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GAYLE'S LAW REVIEW

ACKNOWLEDGMENTS

In the spirit of respect, the reviewers acknowledge the people and the Elders of the Aboriginal and Torres Strait Islander Nations who are the Traditional Owners of the land and seas of Australia, and value the contribution that Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal and Torres Strait Islander midwives, nurses, health practitioners, health services managers, leaders and community members make to health care delivery in remote areas of South Australia, generating new ideas and innovative solutions to improving health in general and have made specific to this review.

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GAYLE'S LAW REVIEW

Review of the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017 and the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (no 2) Variation Regulations 2019

May 2021

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EXECUTIVE SUMMARY

INTRODUCTION

This independent review was undertaken to determine whether the implementation of Gayle's Law and associated Regulations has achieved the intended objective of providing better protection for health practitioners working in remote areas of South Australia, and minimising risks to their personal safety.

The South Australian Parliament passed the *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act*, which is more commonly referred to as 'Gayle's Law', in response to the tragic death of Gayle Woodford, a dedicated nurse who was murdered while working in a remote community in South Australia. The Law and associated Regulations were enacted on 1 July 2019, with amendments to the Regulations enacted in November 2019. Under Gayle's Law, health service providers who employ health practitioners in a remote area must ensure that a second responder accompanies and remains with the health practitioner when attending an out of hours callout or unscheduled callout. The second responder accompanies the health practitioner on these types of callouts to reduce the chances of personal attack.

The Act and the Regulations also included the requirement for the Act to be reviewed, with Regulation 11H (2) setting out that the review must be completed after the first anniversary of the commencement of the 2019 Variation, but no later than 6 months after that anniversary, and that a report of the review is to be tabled in Parliament by the Minister for Health and Wellbeing (the Minister).

In conducting the review, Flinders University assessed the operation of the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017 and the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No 2) Variation Regulations 2019. This included assessing whether: health service providers had implemented the Act and Regulations as intended; the impact that the Act and Regulations have had on the safety of health practitioners, persons providing health services; and the provision of health services to members of the community in the remote areas of South Australia covered by the Act and the Regulations.

The review examined key provisions within the Regulations relating to the requirements for people engaged as second responders; circumstances under which a second responder is required and not required; and minimum requirements to be covered in organizational policies and procedures. In addition, the review considered whether any amendments to the Act or Regulations would improve their operation.

This executive summary provides an overview of the scope of the review, the methodology, and outcomes with key findings. It makes recommendations, including potential amendments to the Act or Regulations, which could improve their operation. The recommendations arising from the review aim to strengthen the effectiveness of existing arrangements for promoting and ensuring the safety of health practitioners and persons providing health services in remote areas of South Australia.

SCOPE OF THE REVIEW

Terms of Reference

The South Australian Government Department for Health and Wellbeing commissioned the review with the following Terms of Reference:

The objective of the Act and Regulations is to provide greater protection for health practitioners and persons providing health services in remote areas of South Australia, by requiring a second responder to accompany them on out of hours and unscheduled callouts. The role of the second responder is to minimise the risk of personal attack on the health practitioner.

The Act and Regulations require that a review is to occur, with the review to consider in particular:

1. whether health service providers have implemented the Act and Regulations as intended;
2. the impact that the Act and the Regulations have had on the safety of health practitioners and persons providing health services in the remote areas of South Australia;
3. the impact that the Act and Regulations have had on members of communities, and the provision of health services in remote areas of South Australia;
4. whether health service providers have suitable mechanisms in place for the recruitment of appropriate second responders to allow services to be provided to the community;
5. the usage of prescribed circumstances in Regulation 11E(2) under which unaccompanied remote area attendance may occur;
6. whether the prescribed circumstances in Regulation 11E, which outline certain circumstances where a second responder will already be in attendance, operate effectively and whether any amendments to the Act or Regulations would improve their operation;
7. the number of instances when a health service has not been provided due to the unavailability of a second responder/alternative responder, and whether this has resulted in any impact on the health practitioner, health service provider or the person seeking a health service.

Health Services Providers (TOR1)

Gayle's Law, and therefore the scope of this review, applies to health services provided by:

- the South Australian Government;
- any person or organisation contracted to provide the service on behalf of the South Australian Government;
- any person or organisation funded, wholly or in part, by the South Australian or Commonwealth Governments to provide the service;
- local councils providing services in remote areas;
- privately practising doctors, nurses, or midwives.

A list of Health Services Providers covered by this review appears as Appendix 4.

Health Practitioners and persons providing services (TOR2)

Gayle's Law, and therefore the scope of this review, applies to any *health practitioner* or *person who provides a health service* in response to an *out of hours or unscheduled callout* in a remote area of South Australia. This includes the services provided by health service providers listed in Appendix 4.

Health practitioner categories are listed in the Definitions. With the introduction of Gayle's Law, a person who provides a health service also includes a person performing the role of second responder.

Under the scope of this review:

- *out of hours callout* is a request for attendance of a health practitioner between 5:00pm and 8:00am, or any time on a Saturday, Sunday or public holiday;
- *unscheduled callout* is request for the attendance of a health practitioner within 24 hours of the request.

Remote Areas of South Australia

Gayle's Law, and therefore the scope of this review, applies to the part of South Australia that covers:

- an area not covered by a local council under the Local Government Act 1999;
- the lands within the meaning of the Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981;
- the area of the District Council of Coober Pedy; and
- the area of the Municipal Council of Roxby Downs.

A map of the areas covered by the review appears as Appendix 5.

METHODOLOGY

This is a complex and sensitive project with key stakeholders including the South Australian Government, the Australian Government, government and non-government health service providers, Aboriginal Community Controlled Health Organisations (ACCHOs), health practitioners, second responders, and professional and industrial organisations. The review is also of interest to other Australian jurisdictions where health services are provided to populations living in remote areas.

The Woodford family, who has campaigned tirelessly for the improvement of the safety and security of health practitioners working in remote Australia, was advised of, and supported the appointment of Professor Aitken and her team to conduct the review.

The findings and recommendations of this review are not simply reflections by, or the opinions of the authors. They are the product of a rigorous evaluation process based on the analysis of a wealth of data collected using a variety of methods, from a significant number of stakeholders, survey respondents, key informants, literature, and documentation. This multifaceted process provided an evidence-based approach to answering the questions posed in the Terms of Reference, as well as providing the opportunity to explore some unintended consequences of the Act and Regulations.

The data collection process included:

- Background briefings from the Department for Health and Wellbeing, the Woodford family and the Woodford family legal counsel;
- Background Literature review (see Appendix 6);
- An expert stakeholder reference group convened twice during the period of the review (see Appendix 7);
- Health Services Policies/Procedures/Guidelines review and mapping for compliance with the Act and Regulations (see Appendix 8);
- Development and distribution of a Health Service Provider audit tool, Health Practitioner Survey and Second Responder Survey to gain information about health service and health practitioner practices (see Appendix 10a, b & c); and
- Key informant interviews with a small number of health practitioners, second responders, health services providers, and representatives from professional and industrial bodies.

Policy officers in the Department for Health and Wellbeing also assisted the review team by providing documentation and performance data from health service providers that had been previously requested by the Minister, and information requested contemporaneously by the review team.

OUTCOME – KEY FINDINGS AND RECOMMENDATIONS

Preamble

The tragic death of Gayle Woodford in 2016, a registered nurse in South Australia, placed a spotlight on the working and living conditions of health practitioners in remote Australia. It raised the awareness of the nature of remote health practice, remote health service delivery and the health outcomes of Australian remote and Indigenous populations. It created a groundswell to take action to improve the safety of health practitioners. With a commitment to taking action, the Government of South Australia introduced Gayle's Law to ensure that health practitioners into the future were safe when providing care during unscheduled and out of hours callouts in remote communities.

The findings and recommendations presented in this report arise from analysis of data from multiple sources and although presented under the Terms of Reference of the review, there is some overlap across the parameters and the suggested actions. Similarly, although Gayle's Law and this review focuses on improving safety when health practitioners attend unscheduled and after-hours callouts, some of the recommendations are broader because the findings have revealed that there are safety concerns for health practitioners (and now second responders) that are related to the unique context of the remote communities to which the Law and Regulations apply that go beyond these callout situations. In addition, there are some findings of this review that extend beyond safety matters, and highlight the interplay between safety and clinical risk, and can apply beyond the remote context. The review team has made note of these issues, but limited recommendations to the core function of the Act and Regulations.

Whilst there are recommendations for some amendments to the Act and Regulations, many of the findings relate to the adequacy and degree to which policies/procedures/guidelines are implemented in practice, and the nexus between the two. Accordingly, where possible, recommendations have been made to strengthen the likelihood of these policies/procedures/guidelines working on-the-ground. It is important to note that neither findings nor recommendations are service specific because the focus of the review was on the implementation of the Act and the Regulations, not the performance of the services. However, some of the recommendations are related to the financial implications of implementing measures to improve safety when the contribution of financial resources can determine the success of the same.

1. Have health service providers implemented the Act and Regulations as intended?

This review found that there has been a genuine commitment from health service providers to implement the provisions of Gayle's Law and the associated Regulations as intended. There are some areas that can be improved through internal health services review processes, and there are some proposed amendments to the legislation that may assist with improving implementation.

Implementation of second responders

Data from all sources confirms that all health service providers, within the geographical location and type of service under the jurisdiction of Gayle's Law, have engaged people who are rostered or available as second responders to accompany a health practitioner when they attend an unscheduled and/or out of hours callout. Some second responders are employed in other roles in the health clinic/centre, including ancillary staff and health practitioners, or are employed by other organisations. They may or may not have health related qualifications, skills, experience and/or knowledge, and may be employed only for callout duties.

Whilst the clinical capabilities possessed by second responders was in part due to pragmatics relating to the potential pool of people available to perform the role, the review found that the nomenclature of 'second responder' also influenced the relative contribution that second responders make to clinical care and health practitioner safety. That is, some health service providers, health practitioners, and second responders expected that the role of the second responder extended beyond ensuring safety of the health practitioner to also include assisting with provision of care, which was not the intention of the Law and Regulations.

'Second responders' is a name most commonly given to personnel who are members of disaster management teams. They are the personnel who arrive when the danger is eliminated, the initial trauma is concluded, and the physical threat is gone, operating during the response and recovery phase of an emergency once the first responder has done their initial work to make the area safe. Such second responders often possess a specific skill set matched to the work that they are required to undertake, and may or may not work alongside the first responder (McNally, 2014).

The term 'second responder' as used in Gayle's Law and Regulations implies a similar chronological sequence of attendance at callouts, and hierarchical order of response, including that Clause 77E(2) exempts the second responder from accompanying the health practitioner during the journey to a callout e.g. a health practitioner is a 'first responder', met by a second responder at the callout site.

Together, the widely known role of a second responder in a disaster management team and the way that the second responder is referred to in Gayle's Law/Regulations has led to variability in the expectations of the second responder role and responsibilities. The review found that the expectation that the second responder possess some capacity to assist with health services provision has had an impact on the cost of implementation in some health services; has had a negative impact on meeting the intended outcome of health practitioner safety; has potential unintended consequences for the safety of the second responder; and delivery of core clinical services during and following a callout.

On the other hand, consistent with the intention of the Act/Regulations to ensure safety of the health practitioner, one health service provider employs a 'second responder' (as described in the

Act) as a support worker who is the 'first person/responder' who engages with the callout request. Although this approach is a positive initiative for minimising risk for the health practitioner, the review found that it also had some unintended consequences. There was potential for community members to expect a clinical response from the support worker; the support worker to triage clinical risk; the support worker to attend a callout alone; and for community members to attend the support worker's home to initiate a callout.

In order to better achieve the intended outcome of Gayle's Law, the Review Team recommends that clear and unambiguous language is used in the Law, Regulations, and health service provider policies, procedures and guidelines to ensure that no-one is ever alone during a callout and that the goal is personal safety of all staff involved. Changing the name of the second responder to a 'Safety Worker' which would then describe the intended role could address the lack of clarity around the role. The findings identified that an employed model for engaging the second person is the most effective and preferred method of engagement, so inclusion of the title 'worker' is appropriate.

RECOMMENDATION 1.1

The Minister gives consideration to amending Gayle's Law and Regulations by replacing the term 'second responder' with a named role reflective of the safety function of the (second) person designated to accompany the health practitioner who has the primary function for providing a health service.

RECOMMENDATION 1.2

The Department for Health and Wellbeing, given the variability of the current content of policies, procedures and guidelines, develop and distribute a template document(s) to assist health service providers to include all relevant elements of the Act and Regulations in revised procedural document(s). The template document needs to ensure that policies/procedures/guidelines clearly articulate:

- the distinction between assessment of risk of health practitioner safety and clinical risk;
- that risk assessment is undertaken to determine attendance by anyone, not the need for a second responder (safety worker);
- that the trigger for a second responder (safety worker) to accompany the health practitioner during a callout is the health practitioner's decision to attend the callout, (i.e. a second responder should attend all callouts, there is no threshold at which a second responder is not required);
- the explicit prohibition of health practitioners being directed to attend callouts without a second responder;
- limitations to liability for not attending a callout if a second responder is not available;
- mechanisms to ensure safe return home (or to another destination) of both health practitioner and second responder; and
- the safety provisions included in Recommendations 2.2, and 2.4.

RECOMMENDATION 1.3

Notwithstanding the suggested role of the Department for Health and Wellbeing, health service providers review their existing policies, procedures and guidelines to include all relevant elements of the Act and Regulations and Recommendations 1.2, 2.2 and 2.4.

2. What is the impact that the Act and the Regulations have had on the safety of health practitioners and persons providing health services in the remote areas of South Australia?

The Review Team found that the Act and Regulations have significantly improved the safety of health practitioners providing health services in remote areas of South Australia while at the same time maintaining callout service provision. Participating health services reported that a 100% response rate was achieved for all callout requests that meet the threshold of clinical risk.

This balance between safety and service delivery requirements has been achieved through:

- health service providers employing second responders and/or rostering existing staff as second responders to accompany health practitioners during unscheduled and out-of-hours callouts;
- implementing procedures/guidelines to ensure that health practitioners and second responders always travel together to a callout in a fit-for-purpose vehicle;
- developing personal safety risk assessment guidelines.

Achieving this balance has also had some positive benefits for health practitioner's mental health and wellbeing.

The review identified that there is still some scope for further improvement to minimise risks to personal safety as there is no requirement for an accompanying second person during the daytime i.e.:

- when patient(s) are being transported (e.g. to and from airports);
- at the health clinic/centre during business hours;
- at the health practitioner or second responder's home at any time;
- at a scheduled visit to a patient's home.

The review also identified that risks to personal safety at the health practitioner's home/accommodation where communication is largely limited to a mobile phone were of concern to some of the interviewed respondents. These respondents identified that in some places the health service vehicle is parked after hours at the health practitioner's home/accommodation. It was explained that the parked vehicle advertises the presence of the health practitioner, and community members seeking assistance will go to the home where the vehicle is located rather than use other communication strategies. At one health service, this risk has been transferred to the second responder, who assumes the role of first contact for out-of-hours callouts.

Participants in the review reported occasions where health practitioners attended callouts without a second responder. Evidence provided by five of the ten relevant South Australian health service providers found that there were occasions when health practitioners had attended a callout without a second responder. In all of these cases the health practitioner followed procedure and used a risk assessment tool, assessed there to be low risk, and there were no untoward outcomes reported.

The respondents to the review identified that there is minimal police presence in remote South Australian communities. When the callout is for attendance at a Police Station, the health practitioners reported that they always engaged a second responder even when there is police presence. The same applies for attendance at accident scenes when emergency workers are present. The engagement of second responders at these sites was based on clinical risk assessment rather than person safety risk assessment.

Despite evidence that health services providers have developed personal risk assessment policies, procedures, guidelines and tools, health practitioners' and second responders' participation in orientation to resources relevant to Gayle's Law was found to be variable. It was often self-directed, and there were limited compliance checks and/or a requirement for regular review. Health practitioners' knowledge about Gayle's Law itself was found to be largely reliant on on-line information rather than the source, the Act and Regulations. The potential for low levels of orientation may increase the likelihood that health practitioners and second responders have limited knowledge about ensuring their own personal safety.

There appears to be two consequences of these low knowledge levels. The first is that health practitioners continue to base the need for a second responder on the assessment of clinical risk (see TOR1 above). The second consequence is that there is a high expectation that second responders should be equipped with health/clinical skills so that they can assist in health care delivery during a callout. Role confusion is highlighted in TOR1, and the expectation for such qualifications and experience is not supported by the Review Team due to the potential loss of focus on safety that such a change would precipitate. The Review Team does not believe that such a change is consistent with the intent of Gayle's Law.

Clinical support for the health practitioner during a callout should be managed through clinical procedures/guidelines which ensure that there is additional clinical support available when required. Such clinical support may be a second on-call health practitioner in addition to the second responder, and/or off-site health practitioner support (e.g. telehealth, phone consultation).

Health service providers, health practitioners and second responders can assist in addressing some of the identified barriers to achieving the intended outcome of Gayle's Law through introduction and application of policy, procedure/guidelines and supporting all staff to be orientated to Gayle's Law and relevant organisational resources and adopting all of these into on-the ground practice. Community members can also play a role by not requesting assistance at the health practitioner or second responder's home/accommodation (see TOR3).

Commencing and concluding a callout

As described in the SA Deputy Coroner's inquest findings (Schapel, 2021), the trigger for Gayle Woodford engaging with the person subsequently convicted of her rape and murder (Dudley Davey), may have been a request for medical assistance (an out-of-hours callout) at her home/ accommodation. As described above this situation has not changed since the implementation of

Gayle's Law. Health practitioner and second responder participants in the review (34% and 40% respectively) identified that community members/people seeking health care services continue to present at health practitioners' homes/accommodation to request an unscheduled or out-of-hours callout. Interviews with health practitioners and second responders, expert reference group members and key informants also confirmed that this practice occurs, and in the case of one health service, callouts can also be initiated at the second responder's home. As described in TOR3 below there is an opportunity for community members and health services consumers to influence this practice and refrain from seeking assistance at the health practitioner's home/accommodation.

There is also scope for health service providers to preclude delivery of health care at the health practitioner's and second responder's home/accommodation through policy and procedural guidelines. Two health service providers have callout request systems whereby community members/health consumers call a central dispatch number and there is an intermediary between the caller and the health services practitioner who assesses for both clinical and safety risk. Other health services have an on-call phone number that diverts to the health practitioner's mobile phone. The health practitioner and the second responder then travel together to provide care at the health clinic, or at the person's home. The advice of the Deputy State Coroner was that precluding callout requests at staff homes would mitigate one of the safety and security issues that played a critical role in Gayle Woodford's death (Schapel, 2021). The findings of this review support this advice.

The review revealed that some respondents held a strong opinion that the amendments to the Act and Regulations should broaden the scope of a second responder (a second person) attending all sites (including the health clinics/centres and health practitioner homes/accommodation), and not just for unscheduled or out of hours callouts, and also at any time of the day or night when health care is required. These opinions were backed up by examples of risks to personal safety that had occurred in the last 12 months during scheduled callouts, at the health clinic/centre, at the health practitioner's home and during the day at any of these sites.

The nature of risk does not change at these times or places or for the respective responders. Health service providers are encouraged to take policy and practice initiatives to reduce the identified risks to the health practitioner. The current Act and Regulations do not entirely achieve the intended outcomes of Gayle's Law, without a provision to ensure safe return home for the health practitioner.

While Regulation 11D5 includes provisions to ensure safe return home for the second responder, the same provision is missing for the health practitioner. Based on the policies, procedures/guidelines reviewed, which are also largely silent on reporting safe conclusion of the callout, the Review Team identify that this omission needs to be rectified if the intent of Gayle's Law is to be achieved.

The review has identified that implementing Gayle's Law and Regulations to date has come at a financial cost for health service providers. For the most part, health service providers report that any increase in funding that they have received has not offset the increased costs associated with employing additional staff, paying additional overtime/on-call salaries, and investing in fit-for-purpose communication and safety equipment. According to the respondents these budgetary pressures have impacted negatively on business hours service delivery capacity. There was no evidence provided that there was a collaborative scoping/business case developed prior to the implementation of the current Act and Regulations. These concerns were expressed by some respondents. However, it is appreciated that extending the scope of the Act will have a further financial impact on health services delivery capability. The Review Team encourages the SA

Department for Health and Wellbeing, in collaboration with the Australian Government Department of Health, health service providers and community members to undertake financial modelling for both the current and future iterations of Gayle's Law and implement appropriate funding accordingly.

The value of the expert reference group in bringing stakeholders together to share information about successful strategies and to discuss the broader concerns identified by respondents about clinical risk, health service delivery and working conditions has been of use to all members. The Review Team suggests that consideration be given to bringing together a steering group/advisory group that spans government, non-government and Aboriginal Community Controlled Health Organisations (ACCHOs) and includes health practitioners, second responders and community members to continue this collaboration into the future.

Of note is that one health service has implemented Gayle's Law with the second responder being the first point of call for callouts, therefore all of the risks and the recommendations described below relate equally to this community member/health services employee as they do to health practitioners. Accordingly, all recommendations include provisions for improving the safety of both health practitioners and second responders (safety workers) irrespective of who responds first or second to a callout, or any episode of health service provision.

RECOMMENDATION 2.1

The Minister consider amending the Act and Regulations to improve the safety of the health practitioner and accompanying second responder by:

- extending the requirement for a second responder (safety worker) attendance beyond the current scope of unscheduled and out of hours callouts to **also** apply to the following:
  - scheduled callouts at any time of the day or night;
  - during the journey to all callout locations;
  - in the untoward event that health services are delivered at the health practitioner's home/accommodation; and
  - all other occasions of health services delivery in a remote area where there is an identified risk to personal safety, irrespective of location and inclusive of the health services facilities.

RECOMMENDATION 2.2

Notwithstanding the requirements contained within the current Act and Regulations, health service providers amend health service policies and procedures/guidelines to ensure that health practitioners are always accompanied by a second responder (safety worker):

- when attending both unscheduled and scheduled callouts at any time of the day or night;
- during the journey to all callout locations;
- in the untoward event that health services are delivered at the health practitioner's home/accommodation; and
- on all other occasions of health services delivery in a remote area where there is an identified risk to personal safety, irrespective of location and inclusive of the health services facility.

RECOMMENDATION 2.3

State and Australian Government Departments of Health give consideration to working with health service providers and community members to develop a business plan to invest funding to support both current business and any future extensions to the Act and Regulations to create a sustainable second responder workforce and well equipped and maintained equipment in health clinics, health worker accommodation and vehicles.

RECOMMENDATION 2.4

Health service providers, in order to decrease the risks posed by presentations for health care at the health practitioner's (or second responder's) home/accommodation:

- review and amend the policies, procedures/guidelines to preclude delivery of health care at the health practitioner's or second responder's home at any time of the day or night;
- implement communications systems that replace the need for in-person callout requests;
- co-design a communication strategy with community members to change the practice of attending the health practitioner's home to request care at any time of the day or night.

RECOMMENDATION 2.5

Health service providers, in order to improve health practitioner safety should:

- improve orientation procedures;
- encourage health service managers and staff to become familiar with the Act and Regulations rather than rely solely on information that interprets the application of the Act/Regulations;
- require that orientation of all health clinic managers, health practitioners, ancillary staff, visiting staff, and second responders, include a face-to-face component conducted by a relevant supervisor;
- implement the following orientation requirements for policies/procedures/guidelines relevant to Gayle's Law:
  - include the requirement for orientation as mandatory on commencement of employment, and as part of annual competency requirements;
  - include policies and procedures relevant to Gayle's Law in pre-employment documentation, first day induction checklists and require evidence of completion within the first month; and
  - document compliance with requirements in employment records and confirm prior to commencing callout duties.

