12 December 2017

# ADAVB response to proposed updates to private hospital regulations discussion paper

## 1 Introduction

The Australian Dental Association Victorian Branch (ADAVB) is the peak body for Victorian dentists. With over 3,500 members, we aim to promote the oral health of all Victorians and the professionals lives of our members.

We welcome the opportunity to comment on the discussion paper on proposed updates to the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013 (Regulations). We acknowledge and support the Department's objectives of promoting safe, high quality health care, and providing for effective oversight and accountability in the health system, which are key drivers of this work.

ADAVB is also mindful of the need to maintain access to dental care, of the regulatory burdens that clinicians and dental practices face, and the costs associated with this, which are necessarily passed on to patients. It is therefore important to maintain a focus on risk-based regulation, which is supported by evidence. It is also important to avoid regulatory duplication, and to maintain consistency with Commonwealth, and other state and territory regulations wherever possible.

We thank the Department for engaging in extensive stakeholder consultation with ADAVB and others to inform these Regulations. This consultation proposes a range of significant reforms to the regulation of health services in Victoria, and we therefore urge ongoing consultation with stakeholders as the health system continues to be reshaped.

ADAVB invited its members to participate in this consultation, and received many responses. Our submission therefore draws on the advice of clinicians, and organisations that would be impacted by the proposed regulatory changes. All those who contacted ADAVB during this consultation expressed a wish to ensure safe, high quality, and accessible health care for their patients.

If you would like ADAVB to elaborate on anything in this submission, please contact us.

Sincerely,

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

VICTORIA

A/Prof Matthew Hopcraft

Chief Executive Officer

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

# 2 Overview of the regulation of dentistry

## 2.1 Qualifying to practice as a dental practitioner

Dentistry is a very technical field of health practice, with high safety and quality standards. To qualify as a general dentist through Australian education programs, a student must complete 4-5 years of education and clinical training in an accredited program. To qualify as a dental specialist, a general dentist must complete a further postgraduate training in an accredited course. Overseas-qualified dentists from most countries are required to pass a course provided by the Australian Dental Council. All registered dental practitioners are also required to undertake a minimum of 60 hours of Continuing Professional Development (CPD) training over each two-year cycle. All of these requirements contribute to producing dental practitioners who provide a safe, high standard of care to their patients,

Dentists may seek endorsement from the Dental Board of Australia to undertake conscious sedation. Conscious sedation is defined by the Dental Board of Australia as a drug-induced depression of consciousness during which patients are able to respond purposefully to verbal commands or light tactile stimulation. Interventions to maintain a patent airway, spontaneous ventilation or cardiovascular function may, in exceptional circumstances, be required. Conscious sedation may be achieved by a wide variety of drugs including propofol, and may accompany local anaesthesia. All conscious sedation techniques should provide a margin of safety that is wide enough to render loss of consciousness unlikely.

To achieve endorsement for providing conscious sedation requires a dentist to undertake a two-year part-time accredited training course at Westmead Hospital in Sydney. This encompasses theoretical and practical experience in the practice of sedation, and also in dealing with emergencies, with an emphasis on non-technical skills and team work, and practical experience in the Oral Health Department and operating theatres at Westmead Hospital.

### Regulation of dental practice

Dentistry is a highly regulated field of practice, with a variety of complex requirements under State and Commonwealth jurisdiction. The following provides a list of regulatory requirements for dental practice.

## 2.2 Registration to practice as a dental practitioner

Dentists must be registered to practice with the Australian Health Practitioner Regulation Agency. Through this, the Dental Board of Australia requires dental practitioners to adhere up to eleven registration standards on: scope of practice, CPD requirements, criminal history check, endorsement for conscious sedation, English language skills, registration for overseas-qualified dental practitioners, limited registration for teaching or research, limited registration for postgraduate training or supervised practice, professional indemnity insurance arrangements, recency of practice, and dental specialist registration. Further, practitioners must also comply with guidelines on social

media use, advertising, the code of conduct (including open disclosure, among other matters), dental record keeping, privacy, infection control, mandatory notifications, and supervision. For dentists endorsed for conscious sedation, compliance with relevant Guidelines published by the Australia and New Zealand College of Anaesthetists (ANZCA), such as PS09 is also required.

