

Physician Assistant (PA)

Clinical Governance Guideline

March 2016

Version 2.0

Physician Assistant – Clinical Governance Guideline

Published by the State of Queensland (Queensland Health), March 2016



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An electronic version of this document is available at www.health.qld.gov.au/qhpolicy/html/index-p.asp

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1. Purpose

This Guideline provides recommendations regarding best practice and a standardised approach to clinical governance for PAs within the Queensland public health system.

This Guideline identifies relevant legislation and policy, and defines processes that support efficient service provision and the delivery of safe and quality health outcomes for Queenslanders.

2. Scope

This Guideline is relevant to PAs and supervising medical practitioners. It provides information for all Queensland public health system employees and all organisations and individuals acting as its agents (including partners, contractors, consultants and volunteers).

This document does not cover the practice of a PA working in the private health sector.

3. Related documents

Procedures, Guidelines, Protocols and Factsheets:

- Factsheets:
 - Clinical Governance Guideline Overview
 - Employment Arrangements
 - Professional Indemnity Insurance
 - Quality Use of Pathology
 - Quality Use of Medical Imaging
 - Quality Use of Medicines
- Physician Assistant Generic Job Description Sample
- Medications Authorisations Summary
(*Health (Drugs and Poisons Regulation) 1996*) (Appendix 5)

Forms and templates:

- Physician Assistant Practice Plan (Appendix 1)
- Physician Assistant Application for Endorsement (Appendix 2)
- Physician Assistant Clinical Practice Report (Appendix 3)
- Physician Assistant Application for Pathology Request Authorisation (Appendix 4)

4. Guideline for Physician Assistant (PA) Role

4.1 Background

The PA role was established in the 1960's in the United States of America (USA) to address issues of rural and remote health access and disparity of care in underserved populations. The role now mirrors most areas of medicine practised by medical and surgical practitioners. The PA role also exists in other countries including Canada, United Kingdom and Netherlands.

In 2011, Health Workforce Australia (HWA) published *The potential role of Physician Assistants in the Australian context*. The report noted evidence of positive workforce and patient access benefits, especially in Indigenous communities and under-serviced areas in comparable health systems internationally.

The role was piloted in Queensland and South Australia between 2008 and 2010, and twice in New Zealand; in 2011, and again in 2013-2015. The Queensland Health pilot was conducted with 5 USA trained PAs to test the potential suitability and contribution value of the role. The Pilot demonstrated the PAs integrated well with their clinical teams, created distinct roles which complemented the existing nursing and medical roles and enhanced service delivery.

The final PA Pilot Steering Committee made several recommendations to support the establishment and introduction of the role in Queensland. The clinical governance developed during the Pilot has been used as a foundation to establish robust clinical governance for the role.

4.1 Role Overview

A PA is a professional who works as a member of a multidisciplinary team under the delegation and supervision of a medical practitioner.

The PA role is generalist in nature, with a focus on primary, emergency and preventative care. However, under delegated practice a PA may specialise, depending on experience and the scope of clinical practice of the supervising medical practitioner.

A PA has similar diagnostic and therapeutic reasoning to a medical practitioner. PA education programs are built on a medical care model which includes, but is not limited to: anatomy; physiology; biochemistry; pharmacology; physical diagnosis; pathophysiology; microbiology; clinical laboratory science; behavioural science; paediatric and adult emergency medicine; medical ethics; clinical skills; clinical decision making; public health; and health of special populations. In most cases, as a pre-requisite to PA education programs in Australia, PAs will have obtained a tertiary level education and had previous healthcare experience.

The collaborative relationship between a PA and the supervising medical practitioner is considered a defining feature of the profession. The nature of supervision and delegated autonomy for each clinical practice activity may vary according to a number of factors such as clinical type, patient acuity, health care setting or context, and the PA experience and competence.

As a PA competence increases, the level of supervision and delegation will change. The supervising medical practitioner determines the activities to be undertaken, defines activities in a Practice Plan and retains overall responsibility for health care delivery.

The PA activities defined in the Practice Plan will be within the scope of clinical practice of the supervising medical practitioner and is endorsed by the Medical Credentialing Committee. At no time does the PA override or substitute for a medical practitioner.

Internationally, the role has been shown to make a positive contribution to the provision of quality health care, including fast tracking patients in emergency departments, reducing waiting lists, reducing medical practitioner burn out, improving patient access as well as providing a medical practitioner the ability to redistribute routine tasks to allow more time for surgery, complex tasks, education and other activities.

This role is relatively new to Australia and is not nationally registered in Australia. The PA role is designed to contribute in meeting Queensland's clinical workforce challenges of the future, and forms part of a broader clinical workforce reform agenda.

5. Clinical Governance Framework

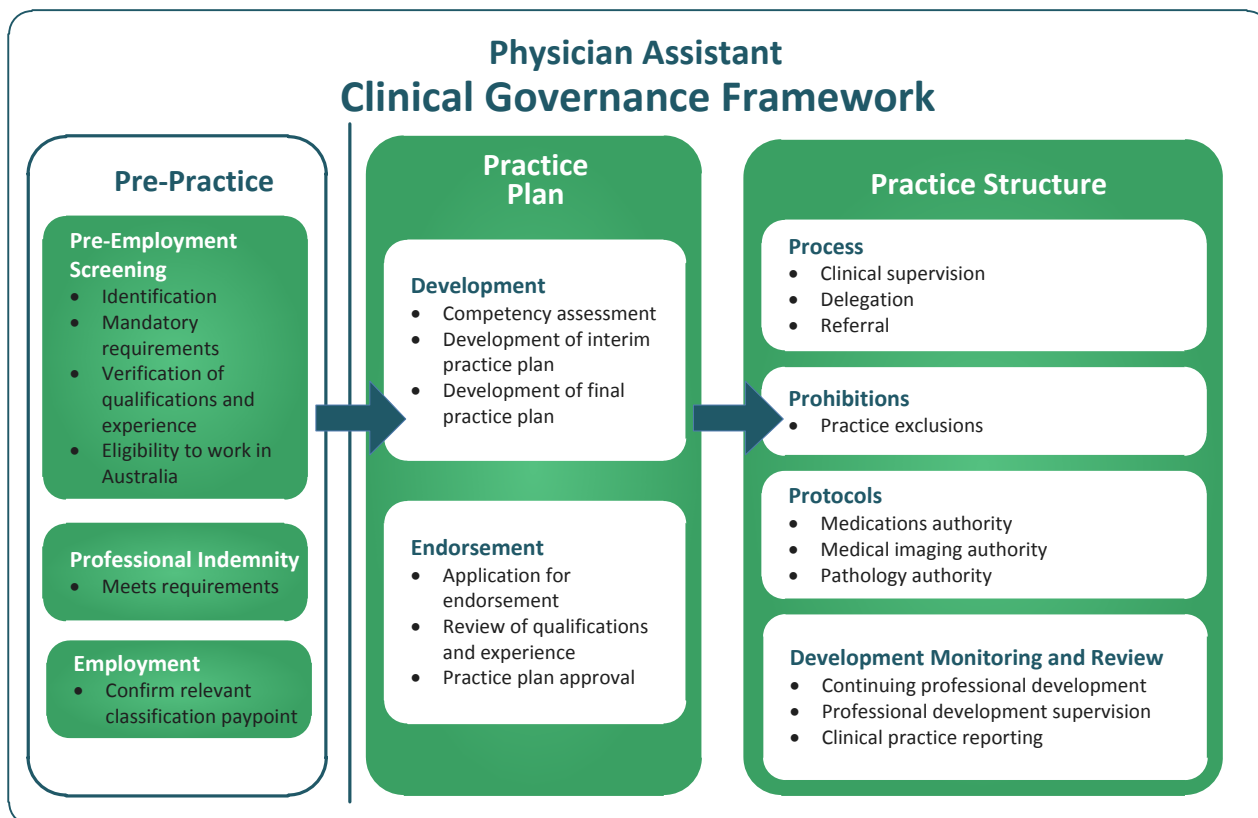


Fig 1. Physician Assistant clinical governance framework

5.1 Overview

The PA Clinical Governance Framework is underpinned by the application of a quality pre-practice verification, assessment and endorsement process and a robust clinical practice structure to guide the standard of accountability, responsibility, authority and other mechanisms to allow a PA to effectively and safely provide patient care.

The PA Clinical Governance Framework provides the recommended minimum standards and processes for all clinically related aspects of the PA role. The framework aligns with the Clinical Governance Frameworks of other professions within the Queensland public health system.

The PA Clinical Governance Guideline outlines fundamental best practise for the role to ensure a systematic approach to managing, maintaining and improving the quality of patient care within the public health system.