RECOMMENDATION 2.6

The Minister consider broadening the Act and Regulations to apply beyond the remote setting to all callout activities (scheduled and unscheduled) undertaken by health practitioners delivering care in any location at any time of day and night in South Australia.

RECOMMENDATION 2.7

South Australian health service providers in areas other than remote locations notwithstanding the requirements contained within the current Act and Regulations, consider adopting the safety recommendations of this review.

RECOMMENDATION 2.8

The Minister consider sharing the findings of this review with other Australian Ministers for Health to consider adopting Gayle's Law and Regulations (with recommended revisions) to apply to remote areas in all Australian States and Territories.

RECOMMENDATION 2.9

South Australia (SA) Health in its role in development of best health care practices consider bringing together a steering/advisory group that spans government, non-government and Aboriginal Community Controlled Health Organisations (ACCHOs) and includes health practitioners, second responders, professional and industrial organisations, and community members to inform and develop ongoing quality improvement processes for implementing Gayle's Law and Regulations.

RECOMMENDATION 2.10

The Minister consider amending Gayle's Law and Regulations to ensure that the current provisions of Clause 77D(3)(b) apply to both second responders (safety workers) and health practitioners in respect to safe arrival at their place of residence or other destination after leaving the callout location.

3. What is the impact that the Act and Regulations have had on members of communities, and the provision of health services in remote areas of South Australia?

Based on the data gathered for this review, the implementation of Gayle's Law Act and Regulations has had a positive impact on health and wellbeing of community members. Not only has the Act and Regulations ensured that an effective callout service is in place, but the engagement of local people in some services as second responders has provided employment opportunities, and potentially career pathways into health for community members. In some communities there is also evidence of a growing sense of 'whole of community' responsibility for health practitioner safety. These factors suggest that there is potential to further enhance health practitioner safety through codesign of strategies to optimise utilisation of health clinics/centres during business hours, minimise callouts, and change community practices whereby community members no longer present at the health practitioner's home/accommodation for health care.

Some negative impacts on provision of health services to community members was reported. When callouts involve health services staff as second responders, business hours service provision may be decreased. That is, a 'cost' associated with second responders in the majority of health clinics/centres with small staffing numbers, in periods where the health centre/clinic is closed for routine health care. Increasing the number of non-clinical second responders through further community employment opportunities would assist in minimising this disruption to health services during business hours. However, additional funding would likely be required for this initiative.

RECOMMENDATIONS 2.1, 2.2 and 2.4 address these findings.

4. Do health service providers have suitable mechanisms in place for the recruitment of appropriate second responders to allow services to be provided to the community?

The review has found that health service providers have suitable mechanisms in place to both recruit people to the role of second responder and recruit persons fulfilling the role to accompany a health practitioner when they attend an unscheduled and/or out of hours callout.

There are however some difficulties in recruiting enough second responders, but the requirements for driver's license, and working with children clearance, did not appear to be a barrier to recruitment as a second responder. One barrier is the differing opinions about what constitutes appropriate skills, knowledge and experience for the second responder role, as previously discussed. This relates to a tension between ensuring health practitioner safety and minimising clinical risk. Employing second responders with first aid or volunteer ambulance skills (Cert II & III) was seen as the preferred model by many health practitioners.

Some respondents identified that the advantages of employing a second responder (or utilising existing health centre staff) with clinical skills ranged from being familiar with the equipment and therefore able to maintain stocks, easily performing equipment cleaning and maintenance and to rapidly respond to health practitioner requests. In one health service where the 'second responder' is the 'first person' responding to a callout, being able to assess, provide and administer care was seen as an advantage in terms of improved health outcomes.

The review identifies that there are concerns with this approach to the second responder role. Not only is there potential for a mismatch between second responder capability and (high) community expectations, but the second responder may instead be seen as a substitute health practitioner. There is also the potential for the second responder to be distracted from their role in maintaining safety and security, and therefore not achieve the intention of Gayle's Law.

RECOMMENDATION 4.1

Health service providers give consideration to the balance between risks and the benefits when employing second responders with entry level health care skills and continue to develop health workforce models that are responsive to local need and the unique conditions of remote health service delivery.

Health services consider working collaboratively with State and Australian Government Departments of Health and communities to develop a business model to expand funding to health service providers for sustainable employment of second responders in part time health service roles.

5. What is the usage of prescribed circumstances in Regulation 11E (2) under which unaccompanied remote area attendance may occur?

The review found that although respondents identified that health practitioners attended the prescribed sites of Police Stations and emergencies attended by emergency workers, they did not report attending alone/without a second responder, which is the provision under Regulation 11E(2).

The rationale for not taking up the exemption provided by 11E(2) was that there was just as much risk to safety during the journey to attend the Police Station or the scene of an emergency that a second responder was necessary for the journey. Second responders were also considered to be helpful during the health service encounter as police were often busy and/or in the opinion of some respondents, the second responder was more skilled to assist.

Based on the principles upon which Gayle's Law is based – that is, better protection for health practitioners working in remote areas of South Australia and the need to reduce the chances of personal attack - there is a strong argument that for safety purposes both Regulation 11E (2) be amended to ensure that health practitioners are accompanied by the second responder at any site, and at any time, including during **any** journey to the location where the callout service is to be provided.

RECOMMENDATION 5.1

The Minister consider amending Gayle's Law and Regulations to remove prescribed locations to ensure that health practitioners are accompanied by a responsible person en-route on any callout regardless of the time of day or night.

6. Do the prescribed circumstances in Regulation 11E, which outline certain circumstances where a second responder will already be in attendance, operate effectively and are there any amendments to the Act or Regulations that would improve their operation?

Based on the principles upon which Gayle's Law is founded, that is, better protection for health practitioners working in remote areas of South Australia and the need to reduce the chances of personal attack there is a strong argument that for safety purposes that Clause 77E (2) of the Act be amended to ensure that health practitioners are accompanied by the second responder at any site, and at any time, including during **any** journey to the location where the callout service is to be provided.

RECOMMENDATION 6.1

The Minister consider amending Clause 77E (2) to ensure that health practitioners are always accompanied by a second responder (safety worker) during the journey to all callout locations.

(See also Recommendation 2.1)

7. What is the number of instances when a health service has not been provided due to the unavailability of a second responder/ alternative responder, and has this resulted in any impact on the health practitioner, health service provider or the person seeking a health service?

Health service providers reported that they have achieved 100% service for callouts over the past 12 months, having no occasions when a health service has not been provided without a second responder/alternative responder.

As described in Terms of Reference three, above, there have been some negative impacts on provision of health services to community members by health practitioners responding to callouts 100% of the time. Particularly in cases when callouts involve health services staff as second responders, business hours service provision may be decreased. On the other hand, health practitioners have described that where non-clinical staff have been employed as second responders, it has significantly reduced the burden of callouts on clinical staff and diminished the associated fatigue.

As described in recommendation 4.1 there is a need to continue to develop health workforce models that are responsive to local need and the unique conditions of remote health service delivery.

RECOMMENDATION 7.1

State and Australian Government Departments of Health give consideration to working collaboratively with health services and communities to develop a business model to expand funding to health service providers for sustainable employment of non-clinical second responders.

8. Other potential amendments to the Act or Regulations which could improve their operation

The ongoing evaluation of the operation of the Act and Regulations is warranted in order to assess the effectiveness of any recommendations that are adopted from this review, and as best practice for ensuring that the Act remains contemporary and fulfils its intended purpose. As articulated in the limitations section of the report, there were a number of challenges to conducting this review. Two specific challenges also have the potential to affect ongoing evaluation, but could potentially be addressed by the Minister.

Evidence of health service compliance

One of the challenges to conducting the review was that there is no requirement within the Regulations for health service providers to supply evidence of compliance with the Act and Regulations. That is, the review team relied on health service providers volunteering documented information and self-reporting data. There are precedents under other Acts whereby records required under the Act must be available for inspection (e.g. South Australia Work Health and Safety Regulations, 2012), or whereby notifiable information relevant to the Act is prescribed and submitted to a Register (e.g. South Australia Public Health (Notifiable and Controlled Notifiable Conditions) Regulations 2012). Inclusion of prescribed reporting requirements in the Regulations would provide a mechanism for ongoing/regular evaluation of the implementation of the Act and Regulations, beyond this 12-month review.

Timeframe for conducting a review

As described in the body of this report, the six-month timeframe for conducting the review did not acknowledge the complexity of conducting an evaluation in the unique and geographically dispersed context of remote health service delivery, whereby the choices of evaluation methodology were narrowed, and consequently limited the breadth and depth of data collection, community participation, and analysis.

RECOMMENDATION 8.1

The Minister consider the mechanism for ongoing evaluation of the implementation of Gayle's Law including:

- a minimum period of 12-months allocated for the process of conducting any further legislated review; and
- inclusion of prescribed reporting requirements in the Gayle's Law Regulations as a mechanism for ongoing evaluation of implementation of the Law and Regulations.

CONCLUSION

This review has found that there has been a genuine commitment to implementing Gayle's Law as intended. The data from multiple data sources have reinforced that there are safety concerns in remote Australia that go beyond callouts.

From a remote health services perspective, there is the potential for safety to be compromised for all persons involved in providing care, at all locations where care may be requested and/or provided in remote areas, during the journey to these locations, and at any time of the day and night. These concerns also extend beyond remote areas, and beyond South Australia, and apply to any context where a health practitioner is delivering health services on their own. This review recommends amendments to the Act and Regulations to address this broader risk. It also acknowledges the important role of policies, and procedures/guidelines in minimising risk and supporting safety.

Policies/procedures/guidelines support implementation of the Act and Regulations, and also serve as adjuncts to legislative measures to extend on-the-ground responses beyond those described in the Act. At the same time, this review has identified that any measure is only as good as it is translated into practice, and that there is a need for better orientation processes and monitoring on-the-ground compliance with safety measures.

Financing the implementation of Gayle's Law has been identified by respondents as problematic, and compromises to routine care to support safety during callouts have been reported. Similarly, the review has highlighted health practitioners' needs for additional clinical support during callouts, and the overall challenges to adequately staffing remote health clinics/centres to deliver comprehensive acute, emergency and primary health care.

Whilst Gayle's Law has contributed to improving health services delivery in remote Australia, further improvements can be made, through improving access to quality health services which goes well beyond the jurisdiction of this Act.

DEFINITIONS/ABBREVIATIONS

ACCHOs – Aboriginal Community Controlled Health Organisations, who may manage an Aboriginal Community Controlled Health Service (ACCHS). An ACCHS is an incorporated Aboriginal organisation initiated and controlled by a locally elected board and based in a local Aboriginal community.

ANMF – Australian Nursing and Midwifery Federation, a professional and industrial body for Australian Nurses and Midwives

CRANA*Plus* – the peak professional body for the remote and isolated health workforce of Australia

Health service providers – include both health services and other providers of health services

Out of hours callout – 77A - means a request for the attendance of a health practitioner at a specified place made by or on behalf of a person where –

a) the attendance occurs, or is to occur-
    i. between the hours of 5pm on one day and 8am on the next day; or
    ii. on a Saturday or Sunday; or
    iii. on a public holiday; and
b) the place at which a health practitioner is to attend pursuant to the request is in a remote area,

but does not include a request of a kind declare by the regulations not to be included in the ambit of the definition.

RAN – Remote area nurse

RDWA – Rural Doctors Workforce Agency

RFDS – Royal Flying Doctor Service

SAAS – South Australian Ambulance Services

Second responder – a person engaged as a second responder in accordance with section 77D;

Clause 77D (3) A person will be taken to be a second responder in respect of a particular call out –

a) from the time that the person is engaged to act as seconder responder in respect of the callout; and
b) until the time the callout is completed.

Unscheduled callout –77AA a request for attendance of a health practitioner made by or on behalf of a person where:

a) the attendance is, or is requested, to occur within 24 hours of the making of the request; and
b) the place at which a health professional is to attend pursuant to the request is in a remote area,

but does not include a request for attendance of a kind declared by the regulations not to be included in the ambit of this definition.

DETAILED RESULTS AND RECOMMENDATIONS

INTRODUCTION

The tragic death of Gayle Woodford in 2016, a registered nurse in South Australia, placed a spotlight on the working and living conditions of health practitioners working in remote Australia. It raised the awareness of the nature of remote health practice, remote health service delivery and the health outcomes of Australian remote and Indigenous populations amongst the public and professional communities more broadly. A foray into health services records; council, police, health, ministerial, media and newspaper archives; Hansard, professional and peer reviewed journals and CRANA*plus* conference proceedings at the time would have revealed that there was nothing new about this situation. It is a 'wicked problem', that requires multiple solutions.

What was new was the groundswell to take action to improve the safety of health practitioners. The Australian Government demonstrated its commitment by commissioning CRANA*plus* and partner organisations to undertake the Working Safe in Rural and Remote Australia Project, which resulted in a suite of resources for Risk Assessment and improving safety (see http://workingsafe.com.au/home/working-safe-in-rural-and-remote-australia-project/).

The Northern Territory Government undertook a review of Remote Area Nurse Safety and Security across the remote health centres that it administered and implemented policy and procedural initiatives that involved implementation of both standard policy and procedures (controls) and additional measures (mitigation), recognising that personal safety is the first priority for remote health centre staff (see https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/927/1/Remote%20Area%20Nurse%20Safety.pdf).

The Government of South Australia introduced Gayle's Law with a genuine commitment to ensuring that health practitioners were safe when providing care during unscheduled and out of hours callouts in remote communities. There was also a genuine commitment to ensuring that implementation of the Act and Regulations achieved their intended aim, with clause 77M(1) of the Act requiring that "*The Minister must cause a review of the operation of this Part to be conducted and a report on the review to be prepared and submitted to the Minister*"(p.9).

This document comprises the report on the review, which was guided by the Terms of Reference and the following overall evaluation questions:

- *Have Health Service Providers implemented the Act and Regulations as intended?*
- *What is the impact that the Act and the Regulations have had on the safety of health practitioners, persons providing health services, and the provision of health services to members of the community in the remote areas of South Australia covered by the Act and the Regulations*?

Of particular importance is that Gayle's Law and Regulations introduced the role of second responder, with the core intention that that no-one should attend an unscheduled or out of hours callout on their own. The emphasis in this review is on how the role of the second responder has been implemented and the feasibility of this approach in achieving the aim of the Act and

Regulations. At times the term second responder can be confusing in practice, nevertheless, is necessary within this report by virtue of its current use in the Act and Regulations.

Gayle's Law and Regulations also include the expectation that health service providers will implement additional measures to ensure health practitioner safety alongside delivery of health care; that these will be clearly articulated in policy and procedure/guidelines documents, and mechanisms will be in place to monitor compliance; and the degree to which other aspects of Gayle's Law have been implemented and achieved their aim.

This report sets out the process the review team undertook to conduct the review. It presents information about the review participants, and then examines the data under each of the Terms of Reference. Recommendations arising from the data analysis are then made to support potential improvements. It should be noted that both the data and recommendations sometimes apply to multiple Terms of Reference and have been either described under the most relevant heading or replicated as appropriate.

METHODOLOGY

Gayle's Law review was an exploratory study using a range of data collection methods and tools to gain as many perspectives as possible to answer the key review questions, and to identify any potential amendments to the Act and Regulations.

Expert Stakeholder Reference Group

An expert stakeholder reference group was established to strengthen the evaluation process, embed guidance from key stakeholders and industry experts into the process and contribute to achievement of deliverables. The Terms of Reference and membership appear as Appendix 7. Key roles of the reference group included:

- providing advice and general guidance relating to the deliverables, framed by the relevant reports, industry standards, industry practices, Act and Regulations, and the Terms of Reference;
- providing input into the approach to gathering data;
- identifying and facilitating access to relevant sources of information, including organisational policies, procedures, guidelines and records of performance;
- facilitating broad engagement with stakeholders and targeted engagement with key informants;
- disseminating information to relevant participants; and
- providing feedback on findings and recommendations.

The expert stakeholder reference group met twice, at the beginning of the review and during the report writing period. In-between times, members of the group acted as key informants, responding to written and verbal requests for advice, and providing relevant documentation wherever possible.

Key Informants

Key informants provided similar input to the review and included health service providers managers (from government, non-government and Aboriginal Community Controlled Health Organisations (ACCHOs) , remote area health practitioners, Aboriginal researchers, clinicians and health care consumers; policy officers; police, solicitors and lawyers.

Health Service Providers on-line self-assessment tool, (audit) , Health Practitioner survey, and Second Responder Survey

All three tools were available as on-line surveys and in recognition that not all remote areas of South Australia have reliable internet/band width, a downloadable, interactive pdf version. All three tools were developed based on the review questions, literature and consultation with the expert stakeholder reference group and key informants.

The tools appear as Appendices 10, 11 and 12. The health services provider audit, the health practitioner survey and the second responder survey included 80, 85 and 45 multiple choice questions respectively, presented in three sections:

Section one included questions relating to implementation of Gayle's Law and Regulations from the perspective of health services providers, health practitioners, and second responders. The questions were a combination of multiple choice and open-ended questions, with most questions including a category for 'other' and/or 'please comment'.

Section two was designed to obtain demographic information relevant to the study. This was an optional component to afford anonymity and encourage participation in the review.

Section three Skip logic directed participants who did not wish, or were ineligible to complete Section one and/or Section two, directly to Section three, with the opportunity to provide comments and/or volunteer to participate in an interview. Participants who completed Sections one and/or two all had the opportunity to complete Section three.

Prior to being used for data collection the tool was piloted amongst the expert stakeholder reference group members. The members provided relevant feedback and the tools were amended several times accordingly. The questionnaires took between 10 and 30 minutes to complete.

Participants

Participants were defined for this project as health service providers, subject to the provisions of Gayle's Law and, health practitioners, and second responders who have worked in a remote area covered by Gayle's Law and Regulations in the past 12 months.

A broad range of strategies were used to maximise participant recruitment. An electronic flyer with links to the audit and survey tools (both on-line and pdf) was distributed via email through expert stakeholder reference group members, the SA Department for Health and Wellbeing, and to Aboriginal Community Controlled Health Organisations (ACCHOs) senior managers. The Australian Nursing and Midwifery Federation (ANMF) , and CRANA*plus* hosted the flyers on their national websites, and the SA Department for Health and Wellbeing hosted the flyer on the intranet. The University of South Australia, University of Adelaide and Flinders University posted the flyer on relevant postgraduate student learning platforms.

Participants clicked the link on the flyer, taking them to the secure survey platform where anonymity was guaranteed. No information was required on the survey or audit tool that would identify the respondent or their organisation. The survey and audit tools could be downloaded and retained by participants.

Mapping health services provider's policies and procedures/guidelines

The Department for Health and Wellbeing supplied the review team with some policies and procedures/guidelines, which had been collected in late 2019. To update these documents and capture additional documents, the review team made direct requests to health service providers to forward their most current policies and procedures/guidelines. They were also asked to provide callout logs, or at a minimum describe callouts in order to meet the last question of the review (TOR7).

Respondent Interviews

The review team interviewed five (5) health practitioners and three (3) second responders who had elected to follow-up on the survey tool. The interview schedule was formulated around the questions that guide the review and probed areas within each survey to gain a greater depth of understanding of the practical implementation of Gayle's Law and Regulations.

Ethical considerations

The review is a commissioned evaluation and followed the NHMRC Ethical considerations in quality assurance and evaluation activities, which did not require the review to be submitted to, or be approved by, a Human Research Ethics Committee. Participants were provided with a plain language statement and consent form. Consent was the trigger for entering the survey. Respondents, who did not consent, were taken to the end of the survey to exit. Data will be stored securely for five (5) years.

Assumptions

It was assumed that the person nominated to complete the health services provider audit was able to provide accurate assessment of their health service's implementation of the Act and Regulations. There was no assumption that any of the respondents would be familiar with the Act and Regulations. The first questions filtered participants so that if they answered honestly, it was assumed that only eligible people could respond.

Analysis

Statistics were analysed in Qualtrics (the on-line survey platform) and Excel for simple counts and frequencies.

Limitations

Despite the elements of project design that support the rigour of this review, there were a number of limitations.

Of significance is that the Act determined the commencement date and the duration of the review; limiting the time for conducting the review to six months. As the six months commenced in November 2020, data collection was ultimately compressed into two-months with time lost between

mid-December 2020 to mid-January 2021 when many people take holidays, and delays in approval and technological processes influencing the distribution of the audit and survey tools. The audit and survey were open for a little over six weeks and despite the high response rate (over 700) this short duration may have contributed to the small numbers of eligible health practitioners (n=34) and second responder (n=10) participants.

The small sample size is a limitation to this review. However, excepting for the absence of community members and Aboriginal Health Practitioners/workers amongst second responder participants, the sample was representative of health practitioners, the variety of remote populations and locations, and services provider types. Saturation of themes was also reached during data analysis. Confidence in the representative nature of the data was also afforded by the additional 45 respondents who, though ineligible due to geographic location, elected to provide comments. These comments were consistent with those from eligible respondents. This may however, reflect the voluntary nature of the surveys. i.e., participants responded because they held similar concerns about Gayle's Law.

Given the time restrictions, use of self-assessment/reporting was chosen as the most time efficient method of data collection, but may have contributed to both inaccuracy and to bias in the results. The potential for health service providers, health practitioners and second responders to over or underestimate implementation of Gayle's Law and Regulations was minimised through triangulation of multiple data sets (audit, survey, interviews and document retrieval), but not entirely eliminated. In order for absolute confidence in compliance mechanisms and behaviours, a more rigorous approach would have been to visit all communities subject to the Act, audit health service providers' records, interview callout participants on-site, observe callouts, view equipment and technology, and host community meetings.

On-site activities were not possible, due both to the time limitations of the review, and also due to travel restrictions imposed by the COVID-19 pandemic. Remote communities were/are particularly vulnerable and new restrictions on travel in addition to the existing permit system meant planning visits further in advance than time allowed. Consequently, the review team was unable to coordinate visits with community meetings, which were the preferred method of consultation in the majority of remote areas covered by Gayle's Law. Instead, the review team asked local councils, art galleries, community stores and health centres to post recruitment flyers in prominent places in remote communities. The review team also attempted to meet with Aboriginal community members in Adelaide and Alice Springs who were attending for health or other purposes, and invited community members and members of the peak body for Aboriginal Community Controlled Health Organisations in South Australia (ACHSA) to participate in the expert reference group. Despite these multiple strategies, no community members participated in this review. Instead, the review team gathered data regarding the impact of the Act and Regulations on the community from the surveys, audits, participant and key informant interviews.

A limitation of the review was also related to the broader environment at the time. As the Coronial inquest into Gayle Woodford's death did not hand down findings until 15 April 2021, there was reluctance by some potential participants to contribute to the review.

Finally, although the Act required a review, it does not compel participation. The data retrieved by the review therefore reflects voluntary responses to requested information and potentially missed the breadth of retrievable documentation and performance data. For example, despite requesting

information about any incidents that had occurred during callouts, no incident records were forthcoming.