## 2.3 To maintain their Endorsement for Conscious Sedation

Endorsed dentists must:

- attend a mandatory yearly accredited training course in emergency management. The Australian Society for Dental Anaesthesiology (ADSA) runs such courses
    - The ASDA course is over two days, and focuses on non-technical skills, and team training, skills development and simulation and members have been encouraged to bring a nurse to attend the course.
    - ASDA has also developed a book of protocols for dental sedationists which, is regularly updated. This document is based on the Australian Resuscitation Council Guidelines, but has been modified to be specific to dental practice
- adhere to the Australia and New Zealand College of Anaesthetists Guidelines (PS09).

## 2.4 Regulation of conscious sedation and anaesthesia– comparison of approaches across jurisdictions

In all jurisdictions in Australia, dentists endorsed for conscious sedation, and anaesthetists are regulated by the Australian Health Practitioner Regulation Agency, and the Dental Board of Australia.

Regulations determining which procedures can be undertaken in dental practices and other office-based settings, and those which must be undertaken in registered facilities are mostly similar from one jurisdiction to another, with the exception of ACT, which requires practice accreditation, and Victoria, which currently does not regulate conscious sedation or anaesthesia in facilities other than hospitals and day procedure centres (**Table 1**).

ADAVB notes with concern that the proposal to require dental sedationists in Victoria to either become a registered mobile health service, or register their practice as a day procedure centre amounts to the highest level of regulation that ADAVB is aware of in any jurisdiction. This is likely to reduce the availability of conscious sedation for patients requiring dental procedures in dental practices.

**Table 1:** Regulatory approaches to anaesthesia in Australia – selected jurisdictions

| Jurisdiction | Regulatory approach | Definition of anaesthesia | Regulatory instrument |
|---|---|---|---|
| **NSW** | Conscious sedation *excluded* from regulation.<br><br>Deep sedation and general anaesthesia required to be undertaken in licensed facilities. | "anaesthesia" means the administration of general, epidural or major regional anaesthetic or **sedation resulting in deeper than conscious sedation, other than sedation provided in connection with dental procedures.** | Private Health Facilities Regulation 2017, made under the Private Health Facilities Act 2007 |
| **SA** | Conscious sedation *excluded* from regulation.<br><br>Deep sedation and general anaesthesia required to be undertaken in licensed facilities. | conscious sedation means the sedation of a person by the intravenous administration of one or more drugs such that communication with the person may be maintained during the sedation<br><br>prescribed health service means—<br>(a) a health service that involves the administration of general, spinal, epidural or major regional block anaesthetic; or<br>(b) a health service that involves intravenous sedation **(other than conscious sedation)** | Health Care Act 2008, and Health Care (Miscellaneous) Amendment Act 2017 (to be implemented 1 May 2018) |
| **QLD** | Conscious sedation *excluded* from regulation.<br><br>Deep sedation and general anaesthesia permitted in licensed facilities only | "day hospital health service" means any of the following health services—<br>(a) a diagnostic, surgical or other procedure performed by a medical practitioner involving—<br>(i) **the administration of a general, spinal or epidural anaesthetic; or**<br>**(ii) sedation, other than simple sedation;** | Private Health Facilities Act 1999 |

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

| | | | |
|---|---|---|---|
| | | (b) a diagnostic, surgical or other procedure—<br>(i) performed by, or under the direction of, a medical practitioner; and<br>(ii) involving a significant risk that a person on whom the procedure is performed may, because of cardiac, respiratory or other complications arising from the performance of the procedure, require resuscitation; and<br>(iii) prescribed under a regulation.<br><br>**"simple sedation" means the administration of one or more drugs to a person, that depress the person's central nervous system, to allow a procedure to be performed on the person by a medical practitioner in a way that—**<br>**(a) allows communication with the person to be maintained while the procedure is being performed; and**<br>**(b) makes loss of the person's consciousness unlikely.** | |
| **VIC** | At present:<br>Conscious sedation and anaesthesia regulated in registered facilities only | | Private Healthcare Facilities Regulations 2013 under the Health Services Act 2008 |
| **ACT** | Conscious sedation for dental procedures:<br>Practice required to be accredited, with compulsory annual auditing by an independent entity | | ACT Health Care Facilities Code of Practice 2001 (an enforceable Code of Practice under the Public Health Act 1997) |

## 2.5 Victorian regulations impacting on dental practice

Further regulation is applied by the State of Victoria on matters including

- Drugs and Poisons permits
- Radiation licencing
- Occupational Health and Safety

## 2.6 Other regulations

Still more regulations are applied through participation in Commonwealth and State-funded dental care schemes.

Voluntary private dental practice accreditation introduces further compliance requirements, which are compulsory in the public sector. If a practitioner works in a hospital, day procedure centre, or public health service they would also be required to be credentialed, comply with employer policies, and may also be required to have a current working with children check.

