply to renew (by 31 December), under the National Law.

If AHPRA receives your application before the end of the one-month late period, you will remain registered and be able to practise within the scope of your registration. Your listing on the national register will be updated when processing of your application is complete.

If AHPRA receives your application during the one-month late period, you will incur a late payment fee. This applies to all registrants who do not renew by the annual registration expiry date (**30 November**) and apply in December.

Will registration mean I have access to Medicare?

No not necessarily. The Board is not involved in determining who has access to Medicare as this is the responsibility of the Commonwealth Government. The Board is only concerned about issues to do with registration and accreditation.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and/or Torres Strait Islander registration standard

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law* (the National Law) as in force in each state or territory, with approval taking effect from 1 July 2012.

Summary and Purpose of Standard

Only persons who are Aboriginal and/or Torres Strait Islander are eligible for registration as an Aboriginal and Torres Strait Islander health practitioner.

The purpose of this standard is to enhance the quality of holistic health care that is provided by Aboriginal and Torres Strait Islander health practitioners to the community in a culturally safe manner.

If the individual fails to meet the requirements in this registration standard, that individual would be unsuitable to be registered in the profession.

Scope of application

This standard applies to all applicants.

Requirements

1. To be eligible to apply for registration as an Aboriginal and Torres Strait Islander health practitioner a person must be:

    a) an Aboriginal and/or Torres Strait Islander person; and

    b) identify as an Aboriginal and/or Torres Strait Islander person; and

    c) be accepted as an Aboriginal and/or Torres Strait Islander person in the community in which he or she lives or did live.

2. Applicants must be able to provide evidence with regard to the above 1a) b) c) upon application. Evidence may include, but is not limited to a letter, to the satisfaction of the Board, stating that a person is an Aboriginal or Torres Strait Islander or both and is accepted as such by a recognised Aboriginal and/or Torres Strait Islander organisation. The letter must carry the organisation's letterhead, hold the organisation's official seal and be dated and signed by a person authorised by the organisation.

3. Pursuant to section 80, of the National Law the Board may seek further evidence of a registrant's claim to be an Aboriginal and/or Torres Strait Islander person.

Definition

Aboriginal and Torres Strait Islander health practitioner means a person registered by the Aboriginal and Torres Strait Islander Health Practice Board. The practitioner may use the titles:

- Aboriginal health practitioner,
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Review

This standard will commence on 1 July 2012. The Board will review this standard at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Continuing professional development registration standard

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law Act*, as in force in each state and territory (the National Law), with approval taking effect from 1 July 2012.

Summary

All registered Aboriginal and Torres Strait Islander health practitioners are required to participate regularly in continuing professional development (CPD) activities.

All registered Aboriginal and Torres Strait Islander health practitioners will be required to undertake CPD activities and maintain records of their CPD activities from 1 July 2012.

Scope of application

This standard will apply to all registered practitioners from 1 July 2012. It will not apply to those with student registration or non-practising registration.

Requirements

1. All Aboriginal and Torres Strait Islander health practitioners will be asked to declare annually on renewal of registration that they have met the CPD standard set by the Board. This declaration may be subject to audit.
2. Practitioners must hold a current first aid certificate which includes cardio pulmonary resuscitation.
3. Practitioners must complete a minimum of 60 hours of CPD activities over a three year cycle, with a minimum of 10 hours in any one year.
4. Of the 60 hours over three years, at least 45 hours are required to be formal CPD activities. The remainder may consist of informal CPD activities.
5. Aboriginal and Torres Strait Islander health practitioners are required to ensure that their CPD activities are able to be recorded and these records produced when the Board requires them to do so as part of an audit investigation. A sample of how to record CPD activities is provided in the guideline for continuing professional development.
6. Records must be kept for four years.
7. CPD activities should be relevant to the context of the practitioner's practice and the employing organisation.

Some examples of CPD include, but are not limited to:

Formal learning activities such as accredited courses, conferences, forums, seminars, undertaking research and presentation of work, online learning and in-service workplace programs.

Informal learning activities such as self-study of reference material, clinical case discussion with other health professionals, and internet research.

Failure to comply

A failure to comply with this CPD standard is a breach of the National Law and may constitute behaviour for which health, conduct, or performance action may be taken under the National Law section 128(2).

Definitions

Aboriginal and Torres Strait Islander health practitioner means a person registered by the Aboriginal and Torres Strait Islander Health Practice Board of Australia. The practitioner may use the titles:

- Aboriginal health practitioner,
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Continuing professional development (CPD) is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

Practice means any role, whether remunerated or not, in which the registrant uses their skills and knowledge in their profession. For the purposes of this registration standard, practice is not restricted to the direct provision of clinical care. It also includes working in a direct non clinical relationship with clients; working in management, administration, education, research, advisory, regulatory or policy development roles; and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Review and implementation

This standard will commence on 1 July 2012.

Prior to 1 July 2015, practitioners will be required to complete a minimum of 10 CPD hours in any one year and 60 hours in total over a three year cycle.

When a practitioner registers for the first time, or has his or her registration restored after it has lapsed, the number of CPD hours to be completed will be calculated on a pro rata basis.

During this period, the requirement for all practitioners to hold a current first aid certificate will continue to apply.

The Board will review this standard at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Criminal history registration standard

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law Act* as in force in each state and territory (the National Law), with the approval taking effect from 1 July 2012.

Summary

In deciding whether a health practitioner's criminal history is relevant to the practice of their profession, the Board will consider the 10 factors set out in this standard. While every case will need to be decided on an individual basis, these 10 factors provide the basis for the Board's consideration.

Scope of application

This standard applies to all applicants and all registered health practitioners. It does not apply to students.

Requirements

In deciding whether a health practitioner's criminal history is relevant to the practice of their profession, the Board will consider the following factors.

1. **The nature and gravity of the offence or alleged offence and its relevance to health practice.**

   The more serious the offence or alleged offence and the greater its relevance to health practice, the more weight that the Board will assign to it.

2. **The period of time since the health practitioner committed, or allegedly committed, the offence.**

   The Board will generally place greater weight on more recent offences.

3. **Whether a finding of guilt or a conviction was recorded for the offence or a charge for the offence is still pending.**

   In considering the relevance of the criminal history information, the Board is to have regard to the type of criminal history information provided. The following types of criminal history information are to be considered, in descending order of relevance:

   a) convictions

   b) findings of guilt

   c) pending charges

   d) non-conviction charges; that is, charges that have been resolved otherwise than by a conviction or finding of guilt, taking into account the availability and source of contextual information which may explain why a non conviction charge did not result in a conviction or finding of guilt.

4. **The sentence imposed for the offence.**

   The weight the Board will place on the sentence will generally increase as the significance of the sentence increases, including any custodial period imposed. The Board will also consider any mitigating factors raised in sentencing, where available, including rehabilitation.

5. **The ages of the health practitioner and of any victim at the time the health practitioner committed, or allegedly committed, the offence.**

   The Board may place less weight on offences committed when the applicant is younger, and particularly under 18 years of age. The Board may place more weight on offences involving victims under 18 years of age or other vulnerable persons.

6. **Whether or not the conduct that constituted the offence or to which the charge relates has been decriminalised since the health practitioner committed, or allegedly committed, the offence.**

   The Board will generally place less or no weight on offences that have been decriminalised since the health practitioner committed, or allegedly committed, the offence.

7. **The health practitioner's behaviour since he or she committed, or allegedly committed, the offence.**

   Indications that the offence was an aberration and evidence of good conduct or rehabilitation since the commission, or alleged commission of the offence, will tend to be a mitigating factor. However, indications that the offence is part of a pattern of behaviour will tend to have the opposite effect.

8. **The likelihood of future threat to a patient of the health practitioner.**

   The Board is likely to place significant weight on the likelihood of future threat to a patient or client of the health practitioner.

9. **Any information given by the health practitioner.**

   Any information provided by the health practitioner such as an explanation or mitigating factors will be reviewed by the Board and taken into account in considering the health practitioner's criminal history.

10. **Any other matter that the Board considers relevant.**

    The Board may take into account any other matter that it considers relevant to the application or notification. A Board will not require an applicant or registered health practitioner to provide further information

that may prejudice their personal situation pending charges and the Board must not draw any adverse inference as a result of the fact that information has not been provided.

Note: the above factors have been numbered for ease of reference only. The numbering does not indicate a priority order of application.

Definitions

Criminal history is defined in the National Law as:

- every conviction of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law,
- every plea of guilty or finding of guilt by a court of the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law and whether or not a conviction is recorded for the offence
- every charge made against the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law.

Under the National Law, spent convictions legislation does not apply to criminal history disclosure requirements.

Review

This standard will commence on 1 July 2012. The Board will review this standard at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and Torres Strait Islander Health Practice Board of Australia

English language skills registration standard

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law Act*, as in force in each state and territory (the National Law), with approval taking effect from 1 July 2012.

Summary

All applicants for Aboriginal and Torres Strait Islander health practitioner registration must be able to demonstrate they have an adequate command of the English language.

Scope of application

This standard applies to all applicants for registration. It does not apply to students.

Requirements

Aboriginal and Torres Strait Islander health practitioners will only be trained in Australia.

English language proficiency can be demonstrated through the completion of the Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) or a qualification considered by the Board to be equivalent.

Practitioners will be required to provide a certified copy of their qualifications upon registration.

The Board retains the power to require further evidence of English language skills under section 80 of the National Law. This may include formal testing of English language proficiency in accordance with the Australian Core Skills Framework.

Definitions

Aboriginal and Torres Strait Islander health practitioner means a person registered by the Aboriginal and Torres Strait Islander Health Practice Board. The practitioner may use the titles:

- Aboriginal health practitioner,
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Review

This standard will commence on 1 July 2012. The Board will review this standard at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Grandparenting Provisions Registration Standard

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law Act*, as in force in each state and territory (the National Law), with approval taking effect from 1 July 2012.

Summary

Practitioners who were registered with the Aboriginal Health Workers Board of the Northern Territory will automatically transition to the new national registration and accreditation scheme from 1 July 2012. Registration under the national scheme is required in all states and territories of Australia that have enacted the National Law.

Aboriginal and Torres Strait Islander health workers who as of 1 July 2012 will be practising in a role designated for Aboriginal and Torres Strait Islander health practitioners, and who do not automatically transition into the national scheme, must apply for registration.

In states and territories which have not had registration prior to 1 July 2012, applicants will need to meet Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) or equivalent.

Applicants who do not meet the qualification requirements under section 53 of the National Law may be eligible to apply for registration under the grandparenting arrangements.

Until 1 July 2015, individuals may be eligible to apply for registration under the grandparenting provisions if they meet the requirements under section 303.

If an applicant does not have the approved qualification, the Board, under the grandparenting provisions, may recognise alternative qualifications and/or experience equivalent to the approved qualification, which may allow an applicant to be considered for registration.

Applicants for registration must also meet the other standards of the Aboriginal and Torres Strait Health Islander Practice Board of Australia in order to be eligible for registration as an Aboriginal and Torres Strait Islander health practitioner and be able to use the protected titles.

Scope of application

This standard applies to all applicants for general registration within the Aboriginal and Torres Strait Islander health practitioner profession under section 303 of the National Law.

Requirements

This section is simplified in the associated guideline.

All applicants must be qualified for registration in order to satisfy the eligibility requirements under section 52. Section 303 sets out the qualifications for general registration. An individual who applies for registration as an Aboriginal and Torres Strait Islander health practitioner before 1 July 2015 may be qualified for general registration in the profession if the individual:

a) Satisfies section 303(1)(a): holds a qualification or has completed training in the profession that the National Board or its delegate considers to be adequate for the purposes of practising the profession.
The National Board considers that Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) or another equivalent qualification is adequate for the purposes of practising the profession; or,

b) Satisfies section 303(1)(b): holds a qualification such as a Certificate III prior to 2008 that includes medication administration and clinical assessment (such as, but not limited to, a Certificate III in Aboriginal Health Work Clinical, a Certificate III in Indigenous Primary Health Care) and has completed any further study, training or a minimum of 500 hours of clinical practice demonstrated by the evidence outlined in (c) below; or

c) Satisfies section 303(1)(c): has practised as a clinical Aboriginal and Torres Strait Islander health worker at any time between 1 July 2002 and 30 June 2012 for a consecutive period of 5 years or for any periods which together amount to 5 years.
An applicant for registration under section 303 (1)(c) must provide the following evidence or equivalent to the satisfaction of the Board:

- a minimum of two recent professional references from people who can be contacted by the Board or their delegate including at least one from a supervisor
- documentary evidence of practising in the profession for a minimum of five years or part time equivalent between 1 July 2002 and 30 June 2012
- copies of position/job descriptions, certified by employer/s with a description of the nature of the qualification, knowledge and skills required
- a resume or professional portfolio

- a statement of service or other documentation from employer/s that support claims of five years of practice
- a declaration declaring that an applicant has practised for five years in the profession

The Board may require an applicant to provide additional evidence of their qualifications training, further study, supervised practice or length of service.

The Board may also investigate an applicant including requiring an applicant to undertake an assessment in accordance with section 80(1) of the National Law.

Definitions

Aboriginal and Torres Strait Islander health practitioner means a person registered by the Aboriginal and Torres Strait Islander Health Practice Board. The practitioner may use the titles:

- Aboriginal health practitioner,
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Clinical practice means direct clinical care of patients, using the current knowledge, skills and attitudes of the profession, whether remunerated or not, and regardless of job title.

Review

This standard will commence on 1 July 2012 and cease on 1 July 2015.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Professional Indemnity Insurance arrangements registration standard

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law Act*, as in force in each state and territory (the National Law), with approval taking effect from 1 July 2012.

Summary

Aboriginal and Torres Strait Islander health practitioners must not practise the profession unless they are covered in the conduct of their practice by appropriate professional indemnity insurance arrangements in accordance with this standard.

Registrants can be covered by either individual insurance arrangements or third party insurance arrangements which may apply through employment or education institution insurance arrangements.

Initial registration and annual renewal of registration will require a declaration from the Aboriginal and Torres Strait Islander health practitioner that they are or will be covered for all aspects of practice for that period of registration.

It is usual for Aboriginal and Torres Strait Islander health practitioners who are not in private practice to be covered by their employer for professional indemnity insurance arrangements. However, it is the responsibility of the individual registrant to check that appropriate professional indemnity insurance arrangements are in place.

Scope of application

This standard applies to all Aboriginal and Torres Strait Islander health practitioners applying for initial registration or renewal of their registration. It does not apply to student registrants or practitioners with non-practising registration.

Requirements

1. When applying for registration or renewal of registration, Aboriginal and Torres Strait Islander health practitioners will be required to declare that appropriate professional indemnity insurance arrangements are, or will be, in place while they are practising the profession.
2. Aboriginal and Torres Strait Islander health practitioners will require professional indemnity insurance to cover the full scope of their practice, whether employed or self-employed, and regardless of whether they are working in the private, non-government or public sector.
3. Aboriginal and Torres Strait Islander health practitioners in a genuine employment relationship would usually be covered vicariously by their employer's professional indemnity insurance. It is the registrant's responsibility to understand the nature of the cover under which they are practising. Aboriginal and Torres Strait Islander health practitioners to whom this applies may be required by the Board in writing to provide documentation from their employers, or education institutions, to verify professional indemnity insurance arrangements.
4. Aboriginal and Torres Strait Islander health practitioners who hold private professional indemnity insurance cover in their own name are required to retain documentary evidence of their insurance and to provide it to the Board on request.
5. Aboriginal and Torres Strait Islander health practitioners must ensure they have adequate cover but this may differ according to an individual's scope of practice and risk. Where an Aboriginal and Torres Strait Islander health practitioner is working for someone other than themselves, they should seek written evidence from their employer that professional indemnity insurance arrangements are in place where appropriate.
6. The Board encourages practitioners who are assessing whether they have appropriate professional indemnity insurance arrangements in place to consider:
    a) the practice setting and the type of services and care delivered
    b) the patient or client group
    c) advice from professional indemnity insurers, professional associations and industrial organisations and
    d) current employment status.
7. The Aboriginal and Torres Strait Islander Health Practice Board may, as per section 129(2) of the National Law, at any time, by written notice, require a registered Aboriginal and Torres Strait health practitioner to give the Board evidence of appropriate professional indemnity insurance arrangements that are in force in relation to the practitioner's practice of the profession.

Definitions

Aboriginal and Torres Strait Islander health practitioner means a person registered by the Aboriginal and Torres Strait Islander Health Practice Board. The practitioner may use the titles:

- Aboriginal health practitioner,
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Professional indemnity insurance arrangements means arrangements that secure, for the practitioner's professional practice, insurance against civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner. This type of insurance is available to practitioners and organisations across a range of industries, and covers the cost and expenses of defending a legal claim, as well as any damages payable. Some government organisations under policies of the owning government are self-insured for the same range of matters.

Practice means any role, whether remunerated or not, in which an individual uses their skills and knowledge as a health practitioner in their profession. For the purpose of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Review

This standard applies from 1 July 2012. The Board will review this standard at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Recency of practice registration standard

Authority

This standard was approved by the Australian Health Workforce Ministerial Council in December 2011 pursuant to the *Health Practitioner Regulation National Law Act*, as in force in each state and territory (the National Law), with approval taking effect from 1 July 2012.

Summary

To ensure Aboriginal and Torres Strait Islander health practitioners are able to practise competently and safely, all Aboriginal and Torres Strait Islander health practitioners must be able to demonstrate recency of practice within their profession.

For Aboriginal and Torres Strait Islander health practitioners returning to practice, the specific requirement for recency of practice depends on the length of absence from the field and the length of practice prior to absence.

Upon applying for initial registration or renewal of registration, practitioners will be required to make a declaration about their recency of practice.

Scope of application

This standard applies to:

a) all applicants seeking registration in a practising category, or renewal of registration.

b) all applicants equally, whether they practise full time or part-time or whether the work is remunerated or not.

This standard does not apply to student registrants or those with non practising registration.

Requirements

1. Applicants who have not practiced for the previous three years

The Board may grant general registration with conditions to an applicant who is otherwise eligible for registration but has not practised for at least three months full time equivalent in the previous three years. The conditions may include, but are not limited to:

- successfully completing a first aid certificate
- successfully completing an assessment against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) and
- working under the supervision of an Aboriginal and Torres Strait Islander health practitioner, Registered Nurse, Registered Midwife or Medical Practitioner.

2. Applicants who have not practised for the previous three to five years

The Board may grant registration with conditions to an applicant who is otherwise eligible for registration, but has not practised for at least six months full time equivalent in the previous three to five years. The conditions may include, but are not limited to:

- successfully completing a first aid certificate
- successfully completing an assessment against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)
- Working under a specified level of supervision of an Aboriginal and Torres Strait Islander health practitioner, Registered Nurse, Registered Midwife or Medical Practitioner
- Providing the Board with supervision reports at six monthly intervals or within a timeframe as determined by the Board from date of commencing employment

3. Applicants who have not practised for the previous five to ten years

The Board may grant registration with conditions to an applicant who has not practised for twelve months full time equivalent in the previous five to ten years.

The Board may also determine that the applicant is not eligible for registration and is required to meet the qualification level set by the Board.

Conditions may include, but are not limited to:

- successfully completing a first aid certificate
- successfully completing an assessment against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)
- working under the direct supervision of an Aboriginal and Torres Strait Islander health practitioner, Registered Nurse, Registered Midwife or Medical Practitioner
- providing the Board with supervision reports at one month and then at six monthly intervals thereafter; or, within a timeframe as determined by the Board.

Applicants will be required to declare that they meet this standard annually upon application for renewal.

The Board may audit compliance against this standard and may request evidence that this standard has been met.

4. **Applicants who have completed their qualification more than two years prior to seeking initial registration may be required to demonstrate competency by:**

   - working under the direct supervision of an Aboriginal and Torres Strait Islander health practitioner, Registered Nurse, Registered Midwife or Medical Practitioner for a period of time or
   - undertaking an assessment against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) or
   - an assessment determined suitable by the Board.

Exemptions

Practitioners applying for or renewing non practising registration.

Definitions

Aboriginal and Torres Strait Islander health practitioner means a person registered by the Aboriginal and Torres Strait Islander Health Practice Board. The practitioner may use the titles:

- Aboriginal health practitioner,
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

A First Aid Certificate means a first aid certificate or equivalent as determined by the Board.

A Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (practice) means the HLT43907 or equivalent as determined by the Board.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of this registration standard, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.

Clinical practice means direct clinical care of patients, using the current knowledge, skills and attitudes of the profession, whether remunerated or not, and regardless of job title.

Recent graduate means a person applying for registration for the first time whose qualification for registration was awarded not more than two years prior to the date of their application.

Recency of practice means that a practitioner has maintained an adequate connection with, and recent practice in, their profession and can demonstrate that they practise the profession competently and safely.