5.1.1 Pre-Practice

PA pre-employment screening principles, requirements and processes must align with Queensland Health policy. The relevant information can be located in the Recruitment and Selection HR Policy B1 (QH-POL-212)¹.

Professional Indemnity is also an element of the pre-practice component of the clinical governance framework. A PA and a supervising medical practitioner employed by Hospital and Health Services (HHSs) or the Department will be covered under the terms and conditions of Indemnity for Queensland Health Medical Practitioners HR Policy I2 (QH-POL-153)², and the *Public Service Act 2008*³.

¹ www.health.qld.gov.au/system-governance/policies-standards/doh-policy/policy/gh-pol-212.pdf

² www.health.qld.gov.au/system-governance/policies-standards/doh-policy/policy/gh-pol-153.pdf

³ www.psc.qld.gov.au/includes/assets/legal-protection-indemnity-guideline.pdf

The PA role has been classified in the Professional Officer stream of the *District Health Service Employees' Award – State 2012* and under the terms and conditions of the *Queensland Public Health Sector Certified Agreement (No8) 2011*.

Generic PA job description samples and PA factsheets relating to employment arrangements and professional indemnity and can be found on the Department's Physician Assistant intranet site⁴.

6. Practice Plan Development & Endorsement

6.1 Competency Assessment

A PA will be subject to a competency assessment to enable the development of the PA Practice Plan. The most appropriate competency assessment will be determined by the supervising medical practitioner. A Mini-CEX is an example of a mechanism to complete the competency assessment⁵.

6.2 Developing an Interim Practice Plan

The principal supervising medical practitioner may determine that a PA works under an interim Practice Plan while the PAs competence and level of required supervision is determined. The PA will continue to work in accordance with the interim Practice Plan until the final Practice Plan is approved by HHS Executive Director of Medical Services (EDMS).

The level of supervision provided under the interim Practice Plan should minimise risk and maximise patient safety. This will include a closer level of monitoring and review than proposed under the final Practice Plan.

6.3 Developing the Practice Plan

The delegated PA clinical practice activities, and the level of supervision required to perform the activities will be documented in the Practice Plan (Appendix 1). The Practice Plan is developed collaboratively between the principal and secondary supervising medical practitioners and the PA.

The Practice Plan identifies:

- Principal and secondary supervising medical practitioner information, including job title, contact details, registration number, credentials and scope of clinical practice
- Clinical practice activities
- Practice exclusions and restrictions
- Supervision and consultation requirements
- Prescription authority
- Pathology authority
- Medical imaging authority
- Agreement by both the supervising medical practitioners and the PA
- Agreement by supplementary supervising medical practitioners
- Approval by the HHS EDMS

The assignment of delegated clinical practice activities should be routinely reviewed by the supervising medical practitioner in consultation with the PA. It is expected that PA delegated practice will develop and expand over time.

6.4 Application for Endorsement

All Practice Plans will be approved by the HHS EDMS. A final Practice Plan shall be attached with other supporting evidence to a PA Application for Endorsement form (Appendix 2) and submitted to

⁴ <http://qheps.health.qld.gov.au/pce/wfpolicy/html/phys-asst-resources.htm>

⁵ www.racp.edu.au/trainees/assessments/work-based-assessments/mini-clinical-evaluation-exercise

the HHS Medical Credentialing Committee. This will occur prior to the expiration of the interim Practice Plan, and within 60 days of commencement of practice.

The HHS EDMS role is to:

- Verify that the identified principal and secondary medical practitioners are suitable to supervise a PA
- Consider and approve the interim Practice Plan
- Consider and approve the Practice Plan (if delegated by HHS Chief Executive) and submit with the PA Application of Endorsement form to the HHS Medical Credentialing Committee
- Consider any appeals and determine decisions.

The HHS Medical Credentialing Committee's role is to:

- Review the verified PA qualifications, and review experience as outlined in the application and supporting evidence
- Ensure the activities outlined in the Practice Plan is within the PA qualification and experience and within the supervising medical practitioner's scope of clinical practice
- Determine whether or not to endorse the PA Application for Endorsement
- Retain a copy of the endorsed Application and Practice Plan
- Provide further advice to the HHS Chief Executive and EDMS if required.

A PA must disclose status of registration or certification (if appropriate) including any conditions, past or present suspensions, reprimands or undertakings, limitations on activity by another facility or jurisdiction; or any other matter that the HHS Medical Credentialing Committee could reasonably expect to be disclosed in order to make an informed decision on endorsement.

6.5 Amending an Endorsed Practice Plan

A Practice Plan must be amended if there is a substantial change in the practice activity or context. This may include a change in the service stream or setting in which the PA works, or change of supervising medical practitioner. Any substantial amendments to a Practice Plan must be submitted to the HHS EDMS (if delegated from HHS Chief Executive) for approval.

The supervising medical practitioner retains the right to immediately limit or reduce the PA activities, or increase the level of supervision without prior approval from the HHS EDMS or HHS Medical Credentialing Committee. This action may be documented in a PA Clinical Practice Report (Appendix 3).

6.6 Duration of Practice Plan

PA endorsement and the associated Practice Plan should have an end date of no more than 3 years from the date of approval by the HHS EDMS. However, it is recommended that the Practice Plan is reviewed by HHS EDMS following the first 12 months of practice; and by the principal supervising medical practitioner during the 6-monthly Performance Appraisal Development (PAD) process.

6.7 Appeals

A PA who has had an Application for Endorsement denied, withheld or limited to that requested, can appeal against the decision.

A request for reconsideration can be made in writing by the PA to the HHS EDMS (if delegated from HHS Chief Executive), 14 business days from receipt of notification. The HHS EDMS will then make a determination to confirm or reject the original decision within 30 business days of receipt of the appeal.

7. Practice Structure

7.1 Delegation

The principal supervising medical practitioner retains overall accountability for the execution of any duties undertaken by the PA, and remains responsible for the overall management and clinical outcomes of the patient and for the decision to delegate activities.

A delegated activity must be:

- Within the credentialed scope of clinical practice of the principal and secondary supervising medical practitioners
- Within the qualifications, experience, knowledge, skills, and competency of the PA
- Lawful i.e. within legislative authority
- Appropriate for the context i.e. sound, evidence-based medical practice, that meets patient needs, and service delivery scope
- Consistent with the service provider's policies
- Negotiated and agreed between the PA and supervisor
- Documented in the Practice Plan.

Accepting delegated activity is an indication that the PA:

- Agrees to accept the specific activity
- Confirms that the activity is within their professional scope of practice and within delegated practice outlined in the Practice Plan
- Has the appropriate experience and competencies
- Acknowledges the level of responsibility and accountability
- Acknowledges they do not take the place of the supervising medical practitioner as the principal medical decision-maker
- Agrees to not delegate activities which have been delegated to them
- Agrees to not undertake any activity which is prohibited.

The PA is responsible and accountable for making a professional judgement about when an activity is beyond their capability, and for initiating immediate attention or consultation with their supervising medical practitioner and other members of the health care team as appropriate.

If necessary, the PA is to institute treatment procedures essential for the life of the patient. Should a patient decline to be assessed or treated by a PA, the PA must immediately refer the patient to a medical practitioner.

7.2 Referral

Another health professional may refer aspects of a patient's care to a PA. Also, a PA may refer aspects of a patient's care to other health professionals, as previously agreed with the supervising medical practitioner.

The referral should be:

- Agreed to be accepted by the referee
- Based upon clinical assessment of patient need
- Within the authority of the referring health professional and/or within the authority of the PA
- Within legislation
- In line with service provider's policies
- Supported by appropriate and sufficient communication and information about the patient and their treatment to enable continuing care.

7.3 Handover

A PA may only handover a patient's care to another health professional with the prior agreement of the supervising medical practitioner.

7.4 Practice Exclusions

It is determined that a PA may not:

- Sign a death certificate. However, a PA may declare 'life extinct' in lieu of the supervising medical practitioner
- Complete or sign a prescription that is eligible for PBS reimbursement either through the PBS access scheme, or one that will be filled by a private pharmacy
- Complete or sign a prescription for highly specialised drugs that require medical specialist authority
- Complete or sign a request for private pathology tests eligible for Medicare rebates covered by the pathology table of the *Health Insurance Act 1973*, or that would otherwise be valid if requested by a registered Medical Practitioner holding a valid Medicare Australia Provider Number for a private patient
- Sign a Workers Compensation Form or Medical Certificate for a Motor Vehicle Driver's Licence
- Sign forms that attract a Commonwealth benefit
- Order blood or blood products unless specified in the Practice Plan
- Perform any medical service, procedure, function or activity which is outside of the assigned role as identified in the Practice Plan
- Work without access to a nominated supervising medical practitioner.

