Code of conduct review - Australian Dental Association

The National Boards are inviting general comments on a revised shared *Code of conduct* (revised shared code) as well as feedback on the following questions. There are three questions (14 – 16) specific to the Chiropractic or Medical Radiation Practice Boards of Australia. They are not relevant to all stakeholders but have been included to provide an overview of the scope of the review. All questions are optional and you are welcome to respond to as many as are relevant or that you have a view on.

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

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

ADA agrees that shorter principles are preferable. More comprehensive details should be included under the shorter guiding principle.

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

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

The ADA supports the use of the word 'patient' as defined in this context. It is a long-standing term in a healthcare setting and has inherent meaning for that reason. The terms 'client' and 'consumer' carry connotations, implying that healthcare is financially-driven and business-centric.

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

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

We welcome the additional content.

The definition is comprehensive with expectations clearly stated to ensure respectful practice for both Aboriginal and Torres Strait Islander people and for all communities, but it comes well after references to cultural safety in the document. You may wish to move it forward in the document.

Unfortunately, it takes a while to scroll through the document to find the useful statements. It would be ideal to include recommended actions that support culturally safe practice for example, in section 2.2 (on page 32 of 83):

We also noted that none of the suggestions "To ensure culturally safe and respectful practice" include reference to the national Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health to develop, implement and evaluate cultural awareness and cultural competency strategies".

You may be aware that there is specific reference to this framework in the NSQHS Standards under which many health care services are accredited.

And while there is a reference to the National Standards below section 2.2 – the link doesn't bring you to the ACSQH website, it brings you to a health promotion charity page.

More appropriate (given this section is on Cultural safety for Aboriginal and Torres Strait Islander Peoples would be to link to the NSQHS Action 1.21 – Improving Cultural competency and the relevant action in the forthcoming standards for the primary care sector.

https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/resources-nsqhs-standards/user-guide-aboriginal-and-torres-strait-islander-health/action-121-improving-cultural-competency

It was pleasing to see "culturally safe practice" mentioned explicitly in 7.3 Maintaining and developing professional capability.

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

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

In general but the content could be more specific in setting out the expectation with regards to professional behaviour between staff as well. For example, the statement in 4.9 **"**never using a professional position to establish or pursue a sexual, exploitative or otherwise inappropriate relationship" is appropriate for **"**anybody under a practitioner's care" but there also needs to be a similar statement under 5.3 to exclude sexual harassment to staff. Sexual harassment in the workplace should be identified as a failure to maintain professional behaviour.

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

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

Yes.

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

   Is this section clear? Why or why not?

Yes, provides minimum guidelines. Valuable warning re risk to practitioners as well as patient.

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

Yes. Marked improvement on previous versions.

Clear statements and content so both public and practitioners can relate better to what the expectations are.

There are opportunities for further clarification where unclear and/or subjective terms are used in recommendations. E.g. "provide *appropriate* support" and "report as *appropriate*" is not practically all that useful.

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

It is clear and relevant. There is some overlap and repetition between the principles but we understand why this is the case.

Re: **1.2 Good care** (page 30 of 83)

Recommend adding a dot point:

"respond to adverse events and implement the principles of open disclosure [see Section 4.5 Adverse Events and open disclosure]"

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

The ADA would recommend reordering the dot points re: **4.5 Adverse events and open disclosure** (page 35 of 83) *as follows:*

a) Act immediately to rectify the problem….seeking help and advice if needed

b) comply with any relevant policies, procedures ……

c) apply the principles of open disclosure

d) recognise what has happened and report to ……..

e) explain to the patient and relevant individuals as promptly …..

f) listen to the patient, acknowledge any distress…….

g) ensure the patient has access to information about the process of making

h) document the adverse event or incident

i) review the event and implement change to reduce……

7.1 Risk management (d) insert word ''implement ''or develop processes…….

"References" (on page 51 of 83) mentions that *the ACSQHC provides guidance on a range of safety and quality issues including:*

- *health literacy*
- *open disclosure and incident management*
- *hand hygiene, and*
- *healthcare rights.*

However, the National Standards cover **many** more topics of relevance to health practitioners than listed here, including a number of which are covered in here the proposed shared Code as well. Is this unnecessary duplication?

The National Boards are also interested in your views on the following specific questions:

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

The ADA believes it is reasonable to expect that practitioners and their teams will require upskilling in areas such as Cultural Sensitivity and Safety in order to meet the expectations set out in this document, however such costs are within reasonable expectations of continuing professional development which presumably apply to the professions for which the Code cover.

11. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects? If so, please describe them.**
The identification of Performance targets has good intentions but may expose practitioners to criticism for actions of their employers that they cannot control. Similarly, many dentists are employed by corporates and the Code makes the practitioner responsible for clinical governance which may be out of their hands.
12. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for vulnerable members of the community? If so, please describe them.**
No
13. **Would the proposed changes to the revised shared Code result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander Peoples? If so, please describe them.**
Not to our knowledge.

Additional questions about the Chiropractic Board of Australia's code of conduct

The following questions are specifically about the Chiropractic Board and its changes to the revised shared code of conduct. They are not relevant to all stakeholders but have been included here to provide an understanding of the whole project.

14. The Chiropractic Board's (the Board) current code of conduct is common to many of the National Boards with the exception that the Board's current code of conduct has minor edits, extra content in its Appendices and additional content relating to modalities. Many of these expectations relating to the Appendices are referred to more broadly in the revised shared code and/or are largely replicated in other relevant board documents such as the recently revised Guidelines for advertising a regulated health service (Appendix 1) and the FAQ: chiropractic diagnostic imaging (Appendix 2). It is proposed that the appendices and section on modalities be removed and additional guidance on these areas be presented in additional guidelines or similar. Noting that the principles and expectations in the current appendices and modalities section are addressed broadly in the revised shared code and other relevant documents do you think it is necessary to keep the additional information in the Appendices and modalities section? Why or why not?
15. If you think keeping the extra information is necessary, do you support that the information be presented as a guideline, or similar, rather than as an appendix to the revised shared code? Why or why not?

Additional question about the Medical Radiation Practice Board of Australia's code of conduct

The following question is specifically about the Medical Radiation Practice Board and their current version of the revised shared code of conduct. They are not relevant to all stakeholders but have been included here to provide an understanding of the whole project.

16. The Medical Radiation Practice Board's (the Board) current code of conduct is common to many of the National Boards with the exception that the Board's current code has extra content in its Appendix A. Appendix A includes expectations specific to medical radiation practitioners about providing good care, effective communication and radiation protection. Many of these expectations are referred to in the Professional capabilities for medical radiation practice (the capabilities), which set out the minimum skills and professional attributes needed for safe, independent practice in diagnostic radiography, nuclear medicine technology and radiation therapy. The Board is proposing to remove Appendix A from the revised code as the content duplicates content included in other documents such as the capabilities. Do you think the extra information in Appendix A should be presented in a guideline or similar, noting that the expectations specific to medical radiation practitioners are referred to in the capabilities? Why or why not?