Review

This standard will commence on 1 July 2012. The Board will review this standard at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

AHPRA

Australian Health Practitioner Regulation Agency

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
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National Board guidelines for registered health practitioners

GUIDELINES FOR ADVERTISING REGULATED HEALTH SERVICES

March 2014

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About the National Boards and AHPRA

The 14 National Boards regulating registered health practitioners in Australia are responsible for registering practitioners and students (except for in psychology, which has provisional psychologists), setting the standards that practitioners must meet, and managing notifications (complaints) about the health, conduct or performance of practitioners.

The Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with the National Boards to implement the National Registration and Accreditation Scheme, under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The core role of the National Boards and AHPRA is to protect the public.

About these guidelines

These *Guidelines for advertising regulated health services* were jointly developed by the National Boards under section 39 of the National Law. The guidelines were developed to help practitioners and others understand their obligations when advertising a regulated health service.

All obligations outlined in this document are those required under the National Law unless stated otherwise.

ADVERTISING GUIDELINES

Contents

Preface

The National Law and these guidelines aim to protect the public.[1] The guidelines explain the limits placed on advertising regulated health services imposed by the National Law. They do not explain how to advertise. The wording of section 133 of the National Law is broad and it is not possible to provide an exhaustive list of advertising that will, or will not, contravene it.

Anyone advertising regulated health services, including individual health practitioners, must make sure that their advertisements comply with the National Law and other relevant legislation.

Neither AHPRA nor the National Boards are able to provide advertisers with legal advice about their advertising, or approve advertising, and these guidelines are not a substitute for legal advice.

Section 133 of the National Law regulates advertising of regulated health services. It states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that—*

   a) *is false, misleading or deceptive or is likely to be misleading or deceptive; or*

   b) *offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or*

   c) *uses testimonials or purported testimonials about the service or business; or*

   d) *creates an unreasonable expectation of beneficial treatment; or*

   e) *directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.*

   Maximum penalty—

   a) *in the case of an individual—$5,000; or*

   b) *in the case of a body corporate—$10,000.*

2. *A person does not commit an offence against subsection (1) merely because the person, as part of the person's business, prints or publishes an advertisement for another person.*

3. *In proceedings for an offence against this section, a court may have regard to a guideline approved by a National Board about the advertising of regulated health services.*

4. *In this section — **regulated health service** means a service provided by, or usually provided by, a health practitioner.*

1 What is the purpose of these guidelines?

These *Guidelines for advertising regulated health services* were jointly developed by the National Boards responsible for regulating registered health practitioners in Australia. They:

- explain and provide guidance on the obligations of advertisers (see definition in Appendix 1) under the National Law
- describe advertising that is prohibited
- comment on the use of factual information in advertising
- explain that advertisers of regulated health services (whether registered health practitioners or not) have responsibilities under other legislation administered by other regulators, and
- explain the consequences of a breach of the advertising provisions of the National Law.

1 Available from the AHPRA website at www.ahpra.gov.au/Legislation-and-Publications/Legislation.aspx.

2 What are the principles underpinning these guidelines?

The following principles underpin these guidelines:

- advertising can be a useful way to communicate the services health practitioners offer to the public so that consumers can make informed choices
- advertising that contains false and misleading information may compromise health care choices and is not in the public interest
- the unnecessary and indiscriminate use of regulated health services is not in the public interest and may lead to the public purchasing or undergoing a regulated health service that they do not need or require.

3 Do these guidelines apply to me?

These guidelines apply to any person (see definition of 'advertiser' in Appendix 1) who advertises a regulated health service or a business that provides a regulated health service, including:

- registered health practitioners
- non-registered health practitioners
- individuals, and
- bodies corporate.

A court may consider these guidelines when hearing advertising offences against section 133 of the National Law.

4 What must I do?

All advertisers of regulated health services must comply with:

- the National Law, including:
  - the advertising requirements under section 133
  - title and practice protection provisions under sections 113–120, and
  - all other applicable legislation, such as the Australian Consumer Law.

4.1 Other laws regulating advertising

Advertising of regulated health services often involves the advertising of products and/or therapeutic goods and you must take care that you comply with all relevant legislation. Australian regulators such as the Australian Competition and Consumer Commission (ACCC) and the Therapeutic Goods Administration (TGA) have a responsibility for laws governing the advertising of health products and services. More information about this is included in Appendixes 2, 3 and 4.

If a complaint about an advertisement may be of interest to another Australian regulatory authority such as the TGA or ACCC, AHPRA may refer the matter to the most appropriate regulator.

4.2 Additional obligations for advertisers who are registered health practitioners

You should read these guidelines with other codes and guidelines published by the National Boards that convey their expected standards of professional conduct for each regulated profession. Each National Board has published a *Code of conduct for registered health practitioners,* or similar document. You have a professional responsibility to be familiar with, and apply, this code. It describes the professional standards expected of practitioners, including when advertising.

5 What happens if advertising breaches the National Law?

A breach of advertising requirements is a criminal offence. A court may impose a penalty up to $5,000 for an individual and $10,000 for a body corporate.

Complaints about possible breaches of the National Law and these guidelines should be reported to AHPRA. Information about how to do this is available on the AHPRA website.[2]

2 Go to www.ahpra.gov.au and follow the *Make a notification* link.

If you are a current or previously registered health practitioner, you may also be subject to disciplinary action under Part 8 of the National Law (which relates to health, performance and conduct) for unprofessional conduct (described as 'unsatisfactory professional conduct' in NSW) in relation to advertising. One of the grounds for a voluntary notification is that the health practitioner has, or may have, contravened the National Law (see section 144).

The options available to the Boards/AHPRA if advertising breaches the National Law are summarised at Appendix 7.

6 What are the advertising provisions of the National Law?

The wording of section 133 is broad and it is not possible to provide an exhaustive list of advertising that will, or will not, breach the National Law. However, this section provides general guidance on the advertising requirements of the National Law.

6.1 Use of factual information in advertising

Factual information in advertisements, as described below, may help health consumers to make informed choices.

You should ask yourself whether your advertising is verifiable and meets the requirements of the National Law.

Information commonly included in health services advertising[3]

- Office details
  - contact details
  - office hours, availability of after-hours services
  - accessibility (such as wheelchair access)
  - languages spoken (this does not affect other guidance provided by the National Board about use of qualified interpreters where appropriate)
  - emergency contact details
- Fees
  - a statement about fees charged (price information must be exact), bulk-billing arrangements, or other insurance plan arrangements and instalment fee plans regularly accepted
- Qualifications and experience
  - a statement of the names of schools and training programs from which the practitioner has graduated and the qualifications received, subject to the advice in Section 6.2 of these guidelines on advertising of qualifications and memberships
  - whether the practitioners have specialist registration or endorsement under the National Law and their area of specialty or endorsement
  - what positions, currently or in the past, the practitioners have held, together with relevant dates
  - whether the practitioner is accredited by a public board or agency, including any affiliations with hospitals or clinics
  - whether the practice is accredited and by whom
- For any surgical and/or invasive procedures, the appropriate warning statement in a clearly visible position[4]
- Photos or drawings of the practitioner or their office
- Any statement providing public health information that helps consumers to improve their health (this information should be based on reputable evidence wherever possible)

3 The list is not intended to be exhaustive.

4 Note that some National Boards may provide specific guidance on the use of warning statements for surgical and invasive procedures. See Appendix 6.

6.2 Prohibited advertising under the National Law

Section 133 of the National Law prohibits advertising that:

- is false, misleading or deceptive or is likely to be so
- offers a gift, discount or other inducement to attract a user of the health service without stating the terms and conditions of the offer
- uses testimonials or purported testimonials
- creates an unreasonable expectation of beneficial treatment, and/or
- encourages the indiscriminate or unnecessary use of health services.

The sections below explain each part of section 133.

6.2.1 Misleading or deceptive advertising

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    a) *Is false, misleading or deceptive or is likely to be misleading or deceptive*

A common meaning of 'mislead or deceive' is 'lead into error'. The courts have considered the phrase 'mislead or deceive'. People who are misled are almost by definition deceived as well. Misleading someone may include lying to them, leading them to a wrong conclusion, creating a false impression, leaving out (or hiding) important information, and/or making false or inaccurate claims.

As the ACCC explains, 'Patients can be physically, psychologically or financially affected by misleading conduct, and these effects can be long lasting. It is essential that patients be given honest, accurate and complete information in a form they can understand.'[5]

Examples of advertising that may be false or misleading include those that:

- mislead, either directly, or by implication, use of emphasis, comparison, contrast or omission
- only provide partial information which could be misleading
- use phrases like 'as low as' or 'lowest prices', or similar words or phrases when advertising fees for services, prices for products or price information in a way which is misleading or deceptive
- imply that the regulated health services can be a substitute for public health vaccination or immunisation
- use words, letters or titles that may mislead or deceive a health consumer into thinking that the provider of a regulated health service is more qualified or more competent than a holder of the same registration category (e.g. 'specialising in XX' when there is no specialist registration category for that profession)
- advertise the health benefits of a regulated health service when there is no proof that such benefits can be attained[6], and/or
- compare different regulated health professions or practitioners, in the same profession or across professions, in a way that may mislead or deceive.

Using comparative advertising often risks misleading and/or deceiving the public because it can be difficult to include complete information when comparing one health service with another.

The ACCC has provided tips on how to avoid being misleading and deceptive when advertising. They may be useful for advertisers considering the requirements of the National Law:

- *Sell your professional services on their merits.*
- *Be honest about what you say and do commercially.*
- *Look at the overall impression of your advertisement. Ask yourself who the audience is and what the advertisement is likely to say or mean to them.*

5 www.accc.gov.au/business/professional-services/medical-professionals

6 Australian Competition and Consumer Commission, *Misleading and deceptive conduct*, www.accc.gov.au/consumers/misleading-claims-advertising/false-or-misleading-claims

- *Remember, at a minimum, that it is the viewpoint of a layperson with little or no knowledge of the professional service you are selling that should be considered.*[7]

More information about the meaning of 'mislead or deceive' is available on the ACCC website.[8]

6.2.2 Gifts and discounts

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

   b) *Offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer*

Any advertisement that offers gifts, prizes or free items must state the terms and conditions of the offer. The use of unclear, unreadable or misleading terms and conditions attached to gifts, discounts and other inducements would not meet this requirement.

Consumers generally consider the word 'free' to mean absolutely free. When the costs of a 'free offer' are recouped through a price rise elsewhere, the offer is not actually free.

An example is an advertisement which offers 'make one consultation appointment, get one free', but raises the price of the first consultation to largely cover the cost of the second (free) appointment. This type of advertising could also be misleading or deceptive.

The terms and conditions should be in plain English, readily understandable, accurate and not in themselves misleading about the conditions and limitations of the offered service.

Advertising may contravene the National Law when it:

- contains price information that is inexact
- contains price information that does not specify any terms and conditions or variables to an advertised price, or that could be considered misleading or deceptive
- states an instalment amount without stating the total cost (which is a condition of the offer), and/or
- does not state the terms and conditions of offers of gifts, discounts or other inducements.

6.2.3 Testimonials

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

   c) *Uses testimonials or purported testimonials about the service or business*

The National Law does not define 'testimonial', so the word has its ordinary meaning of a positive statement about a person or thing. In the context of the National Law, a testimonial includes recommendations, or statements about the quality of a regulated health service including clinical care, personal experiences of a regulated health service or about the benefits of a particular practitioner or regulated health service by someone who received the service.

Testimonials can distort a person's judgement in their choice of health practitioner. They may misrepresent the skills and or expertise of practitioners and create unrealistic expectations of the benefits such practitioners may offer health consumers. Testimonials in advertising include:

1. using or quoting testimonials on a website, such as patients posting comments about a practitioner on the practitioner's business website, particularly when the website encourages patients to post comments and/or selectively publishes patient comments, and/or

2. the use of patient stories to promote a practitioner or regulated health service.

There are a number of independent websites that invite public feedback/reviews about a patient's experience of a regulated health practitioner, business

7 Australian Competition and Consumer Commission, *Professions and the Competition and Consumer Act, 2011*, www.accc.gov.au/content/index.phtml/tag/professions

8 www.accc.gov.au/business/advertising-promoting-your-business/false-or-misleading-claims

and/or service. These websites are designed to help consumers make more informed decisions and increase transparency of interactions.

A review is not considered to be a testimonial or purported testimonial, in breach of section 133 (1)(c) of the National Law when it only comments on non-clinical issues, regardless of whether it is positive, negative or neutral.

Reviews must not contain statements about the quality of clinical care received from the regulated health practitioner, business and/or service.

A practitioner must take reasonable steps to have any testimonials associated with their health service or business removed when they become aware of them, even if they appear on a website that is not directly associated and/or under the direct control or administration of that health practitioner and/or their business or service. This includes unsolicited testimonials.

'Reasonable steps' include taking action in the practitioner's power, such as directly removing, or requesting removal, of the testimonials. For example, a review on a social media site that states 'Appointment ran very late and magazines were old', is not considered a testimonial as it makes no reference to the clinical care provided by a regulated health practitioner, business or service. However, a review on the same social media site that states 'Practitioner was quick to diagnose my illness and gave excellent treatment', is a testimonial which references clinical care and is considered in breach of the National Law.

Once the practitioner becomes aware of the testimonial, they must take reasonable steps to have the testimonial removed (also refer to Section 7.1 on social media).

6.2.4 Unreasonable expectation of beneficial treatment

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

    d) *Creates an unreasonable expectation of beneficial treatment*

This can arise when advertisers take advantage of the vulnerability of health consumers in their search for a cure or remedy. The claims of beneficial treatment can range from unsubstantiated scientific claims, through to miracle cures. Advertising of treatments or services must not encourage or promote unreasonable expectations.

For example, advertising may contravene the National Law when it:

- creates an unreasonable expectation (such as by exaggerating or by providing incomplete or biased information) of recovery time after providing a regulated health service
- fails to disclose the health risks associated with a treatment
- omits the necessary warning statement about a surgical or invasive procedure[9]
- contains any inappropriate or unnecessary information or material that is likely to make a person believe their health or wellbeing may suffer from not taking or undertaking the health service, and/or
- contains a claim, statement or implication that is likely to create an unreasonable expectation of beneficial treatment by:
    - either expressly, or by omission, indicating that the treatment is infallible, unfailing, magical, miraculous or a certain, guaranteed or sure cure, and/or

9 Note that some National Boards may provide specific guidance on the use of warning statements for surgical and invasive procedures. See Appendix 6.

- a practitioner has an exclusive or unique skill or remedy, or that a product is 'exclusive' or contains a 'secret ingredient' that will benefit the patient.

6.2.5 Encouraging indiscriminate or unnecessary use of health services

Section 133 of the National Law states:

1. *A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that–*

   e) *Directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services*

The unnecessary and indiscriminate use of regulated health services is not in the public interest and may lead to the public purchasing or undergoing a regulated health service that they do not need or require.

Advertising may contravene the National Law when it:

- encourages a person to improve their physical appearance together with the use of phrases such as 'don't delay', 'achieve the look you want' and 'looking better and feeling more confident'
- provides a patient or client with an unsolicited appointment time
- uses prizes, bonuses, bulk purchases, bulk discounts or other endorsements to encourage the unnecessary consumption of health services that are unrelated to clinical need or therapeutic benefit
- uses promotional techniques that are likely to encourage consumers to use health services regardless of clinical need or therapeutic benefit, such as offers or discounts, online/internet deals, vouchers, and/or coupons, and/or
- makes use of time-limited offers which influence a consumer to make decisions under the pressure of time and money rather than about their health care needs. An offer is considered time-limited if it is made to purchase for a limited or specific period of time, or available for use within a limited period of time or by a specific date, without an option to exit the arrangement.

7 Further information about specific types of advertising

These guidelines cover all types of advertising, including social media, blogs and websites. The following sections discuss some aspects of advertising in more detail, to provide further guidance to practitioners.

7.1 Social media

The National Law prohibits advertising in any way that uses testimonials or purported testimonials. Testimonials, or comments that may amount to testimonials, made on social media sites by patients or other people may contravene the National Law (refer to Section 6.2.3 of these guidelines for more information on testimonials).

Social media includes work-related and personal pages on social networks such as Facebook, LinkedIn and Twitter.

A person is responsible for content on their social networking pages even if they were not responsible for the initial publication of the information or testimonial. This is because a person responsible for a social networking account accepts responsibility for any comment published on it, once alerted to the comment. Practitioners with social networking accounts should carefully review content regularly to make sure that all material complies with their obligations under the National Law.

These guidelines should be read in conjunction with the *Social media policy*, published on National Boards' websites.

7.2 Advertising qualifications or memberships

Advertising qualifications or memberships may be a useful way to provide the public with information about the experience and expertise of health practitioners. However, it may be misleading or deceptive if the advertisement implies that the practitioner has more skill or experience than is the case.

Including professional qualifications in an advertisement that also promotes the use or supply of therapeutic goods may be interpreted as a professional endorsement. Professional endorsements of therapeutic goods are prohibited under the *Therapeutic goods advertising code 2007.*

Patients or clients are best protected when advertisers promote practitioners' qualifications that are:

- approved for the purposes of registration, including specialist registration and endorsement of registration
- conferred by approved higher education providers[10], or
- conferred by an education provider that has been accredited by an accreditation authority.

A list of accreditation authorities and approved qualifications for each health profession is available on the relevant National Board's website.

10 Within the meaning of the *Higher Education Support Act 2003* (Cth).

Helpful questions to consider

Practitioners who are considering the use of titles, words or letters to identify and distinguish themselves in advertising, other than those professional titles protected under the National Law for their profession, are encouraged to ask themselves the following questions:

- Is it appropriate for me to use this title, qualification, membership, words or letters in advertising material?
- Am I skilled in the services I am advertising?
- If I display or promote my qualifications in advertising materials, is it easy to understand?
- Is there any risk of people being misled or deceived by the words, letters or titles that I use?
- Is the basis for my use of title, qualification, membership, or other words or letters:
  - relevant to my practice
  - current
  - verifiable, and
  - credible?

7.3 Use of titles in advertising

The National Law regulates the use of certain titles. Misuse of a protected title is an offence under the National Law. The misuse of titles in advertising may also contravene other sections of the National Law related to title protection (please refer to Appendix 5(a)). For specific guidance on use of titles in the psychology and physiotherapy professions, please refer to Appendix 5(b).

Advertisers should be aware of the protected titles for the profession that they are advertising.[11]

There is no provision in the National Law that prohibits

11 Refer to the relevant National Board website for a list of the endorsements and recognised specialties for that profession.

a practitioner from using titles such as 'doctor' but there is potential to mislead or deceive if the title is not applied clearly. If practitioners choose to adopt the title 'Dr' in their advertising and they are not registered medical practitioners, then (whether or not they hold a Doctorate degree or PhD) they should clearly state their profession.

Advertisers should avoid developing abbreviations of protected titles as these may mislead the public (e.g. 'pod', 'psych', 'RN'). It may also be misleading to use symbols, words or descriptions associated with titles.

Clarity may be achieved by including a reference to their health profession whenever the title is used, such as:

- Dr Isobel Jones (Dentist), and
- Dr Walter Lin (Chiropractor).

7.4 Advertising specialties and endorsements

The National Law allows for and protects specialist titles and endorsements (an endorsement on a practitioner's registration indicates that the practitioner is qualified to engage, for example, in a wider scope of practice than other registrants).

A registered health practitioner who does not hold specialist registration may not use the title 'specialist', or through advertising or other means, present themselves to the public as holding specialist registration in a health profession.

The National Law prohibits claims of:

- holding a type of registration, including specialist registration, or endorsement of registration not held, and/or
- being qualified to hold an endorsement they do not hold.

While the National Law protects specific titles, use of some words (such as 'specialises in') may be misleading or deceptive as patients or clients can interpret the advertisements as implying that the practitioner is more skilled or has greater experience than is the case.

These words should be used with caution and need to be supported by fact. Words such as 'substantial experience in' or 'working primarily in' are less likely to be misunderstood as a reference to endorsement or specialist registration.

A registered health practitioner who does not hold an endorsement may not, through advertising or other means, present themselves to the public as holding such an endorsement (such as using professional titles that are associated with an approved area of practice endorsement).

A list of health professions with approved specialties, endorsements, including endorsements for scheduled medicines and area of practice endorsements, is available on the websites of the relevant National Board. These websites also explain the titles that a registered health practitioner with an area of practice endorsement may use.

7.5 Advertising price information

Any information about the price of procedures in advertising of regulated health services must be clear and not misleading.

It is often difficult to provide an accurate price for a regulated health service in an advertisement due to the individual nature of services and the number of variables involved in the treatment. If fees and price information are to be advertised, then price information should be clear, with all costs involved and out of pocket expenses clearly identifiable, and any conditions or other variables to an advertised price or fee disclosed. This is to avoid misleading consumers and ensure they are fully informed and able to provide their full consent about health services.

Use of phrases like 'as low as' or 'lowest prices', or similar words, phrases or questions when advertising fees for services, prices for products or price information, or stating an instalment amount without stating the total cost may be misleading and could contravene the advertising provisions of the National Law.

