International Centre for Allied Health Evidence

Tools to assist in the implementation of Extended Scope Practice Allied Health Roles Starter Pack

University of South Australia
International Centre for Allied Health Evidence
A member of the Sansom Institute

ACT Government Health

CANBERRA HOSPITAL AND HEALTH SERVICES

 – ISBN **978-971-606-559**

FOREWORD

BY MS KAREN MURPHY–
ALLIED HEALTH ADVISOR ACT HEALTH DIRECTORATE

Since 2005 the ACT Health Directorate has had a keen interested in extended scope practice for Allied Health to explore new and novel models of care. This work has been undertaken in collaboration with the International Centre for Allied Health Evidence at the University of South Australia. This partnership has ensured that this work has academic rigour, whilst at all times focussing on health care delivery and patient-centred care.

This tool pack includes documents to assist other healthcare providers/institutions introduce extended scope practice roles, highlighting the requirements as well as the potential pitfalls. The aim of this pack is to ensure that efficient workforce redesign principles are employed at other sites and that these principles are underpinned in evidence-based practice and research.

The work included in this pack has been developed under the guidance of a committed and hardworking team whose ethos is innovative and patient-focussed care. The team includes Doctors, Allied Health, Educators, Academics, Nurses, Managers and Executives, this work would not have been possible without them.

ISBN: 978-971-606-559

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MODULE 2

AUTHORS

ICAHE TEAM:

Prof Karen Grimmer,
Dr Steve Milanese,
Dr Saravana Kumar,
Ms Jess Stanhope,
Ms Lucylynn Lizarondo,
Ms Kate Beaton

Karen Murphy
Jo Morris
Lisa Gilmore
Dr Bryan Ashman
Dr Andrew Brooks
Corinne Coulter
June Gunning
Assoc Prof Greg Kyle
Dr David Lamond
Miriam Lawrence
Helen Matthews
Elaine Men
Katrina Milbourne
Dr ChandimaPerera
Katie Vine
Prof Gordon Waddington
Cathy Watson

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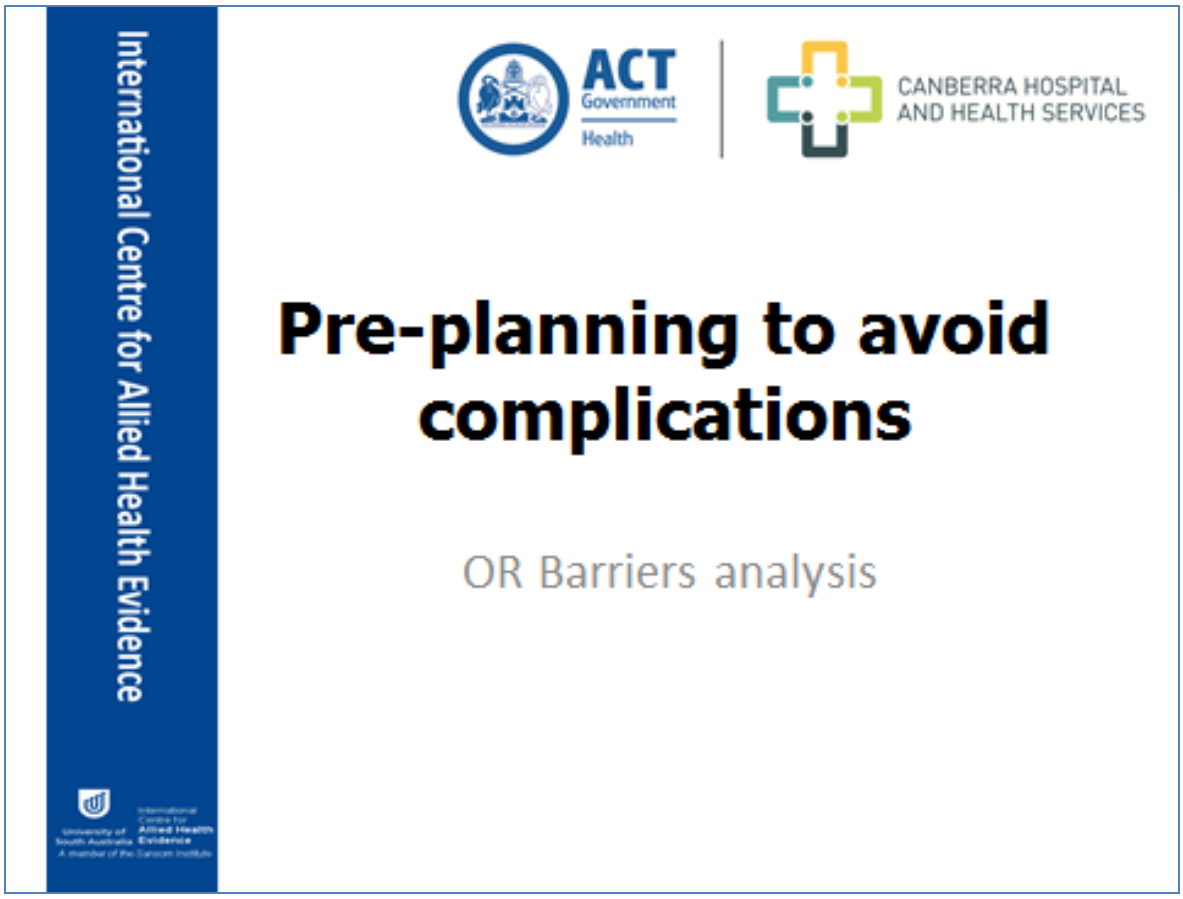

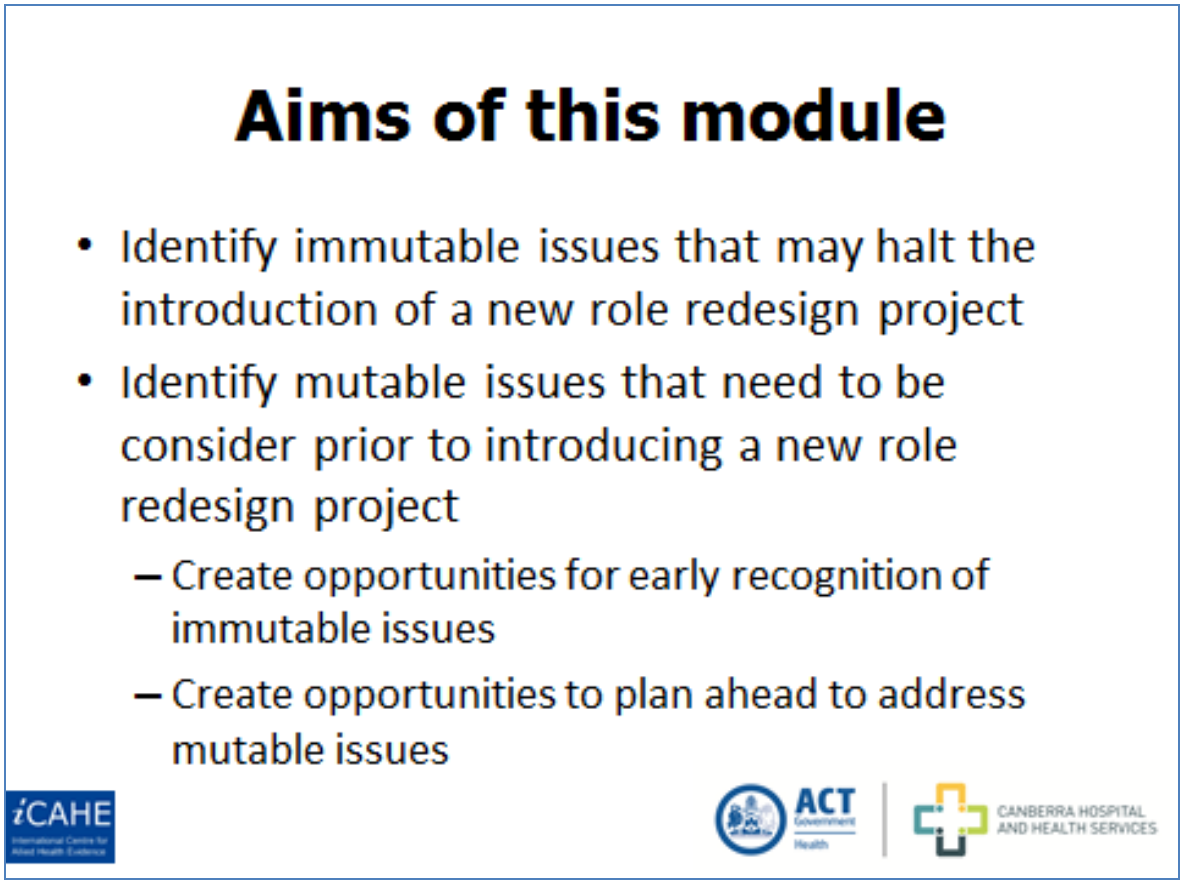

Getting support from the right people is a maker!

Organisational culture

- Traditional practice and workforce expectations
- Drivers for change?
- Profile of allied health
  - Leadership and capacity to steer change
  - Staff capacity to adopt skills escalation
- Current organisational focus re areas targeted for change
- Inter-professional environment

Budgetary Matters

- Re-organisation of the current budget
- Potential to increase cost-efficiences
- New monies available to the initiating department (e.g. physio dept reimbursed for savings produced by ESP PT in Orthopaedic Outpatients)

Workbook activity

Phase 1 Opportunity identification

- What are the service needs which require this new role?
- What are the drivers for this new role?
- What service gaps does this new role aim to address?
- Has a business case been developed and has it been defended at the appropriate forums?
- Have all key stakeholders been consulted?

Phase 2 Planning and Design

- How will this new role impact on existing services?
- How will the new role impact on fellow health professionals?
- What are the specific, actionable strategies for this new role?
- Are there appropriate structures (career, remuneration, ongoing training) and processes (support, mentoring, supervision, delegation) in place to support this new role?
- Are there appropriate strategies in place for ongoing monitoring and evaluation (such as data collection)?
- Have appropriate legislation and registration requirements been considered?

Phase 3 Implementation

- Is there a staged implementation planned?
- Has a barrier analysis been conducted and enabling strategies implemented?
- How will findings from the pilot implementation be utilised to inform larger implementation?
- Is the implementation plan flexible to account for local, contextual realities?
- Is the implementation plan built upon best practice in change management?
- Is a multifaceted implementation approach in place

Phase 4 Evaluation

- How will the development and implementation of the new role been evaluated?
- Have clear outcomes, taking into account multiple stakeholders perspectives, been captured and reported?
- How will the effectiveness and efficiency of the new role be captured and reported?
- How will the findings of the evaluation inform ongoing implementation?
- How will the findings of the evaluation, and its outcomes on the implementation, be disseminated to key stakeholders?
- Has ongoing evaluation been built into routine practice?

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FACTOR	NATURE OF POTENTIAL BARRIER/S
Patient	Eg 1: The sheer volume of patients
The innovation itself	Eg 1: Identification and implementing evidence is a difficult process (What is evidence? How and where do we access it?)
Team issues	Eg 1: Too many practitioners and hence will require a uniform approach. Is that possible?

FACTOR	NATURE OF POTENTIAL BARRIER/S
Care process	Eg 1: Wide ranging service models of care delivery even for one patient!
Management and organizational context	Eg 1: No recognized clinical champions in this field
Time/facilities/cost	Eg 1: Time pressure

FACTOR	NATURE OF POTENTIAL BARRIER/S
Health System	
Social context	
Economic environment	

*This tool is derived heavily from the NICS barrier tool. Permission has been sought from NICS for the utilisation of this tool. The NICS barrier tool can be accessed upon contact at **National Institute of Clinical Studies,** Fawkner Centre, Level 5, 499 St Kilda Road, Melbourne VIC 3004. **T:** +61 3 8866 0400 **F:** +61388660499 **E:**nics@nhmrc.gov.aumailto:admin@nicsl.com.au**W:**http://www.nhmrc.gov.au/nics/asp/index.asp

Document Number *CHHS13/330*

Operational Support / Acute Support / Physiotherapy Standard Operating Procedure
Management of Medications by Extended Scope Physiotherapists

Purpose

To ensure safe and appropriate management of medication by extended scope physiotherapists (in-training or credentialed).

Scope

This Standard Operating Procedure (SOP) pertains to physiotherapists appointed and endorsed to work in approved expanded trial roles in Orthopaedic Outpatients and the Emergency Department.

Procedure

1. Medication Protocols (Appendix A)

Medication protocols have been developed for each medicine authorised for use in the extended scope physiotherapist trial project according to the Public Employees Permit (Medicines, Poisons and Therapeutic Goods ACT 2008, Section 85) No 00500/11 (see Appendix B). The protocols contain the following information:

- Drug name, strength & form
- Approved indications for treatment
- Included patients
- Excluded patients
- Dosing information
- Supply and administration instructions
- Clinically significant drug interactions
- Expected adverse drug reactions
- Specific patient counselling points
- References and approvals information

The protocols define and govern the scope of use for each medication and must be followed by the extended scope physiotherapist (in-training or credentialed) as written. Use of the medication for indications, doses, forms or ways not explicitly described are by definition out of scope and unauthorised. The want or need to vary medicine use necessitates referral onwards to the multidisciplinary team in Orthopaedic Outpatients or an appropriate medical practitioner in the Emergency Department (dependent on the clinical location of the physiotherapist).

2. Patient suitability

Operational Support / Acute Support / Physiotherapy

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indications, doses, forms or ways not explicitly described are by definition out of scope and unauthorised. The want or need to vary medicine use necessitates referral onwards to the multidisciplinary team in Orthopaedic Outpatients or an appropriate medical practitioner in the Emergency Department (dependent on the clinical location of the physiotherapist).

2. Patient suitability

The extended scope physiotherapist (in training or credentialed) must:

a. obtain a full medical and clinical history in order to establish a working diagnosis and determine that a medication is appropriate
b. consult and apply the relevant medication protocol to ensure a specific medication is indicated and suitable for the individual patient
c. systematically document in the medical record absence of exclusion criteria and suitability for supply of medicines.

Included patients

Patients for provision of a medicine by an extended scope physiotherapist (in training or credentialed) include all suitable patients (ages 2 years and over) assessed and managed by the physiotherapist in the Multidisciplinary and Physiotherapy-led Outpatient Orthopaedic clinics or the Emergency Department.

Excluded patients

Some patients will have individual characteristics that place them beyond scope for accessing a medication protocol by the physiotherapist. For these patients the physiotherapist should consider alternative treatment options or refer to the multidisciplinary team in Orthopaedic Outpatients or an appropriate medical practitioner in the Emergency Department.

Specific contraindications are listed for each agent in the medication protocols.

Generic characteristics that may exclude a patient include:

- Existing treatment with the medicine itself or a related agent (from same / similar class, or duplicated clinical effect).
- Hypersensitivity to the medication or ingredient.
- Under the age of 2 years
- Over the age of 90 years
- Patients where the medication is inappropriate (not safe or suitable) due to parameters such as -
  - severely unwell, multiple co-morbidities, over/under weight
  - pregnancy, breastfeeding,
  - medical contraindications (ie existing medical conditions – renal / hepatic failure),
  - drug poly pharmacy, food allergies, medication allergies
  - intolerance or previous ADR

Findings, reasoning for exclusion and referral plan should be systematically documented in the medical record.

NB: Specific inclusion and exclusion criteria and dosing information is detailed in the individual Medication Protocol for each medication

Drug interactions

Potential drug interactions may exclude a medication from use. Medications producing clinically significant interactions are listed in each medication protocol with an appropriate action. Patients regular medications derived from a clinical history should be compared to the protocol in each case. If a patient is currently taking a medication named on the protocol as having a potential interaction an alternative medication should be considered and the physiotherapist should refer to the multidisciplinary team in Orthopaedic Outpatients or an appropriate medical practitioner in the Emergency Department.

3. Medication Selection

To determine if a medicine may be suitable for administration or supply, the following table should be applied:

Agent	Indication and Authorised Use
Paracetamol	Simple oral analgesic. Indicated for relief of pain from any musculoskeletal condition. Reduction of required NSAID dose. **Should be employed as first line for all analgesia (unless already in use).** Note: multiple OTC products exist and use may not be recognised or disclosed by patients.
Ibuprofen	Short acting oral non steroidal anti inflammatory. Indicated for relief from pain associated with tissue damage and inflammation from musculoskeletal conditions. **Should be considered where non-drug measures and paracetamol alone have not provided adequate analgesia.** Doses used must be lowest and shortest course of single NSAID at a time required for relief. Combine with paracetamol to reduce required dose.
Naproxen	Intermediate acting oral non steroidal anti inflammatory. Indicated for relief from pain associated with tissue damage and inflammation from musculoskeletal conditions. **Should be considered where less GI toxic and shorter acting NSAIDs (ibuprofen) have failed.** Doses used must be lowest and shortest course required single NSAID at a time required for relief. Combine with paracetamol to reduce required dose.

Lignocaine	Local Anaesthetic Indicated to reduce acute pain during concomitant administration of intra-articular and associated joint structure corticosteroid injections For local infiltration of structures along needle insertion track utilised for intra-articular and soft tissue steroid injections May be mixed with steroid or used separately immediately prior to steroid injection **CAUTION – NOT to be injected by any other means or route** **CAUTION – simple product WITHOUT adrenaline to be used only**
Bupivacaine	Local Anaesthetic Indicated to reduce acute pain during procedures such as small joint relocation and fracture reduction. **CAUTION – NOT to be injected by any other means or route.**
Triamcinolone	Corticosteroid - long acting injection Very long lasting localised musculoskeletal analgesia and control of inflammation For single, aseptic administration into joint and associated structures Indicated where steroids may offer relief and adverse effects of systemic administration are unacceptable **CAUTION - for intra-articular and intra-lesional injection only – NOT to be injected by any other route** **CAUTION – use only Kenacort-A preparations**

Agent	**Indication and Authorised Use**
Betamethasone	Corticosteroid Long lasting localised musculoskeletal analgesia and control of inflammation For single, aseptic administration into joint and associated structures Indicated where steroids may offer relief and adverse effects of systemic administration are unacceptable **CAUTION - for intra-articular and intra-lesional injection only – NOT to be injected by any other route** **CAUTION – use only Celestone Chronodose preparations**

4. Medication History Taking

A complete medicines history is required to determine patient suitability. This should be done thoroughly and systematically to elicit the following information:

Current medication use	ALL Prescribed medication Oral, inhaled, topical (creams, ointments, patches), rectal, vaginal, etc Indication, formulation, dose, strength, frequency information may assist decision making Over the Counter (OTC) products Alternative and complimentary medications (vitamins, herbal products) Where known that concurrent prescription medications are taken but a complete or accurate history cannot be obtained (or doubts exist regarding veracity) the patient may not be appropriate for supply . Medications should be converted to generic name for comparison to the medication protocol. Polypharmacy is an indicator of multiple co-morbidities and is a trigger for considering patient suitability (inclusion). Medication related problems (ie adverse effects of existing medications) require referral.
Allergies	Medication hypersensitivities Food, substance or chemical reactions Past adverse drug reactions or intolerances Detail on nature, severity, treatment and when reaction occurred
Patient specific parameters	Pregnancy Breast feeding Very high or low weight Very old or very young Renal or liver failure, other significant alterations to pharmacokinetic parameters
Other medication Issues	Compliance Swallowing problems Use of dosage aids Drug misuse or abuse (eg analgesics, laxatives)

All findings will support decision making required for administration or supply of medication. Relevant findings should be documented in the patient notes.

5. Supply of Medicine

Pre-packs

The following medications for patient self-administration will be supplied as a single pre-packaged quantity per patient:

Paracetamol	500mg caplets x 24	
Ibuprofen	200mg tablets x 24	
Paracetamol suspension	Age 2-5 years	Pack 120mg/5 mL 200mL
	Age 5-12 years	Pack 240mg/5ml 200mL
Ibuprofen suspension	Age 2-5 years	Pack 100mg/5mL 100mL
	Age 5-12 years	Pack 200mg/5mL 100mL

Orthopaedic Outpatients:

Suitable quantities of pre-packs will be made available for storage under the control of the extended scope physiotherapist. The physiotherapist should seek resupply via the pharmacy as required. They may be directly issued to the patient. A record of issue should be made in the patient notes.

These medications are ready and labelled for immediate issue without further intervention or labelling. These quantities should not be repackaged or broken. Patients should not be provided with multiple packs. Patients should be advised that further quantities may be sourced from a community pharmacy or supermarket.

The Emergency Department:

Suitable quantities of pre-packs will be made available for storage under the control of the extended scope physiotherapist. The physiotherapist should seek resupply via the pharmacy as required. They may be directly issued to the patient. A record of issue should be made in the patient notes.

These medications are ready and labelled for immediate issue without further intervention or labelling. These quantities should not be repackaged or broken. Patients should not be provided with multiple packs. Patients should be advised that further quantities may be sourced from a community pharmacy or supermarket.