# 3 Impact of regulation

All of these requirements protect public safety, promote high quality care, accountability, and public confidence in dental practitioners and in the health system. They also contribute to an expensive 'red-tape' regulatory burden, which increases the administrative load for practitioners (reducing clinical practice hours), and the cost to the public of accessing dental care.

We therefore urge the Department and the Victorian Government to resist the urge to duplicate existing regulations, and only propose evidence-based, and risk-proportionate regulatory measures where none currently exist.

# 4 Statement about dental sedation

The advice from clinicians is that, unlike almost all other patient groups who undergo sedation, dental patients needing sedation for outpatient procedures only need the sedation for relief of anxiety, not for analgesia.

This means that dental sedation is one of the only forms of sedation which can truly be done in a conscious fashion.

Almost all other patient groups who require or desire sedation for other procedures, (e.g. gastroenterological procedures, gynaecological procedures, urological procedures and cardiac procedures) cannot have excellent analgesia by local anaesthesia only and thus often require intravenous analgesia and all intravenous analgesics produce sedation, which can quickly become deep sedation or general anaesthesia.

For conscious sedation, ASDA discourages sedation of patients for very long procedures, supports the use of modest intermittent doses of midazolam and fentanyl for sedation, and suggests that only ASA 1 and 2

patients be sedated. ASDA also strongly suggests that all members have arrangements in place to refer patients, who have significant comorbities, or whom are unsuitable for conscious sedation, to a facility where an anaesthetist can sedate them or provide general anaesthesia.

The dental patient group that requires sedation are those who experience anxiety in relation to dental procedures. These patients are unlikely to be treated unless they are sedated, until they experience significant dental pain. Many of these patients are not affluent, and cannot afford the large increase in cost that would be associated with needing to attend a registered day procedure centre. They therefore would likely not continue to receive appropriate dental care if conscious sedation in the dental practice was not available.

# 5 Models of care: dental sedation and general anaesthesia in practices

Submissions made to ADAVB throughout the consultation process have revealed that there are a range of different models of care for providing sedation and general anaesthesia in dentistry, these include (but may not be limited to):

- Conscious sedation, provided by endorsed dentists, either
    - In their own dental practice, or
    - As a mobile service, which visits other dental practices
- Conscious sedation and/or anaesthesia, provided by specialist anaesthetists, either
    - As a mobile service, which visits dental practices,
    - As part of a dental practice, where anaesthesia equipment has been installed, or
    - In registered facilities

When providing these services, both endorsed dentists and specialist anaesthetists are required to comply in the ANZCA Guideline PS09.

# 6 Responses to discussion paper questions

## 6.1 Definitions of prescribed services and admission

**Q1: What are the merits and disadvantages of the proposed definitions of medical health services, surgical health services, or speciality health services?**

ADAVB's responses to this question are divided according to the three category definitions:

**Medical Health Services**:

No comment

**Surgical Health Services**:

This definition is accepted, and ADAVB recommends adding the following: 'this definition excludes dental block injections'.

**Speciality Health Services:**

ADAVB views that there is a risk that this definition could capture specialist dental services provided in the dental practice, which are low-risk, and should be excluded from these regulations. One option is word the definition as follows:

**Speciality Health Services**: means health services that are ordinarily undertaken only by, or under the supervision of, a specialist registered medical practitioner, ~~specialist registered dental practitione~~r, registered medical radiation practitioner, or a registered podiatrist that require:
(a) the use of specialist equipment **and**~~/or~~
(b) the area in which the services are provided to be fitted out specifically for those kinds of services and is a prescribed speciality health service in Regulation 6 or 7 (list of speciality health services).

One disadvantage of this definition is that it is very prescriptive, and therefore may not be flexible enough to accommodate advances in technology or innovation in practice.

**Q2: What are the merits and disadvantages of the Queensland definition of diagnostic, surgical or other procedures?**

The Queensland definition of diagnostic, surgical, or other procedures is preferred, as it is broader, and specifies that the definition only includes those procedures, which involve significant risk. It also avoids the need to prescribe a list of in-scope services, which affords more flexibility to capture/exclude procedures and services according to the level of risk, as appropriate.

**Q3: Does this definition adequately define emergency stabilisation treatment?**

This definition is accepted.

**Q4: What is a suitable definition for admission?**

ADAVB supports the current definition of admission, recognising that this could potentially require registered mobile anaesthesia and IV sedation services to 'admit' patients, given that sedation and general anaesthesia are criteria for automatic admission according to the 'Victorian Admitted Episodes Dataset: Criteria for Reporting' document.