7.6 Use of scientific information in advertising

To not mislead or create false impressions, caution should be taken when using scientific information in advertising.

When a practitioner chooses to include scientific information in advertising, the information should:

- be presented in a manner that is accurate, balanced and not misleading
- use terminology that is understood readily by the target audience
- identify clearly the relevant researchers, sponsors and the academic publication in which the results appear, and
- be from a reputable (e.g. peer reviewed) and verifiable source.

7.7 Advertising therapeutic goods

The Therapeutic Goods Administration (TGA) is responsible for regulating therapeutic goods including medicines, medical devices, biologicals, blood and blood products.

If the advertising only comprises pricing for prescription-only (Schedule 4 and 8) and certain pharmacist-only (Schedule 3 of the Poisons Standard) medicines, then the advertisement must comply with the *Therapeutic Goods Act 1989,* Therapeutic Goods Regulations 1990, the *Therapeutic goods advertising code 2007* and the *Price information code of practice*. A list of practitioners permitted to advertise price information for certain Schedule 3, Schedule 4 and Schedule 8 medicines is included in the *Price information code of practice*, available via the TGA website: www.tga.gov.au.

If the advertising promotes one or more therapeutic goods (under the *Therapeutic Goods Act 1989*), then the advertising must comply with the *Therapeutic Goods Act 1989*, Therapeutic Goods Regulations 1990, the *Therapeutic goods advertising code 2007* and, where relevant, the *Price information code of practice*.

Advertisers should note the definition of 'advertisement' in the *Therapeutic Goods Act 1989*.

See Appendix 4 for more information about advertising therapeutic goods.

8 Definitions

A list of definitions is included in Appendix 1.

Restrictions on advertising are included in other legislation. Advertisers should note that definitions in other legislation may be different to the definitions in these guidelines and should refer to the relevant definitions to ensure they comply with all relevant legislation.

Associated legislation and agencies are listed at Appendix 2.

9 Associated documents

These guidelines should be read in conjunction with codes and guidelines published by National Boards that describe the standards of professional practice expected by National Boards.

Review

Date of issue: 17 March 2014

Date of review: These guidelines will be reviewed from time to time as required. This will generally be at least every three years.

Appendix 1 Definitions

Advertiser

Any person or business that advertises a regulated health service.

Advertising

For the purpose of the guidelines, advertising includes but is not limited to all forms of printed and electronic media that promotes a regulated health service and includes any public communication using:

- television
- radio
- motion pictures
- newspapers
- billboards
- books
- public and professional lists
- pictorial representations
- designs
- mobile communications or other displays
- internet
- social media
- all electronic media that promote a regulated health service
- business cards, announcement cards
- office signs
- letterhead
- public and professional directory listings, and
- any other similar professional notice (e.g. patient recall notices).

Advertising also includes situations in which practitioners make themselves available or provide information for media reports, magazine articles or advertorials, including when practitioners make comment or provide information about particular products or services, or particular practitioners for the purposes of promoting or advertising a regulated health service.

This definition *excludes* material:

- issued to patients or clients during consultations when this material is designed to provide the person with clinical or technical information about health conditions or procedures, and when the person is given adequate opportunity to discuss and ask questions about the material. The information should not refer to services by the practitioner that could be interpreted as promoting that practitioner's services, as opposed to providing general information to the patient or client about a procedure or practice
- issued by a person or organisation for the purpose of public health information, or as part of a public health program or to health promotion activities (e.g. free diabetes screening, which confer no promotional benefits on the practitioners involved), and
- tenders, tender process, competitive business quotations and proposals, and the use of references about non-health services in those processes, provided the relevant material is not made available to the general public or used for promotional purposes (such as being published on a website).

The definition of 'advertising' and 'advertisement' may be different in other legislation. These definitions should be taken into account when considering compliance with that legislation. In particular the definition of 'advertisement' in the *Therapeutic Goods Act 1989* should be noted.

AHPRA

AHPRA is the abbreviation for the Australian Health Practitioner Regulation Agency. AHPRA's operations are governed by the National Law (defined below), which came into effect on 1 July 2010. AHPRA supports the 14 National Boards that are responsible for regulating the health professions. The primary role of

the National Boards is to protect the public and they set standards and policies that all registered health practitioners must meet.

Health practitioner

A health practitioner means an individual who practises a health profession.

Health service

A health service includes the following services, whether provided as public or private services:

1. services provided by registered health practitioners
2. hospital services
3. mental health services
4. pharmaceutical services
5. ambulance services
6. community health services
7. health education services
8. welfare services necessary to implement any services referred to in 1 to 7 above
9. services provided by dieticians, masseurs, naturopaths, social workers, speech pathologists, audiologists or audiometrists, and
10. pathology services.

Also refer to the definition of regulated health service.

Invasive procedure

For the purposes of these guidelines, invasive procedure means any operation or other procedure that:

1. penetrates or pierces the skin by any instrument other than a needle, other than minor dental or minor podiatric procedures, or
2. is an elective procedure requiring more than local anaesthetic or sedation, or
3. requires admission to a day procedure centre (DPC) or hospital, or
4. involves significant risk associated with surgical and/or anaesthetic complications.

National Board

National Board means a National Health Practitioner Board established by section 31 of the National Law.

National Law

The 'National Law' means the Health Practitioner Regulation National Law, as in force in each state and territory.

Person

A person includes an individual or a body politic or corporate.

Purported testimonial

A purported testimonial is a statement or representation that appears to be a testimonial.

Product

For the purpose of these guidelines, a 'product' is a therapeutic good within the meaning of the *Therapeutic Goods Act 1989* (Cth) and does not apply to the advertising of other products that are not associated with the provision of regulated health services.

Regulated health service

Means a service provided by, or usually provided by, a health practitioner (as defined in the National Law).

Social media

'Social media' describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips and includes websites and applications used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), WOMO, True Local and microblogs such as Twitter, content sharing websites such as YouTube and Instagram, and discussion forums and message boards.

Appendix 2
Associated legislation and agencies

Legislation	Responsible agency	Further information
Australian Consumer Law	Australian Competition and Consumer Commission (ACCC) and relevant state and territory consumer protection departments and agencies	www.accc.gov.au
• *Therapeutic Goods Act 1989* (Cth) • Therapeutic Goods Regulations 1990 • *Therapeutic goods advertising code 2007* • *Price information code of practice*	Department of Health and Ageing–Therapeutic Goods Administration	www.tga.gov.au
Poisons Standard (Standard for the Uniform Scheduling of Medicines and Poisons)	Department of Health and Ageing–Therapeutic Goods Administration	www.tga.gov.au

Legislation	Responsible agency	Further information
Drugs and poisons legislation	Agencies in each Australian state and territory	**Queensland**: Health (Drugs and Poisons) Regulation 1996, www.legislation.qld.gov.au/OQPChome.htm **New South Wales**: *Poisons and Therapeutic Goods Act 1966*, Poisons and Therapeutic Goods Regulation 2008, www.legislation.nsw.gov.au **Victoria:** *Drugs, Poisons and Controlled Substances Act 1981*, Drugs, Poisons and Controlled Substances Regulations 2006, www.legislation.vic.gov.au/ **Tasmania**: *Poisons Act 1971*, www.thelaw.tas.gov.au **ACT:** *Medicines, Poisons and Therapeutic Goods Act 2008*, Medicines, Poisons and Therapeutic Goods Regulation 2008, www.legislation.act.gov.au **South Australia:** *Controlled Substances Act 1984*, Controlled Substances (Poisons) Regulations 2011, www.legislation.sa.gov.au **Western Australia:** *Poisons Act 1964*, Poisons Regulations 1965 www.slp.wa.gov.au/legislation/statutes.nsf/default.html **Northern Territory:** *Poisons & Dangerous Drugs Act*, www.dcm.nt.gov.au/strong_service_delivery/supporting_government/current_northern_territory_legislation_database
Privacy Act 1988	National Health Practitioner Ombudsman and Privacy Commissioner	www.nhpopc.gov.au/

Appendix 3
The Australian Consumer Law

In addition to complying with these guidelines, regulated health services need to comply with the Australian Consumer Law (ACL) which commenced on 1 January 2011. The ACL harmonised the consumer protection provisions in the *Trade Practices Act 1974* (TPA) and in state and territory fair trading laws, and replaced consumer protection provisions in at least 20 different Commonwealth, state and territory laws with one law.

The ACL is a national law that applies in the same way to all sectors and in all Australian jurisdictions. This means that all consumers in Australia enjoy the same rights and all businesses have the same obligations, irrespective of which state or territory they engaged in transactions.

The ACL covers general standards of business conduct, prohibits unfair trading practices, regulates specific types of business-to-consumer transactions, provides basic consumer guarantees for goods and services and regulates the safety of consumer products and product-related services.

The ACL is located in Schedule 2 of the *Competition and Consumer Act 2010* (Cth).

The ACL includes:

- a national unfair contract terms law covering standard form consumer contracts
- a national law guaranteeing consumer rights when buying goods and services
- a national product safety law and enforcement system
- a national law for unsolicited consumer agreements covering door-to-door sales and telephone sales
- simple national rules for lay-by agreements, and
- new penalties, enforcement powers and consumer redress options.

The ACL applies nationally and in all states and territories, and to all Australian businesses. For transactions that occurred before 1 January 2011, the previous national, state and territory consumer laws continue to apply.

The ACL is administered and enforced jointly by the Australian Competition and Consumer Commission and the state and territory consumer protection agencies, with the involvement of the Australian Securities and Investments Commission for financial services matters.

Advertisements must comply with all requirements of the ACL in addition to compliance with these guidelines.

Appendix 4
Advertising therapeutic goods

As stated, compliance with these guidelines does not exempt advertisements for regulated health services from the need to comply with other applicable laws. This includes legislation administered by the Therapeutic Goods Administration (TGA).

The TGA is part of the Australian Government Department of Health and Ageing, and is responsible for regulating therapeutic goods including medicines, medical devices, biological, blood and blood products.

Certain advertisements directed at consumers require approval before broadcast or publication.

The advertising of therapeutic goods to consumers and health practitioners is controlled respectively by statutory measures administered by the TGA and self-regulation through codes of practice administered by the relevant therapeutic goods industry associations. Certain advertisements directed to consumers require approval before being broadcast or published.

Advertisements for therapeutic goods in Australia are subject to the requirements of the *Therapeutic Goods Act 1989*, Therapeutic Goods Regulations 1990, the *Therapeutic goods advertising code* and the *Price information code of practice* (collectively the 'therapeutic goods legislation') and other relevant laws including the *Competition and Consumer Act 2010.*

Health practitioners should note the definition of 'advertisement' in the *Therapeutic Goods Act 1989* when considering their compliance with the therapeutic goods legislation. Implicit and explicit references to specific therapeutic products as well as more generic references may fall within the meaning of 'advertisement'.

In general, the advertising to the public of 'prescription medicines' (Schedule 4) or 'controlled drugs' (Schedule 8) and certain 'pharmacist-only medicines' (Schedule 3 of the Poisons Standard) is prohibited by the therapeutic goods legislation. Exceptions to this are set out in the therapeutic goods legislation.

The purpose of these requirements is to protect public health by promoting the safe use of therapeutic goods and ensuring that they are honestly promoted as to their benefits, uses and effects. Controls are placed on the advertising of therapeutic goods (medicines and medical devices) to ensure advertisements are socially responsible, truthful, appropriate and not misleading.

Further information on Australia's advertising regulation for therapeutic goods, including details of the Complaints Resolution Panel (TGACRP) and the Complaints register, may be obtained from the TGACC website and the TGACRP website.

This includes:

- advertising to consumers
- advertising prescription medications to health practitioners (including *Best practice guideline on prescription medicine labelling)*
- advertising medical services that include Schedule 4 (prescription) substances
- *Price information code of practice*, and
- the application and approval process for advertising of therapeutic goods.

Those intending to advertise therapeutic goods are advised to familiarise themselves with the requirements of the therapeutic goods legislation in addition to any requirements under the National Law and in these guidelines.

Appendix 5
Title protection

A5(a) Summary of relevant sections of the National Law

Sections 113–119 describe the title and practice protections under the National Law including the penalties for offences by individuals and bodies corporate.

Section 113 provides that a person cannot knowingly or recklessly take or use a protected title found in the table of that section or a prescribed title for a health profession which would induce a belief that the person is registered in that profession.

Section 115 provides that a person cannot knowingly or recklessly take or use the titles, 'dental specialist', 'medical specialist' or 'a specialist title for a recognised specialty' unless the person is registered under that specialty.

Section 116 provides that a person who is not a registered health practitioner must not knowingly or recklessly (i) take or use the title 'registered health practitioner' or claim to be so registered or (ii) take or use a title, name, initial, symbol, word or description to indicate the person is a health practitioner or claim to be a health practitioner or (iii) indicate the person is authorised or qualified to practise as a health practitioner.

Section 117 provides that a person must not knowingly or recklessly claim or hold him or herself out to be registered or qualified to practise in a health profession or a division of a health profession if the person is not so registered. Section 117 also provides that a person cannot use or take a title which would induce a belief that such a person is so registered.

Section 118 provides that a person who is not a specialist health practitioner must not knowingly or recklessly take or use the title 'specialist health practitioner'. Further a person must not use a title, name, symbol, word or description that would induce a belief that a person is or is authorised or qualified as a specialist health practitioner. Further the person must not claim or hold out to be registered in a recognised specialty or claim to be qualified to practise as a specialist health practitioner.

Section 119 provides that a person must not knowingly or recklessly make claims about a type of registration, endorsement, or registration in a recognised specialty, that the person does not have. Further, a person must not knowingly or recklessly make claims about another person having a type of registration, endorsement, or registration in a specialty that the person does not have. These are called 'holding out' provisions.

Note: *the above is a summary only – please consult the National Law for more detail.*

A5(b) Board-specific advice on the use of titles in advertising

Some Boards have developed statements to assist in the use of titles by the practitioners of the specific profession.

Psychology Board of Australia

The Psychology Board of Australia advises registered psychologists that use of the title 'doctor' in their practice has the potential to mislead members of the public.

Specifically, the use of tiles may be misleading into believing that the practitioner is a psychiatrist when they are not. Therefore, registered psychologists may not use such a title unless they hold a doctoral qualification from an approved higher education provider or an overseas institution with an equivalent accreditation status.

Where a registered psychologist holds a doctoral qualification that meets the above, if they advertise their services to the public, they should make it clear when using the title 'doctor' that they are not a registered medical practitioner or psychiatrist, for example:

- Dr Vanessa Singh (Psychologist), and
- Dr Ivan Hassam (Doctor of Psychology).

Physiotherapy Board of Australia

The Physiotherapy Board of Australia recognises the established history of specialised physiotherapy practice achieved through recognised higher education through the Australian College of Physiotherapy. As such the Board considers that appropriate use of qualifications in advertising is acceptable when accompanied by wording that establishes those credentials.

For example: 'Mr P Smith, Specialist Musculoskeletal Physiotherapist (as awarded by the Australian College of Physiotherapists in 2008)'.

Appendix 6
Use of graphic or visual representations and warning statements for surgical or invasive procedures

A6(a) Use of graphic or visual representations

If a practitioner chooses to use any graphic or visual representations in health service advertising (including photographs of patients, clients or models; diagram; cartoons; or other images), they should be used with caution.

If photographs of people are used in advertising of treatments, use of a real patient or client who has actually undergone the advertised treatment by the advertising practitioner or practice, and who has provided written consent for publication of the photograph in the circumstances in which the photograph is used, is less likely to be misleading.

Practitioners should not use photographs of actual patients or clients if the patient or client is vulnerable as a result of the type of treatment involved, or if their ability to consent may be otherwise impaired.

Use of 'before and after' photographs in advertising of regulated health services has a significant potential to be misleading or deceptive, to convey to a member of the public inappropriately high expectations of a successful outcome and to encourage the unnecessary use of health services.

Use of 'before and after' photographs is less likely to be misleading if:

- the images are as similar as possible in content, camera angle, background, framing and exposure
- there is consistency in posture, clothing and make-up
- there is consistency in lighting and contrast
- there is an explanation if photographs have been altered in any way, and
- the referenced procedure is the only visible change that has occurred for the person being photographed.

The guidelines do not limit use of stock photographs and models other than in relation to the advertising of particular treatments, provided that the provisions of the National Law and these guidelines are otherwise met. However, practitioners should exercise caution due to the potential to mislead consumers.

A6(b) Use of warning statements for surgical or invasive procedures

Where a surgical (or 'an invasive') procedure is advertised directly to the public, the advertisement should include a clearly visible warning, with text along the following lines:

'Any surgical or invasive procedure carries risks. Before proceeding, you should seek a second opinion from an appropriately qualified health practitioner.'

If the text of any warning label is in smaller print than the main text or placed in an obscure position of an advertisement, the advertisement may contravene the National Law.

Appendix 7
Options available to the National Boards/AHPRA if advertising breaches the National Law

Who breached the National Law or guidelines	Options available to the Boards/AHPRA
• Registered health practitioners • Persons who are not currently registered but who have previously been registered as health practitioners	• Prosecute under the advertising provisions of the National Law in the relevant state or territory magistrates court, which may lead to a financial penalty • Take action under the National Law for unprofessional conduct (described as 'unsatisfactory professional conduct' in NSW) • Take action under the title protection provisions of the National Law, as relevant • Refer the matter to another regulator for investigation of a potential breach of other legislation • A person (see definition in Appendix 1) may also be disciplined under the National Law as a result of action taken under other legislation. This can occur regardless of whether or not they are prosecuted under the National Law or any other legislation
• Persons who are not registered health practitioners • Bodies corporate	• Prosecute under the advertising provisions of the National Law in the relevant state or territory magistrates court, which may lead to a financial penalty • Take action under the National Law regarding the use of protected titles • Refer the matter to another regulator for investigation of a potential breach of other legislation

Guidelines for continuing professional development

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Introduction

The Aboriginal and Torres Strait Islander Health Practice Board of Australia (the Board) has developed these guidelines under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law[1]).

The purpose of these guidelines is to provide further information about continuing professional development (CPD) requirements outlined in the *Continuing professional development registration standard* (the Standard).

The guidelines:

- explain the activities that qualify as CPD, and
- provide information for Aboriginal and Torres Strait Islander health practitioners on how to establish and maintain appropriate records of CPD activities.

Who needs to use these guidelines?

The Standard applies to all Aboriginal and Torres Strait Islander health practitioners except students and those with non-practising registration.

Under the National Law, all Aboriginal and Torres Islander health practitioners must undertake CPD as a condition of registration. These guidelines should be used together with the Standard.

Background

The Aboriginal and Torres Strait Islander community has a right to expect that Aboriginal and Torres Strait Islander health practitioners will provide services in a competent and contemporary way, and meet best practice standards.

CPD is an interactive process to maintain and extend the practitioner's knowledge, expertise and competence throughout their career, vital in the provision of safe and effective health services.

All practitioners must become familiar with the following requirements outlined in the Standard.

1 The National Law is contained in the schedule to the Health Practitioner Regulation National Law Act 2009 (Qld).

1. Requirements

All CPD undertaken must be relevant to the profession.

As specified in the Standard:

(a) All practising Aboriginal and Torres Strait Islander health practitioners must complete a minimum of 10 hours of CPD per year and a minimum of 60 hours over three years towards maintaining and improving competence in their area of practice.

(b) The CPD activities claimed must be directed towards improving the practitioner's competence.

(c) Of the 60 hours over three years, at least 45 hours are required to be formal CPD activities. The remainder may consist of informal CPD activities.

(d) Your 60 CPD hours are in addition to your core requirement of completing a current first aid certificate which includes annual training in cardio pulmonary resuscitation.

(e) The standard will commence on 1 July 2012. Prior to 1 July 2015, practitioners will be required to complete a minimum of 10 CPD hours per year with a total of 60 CPD hours over a three year cycle. When a practitioner registers for the first time, or has his or her registration restored after it has lapsed, the number of CPD hours to be completed will be calculated on a pro rata basis.

(f) A CPD record must be kept to document details of activities completed over the past four years and must be available for audit by the Board.

(g) Practitioners will be required to sign a declaration of compliance with the CPD registration standard when renewing their registration each year.

(h) Periodic audits may be conducted to ensure that practitioners are compliant with this standard. If audited a practitioner must produce their CPD record as evidence.

1.1 Board monitoring of CPD

An Aboriginal and Torres Strait Islander health practitioner renewing their registration will be required to make a declaration stating that they have undertaken CPD throughout the period of registration as required by the Standard.

In line with its function to monitor the competence of Aboriginal and Torres Strait Islander health practitioners, the Board may conduct an annual audit of Aboriginal and Torres Strait Islander health practitioners registered in Australia.

The Board may randomly select a sample of practitioners and request in writing a copy of the practitioner's record of CPD activities, detailing formal and informal learning activities. Aboriginal and Torres Strait Islander health practitioners contacted will have to provide their documentation within the specified time.