RESULTS

Health Service Audit

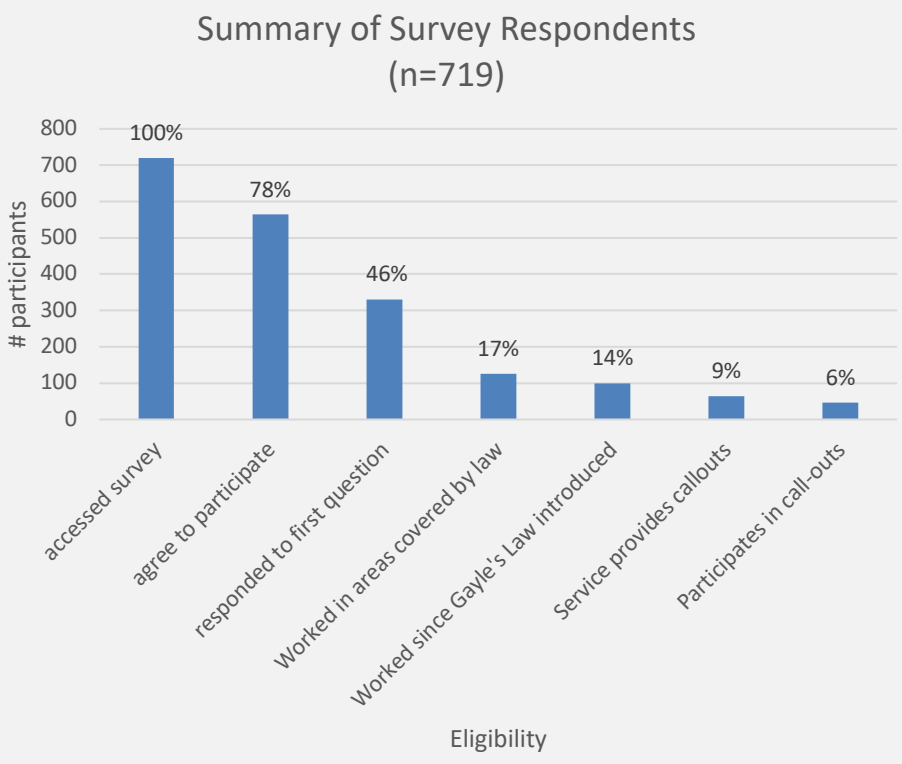
There were seven health service provider respondents, with one response discarded due to lack of integrity (cross-check of answers did not match), the data was based on six respondents. At least two of the respondents provided data based on the multiple health centres that they manage.

One third of respondents preferred not to contribute demographic information. Of these respondents, two thirds described themselves as Aboriginal Medical Services and Non-Government Organisations and identified that their services covered a range of community sizes: 100 - 1000 people.

Health Practitioner Survey

The response to the survey from health practitioners was considerable, with 719 persons accessing the survey. Of these participants, 331 continued on to identify what information they had accessed about Gayle's Law, 125 (17%) had worked in the areas subject to Gayle's Law, and 99 (14%) had worked in these areas since the introduction of Gayle's Law. There were 46 (6%) respondents who had both worked in services that responded to callouts and participated in callouts as the health worker first responder and who were eligible to participate. Figure 1 illustrates the characteristics of these respondents.

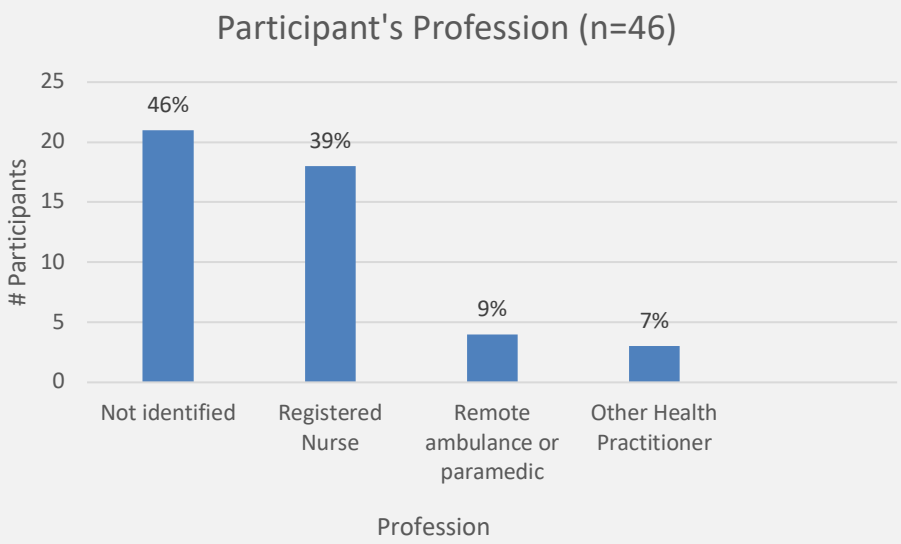
Figure 1



Demographics of health practitioner participants

Of the 46 participants who were eligible to complete the survey, 21 (46%) preferred not to identify their profession, registered nurses made up the majority of respondents (39%), followed by respondents who identified as remote ambulance officers or paramedics (n=4; 9%), and respondents who identified as other health professionals including allied health and midwifery (n=3; 7%). See Figure 2 below.

Figure 2



Length of Service, populations, experience and employment

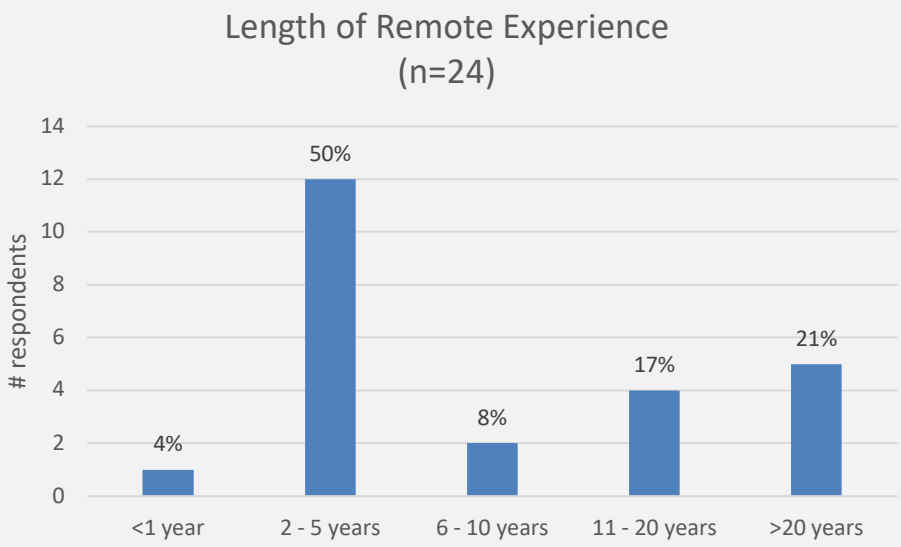
Although a number of participants elected not to provide demographic data, the participants who did were from a variety of backgrounds reflective of the range of employment, experience, health service types and population sizes that are within the scope of Gayle's Law. Together with the data from the health service provider audit, and the advice from the expert reference group, the participants' responses to the implementation and impact of the Act may be considered broadly reflective of the experiences on the ground.

Participants who provided information had been employed by their current health service for between a number of months (including locum and agency staff may/may not have returned multiple times) and a maximum of 35 years. The median length of time was 4.5 years and the average length of time was 8 years.

Of the 24 participants who provided information, their length of experience in the remote setting ranged from 4 months to 39 years (see Figure 3). With the exception of the one respondent with less than 12 months experience, roughly half of the respondents had between two to five years' experience, a small number between six and ten years' experience and the remaining 38% between 11 and more than 20 years' experience.

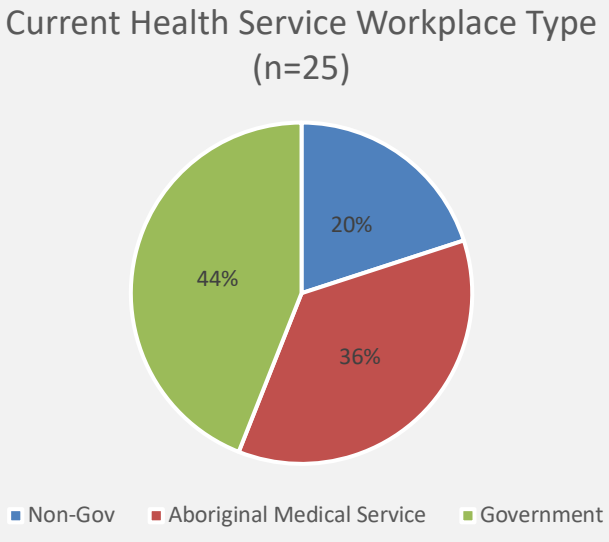
Of the participants who responded, their length of experience in the remote setting ranged from 4 months to 39 years (see Figure 3). With the exception of the one respondent with less than 12 months' experience, roughly half of the respondents had between two to five years' experience, a small number between six and ten years' experience and the remaining 38% between 11 and more than 20 years' experience.

Figure 3



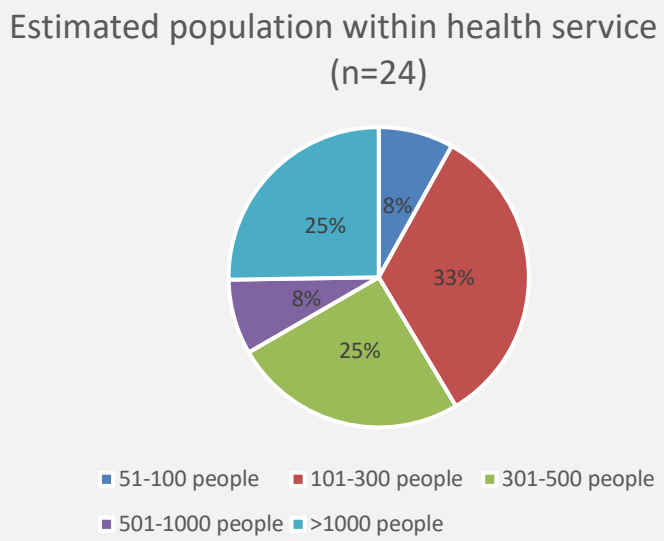
The majority of the respondents were health service provider employees (n=19; 79%), with a small number of Agency employed nurses (n=5; 21%). Respondents identified that they were currently working in Public (Government) administered health services (n=11; 44%); Aboriginal Community Controlled Health Organisations (ACCHOs)/Aboriginal Medical Services (AMS) (n=9; 36%); and non-government health service providers (n=5; 20%).

Figure 4



Health practitioners worked at health service providers who deliver care to a variety of population sizes ranging from 51-100 people to over 1000 people. The single most identified population size was 101-300 people (n=8; 33%), with one half of the respondents working in services with a remit for either populations of between 301-500 people or over 1000 people (see Figure 5 below).

Figure 5

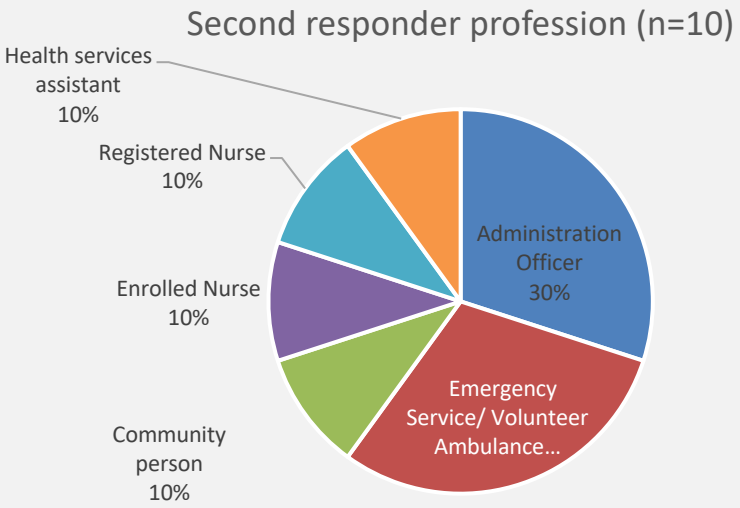


Second Responders Survey

After an initial 30 people responding to the questionnaire, 10 people proceeded to participate.

Second responders identified themselves as Administrative Officers (n=3;30%), Emergency Service Personnel/Volunteer Ambulance (n=3;30%); and one each (10%) as a health services assistant, enrolled nurse, registered nurse and community person (see Figure 6).

Figure 6



All respondents identified that they performed this role as an employee of the health service provider.

This is consistent with the data from the health service provider audit, which identified that personnel employed in these roles participate in callouts as second responders. Of note is that two health service provider respondents identified that the majority of Health Services Assistants (HSAs) also had Volunteer Ambulance qualifications, and if not, the health service was working towards this for all HSAs. It was not clear from the responses to the survey whether the Health Service Assistant who responded also had Cert III or IV ambulance qualifications.

The survey did not capture information from any Aboriginal Health Worker/Practitioners, transport personnel, family members of the first responder or health staff from other services who were amongst the most reported categories of people identified by respondents to the health practitioner survey (see Figure 7 – second responder profile).

FINDINGS

The findings from all data sets are described below to answer the question(s) which formed the terms of reference of the review.

1. Have health service providers implemented the Act and Regulations as intended?

Clause 77E(1) requires that "*a health practitioner to whom this Division applies must not attend a callout to which this Division applies unless the health practitioner is accompanied by a second responder*".

Based on respondent responses, the review has confirmed that the majority of health service providers have implemented most elements of the Act and Regulations as intended. However, there remains room for improvements in policies and procedures/guidelines and the on-the-ground implementation of the same.

To reach this conclusion, the review team assessed the available policies, procedures and guidelines documents against the legislative/regulatory requirements and sought information about their on-the-ground implementation from the perspectives of health service providers, health practitioners and the expert reference group.

Subject to the definitions and provisions of the Act and Regulations, health service providers must have policies and procedures in place to ensure the safety and security of health practitioners. Under Gayle's Law these policies and procedures must:

- include the requirement that a health practitioner must not attend an unscheduled or out-of-hours callout unless they are accompanied by a second responder;
- require any person employed by the health service provider to comply with the requirements of Gayle's Law;
- include a provision preventing anyone from directing or requiring a health practitioner to attend a callout without a second responder;
- include provisions to assist in assessing the eligibility and selection of someone to be a second responder;
- include provisions to manage any risks to the safety and security of health practitioners that have been identified in relation to the delivery of health services at, or from a particular location;
- include provisions to manage any risks to the safety and security of health practitioners that have been identified in relation to the delivery of health services by a specific health service provider.

The findings of the assessment against each of these requirements are described below.

Implementation of 'second responders'

Data from all sources confirms that all health service providers within the geographical location and type of service under the jurisdiction of Gayle's Law have engaged people who are available as second responders to accompany a health practitioner when they attend an unscheduled and/or out of hours callout.

Regulation 11G(a) requires that provisions to assist in assessing the eligibility and selection of persons to be second responders are included in Health Service Providers' policies and procedures.

Health service providers who participated in the survey all confirmed that their employment policies ensured that all relevant personnel meet these eligibility criteria prior to employment of second responders, and nine of the ten policies/procedures submitted to the review team contained these provisions. All ten (10) second responders who completed the survey confirmed that they met these criteria for employment.

However, the policies and procedures/guidelines mapping exercise, key health services provider informant interviews, responses to the health services provider audit, along with interviews with five second responders, identified that there is some role confusion arising from the person designated to accompany the health practitioner being named 'second responder'.

Nomenclature and role of second responder

Second responders are defined in the Act under Clause 77D as a person who is engaged as a second responder and satisfies any requirements set out in the Regulations for the purposes of this subsection. Clause 77D identifies when the person assumes the role of second responder, and refers to Clause 11D(2) of the Regulation that requires that a person engaged as a second responding:

a) must hold a current Australian driver's licence; and
b) must have been subject to a working with children check (within the meaning of the Child Safety (Prohibited Persons) Act 2016) within the preceding 5 years; and
c) must not be prohibited from working with children under the Child Safety (Prohibited Persons) Act 2016 or a law of the Commonwealth or of another State or Territory

There is no definition or use of the term 'first responder' in either the Act or the Regulations. Clause 77D implies that a health practitioner, who engages the second responder for a period of time, is the first contact for a callout, and therefore a first responder. This chronological sequence is reinforced by Clause 77E(2), which exempts the second responder from accompanying the health practitioner during the journey to a callout e.g. a health practitioner is a 'first responder', met by a second responder at the callout site. There is also an implied hierarchical relationship with discourse relating to Gayle's Law explicitly stating that the purpose of the second responder is to ensure the safety of the health practitioner.

In the absence of a role definition, one health service refers to the person who accompanies the health practitioner as the first responder, and the procedure/guidelines identifies this community person as the point of first contact for callouts. This person triages the call, may be approached at their own house for a callout request, and their role is advertised by the health services provider vehicle parked at their home.

Other responses from participants indicate that role definition is complicated by the qualifications, skills, experience and knowledge possessed by the person assuming the role of second responder. When such a person has health qualifications or even first aid knowledge, their role of ensuring the safety of the health practitioner becomes secondary, or ceases to exist when they assist the health practitioner with providing clinical care. For example, one interview participant said:

"Having experience is an important aspect of my role [as a second responder] as I can be a second pair of hands in an emergency situation, and sometimes even have better skills than the nurse who I am employed to accompany" (SRI2).

In addition to the potential unintended negative consequences for both health practitioner safety and the second responder's own safety, other unintended consequences of the absence of clear definitions and the subsequent role confusion, are increased costs for implementing Gayle's Law, and interruption to delivery of core clinical services during and following a callout.

In light of these potentially negative impacts on implementation of the Act as intended, changing the name of the second responder to identify that they are engaged in a role, not a position would be appropriate. In addition, a clear role definition that describes that the primary responsibility of this role is ensuring safety, irrespective of any clinical qualifications, skills, experience and/or knowledge that they may have is indicated. Given the current confusion, re-setting the understanding of existing staff, and ensuring that such role definition is a component of mandatory orientation for all new health service provider staff and second responders is essential.

An example of an existing role in health that is based on a similar approach is the role of Fire Warden. A name such as 'Safety Worker' that describes the intended role would address this problem. Multiple survey respondents and interview participants have indicated that an employed model for engaging the second person is the most effective and preferred method of engagement, so inclusion of the title 'worker' is appropriate.

RECOMMENDATION 1.1

The Minister gives consideration to amending Gayle's Law and Regulations by replacing the term 'second responder' with a named role reflective of the safety function of the (second) person designated to accompany the health practitioner who has the primary function for providing a health service.

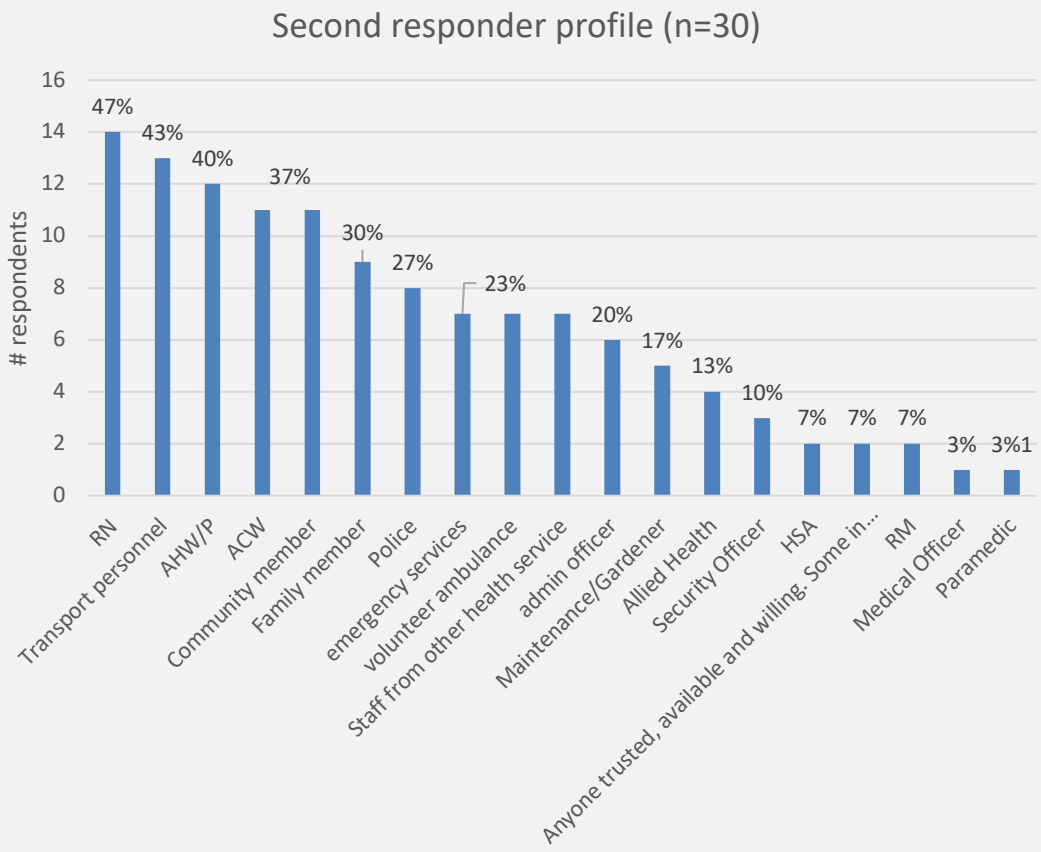
Investment in second responders

All health service providers who responded to the audit identified that they had to employ additional staff to ensure that a second responder was always available 24hours/day, 7 days/week to meet the requirements of the Act. Investments included implementation of new health services assistant roles, employing drivers, and administrative staff (see also responses to Question 4 and relevant recommendation).

Members of the expert reference group and interviews with health service providers identified that changes to employment conditions of clinical and non-clinical staff had also enabled their service to meet the requirements of supplying a second responder for all callouts. This included asking staff to volunteer for callout duties, and incorporating callout duties in some existing and all new employment contracts. Health practitioner respondents identified health practitioners as the largest single group of personnel undertaking second responder responsibilities across the multiple sites (47%). However, second responders employed in new roles (such as the Health Services Assistants)

(43%) and volunteer ambulance personnel (23%) when considered together, constituted two-thirds of all identified second responders (see Figure 7).

Figure 7



This investment has come at a cost. Costs are identified below as a factor influencing the contribution that employment of second responders has made to achieve the positive impact on the safety of health practitioners and persons providing health services in the remote areas of South Australia (TOR2).

Preparation and adoption of policies and procedures by health service providers

The review has confirmed that all health service provider organisations have written health service policies, procedures and/or guidelines relevant to implementing Gayle's Law and Regulations. There are however, varying degrees to which these documents include all elements required by the Act/Regulations.

The elements that were well articulated and clearly aligned with the intention of the Act and Regulations included:

- The purpose and scope of the policy/procedure/guideline (100%)
- The roles and responsibilities of Executive Managers / all managers / all workers for compliance with the Act/Act (100%)

- Definition of out of hours callout (100%)
- Definition/description of the locations and health services to which the Act/Act applies (90%)
- Eligibility of second responders (90%)
- Risk assessment policies and procedures/guidelines (80%)
- Prescribed sites (60%)

Appendix 8 maps all available Health Service Provider policies/procedures/guidelines against specific elements of the Act and Regulations. Areas of note for poor compliance either in policy, or in practice are described below.

Directing health practitioners to attend callouts

Of particular note in regard to low compliance is that only four (40%) of the ten health service provider policies/procedures/ guidelines that were assessed by the review team against the requirements of the Act/ Regulations included a provision expressly required under Clause 77H(2)(a).

Clause 77H (2)(a) of the Act identifies that providers of health service policies and procedures must contain:

A provision expressly preventing any person from directing or requiring (however described) a health practitioner to whom Division 2 applies to attend a callout in contravention of section 77E (1).

Clause 77E(1) requires that *"a health practitioner to whom this Division applies must not attend a callout to which this Division applies unless the health practitioner is accompanied by a second responder"*.

The omission of this prohibition by 60% of health service providers introduces the possibility that the safety of health practitioners may be at risk despite the introduction of the Act. As the Deputy Coroner noted in the inquest into the death of Gayle Elizabeth Woodford (Schapel, 2021), the degree to which policies/procedures/guidelines are implemented in practice is in part determined by how well they are supported by health service provider management.