For Immediate Single Dose of Ibuprofen, Paracetamol or Bupivacaine in the Emergency Department:

Physiotherapists exercising a standing order for immediate single dose will record on an appropriate TCH medication chart in legible, printed script using approved terminology as per TCH Prescribing Policy (TCH09-070):

- that administration of the medication is the exercise of a standing order
- the full name & position of the person initiating the order
- the medication (approved generic name), route/form, dose, frequency (if applicable)

- the standing order approval number of the order being exercised
- day and time of administration of the medication
- signature/mark of the person administering the medicine under the order
- the expiration/duration of this specific order

Where possible a copy of the appropriate standing order will be kept with the medication chart while the standing order is in force/being exercised.

ONCE ONLY, PRE-MEDICATION, TELEPHONE ORDERS & NURSE INITIATED MEDICATIONS

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/ Time of dose	Prescriber/Nurse Initiator (NI)		Given by	Time Given	Pharmacy
					Signature	Print Name			
10/8/12	Panadol	PO	ii	10/8/12 14:10	APhysio	A Physio	AP	14:10	

Date	Medication (Print Generic Name)	Tick if Stop				
Route	Dose Frequency & NOW enter times					
Indication	Pharmacy					
Prescriber Signature	Print Your Name	Contact				

Recording Example Only – Not Valid Standing Orders

Prescriptions

The following medications should be prescribed on standard pre-printed document – see Appendix C:

The Emergency Department Prescriptions:

Naproxen	500mg tablets, ONE TWICE DAILY x 5 days therapy.

A legal prescription is required that must include:

- Prescriber name
- Date of prescribing
- Patient Name and Address (URN sticker acceptable)
- Medication, strength, and supply quantity / duration
- Dose (frequency)
- Prescriber signature

Prescriptions must be written in pen and legible. Incomplete prescriptions are illegal and unsafe. A record of the prescription issue should be made in the patient notes.

Patients should be directed to the TCH Pharmacy Department (M-F, 8.30-5.30) for dispensing. All prescriptions attract a patient copayment.

Orthopaedic Outpatient Prescriptions:

Naproxen	500mg tablets, ONE TWICE DAILY x 12 days therapy.

A legal prescription is required that must include:

- Prescriber name
- Date of prescribing
- Patient Name and Address (URN sticker acceptable)
- Medication, strength, and supply quantity / duration
- Dose (frequency)
- Prescriber signature

Prescriptions must be written in pen and legible. Incomplete prescriptions are illegal and unsafe. A record of the prescription issue should be made in the patient notes.

Patients should be directed to the TCH Pharmacy Department (M-F, 8.30-5.30) for dispensing. All prescriptions attract a patient copayment.

Imprest stock / onsite administration

The following medications are for administration on site by the physiotherapist and will be sourced from existing hospital imprest supplies:

Lignocaine	1% injection, 5 ml ampoule x 1
Betamethasone	5.7 mg / ml injection, 1 ml ampoule x 1
Triamcinolone	10 mg / ml injection, 1 ml ampoule x 1
Triamcinolone	40 mg / ml injection, 1 ml ampoule x 1
Bupivacaine	0.5% injection, 20ml ampoule x 1

Items required from imprest should be sourced and selected individually as required. They should remain securely stored in imprest locations until needed and returned immediately if unused.

Product check and error minimisation

Perform a "time out" check prior to releasing a medication for administration or supply to ensure no error has been made in product selection. Critically inspect the item to review and confirm:

- Has the correct drug as intended from the medication protocol been selected from the shelf?
- Is the product selected the form and strength intended?

Wherever possible a double check of product selection should be obtained by an independent qualified health professional authorised to prescribe or administer medicines. Any double check procedure should be recorded.

Report any supply error via riskman and contact the multidisciplinary team and TCH pharmacy immediately for advice on response.

Record keeping

Record the physical supply of a medicine in the patient's medical record. Include the following details:

- Medication name
- Form
- Strength
- Total quantity supplied
- Labelling instructions (directions)

6. Patient Counselling

All patients must be provided detailed information about any medicine supplied, prescribed or administered. This should be done during a consultation and utilize the methods:

- Provision of Consumer Medicines Information (CMI) see Appendix D
- Verbal instructions and advice
- Provision of appropriate standardised written treatment information

Consumer Medicines Information

CMI is supplied by the manufacturer for all Australian medicines as a regulatory standard. It is an ethical, legal and consumer standard that every patient must be provided with CMI. CMI is available with the medication or supplied via TCH pharmacy. It can be obtained from any community pharmacy, from the manufacturer's website or via the National Prescribing (NPS) website.

For best practice CMI must:

- Be provided for each product dispensed
- Be matched to the product provided (CMI is product and brand specific)
- Provided in full (ie not shortened or abridged)
- NOT be altered
- Complement verbal counselling
- NOT be used as a substitute or short cut to complete verbal counselling

In the provision of CMI patients should be reminded:

- To read the CMI prior to taking the medication
- To use the CMI in the first instance for any questions post consultation
- CMI may have information that does NOT relate to their specific condition or may vary from the specific instructions provided by their health professional
- CMI does not replace professional expertise
- CMI is not exhaustive in its coverage especially with regard to adverse reactions

Information Leaflets

In addition to CMI the following information may prove useful for patients and should be provided where relevant:

1. Arthritis Australia / Australian Rheumatology Association medicines fact sheets on paracetamol and NSAIDs- available at: www.arthritisaustralia.org.au or www.rheumatology.org.au
2. Extended Scope Physiotherapy Project approved patient information sheet on corticosteroid injections.

Verbal Counselling

Verbal counselling is mandatory for every medicine provided, to promote quality use of medicines. The Extended Scope Physiotherapist should be mindful of language and communication barriers and appropriately address these during the counselling process.

Address or consider the following medicines related issues during medicines provision:

Condition	What is working diagnosis Why does it need medication treatment What other alternative and complimentary non-pharmacological treatments exist
Name and description	Generic and brand names

	Formulation type (liquid, tablet, capsule, cream, ointment) Physical description (size, shape, appearance) Strength or concentration
Intended purpose	Type or class of medication Mechanism of action Condition being treated
Dosing instructions	Dose (number of tablets or ml of liquid, etc) Frequency of administration Dose timing (am, pm) Relationship to meals Administration route (special attention if not oral) Intended duration of treatment
Administration	How to take tablets and capsules Specific advice on soft tissue, local anaesthetic infiltration or intra-articular injection
Medicines handling and storage	Medicines storage instructions (out of reach of children, keep in original container, discard unused portion, etc) Discarding Medicines (via community pharmacy return unwanted medicines project)
Monitoring	Expected time for symptomatic relief or cure (how long will it take to work) Efficacy criteria (how will patient know if medicine is working) Self-monitoring of condition Time and criteria for referral to health practitioner
Missed doses	Actions in event of missed doses
Interactions	Relevant drug-drug, drug-food, drug-alcohol and drug-test/procedure interactions Identify and discuss potential effect on current medication regimen Interaction nature, likelihood, severity Patient actions and criteria for referral to a health practitioner
	A patient may not cease regular prescribed medication on advice of the physiotherapist NO specific advice can be provided on existing medications.

	Patients MUST be referred to their doctor or pharmacist for review and advice.
Adverse Drug Reactions	List common and severe adverse effects (side effects) Likelihood of occurrence and expected severity Signs and symptoms of adverse effects Patient actions and treatments Cessation of medication (when should/can medicine be stopped) Referral criteria (when to seek expert help) Patient reporting adverse events: 1300 134 237
Supply	Amount supplied and number of days treatment Total treatment required (if different) Obtaining further supplies of medicines (if appropriate)
Referral	Follow up instructions (if required) When to seek other advice Obtaining specialist advice Where to gain extended medicines information: Local Doctor or Pharmacist NPS Medicines Information Line 1300 888 763 Electronic provision of CMI www.nps.org.au
Specialist advice	Breast feeding Pregnancy Specific medicines advice in these areas must only be provided by qualified and indemnified specialist health professionals. More information can be provided by Mothersafe line (NSW), TCH pharmacy or W&CH, or community pharmacies

7. Follow up / Monitoring for response

All patients provided or administered medicines must be followed up for efficacy and safety. This review should specifically question:

- Compliance with supplied medicines
- Understanding and need for further information or advice
- Correct use and dosing
- Continuation / source of further supplies
- Status of treated condition and improvement / worsening of symptoms

- Specific review of analgesia and pain scales
- Adverse effects, intolerance and allergy
- Need for referral

Findings and actions should be recorded in the medical notes. Any medicines problems, lack of efficacy or adverse effects should be referred to the multidisciplinary team for consideration and patient advice.

Evaluation

Outcome Measures

- Trial Success and Research Goals
- Patient Satisfaction
- Drug Errors
- Clinical Supervision Review

Method

- Patient interviews – as per the Project Ethics Committee approval ETH: 6.10.259
- Data collection – monitoring adverse events, numbers of prescriptions provided, efficacy of the treatment provided via patient interviews

Related Legislation, Policies and Standards

Legislation

ACT Government (2008) Medicines, Policies and therapeutic goods act and regulation

Public Employees Permit (Medicines, Poisons and Therapeutic Goods ACT 2008, Section 85) No 00500/11

Standards

Medication Standing Order Standard Operating Procedure – TCH and Health Services

Attachments

Appendix A: Medication protocols for all medications listed on the prescribing permit

Appendix B: Permit – an amendment of this is currently being sought – attached is the version current 13 December 2012.

Appendix C: Prescription for Naproxen (Emergency Department and Orthopaedic Outpatients)

Appendix D: Links to CMIs

Disclaimer: *This document has been developed by Health Directorate, <Name of Division/ Branch/Unit> specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Health Directorate assumes no responsibility whatsoever.*

Appendix A

ED medication protocols

Drug and Therapeutics Committee

Ibuprofen - MEDICATION PROTOCOL

Medication Details

Name:	Ibuprofen	Class / Actions:	NSAID
Route:	Per Oral (adults: tablets, children: oral liquid)	Dose: >41Kg or adults	2 x 200mg
		Dose: 2-3 years (10-14kg)	4-6mL
		Dose: 3-5 years (10-14kg)	6-7mL
		Dose: 5-7 years (18-22kg)	7-9mL
		Dose: 7-9 years (22-28kg)	9-11mL
		Dose: 9-11 years (28-36kg)	11-14mL
		Dose: 11-12 years (36-41kg)	14-15mL
Frequency:	Two tablets every 6-8 hours	Duration: This medication protocol authorises 24 hours of on-site dosing followed by a ongoing supply of 24 tablets for adults, 100mL for children ages 2-5 years or 200mL for children ages 5-12 years.	
Max Dose:	Adults: 400 mg (two tablets);Children 10mg/kg		
Max. daily dose:	Repeated doses at a frequency of no less than 6 hours with no greater than 1600mg for adults and 40mg/kg for children in 24 hours.		

Indications / Criteria for use

Indication for use:	For the treatment of mild to moderate pain or inflammation in patients with an musculoskeletal condition or injury.
Patient Population:	All patients attending the Emergency Department (ED), under the treatment of the extended scope of practice physiotherapist
Exclusions:	Under 2 years of age
Ward / Unit:	The Emergency Department
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Pregnant or breast feeding mothers – Known hypersensitivity to Aspirin, Ibuprofen or other NSAID – Current or previous history of dyspepsia or peptic ulceration or GI bleeding – Asthmatics, who have never used NSAID before or have severe asthma or had worsening

	of asthma symptoms after previous use – Patients with known severe cardiac disease, heart failure, oedema or hypertension – Patients with known renal impairment
Precautions:	– Asthma; prolonged use; children < 12 years – Patients taking any medication that may interact with Ibuprofen, including: – Fluconazole or Voriconazole - May inhibit Ibuprofen's metabolism, increasing its concentration, and may increase risk of adverse effects. → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Alendronate - May increase risk of gastric ulceration with NSAIDs; avoid combination or monitor carefully. – Tacrolimus, Cyclosporin - Increased risk of nephrotoxicity with NSAIDs→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Oral Corticosteroids - Increased risk of gastrointestinal bleeding→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Antiplatelets or Anticoagulants e.g. Aspirin, Clopidogrel, Phenindione, Warfarin, Rivaroxaban, Dabigatran - – Other NSAIDs - NSAIDs increase the risk of bleeding (antiplatelet effect) → Use Paracetamol or refer to GP – Methotrexate - Decreased elimination of methotrexate, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Lithium - Decreased elimination of lithium, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Loop Diuretics (e.g. Frusemide, Bumetanide, Ethacrynic acid) - Reduced diuretic effect and increased risk of nephrotoxicity due to Ibuprofen NSAIDs → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Thiazide Diuretics (e.g. Chlorthalidone, Hydrochlorothiazide, Indapamide) – ACE Inhibitors (e.g. Captopril, Enalapril, Fosinopril, Lisinopril, Perindopril, Quinapril, Ramipril, Trandolapril) and - Sartans (e.g. Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan) - NSAIDs may reduce antihypertensive effect and may increase risk of renal impairment and hyperkalaemia (risk is further increased if a thiazide diuretic also taken). Avoid combination in the elderly or if renal hypoperfusion or impairment exists → refer to GP or another member of the multidisciplinary team for advice and or increased monitoring of BP, weight, serum creatinine and potassium concentration. – Aldosterone Antagonists (e.g. Eplerenone, Spironolactone), Amiloride and Potassium Supplements - NSAIDs may increase the risk of hyperkalaemia (can cause hyperkalaemia and also reduce renal function) → refer to GP or another member of the multidisciplinary team to allow monitoring of serum potassium and creatinine, particularly in the elderly and patients with renal impairment – Beta Blockers e.g. Bisoprolol, Carvedilol, Metoprolol, Nebivolol, Propranolol, Sotalol - NSAIDs may impair antihypertensive effect of beta-blockers; avoid combination or monitor BP and adjust dose of beta-blocker if necessary. → refer to GP or another member of the multidisciplinary team for advice and or monitoring – Thiazolidinediones (eg Pioglitazone, Rosiglitazone) - NSAIDs may increase risk of fluid retention with thiazolidinediones, and may increase the risk of heart failure; use cautiously→ refer to GP or another member of the multidisciplinary team for advice
Adverse Reactions:	– Nausea, vomiting, oesophageal reflux or abdominal pain - Common side effect which can be alleviated by taking dose with food – Loss of appetite, altered bowel habit, headache - These side effects are usually mild, refer to GP if they become a problem – Haematemesis or maleana - This may indicate gastric bleeding or ulceration → refer to ED immediately – Angiooedema or urticaria - This may indicate an allergic reaction to Ibuprofen → refer to the ED immediately – Shortness of breath and/or wheeze – This may indicate bronchial hyper reactivity in the absence of a previous diagnosis of asthma → refer to ED immediately

Monitoring / Obs:	– Monitor for signs of allergic reaction– as above
Referral Criteria:	– Any signs of allergic reaction or can be a medical emergency and the patient is referred to the emergency department.
Counselling Points:	– Take medicine with or after food – Ibuprofen may be taken with Paracetamol if necessary – Advise the patient not to take other NSAID containing products at the same time e.g. over-the-counter medicines containing Aspirin – Discontinue if indigestion or other gastro-intestinal symptoms develop – If condition worsens or symptoms persist then seek further medical advice – Obtain further supply from a community pharmacy

Approval Details

Approval No:	To be assigned by DTC		
Clinical Sponsor:	Dr David Lamond	Signature:	
Approval Date:		Review Date:	
DTC Chair:		Signature:	

Drug and Therapeutics Committee

Naproxen - MEDICATION PROTOCOL

Medication Details

Name:	Naproxen	Class / Actions:	NSAID
Route:	Oral	Dose:	500mg
Frequency:	Twice daily	Duration:	5 days (10 tablets)
Max Dose:	500 mg (two tablets)		
Max. daily dose:	1000mg in 24 hours.		

Indications / Criteria for use

Indication for use:	For the treatment of mild to moderate pain or inflammation in patients with an musculoskeletal condition or injury.
Patient Population:	All patients attending the Emergency Department (ED), under the treatment of the extended scope of practice physiotherapist
Exclusions:	Under 16 years of age
Ward / Unit:	The Emergency Department
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– regnant or breast feeding mothers – Known hypersensitivity to Aspirin, Naproxen or other NSAIDs – Current or previous history of dyspepsia or peptic ulceration or GI bleeding – Asthmatics, who have never used NSAID before or have severe asthma or had worsening of asthma symptoms after previous use – Patients with known severe cardiac disease, heart failure, oedema or hypertension – Patients with known renal impairment
Precautions:	Patients taking any medication that may interact with Naproxen, including: – Fluconazole or Voriconazole - May inhibit Ibuprofen's metabolism, increasing its concentration, and may increase risk of adverse effects. → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Alendronate - May increase risk of gastric ulceration with NSAIDs; avoid combination or monitor carefully. – Tacrolimus, Cyclosporin - Increased risk of nephrotoxicity with NSAIDs→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Oral Corticosteroids - Increased risk of gastrointestinal bleeding→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Antiplatelets or Anticoagulants e.g. Aspirin, Clopidogrel, Phenindione, Warfarin, Rivaroxaban, Dabigatran - – Other NSAIDs - NSAIDs increase the risk of bleeding (antiplatelet effect) → Use Paracetamol

	or refer to GP – Methotrexate - Decreased elimination of methotrexate, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Lithium - Decreased elimination of lithium, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Loop Diuretics (e.g. Frusemide, Bumetanide, Ethacrynic acid) - Reduced diuretic effect and increased risk of nephrotoxicity due to Ibuprofen NSAIDs → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Thiazide Diuretics (e.g. Chlorthalidone, Hydrochlorothiazide, Indapamide) – ACE Inhibitors (e.g. Captopril, Enalapril, Fosinopril, Lisinopril, Perindopril, Quinapril, Ramipril, Trandolapril) and - Sartans (e.g. Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan) - NSAIDs may reduce antihypertensive effect and may increase risk of renal impairment and hyperkalaemia (risk is further increased if a thiazide diuretic also taken). Avoid combination in the elderly or if renal hypoperfusion or impairment exists → refer to GP or another member of the multidisciplinary team for advice and or increased monitoring of BP, weight, serum creatinine and potassium concentration. – Aldosterone Antagonists (e.g. Eplerenone, Spironolactone), Amiloride and Potassium Supplements - NSAIDs may increase the risk of hyperkalaemia (can cause hyperkalaemia and also reduce renal function) → refer to GP or another member of the multidisciplinary team to allow monitoring of serum potassium and creatinine, particularly in the elderly and patients with renal impairment – Beta Blockers e.g. Bisoprolol, Carvedilol, Metoprolol, Nebivolol, Propranolol, Sotalol - NSAIDs may impair antihypertensive effect of beta-blockers; avoid combination or monitor BP and adjust dose of beta-blocker if necessary. → refer to GP or another member of the multidisciplinary team for advice and or monitoring – Thiazolidinediones (eg Pioglitazone, Rosiglitazone) - NSAIDs may increase risk of fluid retention with thiazolidinediones, and may increase the risk of heart failure; use cautiously→ refer to GP or another member of the multidisciplinary team for advice
Adverse Reactions:	– Nausea, vomiting, oesophageal reflux or abdominal pain - Common side effect which can be alleviated by taking dose with food – Loss of appetite, altered bowel habit, headache - These side effects are usually mild, refer to GP if they become a problem – Haematemesis or maleana - This may indicate gastric bleeding or ulceration → refer to ED immediately – Angiooedema or urticaria - This may indicate an allergic reaction to Ibuprofen → refer to the ED immediately – Shortness of breath and/or wheeze – This may indicate bronchial hyper reactivity in the absence of a previous diagnosis of asthma → refer to ED immediately
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	Any sign of allergic reaction is a medical emergency and the patient will be referred to the emergency department.
Counselling Points	– Take medicine with or after food – Naproxen may be taken with Paracetamol if necessary – Advise the client not to take other NSAID containing products at the same time e.g. over-the-counter medicines containing Aspirin – Discontinue if indigestion or other gastro-intestinal symptoms develop – If condition worsens or symptoms persist then seek further medical advice – Obtain further supply from TCH pharmacy department on a hospital prescription

Approval Details

Approval No:	To be assigned by DTC

Clinical Sponsor:	Dr David Lamond	Signature:	
Approval Date:		Review Date:	
DTC Chair:		Signature:	

Paracetamol - MEDICATION PROTOCOL

Medication Details

Name:	Paracetamol	Class / Actions:	Analgesic
Route:	Oral	Dose:	Adults: 1g Children: 15mg/kg
Frequency:	Four times a day	Duration:	This SO authorises 24 hours of on-site dosing followed by a ongoing supply of 24 tablets for adults, 100mL for children ages 2-5 years or 200mL for children ages 5-12 years.
Max Dose:	Adults: 1000 mg ; Children 15mg/kg		
Max. daily dose:	Four doses in 24 hours.		