7.5 Clinical Supervision

A PA must work under the direction of the supervising medical practitioners appointed as a principal supervisor and a secondary supervisor as indicated in the Practice Plan. In addition, shift supervision may be provided by supplementary supervisor/s as appropriate.

7.5.1 Responsibilities of the Principal Supervising Medical Practitioner

The principal supervising medical practitioner is required to:

- Hold general or specialist registration with the Medical Board of Australia and must have been credentialed and granted scope of clinical practice by the HHS Medical Credentialing Committee
- Be eligible to supervise a PA as determined by the HHS EDMS
- Nominate a secondary supervisor
- Identify and collaborate with the secondary supervisor
- Assess PA competencies
- Collaboratively develop, agree and sign a Practice Plan
- Submit a PA Application for Endorsement to the HHS Medical Credentialing Committee
- Assign activities based on individual competencies and case complexity; with regard to the services that can be provided by the health facility and the supervisors scope of clinical practice
- Clearly communicate directions and expectations of how the activity is to be performed
- Arrange for the secondary supervisor to be available in periods of absence
- Provide direct assistance and/or intervention and/or consultation when required
- Review a minimum of 10% of PA treated patient charts
- Assess and appraise performance through direct observation, consultation with other stakeholders, review of documentation, use of assessment tools etc.
- Review and countersign relevant records and documentation
- Facilitate developmental opportunities

- Complete written reports as required
- Have the appropriate skills, attributes and capacity to provide clinical supervision.

It is recommended that a principal supervising medical practitioner only supervises a maximum of two PAs at any one time.

Medical practitioners with limited registration cannot be appointed as the PA principal supervisor.

7.5.2 Responsibilities of the Secondary Supervising Medical Practitioner

The secondary supervising medical practitioner is required to:

- Hold general or specialist registration with the Medical Board of Australia and must have been credentialed and granted scope of clinical practice by the HHS Medical Credentialing Committee
- Be eligible to supervise a PA as determined by the HHS EDMS
- Assist in assessing PA competencies
- Collaboratively develop and sign a Practice Plan
- Provide direct assistance and/or intervention and/or consultation when required
- Assume the role of principal supervising medical practitioner in the event the principal supervising medical practitioner is not available or on periods of absence.

7.5.3 Responsibilities of the Supplementary Supervising Medical Practitioner/s

The supplementary supervisor will provide direct and/or indirect supervision to a PA on a shift by shift basis. Only supervisors that are named on the practice plan will be able to supervise a PA.

Supplementary supervisors will be required to:

- Hold general or specialist registration with the Medical Board of Australia and must have been credentialed and granted scope of clinical practice by the HHS Medical Credentialing Committee
- Be aware of the purpose of supervision and agree to assume the role and responsibilities of a supplementary supervisor
- Have the appropriate skills, attributes and capacity to provide supplementary supervision
- Be familiar with the PA Practice Plan and sign to indicate agreement to being a supplementary supervisor
- Provide direct assistance and/or intervention when required
- Review and countersign relevant records and documentation.

7.5.4 Levels of Clinical Supervision

Supervision may be provided through three levels of supervision – direct, indirect and remote. Different activities may require different levels of supervision which will be defined in the Practice Plan.

The nature of supervision may vary according to a number of factors including:

- Patient type
- Service type
- Clinical Services Capability Framework of the facility
- Level of acuity and complexity of patient care required
- PA experience and competence
- Location

Level One - Direct Clinical Supervision

Direct clinical supervision may occur until the PA has become familiar with the role and the practice environment. This level of supervision may be necessary until the supervisor has determined the skills and competence of the PA.

Features may include the supervising practitioner:

- Retaining direct and principal responsibility for the patient
- Being predominantly present, giving directions and observing the PA
- Providing cooperative care and shadowing arrangements
- Being immediately available when clinical care is being provided by the PA
- Countersigning all medical records and documentation
- Completion of the formal reporting as defined in the Practice Plan.

Level Two - Indirect Clinical Supervision

Indirect clinical supervision may remain appropriate for delegated practice, or may occur until the supervising medical practitioner is confident that the skills and competence of the PA are such that level three supervision is appropriate for some specific activities.

Features may include the supervising practitioner:

- Remaining accountable for patient outcomes and care but the PA takes primary responsibility for individual patient care
- Working within the same service setting, but not constantly observing PA clinical practice
- Being contactable for consultation
- Working within the same service setting/facility and undertakes periodic review of performance
- Ensuring appropriate safeguards are in place for regular and detailed monitoring of performance and referral
- Ensuring a medical practitioner is present in the workplace at all times
- Agreeing with a PA to meet daily initially until determining when to reduce the frequency of the meetings
- Ensuring supervision meetings include a review of a sample of medical records from patients seen by the PA. Charts should be selected to ensure a sufficient range of clinical presentations and treatment interventions are reviewed.

Level Three – Remote Clinical Supervision

Remote clinical supervision allows for a PA to work with more delegated autonomy for specific activities defined in the Practice Plan. This may occur once the supervising medical practitioner is confident that the PA demonstrates the skills and competence to provide safe and effective patient care with a lower level of monitoring.

Features may include the supervising practitioner:

- Readily contactable by telephone or other means of communication if not immediately available in person
- Ensuring appropriate safeguards are in place for monitoring and referral
- Defining the frequency of meetings in the Practice Plan
- Ensuring supervision meetings include a review of a sample of medical records from patients treated by the PA.

7.6 Medications

A PA has the authority to prescribe, supply, possess, and administer a wide range of medications to patients under the *Health (Drugs and Poisons) Regulation 1996 (HDPR)*.

In addition, they have the authority to instruct other clinicians to supply, possess and administer medications to patients within stated prescribed circumstances. A PA must be aware of the drug possession and administration limitations of other clinicians prior to any instruction.

Specific prescribing and administration requirements will be defined in the Practice Plan. The PA Practice Plan template at Appendix 1 has been approved by the Director-General as required by the HDPR.

7.6.1 Legislation, Regulation and Policy

The *Health (Drugs and Poisons) Regulation 1996* is established under the provisions of Section 132 of the *Health Act 1937*. It provides the legislative authority for a PA who is “appointed by the Chief Executive, and employed by the Department as a physician assistant; or appointed by a Hospital and Health Service, and employed by the Service, as a physician’s assistant” to possess, prescribe, supply and administer:

- Schedule 2 drugs and poisons (pharmacy medicine)
- Schedule 3 drugs and poisons (pharmacist only medicine)
- Schedule 4 restricted drugs (prescription only medicine)
- Schedule 8 controlled drugs (possession without authority is illegal)

The full text of relevant sections and the definitions relevant to the Regulation is reproduced at Appendix 5.

A PA is required to comply with the National Policy on the Quality Use of Medicines⁶.

7.6.2 Prescribing

Medications are usually supplied to patients through an ‘imprest system’, and/or through the patient’s individual supply. Prescriptions for medicines which are supplied through the imprest system do not require a PA to have a Pharmaceutical Benefit Scheme (PBS) Prescriber Number.

7.6.3 Prescribing Exclusions

Pharmaceutical Benefit Scheme (PBS)

A PA cannot complete or sign a prescription that is eligible for PBS reimbursement, either through the PBS access scheme, or through a private pharmacy. Therefore a PA cannot write a prescription for drugs and/ or poisons that will not be provided directly to the patient through the imprest system or filled through the hospital pharmacy.

Medical Superintendent Signed Authority Protocol

There are a small number of medicines on the List of Approved Medicines that are listed within the ‘Medical Superintendent Signed Authority Protocol’ restriction. A PA is unable to prescribe medicines that fall within this restriction⁷.

Therapeutic Goods Administration

A PA must not prescribe, give a written or oral instruction, supply or administer medicines that have not been approved by the Therapeutic Goods Administration. www.tga.gov.au

‘Off-Label’ Use

A PA must not practice outside the terms of the manufacturer’s product information (‘off-label’), unless instructed and documented by the supervising medical practitioner and there is sufficient evidence base to demonstrate the safety and efficacy of using the drug or poison.

⁶ www.health.gov.au/internet/main/publishing.nsf/content/nmp-quality.htm

⁷ www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/approved-list/default.asp

7.7 Medical Imaging

Medical imaging encompasses a range of technologies used to produce images of internal body structures. These technologies are known as modalities and include: plain film radiography, ultrasound, fluoroscopy, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), angiography and nuclear medicine. Most of these modalities use ionising radiation, with the exception of ultrasound and MRI.

The range of modalities that can be requested by a PA will be determined by delegated practice and defined in the PA Practice Plan, and must align with legislative requirements and the appropriate clinical guidelines. Internal protocols may need to be developed in collaboration with the medical imaging service provider.