Admission procedure requirements may vary according to the type of health service, the patient, and the procedure to be undertaken, and prescribed minimum admission requirements would need to accommodate this. ADAVB may comment further on this area when the draft regulations are provided for public consultation.

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

# 7 Speciality health services

## 7.1 Proposed additions

**Q5: Are these proposed changes the correct ones? Are there services that should not be removed, or services not listed that should be added to the list of prescribed services?**

ADAVB supports the addition of anaesthesia (as defined) to the list of prescribed health services. We query whether it is necessary to add a broad category of 'paediatric services', as this has the potential to capture many low-risk services, which are delivered outside of the hospital/day procedure setting (see also, responses to Q7 and Q8).

**Q6: Does a change in the list of prescribed services create access to care issues? If so, how should these be addressed?**

This change to add anaesthesia to the list of prescribed services will reduce access to care in dental practices. Please see responses to Q16 and Q17 for further discussion on this issue.

**Q7: Are the proposed definitions for any of the services (currently prescribed or proposed) accurate? If not, how should they be amended?**

Please see Q. 1 response for recommendations on a modification to the definition of anaesthesia.

For further discussion of the definition of 'paediatrics', please see the response to Q.8.

# 8 Paediatrics

**Q8: Should paediatrics be added to the list of prescribed services?**

**Regulatory impacts of listing a particular service as a prescribed health service:**

The current definition of a day procedure centre under Part 1 of the Health Services Act 1988 (incorporating amendments to 7 August 2017) is as follows:

"day procedure centre means premises where— (a) a major activity carried on is the **provision of health services of a prescribed kind or kinds and for which a charge is made**; and (b) persons to whom treatment of that kind or those kinds is provided are reasonably expected to be admitted and discharged on the same date— but does not include a public hospital, denominational hospital or private hospital;" (emphasis added)

ADAVB therefore views that if 'paediatrics' is added as a prescribed health service, then there is a risk of capturing unregistered health services, such as some dental practices, where low-risk paediatric services are offered. The Department has indicated to ADAVB that this is not the intention however, it appears that technically, these dental practices could meet the definition of a day procedure centre requiring registration under the Health Services Act 1998 if paediatric services become prescribed services. This is unnecessary, and should be avoided.

**Value of adding paediatrics to the list of prescribed health services:**

ADAVB queries whether procedures on children, which involve increased risk, might already be captured under the other prescribed services definitions, which would mean that including paediatrics as a separate prescribed health service would not be necessary.

ADAVB therefore recommends that if paediatric services are to be listed as a prescribed service, that this be made more specific, and limited to areas of practice that involve a level of risk requiring increased regulation.

## 9 Alcohol and other drugs

**Q9: What would be the impacts on businesses currently providing alcohol and other drug withdrawal (detoxification) services?**

NA

**Q10: Would regulating alcohol and other drug withdrawal (detoxification) services cause any issues with access to care?**

NA

## 10 Liposuction

**Q11: Is it appropriate to require liposuction (200 ml or more of lipoaspirate) to only be carried out in registered facilities?**

NA

**Q12: is the 200 ml threshold appropriate to manage patient safety risks or should another level be set?**

**NA**

## 11 Obstetrics

**Q13: Is it reasonable to require that births take place in a registered facility (with the exception of those taking place in the home of the mother or a relative) to ensure patient safety? Would this cause any issues with access to care?**

NA

## 12 Laser eye surgery

**Q14: Should laser eye surgery be regulated? If not, what is the safety risk to patient care?**

NA

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

## 13 Anaesthesia and sedation

**Q15: Should general medical practitioners and dental practices specifically be excluded in the Regulations if they are undertaking minor procedures with local anaesthesia?**

Yes. The discussion paper states that the Government will take a risk-based approach to regulating health services, and general medical and dental practices undertaking minor procedures under local anaesthesia provide an essential low-risk health service to the community, which does not require additional regulation.

There are thousands of these practices in Victoria, which are required to meet a large volume of compliance requirements to ensure the delivery of safe, high quality healthcare. Further regulation is therefore unjustified and impractical. Furthermore, ADAVB is not aware of any evidence to support the need to apply increased regulation to these types of services, or that it would result in increased public safety.