The audit may cover any period after beginning of the National Registration and Accreditation Scheme (the National Scheme) but will not extend beyond three years.

2. Continuing professional development (CPD)

CPD is the maintenance, enhancement and extension of the knowledge, expertise and competence of health practitioners throughout their careers.

It is important to recognise that people learn in different ways and CPD may include formal and informal learning activities.

3. The importance of CPD

CPD can improve competence and result in better outcomes for patients and clients. CPD is important in the continued provision of safe and effective services by health professionals.

4. CPD learning activities

All learning activities which help Aboriginal and Torres Strait Islander health practitioners maintain competence will be accepted as CPD, as long as the practitioner completes a minimum of 45 hours of formal learning over a three year period.

CPD must also be made up of three different activities. For example, a total of 45 hours of formal learning cannot be achieved by attending conferences only. Examples of formal and informal learning activities include but are not limited to the following.

4.1 Formal learning activities

- Tertiary courses
- Accredited courses
- Conferences, forums and seminars
- Undertaking research and presentation of work
- Courses leading to a certificate, diploma, degree or higher degree
- Online learning (interactive discussion and chat rooms)
- In-service education programs

- Making presentations
- Videoconferencing

4.2 Non-formal and incidental learning activities

- Reflecting on experience in day-to-day activities
- Reading books, journals, etc.
- Secondment and/or contact with other health professionals
- Quality assurance activities, such as accreditation
- Participation in committees
- Information sharing at meetings
- Discussion with colleagues
- Internet research

5. Recording CPD

It is a requirement of the registration standard that Aboriginal and Torres Strait Islander health practitioners record their CPD activities. This record should include:

- a personal collection of evidence of ongoing development
- a record of informal and incidental learning (details of what you did and what you learnt)
- a record of attendance at formal learning activities, and
- important supporting documents.

If an Aboriginal and Torres Strait Islander health practitioner is required to provide the Board with evidence of CPD, their record of CPD activities will enable them to demonstrate that they have met the minimum CPD requirements.

6. Action by the Board

If the Board finds, through declaration or audit, that an Aboriginal and Torres Strait Islander health practitioner does not meet the CPD requirement, it will take appropriate action, which may include:

- requesting the practitioner to undertake further CPD or supervised practice, and/or
- imposing conditions on the practitioner's registration.

7. Definitions

An **Aboriginal and Torres Strait Islander health practitioner** is an individual registered by the Aboriginal and Torres Strait Islander Health Practice Board of Australia. The practitioner may use the titles:

- Aboriginal health practitioner
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Continuing professional development is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

Practice means any role, whether paid or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of these guidelines, practice is not restricted to the provision of direct clinical care. It also includes:

- working in a direct nonclinical relationship with clients
- working in management, administration, education, research, advisory, regulatory or policy development roles, andany other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Professional development activities means participation in formal learning activities, such as attendance at courses or conferences, as well as informal learning gained through experience and interaction with colleagues.

Appendices

Appendix 1: Continuing Professional Development Record of Activities

Attachments

Attachment A: Extract of relevant provisions from the Health Practitioner Regulation National Law Act 2009(QLD)

Date: 27 March 2012

Date of review: This guideline will be reviewed at least every three years

Last reviewed: 27 March 2012

Appendix 1
Continuing professional development record of activities

Continuing professional development (CPD)

CPD is a requirement of Aboriginal and Torres Strait Islander Health Practice Board of Australia registration. Every year when you renew your registration, you will be required to sign a declaration stating that you have undertaken sufficient CPD to maintain your competence throughout the past 12 months and that you commit to undertake sufficient CPD to maintain competence throughout the next 12 months. This record of activities gives an example of how to record your professional development plan and activities to meet the Board's requirements. All your CPD should be recorded. A minimum of 10 hours is required annually with a total of 60 hours over a three-year period.over a three year period.

Name:	Registration Period:

Development Plan

Goals	Outcomes

Formal Learning Activities

Date	Activity	Time	Provider	Learning outcome

Informal and Incidental Activities

Date	Activity	Time	Provider	Learning outcome

Attachment A
Extract of relevant provisions from the Health Practitioner Regulation National Law Act 2009 (Qld)

Division 3 Registration standards and codes and guidelines

Section 39 – Codes and guidelines

A National Board may develop and approve codes and guidelines—

(a) to provide guidance to the health practitioners it registers; and

(b) about other matters relevant to the exercise of its functions.

***Example.** A National Board may develop guidelines about the advertising of regulated health services by health practitioners registered by the Board or other persons for the purposes of Section 133.*

Section 40 – Consultation about registration standards, codes and guidelines

(1) If a National Board develops a registration standard or a code or guideline, it must ensure there is wide-ranging consultation about its content.

(2) A contravention of subsection (1) does not invalidate a registration standard, code or guideline.

(3) The following must be published on a National Board's website—

(a) a registration standard developed by the Board and approved by the Ministerial Council;

(b) a code or guideline approved by the National Board.

(4) An approved registration standard or a code or guideline takes effect—

(a) on the day it is published on the National Board's website; or

(b) if a later day is stated in the registration standard, code or guideline, on that day.

Section 41 – Use of registration standards, codes or guidelines in disciplinary proceedings

An approved registration standard for a health profession, or a code or guideline approved by a National Board, is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the health profession.

Specific provisions

Subdivision 3 Obligations of registered health practitioners and students

Section 128 – Continuing professional development

(1) A registered health practitioner must undertake the continuing professional development required by an approved registration standard for the health profession in which the practitioner is registered.

(2) A contravention of subsection (1) by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

*(3) In this section— **registered health practitioner** does not include a registered health practitioner who holds non-practising registration in the profession.*

Aboriginal and Torres Strait Islander Health Practice Board of Australia

AHPRA

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

National Board guidelines for registered health practitioners

GUIDELINES FOR **MANDATORY NOTIFICATIONS**

March 2014

ALLF1401 03 9987

MANDATORY NOTIFICATIONS GUIDELINES

About the National Boards and AHPRA

The 14 National Boards regulating registered health practitioners in Australia are responsible for registering practitioners and students (except for in psychology, which has provisional psychologists), setting the standards that practitioners must meet, and managing notifications (complaints) about the health, conduct or performance of practitioners.

The Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with the National Boards to implement the National Registration and Accreditation Scheme, under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The core role of the National Boards and AHPRA is to protect the public.

About these guidelines

These guidelines have been developed jointly by the National Boards under section 39 of the National Law. The guidelines are developed to provide direction to registered health practitioners, employers of practitioners and education providers about the requirements for mandatory notifications under the National Law.

The inclusion of mandatory notification requirements in the National Law is an important policy initiative for public protection.

The relevant sections of the National Law are attached.

Who needs to use these guidelines?

These guidelines are relevant to:

- health practitioners registered under the National Law
- employers of practitioners, and
- education providers.

Students who are registered in a health profession under the National Law should be familiar with these guidelines. Although the National Law does not require a student to make a mandatory notification, a notification can be made about an impaired student.

MANDATORY NOTIFICATIONS GUIDELINES

Contents

SUMMARY

These guidelines explain the requirements for registered health practitioners, employers of practitioners and education providers to make mandatory notifications under the National Law to prevent the public being placed at risk of harm.

The threshold to be met to trigger a mandatory notification in relation to a practitioner is high. The practitioner or employer must have first formed a reasonable belief that the behaviour constitutes notifiable conduct or a notifiable impairment or, in the case of an education provider, a notifiable impairment (see Section 3 for the definition of 'notifiable conduct' and Appendix A for the definition of 'impairment').

Making a mandatory notification is a serious step to prevent the public from being placed at risk of harm and should only be taken on sufficient grounds. The guidelines explain when these grounds are likely to arise.

Importantly, the obligation to make a mandatory notification applies to the conduct or impairment of all practitioners, not just those within the practitioner's own health profession.

These guidelines also address the role of the Australian Health Practitioner Regulation Agency (AHPRA) as the body for receiving notifications and referring them to the relevant National Board.

1 Introduction

The National Law requires practitioners, employers and education providers to report 'notifiable conduct', as defined in section 140 of the National Law, to AHPRA in order to prevent the public being placed at risk of harm.

These guidelines explain how the Boards will interpret these mandatory notification requirements. They will help practitioners, employers and education providers understand how to work with these requirements – that is, whether they must make a notification about a practitioner's conduct and when.

The threshold to be met to trigger the requirement to report notifiable conduct in relation to a practitioner is high and the practitioner or employer must have first formed a reasonable belief that the behaviour constitutes notifiable conduct.

The aim of the mandatory notification requirements is to prevent the public from being placed at risk of harm. The intention is that practitioners notify AHPRA if they believe that another practitioner has behaved in a way which presents a serious risk to the public. The requirements focus on serious instances of substandard practice or conduct by practitioners, or serious cases of impairment, that could place

members of the public at risk. For students, the requirements focus on serious cases of impairment of students.

That is, the requirements focus on behaviour that puts the public at risk of harm, rather than not liking the way someone else does something or feeling that they could do their job better.

Similarly, if the only risk is to the practitioner alone, and there is no risk to the public, the threshold for making a mandatory notification would not be reached. For example, in a case where the risk is clearly addressed by being appropriately managed through treatment and the practitioner is known to be fully compliant with that, mandatory notification would not be required. Conversely, a mandatory notification is required if the risk to the public is not mitigated by treatment of the practitioner or in some other way.

1.1 Voluntary notifications

The National Law also provides for voluntary notifications for behaviour that presents a risk but does not meet the threshold for notifiable conduct, or for notifications made by individuals who are not subject to the mandatory notification obligations such as patients or clients (see ss. 144 and 145 of the National Law).

1.2 Protection for people making a notification

The National Law protects practitioners, employers and education providers who make notifications in good faith under the National Law. 'Good faith' is not defined in the National Law so has its ordinary meaning of being well-intentioned or without malice. Section 237 provides protection from civil, criminal and administrative liability, including defamation, for people making notifications in good faith. The National Law clarifies that making a notification is not a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct.

These provisions protect practitioners making mandatory notifications from legal liability and reinforce that making mandatory notifications under the National Law is consistent with professional conduct and a practitioner's ethical responsibilities. Legally mandated notification requirements override privacy laws. Practitioners should be aware that if they make notifications that are frivolous, vexatious or not in good faith, they may be subject to conduct action.

2 General obligations

The obligation is on any practitioner or employer who forms a reasonable belief that another practitioner has engaged in notifiable conduct to make a report to AHPRA as soon as practicable. The definition of 'notifiable conduct' is set out in section 140 of the National Law (also refer to Section 3 of these guidelines for more information on notifiable conduct). In this context, the word 'practicable' has its ordinary meaning of 'feasible' or 'possible'.

The mandatory notification obligation applies to all practitioners and employers of practitioners in relation to the notifiable conduct of practitioners. The obligation applies to practitioners in all registered health professions, not just those in the same health profession as the practitioner. It also applies where the notifying practitioner is also the treating practitioner for a practitioner, except in Western Australia and Queensland in certain circumstances (see Section 4 *Exceptions to the requirement of practitioners to make a mandatory notification* of these guidelines for details).

There is also a mandatory obligation for education providers and practitioners to report a student with an impairment that may place the public at substantial risk of harm.

While the mandatory reporting provisions in the National Law are an important policy change, the duties covered in them are consistent with general ethical practice and professional obligations. In addition to their legal obligations with respect to mandatory reporting, practitioners are also under an ethical obligation to notify concerns about a practitioner, in accordance with the broad ethical framework set out in the health profession's code of conduct (see the *Code of conduct* and the voluntary reporting provisions of the National Law). More information about making

a voluntary notification is published on the National Boards' and AHPRA's websites.

There are some exceptions to the requirement for practitioners to notify AHPRA of notifiable conduct, which are discussed at Section 4 *Exceptions to the requirement of practitioners to make a mandatory notification.*

These guidelines do not affect other mandatory reporting requirements that may be established in separate legislation, for example requirements to report child abuse.

2.1 What is a reasonable belief?

For practitioners reporting notifiable conduct, a 'reasonable belief' must be formed in the course of practising the profession. The following principles are drawn from legal cases which have considered the meaning of reasonable belief.

1. A belief is a state of mind.
2. A reasonable belief is a belief based on reasonable grounds.
3. A belief is based on reasonable grounds when:
    i. all known considerations relevant to the formation of a belief are taken into account including matters of opinion, and
    ii. those known considerations are objectively assessed.
4. A just and fair judgement that reasonable grounds exist in support of a belief can be made when all known considerations are taken into account and objectively assessed.

A reasonable belief requires a stronger level of knowledge than a mere suspicion. Generally it would involve direct knowledge or observation of the behaviour which gives rise to the notification, or, in the case of an employer, it could also involve a report from a reliable source or sources. Mere speculation, rumours, gossip or innuendo are not enough to form a reasonable belief.

A reasonable belief has an objective element – that there are facts which could cause the belief in a reasonable person; and a subjective element – that the person making the notification actually has that belief.

A notification should be based on personal knowledge of facts or circumstances that are reasonably trustworthy and that would justify a person of average caution, acting in good faith, to believe that notifiable conduct has occurred or that a notifiable impairment exists. Conclusive proof is not needed. The professional background, experience and expertise of a practitioner, employer or education provider will also be relevant in forming a reasonable belief.

The most likely example of where a practitioner or employer would form a reasonable belief is where the person directly observes notifiable conduct, or, in relation to an education provider, observes the behaviour of an impaired student. When a practitioner is told about notifiable conduct that another practitioner or patient has directly experienced or observed, the person with most direct knowledge about the notifiable conduct should generally be encouraged to make a notification themselves.

2.2 What is 'the public'?

Several of the mandatory notification provisions refer to 'the public being placed at risk of harm'. In the context of notifications, 'the public' can be interpreted as persons that access the practitioner's regulated health services or the wider community which could potentially have been placed at risk of harm by the practitioner's services.

3 Notifiable conduct

Section 140 of the National Law defines 'notifiable conduct' as when a practitioner has:

a) practised the practitioner's profession while intoxicated by alcohol or drugs; or

b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or

c) *placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or*

d) *placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.*

The following sections of the guidelines discuss these types of notifiable conduct, followed by the exceptions. The guidelines are only examples of decision-making processes, so practitioners, employers and education providers should check the exceptions to make sure they do not apply.

If a practitioner engages in more than one type of notifiable conduct, each type is required to be notified.

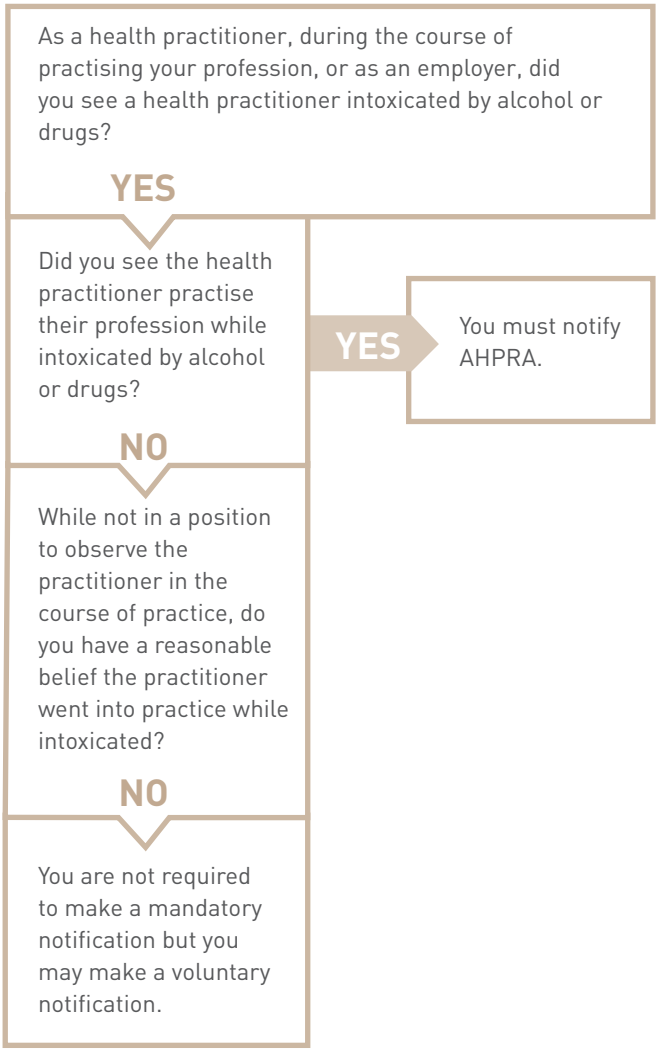
3.1 Practise while intoxicated by alcohol or drugs (section 140(a))

The requirement to make a mandatory notification is triggered by a practitioner practising their profession while intoxicated by alcohol or drugs. The word 'intoxicated' is not defined in the National Law, so the word has its ordinary meaning of 'under the influence of alcohol or drugs'.

The Boards will consider a practitioner to be intoxicated where their capacity to exercise reasonable care and skill in the practice of the health profession is impaired or adversely affected as a result of being under the influence of drugs or alcohol. The key issue is that the practitioner has practised while intoxicated, regardless of the time that the drugs or alcohol were consumed.

The National Law does not require mandatory notification of a practitioner who is intoxicated when they are not practising their health profession (that is, in their private life), unless the intoxication triggers another ground for mandatory notification.

3.2 Decision guide – notifying intoxication



3.3

3.4 Sexual misconduct in connection with the practice of the practitioner's profession (section 140(b))

Section 140(b) relates to sexual misconduct in connection with the practice of the practitioner's health profession; that is, in relation to persons under the practitioner's care or linked to the practitioner's practice of their health profession.

Engaging in sexual activity with a current patient or client will constitute sexual misconduct in connection with the practice of the practitioner's health profession, regardless of whether the patient or client consented to the activity or not. This is because of the power imbalance between practitioners and their patients or clients.

Sexual misconduct also includes making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient or client. Engaging in sexual activity with a person who is closely related to a patient or client under the practitioner's care may also constitute misconduct. In some cases, someone who is closely related to a patient or client may also be considered a patient or client, for example the parent of a child patient or client.

Engaging in sexual activity with a person formerly under a practitioner's care (i.e. after the termination of the practitioner–patient/client relationship) may also constitute sexual misconduct. Relevant factors will include the cultural context, the vulnerability of the patient or client due to issues such as age, capacity and/or health conditions; the extent of the professional relationship; for example, a one-off treatment in an emergency department compared to a long-term program of treatment; and the length of time since the practitioner–patient/client relationship ceased.

3.5 Decision guide – notifying sexual misconduct

As a practitioner, during the course of practising your health profession, or as an employer, do you reasonably believe that another practitioner has engaged in sexual misconduct, e.g. (a) sexual activity with a person under the practitioner's care or (b) sexual activity with a person previously under the practitioner's care where circumstances such as the vulnerability of the patient or client results in misconduct?

NO	YES
You are not required to make a mandatory notification but you may make a voluntary notification.	You must notify AHPRA.

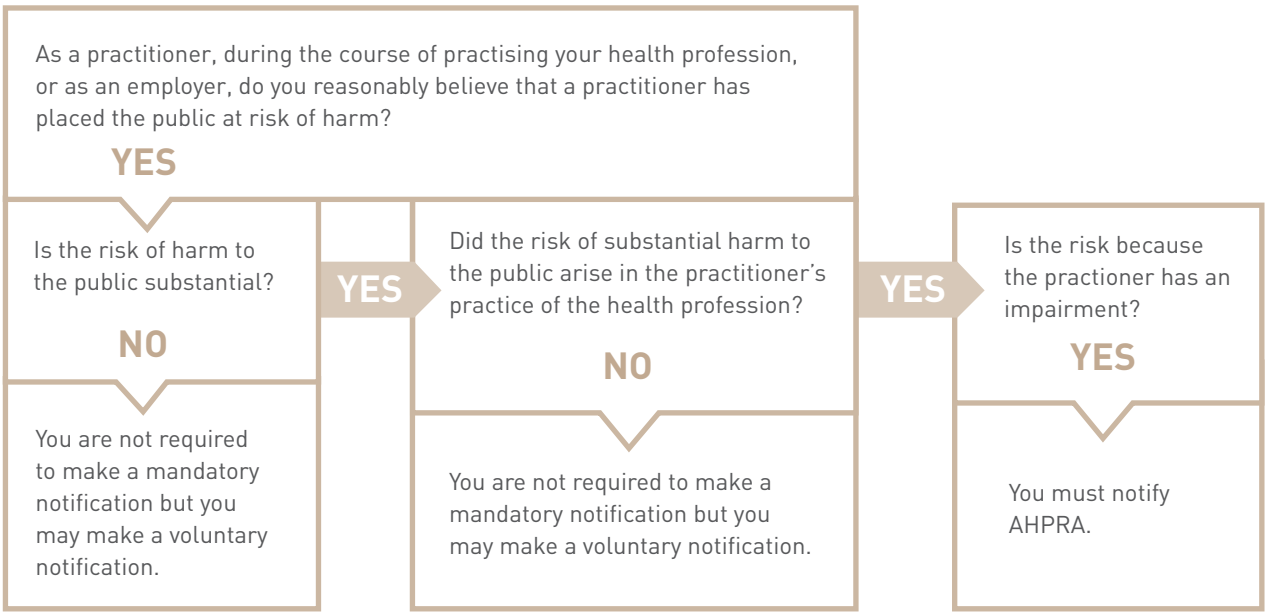
3.6 Placing the public at risk of substantial harm because of an impairment (section 140(c))

Section 5 of the National Law defines 'impairment' for a practitioner or an applicant for registration in a health profession as meaning a person has 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession.'