7.7.1 Legislation and Regulation

A PA is subject to, and required to comply with, the *Queensland Radiation Safety Act 1999* and the *Queensland Radiation Safety Regulation 2010*.

Radiation Safety Act 1999

It is a requirement under the *Radiation Safety Act 1999*, that only an 'Authorised Person' may request a diagnostic procedure for another person. (Division 4, section 41 Diagnostic or therapeutic procedures).

Radiation Safety Regulation 2010

The *Radiation Safety Regulation 2010* defines a PA as "appointed by the chief executive, and employed by the department, as a physician assistant; or appointed by a Hospital and Health Service established under the Hospital and Health Boards Act 2011, and employed by the Service as a physician assistant".

Under Part 10, Section 64 of the *Radiation Safety Regulation 2010*, PAs are identified as authorised persons to request a diagnostic procedure where:

- a) The PA's Practice Plan states they can request a diagnostic procedure; and
- b) The PA requests the diagnostic procedure under the supervision of their supervising medical practitioner; and
- c) The supervising medical practitioner is identified in authorised under section 63 (of the *Radiation Safety Regulation 2010*) to request the diagnostic procedure.

A diagnostic procedure is defined in Schedule 6, Part 1 of the *Radiation Safety Regulation 2010*.

7.7.2 Medical Imaging Exclusions

MRI is currently managed through specific requestor, provider and item level restrictions set by the Federal Department of Health, and is therefore considered to be out of scope for a PA.

7.7.3 Access to Results and Reporting

All public medical facilities have access to a Radiology Information System (RIS) and a Picture Archiving and Communication System (PACS). These systems provide on-line access to diagnostic images and imaging reports.

It should be noted that there are a number of different systems in use across the state. A PA will require access to the appropriate systems at the facility in which they are practicing in order to access medical imaging results. It is suggested that access to the RIS and PACS systems to be arranged as part of the PA's orientation to the facility.

Information and recommendations regarding best practice for the reporting of diagnostics imaging procedures is available through the *Guideline for the Provision of Diagnostic Imaging Reports*⁸.

⁸ www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-017.pdf

7.7.4 Medical Imaging - Medicare Billing Eligibility

Medical imaging is a service which attracts a Medicare benefit when the services are requested by a clinician with an appropriate Medicare Provider Number (MPN). At this time, Medicare Australia does not issue MPNs to PAs. Therefore, a PA working within public facilities cannot request a medical imaging service that will attract a Medicare benefit.

7.8 Pathology

A PA requires access to a wide range of clinical information to facilitate clinical reasoning and support the formation of a differential diagnosis. A PA may be responsible for some or all aspects of a pathology request, including signing off on pathology tests. The PA delegated practice, including pathology requesting and collection exclusions, will be defined in the Practice Plan.

7.8.1 Legislation and Regulation

A PA is not subject to pathology specific legislation or regulations. However, they are required to follow the protocols and guidelines that have been determined by Pathology Queensland, and at the facility level. In addition, they are required to follow Medicare procedures in relation to pathology ordering.

7.8.2 Pathology Queensland Guidelines

Pathology Queensland provides:

- A comprehensive diagnostic pathology service in accordance with published Pathology Queensland test list, including chemical pathology, haematology, transfusion medicine, microbiology, immunology, anatomical pathology and cytopathology.
- Written guidelines and pro-formas that should be followed when collecting specimens and requesting pathology tests⁹.
- Access to test results on the laboratory information system. Laboratory Information Systems and Solutions (LISS) support and manage the relevant information systems AUSCARE and AUSLAB.
- PA authorisation to request pathology tests. Application forms are available via the Laboratory Information Systems and Solutions Intranet page¹⁰. A content example application for authorisation is at Appendix 4.

7.8.3 Pathology - Medicare Billing Eligibility

A PA is not issued with a Medicare Provider Number (MPN). However, it has been agreed that within public health facilities, a PA will be able to request pathology tests without a MPN. On application to LISS, the PA will be issued with an AUSLAB code which must be used for all pathology tests.

However, it should be noted that the pathology order number does not allow PAs to bill pathology services to the MBS. Any billed pathology requests must be requested and authorised by the supervising medical practitioner.

8. Development, Monitoring & Review

8.1 Continuing Professional Development

A PA who is engaged in any form of medical practice is required to participate regularly in continuing professional development (CPD) that is relevant to their professional scope of practice in order to maintain, develop, and enhance their knowledge, skills and performance to ensure that they deliver appropriate and safe care.

⁹ <http://qheps.health.qld.gov.au/hssa/pathology/testing/specimen-collection.htm>

¹⁰ http://qheps.health.qld.gov.au/liss/auslab/auslab_forms.htm

CPD should include a range of activities to meet individual learning needs including practice-based reflective elements, such as clinical audit, peer-review or performance appraisal. A PA should also participate in activities to enhance knowledge such as courses, conferences and online learning. The CPD programs of medical colleges accredited by the Australian Medical Council (AMC) meet these requirements.

8.1.1 CPD requirements

Aligning generally to Australian Health Practitioner Regulation Agency (AHPRA) continuing professional development registration standards, it is recommended that:

- CPD requirements will be discussed with the principal supervising medical practitioner
- CPD will include annual basic life support education
- A practical level for CPD would be recommended at 20 hours per year
- The CPD should be relevant to the practice as a PA and the context of practice
- Additionally, 10 hours per year in medication related education (if included in practice scope and endorsed from the medical credentialing committee to prescribe, supply, possess and administer drugs and poisons)
- One hour of active learning will equal one hour of CPD. It is the PAs responsibility to calculate how many hours of active learning have taken place
- A PA should keep written documentation that demonstrates evidence of completion of CPD
- Documentation of self-directed CPD must include dates, a brief description of key learning, and the number of hours spent undertaking each activity
- Participation in mandatory training as set by the HHS may be counted as CPD
- In addition to the CPD portfolio, where applicable, a PA is required to retain any receipts, tax invoices or certificates of attendance to verify participation in CPD activities.

8.1.2 Approved development programs

As formal professional development programs for PAs are limited, alternative programs available for other health professions including medical practitioners may be accessed for the purposes of CPD.

The Australian College of Rural and Remote Medicine (ACRRM) has issued a position statement in recognition of the PA role and accepts PAs into its CPD programs. Completion of the ACRRM CPD programs will provide a PA with formal CPD points.

CPD may be achieved through education programs, seminars, workshops, lectures, conferences, discussion groups, multimedia or website-based programs, or the research and preparation of articles published in medical publications or such other publications relevant to their area of practice, or review of professional journals, or any combination of two or more of the above or self-directed learning consistent with maintenance of competence.

8.1.3 Professional Development Supervision

In addition to the clinical supervision provided by the supervising medical practitioner in relation to the PAs clinical practice, it is recommended that CPD related supervision is provided to specifically focus on the PAs professional development requirements.

This is regular protected time that enables in-depth discussion of, and reflection on clinical practice, and may include:

- Review and feedback on performance; identifying strengths and weaknesses and performance issues
- Observation of practical skills including procedural skills and patient interaction
- Discussion of difficult or unusual cases
- Discussion of cultural and management issues
- Medical record reviews.

Professional development supervision may be a planned formal process or undertaken on an ad hoc basis. These sessions may be documented in a Professional Development Supervision Plan or alternatively, the planned formal sessions may be achieved through the Performance Appraisal and Development Plan.

8.2 Clinical Practice Reporting

It is important to consider a process for monitoring PA progress and contribution to clinical service and patient outcomes. This will assist in ensuring the provision of a quality patient care, maximising input and outcomes.

The frequency and extent of review depends on the skill and competence of the PA and the scope in which they are practicing. The frequency will be determined locally, and a minimum of 10% of patients treated by the PA is recommended.

It is recommended that the Physician Assistant Clinical Practice Report (Appendix 3) is completed at formal review meetings. This report does not replace the need for self-monitoring by the PA, nor does it abrogate responsibility of the supervising medical practitioners to monitor the case load, competency and clinical practice of the PA.

A copy of this report must be retained by the principal supervising medical practitioner and may be submitted to the HHS EDMS on request or HHS Medical Credentialing Committee in support of a renewal or amendment Application for Endorsement.