**Q16: Will the proposed Regulations diminish patient's access to care?**

The proposed Regulations will have the consequence of increasing the cost of care and therefore diminishing access to care. It is very difficult (and expensive) for some people to access anaesthesia and IV conscious sedation for dental procedures in registered facilities, and the continued provision of these services in the dental practice in a safe and high-quality manner is therefore critical.

Already some of our members have contacted us to advise that the increased regulatory burden expected to result from the need to register a mobile anaesthesia/conscious sedation service means that they will no longer offer this service to their patients. These patients will need to seek referral to another provider, or admission to a hospital or day procedure centre to access the care that they need, which would involve a significant increase in out of pocket costs due to facility fees.

We therefore urge the Department to ensure that mobile anaesthesia and IV conscious sedation services can register and operate within a regulatory framework, which both ensures patient safety, and recognises that a small mobile health service needs to have regulatory provisions that are proportionate to the size and complexity of the service, and the level of risk involved.

It would therefore not be practical or appropriate to apply all of the current and proposed registration requirements to a small mobile health service in the same way that they would be applied to a large registered hospital or day procedure centre.

**Q17: Is the proposal to regulate anaesthesia and sedation as described above targeted at the right level to ensure patient safety without impeding procedures that can safely be done in practices?**

Conscious sedation in dental practices generally has a good safety record in Australia. Therefore, most jurisdictions exclude IV conscious sedation in the dental practice from health services regulations, recognising that the practitioners who provide these services are already regulated under the Health Practitioner Regulation National Law.

However, ADAVB recognises and supports the Department's objective to ensure safe, high quality patient care, with effective oversight and accountability. We therefore offer qualified support for the proposal to require mobile health services providing IV sedation and general anaesthesia to become registered, provided that the registration requirements are proportionate to the level of risk, and the size and complexity of the health service. Continued access to care must be assured.

The proposed level of regulation needs to recognise that a large registered health service such as a hospital employs teams of staff to manage the regulatory burden, and this would not be possible for a small mobile service. Regulations also need to recognise that mobile anaesthesia and sedation services provide healthcare in office-based settings, which do not need to be purpose-built with the intention of complying with the facility design requirements for hospitals.

An alternative regulatory model is that used in ACT, which involves accreditation and annual auditing. This may have the potential to reduce the regulatory burden that would be imposed by requiring anaesthesia and sedation services to become registered.

## 14 Mobile services

**Q18: What are the types of mobile services are likely to emerge and what are the minimum patient safety and quality of care measures that should be stipulated for these mobile businesses?**

No comment.

**Q19: What is the likely impact as a result in regulation both in terms of cost to the patient, change of access to services by patients and impact on existing businesses not currently regulated by the department (for example, dental clinics, interventional radiology clinics)?**

**Cost to patients of regulating mobile anaesthesia and IV sedation services that provide services in dental clinics:**

It is expected that the cost to patients will increase to account for the increased regulatory burden and any new or different requirements for staffing.

**Change of access to services:**

It is expected that access to anaesthesia and IV sedation services in dental practices will be reduced as a result of these regulatory changes. Already members have contacted ADAVB to advise that, given the increased regulatory hurdles expected, they will no longer be offering these services.

One possible consequence of this is that people, who can afford it, will seek services at registered hospitals and day procedure centres. These types of services have limited availability at present due to the costs associated with offering them. For example, dental surgery has a very low rebate rate for hospital anaesthesia. Clinicians have advised that some facilities charge a facility fee of over $1400 per hour, and only the first hour would be rebated by private health insurance. Any further fees would result in an out-of-pocket cost to the patient. Patients who need dental care under anaesthesia or IV sedation, and who can't afford the fees associated with hospital admission may have limited or no other choices.

**Issues of eligibility and access – the Child Dental Benefits Schedule**

This Medicare-funded scheme is available to children aged 2-17, whose family is eligible for Family Tax Benefit Part A. Up to $1,000 of dental care is funded over a two-year period.

As the Department has acknowledged, this scheme is not available if the dental care is part of an episode of hospital treatment or hospital-substitute treatment. Therefore, if the child requires IV sedation or general anaesthesia to receive dental care, they would not have access to this scheme unless the care is provided in a dental practice.

For these children and their families, the impacts of the proposal to regulate mobile services will be that those who most need access to dental care are more likely to face increased access barriers, out of pocket costs and longer waiting times. Children, who need to access dental care under general anaesthesia in the public sector would usually be placed on a waiting list. During this time, a relatively early-stage dental problem can develop into advanced disease, where the only option is to extract teeth, rather than restore them.