To trigger this notification, a practitioner must have placed the public at risk of substantial harm. 'Substantial harm' has its ordinary meaning; that is, considerable harm such as a failure to correctly or appropriately diagnose or treat because of the impairment. For example, a practitioner who has an illness which causes cognitive impairment so they cannot practise effectively would require a mandatory notification. However, a practitioner who has a blood-borne virus who practises appropriately and safely in light of their condition and complies with any registration standards or guidelines and professional standards and protocols would not trigger a notification.

The context of the practitioner's work is also relevant. If registered health practitioners, employers and education providers are aware that the employer knows of the practitioner's impairment, and has put safeguards in place such as monitoring and supervision, this may reduce or prevent the risk of substantial harm.

3.7 Decision guide – notifying impairment in relation to a practitioner



* for notification of student impairment, please see Section 5 of these guidelines

3.8 Placing the public at risk of harm because of practice that constitutes a significant departure from accepted professional standards (section 140(d))

The term 'accepted professional standards' requires knowledge of the professional standards that are accepted within the health profession and a judgement about whether there has been a significant departure from them. This judgement may be easier for other members of the practitioner's health profession.

Mandatory notifications about a practitioner from another health profession are most likely to arise in a team environment where different health professions are working closely together and have a good understanding of the contribution of each practitioner; for example, a surgical or mental health team.

The difference from accepted professional standards must be significant. The term 'significant' means important, or of consequence *(Macquarie concise dictionary)*. Professional standards cover not only clinical skills but also other standards of professional behaviour. A significant departure is one which is serious and would be obvious to any reasonable practitioner.

The notifiable conduct of the practitioner must place the public at risk of harm as well as being a significant departure from accepted professional standards before a notification is required. However, the risk of harm just needs to be present – it does not need to be a substantial risk, as long as the practitioner's practice involves a significant departure from accepted professional standards. For example, a clear breach of the health profession's code of conduct which places the public at risk of harm would be enough.

This provision is not meant to trigger notifications based on different professional standards within a health profession, provided the standards are accepted within the health profession; that is, by a reasonable proportion of practitioners. For example, if one practitioner uses a different standard to another practitioner, but both are accepted standards within the particular health profession, this would not qualify as a case of notifiable conduct.

Similarly, if a practitioner is engaged in innovative practice but within accepted professional standards, it would not trigger the requirement to report.

3.9 Decision guide – significant departure from accepted professional standards

4 Exceptions to the requirement of practitioners to make a mandatory notification

There are particular exceptions to the requirement to make a mandatory notification for practitioners. The exceptions relate to the circumstances in which the practitioner forms the reasonable belief in misconduct or impairment. They arise where the practitioner who would be required to make the notification:

a. is employed or engaged by a professional indemnity insurer, and forms the belief because of a disclosure in the course of a legal proceeding or the provision of legal advice arising from the insurance policy

b. forms the belief while providing advice about legal proceedings or the preparation of legal advice

c. is exercising functions as a member of a quality assurance committee, council or other similar body approved or authorised under legislation which prohibits the disclosure of the information

d. reasonably believes that someone else has already made a notification,

e. is a treating practitioner, practising in Western Australia, or

f. is a treating practitioner, practising in Queensland in certain circumstances.[1]

Practitioners in Western Australia are not required to make a mandatory notification when their reasonable belief about misconduct or impairment is formed in the course of providing health services to a health practitioner or student. However, practitioners in Western Australia continue to have a professional and ethical obligation to protect and promote public health and safety. They may therefore make a voluntary notification or may encourage the practitioner or student they are treating to self-report.

From the commencement of the *Health Ombudsman Act 2013*, practitioners in Queensland are not required to make a mandatory notification when their reasonable belief is formed as a result of providing a health service to a health practitioner, where the practitioner providing the service reasonably believes that the notifiable conduct relates to an impairment which will not place the public at substantial risk of harm and is not professional misconduct. Once the Act is in force in Queensland, mandatory notifications must be made to the Health Ombudsman, rather than AHPRA. The Ombudsman must advise AHPRA about the notification in certain circumstances.

Practitioners should refer to Appendix A of these guidelines for an extract of the relevant legislation; see section 141 if it is possible one of these exceptions might apply.

5 Mandatory notifications about impaired students

Education providers are also required, under section 143 of the National Law, to make mandatory notifications in relation to students, if the provider reasonably believes:

a) 'a student enrolled with the provider has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm, or

b) a student for whom the provider has arranged clinical training has an impairment that, in the course of the student undertaking the clinical training, may place the public at substantial risk of harm.'

Practitioners are required to make a mandatory notification in relation to a student if the practitioner reasonably believes that a student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm (section141(1)(b)).

In all cases, the student's impairment must place the public at substantial, or considerable, risk of harm in the course of clinical training.

1 These changes are made in the *Health Ombudsman Act 2013* (Qld), which was assented to on 29 August 2013 and will commence on a day to be fixed by proclamation. These mandatory notifications guidelines will be updated to reflect the commencement.

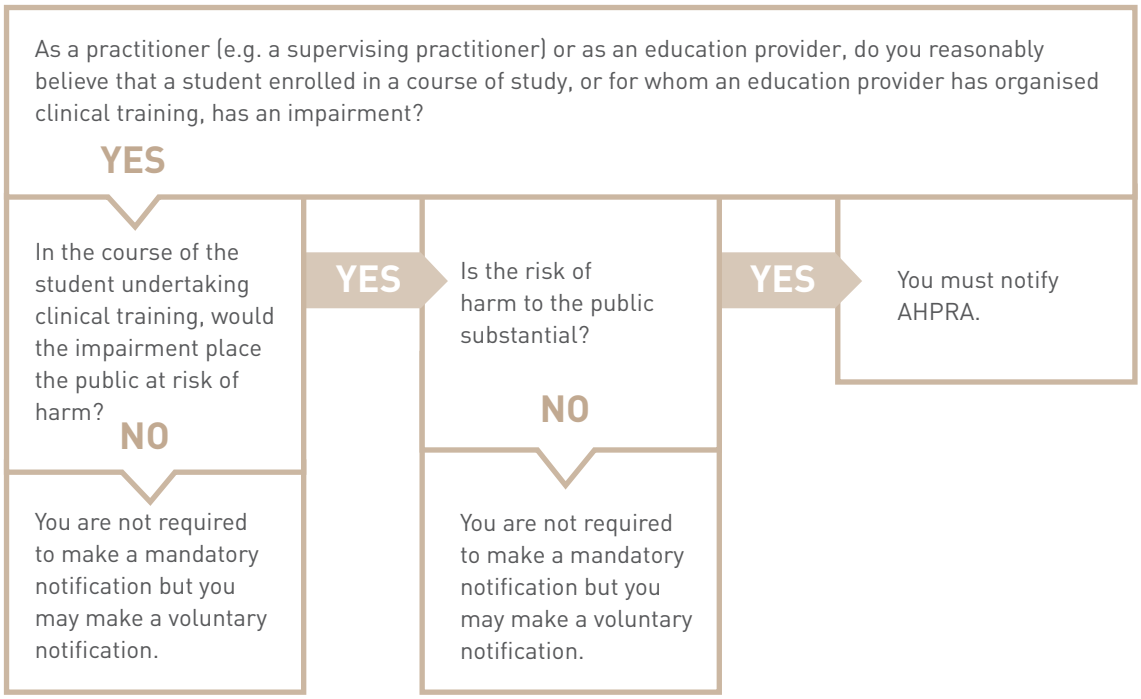
In relation to a student, 'impairment' is defined under section 5 of the National Law to mean the student 'has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the student's capacity to undertake clinical training –

(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.'

An education provider who does not notify AHPRA as required by section 143 does not commit an offence. However, the National Board that registered the student must publish details of the failure to notify on the Board's website and AHPRA may, on the recommendation of the National Board, include a statement about the failure in AHPRA's annual report.

5.1 Decision guide – student impairment



6 Consequences of failure to notify

6.1 Registered health practitioners

Although there are no penalties prescribed under the National Law for a practitioner who fails to make a mandatory notification, any practitioner who fails to make a mandatory notification when required may be subject to health, conduct or performance action.

6.2 Employers of practitioners

There are also consequences for an employer who fails to notify AHPRA of notifiable conduct as required by section 142 of the National Law.

If AHPRA becomes aware of such a failure, it must give a written report about the failure to the responsible Minister for the jurisdiction in which the notifiable conduct occurred. As soon as practicable after receiving such a report, the responsible Minister must report the employer's failure to notify to a health complaints entity, the employer's licensing authority or another appropriate entity in that participating jurisdiction.

Importantly, the requirement to make a mandatory notification does not reduce an employer's responsibility to manage the practitioner employee's performance and protect the public from being placed at risk of harm. However, if an employer has a reasonable belief that a practitioner has behaved in a way that constitutes notifiable conduct, then the employer must notify, regardless of whether steps are put in place to prevent recurrence of the conduct or impairment, or whether the practitioner subsequently leaves the employment.

7 How a notification is made (section 146)

Under the National Law, notifications are be made to AHPRA, which receives notifications and refers them to the relevant National Board.

The notification must include the basis for making the notification; that is, practitioners, employers and education providers must say what the notification is about. It may assist practitioners, employers and education providers in making a notification if they have documented the reasons for the notification, including the date and time that they noticed the conduct or impairment.

To make a notification verbally, practitioners, employers and education providers may ring 1300 419 495 or go to any of the state and territory AHPRA offices.

To make a notification in writing, go to the *Notifications and outcomes* section of the AHPRA website at www.ahpra.gov.au, download a notification form and post your completed form to AHPRA, GPO Box 9958 in your capital city.

If you are unsure about whether to make a mandatory notification, you may wish to seek advice from your insurer and/or professional association.

Review

Date of issue: 17 March 2014

Date of review: These guidelines will be reviewed from time to time as required. This will generally be at least every three years.

Last reviewed: September 2013

Appendix A
Extract of relevant provisions from the National Law

s. 5 ***impairment****, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect—*

(a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or

(b) for a student, the student's capacity to undertake clinical training—

(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.

Education provider means—

(a) a university; or

(b) a tertiary education institution, or another institution or organisation, that provides vocational training; or

(c) a specialist medical college or other health profession college.

Part 5, Division 3 Registration standards and codes and guidelines

39 Codes and guidelines

A National Board may develop and approve codes and guidelines—

(a) to provide guidance to the health practitioners it registers; and

(b) about other matters relevant to the exercise of its functions.

Example. A National Board may develop guidelines about the advertising of regulated health services by health practitioners registered by the Board or other persons for the purposes of section 133.

40 Consultation about registration standards, codes and guidelines

(1) If a National Board develops a registration standard or a code or guideline, it must ensure there is wide-ranging consultation about its content.

(2) A contravention of subsection (1) does not invalidate a registration standard, code or guideline.

(3) The following must be published on a National Board's website—

(a) a registration standard developed by the Board and approved by the Ministerial Council;

(b) a code or guideline approved by the National Board.

(4) An approved registration standard or a code or guideline takes effect—

(a) on the day it is published on the National Board's website; or

(b) if a later day is stated in the registration standard, code or guideline, on that day.

41 Use of registration standards, codes or guidelines in disciplinary proceedings

An approved registration standard for a health profession, or a code or guideline approved by a National Board, is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the health profession.

Part 8, Division 2 Mandatory notifications

140 Definition of notifiable conduct

In this Division—
notifiable conduct*, in relation to a registered health practitioner, means the practitioner has—*

(a) practised the practitioner's profession while intoxicated by alcohol or drugs; or

(b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or

(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or

(d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

141 Mandatory notifications by health practitioners

*(1) This section applies to a registered health practitioner (the **first health practitioner**) who, in the course of practising the first health practitioner's profession, forms a reasonable belief that—*

*(a) another registered health practitioner (the **second health practitioner**) has behaved in a way that constitutes notifiable conduct; or*

(b) a student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm.

(2) The first health practitioner must, as soon as practicable after forming the reasonable belief, notify the National Agency of the second health practitioner's notifiable conduct or the student's impairment.

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law. Section 237(3) provides that the making of a notification does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct and nor is any liability for defamation incurred.

(3) A contravention of subsection (2) by a registered health practitioner does not constitute an offence but may constitute behaviour for which action may be taken under this Part.

(4) For the purposes of subsection (1), the first health practitioner does not form the reasonable belief in the course of practising the profession if—

(a) the first health practitioner—

(i) is employed or otherwise engaged by an insurer that provides professional indemnity insurance that relates to the second health practitioner or student; and

(ii) forms the reasonable belief the second health practitioner has behaved in a way that constitutes notifiable conduct, or the student has an impairment, as a result of a disclosure made by a person to the first health practitioner in the course of a legal proceeding or the provision of legal advice arising from the insurance policy; or

(b) the first health practitioner forms the reasonable belief in the course of providing advice in relation to the notifiable conduct or impairment for the purposes of a legal proceeding or the preparation of legal advice; or

(c) the first health practitioner is a legal practitioner and forms the reasonable belief in the course of providing legal services to the second health practitioner or student in relation to a legal proceeding or the preparation of legal advice in which the notifiable conduct or impairment is an issue; or

APPLICATION OF THE NATIONAL LAW IN WESTERN AUSTRALIA

Part 2, Section 4(7) *Health Practitioner Regulation National Law (WA) Act 2010*

In this Schedule after section 141(4)(c) *insert*—

141(4)(d) the first health practitioner forms the reasonable belief in the course of providing health services to the second health practitioner or student; or

APPLICATION OF THE NATIONAL LAW IN QUEENSLAND

section 25 *Health Ombudsman Act 2013* (3) National Law provisions, section 141— *insert*—

(5) Subsection (2) does not apply in relation to the second health practitioner's notifiable conduct if the first health practitioner—

(a) forms the reasonable belief as a result of providing a health service to the second health practitioner; and

(b) reasonably believes that the notifiable conduct—

(i) relates to an impairment which will not place the public at substantial risk of harm; and

(ii) is not professional misconduct

(d) the first health practitioner—

(i) forms the reasonable belief in the course of exercising functions as a member of a quality assurance committee, council or other body approved or authorised under an Act of a participating jurisdiction; and

(ii) is unable to disclose the information that forms the basis of the reasonable belief because a provision of that Act prohibits the disclosure of the information; or

(e) the first health practitioner knows, or reasonably believes, the National Agency has been notified of the notifiable conduct or impairment that forms the basis of the reasonable belief.

142 Mandatory notifications by employers

(1) If an employer of a registered health practitioner reasonably believes the health practitioner has behaved in a way that constitutes notifiable conduct, the employer must notify the National Agency of the notifiable conduct.

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law. Section 237(3) provides that the making of a notification does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct and nor is any liability for defamation incurred.

(2) If the National Agency becomes aware that an employer of a registered health practitioner has failed to notify the Agency of notifiable conduct as required by subsection (1), the Agency must give a written report about the failure to the responsible Minister for the participating jurisdiction in which the notifiable conduct occurred.

(3) As soon as practicable after receiving a report under subsection (2), the responsible Minister must report the employer's failure to notify the Agency of the notifiable conduct to a health complaints entity, the employer's licensing authority or another appropriate entity in that participating jurisdiction.

(4) In this section—
employer, of a registered health practitioner, means an entity that employs the health practitioner under a contract of employment or a contract for services.

licensing authority, of an employer, means an entity that under a law of a participating jurisdiction is responsible for licensing, registering or authorising the employer to conduct the employer's business.

143 Mandatory notifications by education providers

(1) An education provider must notify the National Agency if the provider reasonably believes—

(a) a student enrolled in a program of study provided by the provider has an impairment that, in the course of the student undertaking clinical training as part of the program of study, may place the public at substantial risk of harm; or

(b) a student for whom the education provider has arranged clinical training has an impairment that, in the course of the student undertaking the clinical training, may place the public at substantial risk of harm;

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who make a notification under this Law. Section 237(3) provides that the making of a notification does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct and nor is any liability for defamation incurred.

(2) A contravention of subsection (1) does not constitute an offence.

(3) However, if an education provider does not comply with subsection (1)-

(a) the National Board that registered the student must publish details of the failure on the board's website; and

(b) the National Agency may, on the recommendation of the National Board, include a statement about the failure in the Agency's annual report.

144 Grounds for voluntary notification

(1) A voluntary notification about a registered health practitioner may be made to the National Agency on any of the following grounds—

(a) that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;

(b) that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the practitioner's health profession is, or may be, below the standard reasonably expected;

(c) that the practitioner is not, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession;

(d) that the practitioner has, or may have, an impairment;

(e) that the practitioner has, or may have, contravened this Law;

(f) that the practitioner has, or may have, contravened a condition of the practitioner's registration or an undertaking given by the practitioner to a National Board;

(g) that the practitioner's registration was, or may have been, improperly obtained because the practitioner or someone else gave the National Board information or a document that was false or misleading in a material particular.

(2) A voluntary notification about a student may be made to the National Agency on the grounds that—

(a) the student has been charged with an offence, or has been convicted or found guilty of an offence, that is punishable by 12 months imprisonment or more; or

(b) the student has, or may have, an impairment; or

(c) that the student has, or may have, contravened a condition of the student's registration or an undertaking given by the student to a National Board.

145 Who may make voluntary notification

Any entity that believes that a ground on which a voluntary notification may be made exists in relation to a registered health practitioner or a student may notify the National Agency.

Note. See section 237 which provides protection from civil, criminal and administrative liability for persons who, in good faith, make a notification under this Law.

Part 8, Division 4 Making a notification

146 How notification is made

(1) A notification may be made to the National Agency—

(a) verbally, including by telephone; or

(b) in writing, including by email or other electronic means.

(2) A notification must include particulars of the basis on which it is made.

(3) If a notification is made verbally, the National Agency must make a record of the notification.

Part 11, Division 1, section 237 Protection from liability for persons making notification or otherwise providing information

(1) This section applies to a person who, in good faith—

(a) makes a notification under this Law; or

(b) gives information in the course of an investigation or for another purpose under this Law to a person exercising functions under this Law.

(2) The person is not liable, civilly, criminally or under an administrative process, for giving the information.

(3) Without limiting subsection (2)—

(a) the making of the notification or giving of the information does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct; and

(b) no liability for defamation is incurred by the person because of the making of the notification or giving of the information.

(4) The protection given to the person by this section extends to—

(a) a person who, in good faith, provided the person with any information on the basis of which the notification was made or the information was given; and

(b) a person who, in good faith, was otherwise concerned in the making of the notification or giving of the information.

APPLICATION OF THE NATIONAL LAW IN QUEENSLAND

section 25 *Health Ombudsman Act 2013*

(1) National Law provisions, section 141(2) and (4(e), 'National Agency'—

omit, insert—

health ombudsman

(2) National Law provisions, section 141(3), after 'this Part'—

insert—

or the *Health Ombudsman Act 2013*

(3) National Law provisions, section 141—insert—

(5) Subsection (2) does not apply in relation to the second health practitioner's notifiable conduct if the first health practitioner—

(a) forms the reasonable belief as a result of providing a health service to the second health practitioner; and

(b) reasonably believes that the notifiable conduct—

(i) relates to an impairment which will not place the public at substantial risk of harm; and

(ii) is not professional misconduct

26 Amendment of s 142 (Mandatory notifications by employers)

(1) National Law provisions, section 142(1), 'National Agency'—

omit, insert—

health ombudsman

(2) National Law provisions, section 142(2) and (3)—

omit, insert—

(2) If the health ombudsman becomes aware that an employer of registered health practitioner has failed to notify the health ombudsman of notifiable conduct as required by subsection (1), the health ombudsman—

(a) must notify the National Agency; and

(b) may—

(i) refer the matter to the employer's licensing authority; or

(ii) refer the matter to another appropriate entity in this jurisdiction or another jurisdiction; or

(iii) advise the responsible Minister of the matter.

(3) National Law provisions, section 142(4)—

renumber as section 142(3).

27 Amendment of s 143 (Mandatory notifications by education providers)

(1) National Law provisions, section 143(1),

'National Agency'—

omit, insert—

health ombudsman

(2) National Law provisions, section 143(2) and (3)—

renumber as section 143(3) and (4).

(3) National Law provisions, section 143—

insert—

(2) The health ombudsman must give to the National Agency a copy of each notification received under subsection (1).