Although the health service provider audit did not include evidence that first responders have been directed to attend without a second responder, some health practitioner survey respondents' comments indicated that there was pressure from their employer to attend callouts without a second responder. Interview participants confirmed that this did occur occasionally.

> *"I would be in the situation where I didn't have a second person for callouts [to act as a second responder], but knew that I would be pressured to go when the client was known to me … Others have told me that it is the same for them" (HP-IV1).*

Clinical Risk

There are also elements of policies and procedures/guidelines that suggest that clinical risk over-rides safety. For example, some health service provider policies/procedures/guidelines require consultation with a medical officer for advice about whether to proceed without a second person. This approach misinterprets the Regulations. The only threshold for requesting the attendance of a second responder is a callout request. The issue of clinical risk is included in Regulation 11D(3)(b) as criteria for the health practitioner to decide whether to decline the callout request or engage

someone who does not meet all requirements of a second responder (driver's license, and working with children clearances) not as a criteria for attendance without a second person.

Accordingly, within these policies/procedures/guidelines there is the potential for the health practitioner to be directed to attend a client without a second responder.

Limitations to Liability

Being directed to attend a callout by a health service provider manager, medical practitioner or fellow health practitioner is not the only reason that health practitioners attend a callout without a second responder. One health practitioner interview respondent identified that being directed to attend a callout without a second responder was accompanied by the inference that non-attendance would constitute a breach of their duty of care to the public. Other reviews (e.g. NT Department of Health Remote Area Nurse Safety, 2016; SA Coronial Inquest into the Death of Gayle Elizabeth Woodford, 2021) have identified that one of the reasons that health practitioners risk their own personal safety is to avoid perceived consequences of losing professional registration, and/or facing an untenable ethical dilemma that their failure to attend will result in a negative outcome for the client.

> *Clause 77F(2) of the Act identifies limitations to liability for* to health practitioners who refuse to attend a callout without the presence of a second responder.
>
> *"A health practitioner or other person who complies with the requirements of this Part (including, to avoid doubt, a health practitioner who refuses to attend a callout to which Division 2 applies in the absence of a second responder)*
> *(a) cannot, by virtue of doing so, be held to have breached any code of professional etiquette or ethics, or to have departed from any accepted form of professional conduct; and*
>
> *(b) to the extent that the health practitioner or person has acted in good faith and without negligence, incurs no civil liability in respect of such compliance (including, to avoid doubt, liability arising under disciplinary or similar proceedings).*

Reference group members identified that this is an essential component of the Act, and one of the reasons that Gayle's Law was implemented as an Amendment to the Health Practitioner National Law in preference to other potential Acts.

None of the ten (10) health service provider organisational policies and procedure/guideline documents reviewed included information about limitations to liability.

Data and recommendations relating to health service provider managers, health practitioner and second responder knowledge of the Act and Regulations and orientation practices and requirements are described under TOR2 below.

RECOMMENDATION 1.2

The Department for Health and Wellbeing, given the variability of the current content of policies, procedures and guidelines, develop and distribute a template document(s) to assist health service providers to include all relevant elements of the Act and Regulations in a revised procedural document. The template document needs to ensure that policies/procedures/guidelines clearly articulate:

- *the distinction between assessment of risk of health practitioner safety and clinical risk;*
- *that risk assessment is undertaken to determine attendance by anyone, not the need for a second responder (safety worker);*
- *that the trigger for a second responder (safety worker) to accompany the health practitioner during a callout is the health practitioner's decision to attend the callout, (i.e. a second responder should attend all callouts, there is no threshold at which a second responder is not required);*
- *the explicit prohibition of health practitioners being directed to attend callouts without a second responder;*
- *limitations to liability for not attending a callout if a second responder is not available;*
- *mechanisms to ensure safe return home (or to another destination) of both health practitioner and second responder; and*
- *the safety provisions included in Recommendations 2.2, and 2.4.*

RECOMMENDATION 1.3

Notwithstanding the suggested role of the Department for Health and Wellbeing, health service providers review their existing policies, procedures and guidelines to include all relevant elements of the Act and Regulations and Recommendations 1.2, 2.2 and 2.4.

2. What impact has the Act and the Regulations had on the safety of health practitioners and persons providing health services in the remote areas of South Australia?

The Review Team has found that the Act and Regulations have significantly improved the safety of health practitioners providing health services in remote areas of South Australia while at the same time achieving a 100% response rate to all callout requests that meet the threshold of clinical risk.

This positive balance between safety and services delivery requirements has been achieved through health service providers employing second responders and/or rostered existing staff as second responders to accompany health practitioners during unscheduled and out-of-hours callouts; implementing procedures/guidelines to ensure that health practitioners and second responders always travel together to a callout in a fit-for-purpose vehicle; and developing personal safety risk assessment guidelines. Achieving this balance has also had positive benefits for health practitioner mental health and wellbeing.

However, there is still some scope for further improvement to minimise risks to personal safety. In particular, although health service providers have employed second responders and/or rostered existing staff as second responders to accompany health practitioners during unscheduled and out-of-hours callouts, there is no requirement for an accompanying second person during daytime or night time scheduled callouts, when patients are transported (e.g. to and from airports), at the health clinic/centre during business hours, or at the health practitioner or second responder's home at any time of day or night.

Risks to personal safety are particularly high at the health practitioner's home/accommodation where the parked health services provider vehicle advertises the presence of the health practitioner and communication is largely limited to a mobile phone. At one health service, this risk has been transferred to the second responder, who assumes the role of first contact for out-of-hours callouts.

Participants in the review did report occasions where health practitioners attended callouts without a second responder. Evidence provided by five of the ten relevant South Australian health service providers found that there were occasions when health practitioners had attended a callout without a second responder. In all of these cases the health practitioner had used a risk assessment tool, assessed there to be low risk and there were no untoward outcomes.

There is minimal police presence in remote South Australian communities, but when the callout is for attendance at a Police Station, the health practitioner always engages a second responder. The same applies for attendance at accident scenes when emergency workers are present. The engagement of second responders at these sites however, is based on clinical risk assessment rather than personal safety risk assessment.

Despite evidence that health service providers have developed personal risk assessment policies, procedures, guidelines and tools, health practitioners have varying levels of knowledge of these resources. Both health practitioners' and second responders' participation in orientation to resources relevant to Gayle's Law is variable. It is often self-directed, and there are limited compliance checks and/or a requirement for regular review. The potential for health practitioners and second responders to have limited knowledge of ensuring their own personal safety is high without good orientation as health practitioners' knowledge about Gayle's Law was found to be largely reliant on on-line information rather than the source Act and Regulations.

There appear to be two consequences of these low knowledge levels. The first is that health practitioners continue to base the need for a second responder on assessment of clinical risk (see TOR1 above), and the second is that there is a high expectation that second responders should be equipped with health/clinical skills so that they can assist in health care delivery during a callout. The role confusion that this expectation creates is highlighted in TOR1, and the requirement for such qualifications and experience is not supported by the review team due to the potential loss of focus on safety that such a change would precipitate. The review team does not believe that this change is consistent with the intent of Gayle's Law, but instead, should be managed through clinical procedures/guidelines that ensure that there is additional clinical support available when required. Such clinical support may be a second on-call health practitioner in addition to the second responder, and/or off-site health practitioner support (e.g. telehealth, phone consultation).

Health service providers, health practitioners and second responders can assist in addressing some of the identified barriers to achieving the intended outcome of Gayle's Law through introducing

policy, procedure/guidelines, orientating and being orientated to Gayle's Law and relevant organisational resources, and adopting all of these into on-the-ground practice. Community members can also play a role by not requesting assistance at the health practitioner or second responder's home/accommodation (see TOR3).

Amendments to the Act and Regulations are also indicated to broaden the scope of second responder attendance to all sites (including the health clinics/centres and health practitioner homes/accommodation), and not just for callouts, but at any time of the day or night when health care is required. While Regulation 11D5 includes provisions to ensure safe return home for the second responder, the same provision is missing for the health practitioner. The nature of risk does not change at these times or places or for the respective responders. Health service providers are encouraged to take policy and practice initiatives to reduce the identified risks, but without including both responders in the current Act and Regulations, they do not entirely achieve the intended outcomes of Gayle's Law, and it is appropriate that they should.

Implementing Gayle's Law and Regulations to date has come at a financial cost. For the most part, health service providers report that their funding has not offset the increased costs associated with employing additional staff, paying additional overtime/on-call salaries, and investing in fit-for-purpose communication and safety equipment. These budgetary pressures have also impacted negatively on business hours service delivery capacity. It appears that there was little collaborative scoping/business case development prior to the implementation of the current Act and Regulations. It is appreciated that extending the scope of the Act will have a further financial impact on health services delivery capability. The SA Department for Health and Wellbeing, in collaboration with the Australian Government Department of Health, health service providers and community members is encouraged to undertake financial modelling for both the current and future iterations of Gayle's Law and implement appropriate funding accordingly.

The value of the expert reference group in bringing stakeholders together to share information about successful strategies and also to discuss the broader concerns about clinical risk, health service delivery and working conditions raised by participants in the review has been acknowledged by all members. Consideration of bringing together a steering group/advisory group that spans government, non-government and Aboriginal Community Controlled Health Organisations (ACCHOs) and includes health practitioners, second responders, professional and industrial organisations, and community members to continue this collaboration into the future is recommended.

Of note is that one health service has implemented Gayle's Law with the second responder being the first point of call for callouts. This approach intends to achieve significant engagement of the community in achieving the aim of Gayle's Law to improve the safety of health practitioners during callouts and minimise risk for harm. However, it also means that many of the risks are also potentially transferred to, or relate equally to the community member as they do to health practitioners. Accordingly, all recommendations of this review include provisions for improving the safety of both health practitioners and second responders irrespective of who responds first or second to a callout, or any episode of health service provision.

Further information and the data supporting these findings appears below.

Callouts

Data from all sources identified that health practitioners respond to an unscheduled (business hours callout) between 1 and 4 times per week and an out-of-hours callout on average 3.5 times per week (between 1 and 7 times per week).

The presence of second responders for callouts was welcomed by health practitioners who identified the variety of staff and paid community members who fulfil this role (see Figure 7 above).

Of the 46 health practitioner participants who responded, 30 (65%) identified that second responders were available at their health service to accompany them on callouts. However, health practitioners responding to surveys and participating in interviews revealed that health practitioners had attended callouts on their own without a second responder. In total, 40% of survey respondents identified that they had engaged in this practice for a total of 55 callouts since the enactment of the Act. Survey respondents did not report the circumstances leading to the callouts or absence of a second responder, nor did they report any adverse events. Interviewees reported that they attended on their own in some emergency situations; were most likely to attend callouts on their own when they involved children or elderly people; had attended to people on their own when they presented to the health practitioner's home/accommodation; and as previously mentioned, when they felt pressured by managers and clinicians.

> *"I've found that even in Health service that have a 2 to attend all patients rule, the management think it's ok to cut corners. You hear, "oh, we know that family" etc, " you'll be fine alone in the daytime" (HPS7).*

Overwhelmingly, the decision to attend alone was based on the person being well known to the health practitioner, and/or the health practitioner knowing that the home they were attending was 'safe'. A major concern about home visits was dogs.

> *"You know, I am pretty confident to visit a person that I know, or if I know their family, but I always make sure that I don't go anywhere where there are 'cheeky' dogs – but I wouldn't go there with another health worker or driver [i.e. second responder] either" (HPI1).*

Other interview participants identified that they were confident identifying the risk to their safety and the need for a callout. Along with one survey respondent, these participants (who identified as male) made judgements based on their experience in remote communities and clinical knowledge.

> *"Quite frankly, I don't know what all of the fuss is about, it feels like I can't make my own decisions anymore. I just make an assessment of the situation and go or not go. I am very confident in my clinical skills and have never been in trouble" (KI3).*

It is unclear whether this health practitioner and other respondents initiated their unaccompanied callouts action based on assessment of safety risk, or clinical risk. It was clear however, that they used risk assessment as a tool to determine whether they were accompanied by a second responder, rather than whether they attended the callout or not. Assessment of risk is explored later in the report.

The review team requested callout logs/registers from 10 health service providers who covered the areas within the jurisdiction of Gayle's Law. Of the records supplied, only one service had documented evidence of health practitioners attending callouts without a second responder. The 14 callouts were all to the health clinic/centre. All clients were either known, or very well known to the

health practitioner, and over half related to repeat consultations over the preceding days. The care was either to follow-up acute issues, or related to an acute minor emergency situation that one of the attending nurses reported *"could be managed by one clinician*". The documentation stated that "*there was no safety concerns for the worker before, during or after the callout*".

Another respondent identified that at least once per month he/she arrived to a callout and the second responder had not attended as anticipated. He/she did not report any adverse events.

Review participants identified that there were no occasions when a health service has not been provided because there has not been a second or alternative responder – i.e. 100% attendance at callout requests. There are however costs to achieving this outcome. Health service providers, interview participants, key informants and members of the Reference group identified that the costs of implementing a second responder workforce include:

- employment of additional staff, and/or
- rostering existing staff for additional callout shifts/duties, and
- the additional hours salary/overtime cost for two, rather than one person attending a callout.

These same review participants identified that to address the additional costs associated with the introduction of Gayle's Law was accompanied by varying levels of funding support from either or both the State and Commonwealth Governments. The data suggests that there was no joint State and Commonwealth business plan for rolling out the practical aspects of Gayle's Law, nor did health service providers themselves or health consumers have input into financial modelling. Health service providers that are more reliant on Commonwealth funding reported that they found it most difficult. The budget pressure created by this situation has impacted on health service delivery in a number of ways including a decrease in service provision the next day if staff are called-out overnight (e.g. clinic may be closed until staff have had adequate time off between shifts), diversion of funding from programmatic work (e.g. chronic diseases management) to acute care (call-outs), and the proportion of salaries as a budget component growing. Investment in communication and other safety equipment has also created financial pressures for these very small, remote communities.

RECOMMENDATION 2.1

The Minister consider amending the Act and Regulations to improve the safety of the health practitioner and accompanying second responder by:

- *extending the requirement for a second responder (safety worker) attendance beyond the current scope of unscheduled and out of hours callouts to also apply to the following:*
  - *scheduled callouts at any time of the day or night;*
  - *during the journey to all callout locations;*
  - *in the untoward event that health services are delivered at the health practitioner's home/accommodation; and*
  - *all other occasions of health services delivery in a remote area where there is an identified risk to personal safety, irrespective of location and inclusive of the health services facilities.*

RECOMMENDATION 2.2

Notwithstanding the requirements contained within the current Act and Regulations, health service providers amend health service policies and procedures/guidelines to ensure that health practitioners are always accompanied by a second responder (safety worker):

- *when attending both unscheduled and scheduled callouts at any time of the day or night;*
- *during the journey to all callout locations;*
- *in the untoward event that health services are delivered at the health practitioner's home/accommodation; and*
- *on all other occasions of health services delivery in a remote area where there is an identified risk to personal safety, irrespective of location and inclusive of the health services facility.*

RECOMMENDATION 2.3

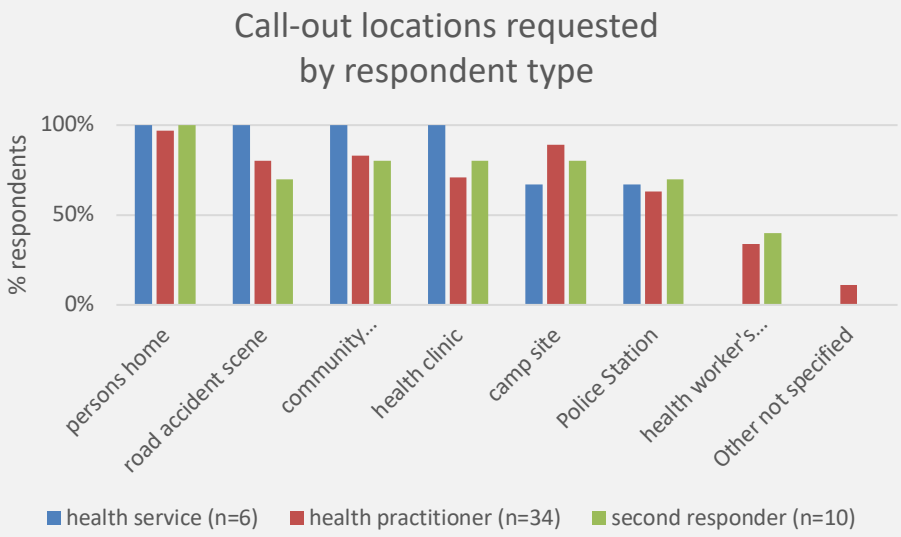
State and Australian Government Departments of Health give consideration to working with health service providers and community members to develop a business plan to invest funding to support both current business and any future extensions to the Act and Regulations to create a sustainable second responder workforce and well equipped and maintained equipment in health clinics, health worker accommodation and vehicles.

Callout locations

The locations of the callouts that were attended and the frequency of attendance is described below.

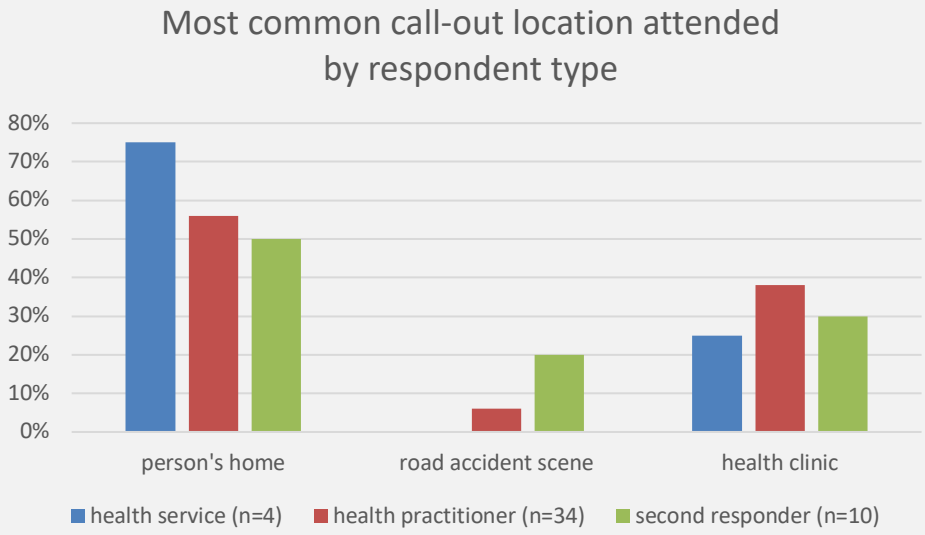
Health Practitioners were requested to attend callouts at a variety of locations, with a number of sites being reported by all three types of audit/survey respondents (health service providers, health practitioners and second responders).

Figure 8



According to health service providers and health practitioners the most common locations attended (in order of frequency) were at the person experiencing the injury's home, the health clinic, and a road accident scene.

Figure 9



The reasons described by respondents for callouts to the health clinic or the health practitioner's home/accommodation were for accidents or an acutely unwell person in their own home, the health practitioner's home / accommodation or at the clinic. In addition, persons experiencing an injury, or attempting to escape from an episode of family violence may present at another person's home, the

clinic or the health practitioner's home. Health Practitioners would also attend motor vehicle accidents with second responders. There were no occasions when health practitioners attended either an accident or a Police Station without a second responder, irrespective of whether an emergency worker or police officer/special constable was in attendance.

All respondents described small services with between two (2) and six (6) people employed during business hours, and generally two (2) staff available to attend either unscheduled callouts during business hours or out of hours callouts. Given the small number of staff to cover health service provision 24hrs/day and 7 days/week and the frequency of health practitioners attending the health clinic for out of hours callouts with a second responder, it was not surprising that health practitioners questioned why Gayle's Law only applies to the clinic location during callouts, and does not require two persons to be at the clinic at any, or all, other time(s).

Safety in health clinics/centres

The requirement for the presence of second responders at any time of day or night was highlighted by a number of respondents including some who withdrew from the survey and by respondents who were interviewed. They identified that small numbers of staff means that during meal breaks, when staff participate in scheduled or unscheduled callouts, and even due to clinic design, there is a risk of being alone in an unsafe situation in a range of settings including the clinic itself, and not just out of hours.

> *"I can be alone in the clinic at lunchtime, I worked in* [a remote community covered by Gayle's Law] *after Gayle's Law was introduced. There was protocols in place to ensure safe call outs . But not always two nurses in the clinic in day time hours… I had a situation where I needed support and had no one to help with a* [potentially aggressive] *patient, police closest was potentially 2 hours away if I was in a dangerous situation. Luckily situation de escalated quick enough . But If not I would hate to think what could have happened…" (HPS88)*
>
> *"Even though we have multiple nurses on staff, we may only overlap some of the time and I might be the only nurse in the community for as long as two weeks" (IV3)*
>
> *"When nurses travel to the airport to make it safe for the plane, they are out on the airstrip alone, and have often left another nurse with the patient" (IV4)*
>
> *"Nurses might travel alone to the airport or to evacuate a patient by road ambulance and leave only one nurse at the clinic" (KI3).*

As another respondent commented:

> *"I am concerned that the Law refers to a second person only being required out of hours. An incident such as the rape and murder can occur at any time of the day. A second person should be mandatory at all times.* (HPS16)".

Based on the principles upon which Gayle's Law was enacted, that is, better protection for health practitioners working in remote areas of South Australia and the need to reduce the chances of personal attack, these are strong examples of why the Act should be extended to include the presence of a second person at any location where care is delivered.

Safety in health practitioner and second responder homes

Around 40% of health practitioners and second responders identified that community members approached health practitioner homes/accommodation to request a callout. Members of the expert reference group, survey respondents, interviewees and key informants identified that the risks associated with providing care at their own home, were no different, or greater than providing callout services at a community person's home, the health clinic, or any other community location. In the case of the health service that uses a community member as the first point of contact (second responder surrogate), this is also identified as a risk.

Some health services have already implemented policy, procedures and/or guidelines that exclude attendance at the health practitioner's home either completely, or without a second responder.

The engagement of community support to discourage presentations at health practitioner's home is recommended in the response to TOR3 below.

> *17.5(2) (2) The Executive Director and Medical Director of the NHC if necessary amend their policies and guidelines to ensure that presentations of persons seeking the services of health practitioners employed by the NHC in remote areas are not made in person by a direct approach to the home address of the health practitioner (p.102-103)*

Based on the principles upon which Gayle's Law is based there is a strong case to extend the Act to include the presence of a second person in the health practitioner or second responder's home as well as any other location where care is delivered. There is also support for this recommendation from the South Australian Deputy Coroner as described in the findings of the inquest into the death of Gayle Woodford (Schapel, 2021).

> *17.(6) That in any review of the operation of the relevant provisions of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the Regulations made thereunder as they apply to health practitioners providing services in remote areas of South Australia, that consideration be given to clarifying whether the requirements in respect of a second responder should apply to presentations by a patient to the home of the health practitioner. The other matter that should be considered in any such review is whether health practitioners should be accompanied by the second responder during any journey to the location where the health service is to be provided (p.103).*

Travelling to and from a callout

Health service providers, health practitioners and second responders identified that unless the callout is to the health practitioner's or second responder's home, they always travel together to the callout site, and never use their own vehicles for callouts. Instead, the health service providers supply a vehicle. This vehicle is most often a large four-wheel-drive vehicle equipped with resuscitation equipment and commonly called an 'Ambulance'. It may or may not have ambulance type markings. Only one third of health service providers audit respondents identified where the vehicles were located, and this was at the health clinic. Policies and procedures/guidelines were also variable, including at the health clinic/centre and either the health practitioner or second responder's home. Health practitioner respondents, including some of the interviewees identified that the vehicle was most commonly located at health practitioner's or second responder's

homes/accommodation. One health practitioner noted the safety considerations relating to this practice:

> *"*[Community] *people know where you live and when you are home because the Ambulance is parked at your house when you are on call. It is an advertisement for people to come to humbug you at your house, to come to your front door when they want attention, and when they are escaping from domestic violence. I guess people can also see if you have returned from a callout safely, but it also means that someone like* [the person charged with Gayle Woodford's murder] *could just lie in wait for you. I don't know the solution". (HPI1)*

At one health service, this risk has been transferred to the second responder, who assumes the role of first contact for out-of-hours callouts. As many respondents noted, this is a 'wicked' problem, with there being a delicate balance between providing a well-equipped vehicle for callouts and protecting the safety of the practitioner.