**Impact on businesses not currently regulated by the Department:**

It is envisaged that mobile IV sedation and anaesthesia services will experience a significantly increased regulatory burden. To ensure he viability of these businesses, the associated costs would need to be passed on to patients. We therefore urge the Department to work with stakeholders who will be impacted by these regulations to develop reasonable and proportionate registration requirements, and to achieve streamlined implementation. ADAVB would be pleased to assist the Department in this work.

We suggest that not all providers of mobile anaesthesia and IV sedation services would have the capacity to become registered, and a number of dental practice proprietors have advised that they would stop offering the service if they were required to register as a Day Procedure Centre.

**RE: Proposed high-level requirements to be applicable to registered mobile services**

Providers of mobile anaesthesia and IV sedation services are registered health practitioners, trained and competent in their fields of expertise. They are required to comply with a large number of requirements, including registration standards and relevant ANZCA guidelines. ADAVB recommends that any new requirements introduced under these regulations are in agreement with existing requirements. Applying different requirements is likely to be counterproductive, and has the potential to cause confusion. The principle document used to guide anaesthesia and IV sedation practices is ANZCA PS09, this should inform the development of high-level requirements for mobile anaesthesia/sedation services, as well as those provided as an integral part of a dental practice.

## Governance

The ASX Corporate Governance Council defines corporate governance as "the framework of rules, relationships, systems and processes within and by which authority is exercised and controlled in corporations. It encompasses the mechanisms by which companies, and those in control, are held to account". In this sense, governance principles relate to large organisations, and not small businesses, to ensure that appropriate controls are in place to monitor performance. Of note, the genesis of this review of regulations comes from failures in large organisations, not small private practices.

ADAVB therefore views that the requirements in Q20-24 should not be applied to dental practices and small mobile sedation/anaesthesia services, however comments on some of these proposals have been offered.

## 15 Facility governance

**Q20: Does the definition of by-laws correctly characterize their purpose?**

NA

**Q21: Is this approach to tasking the highest level of governance with regulatory responsibility reasonable?**

NA

**Q22: What would be an appropriate meeting frequency for the highest level of governance in small facilities and large facilities?**

Determining appropriate meeting frequencies should be at the discretion of the health service, and should ensure appropriate oversight and accountability. The frequency of meetings necessary to achieve this may vary according to the level of complexity and the size of the relevant health service, and should therefore not be prescribed in Victorian regulations.

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

**Q23: Are the requirements listed above sufficient to maintain adequate governance with the view to ensuring patient safety across the sector?**

NA

**Q24: Could the interests of the patient be ensured through the proposed highest level of governance, without an independent member?**

In the case of small facilities, particularly single owner operators, it is too onerous to ask for an independent member to be included as part of the highest level of governance. It is not practical to expect that larger entities and their directors would be willing or able to partner with a smaller entity for governance matters. To do so would require the larger organisation to assume a significant level of responsibility for the actions of their partner, without having any real control over the mobile service, which that they neither own nor operate. Financial disclosures between the two parties may also be required, and this is unlikely to be acceptable.

ADAVB suggests that underwriters of board of director indemnity insurance policies are unlikely to view this proposal as an acceptable risk, and that legal advisors may advise health service boards not to enter into these types of relationships.

Further, if the smaller health service is viewed as a competitor by the larger one, asking them to partner on governance matters could create a conflict of interest.

## Clinical governance

## 16 Senior Nursing

ADAVB's focus in this submission is on conscious sedation and anaesthesia provided in dental practices. We recommend that small mobile health services and dental practices be exempt from any requirement for the service to employ a Director of Nursing, as this is unnecessary and impractical, and we are not aware of any evidence to suggest that it would improve patient safety in the dental practice setting.

Under the Health Practitioner Regulation National Law, registered health practitioners are ultimately responsible for the safety and quality of care provided to their patients. In small mobile health services, clinical oversight whenever a list is run would therefore be the responsibility of the clinicians who provide care to the patients. We therefore view that Q25 – 27 do not apply to mobile health services or dental practices offering conscious sedation/anaesthesia.

**Q25: Should the Director of Nursing have at least five years of clinical practice and at least 12 months' experience in nursing management? If not, how much experience is necessary and why?**

**Q26: What other options would offer assurance that Directors of Nursing have sufficient experience to oversee appropriate clinical management of patient care?**

**Q27: Should proprietors be responsible for ensuring a senior clinical nurse with suitable training and competence in the procedures being undertaken is designated as responsible for clinical oversight whenever a list is run, and while stage one post-operative patient care is provided?**

## 17 Credentialing and scope of practice

ADAVB believes that credentialing and scope of practice policies should not apply to operators of small-scale mobile services and dental practices, as the size of these businesses does not permit them to have the level of organisation structure envisaged by these questions.