9. Review

This Guideline is due for review on: 1 March 2018

Date of Last Review: 1 March 2016

Supersedes: Version 1.0

10. Business Area Contact

Workforce Strategy Branch
Strategy, Policy and Planning Division
3234 1453
PA@health.qld.gov.au

11. Approval and Implementation

Policy Custodian:

Senior Director, Workforce Strategy Branch

Responsible Executive Team Member:

Deputy Director-General, Strategy, Policy and Planning Division

Effective from: 1 March 2016

12. Definitions of terms used in the policy and supporting documents

Term	Definition / Explanation / Details
AUSLAB	<p>The Queensland Pathology State-wide pathology information system. Available in Queensland public health facilities, it provides clinical staff with a standard user interface for all pathology and scientific testing performed within the Department of Health network.</p> <p>In addition, it provides integrated access to all patient records on the system, irrespective of the testing laboratory or patient location.</p>
AUSCARE	<p>A State-wide business critical, results acknowledgment application which delivers on-line access to diagnostic results by clinicians across the State.</p>
Continuing Professional Development	<p>The means by which PAs maintain, improve and broaden their knowledge, expertise and competence, and develop the personal qualities required in their professional lives.</p>
Delegation	<p>Requesting another health care professional to provide care on your behalf while you retain overall responsibility for the patient's care.</p>
Handover	<p>The process of transferring all responsibility to another health care professional.</p>
MiniCex	<p>A clinical evaluation exercise for assessing clinical performance and core clinical skills, consisting of an observed clinical encounter with a patient.</p>
Practice	<p>Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner within their profession.</p> <p>For the purposes of this Guideline, practice is not restricted to the provision of clinical care. It includes using professional knowledge in a direct non-clinical relationship with clients, working management, administration, education, research, advisory, regulatory or policy development roles, and any roles that impact on safe, effective delivery of services in the profession.</p>
Professional indemnity insurance arrangements	<p>Arrangements that secure for the practitioner, insurance against civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner.</p> <p>This type of insurance is available to practitioners and organisation across a range of industries and covers the costs and expenses of defending a legal claim, as well as any payable damages.</p> <p>Some government organisations, under policies of the owning governments, are self-insured for the same range of matters.</p>
Referral	<p>Directing a patient to obtain an opinion and/ or treatment from another health care professional.</p> <p>This usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose; such as care outside your area of expertise.</p>
Renewal application for	<p>Application to Credentialing Committee to renew the endorsed</p>

Endorsement	Practice Plan which is due to expire.
Run-off cover	Insurance that protects a practitioner who has ceased a particular practice or business, against claims that arise out of activities which occurred s/he was conducting that practice or business. This type of cover is included in <i>HR13 Policy</i> .

Physician Assistant Practice Plan

The purpose of the Practice Plan is to provide a framework for clinical practice and supervision of the Physician Assistant. The Physician Assistant Practice Plan will be used in accordance with the **Physician Assistant Clinical Governance Guideline** (the Guideline) www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-397.pdf. Section 6 of the Guideline requires a Practice Plan to be developed in collaboration with the PA supervising medical practitioners that defines their level of practice.

An interim Practice Plan is developed during the initial competency assessment period. A (final) Practice Plan is then agreed and an Application for Endorsement is submitted to Hospital and Health Service Medical Credentialing Committee. The Practice Plan must be approved by Hospital and Health Services (HHS) Executive Director Medical Services.

This form complies with Section 48 of the Acts Interpretation Act 1954 and is approved by the Director-General, Department of Health in accordance with the definition of 'practice plan' as stated under:

- Appendix 9 (Dictionary) of the Queensland Health (Drugs and Poisons) Regulation 1996.
- Schedule 9 (Dictionary) of the Radiation Safety Regulation 2010.

 Interim Practice Plan
 Practice Plan

An interim Practice Plan may be used for a period of up to 60 days to assess the PA competencies.

Practice Plan Start Date:		Review Date:	
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Physician Assistant	
Practice Location/s:	
Name:	
Contact Telephone Number:	

Principal Supervising Medical Practitioner	
Name:	
Position Title:	
Contact Telephone Number:	
Scope of Clinical Practice:	

Secondary Supervising Medical Practitioner	
Name:	
Position Title:	
Contact Telephone Number:	
Scope of Clinical Practice:	

Please note:

- The principal supervising medical practitioners can serve as a supervisor to a maximum of 2 Physician Assistants (including the applicant named in this Practice Plan).
- In the absence of the principal supervisor, the secondary supervisor is expected to fulfil this role. If the absence is for an extended period of time, an appointment of a principal and secondary supervisor is required.

3. Practice Exclusions

There are some activities which a PA is prohibited to undertake:

- Sign a death certificate. A PA may declare 'life extinct' in lieu of the supervising medical practitioner.
- Complete or sign a prescription that is eligible for reimbursement through the Pharmaceutical Benefits Scheme (facility pharmacies), or that will be filled by a private pharmacy.
- Complete or sign a prescription for highly specialised drugs that require medical specialist authority.
- Complete or sign a request for private pathology tests which are eligible for Medicare rebates covered by the pathology table of the *Health Insurance Act 1973*, or that otherwise would be valid if requested by a registered Medical Practitioner holding a valid Medicare Australia Provider Number for a private patient.
- Sign a workers compensation form or a medical certificate for a motor vehicle driver's licence.
- Sign forms that attract a Commonwealth benefit (e.g. Centrelink).
- Perform any medical service, procedure, function or activity, which is outside of the assigned role.
- Work without access to a nominated supervisor.
- Other:

4. Medication Authority

Yes / No	The Physician Assistant has been assessed as competent and is authorised to prescribe and administer including writing medical orders in a patient's medication and history charts. (refer to <i>Assessing Medication Prescribing Competency – Attachment A</i>)
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5. Medication Restrictions

The following 2, 3, 4 & 8 scheduled medications can be prescribed and administered with the following RESTRICTIONS: (complete as required)

Medication Schedule	Level of Supervision (determined by, and oversighted by the supervising medical practitioners)		
	Level 1 <i>All orders approved and co-signed in real time</i>	Level 2 <i>All orders co-signed within 24 hours</i>	Level 3 <i>Random Review</i>
Schedule 2			
Schedule 3			
Schedule 4			
Schedule 8			

The following medications are not permitted except under a written instruction:

(e.g. concentrated electrolytes, insulin and oral hypoglycaemics, NSAIDS, Cytotoxics & immune suppressants, anticoagulants, aminoglycosides)

6. Pathology Authority	
Yes / No	The PA is authorised to request public pathology tests within the approved Queensland Pathology guidelines.
Exceptions/Restrictions:	

Yes / No	The PA is authorised to order blood and blood products.
Exceptions/Restrictions:	

7. Medical Imaging Authority	
The PA is authorised to request medical imaging procedures as follows:	
Yes / No	Plain film x-rays
Yes / No	Ultrasound
Yes / No	Computed Tomography
Exceptions/Restrictions:	

8. Agreement	
I accept and agree to the delegated activities defined within this Practice Plan.	
Physician Assistant Name:	Signed:
	Date:

Principal Supervising Medical Practitioner Name:	Signed:
Registration Number:	Date:

Secondary Supervising Medical Practitioner Name:	Signed:
Registration Number:	Date:

Supplementary Supervising Medical Practitioner Name:	Signed:
Registration Number:	Date:

Supplementary Supervising Medical Practitioner Name:	Signed:
Registration Number:	Date:

9. Approval From Hospital and Health Service Executive Director Medical Services			
<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved		
Signature:			
Name:			
Title:	Date:		

Assessing Medication Prescribing Competency

This is to be completed by the PA and the supervising medical practitioners, and attached to the PA Practice Plan.

Competency Area and Key Performance Indicators	Competent	Comment if No
Date Completed: _____		
Information Gathering		
<ul style="list-style-type: none"> Takes and/ or reviews the medical and medication history and undertakes a physical examination as appropriate. 	Yes / No	
<ul style="list-style-type: none"> Assesses and interprets all relevant patient records to ensure knowledge of patient's management. 	Yes / No	
Prescribing Decision (<i>clinical and pharmaceutical knowledge</i>)		
<ul style="list-style-type: none"> Assesses the potential for unwanted effects (e.g. allergy, drug interactions, special precautions, and contraindications) and how to avoid/ minimise, recognise and manage them. 	Yes / No	
<ul style="list-style-type: none"> Assesses the effect of multiple pathologies, existing medication and contraindications; demonstrating an understanding of the mode of action and pharmacokinetics of medicines how these mechanisms can be altered (e.g. age renal impairment), and effects on dosage. 	Yes / No	
<ul style="list-style-type: none"> Selects the most appropriate medicine, dose, formulation and route for the individual patient. 	Yes / No	
<ul style="list-style-type: none"> Knows the limits of own knowledge and skills, and works within them, referring back to the supervising medical practitioner. 	Yes / No	
<ul style="list-style-type: none"> Establishes multi-professional links with practitioners working in the same specialist area. 	Yes / No	
<ul style="list-style-type: none"> Accesses reference tools (e.g. MIMS and Antibiotic Guidelines) to inform decision. 	Yes / No	
<ul style="list-style-type: none"> Understands the restriction on completing or signing a prescription: <ul style="list-style-type: none"> ~ for highly specialised drugs that require medical specialist authority; ~ that is eligible for reimbursement through the Pharmaceutical Benefits Scheme (facility pharmacies), or that will be filled by a private pharmacy. 	Yes / No	
Communication (<i>appropriate written and verbal</i>)		
<ul style="list-style-type: none"> Writes legible, clear and complete medication instructions (e.g. prescriptions/ written orders) which meet legal requirements. 	Yes / No	
<ul style="list-style-type: none"> Prescriptions and written medication orders are signed by the Physician Assistant, and include printed, stamped or hand printed name of the appropriate supervising medical practitioner. 	Yes / No	
<ul style="list-style-type: none"> Gives clear instructions to the patient about their medication (e.g. compliance requirements, possible side effects, self-administration). 	Yes / No	
<ul style="list-style-type: none"> Explains the nature of the patient's condition, and the rationale behind (including benefits and potential risks) of management options. 	Yes / No	
<ul style="list-style-type: none"> Checks and confirms the patient's understanding of, and agreement to, their treatment. 	Yes / No	
Review		
<ul style="list-style-type: none"> Monitors effectiveness of treatment, and potential side effects. 	Yes / No	
<ul style="list-style-type: none"> Makes changes in light of the therapeutic objective and treatment outcome. 	Yes / No	