There has been significant benefit from bringing stakeholders together as the expert reference group for the review for both the review team and the members. It has provided a platform to share information about successful strategies and also to discuss the broader concerns about clinical risk, health service delivery and working conditions raised by review participants. One strategy to address difficult problems such as the location of the health services vehicle would be to bring together a steering group/advisory group that spans government, non-government and Aboriginal Community Controlled Health Organisations (ACCHOs) and includes health practitioners, second responders and community members to continue this collaboration into the future is recommended.

SA Health in its role in development of best health care practices would be an appropriate convenor of such a group. Another potential convenor is CRANA*plus*, the professional organisation for remote health practitioners.

Regardless of the location of the health services vehicle, the review of policy, procedure/guidelines against the Act and Regulations identified that even though Clause 77E(2) permits the second responder and health practitioner to travel independently to the callout location, this practice was prohibited by health service providers.

By including this exclusion in guidelines, health service providers have taken an initiative to improve protection for health practitioners working in remote areas of South Australia and reduce the chances of personal attack, ahead of the 15 April 2021 recommendation arising from the South Australian Deputy Coroner's inquest into the death of Gayle Woodford (Schapel, 2021).

> *17.5 (8) Notwithstanding the requirements contained within the relevant provisions of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the Regulations made thereunder (Gayle's Law), that the NHC establishes processes to ensure that its health practitioners are accompanied by a responsible person en route on any callout regardless of the time of day or night… "(p.101-102).*
>
> And
>
> *17.(9) That in any review of the operation of the relevant provisions of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the Regulations made thereunder as they apply to health practitioners providing services in remote areas of South Australia, that consideration be given to clarifying whether the requirements in respect of a*

> *second responder should apply to presentations by a patient to the home of the health practitioner. The other matter that should be considered in any such review is whether health practitioners should be accompanied by the second responder during any journey to the location where the health service is to be provided. (p.103).*

This review supports such changes to Gayle's Law and Regulations (see Recommendation 2.6). However, notwithstanding any potential legislative changes, it is important that health service providers implement policies, procedures/guidelines that support improvements, and the review team have made recommendations accordingly (see Recommendation 2.7).

It is appreciated that any proposed extensions to the scope of the Act will have a further financial impact on health services delivery capability, and that implementation of extensions should be accompanied by appropriate consultation and business planning to ensure appropriate additional funding is available to health service providers (see Recommendation 2.3).

Commencing and concluding a callout

As described in the SA Deputy Coroner's inquest findings (Schapel, 2021), the trigger for Gayle Woodford engaging with the person subsequently convicted of her rape and murder (Dudley Davey), may have been a request for medical assistance (an out-of-hours callout) at her home/ accommodation. As described above this situation has not changed since the implementation of Gayle's Law. Health practitioner and second responder participants in the review (34% and 40% respectively) identified that community members/people seeking health care services present at health practitioner's homes/accommodation to request an unscheduled or out-of-hours callout. Interviews with health practitioners and second responders, expert reference group members and key informants also confirmed that this practice occurs, and in the case of one health service, callouts can also be initiated at the second responder's home. As described in TOR3 below there is an opportunity for community members and health services consumers to influence this practice and refrain from seeking assistance at the health practitioner's home/accommodation. There is also scope for health service providers to preclude delivery of health services at the health practitioner's and second responder's home/accommodation through policy and procedural guidelines.

Two health service providers have a callout request system whereby community members/health consumers call a central dispatch number and there is an intermediary between the caller and the health services practitioner who assesses for both clinical and safety risk. Other health services have an on-call phone number that diverts to the health practitioner's mobile phone. The health practitioner and the second responder then travel together to provide care at the health clinic, or at the person's home. A central despatch or call diversion approach would mitigate one of the safety and security issues that played a critical role in Gayle Woodford's death (Schapel, 2021).

Risks associated with travelling to and from the callout are described above, but there is also an important omission in the current Regulations. Despite travelling together to the callout, there is always a time when one of the personnel is travelling alone.

Regulation 11D(5) provides for a mechanism to ensure that the second responder arrives home safely following a callout.

> *Pursuant to section 77D(3)(b) of the Act, a callout is completed in respect of a second responder when, after leaving the location of the callout or any other place at which the*

second responder attended in relation to the callout, the second responder arrives at their place of residence or other destination nominated by the second responder and advised to the health practitioner.

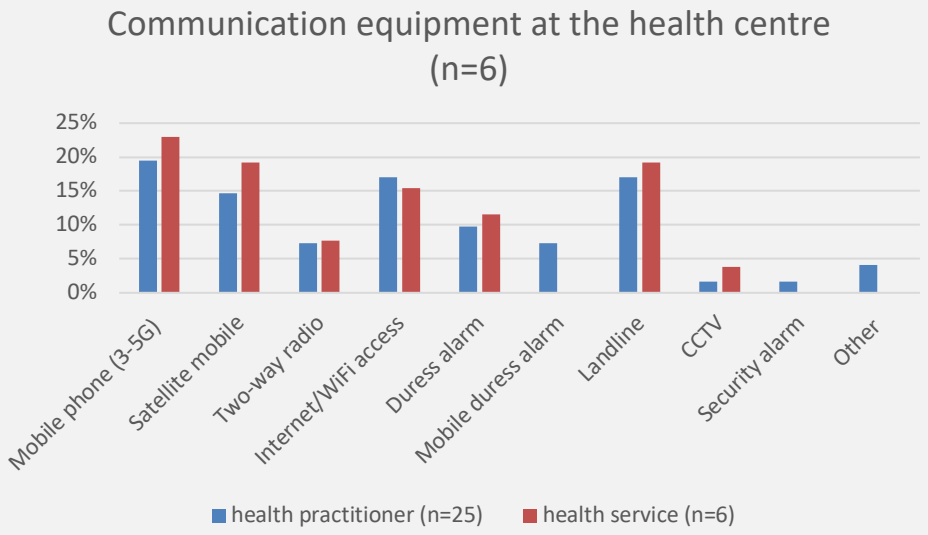
The same provisions are not in place for the health practitioner, and the Review Team recommends that consideration be given to extending these provisions to cover both the second responder and the health practitioner (see Recommendation 2.10).

When mapping the health service providers policies and procedures/guidelines against the provisions of the Act and Regulations there was variability in how this requirement was met for second responders. Accordingly, it is also recommended that the health services policies and procedures/guidelines are reviewed to ensure that there are mechanisms in place to identify when both health practitioner and second responder have returned home or to another destination safely. Review participants identified examples of mechanisms currently in place to include: callout logs, registers to document out of hours callouts, telephone communication between health practitioners and second responders, telephone communication between health practitioners, second responders and health services managers and/or a central call service, with safety confirmed through text messaging after the callout (See Recommendation 1.2).

Communication, Security and Safety equipment

Communication equipment plays an important part in security. Health service providers and health practitioners described the range of equipment available for use in the health services. The most common items were phones and Wi-Fi was readily available.

Figure 10



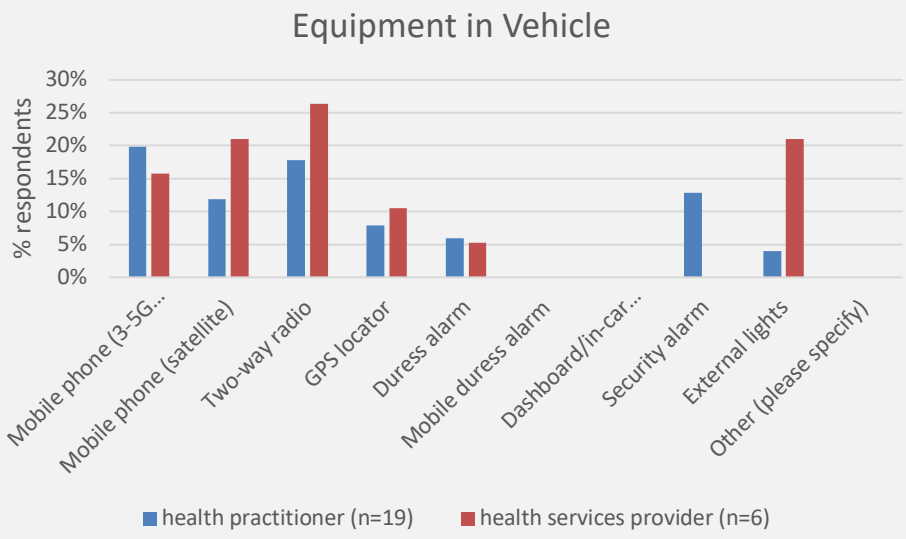
There is significant reliance on mobile phones in the community with satellite phones essential when travelling away from the community. Despite two-way-radios being a common communication tool in communities, health service providers and health practitioners limited their use due to the lack of privacy experienced when using them.

Only one third of the responding health service providers and 41% of health practitioner survey respondents identified that the same equipment was available at staff accommodation and the clinic. The remaining two thirds of health service providers and 41% of health practitioners identified that mobile phones were the only communication equipment located at staff accommodation and that this was not adequate. Instead, they noted that long range handsets for land-line phones were useful, and that mobile duress alarms and satellite phones would be desirable. Health service providers reported that fixed duress alarms (not mobile alarms) were available at the health clinic, but not at all homes. It appears that some health practitioners were purchasing their own mobile duress devices and this was the most common device that health practitioners identified as an addition to communication equipment currently available. One health practitioner interviewee said:

> *"It would be good to have a loud alarm to carry around in the community particularly during usual work hours when there is no 2nd responder with me. It would be a good deterrent…. But with the lack of police or other people around in the community who can respond in an emergency so I'm not sure how useful this would be" (HPK3).*

The range of equipment available in vehicles used for callout attendance is illustrated in Figure 11 below.

Figure 11



There were no dashboard/in-car cameras or mobile duress devices reported as being available in vehicles and there were mixed reports regarding whether these were necessary or not. Two thirds of respondents identified that the equipment was similar in all vehicles. Surprisingly, given that the GPS

locator played a role in finding Gayle Woodford, this device was only reported as available by around 10% of respondents.

The four barriers to ensuring that equipment is available and in working order all of the time included (in order of frequency): equipment has to be sent off-site for repair; competing demands; no replacements available for equipment requiring repair; and insufficient financial resources to cover enough equipment (quantity). As these barriers largely relate to prioritising existing equipment and investing in more equipment, recommendations relating to improving this situation are those elsewhere in the report relating to developing business plans to create well equipped and maintained equipment in health clinics, health practitioner accommodation and vehicles.

Clinical Risk

There was a recurrent theme in the comments from health practitioner survey respondents that second responders should be equipped with clinical skills to mitigate clinical risk associated with unscheduled and out of hours callouts. Review participants did not report any negative clinical outcomes due to the non-clinical skill set of second responders, but there is a sense that the callout situation could be resolved more rapidly, and be less stressful on the health practitioner if there were always two health practitioners attending a callout. Review participants particularly highlighted the Health Services Assistant (HSA) model used by some health service providers. In this model, second responders have some health qualifications ranging from first aid to volunteer ambulance (Cert III & Cert IV), and may or may not have received additional training once employed.

There was a strong call by many respondents for the Act to go beyond a second 'responsible person' and include the requirement that both responders to callouts are health practitioners. There appeared to be some disappointment that this requirement was not included in the current Act and that accordingly, Gayle's Law had not met the intended purpose. The health practitioners who contributed this perspective during interview expressed the opinion that the scope of Gayle's Law should have been to:

> *"fix all of the problems of remote area nursing that have been ignored for so long. I just won't work anywhere that still has one nurse posts (and that hasn't changed), and insist that two nurses attend all callouts. We need more nurses for all shifts. Money is being wasted on employing people with non-clinical skills when everyone is so exhausted" (HPI2).*

Other participants held a view that more closely aligned with the intention of Gayle's Law and Regulations to enhance personal safety, while still acknowledging that there are circumstances where two health practitioners are required during a callout. One participant provided the following advice:

> *"I firmly believe that at times, when the situation arises - minimum of 2 Registered Nurses is required. At the very least - be available" (HPS10).*

Based on the data available the review team considers that a designated responsible person accompanying the health practitioner, as per the current Act, has been sufficient to achieve the safety and security aim of Gayle's Law. Of importance is that there is a tension between the need for managing clinical risk and personal safety at the same time. If the second responder is also a health practitioner during a callout with two providers, and both persons are engaged in complex clinical care, then there is a risk that the safety function of the second responder role is not met. That is, all

in attendance are engaged in clinical care and not observing the situation for safety risks. One survey respondent commented:

> *"I feel strongly regarding safety. I am a duel registered nurse/paramedic …. The environment I work in is often unpredictable with multiple hazards. It is essential to have 2 people who can attend call outs, you need to be able to deliver care in a safe and non-hostile setting. The increased use of drugs, alcohol and acute mental crisis have made the job more difficult and unsafe." (HPS17)*

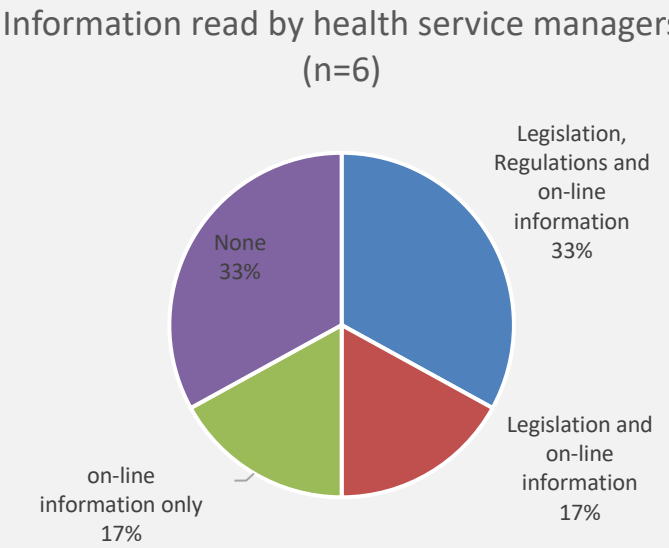
Extending Gayle's Law and/or Regulations to include two health practitioners at all callouts is based on clinical risk, and the review team recommend that this is a health service matter, not a legislative matter. Including a provision for a second health practitioner when required, along with guidance on assessing this need in clinical policies and procedures/guidelines would most likely achieve the desired outcome. Health service providers should, as a matter of good clinical governance, ensure that staffing levels are sufficient for a second health practitioner to be available and health funding bodies should ensure that adequate funds are available to implement this practice.

Knowledge of Gayle's Law and Regulations

Knowledge of Gayle's Law and Regulations, and orientation to the intent of Gayle's Law, health service provider policies and procedures/guidelines relevant to implementation of Gayle's Law, the role of the second responder and the assessment of risk is a critical component of ensuring that the intended outcomes of Gayle's Law and Regulations are achieved.

The variability of the consistency between health service provider policies/procedures/guidelines, Gayle's Law and Regulations and implementation of Gayle's Law as intended may in part be due to lack of familiarity with the Act and Regulations themselves. Only half of the Health Service Provider audit respondents had not read the Act or the Regulations. Instead, respondents relied heavily on on-line information (including Department for Health and Wellbeing fact sheets) as illustrated in Figure 12.

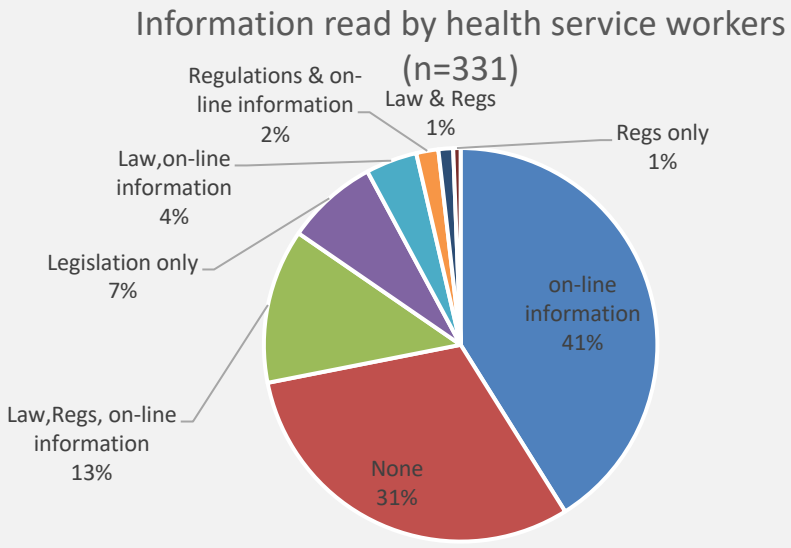
Figure 12



Orientation

As the Deputy Coroner noted in the inquest into the death of Gayle Woodford (Schapel, 2021) the degree to which policies/procedures/guidelines are implemented in practice is in part determined by how well they are followed by health practitioners. Orientation to policies, procedures and guidelines plays a key role in health practitioner practice. Orientation to Gayle's Law and the relevant procedures is of specific relevance to staff safety because approximately one-third of the 331 respondents who largely did not proceed with the health practitioner survey had not read any of the materials relevant to Gayle's Law. The most accessed information was on-line information (60%), with only 13% of respondents having read all options provided: the Act, the Regulations and the on-line information. Approximately one quarter (26%) of respondents had read the Act, with only 16% having read the Regulations. Figure 13 illustrates the variety of information that respondents had read.

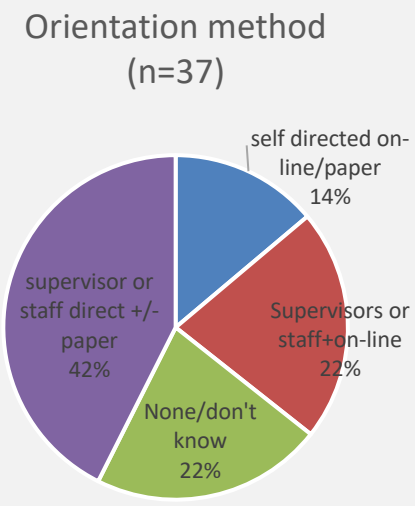
Figure 13



Five out of six health service providers responding to the audit identified that staff orientation to callout policies procedures, and/or guidelines was mostly mandated either for all staff, or all staff rostered for a callout including both first and second responders. Staff were orientated at varying points in their employment, but all health service providers stated that staff cannot work as a responder until they are oriented. Staff are then required to review the policy/procedure either every 3 months, an annual review, or not at all.

Health service providers indicated that the orientation program is mostly delivered by supervisors or staff, and is combined face-to-face and paper based, and may also incorporate an on-line policy. Health practitioners who responded to the survey confirmed that these orientation methods are available.

Figure 14



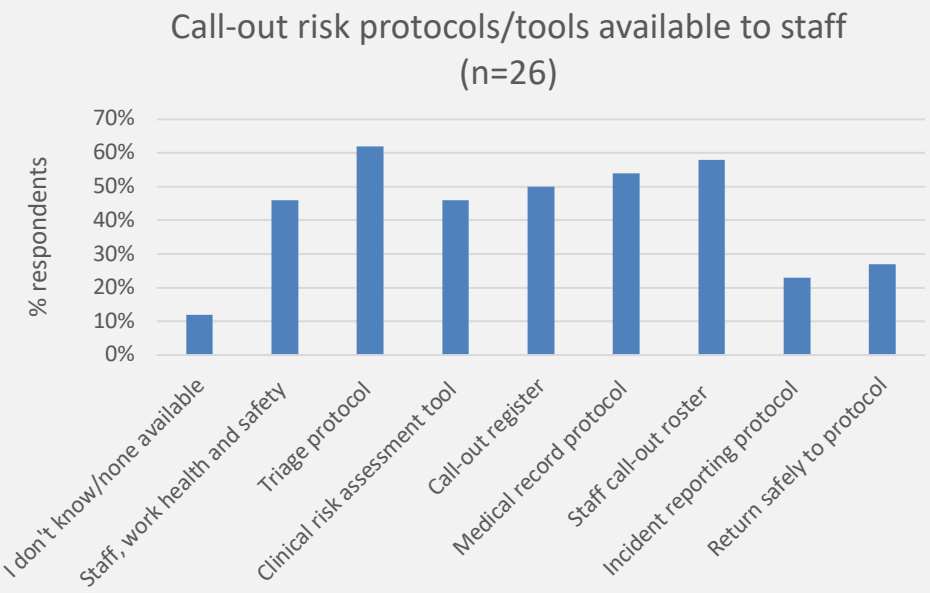
Of the 37 health practitioners who responded to this survey question, only just over half (57%) had participated in an organisational orientation program. Forty-three percent (43%) identified that they were expected to orientate themselves with two thirds identifying that this was through an on-line package, one third would receive information from their supervisor and one third didn't know what materials were available to access for orientation. In addition, interview respondents identified that assumptions were made about existing knowledge of procedures/guidelines relating to Gayle's Law if the second responder was employed elsewhere, or had previously worked in a remote area. One second responder commented:

> *"I thought that orientation was not necessary because I was assisting the RAN who should know about the safety requirements" (IV4).*

Accordingly, there was a disconnect between the stated mandatory requirement by health service providers and the on-the-ground compliance by health practitioners.

A specific example of the impact of variable uptake of orientation on health practitioner safety is the variability of knowledge about policies, procedures/guidelines relating to risk assessment. Of the ten (10) health service providers who provided policies and procedures/guidelines to the review team (80%) included clinical, safety, hazard and/or personal risk assessment tools. However, there was significant variation in the knowledge of the existence of these documents/tools amongst health practitioner respondents (see Figure 15).

Figure 15



This lack of knowledge about risk assessment resources has the potential to negatively impact on the safety of health practitioners given the information about callout intentions and practices. Data is described above that identifies health practitioner's concern about being directed to attend callouts based on clinical risk. At the same time (as described under TOR2) one of the dominant themes of both open-ended questions and interviews was that health practitioner respondents would prefer that the second responder have a minimum level of clinical skills and 40% of respondents reported attending callouts on their own. Without a good orientation to personal risk assessment procedures and tools it is likely that clinicians will make decisions about attending callouts based on clinical risk alone.

Mental Health

Feedback from health service providers, health practitioners, key informants and the expert reference group identifies that the legislated requirement for a second person to accompany health practitioners during all unscheduled and out-of-hours callouts has had a positive effect on the mental health of remote health staff. Relieving worry about whether a second person will be available, and what situations they might encounter on their own has been a contributing factor. So too has been reducing the tension between clinical risk and safety risk. That is, the availability of a second responder means that the health practitioner does not need to weigh up the relative risk of a person experiencing adverse clinical outcomes if they don't attend, but being fearful of attending an unknown circumstance.

The ability to identify another person who the health practitioner knows and trusts to accompany them during a callout if an employed second responder (who meets all of the legislative criteria) is not available, was reported as also reassuring by participants. This role is not named in the Act or

Regulations, but is referred to as an 'alternative responder' in the on-line information about Gayle's Law.

The relative certainty that a second person will be available is evident from the data confirming that a minimum number of callouts were reported as unaccompanied, and that 100% of callouts assessed as necessary were attended.