Indications / Criteria for use

Indication for use:	For the treatment of mild to moderate pain
Patient Population:	All patients attending the Emergency Department (ED), under the treatment of the extended scope of practice physiotherapist
Exclusions:	Under 2 years of age
Ward / Unit:	The Emergency Department
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Clients who have had a previous adverse reaction or history of allergy to Paracetamol – Chronic liver disease
Precautions:	– Patients taking any medication that may interact with Paracetamnol, including: – Cholestyramine reduces the absorption of paracetamol if given within one hour of Paracetamol → ensure client has not had Cholestyramine within one hour of Paracetamol dose – Rifampicin, Alcohol, Barbiturates, Phenytoin or Carbamazepine. These drugs induce CYP450 enzymes, and therefore increase the risk of Paracetamol toxicity → Patients requiring ongoing use of Paracetamol should be referred to their GP or another member of the multidisciplinary team – Warfarin - INR may increase in clients on a stable warfarin regimen who begin taking >3.5 g paracetamol each week → Refer to GP or another member of the multidisciplinary team for INR monitoring if regular paracetamol is commenced – Zidovudine - When used concurrently with Paracetamol, an increased tendency for neutropenia may develop → Combination should be avoided. Use NSAID or refer to GP or another member of the multidisciplinary team

Adverse Reactions:	– Dyspepsia or Nausea - Rare adverse effects, advise client to seek medical advice if this worries them – Jaundice, Liver dysfunction - Refer to GP if patient experiences symptoms of jaundice (yellow skin and/or eyes) – Rash - May indicate allergy to Paracetamol → refer to GP
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	If any signs of allergic reaction occur the patient is referred to the general practitioner.
Counselling Points	– If pain and/or fever lasts for >48 hours, refer to GP. – No more than 4 doses of paracetamol or paracetamol containing products in 24 hours – There are many brands of paracetamol. It is also contained in many cough and cold products. Prevent overdosing by checking carefully which strength product is being used, and the correct dose for that product. Avoid using more than one product containing paracetamol at the same time – Too much paracetamol can cause liver damage. – Onset of pain relief is approximately 30 minutes after oral administration – See the community pharmacist for further supply

Approval Details

Approval No:	To be assigned by DTC		
Clinical Sponsor:	Dr David Lamond	Signature:	
Approval Date:		Review Date:	
DTC Chair:		Signature:	

Bupivacaine - MEDICATION PROTOCOL

Medication Details

Name:	Bupivacaine 0.5% 20mL	Class / Actions:	Local Anaesthetic
Route:	Subcutaneous Injection	Dose:	Dose is dependent on digit size, enough bupivacaine should be instilled to produce visible soft tissue swelling, approximately 3-5mL per injection site
Frequency:	Once only	Duration:	Not applicable Onset of action is intermediate to slow (less than Lignocaine) and effects can last from 4-12 hours
Max Dose:	Single dose no greater than 2mg per kg. ie 70kg male = 140mg or 28mls of 0.5%		
Max. daily dose:	Repeated doses at a frequency of no less than 3 hours with no greater than 400mg in 24 hours.		

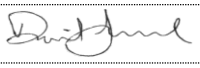
Indications / Criteria for use

Indication for use:	Used for digital ring blocks to provide regional anaesthesia to digits for procedures such as relocation of metacarpal and metatarsal interphalangeal joint, interphalangeal joint dislocations or reduction of closed fractures.
Patient Population:	All patients attending the Emergency Department (ED), under the treatment of the extended scope of practice physiotherapist
Exclusions:	- Known hypersensitivity to amide type local anaesthetics - Inflammation or sepsis at the proposed site of injection
Ward / Unit:	The Emergency Department
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed"

Clinical Information

Contraindications:	- Known hypersensitivity to amide type local anaesthetics - Inflammation or sepsis at the proposed site of injection
Precautions:	1. Hyperthyroidism – increases risk of toxicity, use cautiously
Adverse Reactions:	- Localised oedema, urticaria, bronchospasm and anaphylaxis. - Anxiety, pallor, tachycardia, hypertension, sweating, peri-oral pins and needles or arrhythmias
Monitoring / Obs:	Monitor for signs of allergic reaction or cardiac toxicity – as above
Referral Criteria:	Any signs of allergic reaction or cardiac toxicity is a medical emergency and requires immediate review by an ED Registrar or Consultant

Approval Details

Approval No:	To be assigned by DTC		
Clinical Sponsor:	Dr David Lamond	Signature:	
Approval Date:	21 June 2012	Review Date:	
DTC Chair:	Dr Carolyn Hawkins	Signature:	

Appendix A

Orthopaedic Outpatient Medication Protocols (signed copies available)

Drug and Therapeutics Committee

Lignocaine - MEDICATION PROTOCOL

Medication Details

Name:	Lignocaine	Class / Actions: Local Anaesthetic
Route:	Intra-articular or soft-tissue injection	Dose: The lowest dosage that results in effective anaesthesia should be used to avoid high plasma levels and serious undesirable systemic side effects
Frequency:	One dose only	Duration: One dose only.
Max Dose:	200mg (or 3mg/kg) which is 20mL of the 1% solution	

Indications / Criteria for use

Indication for use:	Local anaesthetic to be used in conjunction with corticosteroid intra-articular injection
Patient Population:	All patients attending orthopaedic outpatient clinics, under the treatment of the extended scope of practice physiotherapist (in training or credentialed).
Exclusions:	- Under 18 years of age
Ward / Unit:	Orthopaedic Outpatient Clinic
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Known hypersensitivity to local anaesthetics; Refer to GP or another member of the multidisciplinary team – Inflammation or sepsis at the proposed site of injection; Refer to GP or another member of the multidisciplinary team
Precautions:	– No significant drug interactions exist when lignocaine is administered subcutaneously
Adverse Reactions:	– Localised oedema, urticaria, bronchospasm and anaphylaxis; Client may be experiencing an allergic reaction → Refer client to ED – Anxiety, pallor, tachycardia, hypertension, sweating or arrhythmias; May indicate a vasoconstrictor reaction which usually resolves on stopping administration → Cease administration and refer client to ED – Restlessness, anxiety, tinnitus, dizziness, blurred vision, tremors, depression or drowsiness; Restlessness, anxiety, tinnitus, dizziness, blurred vision, tremors, depression or drowsiness
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	Any sign of allergic reaction is a medical emergency and the patient will be referred to the emergency department.
Counselling Points:	– Refer patient to: – "Orthopaedic Multi-Disciplinary Clinic – Patient Injection Information" sheet

– "Orthopaedic Multi-Disciplinary Clinic – Patient Injection Consent" sheet

Approval Details

Approval No:	To be assigned by DTC	
Clinical Sponsor:	Dr Chandima Perera	Signature:
Approval Date:		Review Date:
DTC Chair:		Signature:

Drug and Therapeutics Committee

Betamethasone – MEDICATION PROTOCOL

Medication Details

Name:	Betamethasone	Class / Actions: Corticosteroid	
Route:	Intra-articular or soft-tissue injection	Dose: Small joint (eg hand)	0.5-1mL
		Dose: Medium sized joint (eg wrist)	1mL
		Dose: Large joint (eg knee)	1-2mL
		Dose: Soft-tissue (eg bursa)	1-2mL
Frequency:	One dose only	Duration: One dose only.	
Max Dose:	No more than 4 injections into any single joint over 1 year (as there is a risk of developing progressive cartilage damage. Avoid further intra-articular injections if there is no response after 2 consecutive injections		

Indications / Criteria for use

Indication for use:	Adjunctive treatment for inflammatory arthritis (eg rheumatoid, osteoarthritis) for joints or soft tissue structures (eg bursae) that fail to respond to systemic treatment according to the administration of injection under guidance from "Physiotherapists Undertaking Intra-articular or soft-tissue Corticosteroid Injections and/or joint aspiration" Standard Operating Procedure
Patient Population:	All patients attending orthopaedic outpatient clinics under the treatment of the extended scope of practice physiotherapist.
Exclusions:	- Under 18 years of age
Ward / Unit:	Orthopaedic Outpatient Clinic
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Pregnant or breast feeding mothers; Refer to GP or another member of the multidisciplinary team – Known hypersensitivity to Betamethasone or other corticosteroids; Refer to GP or another member of the multidisciplinary team – Suspected or confirmed infection of the skin at the injection site, of the joint, or systemically → Review once infection has been treated of refer to GP or another member of the multidisciplinary team
Precautions:	– Nil significant drug interactions exist with local administration of Betamethasone

Adverse Reactions:	– Intra-articular pain or pain at the injection site; Pain at the site of injection can be expected for a few hours post injection. If significant pain continues, seek medical advice – Transient increase in blood glucose levels; Most patients experience a transient (24 to 48 hours) increase in blood glucose post injection. Patients with diabetes should be more closely monitored for the 48 hours post injection and their treatment adjusted accordingly. – Post injection flare or flushing of the face; This is a common side effect, seek medical advice if it worries you – Hyper and hypopigmentation or fat loss around the injection site; This is a common side effect, seek medical advice if it worries you – Septic arthritis, local cutaneous atrophy, calcinosis, accelerated joint destruction, and crystal-induced inflammation; These are infrequent local reactions. If any of these develop, advise patient to seek medical advice – Local osteoporosis, joint damage, osteonecrosis and tendon rupture; These adverse effects have been seen with repeated intra-articular injections. If any of these develop, advise patient to seek medical advice
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	Any sign of allergic reaction is a medical emergency and the patient will be referred to the emergency department.
Counselling Points:	– Instruct patients not to overuse the joint following intra-articular injection as there is a risk of further joint deterioration and beneficial effects may be reduced – Refer patient to: – "Orthopaedic Multi-Disciplinary Clinic – Patient Injection Information" sheet – "Orthopaedic Multi-Disciplinary Clinic – Patient Injection Consent" sheet

Approval Details

Approval No:	To be assigned by DTC	
Clinical Sponsor:	Dr Chandima Perera	Signature:
Approval Date:		Review Date:
DTC Chair:		Signature:

Drug and Therapeutics Committee

Triamcinolone - MEDICATION PROTOCOL

Medication Details

Name:	Triamcinolone	Class / Actions: Corticosteroid		
Route:	Intra-articular or soft-tissue injection	Joint Size	**10mg/mL**	**40mg/mL**
		Small joint (eg hand)	0.5 – 1mL	n/a
		Medium sized joint (eg wrist)	1mL	n/a
		Large joint (eg knee)	1 – 2mL	0.5mL
		Soft tissue (eg burse)	1 – 2mL	n/a
Frequency:	One dose only	Duration: One dose only.		
Max Dose:	Maximum total dose of 80mg when injected into several joints No more than 4 injections into any single joint over 1 year (as there is a risk of developing progressive cartilage damage.) Avoid further intra-articular injections if there is no response after 2 consecutive injections			

Indications / Criteria for use

Indication for use:	Adjunctive treatment for inflammatory arthritis (eg rheumatoid, osteoarthritis) for joints or soft tissue structures (eg bursae) that fail to respond to systemic treatment according to the administration of injection under guidance from "Physiotherapists Undertaking Intra-articular or soft-tissue Corticosteroid Injections and/or joint aspiration" Standard Operating Procedure
Patient Population:	All patients attending orthopaedic outpatient clinic, under the treatment of the extended scope of practice physiotherapist (in training or credentialed).
Exclusions:	- Under 18 years of age
Ward / Unit:	Orthopaedic Outpatient Clinic
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Pregnant or breast feeding mothers; Refer to GP or another member of the multidisciplinary team – Known hypersensitivity to Triamcinolone or other corticosteroids; Refer to GP or another member of the multidisciplinary team – Suspected or confirmed infection of the skin at the injection site, of the joint, or systemically; Infection is a contraindication for intra-articular or soft tissue corticosteroid injections → Review once infection has been treated of refer to GP or another member of the multidisciplinary team

Precautions:	– Nil significant drug interactions exist with local administration of triamcinolone
Adverse Reactions:	– Intra-articular pain or pain at the injection site; Pain at the site of injection can be expected for a few hours post injection. If significant pain continues, instruct the patient to seek medical advice – Transient increase in blood glucose levels; Most patients experience a transient (24 to 48 hours) increase in blood glucose post injection. Patients with diabetes should be more closely monitored for the 48 hours post injection and their treatment adjusted accordingly. – Post injection flare or flushing of the face; This is a common side effect, seek medical advice if it is of concern. – Hyper and hypopigmentation or fat loss around the injection site; This is a common side effect, seek medical advice if it is of concern. – Septic arthritis, local cutaneous atrophy, calcinosis, accelerated joint destruction, and crystal-induced inflammation; These are infrequent local reactions. If any of these develop, advise patient to seek medical advice – Local osteoporosis, joint damage, osteonecrosis and tendon rupture; These adverse effcetct have been seen with repeated intra-articular injections. If any of these develop, advise patient to seek medical advice
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	Any sign of allergic reaction is a medical emergency and the patient will be referred to the emergency department.
Counselling Points:	– Instruct patients not to overuse the joint following intra-articular injection as there is a risk of further joint deterioration and beneficial effects may be reduced – Refer patient to: – "Orthopaedic Multi-Disciplinary Clinic – Patient Injection Information" sheet – "Orthopaedic Multi-Disciplinary Clinic – Patient Injection Consent" sheet

Approval Details

Approval No:	To be assigned by DTC	
Clinical Sponsor:	Dr Chandima Perera	Signature:
Approval Date:		Review Date:
DTC Chair:		Signature:

Drug and Therapeutics Committee

Paracetamol - MEDICATION PROTOCOL

Medication Details

Name:	Paracetamol	Class / Actions:	Analgesic
Route:	Oral	Dose:	Adults: 1g Children: 15mg/kg
Frequency:	Four times a day	Duration:	This SO authorises a supply of 24 tablets for adults, 100mL for children ages 2-5 years or 200mL for children ages 5-12 years.
Max Dose:	Adults: 1000 mg ; Children 15mg/kg		
Max. daily dose:	Four doses in 24 hours.		

Indications / Criteria for use

Indication for use:	For the treatment of mild to moderate pain
Patient Population:	All patients attending orthopaedic Outpatient Clinics, under the treatment of the extended scope of practice physiotherapist
Exclusions:	Under 2 years of age
Ward / Unit:	Orthopaedic Outpatient Clinics
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Clients who have had a previous adverse reaction or history of allergy to Paracetamol – Chronic liver disease
Precautions:	– Patients taking any medication that may interact with Paracetamnol, including: – Cholestyramine reduces the absorption of paracetamol if given within one hour of Paracetamol → ensure client has not had Cholestyramine within one hour of Paracetamol dose – Rifampicin, Alcohol, Barbiturates, Phenytoin or Carbamazepine. These drugs induce CYP450 enzymes, and therefore increase the risk of Paracetamol toxicity → Patients requiring ongoing use of Paracetamol should be referred to their GP or another member of the multidisciplinary team – Warfarin - INR may increase in clients on a stable warfarin regimen who begin taking >3.5 g paracetamol each week → Refer to GP or another member of the multidisciplinary team for INR monitoring if regular paracetamol is commenced – Zidovudine - When used concurrently with Paracetamol, an increased tendency for neutropenia may develop → Combination should be avoided. Use NSAID or refer to GP or another member of the multidisciplinary team

Adverse Reactions:	– Dyspepsia or Nausea - Rare adverse effects, advise client to seek medical advice if this worries them – Jaundice, Liver dysfunction - Refer to GP if patient experiences symptoms of jaundice (yellow skin and/or eyes) – Rash - May indicate allergy to Paracetamol → refer to GP
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	If any signs of allergic reaction occur the patient is referred to the general practitioner.
Counselling Points	– If pain and/or fever lasts for >48 hours, refer to GP. – No more than 4 doses of paracetamol or paracetamol containing products in 24 hours – There are many brands of paracetamol. It is also contained in many cough and cold products. Prevent overdosing by checking carefully which strength product is being used, and the correct dose for that product. Avoid using more than one product containing paracetamol at the same time – Too much paracetamol can cause liver damage. – Onset of pain relief is approximately 30 minutes after oral administration – See the community pharmacist for further supply

Approval Details

Approval No:	To be assigned by DTC	
Clinical Sponsor:	Dr Chandima Perera	Signature:
Approval Date:		Review Date:
DTC Chair:		Signature:

Naproxen - MEDICATION PROTOCOL

Medication Details

Name:	Naproxen	Class / Actions:	NSAID
Route:	Oral	Dose:	500mg
Frequency:	Twice daily	Duration:	12 days (24 tablets)
Max Dose:	500 mg (one tablet)		
Max. daily dose:	1000mg in 24 hours.		

Indications / Criteria for use

Indication for use:	For the treatment of mild to moderate pain or inflammation in patients with a musculoskeletal condition or injury.
Patient Population:	All patients attending the Orthopaedic Outpatient Clinics, under the treatment of the extended scope of practice physiotherapist
Exclusions:	Under 16 years of age
Ward / Unit:	Orthopaedic Outpatient Clinic
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Pregnant or breast feeding mothers – Known hypersensitivity to Aspirin, Naproxen or other NSAIDs – Current or previous history of dyspepsia or peptic ulceration or GI bleeding – Asthmatics, who have never used NSAID before or have severe asthma or had worsening of asthma symptoms after previous use – Patients with known severe cardiac disease, heart failure, oedema or hypertension – Patients with known renal impairment
Precautions:	Patients taking any medication that may interact with Naproxen, including: – Fluconazole or Voriconazole - May inhibit Ibuprofen's metabolism, increasing its concentration, and may increase risk of adverse effects. → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Alendronate - May increase risk of gastric ulceration with NSAIDs; avoid combination or monitor carefully. – Tacrolimus, Cyclosporin - Increased risk of nephrotoxicity with NSAIDs→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Oral Corticosteroids - Increased risk of gastrointestinal bleeding→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Antiplatelets or Anticoagulants e.g. Aspirin, Clopidogrel, Phenindione, Warfarin, Rivaroxaban, Dabigatran - – Other NSAIDs - NSAIDs increase the risk of bleeding (antiplatelet effect) → Use Paracetamol or refer to GP

	– Methotrexate - Decreased elimination of methotrexate, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Lithium - Decreased elimination of lithium, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Loop Diuretics (e.g. Frusemide, Bumetanide, Ethacrynic acid) - Reduced diuretic effect and increased risk of nephrotoxicity due to Ibuprofen NSAIDs → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Thiazide Diuretics (e.g. Chlorthalidone, Hydrochlorothiazide, Indapamide) – ACE Inhibitors (e.g. Captopril, Enalapril, Fosinopril, Lisinopril, Perindopril, Quinapril, Ramipril, Trandolapril) and - Sartans (e.g. Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan) - NSAIDs may reduce antihypertensive effect and may increase risk of renal impairment and hyperkalaemia (risk is further increased if a thiazide diuretic also taken). Avoid combination in the elderly or if renal hypoperfusion or impairment exists → refer to GP or another member of the multidisciplinary team for advice and or increased monitoring of BP, weight, serum creatinine and potassium concentration. – Aldosterone Antagonists (e.g. Eplerenone, Spironolactone), Amiloride and Potassium Supplements - NSAIDs may increase the risk of hyperkalaemia (can cause hyperkalaemia and also reduce renal function) → refer to GP or another member of the multidisciplinary team to allow monitoring of serum potassium and creatinine, particularly in the elderly and patients with renal impairment – Beta Blockers e.g. Bisoprolol, Carvedilol, Metoprolol, Nebivolol, Propranolol, Sotalol - NSAIDs may impair antihypertensive effect of beta-blockers; avoid combination or monitor BP and adjust dose of beta-blocker if necessary. → refer to GP or another member of the multidisciplinary team for advice and or monitoring – Thiazolidinediones (eg Pioglitazone, Rosiglitazone) - NSAIDs may increase risk of fluid retention with thiazolidinediones, and may increase the risk of heart failure; use cautiously→ refer to GP or another member of the multidisciplinary team for advice
Adverse Reactions:	– Nausea, vomiting, oesophageal reflux or abdominal pain - Common side effect which can be alleviated by taking dose with food – Loss of appetite, altered bowel habit, headache - These side effects are usually mild, refer to GP if they become a problem – Haematemesis or maleana - This may indicate gastric bleeding or ulceration → refer to ED immediately – Angiooedema or urticaria - This may indicate an allergic reaction to Ibuprofen → refer to the ED immediately – Shortness of breath and/or wheeze – This may indicate bronchial hyper reactivity in the absence of a previous diagnosis of asthma → refer to ED immediately
Monitoring / Obs:	Monitor for signs of allergic reaction– as above
Referral Criteria:	Any sign of allergic reaction is a medical emergency and the patient will be referred to the emergency department.
Counselling Points	– Take medicine with or after food – Naproxen may be taken with Paracetamol if necessary – Advise the client not to take other NSAID containing products at the same time e.g. over-the-counter medicines containing Aspirin – Discontinue if indigestion or other gastro-intestinal symptoms develop – If condition worsens or symptoms persist then seek further medical advice – Further supply to be discussed by the patient with their GP

Approval Details

Approval No:	To be assigned by DTC

Clinical Sponsor:	Dr Chandima Perera	Signature:
Approval Date:		Review Date:
DTC Chair:		Signature:

Drug and Therapeutics Committee

Ibuprofen - MEDICATION PROTOCOL

Medication Details

Name:	Ibuprofen	Class / Actions:	NSAID
Route:	Per Oral (adults: tablets, children: oral liquid)	Dose: >41Kg or adults	2 x 200mg
		Dose: 2-3 years (10-14kg)	4-6mL
		Dose: 3-5 years (10-14kg)	6-7mL
		Dose: 5-7 years (18-22kg)	7-9mL
		Dose: 7-9 years (22-28kg)	9-11mL
		Dose: 9-11 years (28-36kg)	11-14mL
		Dose: 11-12 years (36-41kg)	14-15mL
Frequency:	Two tablets every 6-8 hours	Duration: This SO a supply of 24 tablets for adults, 100mL for children ages 2-5 years or 200mL for children ages 5-12 years.	
Max Dose:	Adults: 400 mg (two tablets);Children 10mg/kg		
Max. daily dose:	Repeated doses at a frequency of no less than 6 hours with no greater than 1600mg for adults and 40mg/kg for children in 24 hours.		