Physician Assistant Application for Endorsement

The information provided in this application is for the purpose of verifying and endorsing the Physician Assistant (PA) to practice as outlined in the Practice Plan (attached).

Access to this information is limited to the Hospital and Health Service (HHS) Chief Executive, Executive Director Medical Services (EDMS), Medical Credentialing Committee (or secretariat) and the principal and secondary supervising medical practitioners who are named on the PA Practice Plan.

This form should be completed by the PA, and submitted to the Hospital and Health Service Medical Credentialing Committee within 60 days of their commencement in the role.

Type of Application

- New Application**
 Renewal Application
 Amendment Application

Personal Details

First Name		Last Name	
Previous Name			
Date of Birth		Sex	<input type="checkbox"/> M <input type="checkbox"/> F

Contact Details

Home Address		Work Address	
Home telephone		Work telephone	
Mobile number		Email	

Required Attachment for Renewal and Amendment Applications

- Physician Assistant Practice Plan
 Evidence of Continuing Professional Development activity
 Physician Assistant Clinical Practice Report (as appropriate)

Required Attachments for New Applications

- Curriculum Vitae/professional portfolio
 Copy of professional awards and qualifications
 Copy of international registration/certification/recertification (if relevant)
 Position description/ employment arrangement
 Physician Assistant Practice Plan
 Credentialing and scope of clinical practice of supervising medical practitioners
 Evidence of Continuing Professional Development activity

References

Please nominate professional referees who can comment on your skills and professional performance in the areas for which you are seeking to practice (as identified in the attached Practice Plan):

Name			
Position Title			
Address			
Work Telephone		Mobile Number	
Email			

Name			
Position Title			
Address			
Work Telephone		Mobile Number	
Email			

Agreement

Physician Assistant Name:			
Signed:		Date:	

Principal Supervising Medical Practitioner Name:			
Signed:		Date:	

Secondary Supervising Medical Practitioner Name:			
Signed:		Date:	

Credentialing Committee Endorsement

Physician Assistant	Principal Supervisor	Secondary Supervisor
<input type="checkbox"/> Qualifications	<input type="checkbox"/> Scope of Clinical Practice	<input type="checkbox"/> Scope of Clinical Practice
<input type="checkbox"/> International Registration/ Certification	<input type="checkbox"/> Eligible to Supervise	<input type="checkbox"/> Eligible to Supervise

PA Application is:		
<input type="checkbox"/> Endorsed	<input type="checkbox"/> Not Endorsed	

Signature:			
Name:			
Title:		Date:	

Physician Assistant Clinical Practice Report

This report is comprised of a chart review and a clinical peer review.

This document is primarily formative to promote high standards of patient safety, and it may be used to:

- *Form part of the Physician Assistant (PA) clinical practice review process.*
- *Substantiate a request from the supervising medical practitioner/s to amend the PA required level of supervision, and/ or delegated activities.*

A PA performance should be compared to the expected performance for this level of position as identified in the Job Description, Performance Appraisal Development and Practice Plan.

Date of Report:	
------------------------	--

Physician Assistant	
Practice Location/s:	
Name:	
Contact Telephone Number:	

Primary Supervising Medical Practitioner	
Name:	
Position Title:	
Contact Telephone Number:	

Secondary Supervising Medical Practitioner (as appropriate)	
Name:	
Position Title:	
Contact Telephone Number:	

Please note:

This report does not replace the need for self-monitoring by the Physician Assistant, nor does it abrogate responsibility of the supervising medical practitioners to monitor the case load, competency and clinical practice of the PA.

2. Chart Review

Charts will be reviewed as part of regular supervision practices. Only one report needs to be completed for each group of charts reviewed.

Charts should be selected to ensure a sufficient number and range of clinical presentations is provided. This is to enable the supervising medical practitioner to determine if the PA is properly managing the clinical caseload, as well as to determine if the current level of supervision is appropriate.

It is suggested there be a mix of complex and routine cases. It is also suggested that a number of selected charts should contain pharmacy or prescriptive orders, and orders for pathology and/ or medical imaging tests.

Please note:

Selection of charts should be done in consultation with the PA to provide them with an opportunity to identify their strengths, and any areas where they may consider further assistance and/ or closer supervision would be of benefit.

Number of charts reviewed:	
-----------------------------------	--

Clinical presentations in reviewed charts:

Clinical Chart Review Criterion	Practice Standard		
	Does not meet Standard	Meets Standard	Performs at a high level
Documentation is chronological and contemporary.			
Admission assessment is complete and includes data related to: <i>presentation history, communication, current medications, allergies/ reactions, past medical history, and spiritual/ cultural/ lifestyle/ personal information.</i>			
Bio-psychosocial admission data is complete, including: <i>presenting signs and symptoms, nutrition/ hydration/ elimination, sensory perception/ mobility and alignment, skin integument, sleep patterns.</i>			
Documentation relies on factual, clear, concise, and objective descriptions of events and behaviours.			
Documentation avoids subjective conclusions and interpretations.			
Documentation to the patient chart is sufficiently detailed to make informed clinical decisions.			
Physical examination and clinical assessment is documented, and corresponds to the patient's primary presentation.			
Diagnosis flows logically from the recorded physical examination, formation of a differential diagnosis and clinical assessment.			
Appropriate medical imaging tests are ordered based on recorded diagnosis or diagnostic workup.			
Medical imaging tests are ordered according to relevant protocol.			
Medical imaging results are correctly interpreted.			
Appropriate pathology tests are ordered based on recorded diagnosis or diagnostic workup.			
Pathology tests are ordered according to the relevant protocol			

Clinical Chart Review Criterion	Practice Standard		
	Does not meet Standard	Meets Standard	Performs at a high level
Pathology results are correctly interpreted.			
The treatment/ management plan is appropriate for the identified primary diagnosis.			
The treatment/ management plan takes into account co-existing conditions.			
The treatment/ management plan is appropriate for the management of chronic conditions.			
An appropriate medication regime is prescribed.			
Care is taken in regard to contraindication/ adverse reactions etc.			
Medications are prescribed/ supplied/ administered only according to the relevant protocol.			
Performed procedures are appropriate, and detailed in the chart documentation including patient consent.			
Pre and post-procedure care is detailed in the chart documentation.			
Referrals are made to specialists/ other practitioners and consultation with supervising medical practitioner is documented where appropriate.			
Discharge planning assessment is completed.			

Chart Administration Review Criterion	Practice Standard		
	Does not meet Standard	Meets Standard	Performs at a high level
Documentation recorded in the chart follows facility requirements (e.g. legible, dated, signed)			
Documentation language demonstrates sensitivity and responsiveness to patient characteristics (e.g. culture, age, gender, disability)			
Health care information/ education provided to patient/ family/ carers are recorded.			

3. Peer Review

Peer reviews can be sought from members of the Physician Assistant's multi-disciplinary health care team. Supervisors can provide comment to the following criterion.

Peer Review Criterion	Practice Standard		
	Does not meet Standard	Meets Standard	Performs at a high level
Works effectively with medical staff and other health care professions as a member or leader of a health care team.			
Effectively interacts with the health delivery team and demonstrates responsiveness to the health care system.			
Demonstrates understanding and application of legal and regulatory framework, as well as the appropriate role of the Physician Assistant.			
Demonstrates application of ethical principles pertaining to the provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices.			
Remains accountable for determining when an assigned activity is beyond their capacity or scope of practice, and initiates appropriate consultation with their supervising medical practitioner			
Demonstrates use of evidence based practice in the provision of patient care.			
Demonstrates the use of information technology to manage patient care information, access online medical information, and to support their own professional development.			