The other factor contributing to wellbeing was the contribution that employing second responders has made to overall staffing levels, as this key informant notes:

> *"It is good for my mental health not to be so tired. Having the extra staff … drivers, admin staff, even gardeners, has meant that I don't have to go out on call so often and can even have a weekend off knowing that I won't be called out at all – I can just read a book" (KII3).*

Improving safety of health practitioners beyond the scope of Gayle's Law

There was widespread interest in this review from nurses who were not currently working in the remote areas of South Australia subject to the provisions of Gayle's Law as evidenced by the 594 participants (82% of all respondents) who were ineligible to complete the health practitioner survey. Of those participants who did not continue with the survey, 46% (n=331) had read the Act, Regulations and/or on-line information about Gayle's Law.

Thirty-three respondents (5%) elected to provide comments to the review team despite not continuing to complete the survey, four of whom were eligible to participate. All made supportive comments about the Act regardless of whether they had read it or not. Three quarters (n=25) had read the Act, Regulations and/or on-line information about Gayle's Law, including two who were eligible to complete the survey.

Of the 33 respondents who provided comments, two thirds (n=22) identified that they were from interstate, and one-third were either currently, or had previously worked in South Australia. Two of the four who did not complete the survey despite meeting the criteria for participation identified themselves as second responders.

Over half of the respondents who provided comments identified that the Act be extended beyond the remote setting, to other jurisdictions sharing the same remote practice circumstances as South Australia; and/or during business hours in remote and community settings.

> *"Nurses currently in all states are working on their own. We do need to feel safe when doing our best for patients. We need our patients to feel safe when we are attending to their care" (HPS27).*

> *"nursing and dangers associated with* [it] *aren't specific to that state, so why are people not meeting the criteria? Only South Australia has the Law…..Act in all States is essential" (HPS28).*

> *"…There needs to be change to help protect those that help protect and care for us!! This tragedy could of easily been avoided on many of accounts, to bad our system does nothing until we fight for change, but by then the heart break and devastating loss is upon us. Make a change!!" (HPS9).*

Potential extensions included for all staff in any geographical location who deliver services in community settings to be accompanied by a second person. Named examples included nurses

working in small country hospitals; country and metropolitan community nurses, mental health workers, other outreach workers and paramedics.

The issues that prompted the implementation of Gayle's Law and the findings of this review are not unique to South Australia. As Gayle's Law is situated within the Health Practitioner National Law and Health Practitioner National Law Regulation, there is scope to introduce Gayle's Law nationally, by using a process in each jurisdiction similar to the process used to implement national registration. Given the degree to which budgetary factors have influenced how health service providers have been able to implement the Act and Regulations in South Australia, and how this in turn affects both the safety and security of health practitioners and second responders, and service delivery to people living in remote areas, should extending the Act elsewhere in Australia be adopted, then it will be essential to develop a business model and provide funding for the same.

RECOMMENDATION 2.4

Health service providers, in order to decrease the risks posed by presentations for health care at the health practitioner's (or second responder's) home/accommodation:

- *review and amend the policies, procedures/guidelines to preclude delivery of health care at the health practitioner's or second responder's home at any time of the day or night;*
- *implement communications systems that replace the need for in-person callout requests;*
- *co-design a communication strategy with community members to change the practice of attending the health practitioner's home to request care at any time of the day or night.*

RECOMMENDATION 2.5

Health service providers, in order to improve health practitioner safety should:

- *improve orientation procedures;*
- *encourage health service managers and staff to become familiar with the Act and Regulations rather than rely solely on information that interprets the application of the Act/Regulations;*
- *require that orientation of all health clinic managers, health practitioners, ancillary staff, visiting staff, and second responders, include a face-to-face component conducted by a relevant supervisor;*
- *implement the following orientation requirements for policies/procedures/guidelines relevant to Gayle's Law:*
  - *include the requirement for orientation as mandatory on commencement of employment, and as part of annual competency requirements:*
  - *include policies and procedures relevant to Gayle's Law in pre-employment documentation, first day induction checklists and require evidence of completion within the first month: and*
  - *document compliance with requirements in employment records and confirm prior to commencing callout duties.*

RECOMMENDATION 2.6

The Minister consider broadening the Act and Regulations to apply beyond the remote setting to all callout activities (scheduled and unscheduled) undertaken by health practitioners delivering care in any location at any time of day and night in South Australia.

RECOMMENDATION 2.7

South Australian health service providers in areas other than remote locations notwithstanding the requirements contained within the current Act and Regulations, consider adopting the safety recommendations of this review.

RECOMMENDATION 2.8

The Minister consider sharing the findings of this review with other Australian Ministers for Health to consider adopting Gayle's Law and Regulations (with recommended revisions) to apply to remote areas in all Australian States and Territories.

RECOMMENDATION 2.9

South Australia (SA) Health in its role in development of best health care practices consider bringing together a steering/advisory group that spans government, non-government and Aboriginal Community Controlled Health Organisations (ACCHOs) and includes health practitioners, second responders, professional and industrial organisations, and community members to inform and develop ongoing quality improvement processes for implementing Gayle's Law and Regulations.

RECOMMENDATION 2.10

The Minister consider amending Gayle's Law and Regulations to ensure that the current provisions of Clause 77D(3)(b) apply to both second responders (safety workers) and health practitioners in respect to safe arrival at their place of residence or other destination after leaving the callout location.

3. What is the impact of the Act and Regulations on members of communities, and the provision of health services in remote areas of South Australia?

Based on the data gathered for this review, the implementation of Gayle's Law Act and Regulations has had a positive impact on health and wellbeing of community members. Not only has the Act and Regulations ensured that an effective callout service is in place, but the engagement of local people in some communities as second responders has provided employment opportunities, and potentially career pathways into health for community members. In some communities there is also evidence of a growing sense of 'whole of community' responsibility for health practitioner safety. These factors

suggest that there is potential to further enhance health practitioner safety through codesign of strategies to optimise utilisation of health clinics/centres during business hours, minimise callouts, and change community practices whereby community members no longer present at the health practitioner's home/accommodation for health care.

There is a perceived stabilisation of the health practitioner workforce in South Australia, and despite the absence of New Zealand nurses due to COVID-19 border closures, a number of other staff are staying longer than planned in remote South Australian communities. Continuity of care has long been associated with improved access to health care, and as a consequence, better health outcomes. Greater collaboration between health practitioners and local Aboriginal and non-Aboriginal people is also seen a positive outcome of a nurse staying on in the one community for longer periods of time.

There was debate amongst review participants however, with regards to whether the introduction of Gayle's Law has strengthened or diminished relationships between community members and health practitioner staff. Strengthened relationships have developed with community member involvement in the second responder role. On the other hand, tensions have developed between health practitioners and community members when health practitioner expectations that community members would be involved as second responders have not been fulfilled.

There is also a role for the community to contribute to the safety and security of health practitioners. One second responder participant commented:

> *"I think that the community has taken on board Gayle's Law and, especially if the person on call is a community member or health worker, they [the community] are thinking twice about calling someone for something minor, and waiting to go to the clinic the next day instead of making a callout overnight.*

If such community engagement was also extended to precluding requests for care by attending the health practitioner's home, then one of the safety and security issues that played a critical role in Gayle Woodford's death could be mitigated.

Clinical skills

As described in the response to TOR2, there is some concern amongst health practitioners that second responders should be equipped with clinical skills to mitigate clinical risk associated with unscheduled and out of hours callouts. Review participants did not report any negative outcomes for community members due to the non-clinical skill set, but there is a sense that the callout situation could be resolved more rapidly, and be less stressful on the health practitioner if there were always two health practitioners attending a callout. Participants were unsure if the health status of people requiring callouts was reflective of a general worsening of health in remote communities, or was specific to the person requesting the callout. One participant provided this advice:

> *"I think that just means that the really sick people are making the callouts while the others are getting better because they are having proper primary health care instead of just a 'cranky' nurse at 2am in the morning because they want some Panadol" (IV3).*

In the long term, this may improve chronic disease management and the health and wellbeing of the population. It may also be possible to build on the strengths of SAAS/Volunteer Ambulance and Remote Area Nurse partnerships that have been established with the introduction of second

responder roles to develop a new model of care, with acute callouts being managed by on-site paramedics and volunteer ambulance workers, and nurses released to engage in interprofessional program work with midwives and allied health professionals. Such a new model would clearly require a business case and potential additional/remodelled budgets.

Services delivery impact

Funding is equally important for the new 'Business As Usual', as highlighted in TOR2. There is a cost to achieving the positive outcome that there have been NO occasions when a health service has not been provided because there has not been a second or alternative responder – i.e. 100% attendance at callout requests.

Although there may be a change to community health behaviours resulting in more proactive engagement with health services during business hours, the paradox is that when callouts involve health services staff as second responders, business hours service provision may be decreased. That is, a 'cost' associated with second responders in the majority of health clinics/centres with small staffing numbers, in periods where the health centre/clinic is closed for routine health care. Similarly, when health services' daytime hours of operation are reduced, the most likely effect is that the focus is on acute care delivery and the time available to staff (and therefore community members/consumers) for primary health care service delivery is reduced.

RECOMMENDATIONS *for TOR2.1, 2.2 and 2.4 address these findings.*

4. Do health service providers have suitable mechanisms in place for the recruitment of appropriate second responders to allow services to be provided to the community?

The data confirms that health service providers have suitable mechanisms in place to both recruit people to the role of second responder and recruit persons fulfilling the role to accompany a health practitioner when they attend an unscheduled and/or out of hours callout. There were differing opinions about what constituted appropriate skills, knowledge and experience for the second responder role, highlighting again the tension between ensuring health practitioner safety and minimising clinical risk. As highlighted in other sections of this report, the impact on services that can be provided to the community during and following an unscheduled or out of hours callout depends on the overall health service provider staffing profile, the size of the second responder pool, and the role of second responders in routine health service provision.

Recruitment to the role of second responder

Health service provider respondents identified that both employers and second responders themselves preferred second responders to be employees rather than volunteers. A volunteer model therefore was not seen to be appropriate or sustainable for the long term.

Second responders were either employed in existing health service provider roles and a callout function was added to their job description (e.g. drivers, administrative staff, health services

assistants, community workers); new roles were added to existing staffing profiles with a callout function as part of the role (e.g. health services assistants); or a new role specifically for callout was created and second responder is their only function (e.g. health services assistants, drivers, community members, *malpas* (cultural guides), employees of other health services, emergency services staff, family members of teachers and health service or other people employed in the community). A summary of the health practitioner respondent responses describing the profile of second responders used by their health service appears as Figure 6.

Recruitment for second responders is through employment advertising, and through word of mouth, particularly from other second responders who enjoy their roles. For example:

> *"In conversation with friends and at other sporting groups I am associated with, I have told of the rewarding feeling of helping people at their most vulnerable times" (SR2).*

Whilst some health service providers identified that there were difficulties in recruiting enough second responders, none of the health service provider respondents identified that the requirements for driver's license, and working with children clearance, was a barrier to recruitment as a second responder. However, some interview respondents identified that these requirements did reduce the pool of potential second responder applicants as these requirements were problematic for some Aboriginal community members.

The opportunity for paid employment was identified as an incentive for attracting persons to the role of second responder in small communities where jobs are often scarce. The roles had even greater attraction when health service providers included a training requirement or component to the role such as sponsoring participation in first aid and volunteer ambulance (Certificate III and Certificate IV) courses. The latter has the benefit of significant potential to provide a career pathway into health professions for Aboriginal people.

Recruiting second responders to accompany a health practitioner callout

Second responders are either rostered for on-call duties or on a list and know that they need to be available. They are contacted via mobile phone. Given the small staffing profile of most health services, most second responders are on-call, or know that they must be available to be on-call most of the time. Some health service providers have adopted a model of part-time employment in a role in the health service during the day to facilitate a break between out of hours on-call duties and business hours duties. Other health services simply employ the second responder for the time involved in a callout, but respondents reported that this model was significantly less reliable than second responders employed in part time roles.

In one case, community members were also identified as second responders in circumstances when there were not enough staff for a 'big' emergency, such as a riot in the community when multiple health practitioners were required to deliver clinical care away from the health services premises and significant risks to safety and security were present. The need for police and additional community members was also identified as necessary in the event of a security alert.

Appropriateness of second responder skills, knowledge and experience

Approximately one third of second responder survey respondents were also volunteer ambulance officers and together with health service providers and health practitioners identified the advantages of these clinical skills in a callout situation. Advantages ranged from being familiar with

the equipment and therefore able to maintain stocks, easily performing equipment cleaning and maintenance and to rapidly respond to health practitioner requests. In health services where the second responder is actually the first person responding to a callout, being able to assess, provide and administer care was seen as an advantage in terms of improved health outcomes. Some respondents reported that this may even mean that the callout does not progress to needing the presence of a health practitioner.

There are however, concerns with this approach to the second responder's role. Not only is there potential for a mismatch between second responder capability and (high) community expectations, but there is also the potential for the second responder to be distracted from their role in maintaining safety and security, and therefore not achieve the intention of Gayle's Law.

Although the ability to drive the callout vehicle is essential, a driver's license also facilitates the working with children clearances that are legislative requirements for the role. Assisting Aboriginal community members to gain a driving license was identified as a positive initiative in terms of eligibility for the second responder role, but also opened up a broader range of employment opportunities for Aboriginal people. Health practitioners, interview participants and reference group members also highlighted the advantages of employing Aboriginal people as second responders (or in the case of one health service – First Responders) in Aboriginal communities for their essential role as cultural advisors and brokers, and for effective communication with Aboriginal language speakers.

RECOMMENDATION 4.1

Health service providers give consideration to the balance between risks and the benefits when employing second responders with entry level health care skills, and continue to develop health workforce models that are responsive to local need and the unique conditions of remote health service delivery.

Health services consider working collaboratively with State and Australian Government Departments of Health and communities to develop a business model to expand funding to health service providers for sustainable employment of second responders in part time health service roles.

5. What is the usage of prescribed circumstances in Regulation 11E(2) under which unaccompanied remote area attendance may occur?

The review found that although respondents identified that health practitioners attended prescribed sites, they did report attending alone/without a second responder.

Regulation 11E(2) includes the provision to waive the requirement that

"a health practitioner must not attend a callout unless they are accompanied by a second responder [77E(1)]

(a) where the callout is to a police station and, before attending the callout, the health practitioner is satisfied, taking into account all information available to the health practitioner in relation to the callout, that at least 1 police officer or special constable will be present at the police station at all times while the health practitioner attends the callout;

(b) *where the callout is in response to an emergency and, before attending the callout, the health practitioner is satisfied, taking into account all information available to the health practitioner in relation to the callout, that at least 1 emergency services worker (other than the health practitioner) will be present at the location of the emergency at all times while the health practitioner attends the callout.*"

Six (60%) of the ten policies and procedures/guidelines submitted to the review team contained a provision for callouts to be made to a prescribed premises without a second responder.

Police Stations

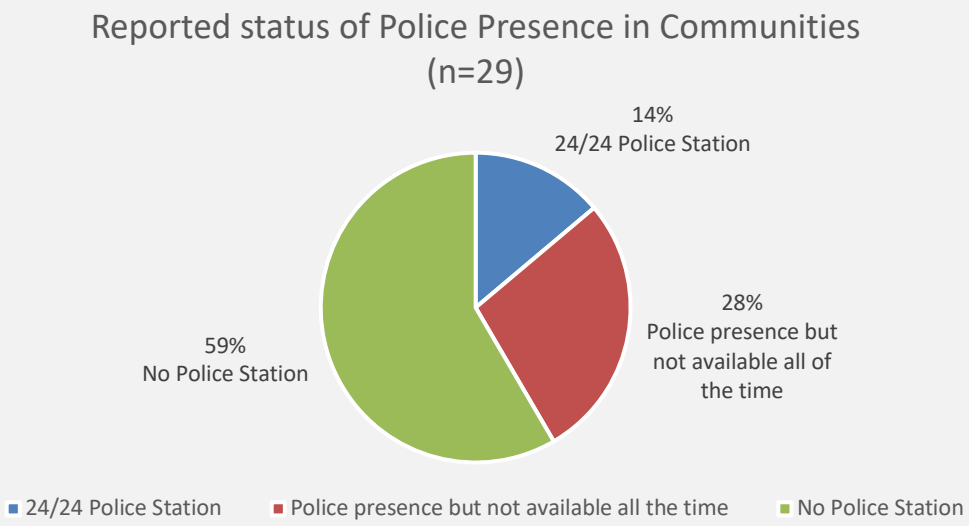
Although many (around 60%) health service provider, health practitioner, and second responder participants identified that they could be asked to attend Police Stations, of the eight sites identified, Police Stations were the least frequent excepting for the health practitioner's home, and did not rank when participants described the most common site that they actually attended (see Figure 9 and 10 on previous pages).

The value of police presence is paramount, with health practitioners specifically identifying the need for police presence when they are required to provide essential and emergency health care in cases of family violence, assault and other instances where recipients of health care are demonstrating aggressive behaviour. However, the value of Police Stations as prescribed sites may be limited because over half (59%) of the health practitioner respondents identified that there was no Police Station at their community, with a further third (28%) identifying that police were not available all of the time. Police availability may have been limited by the Police Station not being staffed 24 hours/ day, police coming from elsewhere, or police being busy outside the Police Station. The following comment was made by one participant:

> *"Some* [police] *live in one community and will spend a short time in the morning in that community and then go to the town [where the health service is located] where they spend most of the rest of the day out and about or attending incidents on the highway or wider community"*.

Figure 16 illustrates police presence as reported by health practitioner respondents.

Figure 16



There were NO reported occasions when health practitioners attended a Police Station without a second responder. The rationale given was that there was just as much risk to safety during the journey to attend the Police Station that a second responder was necessary for the journey. Second responders were also helpful during the health service encounter as police were often busy and/or the second responder was more skilled to assist.

Emergency Workers

Similar to the situation with attending a Police Station, a second responder was deemed necessary by participants when travelling to the accident scene. Once at the scene, the second responder was invaluable because they would continue to monitor safety when the emergency worker was pre-occupied with continuing care.

RECOMMENDATION 5.1

The Minister consider amending Gayle's Law and Regulations to remove prescribed locations to ensure that health practitioners are accompanied by a responsible person en-route on any callout regardless of the time of day or night.

6. Do the prescribed circumstances in Regulation 11E, which outline certain circumstances where a second responder will already be in attendance, operate effectively and are there any amendments to the Act or Regulations that would improve their operation?

As described above, clause 11E is best removed. However, there is also a strong argument that for safety purposes, Clause 77E(2) of the Act, be amended to ensure that health practitioners are accompanied by the second responder during **any** journey to the location where the callout service is to be provided.

RECOMMENDATION 6.1

The Minister considers amending Clause 77E (2) to ensure that health practitioners are always accompanied by a second responder (safety worker) during the journey to all callout locations.

(See also Recommendation 2.1)

7. What is the number of instances when a health service has not been provided due to the unavailability of a second responder/ alternative responder, and has this resulted in any impact on the health practitioner, health service provider or the person seeking a health service?

Health service providers reported that they have achieved 100% service for callouts over the past 12 months, having NO occasions when a health service has not been provided without a second responder/alternative responder. The expert reference group confirmed that this was also their experience, as did the survey and interview participants.

As described in TOR3 above, there have been some negative impacts on provision of health services to community members by health practitioners responding to callouts 100% of the time. Particularly in cases when callouts involve health services staff as second responders, business hours service provision may be decreased. Health practitioners however, described that employing non-clinical staff as second responders has significantly reduced the burden of callouts, and associated fatigue.

As described in recommendation 4.1 there is a need to continue to develop health workforce models that are responsive to local need and the unique conditions of remote health service delivery.

RECOMMENDATION 7.1

State and Australian Government Departments of Health give consideration to working collaboratively with health services and communities to develop a business model to expand funding to health service providers for sustainable employment of non-clinical second responders.

CONCLUSION

This review has found that there has been a genuine commitment to implementing Gayle's Law as intended. The data from multiple data sources have reinforced that there are safety concerns in remote Australia that go beyond callouts.

From a remote health services perspective, there is the potential for safety to be compromised for all persons involved in providing care, at all locations where care may be requested and/or provided in remote areas, during the journey to these locations, and at any time of the day and night. These concerns also extend beyond remote areas, and beyond South Australia, and apply to any context where a health practitioner is delivering health services on their own. This review recommends amendments to the Act and Regulations to address this broader risk. It also acknowledges the important role of policies, and procedures/guidelines in minimising risk and supporting safety.

Policies/procedures/guidelines support implementation of the Act and Regulations, and also serve as adjuncts to legislative measures to extend on-the-ground responses beyond those described in the Act. At the same time, this review has identified that any measure is only as good as it is translated into practice, and that there is a need for better orientation processes and monitoring on-the-ground compliance with safety measures.

Financing the implementation of Gayle's Law has been identified by respondents as problematic, and compromises to routine care to support safety during callouts have been reported. Similarly, the review has highlighted health practitioners' needs for additional clinical support during callouts, and the overall challenges to adequately staffing remote health clinics/centres to deliver comprehensive acute, emergency and primary health care.

Whilst Gayle's Law has contributed to improving health services delivery in remote Australia, further improvements can be made, through improving access to quality health services which goes well beyond the jurisdiction of this Act.

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APPENDICES

APPENDIX 1: Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017

No 56 of 2017 assented to 12.12.2017

South Australia

Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017

An Act to amend the *Health Practitioner Regulation National Law (South Australia) Act 2010*.

Contents

The Parliament of South Australia enacts as follows:

Part 1—Preliminary

1—Short title

This Act may be cited as the *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017*.

2—Commencement

This Act will come into operation on a day to be fixed by proclamation.

3—Amendment provisions

In this Act, a provision under a heading referring to the amendment of a specified Act amends the Act so specified.

Part 2—Amendment of *Health Practitioner Regulation National Law (South Australia) Act 2010*

4—Insertion of Part 5A

After section 77 insert:

Part 5A—Restrictions on single person attendances in remote areas

Division 1—Preliminary

77A—Interpretation

(1) In this Part—

callout to which Division 2 applies—see section 77C(2);

health practitioner means—

(a) a health practitioner within the meaning of the *Health Practitioner Regulation National Law (South Australia)*; and

(b) any other person declared by the regulations to be included in the ambit of this definition for the purposes of this Act;

health service means—

(a) a health service within the meaning of the *Health Practitioner Regulation National Law (South Australia)*; and

(b) any other service or activity declared by the regulations to be included in the ambit of this definition for the purposes of this Act;

out of hours callout means a request for the attendance of a health practitioner at a specified place made by or on behalf of a person where—

(a) the attendance occurs, or is to occur—

(i) between the hours of 5 pm on one day and 8 am on the next day; or

(ii) on a Saturday or Sunday; or

(iii) on a public holiday; and

(b) the place at which a health practitioner is to attend pursuant to the request is in a remote area,

but does not include a request of a kind declared by the regulations not to be included in the ambit of this definition;

remote area—see subsection (2);

second responder means a person engaged as a second responder in accordance with section 77D;

State authority means—

(a) a public sector agency; or

Note—

This includes, for example, entities such as incorporated hospitals under the *Health Care Act 2008*.

(b) a local council constituted under the *Local Government Act 1999*; or

(c) any other person or body declared by the regulations to be a State authority for the purposes of this Part,

but does not include a person or body declared by the regulations to be excluded from the ambit of this definition;

unscheduled callout means a request for the attendance of a health practitioner made by or on behalf of a person where—

(a) the attendance is, or is requested, to occur within 24 hours of the making of the request; and

(b) the place at which a health practitioner is to attend pursuant to the request is in a remote area,

but does not include a request for attendance of a kind declared by the regulations not to be included in the ambit of this definition.

