17 October 2007

Sue Kedgley
Chairperson
Health Committee
Parliament House
Wellington 1

Dear Ms Kedgley,

Thank you for your letter of the 11th October to Mr Chris Webb indicating that a submission from the Auckland University of Technology (AUT) Para-medicine & Emergency Management academic staff would be of interest to the Health Committee.

Background

The Auckland University of Technology (AUT) is clearly focussed on the provision of quality education for Paramedics and Ambulance Officers' throughout New Zealand to enable them to initiate and implement appropriate out-of-hospital quality care for the public of New Zealand.

Our commitment to Pre-Hospital Emergency Care education and nationally consistent education programmes was established in 1986 with the National Ambulance Officer's Training School (NAOTS) becoming a valued school within the Faculty of Health & Environmental Studies. The national school was closed in 1999 due to the Ambulance Education Council (AEC) Industry Training Organisation drive to a model of multiple education providers. The AEC subsequently closed, and the Electro Technology Industry Technology Organisation (ETITO) took over as the registered standards setting body for the ambulance sector for unit standard based education.

In 2000 AUT became New Zealand's newest university. The university also gained Ministry of Education funding for Paramedic and Ambulance Officer programmes, established an educational undergraduate major in Para-medicine, and established an Emergency Management pathway.

AUT presently offers the:

- BHSc Paramedic
- The National Diploma in Ambulance (Paramedic) is embedded in the degree programme to facilitate dual qualification at Advanced Paramedic level
- Diploma in Military Medicine
- Graduate Certificate in Emergency Management
- Masters in Emergency Management (from 2008)

AUT is accredited to offer the National Certificate in Ambulance (Patient Care & Transport); District Health Board ambulance services offered the AUT program until the end of 2006.

The BHSc Paramedic caters for the working Paramedic moving to Advanced Paramedic practice, the Advanced Paramedic who wishes to update their qualifications, and the direct entry student that is seeking a career in Para-medicine. The primary purpose of educational and associated activities within the Faculty is to serve the health needs of New Zealanders. This reflects a commitment to be responsive to the changing health care environment and needs, as identified by government, research and/or articulated by consumer and voluntary organisations, professional and scientific bodies, students and Faculty staff.

Prior to 2000 all Paramedic and Ambulance Officer education was funded by the employer, with ITO funded support from the mid-nineties. Only people who were employed as a volunteer or a paid member of an ambulance service could receive pre-hospital emergency care education beyond first responder program level before 2000.

Pre-employment education presently works in tandem with the ambulance in-service education model. Most states in Australia have totally moved to a pre-employment degree education model. As the situation stands, New Zealand ambulance services can employ a person in a voluntary or paid capacity and on completion of a five day Pre-hospital Emergency Care short course certificate and a driving course this person can be in uniform responding to whatever incident they are directed to by the dispatcher.

AUT is presently participating in the Standards New Zealand Committee (DZ 8156) rewrite of the Ambulance and Paramedical Services Standard.

The university is also voluntarily completing the Australasian Convention of Ambulance Authorities professional accreditation process along with all other universities offering Paramedic degrees in Australia. This collegial initiative will provide benchmarking and enhance Trans-Tasman employment opportunities for our graduates.

It is from this extensive experience base that AUT makes a submission to the Health Committee with a particular focus on the performance and regulatory framework of ambulance services.

AUT would welcome the opportunity to make an oral presentation to the Health Committee if you see fit.

Yours sincerely,

Brenda Costa-Scorse
Senior Lecturer
Para-medicine & Emergency Management
Faculty of Health & Environmental Studies
AUT University

brenda.costa-scorse@aut.ac.nz

Submission on the Inquiry into the Provision of Ambulance Services

1. Performance & Regulatory Framework

1.1 It is imperative that Paramedics are included under the Health Practitioners' Competency Assurance Act (2003) to protect the public from harm due to pre-hospital emergency care practices and to ensure that Paramedics are competent and fit to practice.

1.2 Paramedics are not at present a profession named in the Act due to their unregistered status, yet they work independently making critical decisions, undertaking invasive complex skills, carrying and administering medications and care for sick or injured people in uncontrolled and unpredictable environments. Such environmental factors often see the capabilities of Paramedics and Ambulance Officers stretched beyond that of their nursing, midwifery, occupational therapy or physiotherapy colleagues, many of whom work in relatively controlled environments.