4. Recommendations from Review

It is recommended that the following amendments be made to the Physician Assistant's delegated activities and/ or level of supervision:

Area of practice	Delegated Activity Range	Level of Supervision
	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase
	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase
	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase
	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase
	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase
	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase	<input type="checkbox"/> Appropriate <input type="checkbox"/> Decrease <input type="checkbox"/> Increase

Please note:

If the practice plan is to be substantially amended, the HHS EDMS must approve the amendment.

5. Agreement

I accept and agree to the recommendations identified in this report.

Physician Assistant Name:

Signed:

Date:

Principal Supervising Medical
Practitioner Name:

Signed:

Date:

Secondary Supervising
Medical Practitioner Name:

Signed:

Date:

AUSLAB/AUSCARE Clinical and Scientific Information System Physician Assistant Access Request

AUSCARE and AUSLAB are registered trademarks of PJA Solutions Pty Ltd.

Complete sections 1 - 5. PLEASE WRITE LEGIBLY

Tick one option only Create New User Modify Current User De-activate Current User Section 1

Applicant Details: (Complete ALL details. Incomplete details will delay processing of your request) Section 2

Have you previously had access to AUSLAB/AUSCARE? Yes No

If **yes**, what is or was your AUSLAB/AUSCARE login? _____, and do you require a new password? Yes No

QLD Health Employee Number? _____

Surname: _____ Given Name: _____ Middle Initial: _____

Hospital/Health Care Facility: _____

Ward/Clinic: _____
(e.g. Intensive Care Unit / Antenatal)

Phone Number: _____ Fax Number: _____

E-mail Address: _____ @health.qld.gov.au

Security Policy: (Access will NOT be provided if this section is not signed and dated) Section 3

- 1 I have been provided with a copy of and understand the requirements of the Queensland Health Code of Conduct, the Queensland Health Information Security Policy (V.4.0) and Information Standard No. 42A: Information Privacy for the Queensland Department of Health.
- 2 I hereby request access to the Queensland Health Clinical and Scientific Information System (AUSLAB/AUSCARE) and declare that I will abide by the principles of the Queensland Health Code of Conduct, the Queensland Health Information Security Policy (V.4.0) and Information Standard No. 42A: Information Privacy for the Queensland Department of Health.
- 3 In particular I will keep confidential all personal, patient and client information acquired in the course of using AUSLAB/AUSCARE.
- 4 I understand that AUSLAB/AUSCARE contains confidential patient information and access is restricted to enquiries made in the direct course of Queensland Health's mission. Unauthorised access and or use of AUSLAB/AUSCARE will result in loss of access privileges and other remedies available to Queensland Health at law.
- 5 I will regard logins and passwords as confidential and will not share or reveal my login details to another person.
- 6 I understand that all enquiry access is logged and audited.

Applicants Signature: _____ Date: _____

Authorisation Details (Clinical Supervisor): (Access will NOT be provided without Clinical Supervisor authorisation) Section 4

Name: _____ E-mail: _____

Position: _____ Department: _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

I declare that the person described in Section 2 **is treating patients** and requires access to Queensland Health Pathology information. I recommend that the person described in Section 2 be given access to the AUSLAB/AUSCARE Clinical and Scientific Information System.

Office Use Only - SENIOR DIRECTOR – Pathology Queensland Approval: Section 5

The above mentioned officer is authorised to access AUSLAB (add special restriction if applicable)

Signature: _____ Date: _____

Comment: _____

Return completed form to Laboratory Information Systems and Solutions via email or fax:
Email: liss@health.qld.gov.au **Fax:** 07 3000 9330 **Phone:** 07 3000 9333
Address: Technology Office Park, Building No. 4, 107 Miles Platting Road, Eight Miles Plains QLD 4113

Need more information?
LISS Home Page on QHEPS
<http://qheps.health.qld.gov.au/liss/home.htm>

Health (Drugs and Poisons) Regulation 1996

Reprinted as in force on 11 December 2015¹¹

Section	Section relating to the Physician's Assistant	Page No
64AA Physician's assistants (Chapter 2 Controlled drugs)	To the extent necessary to perform duties under a practice plan developed for a physician's assistant, the physician's assistant acting under the supervision of his or her supervising medical officer is authorised to— (a) possess a controlled drug at the place where the physician's assistant practices; or (b) administer, prescribe or supply a controlled drug; or (c) give someone who may administer or supply a controlled drug an oral or written instruction to administer or supply the drug.	62
171A Physician's assistants (Chapter 3 Restricted drugs)	To the extent necessary to perform duties under a practice plan developed for a physician's assistant, the physician's assistant acting under the supervision of his or her supervising medical officer is authorised to— (a) possess a restricted drug at the place where the physician's assistant practices; or (b) administer, prescribe or supply a restricted drug; or (c) give someone who may administer or supply a restricted drug an oral or	152
258A Physician's assistants (Chapter 4 Poisons)	To the extent necessary to perform duties under a practice plan developed for a physician's assistant, the physician's assistant acting under the supervision of his or her supervising medical officer is authorised to— (a) administer, prescribe or supply an S2 or S3 poison; or (b) give someone who may administer or supply an S2 or S3 poison an oral or written instruction to administer or supply the poison.	226
58A Enrolled nurses (Chapter 2 Controlled drugs)	(1) To the extent necessary to practise nursing, an enrolled nurse is authorised to— (b) administer a controlled drug, other than an anaesthetic— (i) on the written instruction of a dentist, doctor, nurse practitioner, physician's assistant or surgical podiatrist; and	57
	(4) To the extent necessary to undergo the course of training, the trainee is authorised to— (b) administer a controlled drug, other than an anaesthetic— (i) on the written instruction of a dentist, doctor, nurse practitioner or physician's assistant; and	58
59A Indigenous health workers (Chapter 2 Controlled drugs)	An Indigenous health worker, while practising in an Aboriginal or Torres Strait Islander community in an isolated practice area in a specified Hospital and Health Service, is authorised— (a) to obtain and possess a controlled drug; or (b) to administer a controlled drug, under a drug therapy protocol, on the oral or written instruction of a doctor, nurse practitioner or physician's assistant.	59
62 Midwives (Chapter 2 Controlled drugs)	To the extent necessary to practise midwifery, a midwife is authorised to— (d) administer or supply a controlled drug— (i) on the oral or written instruction of a doctor, nurse practitioner or physician's assistant; or (ii) under a drug therapy protocol.	61

¹¹ www.legislation.qld.gov.au/legisln/current/H/HealDrAPOR96.pdf

<p>64 Pharmacists (Chapter 2 Controlled drugs)</p>	<p>(1) To the extent necessary to practise pharmacy, a pharmacist is authorised to— (e) for a pharmacist practising pharmacy at a public sector hospital—supply a controlled drug, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or an outpatient of the hospital; or</p>	<p>62</p>
<p>66 Queensland Ambulance Service (Chapter 2 Controlled drugs)</p>	<p>(c) administer or supply a controlled drug to a person— (i) on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant; or (ii) under a drug therapy protocol.</p>	<p>64</p>
<p>67 Registered nurses (Chapter 2 Controlled drugs)</p>	<p>(1) To the extent necessary to practise nursing, a registered nurse is authorised to— (b) administer a controlled drug— (i) on the oral or written instruction of a dentist, doctor, nurse practitioner or physician’s assistant; (2) To the extent necessary to practise nursing in a rural hospital or an isolated practice area, a rural and isolated practice endorsed nurse is authorised to— (a) obtain a controlled drug; or (b) supply a controlled drug to a person— (i) on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant; or (ii) under a drug therapy protocol;</p>	<p>65</p>
	<p>(3) To the extent necessary to practise nursing at a hospital within an isolated practice area, a registered nurse is authorised to supply a controlled drug, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or to an outpatient of the hospital.</p>	<p>66</p>
<p>68 Certain registered nurses at rural hospitals (Chapter 2 Controlled drugs)</p>	<p>(1) To the extent necessary to practise nursing at a rural hospital, the following persons are authorised to supply a controlled drug, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or an outpatient of the hospital—</p>	<p>66</p>
<p>79 Prescribing controlled drugs (Chapter 2 Controlled drugs)</p>	<p>(h) if a doctor, nurse practitioner or physician’s assistant prescribes a dose that is more than the official dose— (i) for a paper prescription—a direction, to dispense the higher dose, that is underlined and initialled by the doctor, nurse practitioner or physician’s assistant; or (ii) for an electronic prescription—an indication that the prescription is for a dose that is more than the official dose; (i) if a doctor, nurse practitioner, physician’s assistant or veterinary surgeon intends that the controlled drug be dispensed more than once—a direction stating— (i) the number of times (after the first) the drug may be dispensed; and (ii) the time that must elapse between each dispensing of the drug;</p>	<p>73</p>
<p>97 Oral instruction must be put in writing (Chapter 2 Controlled drugs)</p>	<p>(1) If, under this chapter, a dentist, doctor, nurse practitioner or physician’s assistant gives an authorised person an oral instruction to administer or supply a controlled drug, the dentist, doctor, nurse practitioner or physician’s assistant must put the instruction into writing within 24 hours after giving the instruction. Maximum penalty—40 penalty units.</p>	<p>97</p>