(2) For the purposes of this Part, a reference to a ***remote area*** will be taken to be a reference to the following areas of the State:

(a) the lands within the meaning of the *Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981*;

(b) the lands within the meaning of the *Maralinga Tjarutja Land Rights Act 1984*;

(c) an area outside of a council area under the *Local Government Act 1999*;

(d) any other area declared by the regulations to be included in the ambit of this definition,

but does not include an area declared by the regulations to be excluded from the ambit of this definition.

(3) For the purposes of this Part, a reference to ***attending a callout*** will be taken to be a reference to attending a specified place in response to a callout to which Division 2 applies.

77B—Interaction with other Acts

This Part is in addition to, and does not derogate from, the provisions of any other Act or law.

Division 2—Restrictions on single person attendances in remote areas

77C—Application of Division

(1) This Division applies to the following health practitioners:

(a) a health practitioner employed by a State authority;

(b) a health practitioner who provides health services for, or on behalf of, a State authority pursuant to a contract for services or other agreement;

(c) a health practitioner who provides health services in a remote area (being health services that are wholly or partly funded under a law of the State);

(d) a health practitioner, or health practitioner of a class, prescribed by the regulations for the purposes of this subsection,

but does not apply to a health practitioner, or health practitioner of a class, declared by the regulations not to be included in the ambit of this subsection.

(2) This Division applies to callouts of the following kinds:

(a) out of hours callouts;

(b) unscheduled callouts;

(c) any other callout of a class prescribed by the regulations for the purposes of this subsection.

77D—Second responders

(1) A health practitioner engages a second responder by taking such action as may be required by the regulations.

(2) Before engaging a second responder, a health practitioner must be satisfied on reasonable grounds that the second responder satisfies any requirements set out in the regulations for the purposes of this subsection.

(3) A person will be taken to be a second responder in respect of a particular callout—

(a) from the time that the person is engaged to act as second responder in respect of the callout; and

(b) until the time that the callout is completed,

(both determined in accordance with the regulations).

(4) The regulations may make further provision in relation to second responders.

(5) Without limiting the generality of subsection (4), the regulations may—

(a) prohibit a specified person, or a person of a specified class, from being engaged as a second responder;

(b) limit the circumstances in which a specified person, or a person of a specified class, may be engaged as a second responder;

(c) provide for, or limit, entitlements accrued by, and the terms and conditions of engagement of, second responders;

(d) limit the civil liability of second responders;

(e) modify the operation of a specified Act or law as it applies to second responders.

77E—Health practitioner to be accompanied by second responder

(1) Subject to this section, a health practitioner to whom this Division applies must not attend a callout to which this Division applies unless the health practitioner is accompanied by a second responder.

(2) A second responder need not accompany a health practitioner attending a callout to which this Division applies during the journey to the place at which health services are to be provided in relation to the callout.

(3) Subsection (1) does not apply—

(a) if the place at which health services are to be provided in relation to the callout is prescribed premises; or

(b) in any other circumstances prescribed by the regulations for the purposes of this subsection.

(4) For the purposes of subsection (1), a second responder accompanies a health practitioner attending a callout—

(a) by being physically present with the health practitioner at any time the health practitioner is in the proximity of the person to whom health services are to be, are being, or have been, provided in relation to the callout; or

(b) by taking action of a kind prescribed by the regulations for the purposes of this paragraph.

(5) For the purposes of this section, a second responder will be taken to be accompanying a health practitioner during the provision of health services to a person despite not being physically present with the health practitioner if—

(a) the health practitioner is of the opinion that, having regard to the nature of the health services and the privacy of the patient, it is not appropriate for the second responder to be physically present during the provision of the health services; and

(b) the second responder remains in the same premises as, and within the hearing of, the health practitioner during the provision of the health services.

77F—Limitation of liability

(1) Despite any other Act or law, no liability attaches to the Crown for any loss or damage arising out of the operation of this Part.

(2) A health practitioner or other person who complies with the requirements of this Part (including, to avoid doubt, a health practitioner who refuses to attend a callout to which Division 2 applies in the absence of a second responder)—

(a) cannot, by virtue of doing so, be held to have breached any code of professional etiquette or ethics, or to have departed from any accepted form of professional conduct; and

(b) to the extent that the health practitioner or person has acted in good faith and without negligence, incurs no civil liability in respect of such compliance (including, to avoid doubt, liability arising under disciplinary or similar proceedings).

(3) For the purposes of section 74 of the *Public Sector Act 2009*, a second responder, in relation to their role as a second responder—

(a) will be taken to be a person to whom that section applies; and

(b) will be taken to be exercising official powers or functions.

Division 3—Providers of health services in remote areas to have policies and procedures to ensure safety and security of health practitioners

77G—Application of Division

This Division applies to the following persons and bodies:

(a) a State authority who provides or may provide health services in a remote area, or on whose behalf such health services are provided;

(b) a person or body who provides, or is to provide, health services in a remote area for, or on behalf of, a State authority pursuant to a contract for services or other agreement;

(c) a person or body who provides, or is to provide, health services in a remote area that are wholly or partly funded under a law of the State;

(d) any other person or body, or person or body of a class, prescribed by the regulations for the purposes of this section,

but does not apply to a person or body, or person or body of a class, declared by the regulations not to be included in the ambit of this section.

77H—Providers of health services in remote areas to prepare or adopt policies and procedures for the safety and security of health practitioners

(1) Each person or body to whom this Division applies must, in accordance with any requirements set out in the regulations, prepare or adopt policies and procedures designed to ensure the safety and security of health practitioners providing health services in remote areas for or on behalf of the person or body.

(2) Without limiting the matters that may be included in the policies and procedures required under this section, those policies and procedures must contain—

(a) a provision expressly preventing any person from directing or requiring (however described) a health practitioner to whom Division 2 applies to attend a callout in contravention of section 77E(1); and

(b) provisions ensuring the compliance of the person or body to whom this Division applies, and any person employed by or on behalf of the person or body, with the requirements of Division 2; and

(c) any other provision, or provision of a kind, required by the regulations.

(3) A person or body to whom this Division applies may, in accordance with any requirements set out in the regulations, from time to time vary or substitute a policy or procedure required under this section.

(4) A person or body to whom this Division applies must, if required to do so by the Minister, provide to the Minister a copy of each policy and procedure prepared or adopted under this section, as in force from time to time.

77I—Policies and procedures to be reviewed

A person or body to whom this Division applies must, in accordance with any requirement set out in the regulations, review the policies and procedures prepared or adopted by the person or body under section 77H at least once in every 5 year period.

77J—State authorities not to contract etc with non-compliant providers

(1) Despite any other Act or law, a State authority must not enter a contract or agreement (however described) relating to the provision of health services in remote areas unless—

(a) the provider of those services has complied with this Division; and

(b) the contract or agreement contains provisions ensuring that the provision of health services pursuant to the contract or agreement will comply with any requirements under Division 2.

(2) Without limiting subsection (1), a term of a contract or agreement that is inconsistent with this section is, to the extent of the inconsistency, void and of no effect.

77K—Power of Minister on refusal etc to comply with Division

(1) If a State authority refuses or fails to comply with a requirement under this Division, the Minister may, after consultation with the State authority—

(a) report the refusal or failure to the Minister responsible for the State authority (if any); and

(b) direct the State authority to comply with the requirement.

(2) If after directing a State authority to comply with a requirement the Minister is not satisfied that the State authority has done so, the Minister must prepare a report to Parliament setting out—

(a) the fact of the State authority's refusal or failure to comply with the requirement; and

(b) the reasons (if any) given by the State authority for the refusal or failure to comply with the requirement; and

(c) any other information required by the regulations.

(3) The Minister must, within 6 sitting days after completing a report under subsection (2), cause a copy of the report to be laid before both Houses of Parliament.

Division 4—Miscellaneous

77L—Exemption

(1) The Minister may, by notice in writing, exempt a specified person, or a specified class of persons, from the operation of a provision or provisions of this Part.

(2) An exemption may be conditional or unconditional.

(3) The Minister may, by notice in writing, vary or revoke an exemption for any reason the Minister thinks fit.

77M—Review of Part

(1) The Minister must cause a review of the operation of this Part to be conducted and a report on the review to be prepared and submitted to the Minister.

(2) The review and the report must be completed after the second, but before the third, anniversary of the commencement of this Part.

(3) The Minister must cause a copy of the report submitted under subsection (1) to be laid before both Houses of Parliament within 6 sitting days after receiving the report.

APPENDIX 2: Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No2) Variation Regulations 2019

No 239 of 2019 published in *Gazette 8.11.2019 p 3836*

South Australia

Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No 2) Variation Regulations 2019

under the *Health Practitioner Regulation National Law (South Australia) Act 2010*

Contents

Part 1—Preliminary

1—Short title

These regulations may be cited as the *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No 2) Variation Regulations 2019*.

2—Commencement

These regulations come into operation on the day on which they are made.

3—Variation provisions

In these regulations, a provision under a heading referring to the variation of specified regulations varies the regulations so specified.

Part 2—Variation of *Health Practitioner Regulation National Law (South Australia) Regulations 2010*

4—Insertion of regulations 11A, 11B, 11C, 11D, 11E, 11F, 11G and 11H

After regulation 11AA insert:

11A—Interaction of regulations with *Work Health and Safety Act 2012*

Nothing in regulations 11B to 11G (inclusive), being regulations made under Part 5A of the Act, derogates from the requirements of the *Work Health and Safety Act 2012* in respect of a person conducting a business or undertaking (within the meaning of that Act).

Note—

See section 77B of the Act.

11B—Definitions in Part 5A (section 77A)

(1) For the purposes of paragraph (b) of the definition of ***health practitioner*** in section 77A(1) of the Act, a health service provider within the meaning of the *Health Practitioner Regulation National Law (South Australia)* (other than a health practitioner within the meaning of the *Health Practitioner Regulation National Law (South Australia)*) is prescribed.

Note—

Health practitioners (within the meaning of the *Health Practitioner Regulation National Law (South Australia)*) are already included in the definition of ***health practitioner*** in section 77A(1) of the Act.

(2) For the purposes of section 77A(2)(d) of the Act, the following areas are included in the ambit of the definition of ***remote area***:

(a) the area of the District Council of Coober Pedy;

(b) the area of the Municipal Council of Roxby Downs.

11C—Application of Part 5A Division 2 of Act

For the purposes of section 77C(1)(d) of the Act, the following health practitioners are prescribed:

(a) a health practitioner registered under the *Health Practitioner Regulation National Law (South Australia)* to practise in the medical profession;

(b) a health practitioner registered under the *Health Practitioner Regulation National Law (South Australia)* to practise in the midwifery profession as a midwife;

(c) a health practitioner registered under the *Health Practitioner Regulation National Law (South Australia)* to practise as a nurse in the registered nurses division of the nursing profession;

(d) a health practitioner employed by, or otherwise providing a health service on behalf of, a person or body wholly or partly funded (by grant, service agreement or other such arrangement) by the Commonwealth Government.

11D—Second responders for remote area attendance

(1) For the purposes of section 77D(1) of the Act, a health practitioner engages a person as a second responder for the purposes of a particular callout by—

(a) contacting the person by telephone or in person; and

(b) advising the person of—

(i) the general nature of the callout including the location and an estimate of the time required; and

(ii) the designated time and place for the health practitioner and the person to meet for the purposes of the callout; and

(c) confirming the eligibility, availability and agreement of the person to attend the callout as a second responder; and

(d) advising that the person is engaged as a second responder for the callout.

(2) Subject to subregulation (3), for the purposes of section 77D(2) of the Act a second responder—

(a) must hold a current Australian driver's licence; and

(b) must have been subject to a working with children check (within the meaning of the *Child Safety (Prohibited Persons) Act 2016*) within the preceding 5 years; and

(c) must not be prohibited from working with children under the *Child Safety (Prohibited Persons) Act 2016* or a law of the Commonwealth or of another State or Territory.

(3) The requirements of subregulation (2) do not apply in respect of a person to be engaged by a health practitioner as a second responder for a particular callout where—

(a) the health practitioner has taken all reasonable steps to engage as a second responder a person who satisfies the requirements of subregulation (2) but has been unable to do so; and

(b) the health practitioner believes on reasonable grounds that the risk to the health of a person to whom health services are to be provided in relation to the callout is high; and

(c) the person is known to the health practitioner and is, in the opinion of the health practitioner, a suitable person to be engaged as a second responder in the circumstances.

(4) Pursuant to section 77D(3)(a) of the Act, a person is engaged to act as a second responder from the time that a health practitioner advises the person that they are engaged as a second responder pursuant to subregulation (1)(d).

(5) Pursuant to section 77D(3)(b) of the Act, a callout is completed in respect of a second responder when, after leaving the location of the callout or any other place at which the second responder attended in relation to the callout, the second responder arrives at their place of residence or other destination nominated by the second responder and advised to the health practitioner.

(6) For the purposes of subregulation (3)(b), the risk to the health of a person to whom health services are to be provided in relation to a callout is not high if the health practitioner is of the opinion that treatment of the person can be delayed—

(a) until the normal operating hours of an available clinic or health facility commence; or

(b) for a period of more than 24 hours.

11E—Prescribed premises and prescribed circumstances for unaccompanied remote area attendance

(1) For the purposes of section 77E(3)(a) of the Act, premises approved by the Minister are prescribed premises.

(2) For the purposes of section 77E(3)(b) of the Act, the following circumstances relating to a callout by a health practitioner are prescribed:

(a) where the callout is to a police station and, before attending the callout, the health practitioner is satisfied, taking into account all information available to the health practitioner in relation to the callout, that at least 1 police officer or special constable will be present at the police station at all times while the health practitioner attends the callout;

(b) where the callout is in response to an emergency and, before attending the callout, the health practitioner is satisfied, taking into account all information available to the health practitioner in relation to the callout, that at least 1 emergency services worker (other than the health practitioner) will be present at the location of the emergency at all times while the health practitioner attends the callout.

(3) In this regulation—

emergency services worker means any of the following persons:

(a) a police officer;

(b) a special constable;

(c) a member of an emergency services organisation within the meaning of the *Fire and Emergency Services Act 2005*;

(d) persons engaged in the provision of emergency ambulance services authorised under the *Health Care Act 2008*;

(e) any other person, or person of a class, approved by the Minister to be an emergency services worker;

special constable has the same meaning as in the *Police Act 1998*.

11F—Application of Part 5A Division 3 of Act

(1) For the purposes of section 77G(d) of the Act, the following persons and bodies are prescribed:

(a) if a designated person provides a health service on behalf of another person or body—that other person or body;

(b) in any other case—a designated person.

(2) The following persons are ***designated persons*** for the purposes of subregulation (1):

(a) a person registered under the *Health Practitioner Regulation National Law (South Australia)* to practise in the medical profession;

(b) a person registered under the *Health Practitioner Regulation National Law (South Australia)* to practise in the midwifery profession as a midwife;

(c) a person registered under the *Health Practitioner Regulation National Law (South Australia)* to practise as a nurse in the registered nurses division of the nursing profession.

11G—Policies and procedures for remote area attendance

For the purposes of section 77H(2)(c) of the Act, the following kinds of provisions are required to be included in policies and procedures under section 77H of the Act:

(a) provisions to assist in assessing the eligibility and selection of persons to be second responders;

(b) provisions to manage risks to the safety and security of health practitioners identified as being specific to the provision of health services—

(i) at, or from, a specific location; or

(ii) by a specific health service provider.

11H—Review of amendments to regulations by *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No 2) Variation Regulations 2019*

(1) The Minister must cause a review of the operation of the amendments made to these regulations by the *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No 2) Variation Regulations 2019* to be conducted and a report on the review to be prepared and submitted to the Minister.

(2) The review and the report must be completed after the first anniversary of the commencement of the *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) (No 2) Variation Regulations 2019* but no later than 6 months after that anniversary.

(3) The Minister must cause a copy of the report submitted under subregulation (1) to be laid before both Houses of Parliament within 6 sitting days after receiving the report.

Note—

As required by section 10AA(2) of the *Subordinate Legislation Act 1978*, the Minister has certified that, in the Minister's opinion, it is necessary or appropriate that these regulations come into operation as set out in these regulations.

Made by the Governor

with the advice and consent of the Executive Council
on

No 239 of 2019

APPENDIX 3: SA Department for Health, Gayle's Law Fact Sheet

Fact Sheet

Gayle's Law

The *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017*, more commonly referred to as "Gayle's Law", was passed by Parliament to provide better protection for health practitioners working in remote areas of South Australia.

Under Gayle's Law, any health practitioner who attends an out of hours or unscheduled callout in a remote area of South Australia must be accompanied by a second responder.

The second responder accompanies the health practitioner on these types of callouts to reduce the chances of personal attack.

Who does Gayle's Law apply to?

Any **health practitioner** who provides a *health service* in response to an **out of hours** or **unscheduled callout** in a **remote area** of South Australia must be accompanied by a second responder.

In terms of the legislation the following definitions are important:

health practitioner – is taken to include any person registered under the *Health Practitioner Regulation National Law* and any person who provides a health service as defined under the *Health Practitioner National Law.*

This includes a practitioner in the following health professions:

- Aboriginal and Torres Strait Islander health practice;
- Chinese medicine;
- chiropractic;
- dental;
- medical;
- medical radiation practice;
- nursing;
- midwifery;
- occupational therapy;
- optometry;
- osteopathy;
- paramedicine;
- pharmacy;
- physiotherapy;
- podiatry; and
- psychology.

In addition any person who provides the following health services:

- services provided by registered health practitioners;
- hospital services;
- mental health services;
- pharmaceutical services;
- ambulance services;
- community health services;
- health education services;
- welfare services necessary to implement any services referred to above;
- services provided by dieticians, masseurs, naturopaths, social workers, speech pathologists, audiologists or audiometrists; and
- pathology services.

When does Gayle's Law apply?

Gayle's Law applies when a health practitioner as defined above is requested to attend an out of hours or unscheduled call out.

out of hours callout – request for attendance of a health practitioner between 5:00pm and 8:00am, or anytime on a Saturday, Sunday or public holiday.

unscheduled callout – request for the attendance of a health practitioner within 24 hours of the request.

remote area – Gayle's Law applies to any out of hours or unscheduled callout if it is within the part of South Australia that covers:

- an area not covered by a local council under the *Local Government Act 1999;*
- the lands within the meaning of the *Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981;*
- the lands within the meaning of the *Maralinga Tjarutja Land Rights Act 1984;*
- the area of the District Council of Coober Pedy; and
- the area of the Municipal Council of Roxby Downs.

The map below shows the parts of South Australia where Gayle's Law applies.

Gayle's Law applies to health services provided by:

1. the South Australian Government;
2. any person or organisation contracted to provide the service on behalf of the South Australian Government;
3. any person or organisation funded, wholly or in part, by the South Australian or Commonwealth Governments to provide the service;
4. local councils providing services in remote areas;
5. privately practising doctors, nurses, or midwives.

When did Gayle's Law commence?

Gayle's Law came into operation on 1 July 2019.

Health service providers must now have arrangements in place for the engagement of second responders and policies and procedures to reflect the legislation.

Gayle's Law Regulations:

Gayle's Law Regulations were made on 7 November 2019. These regulations replace those made on 1 July 2019 which were disallowed on 16 October 2019.

Circumstances where a second responder is not required:

The regulations prescribe two circumstances under which a health practitioner may attend an out of hours or unscheduled callout in a remote area without a second responder. These circumstances are:

1. when the callout is to a police station and at least one police officer or special constable will be present at all times while the health practitioner attends the callout; and
2. when the callout is in response to an emergency, e.g. highway vehicle accident, where at least one emergency services worker (other than the health practitioner) will be present at the location of the emergency while the health practitioner is attending.

Who is a second responder?

The Act does not define a second responder but it is taken to mean a trusted community member. It could be a person from the local community, another employee of a health service, or another Government employee.

Second responders may be paid employees or volunteers.

Under the regulations a second responder must:

a) have a current driver's licence; and

b) have a working with children check; and

c) not be prohibited from working with children.

There are circumstances where these requirements do not apply. A health practitioner may engage an alternative second responder where:

a) a designated second responder is not available;

b) the alternative second responder is known to the health practitioner and is, in the opinion of the health practitioner, a suitable person to be engaged on a one-off basis as a second responder;

c) the risk to the health of the patient is high – i.e. attendance/treatment cannot be delayed until normal operating hours of an available clinic, or for more than 24 hours.

What policies and procedures are required?

Under Gayle's Law, health service providers must have policies and procedures in place to ensure the safety and security of health practitioners.

Under Gayle's Law these policies and procedures must:

(a) require the provider and any person employed by them to comply with the requirements of Gayle's Law;

(b) include a provision preventing anyone from directing or requiring a health practitioner to attend a callout without a second responder;

(c) include provisions to assist in assessing the eligibility and selection of someone to be a second responder;

(d) include provisions to manage any risks to the safety and security of health practitioners that have been identified in relation to the delivery of health services at, or from a particular location,

(e) include provisions to manage any risks to the safety and security of health practitioners that have been identified in relation to the delivery of health services by a specific health service provider.

Further information

Should you require further information about Gayle's Law please telephone (08) 8226 7392 or email HealthPolicyLegislation@sa.gov.au.

APPENDIX 4: Health service providers covered by the review

- Nganampa Health Council
- Oak Valley Health Service (Maralinga)
- Pika Wiya Health Service
- Royal Flying Doctor Service
- Rural Doctors Workforce Agency
- South Australian Ambulance Service
- South Australian Department of Education
- South Australian Department for Health and Wellbeing
- Tullawon Health Service, Yalata
- Umoona Tjutagku HS (UTHS) Coober Pedy

APPENDIX 5: Map showing areas of South Australia where Gayle's Law applies

APPENDIX 6: Background Literature Review

A review of the current literature has revealed that there had been few related publications since the tragic murder of Gayle Woodford and the introduction of the "Gayle's Law". Whilst there have not been many publications there have been a number of organisations engage in activities designed to support the safety of rural and remote health workers, among them is CRANAplus; which has long held the position that remote health practitioners should never 'work alone'.[1]

In 2017 CRANAplus delivers high-quality courses to support and develop remote and isolated health practitioners developed a project proposal which resulted in the *Working Safe in Rural and Remote Australia Project*.[2] This project was a collaboration between the Rural Doctors Association of Australia (RDAA), the Australian College of Rural and Remote Medicine (ACRRM), the Australian Nursing Midwifery Federation (ANMF), the Police Federation of Australia, the Queensland Teachers' Union as well as CRANA*plus*. The project was funded by the Department of Health and Ageing (DoHA). The Working Safe Project aimed to promote and facilitate a national framework and whole-of-community response to safe work environments in rural and remote Australia, the results of this project were distributed widely by all organisations involved. CRANAplus shared the results of the study at the National Rural Health Conference held in 2017.

'Professionals who work in rural and remote Australia face some unique challenges when compared to their urban counterparts. For some, these challenges may make them more susceptible to workplace violence or make the impact of workplace violence more serious.'[3]

Within the Project, CRANAplus developed a series of resources, namely: Safety and Security Guidelines for Remote and Isolated Health; Working Safe in Remote and Isolated Health handbook; Rapid Remote Assessment tool (self-assessment); an App; online module and a website for all employers and health practitioners to adopt to improve workplace safety and prevent work-place violence. In addition, to these specific project resources has continued the development of resources to assist a pathway for health workers to respond to critical events.