1.3 It is recommended that the Ambulance and Paramedical Services Standard (DZ 8156) should be deemed a mandatory standard and not a voluntary standard (as is currently the case) to assure the public of a high standard of care and service from both practitioners and ambulance services.

1.4 Inclusion of clinical response times / best practice guidelines should be considered for inclusion in the Ambulance and Paramedical Services Standard (DZ 8156) in the future.

1.5 Optimum patient care requires two qualified staff. Single crewing is not optimum patient care as one person on scene limits the capacity to provide effective life support and this practice also leaves sick patients unattended during transport in an ambulance. This unfortunate reality needs to be addressed within the Ambulance and Paramedical Services Standard (DZ 8156) and in government contracts with Ambulance Services.

1.6 The Medicine (Standing Order) Regulations (2002) places hefty legal responsibility for practice standards on the Medical Directors shoulders, the onus for professional responsibility for Paramedic practice should be on the profession themselves with the formation of an independent registration body.

1.7 Registered Paramedics. AUT views that registration of Paramedics should be achieved on successful completion of the Bachelor of Health Science Paramedic. All other health professionals are registered on completion of an undergraduate degree.

1.8 Registration is viewed by many NZ Paramedics as the coming of age of the discipline, and an opportunity for other health professionals to recognise their scopes of practice and for Paramedics to direct the future of this specialized field of emergency medicine. Professional self-determination should be catered for in the future of the provision of Ambulance Services.

1.9 “Grandfather” clauses should be included in registration for Advanced Paramedics awarded the National Diploma in Ambulance (Paramedic) or the NZ Advanced Ambulance Aid Certificate, with clear professional development requirements to bridge these practitioners into the degree within a defined time period in order to maintain registration.

1.10 Recognition of prior learning procedures can easily facilitate this transition as both of these ALS qualifications receive considerable credit into the degree pathway.

1.11 Intermediate Care level Paramedics (ILS) do not have a distinct qualification and should not be included in full registration. To allow basic certificate qualifications (National Certificate in Ambulance or NZ Proficiency Ambulance Aid) combined with experience and short course certificates in intravenous therapy and cardiology as a standard for registration is inappropriate. Experience is potentially a subjective term open to interpretation. Short courses are not an integrated educational solution; safe practice is anchored by a comprehensive and rigorous education. This group of practitioners needs to be educated to degree level or at the very least complete a Diploma in Paramedic Science.

1.12 Ambulance Officers / Paramedics at ILS level: Ambulance Officers at BLS level and First Responders present a challenge in the move to registration as there is as much potential for harm at Basic Life Support level (BLS) as at advanced level (ALS). It is of note that the United Kingdom has the challenge of censor and prevention from practicing at present with unregistered health care assistants; it will be of interest to note the UK solution to this dilemma.

1.13 It is also of note that as medicine advances there is an increasing propensity in the ambulance sector to do short skill-based add-on workshops and assignments leading to a creep in the competencies and the responsibilities of Ambulance Officers. A comprehensive education platform that develops the practitioner is essential to ensure that they are well equipped in knowledge and skills to meet these advances in scope of practice. In 1984 the government commissioned Walton Offenberger to review the Ambulance Officer education system; this review resulted in the recommendation to move Ambulance Officer education into the tertiary education system, this is presently not the case.

1.14 A secondary form of endorsement should be considered for ILS level Ambulance Officers’ / ILS Paramedics and BLS level Ambulance Officers’ to cover the situation where people with these competencies are practising unprofessionally and /or beyond their delegated scope which endangers the public.

1.15 The scope of practice should be defined for people who provide ILS and BLS care, with limitations on how many short add-on courses can be utilised by employers to up-skill lower qualified staff to increase their scope of practice. This education approach leads to national differences in practitioners that wear the same qualification insignia.

1.16 Enhanced first aid encompasses the use of Advisory Shock Defibrillation. These automated defibrillators are in use by the general public challenging traditional boundaries of scopes of practice and educational requirements

1.17 The common argument from the sector, that volunteer staff and the wide range of lower level qualifications means the sector is not ready for registration, needs close scrutiny. This premise constantly drives the profession down to the lowest common denominator rather than raising the bar to a gold standard which many Paramedics currently practice at, and others can aspire to.