	<p>(2) If an indigenous health worker, isolated practice area paramedic, registered nurse or midwife acts on the oral instruction of a dentist, doctor, nurse practitioner or physician's assistant and the dentist, doctor, nurse practitioner or physician's assistant does not put the instruction in writing within 24 hours after giving the instruction, the indigenous health worker, paramedic, registered nurse or midwife must report the instruction to—</p> <p>(a) for an instruction given at a hospital—the hospital's director of nursing; or</p> <p>(b) for an instruction given at a detention centre, nursing home or prison—the director of nursing or person in charge of the detention centre, nursing home or prison; or</p> <p>(c) in any other case—the person in charge of the place</p> <p>Maximum penalty—40 penalty units.</p>	97
	<p>(3) If a dentist, doctor, nurse practitioner or physician's assistant contravenes subsection (1)—</p> <p>(a) for an instruction given at a hospital—the hospital's director of nursing must, within 48 hours of becoming aware of the contravention, report the circumstances to the hospital's medical superintendent or the chief executive; or</p> <p>(b) for an instruction given at a detention centre, nursing home or prison—the director of nursing or person in charge of the detention centre, nursing home or prison must, within 48 hours of becoming aware of the contravention, report the circumstances to the chief executive; or</p> <p>(c) for another case—the person given the instruction must, within 48 hours of becoming aware of the contravention, report the circumstances to the chief executive.</p> <p>Maximum penalty—40 penalty units.</p>	98
<p>121 Controlled drugs not to be obtained unless information Disclosed (Chapter 2 Controlled drugs)</p>	<p>(1) This section applies to a person who—</p> <p>(a) consults a dentist, doctor, nurse practitioner, physician's assistant or surgical podiatrist (the <i>earlier practitioner</i>); and</p> <p>(b) obtains a controlled drug or restricted drug of dependency, or a prescription for a controlled drug or restricted drug of dependency, from the earlier practitioner; and</p> <p>(c) consults another dentist, doctor, nurse practitioner, physician's assistant or surgical podiatrist (the <i>other practitioner</i>) within 2 months after consulting the earlier practitioner.</p>	117
<p>162 Enrolled nurses (Chapter 3 Restricted drugs)</p>	<p>(1) To the extent necessary to practise nursing, an enrolled nurse is authorised to—</p> <p>(a) possess a restricted drug at the place where the person practises nursing; or</p> <p>(b) administer a restricted drug, other than an anaesthetic—</p> <p>(i) on the oral or written instruction of a dentist, doctor, nurse practitioner or physician's assistant; and</p> <p>(ii) under the supervision of a dentist, doctor, midwife or registered nurse; or</p>	142
	<p>(4) To the extent necessary to undergo the course of training, the trainee is authorised to—</p> <p>(a) possess a restricted drug under the direction of a registered nurse at the place where the registered nurse practises nursing; or</p> <p>(b) administer a restricted drug, other than an anaesthetic—</p> <p>(i) on the oral or written instruction of a dentist, doctor, nurse practitioner or physician's assistant; and</p> <p>(ii) under the personal supervision of a dentist, doctor, midwife or registered nurse; or</p>	143

164A Indigenous health workers (Chapter 3 Restricted drugs)	An indigenous health worker, while practising in an Aboriginal or Torres Strait Islander community in an isolated practice area in a specified Hospital and Health Service, is authorised— (a) to obtain and possess a restricted drug; or (b) to administer or supply a restricted drug, under a drug therapy protocol, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant.	146
167 Midwives (Chapter 3 Restricted drugs)	(1) To the extent necessary to practise midwifery, a midwife is authorised to— (d) administer or supply a restricted drug— (i) on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant; or (ii) under a drug therapy protocol.	147
171 Pharmacists (Chapter 3 Restricted drugs)	(1) To the extent necessary to practise pharmacy, a pharmacist is authorised to— (e) for a pharmacist practising pharmacy at a public sector hospital—supply a restricted drug, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or an outpatient of the hospital; or	151
174 Queensland Ambulance Service (Chapter 3 Restricted drugs)	(2A) To the extent necessary to perform ambulance duties for the Queensland Ambulance Service, an isolated practice area paramedic at an isolated practice area (paramedics) is authorised to— (a) obtain a restricted drug; or (b) possess a restricted drug at a place in the isolated practice area (paramedics); or (c) administer or supply a restricted drug to a person— (i) on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant; or (ii) under a drug therapy protocol.	155
175 Registered nurses (Chapter 3 Restricted drugs)	(1) To the extent necessary to practise nursing, a registered nurse is authorised to— (a) possess a restricted drug at a place where he or she practises nursing; or (b) administer a restricted drug— (i) on the oral or written instruction of a dentist, doctor, nurse practitioner or physician’s assistant; or (ii) on the written instruction of a surgical podiatrist; or (iii) to the person for whom it has been dispensed under the instructions stated by the dispenser.	158
	(2) To the extent necessary to practise nursing in a rural hospital or an isolated practice area, a rural and isolated practice endorsed nurse is authorised to— (a) obtain a restricted drug; or (b) supply a restricted drug to a person— (i) on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant; or (ii) under a drug therapy protocol; or (c) administer a restricted drug to a person under a drug therapy protocol.	158
	(2A) To the extent necessary to practise nursing at a hospital within an isolated practice area, a registered nurse is authorised to supply a restricted drug, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or to an outpatient of the hospital.	158

176 Certain registered nurses at rural hospitals (Chapter 3 Restricted drugs)	(1) To the extent necessary to practise nursing at a rural hospital, the following persons are authorised to supply a restricted drug, on the oral or written instruction of a dentist, doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or an outpatient of the hospital— (a) the hospital’s director of nursing; (b) a registered nurse nominated by the hospital’s director of nursing.	160
190 Prescribing restricted drugs (Chapter 3 Restricted drugs)	(2) The following particulars must appear on the front of a paper prescription or in an electronic prescription— (h) if a prescriber, other than a veterinary surgeon, prescribes a dose that is more than the official dose— (i) for a paper prescription—a direction, to dispense the higher dose, that is underlined and initialled by the doctor, nurse practitioner or physician’s assistant; or (ii) for an electronic prescription—an indication that the prescription is for a dose that is more than the official dose;	173
263 Registered nurses (Chapter 4 Poisons)	(3) To the extent necessary to practise nursing at a hospital within an isolated practice area, a registered nurse is authorised to supply an S2 or S3 poison, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or to an outpatient of the hospital.	230
263A Certain registered nurses at rural hospitals (Chapter 4 Poisons)	(1) To the extent necessary to practise nursing at a rural hospital, the following persons are authorised to supply an S2 or S3 poison, on the oral or written instruction of a doctor, nurse practitioner or physician’s assistant, to a person being discharged from the hospital or an outpatient of the hospital— (a) the hospital’s director of nursing; (b) a registered nurse nominated by the hospital’s director of nursing.	231
Appendix 9 Dictionary	<i>physician’s assistant</i> means a person— (a) appointed by the chief executive, and employed by the department, as a physician’s assistant; or (b) appointed by a Hospital and Health Service, and employed by the Service, as a physician’s assistant.	311
	<i>practice plan</i> , for a physician’s assistant, means a document that— (a) is developed and signed by a physician’s assistant and his or her supervising medical officer; and (b) states the circumstances and conditions for a physician’s assistant to use a controlled drug, restricted drug or poison; and (c) is in a form approved by the chief executive.	312
	<i>supervising medical officer</i> , for a physician’s assistant, means a person who— (a) is a medical practitioner; and (b) supervises the work performed by the physician’s assistant in his or her employment in the department or a Hospital and Health Service.	316
	Physician’s assistants s 64AA ins 2008 SL No. 422 s 7	335
	Physician’s assistants s 171A ins 2008 SL No. 422 s 20	342
	Physician’s assistants s 258A ins 2008 SL No. 422 s 27	350
	def “ physician’s assistant ” ins 2008 SL No. 422 s 30 sub 2012 SL No. 90 s 41 sch	359

Physician Assistant – Clinical Governance Guideline
Published by the State of Queensland (Queensland Health), March 2016