Indications / Criteria for use

Indication for use:	For the treatment of mild to moderate pain or inflammation in patients with an musculoskeletal condition or injury.
Patient Population:	All patients attending Orthopaedic Outpatient Clinics, under the treatment of the extended scope of practice physiotherapist
Exclusions:	Under 2 years of age
Ward / Unit:	Orthopaedic Outpatient Clinics
Authorised staff:	Extended scope physiotherapists-in-training (under supervision) or credentialed

Clinical Information

Contraindications:	– Pregnant or breast feeding mothers – Known hypersensitivity to Aspirin, Ibuprofen or other NSAID – Current or previous history of dyspepsia or peptic ulceration or GI bleeding – Asthmatics, who have never used NSAID before or have severe asthma or had worsening of asthma symptoms after previous use – Patients with known severe cardiac disease, heart failure, oedema or hypertension – Patients with known renal impairment
Precautions:	– Asthma; prolonged use; children < 12 years

	– Patients taking any medication that may interact with Ibuprofen, including: – Fluconazole or Voriconazole - May inhibit Ibuprofen's metabolism, increasing its concentration, and may increase risk of adverse effects. → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Alendronate - May increase risk of gastric ulceration with NSAIDs; avoid combination or monitor carefully. – Tacrolimus, Cyclosporin - Increased risk of nephrotoxicity with NSAIDs→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Oral Corticosteroids - Increased risk of gastrointestinal bleeding→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Antiplatelets or Anticoagulants e.g. Aspirin, Clopidogrel, Phenindione, Warfarin, Rivaroxaban, Dabigatran - – Other NSAIDs - NSAIDs increase the risk of bleeding (antiplatelet effect) → Use Paracetamol or refer to GP – Methotrexate - Decreased elimination of methotrexate, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Lithium - Decreased elimination of lithium, therefore increased risk of toxicity→ Use Paracetamol or refer to GP or another member of the multidisciplinary team – Loop Diuretics (e.g. Frusemide, Bumetanide, Ethacrynic acid) - Reduced diuretic effect and increased risk of nephrotoxicity due to Ibuprofen NSAIDs → Use Paracetamol or refer to GP or another member of the multidisciplinary team – Thiazide Diuretics (e.g. Chlorthalidone, Hydrochlorothiazide, Indapamide) – ACE Inhibitors (e.g. Captopril, Enalapril, Fosinopril, Lisinopril, Perindopril, Quinapril, Ramipril, Trandolapril) and - Sartans (e.g. Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan) - NSAIDs may reduce antihypertensive effect and may increase risk of renal impairment and hyperkalaemia (risk is further increased if a thiazide diuretic also taken). Avoid combination in the elderly or if renal hypoperfusion or impairment exists → refer to GP or another member of the multidisciplinary team for advice and or increased monitoring of BP, weight, serum creatinine and potassium concentration. – Aldosterone Antagonists (e.g. Eplerenone, Spironolactone), Amiloride and Potassium Supplements - NSAIDs may increase the risk of hyperkalaemia (can cause hyperkalaemia and also reduce renal function) → refer to GP or another member of the multidisciplinary team to allow monitoring of serum potassium and creatinine, particularly in the elderly and patients with renal impairment – Beta Blockers e.g. Bisoprolol, Carvedilol, Metoprolol, Nebivolol, Propranolol, Sotalol - NSAIDs may impair antihypertensive effect of beta-blockers; avoid combination or monitor BP and adjust dose of beta-blocker if necessary. → refer to GP or another member of the multidisciplinary team for advice and or monitoring – Thiazolidinediones (eg Pioglitazone, Rosiglitazone) - NSAIDs may increase risk of fluid retention with thiazolidinediones, and may increase the risk of heart failure; use cautiously→ refer to GP or another member of the multidisciplinary team for advice
Adverse Reactions:	– Nausea, vomiting, oesophageal reflux or abdominal pain - Common side effect which can be alleviated by taking dose with food – Loss of appetite, altered bowel habit, headache - These side effects are usually mild, refer to GP if they become a problem – Haematemesis or maleana - This may indicate gastric bleeding or ulceration → refer to ED immediately – Angiooedema or urticaria - This may indicate an allergic reaction to Ibuprofen → refer to the ED immediately – Shortness of breath and/or wheeze – This may indicate bronchial hyper reactivity in the absence of a previous diagnosis of asthma → refer to ED immediately
Monitoring / Obs:	– Monitor for signs of allergic reaction– as above
Referral Criteria:	– Any sign of allergic reaction is a medical emergency and the patient will be referred to the emergency department.
Counselling Points:	– Take medicine with or after food

	– Ibuprofen may be taken with Paracetamol if necessary – Advise the patient not to take other NSAID containing products at the same time e.g. over-the-counter medicines containing Aspirin – Discontinue if indigestion or other gastro-intestinal symptoms develop – If condition worsens or symptoms persist then seek further medical advice – Obtain further supply from a community pharmacy

Approval Details

Approval No:	To be assigned by DTC	
Clinical Sponsor:	Dr Chadima Perera	Signature:
Approval Date:		Review Date:
DTC Chair:		Signature:

Appendix B

ACT Government
Health

Public Employees Permit

Medicines, Poisons and Therapeutic Goods Act 2008, Section 85

Permit No: 0050/11

MS KAREN MURPHY

ACT HEALTH

ACT HEALTH - ALLIED HEALTH ADVISER'S OFFICE LEVEL 2 - 11 MOORE STREET CANBERRA CITY ACT 2601

This licence authorises **Ms Karen Murphy** to deal with the substances in accordance with the following conditions, at the above address, for the period **16/06/2012** to **16/06/2013**.

An authorised person may deal with an authorised substance as follows: supply , administer , prescribe

Standard Conditions

1. This licence is subject to the requirements of the *Medicines, Poisons and Therapeutic Goods Act 2008* and the Medicines, Poisons and Therapeutic Goods Regulation 2008.
2. The licensee must inform the Health Protection Service of any amendment to the details above within seven (7) days of the change.
3. This licence is subject to any special conditions below.

Special Conditions

1. Authorised substances or goods under this permit are listed in Schedule 1.
2. Persons authorised under the permit are listed in Schedule 2.
3. This permit applies for dealings with an authorised substance within an Orthopaedic Outpatients clinic at The Canberra Hospital only.
4. Authorised persons listed in Schedule 2 must undertake a formal training program in Extended Scope Practice Physiotherapy, as directed by the ACT Government (Health Directorate) Office of the Allied Health Advisor.
5. A full evaluation of the Physiotherapy Extended Scope Practice project must be provided on reapplication for a subsequent permit.

John Woollard
Director
Health Protection Service

24 July 2012

File Number: 11/000394

ACT Government
Health

Permit No: 0050/11

Schedule 1

Authorised Substances

Substance	Strength	Form	Max Quantity*	Total Quantity#
Lignocaine	1%	injection	-	-
Paracetamol	500mg	tablet	-	-
Naproxen	500mg	tablet	-	-
Ibuprofen	200mg	tablet	-	-
Triamcinolone	40mg	injection	-	-
Triamcinolone	10mg	injection	-	-
Betamethasone	5.7mg	injection	-	-

Authorised Goods

Name of Goods	Description of Goods	Quantity
None Listed	N/A	N/A

Schedule 2

Persons Authorised to Deal with a Medicine under a Public Employees Permit

Full Name	Address	Occupation	Board Rego No
Extended Scope Physiotherapist - Orthopaedics Position No: 20813	The Canberra Hospital ACT Health	Physiotherapist	N/A

* **Max Quantity**: the quantity that would be possessed under the licence at any one time.
#**Total Quantity**: the quantity that may be possessed during the licence period.

File Number: 11/000394

Appendix C

Department of Pharmacy Services

Yamba Drive, Garran ACT 2605
PO Box 11 Woden ACT 2606
Phone: (02) 6244 2121 Fax: (02) 6244 4624
Website: www.health.act.gov.au
ABN: 82 049 056 234

Extended Scope Physiotherapy Trial Project

PRESCRIPTION – EMERGENCY DEPARTMENT

Patient Name: _____ Or attach

URN: _____ patient

Address: _____ sticker

_____

DOB: _____

Prescription Date: _____

Please Supply:

Naproxen 500 mg tablets X 10

Label:

Take ONE tablet TWICE DAILY with or after food

Physiotherapist Name: _____

Physiotherapist Signature: _____

PATIENT INSTRUCTIONS

This prescription is ONLY valid for use at TCH and may not be used elsewhere.

It can be presented for dispensing to the TCH Pharmacy located on level 2 in building 1.

Pharmacy hours are 8:30am to 5:30pm Monday to Friday

Standard prescriptions charges are $28.90 (general) and $5.90 (concession)

Department of Pharmacy Services

Yamba Drive, Garran ACT 2605
PO Box 11 Woden ACT 2606
Phone: (02) 6244 2121 Fax: (02) 6244 4624
Website: www.health.act.gov.au
ABN: 82 049 056 234

Extended Scope Physiotherapy Trial Project

PRESCRIPTION – ORTHOPAEDIC OUTPATIENTS

Patient Name: _____ Or attach

URN: _____ patient

Address: _____ sticker

_____

DOB: _____

Prescription Date: _____

Please Supply:

Naproxen 500 mg tablets X 24

Label:

Take ONE tablet TWICE DAILY with or after food

Physiotherapist Name: _____

Physiotherapist Signature: _____

PATIENT INSTRUCTIONS

This prescription is ONLY valid for use at TCH and may not be used elsewhere.

It can be presented for dispensing to the TCH Pharmacy located on level 2 in building 1.

Pharmacy hours are 8:30am to 5:30pm Monday to Friday

Standard prescriptions charges are $28.90 (general) and $5.90 (concession)

Appendix D

Links to Consumer Medicines Information (CMI)

Paracetamol: http://www.rheumatology.org.au/community/documents/Paracetamol210208.pdf

Ibuprofen: http://www.rheumatology.org.au/downloads/NSAIDS011010.pdf

Naproxen: http://www.mydr.com.au/cmis/ReducedPDFs/CMR08713.pdf

Kenacort 40: http://www.mydr.com.au/cmis/ReducedPDFs/CMR09082.pdf

Kenacort 10: http://www.mydr.com.au/cmis/ReducedPDFs/CMR09081.pdf

Celestone Chronodose Injection: http://www.mydr.com.au/cmis/ReducedPDFs/CMR08083.pdf

EMERGENCY DEPARTMENT.
Fast Track

ACT Health

RIB PAIN/INJURY

RED FLAGS identify the POTENTIAL for serious illness or risk NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY

Standard Operating Procedure 4.3.11

Objective

- A Physiotherapist will be the health professional that manages the treatment of patient's that present to fast track with a musculoskeletal injury as the primary compliant

Principles

- To relieve symptoms of rib pain/injury
- To commence treatment for the injury/pain

Inclusions

- Simple rib pain
- Haematoma
- Pins and needles and numbness
- Pain with breathing and coughing

Exclusions / Red Flags

1) Non-musculoskeletal pain (e.g. chest pain), 2) Respiratory changes, 3) Pneumothorax, 4) Underlying chronic respiratory conditions, 5) Obvious flail segment, 6) Blackouts / LOC, 7) malignancy, 8) History of osteoporosis, 9) Absent reflexes and decreased muscle strength

Assessment

The physiotherapist can conduct a thorough assessment unless the patient exhibits a red flag.

Symptomatic treatment

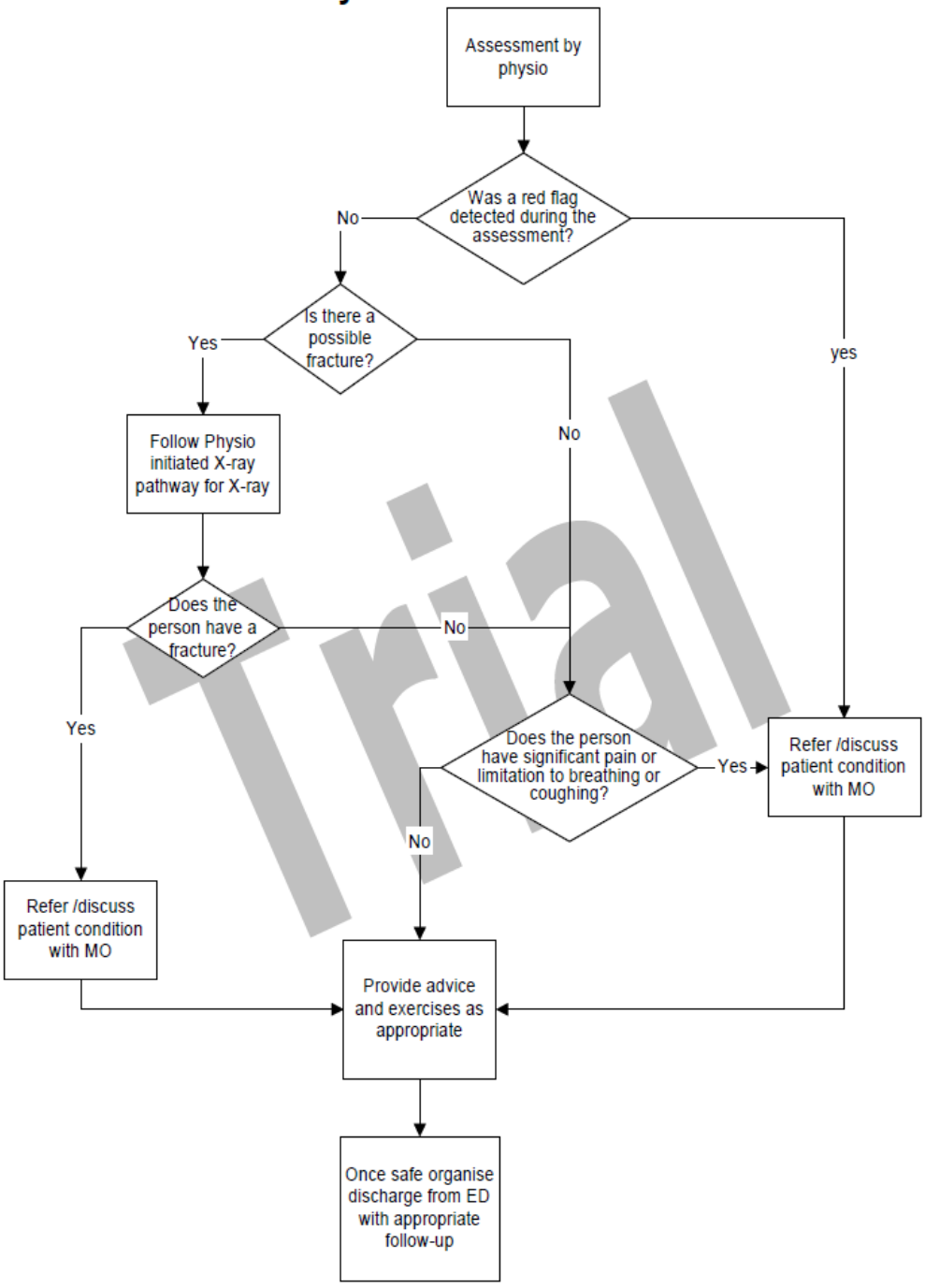
The following pathway prescribes the examination, treatment and follow up physiotherapists in fast track are to follow for people with rib pain/injury where no red flags have been identified.

Authorised by:	Signature:	Modified:	Review Date: 1 April 2009

Page 2 — RIB PAIN / INJURY

RED FLAGS identify the POTENTIAL for serious illness or risk **NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY**

Treatment Pathway



Standard Operating Procedure 4.3.11

Skill sets and competencies to support the use of this protocol:
Qualified Physiotherapist
Successfully completed TCH ED Physiotherapy competency assessment

EMERGENCY DEPARTMENT.
Fast Track

ACT Health

PHYSIOTHERAPY INITIATED X-RAY PATHWAY

Standard Operating Procedure 4.3.10

Physiotherapists who have completed the core competencies package to work as primary contact practitioners in ED are permitted to order the following X-rays:

Principles
To provide timely and appropriate investigations to patient's within the physiotherapists scope of practice.

Inclusions
Wrist/hand; Elbow; shoulder (including scapula views); cervical spine; thoracic spine; lumbar spine; hip; knee; ankle; and long bones of the upper and lower limb.

The physiotherapist must follow the SOPs and core competencies guidelines to complete the X-ray request. (N.B core competencies follow the Ottawa guidelines where applicable)

Exclusions
- Patient's with conditions outside Physiotherapist scope of practice
- Patient's with neurovascular compromise, obvious dislocation or suspected infection
- See SOPs for specific area exclusion criteria

Assessment

The physiotherapist can order an X-ray as per the SOPs and core competencies unless the patient exhibits any of the exclusion criteria.

Skill sets and competencies to support the use of this protocol:
Qualified Physiotherapist
Successfully completed TCH ED Physiotherapy competency assessment

Authorised by:	Signature:	Modified:	Review Date: 1Sept 2008

International Centre for Allied Health Evidence

ACT Government Health

CANBERRA HOSPITAL AND HEALTH SERVICES

EMERGENCY DEPARTMENT.
Fast Track

ACT Health

THORACIC PAIN / INJURY

RED FLAGS identify the POTENTIAL for serious illness or risk NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY

Standard Operating Procedure 4.3.12

Objective

- Physiotherapists will be the health professional that manages the treatment of patients that present to Fast Track with a musculoskeletal injury as the primary complaint.

Principles

- To relieve symptoms of thoracic back pain
- To commence treatment for the injury

Inclusions

- Referred pain into the limbs
- Reported muscle weakness
- Pins and needles/numbness
- Protective deformity
- Simple thoracic back pain

Exclusions / Red Flags

1) Diplopia, 2) dysphagia, 3) dysarthria, 4) drop attacks, 5) dizziness, 6) blackouts / LOC, 7) hemiparesis, 8) malignancy, 9) history of osteoporosis, 10) absent reflexes and decreased muscle strength, 11) fall from greater than 1m

Assessment

The physiotherapist can conduct a thorough assessment unless the patient exhibits a red flag or the patient has been bought to the ED on a spinal board or wearing a collar.