1.18 The BHSc Paramedic students study in the Paramedic major plus undertake shared learning in papers with registered health professions; namely, nursing, midwifery, physiotherapy and occupational therapy programs. This educational pathway places the profession in a good position to move to registration in the not to distant future.

2. Maintaining Registration

2.1 An annual practising certificate with a requirement to maintain professional standards by set measures should be necessary to ensure maintenance of registration. This should include both continuing education and demonstration of competency at the current scope of practice as now required by other health disciplines.

3. Scope of Practice

3.1 Paramedics are a developing health profession in New Zealand. They work autonomously out-of-hospital, often in hostile isolated settings. The Paramedic assesses and determines the appropriate management of a person who is injured or ill. This may involve the use of medication or specific interventions such as endotracheal intubations and intravenous therapy. In practical terms, the Paramedic is independently prescribing treatments under these guidelines. For example the appropriate dosage of morphine is determined by the individual Paramedic. This level of autonomy, with critical often-complex decision-making needs to be reflected in registration scopes of practice

3.2 Ambulance Officers and Paramedics work under the Medicines (Standing Order) Regulations (2002); a framework for delegated powers that is being strengthened at present. Of note is that Paramedics are included alongside registered counterparts namely nurses and physiotherapists in the revised documentation. Ambulance Officers and Paramedics presently utilise St John, DHB or Wellington Free Ambulance Authorised Procedures. Under the New Zealand Ambulance Board, there were national procedures but, with the formation of Ambulance New Zealand, the national clinical advisory committee was dissolved. This led to creation of in-house solutions in the various ambulance services and variation in the scopes of practice throughout the country. A national Clinical Advisory Committee should be reformed by a statutory body or by Ambulance New Zealand with a reporting requirement to the Ministry of Health. Medical Directors carry a huge level of responsibility in terms of the staff under their jurisdiction and this should be assessed both from a legal viewpoint and in practical terms. It is impossible when not on the scene of every incident, or in contact with staff making these complex decisions, for Medical Directors to provide minute by minute support in clinical decisions and with qualified staff this is mostly unnecessary. It is also of note that people without clinical qualifications serve on clinical management groups / clinical advisory groups making decisions on scopes of practice of Paramedics and Ambulance Officers; the make up of such committees should be defined by a registration body or the government.

4. **Title Protection**.

4.1 The title “Registered Paramedic” most definitely should be protected as officers at this level have advanced clinical and life support capabilities.

4.2 Use of this the term Paramedic is very loose at present as it means literally someone who works around medicine. First Responders can presently give themselves the paramedic label and potentially compromise sick and injured persons by being unable to administer an appropriate level of advanced care. It is of concern that Ambulance Officers who were originally called Intermediate Care Officers were re-categorised overnight as Paramedics; the practice level originally kept for the Advanced Paramedic level. The downgrade of the title Paramedic to ILS level practitioners for contractual expedience should be reversed. In some parts of New Zealand the term Intensive Care Paramedic is used, and in others Advanced Paramedic or Paramedic. It would be logical to have one protected title to ensure there is no confusion in terms of expectation from members of the public.

4.3 Advanced Care Life Support skills should be a restricted scope of practice for Registered Paramedics. The present scope includes the following: intubations, cricothyroid puncture, chest decompression, vascular access via intraosseous, intravenous and external jugular cannulation, cricothyroid puncture, and, intramuscular and intravenous medications.

5. Annual practising certificates and annual licences

5.1 Refer 3.1

5.2 An ISO standard licensing system for the overall Ambulance Services should be separate to the need to register individual Paramedics.

6. Competence

6.1 Proof of maintenance of competency should be required in order to receive an annual practicing certificate.

6.2 Employers should demonstrate that professional development provision is made for staff to maintain competency.

6.3 The registering authority should be able to review competence.

7. Compliance costs

7.1 A joint employer / practitioner responsibility.

8. Removal from, or challenges to, registration

8.1 Where a colleague raises concerns with an employer about another practitioner, the onus should be on the employer to audit this person to ascertain if this is a valid and fair concern.