**Q28: Should the highest level of governance of each registered facility in Victoria have oversight and responsibility for the facility's credentialing and scope of practice policy or by-laws for medical practitioners who provide services at the facility?**

**Q29: If the highest level of governance is not the appropriate level, which level of governance would be appropriate to carry this responsibility (bearing in mind that the requirement will need to apply from sole practitioner operated facilities up to large hospitals and national/international organisations)?**

**Q30: Is the proposed ongoing process for credentialing medical practitioners, and defining their scope of practice useful/necessary to maintain patient safety?**

**Q31: Should by-laws govern the actions of all credentialled medical practitioners while on site at a private hospital or day procedure centre? Should this be the responsibility of the proprietor of the facility to ensure? Please suggest alternative mechanisms.**

**Q32: How should a hospital or day procedure centre ensure admission staff and theatre staff are informed of a medical practitioner's scope of practice and are able to use that information to ensure the practitioner operates within their defined scope?**

**Q33: Should the Regulations require that every admission be cross checked against the medical practitioner's scope of practice?**

**Q34: What options are there for addressing the issue of theatre nurses being informed of the scope of practice of medical practitioners and for reporting those practitioners who operate beyond their defined scope?**

## 18 Operating theatre and procedure room drug register

**Q35: Would a requirement for registered hospitals and day procedure centres to maintain a drugs register in operating theatres and procedure rooms create any issues for facilities?**

NA

## 19 Open disclosure

**Q36: Should open disclosure be regulated across all registered health care facilities in Victoria, as a process of open dialogue in the provision of information to a patient?**

ADAVB's view is that it is not necessary to further regulate open disclose across all registered health care facilities in Victoria - this would duplicate existing measures. Open disclosure is already mandatory for registered practitioners through the Code of Conduct, and it is an accreditation requirement for registered health services. ADAVB is not convinced that further regulation alone would increase compliance with the open disclosure framework, and suggests that education of health services about open disclosure obligations may be more effective in promoting compliance.

## 20 Admission processes

**Q37: Is it practical to propose a requirement that all facilities have received, reviewed and documented each patient's clinical risk assessment prior to admission?**

ADAVB views that this question is relevant to large health services, but would not apply to small mobile anaesthesia/sedation services or fixed service in dental practices.

## 21 Discharge processes

**Q38: Should the Regulations require that upon discharge from a private health facility, patients should be provided with a clear explanation, in writing, of any recommendations and arrangements that have been made for follow-up care?**

ADAVB views this as a reasonable requirement.

**Q39: How can post discharge follow up and patient care be improved, and should there be a minimum regulated requirement?**

The ADAVB is not aware that there is presently any issue with post-discharge follow-up and patient care following conscious sedation or general anaesthesia for dental procedures in dental practices. Therefore, we do not believe that further regulation is required.

**Q40: How would regulation of discharge processes from private hospitals and day procedure centres improve patient-centred standard clinical pathways?**

NA

## 22 Clinical handover for patient transport

**Q41: Would a requirement for hospitals to provide clinical handover to transport crews create any issues or unintended consequences?**

NA

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E

## 23 Evacuation plans

**Q42: Will this requirement create any issues for facilities and if so, why?**

ADAVB supports the need for an evacuation plan for all facilities that provide conscious sedation or general anaesthesia, however the requirements for this would need to be flexible to accommodate the different types of health care teams that might work in dental practices (e.g. mobile sedation anaesthesia services, dental clinics that have fixed sedation or general anaesthesia services). In the case of mobile sedation/anaesthesia services, the requirement needs to be applied to the mobile service, rather than the practice it visits.

# Data

## 24 Data collection

We urge the Department to

- Be mindful of the burden of data collection for small businesses, who do not have dedicated staff for this purpose.
- Assist these recently captured organisations to comply with data collection requirements by:
    - Only asking them to collect the minimum data necessary to meet requirements
    - making the collection process streamlined, and
    - working in partnership with stakeholders to educate and support mobile health service organisations/their proprietors to understand and comply with their reporting requirements. For example, sentinel event reporting criteria and process.

## 25 Clinical Outcomes

### 25.1 Sentinel events

**Q43: Is it reasonable to request that private hospitals and day procedure centres report sentinel events in the same way that public facilities are required to?**

While it is acknowledged that monitoring sentinel events is important to ensure quality and safety, the reporting process should be streamlined for small businesses such as registered mobile health services, to make it as straight forward as possible.