Symptomatic treatment

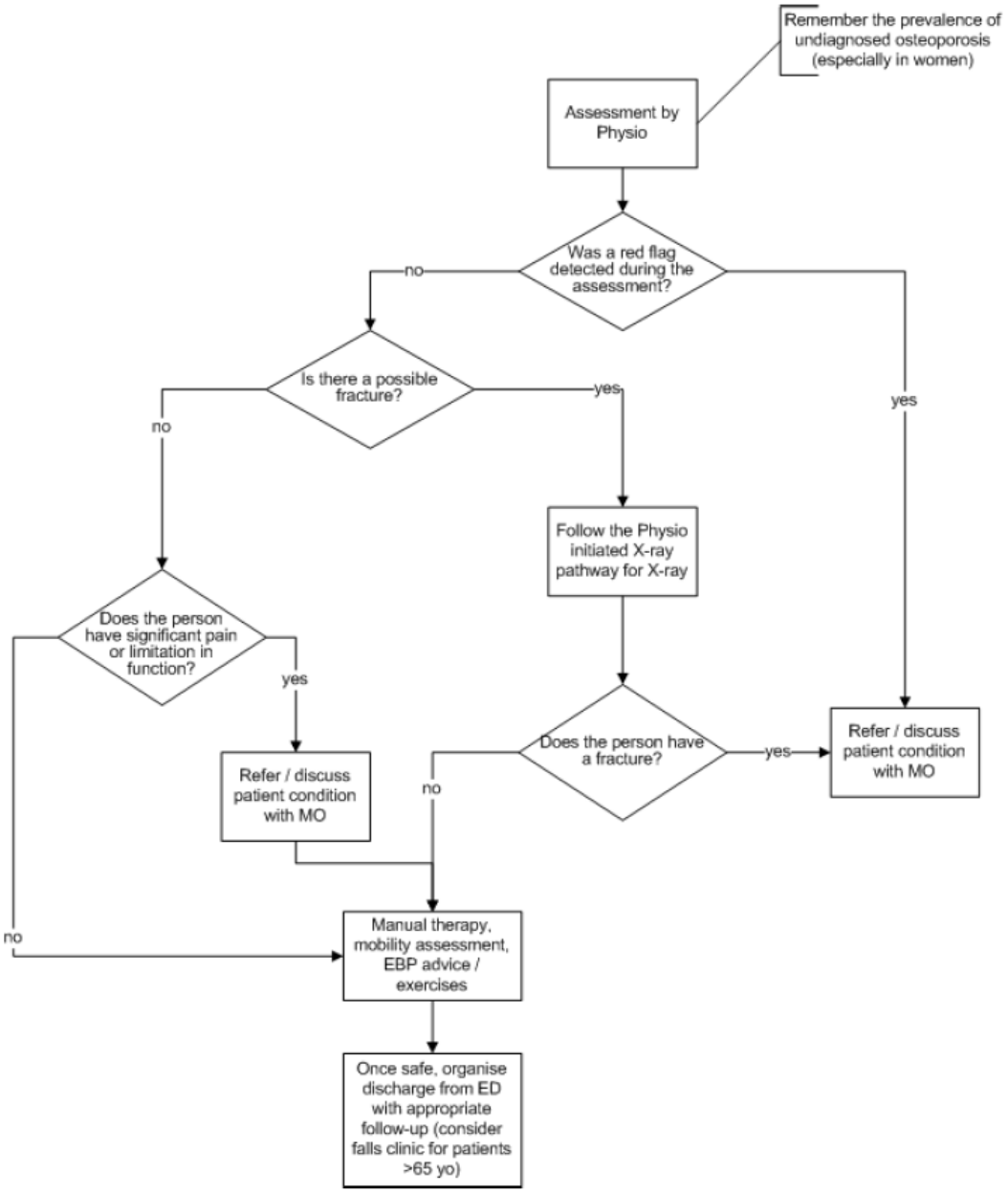
The following pathway prescribes the examination, treatment and follow up physiotherapists in fast track are to follow for people with thoracic back pain / injury where no red flags have been identified.

Authorised by:	Signature:	Modified:	Review Date: 1 April 2008

Page 2 THORACIC BACK PAIN / INJURY

RED FLAGS identify the POTENTIAL for serious illness or risk NOTIFY TEAM LEADER /ED STAFF SPECIALIST or REGISTRAR IMMEDIATELY

Treatment Pathway



Standard Operating Procedure 4.3.12

Skill sets and competencies to support the use of this protocol:
Qualified Physiotherapist
Successfully completed TCH ED Physiotherapy competency assessment

CORE COMPETENCIES FASTRACK
Scope
• Clinical reasoning and the ability to identify red and yellow flags. • Ability to follow standard operating procedures for Fastrack Physiotherapy

PHYSIOTHERAPIST:	

LUMBAR SPINE	**Initial Ax:** Date: ✓ / ✗	**12/12** Date: ✓ / ✗
Red Flags		
• Direct Trauma/MOI		
• Weight loss		
• Bladder/bowel		
• Major neurological changes (bilateral pins and needles, weakness, major sensory loss)		
• Cauda equina signs		
• Gait disturbance		
• When to X-ray: – Direct trauma – Central tenderness on palpation (spinal precautions) – Osteoporosis (previous #'s) – History of Ca – Fall from height < 1 metre – Hyperextension injuries in sport (be guided by central tenderness)		
Precautions		
• Ensure mechanical pain (eg kidneys or Ca)		
• Hyperextension injuries in sport (see above)		
• Unable to weight bear/mobilise		
• Groin pain (occasionally triage report back pain when its hip pain – therefore be aware of all hip precaution/red flags)		
• Pelvic fractures (such as pubic rami #)		
• Pregnancy		
• Previous spinal surgery		

Supervisor: Signature		
Print		

THORACIC SPINE & RIBS	Initial Ax: Date:	12/12 Date:
Red Flags		
• Direct Trauma/MOI		
• Weight loss		
• Major neurological loss (weakness)		
• Chest pain (medical not mechanical in origin)		
• SOB or SOBOE		
• When to X-ray: – Direct trauma – Osteoporosis (age of client, sex) – History of Ca – Central tenderness on palpation (spinal precautions) – Previous #'s – Hyperextension injuries in sport eg gymnastics – Pain with breathing (chest X-ray) – Changes on auscultation – Point tenderness on palpation of ribs		
Precautions		
• Thoracic Outlet Syndrome • Parasympathetic pain • Hyperextension injuries in sport (see above) • Medical history (especially cardiorespiratory)		

Supervisor: Signature		
Print		

CERVICAL SPINE	Initial Ax: Date:	12/12 Date:
Red Flags		
• In a hard collar (full spinal precautions)		
• Dysarthria		
• Dysphasia		
• Diplopia		
• Dizziness		
• Drop attacks		
• Marked neural changes		
• Gait disturbance		
• Weight loss		
• Head injury/LOC		
• VBI		
• When to X-ray: – Central tenderness on palpation (spinal precautions) – Hx of Ca – Previous spinal #'s – Hyperextension injury in sport eg rugby – Direct trauma – Osteoporosis (age of client, sex) – ?MVA (discuss with medical team)		
Precautions		
• Previous surgery		

Supervisor: Signature		
Print		

HIP	Initial Ax: Date:	12/12 Date:
Red Flags		
• Shortening and ER		
• Neurovascular compromise (posterior tibial artery and dorsalis pedis artery)		
• When to X-ray: – Direct trauma – Shortening and ER – Osteoporosis – History of Ca – Dislocation episode (commonly in THR) – Unable to weight-bear		
Precautions		
• LSP referral		
• Labral injury (hip flexion & rotation, deep-clicking/catching pain)		
• Ostitis pubis (resisted adduction)		
• Impingement syndrome (generally anterior pain ↑ with internal rotation)		
• Femoral shaft stress # (hop test & fulcrum test)		
• Inguinal Hernia (tender on palpation)		

Supervisor: Signature		
Print		

KNEE	Initial Ax: Date:	12/12 Date:
Red Flags		
• Neurovascular compromise (dorsalis pedis artery pulse and posterior tibial artery)		
• Cardinal sign (large, rapid onset of swelling)		
• Ottawa rules of when to X-ray (3/5): 1. Age 55 years or older 2. Tenderness at head of fibula 3. Isolated tenderness of patella 4. Inability to flex to 90˚ 5. Inability to walk four weight-bearing steps immediately after the injury and in the ED 6. Multi-ligament injury		
Precautions		
• Referred pain from the hip		
• Patella dislocation (may require X-ray)		
• Patella subluxation		
• Ligament laxity (MCL, PCL, ACL, LCL)		
• Meniscal injury		
• Muscle injuries (hams, quads, calf)		
• Patella tendinitis		
• Osgood Schlatters		
• Bursitis		

Supervisor: Signature		
Print		

ANKLE	Initial Ax: Date:	12/12 Date:
Red Flags		
• Neurovascular compromise (dorsalis pedis artery pulse and posterior tibial artery)		
• DVT		
• Tendon injuries		
• Ottawa rules (see attachment for more details). Pain in ankle should be X-rayed if there is: – Bone tenderness on palpation of the posterior edge or tip of lateral malleolus – 6cm – Bone tenderness on palpation of the posterior edge or tip of lateral malleolus – 6cm – Inability to bear weight both immediately and in the ED Pain in the mid-foot zone should have an ankle series of X-rays if there is: – Bone tenderness on palpation of the base of the 5th metatarsal – Bone tenderness on palpation of navicular – Inability to bear weight both immediately and in the ED • Be aware of Lisfranc injury (MOI/presentation) • Phalangeal #'s		
Precautions		
• Cuboid subluxation (MOI, i.e. most commonly seen with inversion injury of ankle)		
• Ligament injuries ATFL, CFL, PTFL, syndesmosis, Deltoid (dependant on grade)		
• Plantar fasciitis		
• Achilles tendonitis		
• Muscle injuries (Gastrocnemius/soleus, peroneal, tibialis anterior, FHL, EHL)		
• Peroneal tendon subluxation (isometric eversion)		
• Sesamoid stress # (?X-ray or ?bone scan)		

Supervisor: Signature			
	Print		

SHOULDER	Initial Ax: Date:	12/12 Date:
Red Flags		
• Deformity (either sulcus sign or ACJ)		
• Neurological changes		
• Posterior translation of SC joint (can result in venous compression or tracheal erosion) – can mimic anterior dislocation		
• When to X-ray: – Bone tenderness on palpation of clavicle +/- evident deformity) – Bone tenderness on palpation of the humeral head/neck/shaft – Bone tenderness on palpation of the scapula – Reported dislocation episode – History of osteoporosis/Ca		
Precautions		
• CSP involvement		
• Palpable thickening/swelling/deformity of the AC joint		
• Previous #'s		
• SC joint injury (posterior dislocation = red flag)		
• Subluxation episode		
• Labral injury		
• LHB rupture/tendonitis/subluxation		
• Multi-directional instability		
• Rotator cuff injury (grading)		
• Impingement syndrome		
• Biceps/triceps/pectoralis muscle injury		

Supervisor: Signature		
Print		

ELBOW	Initial Ax: Date:	12/12 Date:
Red Flags		
• Always check wrist/hand & shoulder		
• Ensure no CSP injury (referred pain)		
• Neurovascular compromise (radial pulse x2)		
• Direct Trauma/MOI		
• When to X-ray: – Deformity/ Dislocation (be aware "pulled arm" in children) – Radial head tenderness – Tenderness on palpation of the medial and lateral epicondyle – Tenderness on palpation of the olecranon – Tenderness on palpation of the distal humerus – History of osteoporosis or Ca		
Precautions		
• Significant ligament injury, more commonly the ulna collateral ligament or MCL (throwing injuries) • Osteochondritis Dissecans (often associated with MCL laxity – lateral elbow pain, catching and locking) (10-16 years) • Medial/Lateral Epicondylitis Triceps/biceps muscle injuries		

Supervisor: Signature		
Print:		

WRIST & HAND	Initial Ax: Date:	12/12 Date:
Red Flags		
• Always check elbow & shoulder (in particular look for radial head injury/dislocation)		
• Neurovascular compromise (radial pulse)		
• Direct Trauma/MOI (FOOSH or punching injury)		
• When to X-ray and what views: – Deformity – Scaphoid tenderness – Radial head tenderness – Ulna styloid tenderness – Distal radius tenderness – Bone tenderness on palpation of midcarpals – Metacarpal tenderness – Phalangeal deformity or bone tenderness – Open wounds		
Precautions		
• Scapholunate instability (Watson test)		
• Perilunate instability (Shuck test)		
• DISI (Dorsal Intercalated Segmental Instability) (test)		
• Ligament injuries (particularly around the thumb)		
• Medical History – particularly osteoporosis		
• Previous injuries/fractures		
• Tendon/pulley injuries		
• TFCC injury		
• Carpal tunnel syndrome		
• When to refer to Plastics team		

Supervisor: Signature		
Print		

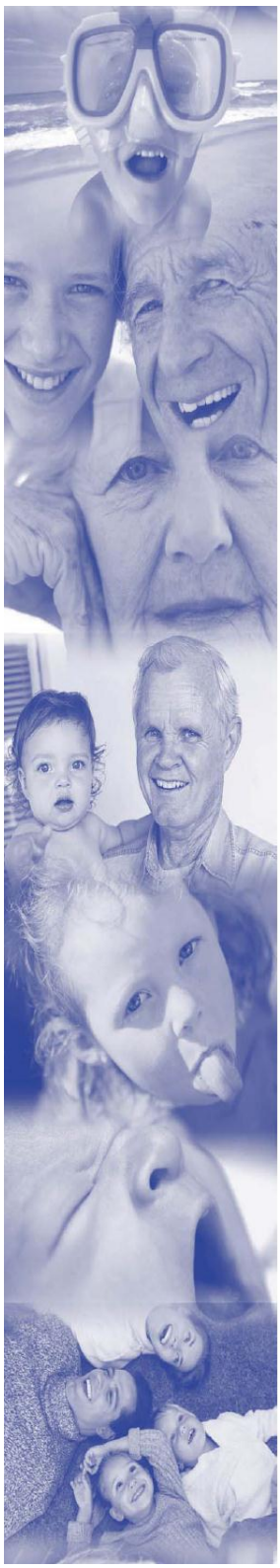
BACKSLABS & POP	Initial Ax: Date:	12/12 Date:
• Scaphoid backslab		
• Volar slab for wrist #		
• Slab for colles # (wrist position)		
• Slab for metacarpal #		
• Backslab lower limb #		
• Backslab for Achilles Tendon rupture		
• U Slab for # of shaft of humerus		
• Long arm backslab for forearm # (degree pro/sup may vary according to type of #)		

Supervisor: Signature		
Print		

Sample Roster for two Extended Scope Physiotherapists working in ED

	ESP1 (1FTE)	ESP2 (1FTE)
Thu	Evening (1400-2200)	Day (0830-1700)
Fri	Evening (1400-2200)	Off
Sat	Off	Off
Sun	Off	Off
Mon	Evening (1400-2200)	Off
Tue	Evening (1400-2200)	Day (0830-1700)
Wed	Off	Evening (1400-2200)
Thu	Evening (1400-2200)	Off
Fri	Day (0830-1700)	Evening (1400-2200)
Sat	Off	Evening (1400-2200)
Sun	Off	Evening (1400-2200)
Mon	Off	Evening (1400-2200)
Tue	Day (0830-1700)	Off
Wed	Day (0830-1700)	Day (0830-1700)
Thu	Day (0830-1700)	Evening (1400-2200)
Fri	Off	Evening (1400-2200)
Sat	Off	Off
Sun	Off	Off
Mon	Off	Evening (1400-2200)
Tue	Day (0830-1700)	Evening (1400-2200)
Wed	Evening (1400-2200)	Off
Thu	Off	Evening (1400-2200)
Fri	Evening (1400-2200)	Day (0830-1700)
Sat	Evening (1400-2200)	Off
Sun	Evening (1400-2200)	Off
Mon	Evening (1400-2200)	Off
Tue	Off	Day (0830-1700)
Wed	Day (0830-1700)	Day (0830-1700)

	ESP1 (1FTE)	ESP2 (1FTE)
Thu	Day (0830-1830)	Evening (1100-2130)
Fri	Off	Evening (1100-2130)
Sat	Off	Off
Sun	Off	Off
Mon	Off	Evening (1100-2130)
Tue	Day (0830-1830)	Evening (1100-2130)
Wed	Evening (1100-2130)	Off
Thu	Off	Evening (1100-2130)
Fri	Evening (1100-2130)	Day (0830-1830)
Sat	Evening (1100-2130)	Off
Sun	Evening (1100-2130)	Off
Mon	Evening (1100-2130)	Off
Tue	Off	Day (0830-1830)
Wed	Day (0830-1830)	Day (0830-1830)
Thu	Evening (1100-2130)	Day (0830-1830)
Fri	Evening (1100-2130)	Off
Sat	Off	Off
Sun	Off	Off
Mon	Evening (1100-2130)	Off
Tue	Evening (1100-2130)	Day (0830-1830)
Wed	Off	Evening (1100-2130)
Thu	Evening (1100-2130)	Off
Fri	Day (0830-1830)	Evening (1100-2130)
Sat	Off	Evening (1100-2130)
Sun	Off	Evening (1100-2130)
Mon	Off	Evening (1100-2130)
Tue	Day (0830-1830)	Off
Wed	Day (0830-1830)	Day (0830-1830)



THE CANBERRA HOSPITAL EMERGENCY DEPARTMENT

FAST TRACK DETAIL DESIGN DOSSIER

SEPTEMBER 2007

International Centre for Allied Health Evidence

ACT Government Health

CANBERRA HOSPITAL AND HEALTH SERVICES

Emergency Department
Sick Certificate

Client Name: _____

Address: _____

Has attended the Emergency Department for

---

and will be unfit for work / study from __/____/____to___/____/____
total number of days _____inclusive.

Additional Comments:

_____
_____
_____

Signature of
Physiotherapist:_____

Name of
Physiotherapist:_____

The Canberra Hospital,
Yamba Dr, Garran, ACT

Date of Issue: _____/____/_____

MINUTE

ACT Health

2

Topic: Physiotherapy Services: ED Fastrack – Issuing of Medical Certificates by Physiotherapy Staff.

To: Ian Thompson, Deputy Chief Executive, ACT Health

From: Jenelle Reading, General Manager, Community Health

File No: **Doc Ident:** **Date:** 2 April 2008

Purpose

To seek endorsement of ED Fastrack Physiotherapy staff issuing Medical Certificates to TCH Fastrack patients as per the Safe Operating Procedures (SOP) attached.

Background

2. Physiotherapists have been working as primary contact practitioners in the Canberra Hospital Emergency Department Fastrack program since October 2007.

3. Staff working in this role undertake competency assessment following specific training. As primary contact practitioners, physiotherapists have the necessary skills and knowledge to assess a patients requirement for restricted duties and/or time off work for a specified range of conditions. This has been recognised at the federal level, with this provision included in the Workplace Amendment Act 2005.

4. Within the ED Fastrack program, if a physiotherapist determines a patient requires a medical certificate, the patient must then be referred to a medical doctor who is required to reassess the patiebnt before issuing a certificate. The length of stay of patients in Fastrack is therefore lengthened when this happens.

5. The Standard Operating Procedure (SOP) for the provision of Medical Certificates by a primary contact physiotherapist has been developed to facilitate improved patient flow, efficiency in patient management and overall reduction in Fasttrack length of service. Drafts of this SOP have been endorsed by the ED Fastrack team, and by the Emergency Department Director, Dr. Andrew Singer. The SOP specifies the scope of practice to which this provision applies.

6. Consultation with Sean McDonnell, IR Advisor, Workforce Strategy, Human Resources Management Branch has occurred. This has resulted in amendments to the SOP to reflect a time limitation for medical certificates issued (5 days) and to identify required ongoing follow up.

7. As members of the general public, ACT Health staff may access the Fasttrack program. The certified agreements relevant to ACT Health staff make provision for medical certificates issued by a physiotherapist under the Workplace Relations Act, 1996.

Issues:

8. This is the first program within ACT Health where physiotherapists, as primary contact practitioners, will be issuing medical certificates. Due to the lack of familiarity of physiotherapists issuing certificates, this may be questioned in some instances by employers.

GPO Box 825 Canberra ACT 2601
Website: www.health.act.gov.au

9. The issuing of medical certificates does occur in private practice, and in other jurisdictions for specific programs.

Recommendation:

10. That you endorse the introduction of ED Fastrack Physiotherapy Staff issuing medical certificates, as per the standard operating procedure (Attachment A).

Jenelle Reading
General Manager, Community Health

AGREED/NOT AGREED/NOTED

Ian Thompson
Deputy Chief Executive

Contact Officer:
Robyn Cross/June Gunning
X 51370

2

EMERGENCY DEPARTMENT.
Fast Track

ACT Health

SICK LEAVE CERTIFICATES – WRITTEN BY PHYSIOTHERAPIST

Standard Operating Procedure 4.3.1

Delete: 2

Physiotherapists are legally authorised to provide patients with documents certifying illness, referred hereto as "sick leave certificates" in accordance with the workplace Amendment Act 2005 - Taken from APA (Australian Physiotherapy Association) Position Statement – March 2006.

Objective

- Physiotherapists to provide patients with documents certifying illness for conditions/injuries within the scope of practice of Physiotherapy (see Standard Operating Procedures 4.3.1 to 4.3.9)

Principles

The following information must be contained in the sick certificate:

- Name and address of the physiotherapist issuing the certificate
- Name of the patient
- Date on which the certificate was issued
- Date(s) on which the patient is unfit for work (limit of five working days)
- A physiotherapist should only include the diagnosis on the certificate with prior patient consent
- Sick leave certificates should be issued on ACT Health letterhead paper
- Sick leave certificates must only be dated on or from the day on which they are written
- Follow up will be arranged for any patients receiving a Physiotherapy sick leave certificate

Patient Selection Criteria

- Sick leave certificates are legal documents and must only be issued when, in the professional opinion of the physiotherapist, the patient is unfit for work due to the injury or a condition for which they have consulted the physiotherapist
- Physiotherapists must not issue certificates for conditions which are out of their scope of practice
- Physiotherapists must not issue certificates fraudulently
- The certificate must be clinically justifiable

Exclusions

- Patient's with conditions outside Physiotherapist scope of practice
- Patient's requiring completion of Workers Compensation documents

Skill sets and competencies to support the use of this protocol:
Qualified Physiotherapist
Successfully completed TCH ED Physiotherapy competency assessment
See supporting documentation – APA Position Statement April 2006, Workplace Relations ACT 1996 (Sections 240, 254 & 256 and Regulation 7.8) and ACT Health Conflict of Interest Policy.