Guidelines for recency of practice

Aboriginal and
Torres Strait Islander
Health Practice
Board of Australia

9698

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Introduction

The Aboriginal and Torres Strait Islander Health Practice Board of Australia (the Board) has developed these guidelines under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law[1]).

The purpose of the guidelines is to provide further information on recency of practice requirements outlined in the Board's *Recency of practice registration standard*. They explain the following:

- why recency of practice is important
- who the recency of practice standard applies to, and
- what documents practitioners will need to provide to demonstrate they have met the recency of practice requirements.

If you seek to register as an Aboriginal and Torres Strait Islander health practitioner, you should read these guidelines together with the *Recency of practice registration standard*, published under *Registration standards* on the Board website.

Who needs to use these guidelines?

The *Recency of practice registration standard* applies to all Aboriginal and Torres Strait Islander health applicants for new registration or renewal of registration, regardless of whether they work full-time or part-time or whether their work is paid or unpaid.

Background

The community has the right to expect that Aboriginal and Torres Strait Islander health practitioners will provide services that are appropriate, relevant and safe. Under the National Law, all practitioners applying for registration must demonstrate their practice is recent so they are able to provide services safely.

1 The National Law is contained in the schedule to the Health Practitioner Regulation National Law Act 2009 (Qld)

Requirements

The Board may grant registration to practitioners who have practised the profession for:

1. At least three months full-time equivalent in the previous three years. Registration may be subject to conditions which may include, but are not limited to:
    - Successfully completing a first aid certificate.
    - Successfully completing an assessment by a training provider accredited by the Board against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice). These units may include, but are not limited to:
        - Applied First Aid or HLTFA301B
        - HLTAHW401B Assess Client Physical Wellbeing
        - HLTAHW402B Assess and Support Client Social and Emotional Wellbeing:
            > Element 2 – Performance Criteria 1–10 Essential Skills and Essential Knowledge
        - HLTAHW404B Monitor Health Care
        - HLTAHW406B Work with Medicines
    - Working under the supervision of an Aboriginal and Torres Strait Islander health practitioner, registered nurse, registered midwife or medical practitioner.
    - Restricting the practitioner from undertaking specific practice.
2. At least six months full-time equivalent in the previous three to five years. Registration may be subject to conditions which may include, but are not limited to:
    - Successfully completing a first aid certificate.
    - Successfully completing an assessment by a training provider accredited by the Board against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice). These units may include, but are not limited to:
        - Applied First Aid or HLTFA301B
        - HLTAHW401B Assess Client Physical Wellbeing
        - HLTAHW402B Assess and Support Client Social and Emotional Wellbeing:
            > Element 2 – Performance Criteria 1–10 Essential Skills and Essential Knowledge
        - HLTAHW404B Monitor Health Care
        - HLTAHW406B Work with Medicines
    - Working under a specified level of supervision of an Aboriginal and Torres Strait Islander health practitioner, registered nurse, registered midwife or medical practitioner.
    - Providing the Board with supervision reports at six monthly intervals or within a timeframe as determined by the Board from date of commencing employment.
    - Restricting the practitioner from undertaking specific practice.
3. At least twelve months full-time equivalent in the previous five to ten years. Registration may be granted subject to conditions which may include, but are not limited to the following. Registration may also be refused subject to attaining the qualification required for registration.
    - Successfully completing a first aid certificate.
    - Successfully completing an assessment by a training provider accredited by the Board against the identified units within the Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice). These units may include, but are not limited to:
        - Applied First Aid or HLTFA301B
        - HLTAHW401B Assess Client Physical Wellbeing
        - HLTAHW402B Assess and Support Client Social and Emotional Wellbeing:
            > Element 2 – Performance Criteria 1–10 Essential Skills and Essential Knowledge
        - HLTAHW404B Monitor Health Care
        - HLTAHW406B Work with Medicines
    - Working under the direct supervision of an Aboriginal and Torres Strait islander health practitioner, registered nurse, registered midwife or medical practitioner.
    - Providing the Board with supervision reports at one month and then at six monthly intervals thereafter; or, within a timeframe as determined by the Board.
    - Restricting the practitioner from undertaking specific practice.

1. Board monitoring of recency of practice

If you are:

- **A student** – students do not need to show recency of practice to the Board.
- **A new graduate** – you must apply for registration to practise for the first time within three years of graduating from your course, and will need to meet the recency of practice standard.
- **A practitioner applying for registration** – every year when an Aboriginal and Torres Strait Islander health practitioner applies for registration, they must make a declaration that they have met the Board's recency of practice requirements.
- **Returning to work after a break in registration** – a practitioner re-applying for registration after a period in which they have not been registered will be asked to provide documents that show whether they have been able to meet the recency of practice requirements. These documents must include, but are not limited to:
  - letters from at least two of the practitioner's supervisors outlining the position the practitioner held and describing the clinical activities they undertook in that role
  - a detailed résumé/curriculum vitae (CV), and
  - other documents that may be useful, such as position descriptions and records of continuing professional development activities.

2. Action by the Board

The Board (or its delegate) will consider each application for registration individually, and make one of the following decisions depending on the situation:

- grant full registration
- impose conditions on registration, or
- refuse registration.

For each application, the Board will consider factors such as:

- the length of time the practitioner has been absent from the profession
- what the practitioner has been doing during the absence
- the extent of practice experience prior to the lapse in registration, and
- any further training or study which has been undertaken.

The Board will give written notice of its decisions regarding renewal of registration and will allow 30 days for a written response to be provided.

The Board may request further evidence as required.

Definitions

An Aboriginal and Torres Strait Islander health practitioner is an individual registered by the Aboriginal and Torres Strait Islander Health Practice Board. The practitioner may use the titles:

- Aboriginal health practitioner
- Aboriginal and Torres Strait Islander health practitioner, or
- Torres Strait Islander health practitioner.

Practice means any role, whether paid or not, in which an individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of these guidelines, practice is not restricted to the provision of direct clinical care. It also includes:

- working in a direct nonclinical relationship with clients
- working in management, administration, education, research, advisory, regulatory or policy development role, and
- any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Professional development activities means participation in formal learning activities, such as attendance at courses or conferences, as well as informal learning gained through experience and interaction with colleagues.

Attachments

Attachment A: Relevant sections of the National Law.

Date: 27 March 2012

Date of review: This guideline will be reviewed at least every three years

Last reviewed: 27 March 2012

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Attachment A
Extract of relevant provisions from the Health Practitioner Regulation National Law Act 2009(QLD)

Division 3 Registration standards and codes and guidelines

Section 39 – Codes and guidelines

A National Board may develop and approve codes and guidelines—

(a) to provide guidance to the health practitioners it registers; and

(b) about other matters relevant to the exercise of its functions.

***Example.** A National Board may develop guidelines about the advertising of regulated health services by health practitioners registered by the Board or other persons for the purposes of Section 133.*

Section 40 – Consultation about registration standards, codes and guideliness

(1) If a National Board develops a registration standard or a code or guideline, it must ensure there is wide-ranging consultation about its content.

(2) A contravention of subsection (1) does not invalidate a registration standard, code or guideline.

(3) The following must be published on a National Board's website—

(a) a registration standard developed by the Board and approved by the Ministerial Council;

(b) a code or guideline approved by the National Board.

(4) An approved registration standard or a code or guideline takes effect—

(a) on the day it is published on the National Board's website; or

(b) if a later day is stated in the registration standard, code or guideline, on that day.

Section 41 – Use of registration standards, codes or guidelines in disciplinary proceedings

An approved registration standard for a health profession, or a code or guideline approved by a National Board, is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the health profession.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Guidelines on grandparenting requirements for registration

Aboriginal and
Torres Strait Islander
Health Practice
Board of Australia

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Introduction

The Aboriginal and Torres Strait Islander Health Practice Board of Australia (the Board) has developed these guidelines to provide further information about the grandparenting provisions and requirements outlined in the Board's *Grandparenting registration standard*.

The grandparenting provisions contained in the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), are designed to make sure that practitioners legitimately practising the profession (particularly those in jurisdictions that did not previously require registration) are not disadvantaged due to:

- their profession not having automatically transitioned to the National Registration and Accreditation Scheme (the National Scheme), or
- not holding an approved qualification.

Who needs to use these guidelines?

Aboriginal and Torres Strait Islander health workers who:

- are not currently registered in the Northern Territory, and
- do not hold a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) but still wish to apply to the Board for registration on the basis of equivalent qualifications and experience.

Background

All practitioners who are currently registered with the Aboriginal Health Workers Board of the Northern Territory were automatically transferred to the National Scheme on 1 July 2012.

Practitioners not currently registered in the Northern Territory but who hold a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) are eligible to apply for registration as an Aboriginal and Torres Strait Islander health practitioner.

All other practitioners, including those not registered in the Northern Territory and those without a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice), may still be eligible to apply for registration up until 1 July 2015 under the grandparenting provisions.

In these cases, it will be up to the Board to decide whether a practitioner's qualifications and experience in direct clinical care are sufficient for registration.

1. Requirements

The Board will consider all applications for registration under the grandparenting provisions to determine whether an individual's qualifications and experience are adequate for registration, noting that the Board's key consideration is to protect the public.

In its *Grandparenting registration standard*, the Board has provided guidance on what is required from practitioners seeking to register under the grandparenting provisions.

At the discretion of the Board, a practitioner with the following may be suitable for registration:

- Demonstrates a qualification (either a certified copy of the original or an authenticated copy from the issuing registered training organisation).

  Example: Certificate III before 2008 that includes medication administration and clinical assessment (such as, but not limited to, a Certificate III in Aboriginal Health Work Clinical, a Certificate III in Indigenous Primary Health Care).

- Has completed any further study, training or a minimum of 500 hours of clinical practice.

- Has practised between 1 July 2002 and 30 June 2012 as a clinical Aboriginal and/or Torres Strait Islander health worker for a total of five years (either five years straight or at intervals totalling five years).

Any applicant who seeks to register under grandparenting provisions must also demonstrate that they meet the requirements of the following Board registrations standards:

- continuing professional development
- criminal history
- English language skills
- professional indemnity insurance arrangements, and
- recency of practice.

The practitioner *must* also be an Aboriginal and/or Torres Strait Islander person.

2. What evidence will the Board need?

If you are applying for registration under grandparenting provisions, you will need to provide documents to support your qualifications and experience.

The Board requires you to provide the following documents:

- A minimum of two recent professional references from people who can be contacted by the Board or by the Australian Health Practitioner Regulation Agency (AHPRA); at least one of your referees should be a supervisor.

  References should provide details of your role in the organisation and provide the Board with an overview of the kind of clinical activities you were responsible for.

  References should also note how skilled you were at carrying out these clinical activities and the amount of supervision, if any, required.

- Documented evidence of your professional practice for a minimum of five years or part-time equivalent between 1 July 2002 and 30 June 2012.

  The Board will need a timeline of positions held over this period. This should include start and finish dates for each position and supporting documented evidence.

  Documented evidence may include pay slips, tax returns or a letter from a manager or senior staff member in the organisation.

- Copies of position/job descriptions, certified by employer/s with a description of the nature of the qualification, knowledge and skills required.

  The Board will require a copy of your qualification, with a breakdown of subjects you studied and results obtained.

  As under bullet point one above, the Board will also require a copy of your job description for each position you have held and a summary of the knowledge and skills you required to fulfil this role.

  Your employer(s) will need to certify this information, for example in the form of a letter to the Board.

- A résumé or professional portfolio.

  The résumé or curriculum vitae (CV) should contain similar details to those outlined above, including start and finish dates for each position and a detailed summary of clinical tasks performed in that role.

- A statement of service or other documentation from employer/s that support claims of five years of practice.

  Covered under bullet point two above.

- A declaration declaring that an applicant has practised for five years in the profession.

  By signing your application form for initial registration or your application to renew registration, you are declaring that you have practised for five years in the profession. Separate documentation is not required.

- The Board may also request additional documents and/or clinical assessment, as required.

The Board will do this in writing and give you a reasonable timeframe to coordinate documents and/or undertake the clinical assessment.

3. Action by the Board

The Board may decide to accept or reject your application for registration, or may apply conditions to your registration, as stipulated by the grandparenting provisions of the National Law.

Definitions

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- working in a direct nonclinical relationship with clients
- working in management, administration, education, research, advisory, regulatory or policy development roles, and
- any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Professional development activities means participation in formal learning activities, such as attendance at courses or conferences, as well as in formal learning gained through experience and interaction with colleagues.

Attachments

Attachment A: Extract of relevant provisions from the Health Practitioner Regulation National Law Act 2009 (QLD)

Date: 27 March 2012

Date of review: This guideline will be reviewed at least every three years

Last reviewed: 27 March 2012

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Attachment A
Extract of relevant provisions from the Health Practitioner Regulation National Law Act 2009(QLD)

Division 3 Registration standards and codes and guidelines

Section 39 - Codes and guidelines

A National Board may develop and approve codes and guidelines—

(a) to provide guidance to the health practitioners it registers; and

(b) about other matters relevant to the exercise of its functions.

***Example.** A National Board may develop guidelines about the advertising of regulated health services by health practitioners registered by the Board or other persons for the purposes of Section 133.*

Section 40 - Consultation about registration standards, codes and guidelines

(1) If a National Board develops a registration standard or a code or guideline, it must ensure there is wide-ranging consultation about its content.

(2) A contravention of subsection (1) does not invalidate a registration standard, code or guideline.

(3) The following must be published on a National Board's website—

(a) a registration standard developed by the Board and approved by the Ministerial Council;

(b) a code or guideline approved by the National Board.

(4) An approved registration standard or a code or guideline takes effect—

(a) on the day it is published on the National Board's website; or

(b) if a later day is stated in the registration standard, code or guideline, on that day.

Section - 41 Use of registration standards, codes or guidelines in disciplinary proceedings

An approved registration standard for a health profession, or a code or guideline approved by a National Board, is admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a health practitioner registered by the Board as evidence of what constitutes appropriate professional conduct or practice for the health profession.

Specific provisions

Section 303 - Qualifications for general registration in relevant profession

(1) For the purposes of section 52(1)(a), an individual who applies for registration in a relevant health profession before 1 July 2015 is qualified for general registration in the profession.

if the individual—

(a) holds a qualification or has completed training in the profession, whether in a participating jurisdiction or elsewhere, that the National Board established for the profession considers is adequate for the purposes of practising the profession; or

(b) holds a qualification or has completed training in the profession, whether in a participating jurisdiction or elsewhere, and has completed any further study, training or supervised practice in the profession required by the Board for the purposes of this section; or

(c) has practised the profession at any time between 1 July 2002 and 30 June 2012 for a consecutive period of five years or for any periods which together amount to five years.

(2) This section applies despite Section 53.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Aboriginal and
Torres Strait Islander
Health Practice
Board of Australia

For registered health practitioners

CODE OF CONDUCT

March 2014

ATSIHPBA1401 01 9990

CODE OF CONDUCT

About the National Boards and AHPRA

The 14 National Boards regulating registered health practitioners in Australia are responsible for registering practitioners and students (except for in psychology, which has provisional psychologists), setting the standards that practitioners must meet, and managing notifications (complaints) about the health, conduct or performance of practitioners.

The Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with the National Boards to implement the National Registration and Accreditation Scheme, under the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

The core role of the National Boards and AHPRA is to protect the public.

About this code

This code has been developed by most National Boards under section 39 of the National Law.

CODE OF CONDUCT

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CODE OF CONDUCT

CODE OF CONDUCT

Overview

This code seeks to assist and support registered health practitioners to deliver effective regulated health services within an ethical framework. Practitioners have a duty to make the care of patients or clients their first concern and to practise safely and effectively. Maintaining a high level of professional competence and conduct is essential for good care.

The code contains important standards for practitioner behaviour in relation to:

- providing good care, including shared decision-making
- working with patients or clients
- working with other practitioners
- working within the healthcare system
- minimising risk
- maintaining professional performance
- professional behaviour and ethical conduct
- ensuring practitioner health
- teaching, supervising and assessing, and
- research.

Making decisions about healthcare is the shared responsibility of the practitioner and the patients or clients (or their representative).

Relationships based on openness, trust and good communication will enable practitioners to work in partnership with their patients or clients. An important part of the practitioner–patient/client relationship is effective communication, in all forms, including in person, written and electronic.

Practitioners have ethical and legal obligations to protect the privacy of people requiring and receiving care. Patients or clients have a right to expect that practitioners and their staff will hold information about them in confidence, unless information is required to be released by law or public interest considerations.

Practitioners need to obtain informed consent for the care that they provide to their patients or clients. Caring for children and young people brings additional responsibilities for practitioners.

Good practice involves genuine efforts to understand the cultural needs and contexts of different patients or clients to obtain good health outcomes. Practitioners need to be aware that some patients or clients have additional needs and modify their approach appropriately.

When adverse events occur, practitioners have a responsibility to be open and honest in communication with patients or clients to review what has occurred.

In some circumstances, the relationship between a practitioner and a patient or client may become ineffective or compromised and may need to end.

Good relationships with colleagues and other practitioners strengthen the practitioner–patient/client relationship and enhance care.

Practitioners have a responsibility to contribute to the effectiveness and efficacy of the healthcare system.

Minimising risk to patients or clients is a fundamental component of practice. Good practice involves understanding and applying the key principles of risk minimisation and management to practice.

Maintaining and developing a practitioner's knowledge, skills and professional behaviour are core aspects of good practice.

Teaching, supervising and mentoring practitioners and students is important for the development of practitioners and for the care of patients or clients. It is part of good practice to contribute to these activities, and provide support, assessment, feedback and supervision for colleagues, practitioners in training and students.

Underpinning this code is the assumption that practitioners will exercise their professional judgement to deliver the best possible outcome for their patients.

CODE OF CONDUCT

1 Introduction

1.1 Use of the code

This code seeks to assist and support practitioners to deliver appropriate, effective services within an ethical framework. Practitioners have a professional responsibility to be familiar with this code and to apply the guidance it contains.

This code will be used:

- to support individual practitioners in the challenging task of providing good healthcare and fulfilling their professional roles and to provide a framework to guide professional judgement
- to assist National Boards in their role of protecting the public by setting and maintaining standards of good practice – Boards will use this code when evaluating the professional conduct of practitioners. If professional conduct varies significantly from this code, practitioners should be prepared to explain and justify their decisions and actions and serious or repeated failure to meet this code may have consequences for registration
- as an additional resource for a range of uses that contribute to enhancing the culture of professionalism in the Australian health system: for example, in practitioner education; orientation, induction and supervision of students; and by administrators and policy makers in hospitals, health services and other institutions, and
- as a guide to the public and consumers of health services about what good practice is and the standard of behavior they should expect from health practitioners.

Practitioners must always act in accordance with the law. The code is not a substitute for the provisions of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law), other relevant legislation and case law. If there is any conflict between the code and the law, the law takes precedence. Practitioners need to be aware of and comply with, the standards, guidelines and policies of their National Board.

The code does not address in detail the range of general legal obligations that apply to practitioners, such as those under privacy, child protection and anti-discrimination legislation; responsibilities to employees and other individuals present at a practice under workplace health and safety legislation; and vicarious liability for employees under the general law. Practitioners should ensure that they are aware of their legal obligations and act in accordance with them.

This code is not an exhaustive study of professional ethics or an ethics guide. It does not address the standards of practice within individual health professions or disciplines. These standards of practice are generally found in documents issued by the relevant National Boards and/or professional bodies.

While good healthcare respects the rights of patients or clients, this code is not a charter of rights (an example of a charter is the *Australian charter of healthcare rights* issued by the Australian Commission on Safety and Quality in Health Care and available at www.safetyandquality.gov.au).

The focus of this code is on good practice and professional behaviour. It is not intended as a mechanism to address disputes between professional colleagues, e.g. in relation to termination of business relationships and disputes over patients or clients.

1.2 Professional values and qualities

While individual practitioners have their own personal beliefs and values, there are certain professional values on which all practitioners are expected to base their practice. These professional values apply to the practitioner's conduct regardless of the setting, including in person and electronically, e.g. social media, e-health etc.

Practitioners have a duty to make the care of patients or clients their first concern and to practise safely and effectively. They must be ethical and trustworthy. Patients or clients trust practitioners because they believe that, in addition to being competent, practitioners will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients or clients also rely on practitioners to protect their confidentiality.

Practitioners have a responsibility to protect and promote the health of individuals and the community.

Good practice is centred on patients or clients. It involves practitioners understanding that each patient or client is unique and working in partnership with patients or clients, adapting what they do to address the needs and reasonable expectations of each person. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, and recognising that these cultural differences may impact on the practitioner–patient/client relationship and on the delivery of services. Good practice also includes being aware that differences such as gender, sexuality, age, belief systems and other anti-discrimination grounds in relevant legislation may influence care needs, and avoiding discrimination on the basis of these differences.

Effective communication in all forms underpins every aspect of good practice.