8.2 Where there is factual evidence of breeches these should be referred to an independent disciplinary body.

9. Power to suspend

9.1 Suspension processes could be enacted after due process.

10. Reporting on practice below an acceptable standard

10.1 Reporting of practice below an acceptable standard should be reported in the first instance to the employer.
10.2 Robust audit processes within organisations should be activated.
10.3 Where the complainant observes inaction by an individual or the employer the registered authority should be notified

11. Temporary suspension & mandatory conditions

Are required.

12. Quality assurance activity

Transparent processes are essential.

13. Complaints assessment committee

It should be mandatory that complaints committees have a layperson.

14. Complaints assessment committee power to resolve

The committee should have power to resolve minor complaints.

15. Separation of registration & disciplinary functions

15.1 Registration functions should be separate from employer bodies.
15.2 Registration functions should be separate from industry training organisations.
15.3 Registration boards could be potentially multidisciplinary to contain costs and repetition of processes. The ambulance sector is small with 3,000 Ambulance Officers. Paramedics make up a small percentage of this figure.
15.4 The concept of a multidisciplinary tribunal is supported as this allows for cross discipline scrutiny and transparency of processes.

16. Future proofing

16.1 Degree education has challenged the traditional model where the employer had controlled who received advanced education. The degree provides for working ambulance officers and paramedics to make their own professional development choices and enables people to gain education to purse a career in the emergency sector on graduating. The scope of practice that a graduate can perform at is presently the decision of the employer. The decisions on scopes of practice are not totally

based on qualification or optimum care provision but are based on years in the job, experience, promotion within the ranks, employer wage costs for increased scopes of practice, and concerns in regard to retention of skills in low work load areas.

16.2 Presently employed ILS Paramedics in the degree program can be practising at ALS level within a month of completion of their third year papers as they pick up the dual qualification of the National Diploma in Ambulance (Paramedic) with most (not all) completing the non-clinical papers of the degree over the next few years these papers include subjects such as health law, risk management, and emergency planning.

16.3 The direct entry degree graduate when employed starts as an Ambulance Officer at BLS level and may not practice at ILS or ALS scope for 12 – 24 months. This system 'gate–keeps' qualified people and leads to an omission in the provision of care of which the practitioner is capable of, undertaking. The lack of a standard graduate programme creates the potential for attrition of knowledge and skill, and also burdens the employer with a complex retesting model. In Australia graduates commence at ILS level and are mentored to independent ALS practice over the first year of employment. An independent registration body that sets scopes of practice could take the onus away from the employer by making these decisions.

16.4 A nationally endorsed graduate program would create a win-win for the sector that capitalizes on the talents of the graduates and for the public of New Zealand. If it is the view of any potential employer, that experience is insufficient in degree education a registration body should establish a minimum clinical practicum time. The AUT degree ensures a minimum of 1080 hours of clinical placement in operational and hospital-based practicum plus 120 hours of high fidelity clinical simulation in a 3600-hour program. This compares very favourably with our Australasian counterparts where NZ has twice the time in applied learning situations.

16.5 Presently the AUT BHSc Paramedic has a quasi state exam function with ensuring graduates are safe to practice. This function is rigorous and involves St John Ambulance Service Medical Advisors on the Viva Voce (oral panel examinations) a practising Advanced Paramedic, and a senior AUT lecturer, a Registration Board could take over this final examination step. Students are also required to demonstrate practical competency at ALS level in high fidelity simulation, this assessment could also potentially be part of a state examination requirement.

16.6 Potentially greater use of the out-of-hospital expertise of Paramedics in community / primary health care could enhance the multi-disciplinary health care team approach. There is an opportunity to develop a model similar to the United Kingdom with Paramedic Practitioners; a similar model is being trialled in rural Australia. The Paramedic Practitioner undertakes comprehensive assessment, enhanced treatment measures, referral to primary health care teams, or discharge. Paramedics at ALS level are certainly capable of this extended scope of practice. A Paramedic Practitioner model could greatly enhance health care outcomes for New Zealanders and markedly reduce the caseload of Emergency Departments; there are many occasions, that the transfer to hospital because of limitations in the opportunity to refer the patient for assessment, not because the person is critically unwell. For example, the frequently falling elderly person that needs a holistic overview of their living situation and aids to assist in maintaining independence could be saved the long wait in a hospital ED by an enhanced primary health care team that includes Paramedic patient care and liaison.