Authorised by:	Signature:	: Modified:	Review Date: 1Sept 2008

Background Information

Hierarchy of Clinical Skills Acquisition

The fundamental basis of the clinical skills log-book approach is skill acquisition and competency, utilising a variety of models to build on the skills the Physiotherapist has already acquired through their career (see *relevant personal specifications* below). On completion of the log-book the physiotherapist will be able to perform the outlined skills within the clinical realm with more confidence, expertise and minimised risk of an inexpertly performed skill which may adversely affect the patient.

The education process embedded in this log-book refers to the practical integration and application of knowledge, skills and attitudes to professional advanced and extended-scope Physiotherapy practice.

This process is facilitated with the provision of professional support, supervision, guidance, feedback and evaluation by a recognised team, including, but not limited to Orthopaedic surgeons, Rheumatologists, members of the Pharmacy department, the Physiotherapy department and the department of medical imaging.

Clinical education from members of the multi-disciplinary team provides the Physiotherapist with context-based learning that is gained through first-hand client and professional interactions and through opportunity to experience "the doing" in the clinical practice setting.

Relevant Personal Specification

It is a pre-requisite stipulated by ACT Health that Physiotherapists in advanced or extended scope roles have:

- At least five years clinical experience post entry-level physiotherapy qualification
- At least three years experience in the relevant specialist area; and/or
- Completion of APA specialisation training to 'titled' member level in the relevant specialist area; and/or
- Completion of a recognised postgraduate qualification and/or advanced training in the relevant specialist area

Senior Musculoskeletal Physiotherapists have recognised advanced theoretical and applied skills in musculoskeletal Physiotherapy and demonstrated skills in the assessment, diagnosis and management of musculoskeletal conditions and these skills assist with an accurate, cost effective diagnosis and appropriate evidence based management of conditions.

It has been identified in the literature that an integral skill-set of physiotherapists in these roles is clinical leadership skills. Clinical leadership behaviour has been defined as falling into 5 categories:

Developing Personal Qualities

- Knowledge of self, team dynamics and process improvement
- Self-reflection and self-management
- Professionalism
- Self-development

Working with Others

- Skills in communication, conflict resolution and team leadership
- Performance appraisal
- Teamwork, cohesion and collaboration
- Motivation and facilitation
- Building and maintaining relationships
- Engaging with clients and consumers
- Inspire trust and confidence
- Help others to feel capable and realise their own potential

Improving Services

- Leading sustainable system improvement and patient safety initiatives
- Developing a culture of patient-centred care within an environment that supports workplace learning
- Critical evaluation of service provision
- Improving health care processes
- Developing new services and roles

Managing Services

- Resource management
- Development and management of policies and protocols
- Performance management
- Information management

Setting Direction

- Identifying opportunities for change
- Applying knowledge and evidence to service provision
- Evaluation of service impact and outcomes
- Monitoring and adapting service delivery trends as indicated
- Innovative and creative approach to service delivery

This log-book will analyse these skills through the peer-review process with the aim of recognising the clinician's level of professionalism, inter-professional collaboration, communication strategies and quality of service delivery.

When a clinician is deemed to be competent on the performance of a task/skill and the number of times a task needs to be completed will be at the discretion of the supervising clinician.

Related Definitions

NAHAC Endorsed National Definitions April 2010

1. Advanced Scope of Practice

"A role that is within currently recognised scope of practice for that profession, but that through custom and practice has been performed by other professions. The advanced role would require additional training, competency development as well as significant clinical experience and formal peer recognition. This role describes the depth of practice."

2 Extended Scope of Practice

"A role that is outside the currently recognised scope of practice and requires legislative change. Extended scope of practice requires some method of credentialing following additional training, competency development and significant clinical experience. Examples include prescribing, injecting and surgery. This role describes the breadth of practice."

It is important to note that scope of practice will change and that some roles considered extended now, may not be in the future.

Acknowledgements:
Department of Health, Victoria for their lead role in developing these definitions.

Specialist:

"Crawford-White (1996) define a specialist in occupational therapy as "one who is devoted to a special branch of learning while a generalist is one whose skills extend to several different fields'. A clinician who demonstrates professional clinical leadership skills; including mentorship, clinical supervision/education and research and is a recognised quality improvement leader."

Senior Musculoskeletal Physiotherapist:

"A physiotherapist with extensive experience in providing expert musculoskeletal assessment, diagnosis and appropriate onward management for patients presenting with chronic and/or acute pain."

Responsibility Statement

I agree to work in an ethically responsible manner in my interactions with patients and colleagues

I agree to work within the designated Scope of Practice for an Advanced and / or Extended Scope Practitioner role, acting within my capabilities and 'signed off' competencies (to date)

I recognise that in my role as an advanced/ extended scope practitioner, I may be part of a multidisciplinary team that has little experience to date, of such a role. I recognise that I have responsibilities to communicate my activities to other team members in a respectful manner that encourages team decision-making and inter-professional learning.

I agree to communicate concerns about patient care in a timely and thorough manner to appropriately skilled colleagues within my team, to ensure the best outcomes for patients and the health system.

I agree to appropriately and accurately record my activities in patient notes, and in any other documentation required of me in the role of an advanced and/ or extended scope physiotherapy practitioner. I particularly recognise the importance of documenting my activities as a physiotherapist working out of 'usual' scope practice, to inform ongoing evaluation of the role, and for quality improvement purposes.

I understand that the role of an advanced/ extended scope physiotherapist is evolving, and therefore the activities I undertake may be subject to change. I recognise the importance of participating wholeheartedly in the change process by engaging in (and documenting, where appropriate) regular personal reflections, and providing respectful and timely feedback to supervisors and colleagues

I agree to undertake ongoing training to improve my skills in advanced and/ or extended scope physiotherapy practice and to recognise when I need to seek advice and mentorship to improve my skills. Should such situations arise, I agree to actively seek advice and mentoring from appropriately skilled/ qualified persons.

I agree to assist willingly in the professional development of colleagues, particularly physiotherapists who are acting within scope or in advanced scope roles, and other health discipline colleagues, as required

I recognise the privilege of the position of an advanced/ extended scope physiotherapy practitioner, and I agree to undertake professional leadership roles, as required.

Physiotherapists Name: _____

Physiotherapist Signature: _____ Date: _____

Name of Witness: _____

Signature of Witness:_____ Date: _____

ACT Government
Health

Public Employees Permit

Medicines, Poisons and Therapeutic Goods Act 2008, Section 85

Permit No: 0050/11

MS KAREN MURPHY

ACT HEALTH

LEVEL 2, 11 MOORE STREET, CANBERRA CITY, ACT, 2601

This permit authorises **Ms Karen Murphy** to deal with the substances in accordance with the following conditions, at the above address, for the period **16/06/2011** to **16/06/2012**.

An authorised person may deal with an authorised substance as follows: supply, administer and prescribe.

Standard Conditions

1. This permit is subject to the requirements of the *Medicines, Poisons and Therapeutic Goods Act 2008* and the Medicines, Poisons and Therapeutic Goods Regulation 2008.
2. The permit holder must inform the Health Protection Service of any amendment to the details above within seven (7) days of the change.
3. This permit is subject to any special conditions below.

Special Conditions

1. Authorised substances or goods under this permit are listed in Schedule 1.
2. Persons authorised under the permit are listed in Schedule 2.
3. Results from the pilot evaluation be provided on reapplication for a subsequent permit.

John Woollard
Director
Health Protection Service

28 March 2012

File Number: 11/000394

ACT Government
Health

Permit No: 0050/11

Schedule 1

Authorised Substances

Substance	Strength	Form	Max Quantity*	Total Quantity#
Lignocaine	1%	injection	-	-
Paracetamol	500mg	tablet	-	-
Naproxen	500mg	tablet	-	-
Ibuprofen	200mg	tablet	-	-
Triamcinolone	40mg	injection	-	-
Triamcinolone	10mg	injection	-	-
Betamethasone	5.7mg	injection	-	-

Authorised Goods

Name of Goods	Description of Goods	Quantity
None Listed	N/A	N/A

* **Max Quantity**: the quantity that would be possessed under the licence at any one time.
#**Total Quantity**: the quantity that may be possessed during the licence period.

File Number: 11/000394

International Centre for Allied Health Evidence

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ACT Government Health | CANBERRA HOSPITAL AND HEALTH SERVICES

Permit No: 0050/11

ACT Government
Health

Schedule 2

Persons Authorised to Deal with a Medicine under a Public Employees Permit

Full Name	Address	Occupation	Board Rego No
Extended Scope Physiotherapist - Orthopaedics Position No: 20813	The Canberra Hospital ACT Health	Physiotherapist	N/A

File Number: 11/000394

Medicines, Poisons and Therapeutic Goods Licence/Permit Application – Extended Scope Physiotherapy Project

Commercial in Confidence

Review of the published evidence of physiotherapy prescribing

Prepared for:	The Office of the Allied Health Advisor – ACT Health
Submitted by:	The University of South Australia Division of Health Sciences
Date due:	4th May 2011

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Engaging our Communities

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ACT Government Health

CANBERRA HOSPITAL AND HEALTH SERVICES

Describe the evidence base for similar ESP Physiotherapist roles, if any exists. You have provided review papers for physiotherapists prescribing unscheduled medicines (paracetamol and NSAIDs). Is there any evidence supporting a) physiotherapist prescribing of prescription medicines and/or b) physiotherapist administration of intra-articular injections?

Currently there is a paucity of published evidence in the peer reviewed literature on the role of physiotherapists in prescribing medicines or administering intra-articular injections, however the Department of Health presented a scoping project report in July 2009 which outlined the state of affairs in the United Kingdom (Department of Health 2009).

In the United Kingdom, physiotherapists have been using medicines for injection therapy since the mid 1990s. In 1995 the scope of physiotherapy practice was extended to include intra-articular and intra-lesional injections within musculoskeletal therapy, provided that physiotherapists had undertaken 'appropriate training' (Atkins 2003).

The extension of physiotherapy practice into prescription and injection therapy occurred via doctors' directions and Patient Specific Directions (PSDs). Since 2000, local anaesthetics and corticosteroids have been used extensively via Patient Group Directions (PGDs) by injection therapists, including physiotherapists, who in 2009 were estimated to number around 3,000 in the UK (Department of Health 2009). PSDs, PGDs and, increasingly, Supplementary Prescribing are used in a range of community and acute settings in the UK, including clinical areas spanning musculoskeletal, pain management, neurological, respiratory, emergency, women's health, paediatric and elderly care, with a range of relevant medicines.

Supplementary Prescribing is a dependent model of prescribing, involving a tripartitie arrangement between the physiotherapist, an independent prescribing doctor and the patient. Following the initial medical diagnosis, Supplementary Prescribing allows suitably trained physiotherapists to take prescribing responsibility for patients in accordance with a specific clinical management plan (CMP) (Cooper et al 2008). In 1999, the Review of Prescribing, Supply and Administration of Medicines by Dr June Crown noted the competence and autonomy of specialist physiotherapists in the UK, and recommended them for early implementation of Independent Prescribing (Crown 1999)

Specialist physiotherapists have a role in tailoring medicines to patients' needs, and when a clinical pathway supports Supplementary Prescribing, allied health professional supplementary prescribers are able to tailor care to improve effectiveness and safety. Physiotherapists are well placed to make timely reductions in analgesic preparation and/or dose as a patient responds to physical treatment, thereby reducing the risk of drug dependency. Similarly, non-steroidal anti-inflammatory drugs, which have documented gastrointestinal and cardiovascular risks, can be reduced as a patient responds to physical intervention and self-management (Department of Health 2009).

The Department of Health report concluded that when the clinical pathway did not support use of Supplementary Prescribing, patients were unable to benefit.

Incompatibility between the mechanisms available to allied health professionals and the needs of patients impacted negatively on safety, effectiveness, patient experience and productivity. The report concluded that there was a strong case for progression to Independent Prescribing for physiotherapists. Greater flexibility of prescribing and medicines supply by allied health professionals has the potential to reduce treatment delays, improve specificity and responsiveness of prescribing and thereby reduce patients' exposure to safety risks.

A review of the role of extended scope practitioners (Hockin and Bannister 1994), identified that a physiotherapist with extended training in local steroid injection was able to manage 85% of selected orthopaedic out-patients independently. The final treatment selected by the physiotherapist was advice in 12% of cases, manipulation or electrophysiotherapy in 31%, orthoses in 20% and local steroid injection in 22%. 10% of patients required surgery and 5% were referred to other medical specialties.

Of patients treated independently by the physiotherapist, 21% estimated that they had improved by less than 40%, 46% by between 40% and 80% and 33% by more than 80%. Altogether 89% of patients and 95% of general practitioners were satisfied with the treatment received (Hockin and Bannister 1994).

An audit of the accuracy and efficacy of injections for subacromial impingement was reported by Chambers et al (2005). This audit compared the relative accuracy of injection technique between a physiotherapist, a Consultant and a Registrar, using radiographs and the Constant shoulder score before and at six weeks after injection. A radiocontrast was included in the therapeutic injection, to allow a measure of accuracy. All radiographs were reviewed by an independent, blinded radiologist recording the position of contrast. Of the 49 patients who presented to the hospital outpatient clinic with subacromial impingement, and which were randomly allocated to each of the therapists, accuracy rates of 67% through an anterior approach were obtained by both the Consultant and the Physiotherapist. At Registrar level 48% accuracy was achieved. Improvement in shoulder score was obtained in 70% of patients with accurate injections.

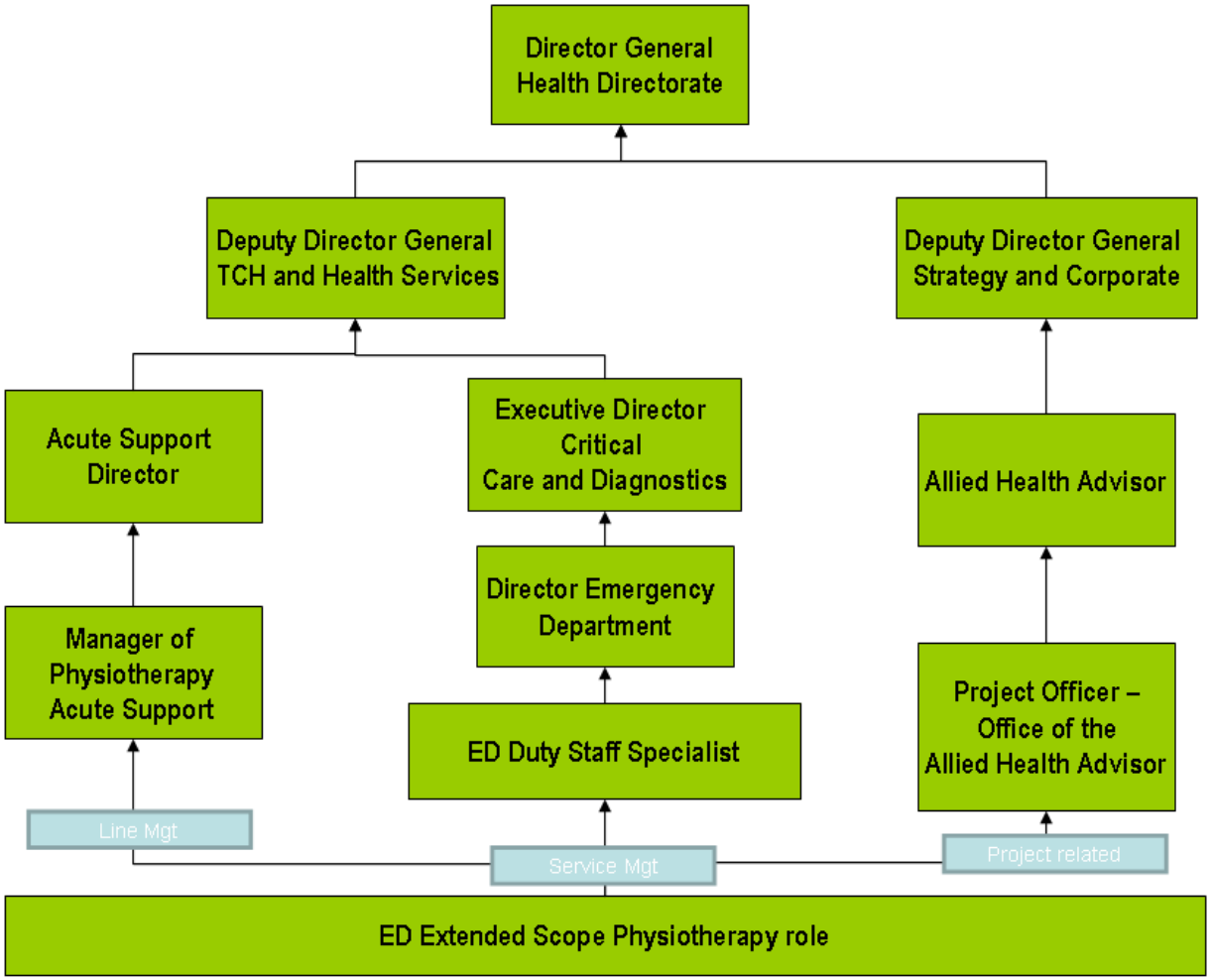
Safety considerations relate to training arrangements, communication of prescribing and governance arrangements, none of which are unique to allied health professionals. Extension of prescribing and medicines supply for certain allied health professions would improve the patient experience, by allowing patients greater access, convenience and choice (Department of Health 2009). With regards to patient safety, whilst the Patient Safety Observatory (National Patient Safety Agency 2007) reported 60,000 medicine incidents across the NHS between January 2005 and June 2006, with an estimated cost to the NHS in England of over £750 million annually, allied health professional prescribers were not identified as being responsible for any of these incidents (Department of Health 2009). The Medical Defence Union reported that they are unaware of any problems relating to prescribing or medicines supply by allied health professionals, and that this was not an area of concern for the Medical Defence Union members.

A systematic review of the evidence regarding the role of extended scope practitioners, who are most likely to prescribe or undertake injections, identified 152 related published resources (Kersten et al 2007). None of the published resources

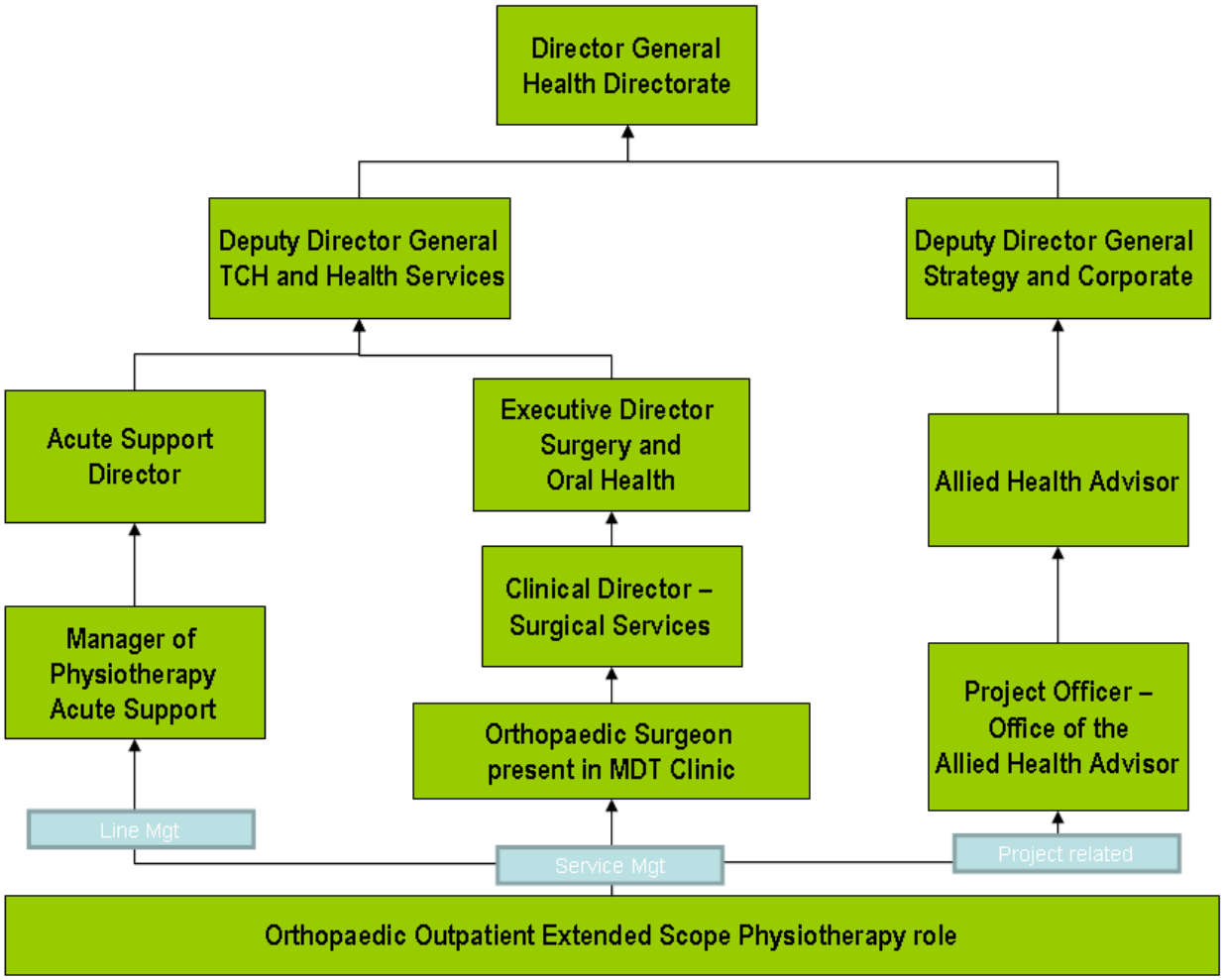
including data was (a) unsupportive of extended scope of practice or (b) expressed any concerns. This review demonstrated overwhelming support for extended scope of practice; the vast majority of resources were supportive despite being largely descriptive or discursive in nature (76%). The authors felt that there was an urgent need for robust research in order to evaluate the expansion of extended scope of practice roles, underpin further development of those roles, and strengthen the evidence base of extended scope of practice in physiotherapy, reflecting the observation of the Department of Health report .