Professionalism embodies all the qualities described here and includes self-awareness and self-reflection. Practitioners are expected to reflect regularly on whether they are practising effectively, on what is happening in their relationships with patients or clients and colleagues, and on their own health and wellbeing. They have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgement as they gain experience, and contribute to their profession.

Practitioners have a responsibility to recognise and work within the limits of their competence and scope of practice. Scopes of practice vary according to different roles; for example, practitioners, researchers and managers will all have quite different competence and scopes of practice. To illustrate, in relation to working within their scope of practice, practitioners may need to consider whether they have the appropriate qualifications and experience to provide advice on over the counter and scheduled medicines, herbal remedies, vitamin supplements, etc.

Practitioners should be committed to safety and quality in healthcare (the Australian Commission on Safety and Quality in Health Care is at www.safetyandquality.gov.au – also see the references section at the end of this code).

1.3 Australia and Australian healthcare

Australia is culturally and linguistically diverse. We inhabit a land that, for many ages, was held and cared for by Aboriginal and/or Torres Strait Islander Australians, whose history and culture have uniquely shaped our nation. Our society is further enriched by the contribution of people from many nations who have made Australia their home.

Practitioners in Australia reflect the cultural diversity of our society and this diversity strengthens the health professions.

There are many ways to practise a health profession in Australia. Practitioners have critical roles in caring for people who are unwell, assisting people to recover and seeking to keep people well. This code focuses on these roles. For practitioners with roles that involve little or no contact with patients or clients, not all of this code may be relevant, but the underpinning principles will still apply.

1.4 Substitute decision-makers

There are several conditions or situations in which patients or clients may have limited competence or capacity to make independent decisions about their health care; for example, people with dementia or acute conditions that temporarily affect competence and children or young people, depending on their age and capacity (see Section 3.5 *Informed consent*).

In this code, reference to the terms 'patients or clients' also includes substitute decision-makers for patients or clients who do not have the capacity to make their own decisions. These can be parents or a legally appointed decision-maker. If in doubt, seek advice from the relevant guardianship authority.

2 Providing good care

2.1 Introduction

Care of the patient or client is the primary concern for health professionals in clinical practice. Providing good care includes:

a) assessing the patient or client, taking into account their history, views and an appropriate physical examination where relevant; the history includes relevant psychological, social and cultural aspects

b) formulating and implementing a suitable management plan (including providing treatment and advice and, where relevant, arranging investigations and liaising with other treating practitioners)

c) facilitating coordination and continuity of care

d) recognising the limits to a practitioner's own skills and competence and referring a patient or client to another practitioner when this is in the best interests of the patients or clients, and

e) recognising and respecting the rights of patients or clients to make their own decisions.

2.2 Good care

Maintaining a high level of professional competence and conduct is essential for good care. Good practice involves:

a) recognising and working within the limits of a practitioner's competence and scope of practice, which may change over time

b) ensuring that practitioners maintain adequate knowledge and skills to provide safe and effective care

c) when moving into a new area of practice, ensuring that a practitioner has undertaken sufficient training and/or qualifications to achieve competency in that area

d) practising patient/client-centred care, including encouraging patients or clients to take interest in, and responsibility for, the management of their health and supporting them in this

e) maintaining adequate records (see Section 8.4 *Health records*)

f) considering the balance of benefit and harm in all clinical management decisions

g) communicating effectively with patients or clients (see Section 3.3 *Effective communication*)

h) providing treatment options based on the best available information and not influenced by financial gain or incentives

i) taking steps to alleviate the symptoms and distress of patients or clients, whether or not a cure is possible

j) supporting the right of the patient or client to seek a second opinion

k) consulting and taking advice from colleagues when appropriate

l) making responsible and effective use of the resources available to practitioners (see Section 5.2 *Wise use of healthcare resources*)

m) ensuring that the personal views of a practitioner do not affect the care of a patient or client adversely

n) practising in accordance with the current and accepted evidence base of the health profession, including clinical outcomes

o) evaluating practice and the decisions and actions in providing good care, and

p) facilitating the quality use of therapeutic products based on the best available evidence and the patient or client's needs.

2.3 Shared decision-making

Making decisions about healthcare is the shared responsibility of the treating practitioner and the patient or client who may wish to involve their family, carer/s and/or others. Practitioners have the responsibility to create and foster conditions for this to occur. (Also see Section 1.4 *Substitute decision-makers*.)

2.4 Decisions about access to care

Practitioner decisions about access to care need to be free from bias and discrimination. Good practice involves:

a) treating patients or clients with respect at all times

b) not prejudicing the care of a patient or client because a practitioner believes that the behaviour of the patient or client has contributed to their condition

c) upholding the duty to the patient or client and not discriminating on grounds irrelevant to healthcare, including race, religion, sex, disability or other grounds specified in anti-discrimination legislation

d) investigating and treating patients or clients on the basis of clinical need and the effectiveness of the proposed investigations or treatment, and not providing unnecessary services or encouraging the indiscriminate or unnecessary use of health services

e) keeping practitioners and their staff safe when caring for patients or clients; while action should be taken to protect practitioners and their staff if a patient or client poses a risk to health or safety, the patient or client should not be denied care, if reasonable steps can be taken to keep practitioners and their staff safe

f) being aware of a practitioner's right to not provide or participate directly in treatments to which the practitioner objects conscientiously, informing patients or clients and, if relevant, colleagues of the objection, and not using that objection to impede access to treatments that are legal, and

g) not allowing moral or religious views to deny patients or clients access to healthcare, recognising that practitioners are free to decline to provide or participate in that care personally.

2.5 Treatment in emergencies

Treating patients or clients in emergencies requires practitioners to consider a range of issues, in addition to the provision of best care. Good practice involves offering assistance in an emergency that takes account of the practitioner's own safety, skills, the availability of other options and the impact on any other patients or clients under the practitioner's care, and continuing to provide that assistance until services are no longer required.

3 Working with patients or clients

3.1 Introduction

Relationships based on respect, trust and good communication will enable practitioners to work in partnership with patients or clients.

3.2 Partnership

A good partnership between a practitioner and the person they are caring for requires high standards of personal conduct. This involves:

a) being courteous, respectful, compassionate and honest

b) treating each patient or client as an individual

c) protecting the privacy and right to confidentiality of patients or clients, unless release of information is required by law or by public interest considerations

d) encouraging and supporting patients or clients and, when relevant, their carer/s or family in caring for themselves and managing their health

e) encouraging and supporting patients or clients to be well-informed about their health and assisting patients or clients to make informed decisions about their healthcare activities and treatments by providing information and advice to the best of a practitioner's ability and according to the stated needs of patients or clients

f) respecting the right of the patient or client to choose whether or not they participate in any treatment or accept advice, and

g) recognising that there is a power imbalance in the practitioner–patient/client relationship and not exploiting patients or clients physically, emotionally, sexually or financially (also see Section 8.2 *Professional boundaries* and Section 8.12 *Financial and commercial dealings*).

3.3 Effective communication

An important part of the practitioner–patient/client relationship is effective communication. This involves:

a) listening to patients or clients, asking for and respecting their views about their health and responding to their concerns and preferences

b) awareness of health literacy issues and taking health literacy into account and/or adjusting their communication in response

c) encouraging patients or clients to tell a practitioner about their condition and how they are managing it, including any other health advice they have received, any prescription or other medications they have been prescribed and any other therapies they are using

d) informing patients or clients of the nature of and need for all aspects of their clinical care, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment

e) discussing with patients or clients their condition and the available healthcare options, including their nature, purpose, possible positive and adverse consequences, limitations and reasonable alternatives wherever they exist

f) endeavouring to confirm that a patient or client understands what a practitioner has said

g) ensuring that patients or clients are informed of the material risks associated with any part of a proposed management plan

h) responding to questions from patients or clients and keeping them informed about their clinical progress

i) making sure, whenever practical, that arrangements are made to meet the specific language, cultural and communication needs of patients or clients and being aware of how these needs affect understanding

j) becoming familiar with, and using wherever necessary, qualified language interpreters or cultural interpreters to help meet the communication needs of patients or clients, including those who require assistance because of their English skills, or because they are speech or hearing impaired (wherever possible, practitioners should use trained translators and interpreters rather than family members or other staff)

k) when using interpreters:

- taking reasonable steps to ensure that the interpreter is competent to work as an interpreter in the relevant context
- taking reasonable steps to ensure that the interpreter is not in a relationship with the patient or client that may impair the interpreter's judgement
- taking reasonable steps to ensure that the interpreter will keep confidential the existence and content of the service provided to the patient or client
- taking reasonable steps to ensure that the interpreter is aware of any other relevant provisions of this code, and
- obtaining informed consent from the patient or client to use the selected interpreter

l) using social media, e-health and personally controlled electronic health records appropriately, consistent with this code, and

m) communicating appropriately with and providing relevant information to other stakeholders, including other treating practitioners, in accordance with applicable privacy requirements.

3.4 Confidentiality and privacy

Practitioners have ethical and legal obligations to protect the privacy of people requiring and receiving care. Patients or clients have a right to expect that practitioners and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations. Good practice involves:

a) treating information about patients or clients as confidential and applying appropriate security to electronic and hard copy information

b) seeking consent from patients or clients before disclosing information, where practicable

c) being aware of the requirements of the privacy and/or health records legislation that operates in relevant states and territories and applying these requirements to information held in all formats, including electronic information

d) sharing information appropriately about patients or clients for their healthcare while remaining consistent with privacy legislation and professional guidelines about confidentiality

e) where relevant, being aware that there are complex issues relating to genetic information and seeking appropriate advice about disclosure of such information

f) providing appropriate surroundings to enable private and confidential consultations and discussions to take place

g) ensuring that all staff are aware of the need to respect the confidentiality and privacy of patients or clients and refrain from discussing patients or clients in a non-professional context

h) complying with relevant legislation, policies and procedures relating to consent

i) using consent processes, including formal documentation if required, for the release and exchange of health and medical information, and

j) ensuring that use of social media and e-health is consistent with the practitioner's ethical and legal obligations to protect privacy.

3.5 Informed consent

Informed consent is a person's voluntary decision about healthcare that is made with knowledge and understanding of the benefits and risks involved. A useful guide to the information that practitioners need to give to patients is available in the National Health and Medical Research Council (NHMRC) publication *General guidelines for medical practitioners in providing information to patients* (www.nhmrc.gov.au). The NHMRC guidelines cover the information that practitioners should provide about their proposed management or approach, including the need to provide more information where the risk of harm is greater and likely to be more serious and advice about how to present information.

Good practice involves:

a) providing information to patients or clients in a way they can understand before asking for their consent

b) obtaining informed consent or other valid authority before undertaking any examination or investigation, providing treatment (this may not be possible in an emergency) or involving patients or clients in teaching or research, including providing information on material risks

c) when referring a patient or client for investigation or treatment, advising the patient or client that there may be additional costs, which they may wish to clarify before proceeding

d) when working with a patient or client whose capacity to give consent is or may be impaired or limited, obtaining the consent of people with legal authority to act on behalf of the patient or client and attempting to obtain the consent of the patient or client as far as practically possible

e) being mindful of additional informed consent requirements when supplying or prescribing products not approved or made in Australia, and

f) documenting consent appropriately, including considering the need for written consent for procedures which may result in serious injury or death.

Fees and financial consent

a) Patients or clients should be made aware of all the fees and charges involved in a course of treatment, preferably before the health service is provided.

b) Discussion about fees should be in a manner appropriate to the professional relationship and should include discussion about the cost of all required services and general agreement about the level of treatment to be provided.

3.6 Children and young people

Caring for children and young people brings additional responsibilities for practitioners. Mandatory reporting of child abuse and neglect is legislated in all states and territories in Australia. Practitioners have a responsibility to be aware of the mandatory reporting requirements in their state or territory.

Good practice involves:

a) placing the interests and wellbeing of the child or young person first

b) considering the young person's capacity for decision-making and consent; in general, where a practitioner judges that a person is of a sufficient age and of sufficient mental and emotional capacity to give consent to a service, then that person should be able to request and provide informed consent to receive services without the consent of a parent, guardian or other legal representative

c) ensuring that, when communicating with a child or young person, practitioners:

- treat the child or young person with respect and listen to their views
- encourage questions and answer those questions to the best of the practitioner's ability
- provide information in a way the child or young person can understand
- recognise the role of parents or guardians and, when appropriate, encourage the child or young person to involve their parents or guardians in decisions about care, and
- remain alert to children and young people who may be at risk and notify appropriate child protection authorities as required by law. This may include where a parent or guardian is refusing treatment for their child or young person and this decision may not be in the best interests of the child or young person.

3.7 Culturally safe and sensitive practice

Good practice involves an awareness of the cultural needs and contexts of all patients and clients, to obtain good health outcomes. This includes:

a) having knowledge of, respect for and sensitivity towards the cultural needs and background of the community practitioners serve, including those of Aboriginal and/or Torres Strait Islander Australians and those from culturally and linguistically diverse backgrounds. For example, better and safer outcomes may be achieved for some patients if they are able to be consulted or treated by a practitioner of the same gender

b) acknowledging the social, economic, cultural, historic and behavioural factors influencing health, both at individual and population levels

c) understanding that a practitioner's own culture and beliefs influence their interactions with patients or clients, and

d) adapting practice to improve engagement with patients or clients and healthcare outcomes.

3.8 Patients who may have additional needs

Some patients or clients (including those with impaired decision-making capacity) have additional needs. Good practice in managing the care of these patients or clients includes:

a) paying particular attention to communication

b) being aware that increased advocacy may be necessary to ensure just access to healthcare

c) recognising that there may be a range of people involved in their care such as carers, family

members or a guardian, and involving them when appropriate, and

d) being aware that these patients or clients may be at greater risk.

3.9 Relatives, carers and partners

Good practice involves:

a) being considerate to relatives, carers, partners and others close to the patient or client and respectful of their role in the care of the patient or client, and

b) with appropriate consent, being responsive in providing information.

3.10 Adverse events and open disclosure

When adverse events occur, practitioners have a responsibility to be open and honest in communication with a patient or client to review what has occurred and to report appropriately (also see 'open disclosure' at Section 6.2(a)). When something goes wrong, good practice involves:

a) recognising what has happened

b) acting immediately to rectify the problem, if possible, including seeking any necessary help and advice

c) explaining to the patient or client as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences

d) listening to the patient or client

e) acknowledging any patient or client distress and providing appropriate support

f) complying with any relevant policies, procedures and reporting requirements, subject to advice from a professional indemnity insurer

g) reviewing adverse events and implementing changes to reduce the risk of recurrence (see Section 6 *Minimising risk*)

h) reporting adverse events to the relevant authority as required (see Section 6 *Minimising risk*), and

i) ensuring patients or clients have access to information about the processes for making a complaint (for example, through the relevant National Board or healthcare complaints commission).

3.11 When a complaint is made

Patients or clients have a right to complain about their care. When a complaint is made or a formal notification is received by a Board, good practice involves:

a) acknowledging the person's right to complain

b) working with the person to resolve the issue where possible

c) providing a prompt, open and constructive response including an explanation and, if appropriate, an apology

d) ensuring the complaint or notification does not affect the person's care adversely; in some cases, it may be advisable to refer the person to another practitioner, and

e) complying with relevant complaints legislation, policies and procedures.

3.12 End-of-life care

Practitioners have a vital role in assisting the community to deal with the reality of death and its consequences. In caring for patients or clients towards the end of their life, good practice involves:

a) taking steps to manage a person's symptoms and concerns in a manner consistent with their values and wishes

b) when relevant, providing or arranging appropriate palliative care

c) understanding the limits of services in prolonging life and recognising when efforts to prolong life may not benefit the person

d) for those practitioners involved in care that may prolong life, understanding that practitioners do not have a duty to try to prolong life at all cost but do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that patients or clients receive appropriate relief from distress

e) accepting that patients or clients have the right to refuse treatment or to request the withdrawal of treatment already started

f) respecting different cultural practices related to death and dying

g) striving to communicate effectively with patients or clients and their families so they are able to understand the outcomes that can and cannot be achieved

h) when relevant, facilitating advanced care planning

i) taking reasonable steps to ensure that support is provided to patients or clients and their families, even when it is not possible to deliver the outcome they desire

j) communicating with patients or clients and their families about bad news or unexpected outcomes in the most appropriate way and providing support for them while they deal with this information, and

k) when a patient or client dies, being willing to explain, to the best of the practitioner's knowledge, the circumstances of the death to appropriate members of their family and carers, unless it is known the patient or client would have objected.

3.13 Ending a professional relationship

In some circumstances, the relationship between a practitioner and a patient or client may become ineffective or compromised and may need to end. Good practice involves ensuring that the patient or client is informed adequately of the decision and facilitating arrangements for the continuing care of the patient or client, including passing on relevant clinical information.

3.14 Understanding boundaries

Good practice includes recognising the potential conflicts, risks and complexities of providing care to those in a close relationship, for example close friends, work colleagues and family members and that this can be inappropriate because of the lack of objectivity, possible discontinuity of care and risks to the practitioner or patient. When a practitioner chooses to provide care to those in a close relationship, good practice requires that:

- adequate records are kept
- confidentiality is maintained
- adequate assessment occurs
- appropriate consent is obtained to the circumstances which is acknowledged by both the practitioner and patient or client
- the personal relationship does not in any way impair clinical judgement, and
- at all times an option to discontinue care is maintained. (Also see Section 8.2 *Professional boundaries.)*

3.15 Working with multiple clients

Where practitioners are considering treating multiple patients or clients simultaneously in class or group work, or more than one individual patient or client at the same time, practitioners should consider whether this mode of treatment is appropriate to the patients or clients involved, including whether it could compromise the quality of care (also see Section 3.4 *Confidentiality and privacy* and Section 3.5 *Informed consent*).

3.16 Closing or relocating a practice

When closing or relocating a practice, or when an employed practitioner moves between practices, good practice involves:

a) giving advance notice where possible and as early as possible, and

b) facilitating arrangements for the continuing care of all current patients, which may include the transfer or appropriate management of all patient records while following the law governing privacy and health records in the jurisdiction.

4 Working with other practitioners

4.1 Introduction

Good relationships with colleagues and other practitioners strengthen the practitioner–patient/client relationship and enhance patient care.

4.2 Respect for colleagues and other practitioners

Good care is enhanced when there is mutual respect and clear communication between all health professionals involved in the care of the patient or client. Good practice involves:

a) communicating clearly, effectively, respectfully and promptly with colleagues and other practitioners caring for the patient or client

b) acknowledging and respecting the contribution of all practitioners involved in the care of the patient or client, and

c) behaving professionally and courteously to colleagues and other practitioners at all times, including when using social media.

4.3 Delegation, referral and handover

Delegation involves one practitioner asking another person or member of staff to provide care on behalf of the delegating practitioner while that practitioner retains overall responsibility for the care of the patient or client.

Referral involves one practitioner sending a patient or client to obtain an opinion or treatment from another practitioner. Referral usually involves the transfer (in part) of responsibility for the care of the patient or client, usually for a defined time and a particular purpose, such as care that is outside the referring practitioner's expertise or scope of practice.

Handover is the process of transferring all responsibility to another practitioner.

Good practice involves:

a) taking reasonable steps to ensure that any person to whom a practitioner delegates, refers or hands over has the qualifications and/or experience and/or knowledge and/or skills to provide the care required

b) understanding that, although a delegating practitioner will not be accountable for the decisions and actions of those to whom they delegate, the delegating practitioner remains responsible for the overall management of the patient or client and for the decision to delegate, and

c) always communicating sufficient information about the patient or client and the treatment needed to enable the continuing care of the patient or client.

4.4 Teamwork

Many practitioners work closely with a wide range of other practitioners, with benefits for patient care.

Effective collaboration is a fundamental aspect of good practice when working in a team. The care of patients or clients is improved when there is mutual respect and clear communication as well as an understanding of the responsibilities, capacities, constraints and ethical codes of each other's health professions. Working in a team does not alter a practitioner's personal accountability for professional conduct and the care provided. When working in a team, good practice involves:

a) understanding the particular role in the team and attending to the responsibilities associated with that role

b) advocating for a clear delineation of roles and responsibilities, including that there is a recognised

team leader or coordinator although care within the team may be provided by different practitioners from different health professions within different models of care

c) communicating effectively with other team members

d) informing patients or clients about the roles of team members

e) acting as a positive role model for team members

f) understanding the nature and consequences of bullying and harassment and seeking to avoid or eliminate such behaviour in the workplace, and

g) supporting students and practitioners receiving supervision and others within the team.

4.5 Coordinating care with other practitioners

Good patient care requires coordination between all treating practitioners. Good practice involves:

a) communicating all the relevant information in a timely way, and

b) ensuring that it is clear to the patient or client, the family and colleagues who has ultimate responsibility for coordinating the care of the patient or client.

5 Working within the healthcare system

5.1 Introduction

Practitioners have a responsibility to contribute to the effectiveness and efficiency of the healthcare system.