Electro Convulsive Treatment (ECT) data

**Q44: Is it reasonable to request that private hospitals and day procedure centres report ECT data to the department? What are the potential barriers to reporting this data?**

NA

## 25.2 Victorian Emergency Minimum Dataset (VEMD)

**Q45: Is it reasonable to request that private hospitals that have an emergency department report VEMD data in the same way that public facilities are required to? What are the potential barriers to reporting this data?**

NA

## 25.3 Victorian Healthcare Associated Infection Surveillance System (VICNISS) data

**Q46: Is it reasonable to request that private hospitals and day procedure centres report VICNISS data in the same way that public facilities are required to? What are the potential barriers to reporting this data?**

ADAVB recommends that mobile anaesthesia and sedation services, and dental practices offering these services, be exempt from this reporting requirement. The discussion paper states that 'surveillance activities are targeted to those patients at highest risk of healthcare associated infections', which would not apply to patients treated by these types of services.

In the unlikely event that a patient experienced a healthcare-associated infection resulting from treatment under IV sedation/anaesthesia in a dental practice, establishing which practitioner or organisation should be reporting it, how and to whom would be difficult. If this requirement was introduced, there would need to be specific directions to report only anaesthesia/IV sedation-associated infections, and not those resulting from dental surgery.

# 26 Patient measures

**Q47: Should the Regulations require that patient experience data be reported to the hospital? If not, why?**

ADAVB questions the purpose of collecting this data, and how it will be used. Whilst it may be useful for hospitals, it is unclear (a) who dental practices would report this data to, and (b) how it would be used to improve patient outcomes.

**Q48: What are the barriers to reporting patient experience data to the department? How could they be remedied?**

Dental practices are not currently set-up to report data to the department, and would require assistance and support from the department in order to facilitate this.

**Q49: Should private hospitals and day procedure centres report patient experience data to the department or should they collect the data for internal review and make it available during inspections?**

As above.

**Q50: Should the regulations require that the same patient experience data be collected or not specify how or what to collect?**

The regulations should refer to a separate document, which defines the minimum dataset required to be collected (unless certain questions do not apply to that setting), but they allow the organisation to determine what other questions it may want to ask to facilitate its own service improvement goals.

## 27 Staff measures

ADAVB views that capturing staff experience data would not be practical in a small mobile health service model, or a dental practice. ADAVB is also not aware of any evidence to support that it would promote staff safety culture in this type of environment. In this scenario one or a handful of practitioners, who may also own the service, would be evaluating their own safety culture behaviours, and that of their business. It would also not be possible to sufficiently deidentify the data for reporting and publication, given the small sample sizes involved.

Staff experience surveys are more appropriate for larger health service entities. ADAVB has therefore not responded directly to Q 51-55.

**Q51: Have the right questions for capturing staff safety culture been identified?**

**Q52: Should the regulations require that staff safety culture data be reported to the hospital? If not, why?**

**Q53: What are the barriers to reporting staff safety culture data to the department? How could they be remedied?**

**Q54: Should private hospitals and day procedure centres report staff safety culture data to the department or should they collect the data for internal review and make it available during inspections?**

**Q55: Should the regulations require that staff safety culture data be collected, but not specify how or what to collect?**

## 28 Fees

**Q56: Do you support the proposal to combine the application fees and registration/registration renewal fees into a single fee, payable every two years?**

The move to simplify and streamline the payment process is welcome. However, a $4000 fee for a small mobile business or dental practice with no beds is excessive, given that practitioners will be responsible for the assessment of facilities and for meeting all of the registration requirements. The rationale for creating a category of 1-26 beds is also questioned, as a facility with one bed requires a different level of management than a facility with 26 beds.

**Recommendation:**

The management of a mobile anaesthesia or IV sedation service, or a dental practice that provides sedation or general anaesthesia, with no actual beds requires a significantly lower level of complexity of management than a health facility with 26 beds. We therefore urge the Department to create another registration category of zero beds, with a significantly lower fee.

**Australian Dental Association Victorian Branch Inc.**
Level 3, 10 Yarra St, South Yarra, Vic 3141
PO Box 9015 South Yarra, Vic 3141
Phone: 03 8825 4600 | Fax: 03 8825 4644 | Email: ask@adavb.org
www.adavb.net

ABN 80 263 088 594 | ARBN 152 948 680
Registered Association No. A0022649E