1. Department of Health 2009, Allied health professions prescribing and medicines supply mechanisms scoping project report. London, Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103948
2. Atkins E, 2003, 'Physiotherapists' Experience of Implementing their Injection Therapy Skills'. Physiotherapy 89:3:pp145-157 .
3. Crown J (1999) *Review of Prescribing, Supply and Administration of Medicines: Final Report.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4077151
4. Hockin J, Bannister G, 1994. The Extended Role of a Physiotherapist in an Out-patient Orthopaedic Clinic. Physiotherapy, 80: 5:pp281-284
5. Chambers I, Hide G, Bayliss N 2005, An audit of accuracy and efficacy of injections for subacromial impingement comparing consultant, registrar and physiotherapist. Journal of Bone and Joint Surgery - British Volume, 87-B:SUPPII:pp160.
6. National Patient Safety Agency (2007) *Safety in doses: medication safety incidents in the NHS. The fourth report from the Patient Safety Observatory*, London, NPSA. www.npsa.nhs.uk/nrls/alerts-and-directives/ directives-guidance/safety-in-doses/
7. Kersten P, McPherson K, Lattimer L, George S, Breton A, Ellis B, 2007, Physiotherapy extended scope of practice – who is doing what and why? Physiotherapy, 93:4:pp 235-242.
8. Cooper RJ, Anderson C, Avery T, Bissell P, Guillaume L, Hutchinson A, James V, Lymn J, McIntosh A, Murphy E, Ratcliffe J, Read S, Ward P 2008, Nurse and pharmacist Supplementary prescribing in the UK—A thematic review of the literature, Health Policy 85:277–292

Clinical Governance Structure ED Extended Scope Physiotherapy Role



Clinical Governance Structure Orthopaedic Outpatient Extended Scope Physiotherapy Role



ALLIED HEALTH

Physiotherapy

Extended Scope Practice: Phase 2

Project Plan

ACT Health

Allied Health Advisor, Physiotherapy Service, Workforce Policy and Planning Unit

March 2010

Version 2.0 (30th March 2010)

Document Version Control History

This is Version 1.1 of the Physiotherapy Extended Scope of Practice Project Plan Phase II

The following information indicates changes made to this document.

Date	Version	Status	Description	Sections Affected
24/02/2010	1.0	Initial draft	First draft of project plan	All
30/03/2010	2.0	Draft	Second Draft – with input from the Executive Management Group	All

1) Project Scope

1.1 Project Title

ACT Health – Phase II: Physiotherapy Extended Scope of Practice Project

1.2 Introduction

The ACT Health Workforce Policy and Planning Unit, Allied Health Advisor and physiotherapy service, have agreed to undertake a joint project. This project will be to devise, implement and evaluate pilot extended scope Physiotherapy roles within the fields of Orthopaedics and the Emergency Department at the Canberra Hospital.

1.3 Project Background

Like other Australian States and Territories the ACT Health system is facing tremendous challenges, including workforce issues. The workforce issues are cross sectoral and involve multiple stakeholders. ACT Health is forward looking and understands the importance of working collaboratively and developing a cooperative approach to progress the challenges in a changing health environment.

New technologies, changing market choices for workers, changing community expectations and generational change in attitudes to work participation are all key drivers impacting upon the health workforce and how it does and will meet the demands of the population. Additional factors include a population where the percentage of older people with chronic and complex disease are requiring increasingly sophisticated technologies and medications, and changes in the modes of delivery of clinical services.

In response to these drivers, the global health industry has begun to introduce extended practice roles for allied health and nursing. Evidence suggests that these roles can improve

the quality of care; and safely and effectively reduce hospital waiting lists, relieving demands on doctors, and increasing access to appropriate treatment.

Extended practice physiotherapy is an accepted role in the UK, for example, in delivering both primary and secondary care for musculoskeletal services. This role can include case management previously reserved for orthopaedic and rheumatology consultants, ordering and interpreting of diagnostic tests (such as scans, x-rays and blood tests), administering certain injections, and directly listing patients for surgery.

This project aims to introduce pilot extended practice physiotherapy roles within ACT Health in the fields of Orthopaedics and Emergency Medicine. In doing so, it supports the Australian National Health Workforce Framework, the Australian Physiotherapy Association Position statement and the ACT Government's Canberra Plan vision for building a stronger community. It also aligns with Objectives 1 and 2 of the *ACT Health Workforce Plan 2005-2010*, the Community Health and Rehabilitation Statement, the Surgical Services Plan and the ACT Health philosophy of collaboration.

Phase II of the Extended Scope Physiotherapy Project – Phase 2 is in alignment with the *Australian Health Workforce Reform 2009-2013* of which a key performance indicator is an increase in the uptake of extended scopes or new or redesigned roles.

1.4 Linkages to Other Plans and Documents

National

Health Workforce Australia

During the life of the project, the new Health Workforce Australia Agency will progressively take over the current work program of the National Health Workforce Taskforce (NHWT). This will include managing and overseeing workplace reform initiatives, including redesigning roles and creating evidence based alternative scopes of practice.

http://www.hwa.gov.au/internet/hwa/publishing.nsf/Content/home-1

National Health Workforce Taskforce

The ACT Health Physiotherapy Extended Scope of Practice Project aligns with the *Australian Health Workforce Reform 2009-2013* of which a key performance indicator is "An increase in the uptake of extended scopes or new or redesigned roles". See:

http://www.nhwt.gov.au/documents/COAG/National%20Partnership%20Agreement%20on%20Hospital%20and%20Health%20Workforce%20Reform.pdf

The Health Workforce Principal Committee (HWPC)

[Formerly Australian Health Workforce Officials Committee (AHWOC)]

The *National Health Workforce Strategic Framework* (April) 2004 released by the Australian Health Ministers Conference is a document that provides a guide for health workforce policy and planning. See URL:

http://www.healthworkforce.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf.

This important strategic Framework identifies national workforce priorities and the ACT Health Physiotherapy Extended Scope of Practice Project, is aligned with Principle 5 in the Framework: To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.

This principle was endorsed by the Productivity Commission's publication "Australia's Health Workforce (December) 2005. See:

http:/www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf

In addition, Principle 5 states the strategic directions "explore opportunities to maximise the flexibility of the workforce, including innovative approaches to skill mix and new workforce roles and changes to scope of practice" and "develop workplace, professional and education and training practices that facilitate team approaches and multidisciplinary care"; and "explore regulatory arrangements that facilitate workforce supply and innovative solutions to work design and recognition of knowledge and skills".

ACT

ACT Health supports investing in activities that will assist with developing a sustainable workforce as a method to achieve better outcomes in the priority areas as outlined in the *ACT Health Access Plan*. In addition the ACT Government is committed to working in partnership with stakeholders to ensure that the initiatives in priority action areas are planned, implemented and monitored.

Working Together: Shaping our future with our People: A Strategic Plan for Building a Sustainable ACT Health Workforce 2004-2007 provides a vehicle through which critical workforce issues can be addressed to meet increasing demand for health services and manage staffing-related implications of changing service delivery models. It has as one of its strategic priorities: "Building our Capacity - achieving a sustainable workforce through planning and analysis, recruitment and retention activities, workplace equity and diversity and establishing career pathways".

In addition, this activity is in alignment with the Government's commitment in *The Canberra Plan 2004* future strategies, which include Canberra's Knowledge Future and Partnerships for Growth. A key commitment in The Canberra plan is "Leading Australia in education, training and lifelong learning". The Canberra Plan 2004 consists of three components - The Canberra Social plan, The Canberra Spatial plan and the Economic White paper. Together these documents provide a comprehensive blueprint for a way forward for the ACT over coming years.

In addition, the *ACT Health Clinical Services Plan 2004 – 2011* provides a strategic framework for the delivery of public hospital and community health services up to 2011.

Finally, the *ACT Health Workforce Plan 2005 – 2010 highlights* that achieving a sustainable health workforce requires workforce redesign and the need to challenge traditional boundaries of service delivery. The main driver in the ACT is a requirement to modernise the current health workforce and then build upon this to a sustainable capacity.

1.5 Objective(s)

The project is expected to:

- Design and implement pilot Extended Scope Physiotherapy roles within the fields of Orthopaedics and the Emergency Department – including development of Duty Statements and Selection Criteria
- Devise an educational and credentialing framework to facilitate the implementation of the proposed pilot roles
- Rigorously evaluate the impact of Extended Scope Physiotherapy roles in the fields of Orthopaedics and the Emergency Department
- Establish clinical support networks/teams for the ongoing assistance for the Extended Scope Physiotherapists
- *Disseminate the project learning*

1.6 Target Outcomes

- Rigorous credentialing, monitoring and educational framework (including tools) for pilot Extended Scope Physiotherapy roles in Orthopaedics and the Emergency Department
- Duty Statements, Selection Criteria and recruitment processes for the pilot Extended Scope Physiotherapy roles
- Initiation of pilot Extended Scope Physiotherapy roles within the fields of Orthopaedics and the Emergency Department
- Evaluation of the pilot roles encompassing organisational, stakeholder and clinical outcome measures
- Make provisions for ongoing training and credentialing for pilot roles
- Develop support networks/mentoring systems for the pilot roles
- A high level assessment of resource implications and challenges
- Identify extended scope of practice champions
- Final report (compilation of all deliverables)
- Dissemination of project learning

The Project Sponsors are accountable for delivering the report.

1.7 Project Activities and Milestones

ID	Description	Who	Scheduled Start	Scheduled Finish	Interdependencies
1	Formation of an Executive Management Group (EMG) Appoint a project officer	Allied Health Advisor, Physiotherapy Lead Professional, Manager Workforce Policy and Planning Unit Elective Surgery Access Manager Clinical Director, Surgery EMG	Jan 2010 8 Feb 10	Jan 2010	Preparation of Terms of Reference (TOR), communication strategy, project plan, Project officer to commence Monday 8th Feb 2010
2	Review barriers and enablers to developing pilot Extended Scope Physio roles	EMG Project officer	Feb 2010	Circulate project plan March 2010	Endorsement of project plan late March / early April
3	Prepare brief for ACT Workforce Policy and Planning Executive Management Group (AWPPEMG), Tertiary Education Liaison Committee (TELC) and Portfolio Executive (PE) on project commencement	Project officer & Allied Health Advisor	Feb 2010	April/May	Completion of TOR, project plan and Communication strategy
4	Formation of a	Key	Feb 2010	10th March	Membership availability

	Steering Group	representatives according to the Steering Group TOR		2010	
5	1st full Steering Group meeting	Steering Group	10th March 2010		Formation of Steering Group
6	Development of Clinical Sub-Groups	Steering Group members – Project Officer to co-ordinate	April 2010	July/Aug 2010	Formation of sub-groups Membership availability
7	Development of Organisational, Stakeholder and Clinical KPI's	Clinical sub-groups iCAHE	1st March	12th May for review/ endorsement by Steering Committee at 2nd meeting	Formation of sub-groups & involvement of iCAHE
8	Develop Duty Statements & Selection Criteria for pilot Extended Scope Physio roles	Clinical sub-groups iCAHE	15th March	12th May for review/ endorsement by Steering Committee at 2nd meeting	Formation of sub-groups & engagement of iCAHE
9	Framework for Research and Data collection	iCAHE Project Officer EMG	15th March	12th May for review/ endorsement by Steering Committee at 2nd meeting	Engagement of iCAHE Availability of baseline data
10	Develop framework of pilot Extended Scope Physio roles	Project Officer and EMG Clinical sub-groups iCAHE	1st March	12th May for review/ endorsement by Steering Committee at 2nd meeting	Engagement of iCAHE Membership availability
11	Develop	Clinical sub-	1st March	12th May for	Membership availability

	Governance Structure for Proposed pilot roles	groups Steering Group		review/ endorsement by Steering Committee at 2nd meeting	
12	Develop educational and credentialing framework for pilot extended scope physio roles	Clinical sub-groups Steering Group iCAHE	April 2010	12th May for review/ endorsement by Steering Committee at 2nd meeting, then ongoing review	Membership availability Engagement of iCAHE
13	2nd full Steering Committee meeting	Steering Committee iCAHE Project officer	19th May 2010	24th May	Membership availability
14	Devise clinical support teams for extended scope physio roles	Clinical sub-groups Steering Committee	April 2010	July 2010	Membership availability
	Initiate recruitment process	EMG	April/May 2010	July 2010	HR availability Selection panel availability Registration Board involvement
16	3rd full Steering Group meeting	Steering Committee	July 2010	July 2010	Membership availability
17	Commence pilot extended scope physio roles	EMG, Steering Group	July/August 2010	July / August 2011	ED Orthopaedics Physiotherapy iCAHE
18	Final Report (a compilation of	Allied Health		TELC	Report endorsed by PE, TELC and AWPPEMG

	deliverables) presented to AWPPEMG, TELC and PE.	Advisor		PE Late 2011 / Early 2012	
19	Project analysis and evaluation - identify and document lessons learnt through the process	Consultant, Project Officer reporting to the Steering Committee		Late 2011 / Early 2012	Report completed and signed off
20	Dissemination of learning	Project Officer		Late 2011 / Early 2012	Availability of resources and key stakeholders

1.8 Budget

	2009/10	**2010/11**	**2011/12**	**2012/13**
Project Officer	$72,000	$75,000	$65,000	$56,000
Physiotherapy positions	$0	$125,000	$275,00	$334,000

This assumes that the Project officer is employed 0.6 from February 2009-June 2012

and 0.5FTE from July 2012-February 2013 and that there are 1 FTE HP4 trial participants (the breakdown of which will be clarified once development of the pilot roles is complete), 2011-2012 funding equates to 2.0-2.5 FTE (dependent upon classification) and 2012-2013 funding equates to 2.5 FTE (may vary dependent upon classification).

Additional support is available to support evaluation.

The Allied Health Advisor will provide a desk space, computer and other consumables for one day each week. The physiotherapy service will provide these items for the remainder of the week.

The ACT Health physiotherapy service will be responsible for the cover of any backfill costs.

1.9 Assumptions and Constraints

It is assumed that the project will be influenced by availability and timeliness of advice and support required to implement advanced practice roles within the changing workforce environment including standards of practice and legislative requirements. The project will be undertaken in consultation with: physiotherapy health professionals; the Physiotherapy registration board; professional associations; the International Centre for Allied Health Evidence (iCAHE); clinical teams from the Emergency Department, Orthopaedics, Medical Imaging, Pharmacy and Pathology; HR- Workforce Strategy and Health Care Consumers as well as educational providers such as the University of Canberra and the Australian National University.

2) Project Management Plan

2.1 Terms of Reference

Prior to the commencement of the project a Steering Group will be established.

Please refer to Attachment 1.1.

2.2 Reporting Requirements

Regular verbal reports from the Project Officer and iCAHE will be provided to the Steering Group. The Steering Group will provide reports to the ACT Workforce Policy and Planning Executive Management Group, the ACT Health Tertiary Education Liaison Committee (TELC), for approval through the Chief Executive, as well as the Portfolio Executive Committee.

Relevant background papers and the evaluation report will be provided to ACT Health and posted on the ACT Health intranet.

2.3 Stakeholder Management & Communication

Stakeholders for the project include:

Internal stakeholders:

- Portfolio Executive—ACT Health
- General Manager TCH / Clinical Board TCH
- Workforce Policy and Planning Executive Management Group —ACT Health
- Physiotherapy Extended Scope of Practice Steering Group—ACT Health
- Directors of Allied Health and the ACT-Wide Allied Health Group
- Calvary Health Care
- Allied Health Advisory Council (when formed)
- Chief Nurse and Medical Adviser

External stakeholders:

- University of Canberra
- ANU Medical School
- ACT Physiotherapy Board
- Australian Physiotherapy Association
- All registered ACT Physiotherapists
- Wider Allied Health Workforces
- International Centre for Allied Health Evidence (iCAHE)
- National Allied Health Advisory Committee (NAHAC)
- Health Workforce Australia (HWA)

A communication strategy will be developed by the Steering Group in consultation with the consultant and submitted to the ACT Workforce Policy and Planning Executive Management Group, ACT Tertiary Education and Liaison Committee and Portfolio Executive for endorsement.

External stakeholders outside of the Steering Committee: A range of clinicians and health administrators, Health Registration Boards, and Professional Associations, will be engaged in the project by making the Communiqué outlining project updates and access to documentation available via the Project Officer and / or website.

2.4 Risk Management Plan

The following risks have been identified and will need to be proactively managed

The major risks for the project are:

1. tight timeframe for the development of the pilot roles
2. keeping scope clearly defined and focussed
3. demands on time of Senior Management
4. time pressures on the Steering Group
5. lack of appropriate stakeholder engagement and the wider allied health community
6. availability of appropriately skilled clinicians
7. availability of appropriate education to match the roles/tasks of the clinicians
8. the project does not deliver on internal stakeholders' needs or expectations
9. delays due to legislative requirements
10. consumers not accepting ESP roles
11. lack of engagement by orthopaedics and Emergency Department medical staff

Mitigation strategies

- Information provided to the stakeholders
- Develop a communication strategy
- Ensure that key stakeholders are represented on the Steering Group
- Lodge the deliverables eg papers on the ACT Health intranet
- *Level of risk associated with the project*
- The level of risk associated with the project is estimated as medium. A key success factor is the monitoring of the project by the Steering Group and Executive management group.
- *Level of risk associated with not addressing the physiotherapy workforce re-design issue*

The level of risk associated with not addressing the physiotherapy extended scope of practice project is high. A key success factor is the engagement of the physiotherapy sector and the wider health community to support the pilot Extended Scope Physiotherapy roles and the acceptance of new physiotherapy roles by consumers.

Risk identification, reviews and reporting

Risks will be regularly updated, reviewed and reported as required.

2.5 Quality Management Plan

The project will be undertaken using the project management methodology described.

The Steering Group will monitor the project regularly with reporting to ACT Health, Workforce Policy and Planning Executive Management Group, Tertiary Education Liaison Committee, through the Chief Executive and Portfolio Executive.

Project Sponsors will review and approve the distribution of papers and the final report.

A hard copy file will be maintained of all project documentation, including consultations and discussions.

2.6 Project Closure

Regular reports of the progress of the Physiotherapy Extended Scope of Practice Project Phase 2 will be provided to ACT Workforce Policy and Planning Executive Management Group, Tertiary and Education Liaison Committee and Portfolio Executive through the standard process for presenting ACT Health reports.

ACT Health, in consultation with the consultant and project officer will feed back the results of the project to other states and territories as deemed appropriate.

3) Attachments

1.1 Terms of Reference - Physiotherapy Extended Scope of Practice, Project Reference Group

1.2 Communication Strategy

ALLIED HEALTH

Physiotherapy

Extended Scope Practice: Phase 2

Project Plan

ACT Government – Health Directorate

Allied Health Advisor, Physiotherapy Service, Workforce Policy and Planning Unit

September 2011

Version 3.0 (28th September 2011)

Document Version Control History

This is Version 1.1 of the Physiotherapy Extended Scope of Practice Project Plan Phase II

The following information indicates changes made to this document.