5.2 Wise use of healthcare resources

It is important to use healthcare resources wisely. Good practice involves:

a) ensuring that the services provided are appropriate for the assessed needs of the patient or client and are not excessive, unnecessary or not reasonably required

b) upholding the right of patients or clients to gain access to the necessary level of healthcare, and, whenever possible, helping them to do so

c) supporting the transparent and equitable allocation of healthcare resources, and

d) understanding that the use of resources can affect the access other patients or clients have to healthcare resources.

5.3 Health advocacy

There are significant disparities in the health status of different groups in the Australian community. These disparities result from social, cultural, geographic, health-related and other factors. In particular, Indigenous Australians bear the burden of gross social, cultural and health inequity. Other groups may experience health disparities including people with intellectual or physical disabilities, those from culturally and linguistically diverse backgrounds and refugees. Good practice involves using expertise and influence to protect and advance the health and wellbeing of individual patients or clients, communities and populations.

5.4 Public health

Practitioners have a responsibility to promote the health of the community through disease prevention and control, education and, where relevant, screening. Good practice involves:

a) understanding the principles of public health, including health education, health promotion, disease prevention and control and screening, and

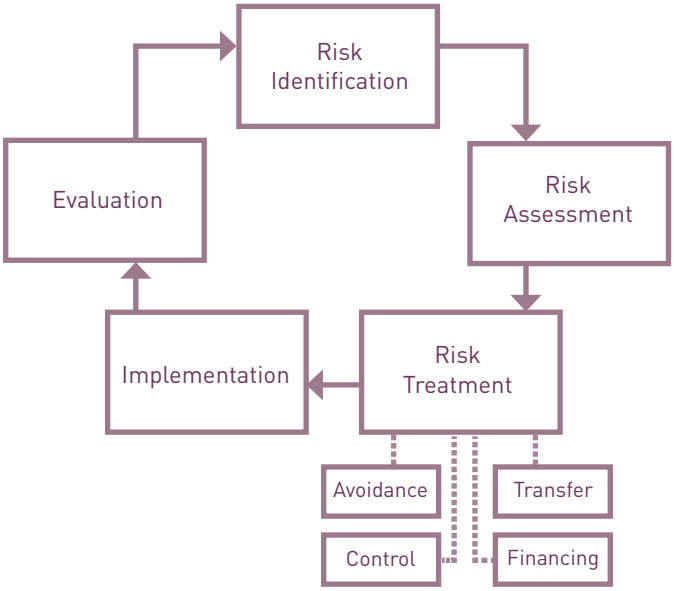
b) participating in efforts to promote the health of the community and being aware of obligations in disease prevention, including screening and reporting notifiable diseases where relevant.

6 Minimising risk

6.1 Introduction

Risk is inherent in healthcare. Minimising risk to patients or clients is an important component of practice. Good practice involves understanding and applying the key principles of risk minimisation and management in practice.

Basic Model of Risk Management



6.2 Risk management

Good practice in relation to risk management involves:

a) being aware of the principles of open disclosure and a non-punitive approach to incident management; a useful reference is the Australian Commission on Safety and Quality in Health Care's National Open Disclosure Standard available at www.safetyandquality.gov.au

b) participating in systems of quality assurance and improvement

c) participating in systems for surveillance and monitoring of adverse events and 'near misses', including reporting such events to the relevant authority

d) if a practitioner has management responsibilities, making sure that systems are in place for raising concerns about risks to patients or clients

e) working in practice and within systems to reduce error and improve the safety of patients or clients and supporting colleagues who raise concerns about the safety of patients or clients, and

f) taking all reasonable steps to address the issue if there is reason to think that the safety of patients or clients may be compromised.

6.3 Practitioner performance

The welfare of patients or clients may be put at risk if a practitioner is performing poorly. If there is a risk, good practice involves:

a) complying with statutory reporting requirements, including those under the National Law

b) recognising and taking steps to minimise the risks of fatigue, including complying with relevant state and territory occupational health and safety legislation

c) if a practitioner knows or suspects that they have a health condition that could adversely affect judgement or performance, following the guidance in Section 9.2 *Practitioner health*

d) taking steps to protect patients or clients from being placed at risk of harm posed by a colleague's conduct, practice or ill health

e) taking appropriate steps to assist a colleague to receive help if there are concerns about the colleague's performance or fitness to practise, and

f) if a practitioner is not sure what to do, seeking advice from an experienced colleague, the employer/s, practitioner health advisory services, professional indemnity insurers, the National Boards or a professional organisation.

7 Maintaining professional performance

7.1 Introduction

Maintaining and developing knowledge, skills and professional behaviour are core aspects of good practice. This requires self-reflection and participation in relevant professional development, practice improvement and performance-appraisal processes to continually develop professional capabilities. These activities must continue through a practitioner's working life as science and technology develop and society changes.

7.2 Continuing professional development (CPD)

Development of knowledge, skills and professional behaviour must continue throughout a practitioner's working life. Good practice involves keeping knowledge and skills up to date to ensure that practitioners continue to work within their competence and scope of practice. The National Law requires practitioners to undertake CPD. Practitioners should refer to the National Board's registration standard and guidelines on CPD for details of these requirements.

8 Professional behaviour

8.1 Introduction

In professional life, practitioners must display a standard of behaviour that warrants the trust and respect of the community. This includes observing and practising the principles of ethical conduct.

The guidance contained in this section emphasises the core qualities and characteristics of good practitioners outlined in Section 1.2 *Professional values and qualities*.

8.2 Professional boundaries

Professional boundaries allow a practitioner and a patient/client to engage safely and effectively in a therapeutic relationship. Professional boundaries refers to the clear separation that should exist between professional conduct aimed at meeting the health needs of patients or clients and a practitioner's own personal views, feelings and relationships which are not relevant to the therapeutic relationship.

Professional boundaries are integral to a good practitioner–patient/client relationship. They promote good care for patients or clients and protect both parties. Good practice involves:

a) maintaining professional boundaries

b) never using a professional position to establish or pursue a sexual, exploitative or otherwise inappropriate relationship with anybody under a practitioner's care; this includes those close to the patient or client, such as their carer, guardian, spouse or the parent of a child patient or client

c) recognising that sexual and other personal relationships with people who have previously been a practitioner's patients or clients are usually inappropriate, depending on the extent of the professional relationship and the vulnerability of a previous patient or client, and

d) avoiding the expression of personal beliefs to patients or clients in ways that exploit their vulnerability or that are likely to cause them distress.

Practitioners need to be aware of and comply with any guidelines of their National Board in relation to professional boundaries.

8.3 Reporting obligations

Practitioners have statutory responsibility under the National Law to report matters to the National Boards: please refer to the Board's guidelines on mandatory reporting and sections 130 and 141 of the National Law. They also have professional obligations to report to the Boards and their employer/s if they have had any limitations placed on their practice. Good practice involves:

a) being aware of these reporting obligations

b) complying with any reporting obligations that apply to practice, and

c) seeking advice from the Boards, professional indemnity insurer or other relevant bodies if practitioners are unsure about their obligations.

8.4 Health records

Maintaining clear and accurate health records is essential for the continuing good care of patients or clients. Practitioners should be aware that some National Boards have specific guidelines in relation to records. Good practice involves:

a) keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients or clients, medication and other management in a form that can be understood by other health practitioners

b) ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard copy

c) ensuring that records show respect for patients or clients and do not include demeaning or derogatory remarks

d) ensuring that records are sufficient to facilitate continuity of care

e) making records at the time of events or as soon as possible afterwards

f) recognising the right of patients or clients to access information contained in their health records and facilitating that access, and

g) promptly facilitating the transfer of health information when requested by patients or clients.

8.5 Insurance

Practitioners have a statutory requirement to ensure that practice is appropriately covered by professional indemnity insurance (see the Board's professional indemnity insurance registration standard).

8.6 Advertising

Advertisements for services can be useful in providing information for patients or clients. All advertisements must comply with the provisions of the National Law on the advertising of regulated health services, relevant consumer protection legislation, and state and territory fair trading Acts and, if applicable, legislation regulating the advertising of therapeutic goods.

Good practice involves complying with the National Law, (explained in the Board's guidelines on advertising of regulated health services) and relevant Commonwealth, state and territory legislation and ensuring that any promotion of therapeutic products is ethical.

8.7 Legal, insurance and other assessments

When a practitioner is contracted by a third party to provide a legal, insurance or other assessment of a person who is not their patient or client, the usual therapeutic practitioner–patient/client relationship does not exist. In this situation, good practice involves:

a) applying the standards or professional behaviour described in this code to the assessment; in particular, being courteous, alert to the concerns of the person and ensuring the person's consent

b) explaining to the person the practitioner's area of practice, role and the purpose, nature and extent of the assessment to be conducted

c) anticipating and seeking to correct any misunderstandings that the person may have about the nature and purpose of the assessment and report

d) providing an impartial report (see Section 8.8 *Reports, certificates and giving evidence*), and

e) recognising that if an unrecognised, serious problem is discovered during the assessment, there is a duty of care to inform the patient or client or their treating practitioner.

8.8 Reports, certificates and giving evidence

The community places a great deal of trust in practitioners. Consequently, some practitioners have been given the authority to sign documents such as sickness or fitness for work certificates on the assumption that they will only sign statements that they know, or reasonably believe, to be true. Good practice involves:

a) being honest and not misleading when writing reports and certificates and only signing documents believed to be accurate

b) taking reasonable steps to verify the content before signing a report or certificate and not omitting relevant information deliberately

c) if so agreed, preparing or signing documents and reports within a reasonable and justifiable timeframe, and

d) making clear the limits of a practitioner's knowledge and not giving opinion beyond those limits when providing evidence.

8.9 Curriculum vitae

When providing curriculum vitae, good practice involves:

a) providing accurate, truthful and verifiable information about a practitioner's experience and qualifications, and

b) not misrepresenting by misstatement or omission a practitioner's experience, qualifications or position.

Also see Section 10.3 *Assessing colleagues* in relation to providing references for colleagues.

8.10 Investigations

Practitioners have responsibilities and rights relating to any legitimate investigation of their practice or that of a colleague. In meeting these responsibilities, it is advisable to seek legal advice or advice from a professional indemnity insurer. Good practice involves:

a) cooperating with any legitimate inquiry into the treatment of a patient or client and with any complaints procedure that applies to a practitioner's work

b) disclosing to anyone entitled to ask for it information relevant to an investigation into the conduct, performance or health of a practitioner or colleague, and

c) assisting the coroner when an inquest or inquiry is held into the death of a patient or client by responding to the coroner's enquiries and by offering all relevant information.

8.11 Conflicts of interest

Patients or clients rely on the independence and trustworthiness of practitioners for any advice or treatment offered. A conflict of interest in practice arises when a practitioner, entrusted with acting in the interests of a patient or client, also has financial, professional or personal interests or relationships with third parties which may affect their care of the patient or client.

Multiple interests are common. They require identification, careful consideration, appropriate disclosure and accountability. When these interests compromise, or might reasonably be perceived by an independent observer to compromise the practitioner's primary duty to the patient or client, practitioners must recognise and resolve this conflict in the best interests of the patient or client.

Good practice involves:

a) recognising potential conflicts of interest that may arise in relation to initiating or continuing a professional relationship with a patient or client

b) acting in the best interests of patients or clients when making referrals and when providing or arranging treatment or care

c) informing patients or clients when a practitioner has an interest that could affect or could be perceived to affect patient or client care

d) recognising that pharmaceutical and other marketing may influence practitioners and being aware of ways in which practice may be influenced

e) not asking for or accepting any inducement, gift or hospitality from companies that sell or market drugs or other products that may affect or be seen to affect the way practitioners prescribe for, treat or refer patients or clients

f) not asking for or accepting fees for meeting sales representatives

g) not offering inducements to colleagues or entering into arrangements that could be perceived to provide inducements, and

h) not allowing any financial or commercial interest in a hospital, other healthcare organisation or company providing healthcare services or products to adversely affect the way in which patients or clients are treated. When practitioners or their immediate family have such an interest and that interest could be perceived to influence the care provided, practitioners must inform their patients or clients.

8.12 Financial and commercial dealings

Practitioners must be honest and transparent in financial arrangements with patients or clients. Good practice involves:

a) not exploiting the vulnerability or lack of knowledge of patients or clients when providing or recommending services

b) not encouraging patients or clients to give, lend or bequeath money or gifts that will benefit a practitioner directly or indirectly

c) not accepting gifts from patients or clients other than tokens of minimal value such as flowers or chocolates, and, if token gifts are accepted, making a file note or informing a colleague where possible

d) not becoming involved financially with patients or clients; for example, through loans and investment schemes

e) not influencing patients or clients or their families to make donations to other people or organisations, and

f) being transparent in financial and commercial matters relating to work, including dealings with employers, insurers and other organisations or individuals and in particular:

- declaring any relevant and material financial or commercial interest that a practitioner or their family might have in any aspect of the care of the patient or client, and
- declaring to patients or clients any professional and financial interest in any product or service a practitioner might endorse or sell from their practice and not making an unjustifiable profit from the sale or endorsement.

9 Ensuring practitioner health

9.1 Introduction

As a practitioner, it is important to maintain health and wellbeing. This includes seeking an appropriate work–life balance.

9.2 Practitioner health

Good practice involves:

a) attending a general practitioner or other appropriate practitioner to meet health needs

b) seeking expert, independent, objective advice when a practitioner needs healthcare and being aware of the risks of self-diagnosis and self-treatment

c) understanding the principles of immunisation against communicable diseases

d) for practitioners who are able to prescribe, conforming to the legislation in the relevant states and territories in relation to self-prescribing

e) recognising the impact of fatigue on practitioner health and ability to care for patients or clients and endeavouring to work safe hours whenever possible

f) being aware of any relevant practitioner health program if advice or help is needed, and

g) if a practitioner knows or suspects that they have a health condition or impairment that could adversely affect judgement, performance or the health of patients or clients:

- not relying on self-assessment of the risk posed to patients or clients
- consulting a doctor or other practitioner as appropriate about whether, and in what ways, the affected practitioner may need to modify practice and following the treating practitioner's advice, and
- being aware of practitioner responsibility under the National Law to notify the Boards in relation to certain impairments.

9.3 Other practitioners' health

Health practitioners have a responsibility to assist their colleagues to maintain good health. Good practice involves:

a) providing practitioners who are patients or clients with the same quality of care provided to other patients or clients

b) notifying the Boards if treating another registered practitioner who has patients or clients at risk of substantial harm when practising their profession because they have an impairment (refer to the Boards' guidelines on mandatory reporting); this is a professional as well as a statutory responsibility under the National Law

c) notifying the Boards and encouraging a colleague (who is not a patient or client) who you work with to seek appropriate help if it is reasonably believed the colleague may be ill and impaired; and if this impairment has placed patients or clients at risk of substantial harm, refer to the notification provisions of the National Law and the Boards' guidelines on mandatory notifications, and

d) recognising the impact of fatigue on the health of colleagues, including those under supervision, and facilitating safe working hours wherever possible.

10 Teaching, supervising and assessing

10.1 Introduction

Teaching, supervising and mentoring practitioners and students is important for their development and for the care of patients or clients. It is part of good practice to contribute to these activities and provide support, assessment, feedback and supervision for colleagues, practitioners in training and students. It also adds value to the supervisor's practice through engagement with the person being supervised and their learning needs. There are a range of supervision models being adopted in the health professions, including coach, mentor and shadow.

10.2 Teaching and supervising

Good practice involves:

a) seeking to develop the skills, attitudes and practices of an effective teacher, whenever a practitioner is involved in teaching

b) as a supervisor, recognising that the onus of supervision cannot be transferred

c) making sure that any practitioner or student under supervision receives adequate oversight and feedback, including undertaking an assessment of each student supervised; reflecting on that student's ability, competence and learning requirements; and planning their supervision based on that assessment rather than any external direction, and

d) avoiding any potential for conflict of interest in the supervisory relationship; for example, by supervising someone who is a close relative or friend or where there is another potential conflict of interest that could impede objectivity and/or interfere with the supervised person's achievement of learning outcomes or relevant experience.

10.3 Assessing colleagues

Assessing colleagues is an important part of making sure that the highest standards or practice are achieved. Good practice involves:

a) being honest, objective and constructive when assessing the performance of colleagues, including students; patients or clients will be put at risk of harm if an assessment describes as competent someone who is not, and

b) when giving references or writing reports about colleagues, providing accurate and justifiable information promptly and including all relevant information.

10.4 Students

Students are learning how best to care for patients or clients. Creating opportunities for learning improves their clinical practice and nurtures the future workforce. Good practice involves:

a) treating students with respect and patience

b) making the scope of the student's role in patient or client care clear to the student, to patients or clients and to other members of the healthcare team, and

c) informing patients or clients about the involvement of students and encouraging their consent for student participation while respecting their right to choose not to consent.

11 Undertaking research

11.1 Introduction

Research involving humans, their tissue samples or their health information is vital in improving the quality of healthcare and reducing uncertainty for patients and clients now and in the future, and in improving the health of the population as a whole. Research in Australia is governed by guidelines issued in accordance with the *National Health and Medical Research Council Act 1992* (Cth). Practitioners undertaking research should familiarise themselves with and follow these guidelines.

Research involving animals is governed by legislation in states and territories and by guidelines issued by the NHMRC.

11.2 Research ethics

Being involved in the design, organisation, conduct or reporting of health research involving humans brings particular responsibilities for practitioners. These responsibilities, drawn from the NHMRC guidelines, include:

a) according to participants the respect and protection that is due to them

b) acting with honesty and integrity

c) ensuring that any protocol for human research has been approved by a human research ethics committee, in accordance with the *National statement on ethical conduct in human research* issued by the NHMRC (which addresses privacy issues, and refers to the need to consider relevant state, territory and federal privacy legislation)

d) disclosing the sources and amounts of funding for research to the human research ethics committee

e) disclosing any potential or actual conflicts of interest to the human research ethics committee

f) ensuring that human participation is voluntary and based on informed consent and an adequate understanding of sufficient information about the purpose, methods, demands, risks and potential benefits of the research

g) ensuring that any dependent relationship between practitioners and their patients or clients is taken into account in the recruitment of patients or clients as research participants

h) seeking advice when research involves children or adults who are not able to give informed consent to ensure that there are appropriate safeguards in place, including ensuring that a person empowered to make decisions on the behalf of patients or

clients has given informed consent or that there is other lawful authority to proceed

i) adhering to the approved research protocol

j) monitoring the progress of the research and reporting adverse events or unexpected outcomes promptly

k) respecting the entitlement of research participants to withdraw from any research at any time and without giving reasons

l) adhering to the guidelines regarding publication of findings, authorship and peer review, and

m) reporting possible fraud or misconduct in research as required under the *Australian code for the responsible conduct of research* issued by the NHMRC.

Practitioners should refer to the NHMRC publications listed above for more guidance.

11.3 Treating practitioners and research

When practitioners are involved in research that involves patients or clients, good practice includes:

a) respecting the right of patients or clients to withdraw from a study without prejudice to their treatment, and

b) ensuring that a decision by patients or clients not to participate does not compromise the practitioner–patient/client relationship or the care of the patient or client.

References

The Australian Commission on Safety and Quality in Health Care's website (www.safetyandquality.gov.au) provides relevant guidance on a range of safety and quality issues. Information of particular relevance to health practitioners includes:

- health literacy
- open disclosure and incident management
- hand hygiene, and
- healthcare rights.

The National Health and Medical Research Council's website (www.nhmrc.gov.au) provides relevant information on informed consent and research issues.

Health Workforce Australia's website (www.hwa.gov.au) provides information on a range of health workforce issues, including resources on clinical supervision.

The Therapeutic Goods Administration's website (www.tga.gov.au) provides relevant information on therapeutic goods.

Definitions

Electronic means any digital form of communication, including email, Skype, internet, social media, etc.

Providing care includes, but is not limited to any care, treatment, advice, service or goods provided in respect of the physical or mental health of a person, whether remunerated or pro bono.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. For the purposes of this code, practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that have an impact on safe, effective delivery of health services in the health profession.

Patient or client includes all consumers of healthcare services.

Social media describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips and includes websites and applications used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), WOMO, True Local and microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards.

CODE OF CONDUCT

Review

Date of issue: 17 March 2014

Date of review: This code of conduct will be reviewed from time to time as required. This will generally be at least every three years.

Aboriginal and Torres Strait Islander Health Practice Board of Australia

Registration for Aboriginal and Torres Strait Islander health practitioners

2013/14

For more information

For more information please contact us:

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Telephone: 1300 419 495

Board website: www.atsihealthpracticeboard.gov.au

- Read about the Board's latest decision through our bi-monthly Communiqué
- Read about issues affecting registered Aboriginal and Torres Strait Islander health practitioners through our bi-annual newsletter
- Check the public register
- Provide us feedback on some of our proposals released for public consultation
- Apply for registration as an Aboriginal and Torres Strait Islander health practitioner
- Apply for registration as a graduate
- Read about individual Board members
- Access the latest statistics on the profession