Date	Version	Status	Description	Sections Affected
24/02/2010	1.0	Initial draft	First draft of project plan	All
30/03/2010	2.0	Draft	Second Draft – with input from the Executive Management Group	All
28/09/2011	3.0	Draft	Updated version – with comments from Executive Management Group	All

4) Project Scope

5) 1.1 Project Title

ACT Government – Health Directorate – Phase II: Physiotherapy Extended Scope of Practice Project.

1.2 Introduction

The ACT Government - Health Directorate Workforce Policy and Planning Unit, Allied Health Advisor and physiotherapy service, have agreed to undertake a joint project. This project will be to devise, implement and evaluate pilot extended scope Physiotherapy roles within the fields of Orthopaedics and the Emergency Department at the Canberra Hospital.

1.3 Project Background

Like other Australian States and Territories the ACT Government - Health system is facing tremendous challenges, including workforce issues. The workforce issues are cross sectoral and involve multiple stakeholders. The Health Directorate is forward looking and understands the importance of working collaboratively and developing a cooperative approach to progress the challenges in a changing health environment.

New technologies, changing market choices for workers, changing community expectations and generational change in attitudes to work participation are all key drivers impacting upon the health workforce and how it does and will meet the demands of the population.

Additional factors include a population where the percentage of older people with chronic and complex disease are requiring increasingly sophisticated technologies and medications, and changes in the modes of delivery of clinical services.

In response to these drivers, the global health industry has begun to introduce extended practice roles for allied health and nursing. Evidence suggests that these roles can improve the quality of care; and safely and effectively reduce hospital waiting lists, relieving demands on doctors, and increasing access to appropriate treatment.

Extended practice physiotherapy is an accepted role in the UK, for example, in delivering both primary and secondary care for musculoskeletal services. This role can include case management previously reserved for orthopaedic and rheumatology consultants, ordering and interpreting of diagnostic tests (such as scans, x-rays and blood tests), administering certain injections, and directly listing patients for surgery.

This project aims to introduce pilot extended practice physiotherapy roles within the Health Directorate in the fields of Orthopaedics and Emergency Medicine. In doing so, it supports the Australian National Health Workforce Framework, the Australian Physiotherapy Association Position statement and the ACT Government's Canberra Plan vision for building a stronger community. It also aligns with Objectives 1 and 2 of the *ACT Health Workforce Plan 2005-2010*, the Community Health and Rehabilitation Statement, the Surgical Services Plan and the ACT Health philosophy of collaboration.

Phase II of the Extended Scope Physiotherapy Project – Phase 2 is in alignment with the *Australian Health Workforce Reform 2009-2013* of which a key performance indicator is an increase in the uptake of extended scopes or new or redesigned roles.

1.4 Linkages to Other Plans and Documents

National

Health Workforce Australia

During the life of the project, the new Health Workforce Australia Agency will progressively take over the current work program of the National Health Workforce Taskforce (NHWT). This will include managing and overseeing workplace reform initiatives, including redesigning roles and creating evidence based alternative scopes of practice.

http://www.hwa.gov.au/internet/hwa/publishing.nsf/Content/home-1

Information, Analysis and Planning Section – Research Projects proposed in 2011:

1. Refining the national workforce planning model.
2. Supply and demand projections for designated medical specialties.
3. Supply and demand projections for designated nursing sectors.

4. Workload measures for priority allied health disciplines.

5. Models for supplementary prescribing.

http://www.hwa.gov.au/work-programs/information-analysis-and-planning/research-collaboration

Workforce and Innovation Framework

National Health Workforce Taskforce

The ACT Government – Health Directorate Physiotherapy Extended Scope of Practice Project aligns with the *Australian Health Workforce Reform 2009-2013* of which a key performance indicator is "An increase in the uptake of extended scopes or new or redesigned roles". See:

http://www.nhwt.gov.au/documents/COAG/National%20Partnership%20Agreement%20on%20Hospital%20and%20Health%20Workforce%20Reform.pdf

The Health Workforce Principal Committee (HWPC)

[Formerly Australian Health Workforce Officials Committee (AHWOC)]

The *National Health Workforce Strategic Framework* (April) 2004 released by the Australian Health Ministers Conference is a document that provides a guide for health workforce policy and planning. See URL:

http://www.healthworkforce.health.nsw.gov.au/amwac/pdf/NHW_stratfwork_AHMC_2004.pdf.

This important strategic Framework identifies national workforce priorities and the ACT Government – Health Directorate Physiotherapy Extended Scope of Practice Project, is aligned with Principle 5 in the Framework: To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.

This principle was endorsed by the Productivity Commission's publication "Australia's Health Workforce (December) 2005. See:

http:/www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf

In addition, Principle 5 states the strategic directions "explore opportunities to maximise the flexibility of the workforce, including innovative approaches to skill mix and new workforce roles and changes to scope of practice" and "develop workplace, professional and education and training practices that facilitate team approaches and multidisciplinary care"; and "explore regulatory arrangements that facilitate workforce supply and innovative solutions to work design and recognition of knowledge and skills".

ACT

The Health Directorate supports investing in activities that will assist with developing a sustainable workforce as a method to achieve better outcomes in the priority areas as outlined in the *ACT Health Access Plan*. In addition the ACT Government is committed to working in partnership with stakeholders to ensure that the initiatives in priority action areas are planned, implemented and monitored.

Working Together: Shaping our future with our People: A Strategic Plan for Building a Sustainable ACT Health Workforce 2004-2007 provides a vehicle through which critical workforce issues can be addressed to meet increasing demand for health services and manage staffing-related implications of changing service delivery models. It has as one of its strategic priorities: "Building our Capacity - achieving a sustainable workforce through planning and analysis, recruitment and retention activities, workplace equity and diversity and establishing career pathways".

In addition, this activity is in alignment with the Government's commitment in *The Canberra Plan 2004* future strategies, which include Canberra's Knowledge Future and Partnerships for Growth. A key commitment in The Canberra plan is "Leading Australia in education, training and lifelong learning". The Canberra Plan 2004 consists of three components - The Canberra Social plan, The Canberra Spatial plan and the Economic White paper. Together these documents provide a comprehensive blueprint for a way forward for the ACT over coming years.

In addition, the *ACT Health Clinical Services Plan 2004 – 2011* provides a strategic framework for the delivery of public hospital and community health services up to 2011.

Finally, the *ACT Health Workforce Plan 2005 – 2010 highlights* that achieving a sustainable health workforce requires workforce redesign and the need to challenge traditional boundaries of service delivery. The main driver in the ACT is a requirement to modernise the current health workforce and then build upon this to a sustainable capacity.

1.5 Objective(s)

The project is expected to:

- Design and implement pilot Extended Scope Physiotherapy roles within the fields of Orthopaedics and the Emergency Department
- Continue to develop an educational and credentialing framework to facilitate the implementation of the pilot roles
- Rigorously evaluate the impact of Extended Scope Physiotherapy roles in the fields of Orthopaedics and the Emergency Department
- Establish clinical support networks/teams for the ongoing assistance for the Extended Scope Physiotherapists
- Undertake exploratory work into extended scope practice physiotherapy roles in the fields of Rheumatology and Obstetrics and Gynaecology

- Disseminate the project learning

1.6 Target Outcomes

- Rigorous credentialing, monitoring and educational framework (including tools) for pilot Extended Scope Physiotherapy roles in Orthopaedics and the Emergency Department
- Monitor pilot Extended Scope Physiotherapy roles within the fields of Orthopaedics and the Emergency Department
- Evaluation of the pilot roles encompassing organisational, stakeholder and clinical outcome measures
- Undertake scoping work for extended scope physiotherapy roles within Rheumatology and Obstetrics and Gynaecology
- Make provisions for ongoing training and credentialing for pilot roles
- Develop support networks/mentoring systems for the pilot roles
- A high level assessment of resource implications and challenges
- Identify extended scope of practice champions
- Final report (compilation of all deliverables)
- Dissemination of project learning

The Project Sponsors are accountable for delivering the report.

1.7 Project Activities and Milestones

Project Plan current from September 2011

ID	Description	Who	Scheduled Start	Scheduled Finish	Interdependencies
1	Recruitment to ED pilot positions	ED Extended Scope Physio interview panel	August 2011	September 2011	Membership availability
2	Early data collection of ED ESP initiative (formation of baseline data and confirmation of appropriate data collection strategies)	iCAHE Project Officer EMG	Sept/Oct 2011	November 2011	Engagement with iCAHE
3	Commencement of UC post-graduate training program – first module Pharmacology	UC EMG Project Officer	Sept/Oct 2011	November 2011	Engagement with UC
4	Evaluation of first UC post-graduate module (pharmacology)	iCAHE UC Project Officer EMG	Sept/Oct 2011	December 2011	Engagement with UC Engagement with iCAHE Availability of resources and key stakeholders
5	Revision/ consideration of current Extended Scope Physiotherapy Outpatient Orthopaedics	Project Officer EMG	September 2011	October 2011	Membership availability Availability of resources

ID	Description	Who	Scheduled Start	Scheduled Finish	Interdependencies
6	Exploration of potential ESP roles in Obstetrics and Gynaecology and Rheumatology	Project Officer iCAHE	September 2011	December 2011	Availability of resources and key stakeholders
7	Consideration of ESP initiatives in Obstetrics and Gynaecology and Rheumatology	Steering Committee EMG iCAHE literature review	Oct/Nov 2011	December 2011	Engagement with iCAHE – outcome of literature review Membership availability
8	5th full Steering Committee meeting	Steering Committee HWA representative to be invited to present on non-medical prescribing and national innovation initiatives With additional invited members as available	Suggested 23rd November 2011	November 2011	Membership availability
9	Further evaluation of the Outpatient Orthopaedic initiative	Project Officer iCAHE	October 2011	December 2011	Engagement with iCAHE
10	6 month evaluation/ review of prescribing permit	Project Officer	December 2011	Jan/Feb 2012	Engagement with iCAHE

ID	Description	Who	Scheduled Start	Scheduled Finish	Interdependencies
		iCAHE EMG			Availability of resources and key stakeholders
12	Consideration of abstract submission to ANZAHPE conference (26-29 June 2012)	Project Officer iCAHE EMG	Jan/Feb 2012	Jan/Feb 2012	Engagement with iCAHE Availability of resources and key stakeholders
11	6 month evaluation of ED pilot positions Report to be submitted to NAP Steering Committee on completion	iCAHE Project Officer EMG	Feb/March 2012	May/June 2012	Engagement with iCAHE
13	6th full Steering Committee meeting	Steering Committee	Feb/March 2012	Feb/March 2012	Membership availability
14	12 month evaluation of Outpatient Orthopaedic initiative Final report of 12month pilot program to hospital executive	iCAHE Project Officer EMG Steering Committee (out of session endorsement	Mar/April 2012	May/June 2012	Engagement with iCAHE Availability of resources and key stakeholders

ID	Description	Who	Scheduled Start	Scheduled Finish	Interdependencies
	Consideration of publications Consideration of benchmarking opportunities (Queensland initiatives)	maybe required)			
15	12month evaluation of prescribing permit. Report to be presented to Health Protection Services	iCAHE EMG Project Officer	May/June 2012	June/July/Aug 2012	Engagement with iCAHE Membership availability
16	Consideration of next steps in prescribing – dependent upon (but not exclusive to) outcome of 12 month prescribing permit National documents/ considerations (HWA)	iCAHE EMG Engagement with Health Protection services, legal considerations and engagement with Pharmacy department Steering Committee	June/July 2012	Aug/Sept 2012	HWA and National position of non-medical prescribing Engagement with iCAHE
17	7th Steering Committee meeting	Steering Committee	July/August 2012	July/August 2012	Membership availability
18	12month evaluation of ED	iCAHE	Aug/Sept 2012	Sept/Oct 2012	Engagement with iCAHE

ID	Description	Who	Scheduled Start	Scheduled Finish	Interdependencies
	pilot positions Report submitted to NAP Steering Committee and hospital executive Consideration of publications	Project Officer EMG			

1.8 Budget

	2009/10	2010/11	2011/12	2012/13
Project Officer	$72,000	$75,000	$65,000	$56,000
Physiotherapy positions	$0	$125,000	$275,00	$334,000
Additional NAP funding			$273,000	

This assumes that the Project officer is employed 0.6 from February 2009-June 2012 and 0.5FTE from July 2012-February 2013 and that there are 1 FTE HP4 trial participants (the breakdown of which will be clarified once development of the pilot roles is complete), 2011-2012 funding equates to 2.0-2.5 FTE (dependent upon classification) and 2012-2013 funding equates to 2.5 FTE (may vary dependent upon classification).

Additional support is available to support evaluation.

The Allied Health Advisor will provide a desk space, computer and other consumables for staff members salaried from the extended scope physiotherapy cost centre.

The Health Directorate physiotherapy service will be responsible for the cover of any backfill costs

1.9 Assumptions and Constraints

It is assumed that the project will be influenced by availability and timeliness of advice and support required to implement advanced and extended practice roles within the changing workforce environment including standards of practice and legislative requirements. The project will be undertaken in consultation with: physiotherapy health professionals; the Physiotherapy registration board; professional associations; the International Centre for Allied Health Evidence (iCAHE); clinical teams from the Emergency Department, Orthopaedics, Medical Imaging, Pharmacy and Pathology; HR- Workforce Strategy and Health Care Consumers as well as educational providers such as the University of Canberra and the Australian National University.

6) Project Management Plan

7) 2.1 Terms of Reference

Prior to the commencement of the project a Steering Group will be established.

Please refer to Attachment 1.1.

2.2 Reporting Requirements

Regular verbal reports from the Project Officer and iCAHE will be provided to the Steering Committee. The Steering Committee will provide reports to the ACT Workforce Policy and Planning Executive Management Group, the ACT Health Tertiary Education Liaison Committee (TELC), for approval through the Chief Executive, as well as the Executive Directors Council and Strategy & Corporate Executive meetings.

Relevant background papers and the evaluation report will be provided to ACT Government – Health Directorate and posted on the Health Directorate intranet.

2.3 Stakeholder Management & Communication

Stakeholders for the project include:

Internal stakeholders:

- Executive Directors Council (EDC) – ACT Government Health Directorate
- Strategy & Corporate Executive Meeting
- Deputy Chief Executive – Canberra Hospital and Health Services
- Workforce Policy and Planning Executive Management Group —ACT Health
- Physiotherapy Extended Scope of Practice Steering Group—ACT Health
- Directors of Allied Health and the ACT-Wide Allied Health Group
- Calvary Health Care
- Allied Health Advisory Council (when formed)
- Chief Nurse and Medical Adviser

- Outpatient Steering Committee meetings
- Emergency Department Executive Management Group meetings

External stakeholders:

- University of Canberra
- ANU Medical School
- ACT Physiotherapy Board
- Australian Physiotherapy Association
- All registered ACT Physiotherapists
- Wider Allied Health Workforces
- International Centre for Allied Health Evidence (iCAHE)
- National Allied Health Advisory Committee (NAHAC)
- Health Workforce Australia (HWA)

A communication strategy has be developed by the Steering Group (see project plan version 2.0 – 30/03/2010) and will be adhered to in this iteration of the project.

External stakeholders outside of the Steering Committee: A range of clinicians and health administrators, Health Registration Boards, and Professional Associations, will be engaged in the project by making the Communiqué outlining project updates and access to documentation available via the Project Officer and / or website.

2.4 Risk Management Plan

A risk matrix has been completed for this iteration of the project

Risks will be regularly updated, reviewed and reported as required

2.5 Quality Management Plan

The project will be undertaken using the project management methodology described.

The Steering Committee will monitor the project regularly with reporting to the Health Directorate, Workforce Policy and Planning Executive Management Group, Tertiary Education Liaison Committee, through the Executive Directors Council, the Strategy & Corporate Executive meeting and the Deputy Director General TCH and Health Services.

Project Sponsors will review and approve the distribution of papers and the final report.

A hard copy file will be maintained of all project documentation, including consultations and discussions.

2.6 Project Closure

Regular reports of the progress of the Physiotherapy Extended Scope of Practice Project Phase 2 will be provided to ACT Workforce Policy and Planning Executive Management

Group, Tertiary and Education Liaison Committee and Executive Directors Council through the standard process for presenting ACT Government – Health Directorate reports.

The Health Directorate, in consultation with the consultant and project officer will feed back the results of the project to other states and territories as deemed appropriate.

8) Attachments

1.1 Terms of Reference - Physiotherapy Extended Scope of Practice, Project Reference Group

1.2 Communication Strategy

1.3 Extended Scope Physiotherapy Project Risk Matrix

Physiotherapy Extended Scope of Practice: Phase 2

Steering Committee

Terms of Reference

Background

This project aims to design, implement, evaluate and support enhanced practice physiotherapy pilot roles within ACT Health. In doing so, it supports the Australian National Health Workforce Framework the Australian Physiotherapy Association statement and the ACT Government's Canberra Plan vision for building a stronger community. It also aligns with Objectives 1 and 2 of the *ACT Health Workforce Plan 2005-2010*, a range of ACT Health service plans, including, but not limited to, the Surgical Services Plan and the ACT Health philosophy of collaboration. The project is consistent with a key performance indicator of the *Australian Health Workforce Reform 2009-2013* which aims to explore extended scopes or new or redesigned roles.

Aim

The Physiotherapy Extended Scope of Practice Steering Committee will provide input and monitor the progress of the Project, and provide direction and guidance to support the project aims.

Project deliverables will be achieved through the development of key project outputs (refer to Project Plan: Physiotherapy Extended Scope of Practice: Phase 2).

Roles and Responsibilities

The Steering Committee will bring key stakeholders together to:

- provide expert advice, direction and guidance to the project
- support the project aims
- support the communication strategy and stakeholder engagement; and
- endorse deliverables.

Frequency of meetings

It is anticipated there will be bimonthly Steering Committee meetings from March - July 2010, depending on the needs of the project.

The Steering Committee will meet to consider the implementation strategies required to initiate a trial of Extended Scope Practice Physiotherapy roles, initially in the field of Orthopaedics and Emergency Medicine. Integral to this process is the Governance Framework and structure required to support this initiative and the training and credentialing requirements.

Reporting

Members will provide regular feedback and progress updates to the ACT Health Divisions, tertiary sector and other relevant groups and organisations.

Deliverables

A training and credentialing framework for the proposed Extended Scope Physiotherapy pilot roles within Orthopaedics and Emergency Medicine
Evaluation of pilot roles
Commence the research arm of the project
Endorse Duty Statements and Selection Criteria for the Recruitment of proposed Extended Scope Physiotherapy pilot roles
Establish clinical support networks/teams for the ongoing assistance for the Extended Scope Physiotherapists
Produce a Final Report, including the evaluation of the impact of the pilot roles
Disseminate the project learnings

Enabling Factors

Communication with physiotherapists, other key health professionals, relevant groups and organisations, and tertiary sectors will be crucial to the success of this project

Membership

The Group consists of the following members:

- Karen Murphy, Allied Health Adviser, ACT Health
- Katrina Milbourne Manager Workforce Policy and Planning Unit, ACT Health
- June Gunning, Acting Director Acute Support, ACT Health
- Lisa Gilmore, Acting Manager Physiotherapy Department, ACT Health
- Cathy Watson, Workforce Policy and Planning Unit, ACT Health
- Elaine Men, Elective Surgery Access Manager, ACT Health
- Brenda Ainsworth, Executive Director, Health Performance, Improvement, Innovation and Redesign, ACT Health
- Professor Graham Buirski, Director of Medical Imaging, ACT Health
- Dr Jennie Scarvell, Clinical Research Coordinator, Trauma & Orthopaedic Research Unit, The Canberra Hospital
- Tania Dufty, Operational Manager, Ambulatory Care Services, ACT Health
- Sean McDonnell, Senior Advisor, Human Resource Management Branch, ACT Health
- Katrina Bracher – Ag General Manager, Community Health
- Christopher Hicks – Ag Allied Health Director, Calvary Healthcare
- APA representative – delegate TBC
- ACT Physiotherapy Registration Board Representative – delegate TBC
- Dr Bryan Ashman, Clinical Director of Surgical Services, ACT Health
- Dr David Lamond, Staff Specialist, Emergency Department, ACT Health
- Neil Keen, Director of Pharmacy, ACT Health
- Consumer Representative – TBC
- Dr Alex Stevenson, GP lecturer, ANU Medical School
- Dr Claire Willington, GP Adviser, ACT Health
- Professor Gordon Waddington, Head of Physiotherapy, University of Canberra
- Head of Allied Health Research, University of Canberra – TBC

- Professor Julia Potter, Executive Director, ACT Pathology
- Jo Morris, Project Officer, Office of the Allied Health Adviser, ACT Health
- Additional input will be co-opted as necessary

Chair

Karen Murphy, Allied Health Advisor, ACT Health.

Agenda

The Secretariat will organise with input from members.

Secretariat

ACT Health, Project Officer, Phase 2: Physiotherapy Extended Scope of Practice.