The recommendations identified for the way forward at that time were:

- Sustaining intervention and promoting a culture of safety.
- Improving orientation and staff preparation
- Logging on-call times, activities, and location
- Developing National Standards for Remote Health Safety and Security
- Challenging bullying, supporting resilience, and improved fatigue management to reduce staff mobility/churn

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1 CRANAplus (Apr 2020) Position Statement: Remote Health Workforce Safety and Security, access website: https://crana.org.au/uploads/pdfs/CRANAplus_SS_PS_2020.pdf

2 CRANAplus 2017. Remote Health Workforce Safety and Security Report: Literature Review, Consultation and Survey report. CRANAplus, Cairns

3 The Working Safe in Rural and Remote Australia Project: Website: *Working Safe in Rural and Remote Australia*: website accessed: http://workingsafe.com.au/

- Do what is possible to reduce the risks from known hazards. Reducing the frequency and severity of aggression and violence in the remote health sector is feasible. It's to everyone's benefit, and its everyone responsibility.[4]

CRANA*plus* also reinforced that "it is important that we keep a balanced perspective. Safety and security of remote health is a critical issue. However, it does not and should not define our perception of remote health practice".[5]

In 2016, the Department of Health, Northern Territory (NT) undertook a review to assess the effectiveness of current guidelines and how they were operationalised in practice for ensuring safety for primary health care staff working in government employed primary health centres. The review found that the remote context is not inherently dangerous, however recognised there are multi-facet factors more likely to be present in remote NT settings and these combined contribute to assessable and manageable risks.[6]

The review made 14 recommendations and emphasised central to the recommendations was a risk management approach, this would involve the implementation of standardise policy and procedures and additional mitigation measures to ensure personal safety being the first priority for all remote health centre's staff.[7] This Project was useful in preparing the South Australia's Review of Gayle's Law's and, its impact, and compliance on health practitioners safety and security and service provision.

In conclusion, while South Australia has embedded Gayle's Law into Health Practitioner National Law (South Australia) (Remote Area Attendance) Amendment Act 2017 and (No 2) Variation Regulations 2019, other states and Northern Territory have addressed solutions at policy level.

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4 Menere R.,2017. *Remote health Workforce Safety & Security: Problems & Solutions*: Presentation was delivered at National Rural Health Alliance Conference 2017.

5 Ibid

6 Department of Health: Remote Area Nurse Safety, On-call and After Hours Security. Published by Northern Territory Government 2016, p.6-7

7 Ibid., p.7

APPENDIX 7: Membership Expert Stakeholder Reference Group

- CRANA*plus*
- Department for Health, Eyre and Far North Local Health Network
- Department for Health, Flinders and Upper North Local Health Network Remote Allied Health Practitioner
- Flinders University SA Rural Workforce Academic
- Remote Nurse SA Health
- Remote Workforce Researcher, Flinders University, member CRANAplus
- Rural Doctors Workforce Agency
- Rural Support Services Rural Support Services, SA Health
- Royal Flying Doctor Service (Central Operations) Remote Area Clinics
- South Australian Ambulance Service – Operations
- NT PHN NT perspective conducted review at time of Gayle's death for NT Health

APPENDIX 8: Health Services Policies/Procedures/Guidelines review and mapping for compliance with the Act and Regulations

GAYLE'S LAW REVIEW – SA Health Services' Policy and Procedures

Review of the SA Health Remote Health Service's Policy and Procedures 'out-of-hours' and 'unscheduled' call-outs against the Health Practitioner National Law (South Australia) (Remote Area Attendance) Amendment Act 2017 & (No 2) Variation Regulations 2019

Amendments and variations associated the National Law (SA) Remote Area Attendance	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Policy /Procedure Description *Purpose and Scope*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Roles and responsibilities to comply *Executive Managers / all managers/ all workers*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Has a Safety & Security Policy/Procedure been developed? 77H(1) *prepare or adopt policies and procedures designed to ensure the safety and security of health practitioners providing health services in remote areas for or on behalf of the person or body* *Next scheduled Review date identified*	Policy Guideline Yes	Policy Not stated	**Procedure (Protocol)** Yes	Policy Not stated	Policy /Procedure Yes	Policy & Procedure Yes	Policy/ Procedure Not stated	Procedure Yes	Interim Procedure Yes	Policy Yes
Does it include the following definitions consistent with the Act/ Regulations: *77A(1)* Health practitioner *1. health practitioner means—* *(a) a health practitioner within the meaning of the Health Practitioner Regulation National Law (South Australia); and*	Yes	Yes	Not stated	Yes	Yes	Yes	Yes	Yes	Refers to other section for definitions / not stated	Yes
(b) any other person declared by the regulations to be included in the ambit of this definition for the purposes of this Act;	Yes	Yes	Not stated	Yes	Yes	Yes	Yes	Yes	As above	Yes
11C *(a) a health practitioner registered under the Health Practitioner Regulation National Law (South Australia) to practise in the medical profession;*	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional	Yes/ General Practitioner	Yes	Not stated	As above	Yes

	1	2	3	4	5	6	7	8	9	10
(b) a health practitioner registered under the Health Practitioner Regulation National Law (South Australia) to practise in the midwifery profession as a midwife	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional		Not identified specific Health Professional	Not stated	As above	Yes
(c) a health practitioner registered under the Health Practitioner Regulation National Law (South Australia) to practise as a nurse in the registered nurses division of the nursing profession;	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional	Enrolled Nurse/ Registered Nurse	Not identified specific Health Professional	Compliant	Refers to other section for definitions / not stated	Yes
d) a health practitioner employed by, or otherwise providing a health service on behalf of, a person or body wholly or partly funded (by grant, service agreement or other such arrangement) by the Commonwealth Government.	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional	Aboriginal Health Practitioner /Aboriginal Health Worker & other designated persons	Not identified specific Health Professional	Not stated	As above	Yes
Does it describe/define all of the designated persons that the policy applies to 11F(2)? *The following persons are designated persons for the purposes of subregulation (1):* *a) a person registered under the Health Practitioner Regulation National Law (South Australia) to practise in the medical profession;*	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional	Yes	Not identified specific Health Professional	Not stated	Refers to other section for definitions / not stated	Yes
(b) a person registered under the Health Practitioner Regulation National Law (South Australia) to practise in the midwifery profession as a midwife;	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional	Yes	Not identified specific Health Professional	Not stated	As above	Yes
c) a person registered under the Health Practitioner Regulation National Law (South Australia) to practise as a nurse in the registered nurses division of the nursing profession.	Yes	Not identified specific Health Professional	Not stated	Yes	Not identified specific Health Professional	Compliant	Not identified specific Health Professional	Compliant	As above	Yes

	1	2	3	4	5	6	7	8	9	10
Does the policy describe / define?: 1st Responder		Not defined	On Call Worker=1st responder	Not defined	Not defined	Yes	Not defined	Not defined	Not defined	Not defined
2nd Responder	Yes	Not defined	RN=2nd responder	Not defined	Not defined	Yes	Not defined		Not defined	Not defined
Response Team		Not defined		Not defined	Not defined	1st & 2nd Responders			Not defined	Not defined
Medical Emergency Back Up Team – another 1&2 responders						Critical emergency - VA				
Health Service *a) a health service within the meaning of the Health Practitioner Regulation National Law (South Australia); and*	Compliant	Compliant	compliant	Compliant	Compliant	Compliant	Compliant	Not stated	Compliant	Compliant
(b) any other service or activity declared by the regulations to be included in the ambit of this definition for the purposes of this Act;	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Not stated	Compliant	Compliant
Remote Area defined Act 2 *(2) For the purposes of this Part, a reference to a **remote area** will be taken to be a reference to the following areas of the State:* *(a) the lands within the meaning of the Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981;* *(b) the lands within the meaning of the Maralinga Tjarutja Land Rights Act 1984;* *(c) an area outside of a council area under the Local Government Act 1999;* 11B(2) *(2) For the purposes of section 77A(2)(d) of the Act, the following areas are included in the ambit of the definition of **remote area**:* *(a) the area of the District Council of Coober Pedy;* *(b) the area of the Municipal Council of Roxby Downs.*	All remote areas identified	All remote areas identified + map of SA shows remote areas	No definition per se –	Remote area identified	Remote area identified	Remote area defined	Remote area defined	Remote area defined	Not stated 'remote' is not defined	Remote area defined

	1	2	3	4	5	6	7	8	9	10
Out of Hours Call-out (Act 1) ***out of hours callout*** *means a request for the attendance of a health practitioner at a specified place made by or on behalf of a person where—* ***(a) the attendance occurs, or is to occur—*** ***(i) between the hours of 5 pm on one day and 8 am on the next day****; or* ***(ii) on a Saturday or Sunday****; or* ***(iii) on a public holiday****; and* *(b) the place at which a health practitioner is to attend pursuant to the request is in a remote area, but does not include a request of a kind declared by the regulations not to be included in the ambit of this definition*	Compliant Yes	Compliant Yes	Complaint Not defined – 'after hours' term used Yes	Compliant Yes	Not stated Yes	Compliant Yes	Compliant Yes	Compliant Yes	'Out of hours' deemed as an unsche-duled call out Not stated Yes	Compliant Yes
Unscheduled Call-out (Act 1) ***unscheduled callout*** *means a request for the attendance of a health practitioner made by or on behalf of a person where—* ***(a) the attendance is, or is requested, to occur within 24 hours of the making of the request****; and*	Compliant	Compliant	Compliant	Compliant	Not identified	Compliant	Not stated	Compliant	Not stated	Compliant
(b) the place at which a health practitioner is to attend pursuant to the request is in a remote area, *but does not include a request for attendance of a kind declared by the regulations not to be included in the ambit of this definition*	Yes	Yes/ home or off site visits	Yes / Clinic	Yes	Yes/ home visits	Yes- after hours emergency care procedure	Yes / clinic	Yes /clinic / home visit not limited to a place of residence /airstrip	Not stated	Yes/ clinic

	1	2	3	4	5	6	7	8	9	10
Second Responder (77D)										
Does the policy comply with the requirements for eligibility of a person to be a second responder? *77D (2) Before engaging a second responder, a health practitioner must be satisfied on reasonable grounds that the second responder satisfies any requirements set out in the regulations for the purposes of this subsection.* ***11G(a) provisions to assist in assessing the eligibility and selection of persons to be second responders;*** *11D(2)(a) must hold a current Australian driver's licence; and*		2nd responder- (health practitioner only)	2nd responder (health practitioner- 1st responder - OCSW							
	Compliant	Not stated - implied coz of held position that the 2nd responder is a health practitioner	*(contra to legislation)* *Not stated*	Compliant	Compliant	Compliant	Compliant	Not stated	Not stated	Compliant
(b) must have been subject to a working with children check (within the meaning of the Child Safety (Prohibited Persons) Act 2016) within the preceding 5 years; and	Compliant	As above	*As RN is 2nd responder – professional requirement for employment/ implied*	Compliant	Compliant	Compliant	Compliant	*As RN professional requirement for employment / implied*	Not stated	Compliant
(c) must not be prohibited from working with children under the Child Safety (Prohibited Persons) Act 2016 or a law of the Commonwealth or of another State or Territory	Compliant	As above	*As above - implied*	Compliant	Compliant	Compliant	Compliant	*As above*	Not stated	Compliant
Other qualifications						Current CPR/First Aide Cert				
Recruitment				Recruitmnt within catchment areas		Govnmnt Employee deemed physically fit				

	1	2	3	4	5	6	7	8	9	10
Does it comply with the requirements for when a Second Responder must accompany the health worker? *77E(1) Subject to this section, a health practitioner to whom this Division applies must not attend a callout to which this Division applies unless the health practitioner is accompanied by a second responder*	Compliant	Compliant	Compliant	Not clearly stated	Compliant	Compliant	Compliant	Compliant HSA- not defined	Determineby risk / not clear	unclear
Does it include and comply with circumstances when a Second Responder is not required to accompany the health practitioner? 77E(2) A second responder need not accompany a health practitioner attending a callout to which this Division applies during the journey to the place at which health services are to be provided in relation to the callout.	Compliant	Not stated	Compliant 1st and 2nd responders travel together	Compliant	Not stated	Compliant – stated preference for 1st & 2nd responders to journey together	Compliant	Compliant	2nd responder no travelling together /a specific location identified to meet up prior proceeding	unclear
Prescribed premise										
77E(3) Subsection (1) does not apply— (a) if the place at which health services are to be provided in relation to the callout is prescribed premises; or ***Does it define prescribed premises in compliance with Regulation 11E?***	Compliant	Compliant	Not stated	Compliant	Compliant	Compliant	Compliant		Compliant	
Police Stations: *(2) For the purposes of section 77E(3)(b) of the Act, the following circumstances relating to a callout by a health practitioner are prescribed: (a**) where the callout is to a police station and, before attending the callout**, the health practitioner is satisfied, taking into account all information available to the health practitioner in relation to the callout, that at least 1 police officer or special constable will be present at the police station at all times while the health practitioner attends the callout;*	Compliant	Compliant	Not stated	Compliant	Compliant	Compliant	Not stated	Not stated	Compliant	Not stated

	1	2	3	4	5	6	7	8	9	10
Emergency Service Worker present: *(b) where the callout is in response to an emergency and, before attending the callout, the health practitioner is satisfied, taking into account all information available to the health practitioner in relation to the callout,* ***that at least 1 emergency services worker (other than the health practitioner) will be present at the location of the emergency at all times while the health practitioner attends the callout.***	Compliant	Compliant	Not stated	Compliant	Emergency service worker – 2nd responder	Compliant	Compliant	Not stated	Compliant	Not stated
Does it define the Emergency Services Worker 11D(3) *(3) In this regulation—* ***emergency services worker*** *means any of the following persons:* *(a) a police officer;* *(b) a special constable;* *(c) a member of an emergency services organisation within the meaning of the Fire and Emergency Services Act 2005;* *(d) persons engaged in the provision of emergency ambulance services authorised under the Health Care Act 2008;* *(e) any other person, or person of a class, approved by the Minister to be an emergency services worker;* ***special constable*** *has the same meaning as in the Police Act 1998.*	Yes Yes Yes Yes	Not stated/ defined	Not stated / defined	Not stated /defined	Yes / unclear who emergency worker referred	Yes Yes Yes	Not stated/ defined	Not stated/ emergency service	Compliant Yes	Not stated Not stated

	1	2	3	4	5	6	7	8	9	10
Does it describe the reasonable steps to engage a second responder? *(3) The requirements of subregulation (2) do not apply in respect of a person to be engaged by a health practitioner as a second responder for a particular callout where—* *(a) the health practitioner has taken all reasonable steps to engage as a second responder a person who satisfies the requirements of subregulation (2) but has been unable to do so; and*	Compliant	Not stated	Compliant	Compliant	Not stated	Yes / Back-up response team	Yes / back up Manager or community staff member	Yes/ accompanied by health service approved non-health worker as second responder	Not stated	Health service to engage 2nd responder for 1st responder
Identify Hazard and Risk Assessment	Yes	Yes	Yes	Yes	Not stated	Yes	Yes	Yes	Yes	Yes
Does it describe Clinical Risk? *(b) the health practitioner believes on reasonable grounds that the risk to the health of a person to whom health services are to be provided in relation to the callout is high; and*	Yes	Not stated	Yes		Not stated	Yes	Yes	Yes		
Rapid Risk Assessment Tool (RRAT) *Response to critical event* *Response to escalating incident tool* *Risk management assessment* *Hazard and Risk Identification Checklist* *Personal Risk Assessment*	Yes Yes Yes	Yes	Yes Yes Yes	Yes		Yes	Yes Yes Yes Yes	Yes	Yes	Yes
Does it describe the suitability criteria for an alternate responder? *(c) the person is known to the health practitioner and is, in the opinion of the health practitioner, a suitable person to be engaged as a second responder in the circumstances.*	Yes	Not stated	Yes	Yes	Yes	Yes	Yes	Implied / not stated	Not stated	Not stated

	1	2	3	4	5	6	7	8	9	10
Does it include and comply with the advice about the definition of risk to the patient (11D(6))? *(6) For the purposes of subregulation (3)(b), the risk to the health of a person to whom health services are to be provided in relation to a callout is not high if the health practitioner is of the opinion that treatment of the person can be delayed—* *(a) until the normal operating hours of an available clinic or health facility commence; or* *(b) for a period of more than 24 hours.*	Compliant	compliant	Compliant	compliant	Not stated	Compliant	Compliant	Not stated /	Not stated	Compliant
Does it include and comply with the requirements for the second responder when the health practitioner is delivering a health service?*77E(5)* *For the purposes of this section, a second responder will be taken to be accompanying a health practitioner during the provision of health services to a person despite not being physically present with the health practitioner if—* *(a) the health practitioner is of the opinion that, having regard to the nature of the health services and the privacy of the patient, it is not appropriate for the second responder to be physically present during the provision of the health services; and*	Compliant Compliant	Compliant Not stated	Compliant Compliant	Compliant Yes/ unclear	Not stated Not stated	Compliant Compliant	Compliant Not stated	Not stated per se/ Implied Not stated/ implied	Unclear – states if the risk is high then a 2nd responder must attend	HP to undertake risk management assessment to determine if safe to attend without a 2nd responder
(b) the second responder remains in the same premises as, and within the hearing of, the health practitioner during the provision of the health services.	compliant	Not stated	Compliant		Compliant	Compliant	Needs more clarity	Not stated/ implied	Not stated	Unclear / needs more clarity

	1	2	3	4	5	6	7	8	9	10
Does it comply with processes for engaging the Second Responder set out in 11D(1)? *(1) For the purposes of section 77D(1) of the Act, a health practitioner engages a person as a second responder for the purposes of a particular callout by—* ***(a) contacting the person by telephone or in person****; and* ***(b) advising the person of—*** ***(i) the general nature of the callout including the location and an estimate of the time required; and*** ***(ii) the designated time and place for the health practitioner and the person to meet for the purposes of the callout; and*** *(c) confirming the eligibility, availability and agreement of the person to attend the callout as a second responder; and* *(d) advising that the person is engaged as a second responder for the callout.*	Compliant	Not stated	The role of the OCSW to follow protocol Compliant	Not stated	Compliant	Compliant – inc. Flow Chart procedure	Partially described statement / needs more clarity	Compliant	Not stated	Not stated
Does it comply with the processes set out in 11D(4) relating to commencement of the engagement? *Pursuant to section 77D(3)(a) of the Act, a person is engaged to act as a second responder from the time that a health practitioner advises the person that they are engaged as a second responder pursuant to subregulation (1)(d).*	Compliant	Not stated	Compliant	Not stated	Compliant	Compliant	Compliant	Compliant	Unclear	Unclear

	1	2	3	4	5	6	7	8	9	10
Does it comply with the processes set out in 11D(5) relating to cessation of the engagement? *(5) Pursuant to section 77D(3)(b) of the Act, a callout is completed in respect of a second responder when, after leaving the location of the callout or any other place at which the second responder attended in relation to the callout, the second responder arrives at their place of residence or other destination nominated by the second responder and advised to the health practitioner.*	Compliant	Not stated	Compliant	Not stated	Not stated	Not stated	Not stated	Yes	Not stated	Not stated
Does it include a statement/provision about limitations to liability? **?***77F(2) A health practitioner or other person who complies with the requirements of this Part (including, to avoid doubt, a health practitioner who refuses to attend a callout to which Division 2 applies in the absence of a second responder)—* *(a) cannot, by virtue of doing so, be held to have breached any code of professional etiquette or ethics, or to have departed from any accepted form of professional conduct; and* *(b) to the extent that the health practitioner or person has acted in good faith and without negligence, incurs no civil liability in respect of such compliance (including, to avoid doubt, liability arising under disciplinary or similar proceedings).*	Not stated Not stated	Not stated Not stated	Not stated Not stated	Compliant Compliant	Not stated Not stated	Not stated Not stated	Not stated Not stated	Not stated Not stated	Not stated Not stated	Not stated Not stated
Does it comply with 77H(2)(a) that prohibits direction of a health practitioner to attend a call-out? *Include a provision expressly preventing any person from directing or requiring (however described) a health practitioner to whom Division 2 applies to attend a callout in contravention of section 77E(1);*	Not stated	Not stated	Compliant	compliant	Not stated	Compliant	Not stated	Not stated	Not stated	Compliant

	1	2	3	4	5	6	7	8	9	10
Does it comply with 77H(2)(b) that requires personnel to comply with the legislation? *provisions ensuring the compliance of the person or body to whom this Division applies, and any person employed by or on behalf of the person or body, with the requirements of Division 2;*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not stated	Not stated
Does it include Risk Management measures in compliance with 11Gb? *(b) provisions to manage risks to the safety and security of health practitioners identified as being specific to the provision of health services—* *(i) at, or from, a specific location; or* *(ii) by a specific health service provider.*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hazard and Risk Identification Checklist (off-site visits)	Yes	Yes & report of Risks	Yes	Yes		Yes			Yes	
Training and Orientation Induction program – specific training – risks of working alone, in isolation or remotely and relevant procedures, using risk assessment tools, security monitoring and communication procedures / 4WD training	Yes		Training for OCSW – personal risk assessment					Yes	yes	Yes
Security and Environmental Design										
Maintain clinical and safety equipment required	Yes		yes			yes		yes		Safety & security arrangemntprovided to health practitioner on arrival (via agency)
Safety features of vehicle inc. sufficient fuel, relevant first aid kit & fire safety equipment- Duress alarms		Yes/duress alarms	yes			yes		Yes	yes	
Accommodation security systems			yes			Yes	yes			
UHF radio system within vehicles and/or each staff house						Yes	Yes			
Clinic safety processes and security screens/doors	yes		yes			Yes	Yes			
Clinic surveillance	yes		yes			Yes	Yes			
Effective Communication systems										
Communication systems (regular review)	yes					Yes		yes		
Communication devices fitted in vehicles / aircrafts								Yes		
Monitor staff's arrival and staff departure	yes		yes					Yes	yes	

	1	2	3	4	5	6	7	8	9	10
Escalation process when worker fails to maintain agreed communication (within 30 mins)	Yes		yes					yes	yes	
Minimum Risk Control Measures										
Investigation and reporting systems in place for all reported incidents	Yes	yes			yes	yes		yes	yes	
Follow up corrective actions in place to control identified hazards and risks arising from workplace	yes		yes							
Staff										
Workers have access to EAP	yes									
Regular consult with staff re development and review of related policies and procedures	yes									

APPENDIX 9: Callout without second responder and missed callouts

	1	2	3	4	5	6	7	8	9	10
Callout occasions without 2nd Responder	14	0	Not provided	Not provided	0	Not provided	Not Provided	0	0	Not provided
Callouts not attended due to availability of 2nd responders	0	0			0			0	0	
Negative consequences	0	0	N/A		0			0	0	0

APPENDIX 10: Health service provider audit tool

College of Medicine & Public Health

Gayle's Law Review – Organisational audit

REVIEW OF THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SOUTH AUSTRALIA) (REMOTE AREA ATTENDANCE) AMENDMENT ACT 2017 AND THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SOUTH AUSTRALIA) (REMOTE AREA ATTENDANCE) (No 2) VARIATION REGULATIONS

The South Australian Parliament passed the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act, which is more commonly referred to as 'Gayle's Law', in response to the tragic death of Gayle Woodford, a dedicated nurse who was murdered while working in a remote community in South Australia. The Law and associated regulations were enacted on 1 July 2019. The intention is that health service providers who employ health practitioners in a remote area must ensure that a second responder accompanies the health practitioner when attending an out of hours callout or unscheduled callout.

Professor Robyn Aitken has been commissioned by the South Australian Department of Health and Wellbeing to undertake the review of Gayle's Law to establish whether it has been implemented as intended; the impact that the Act and Regulations have had on health services, the safety of health practitioners and persons providing health services, and communities in the remote areas of South Australia. The review will also consider whether any amendments to the Act or Regulations would improve their operation. A/Professor Lesley Siegloff is working alongside Professor Aitken to complete the review.

You are invited to participate in this voluntary and anonymous audit to provide information relevant to the review.

We appreciate that health staff are very busy, so there are four ways that you can respond to our request. You can:

- ❑ Complete the on-line audit by clicking on this link
- ❑ Download this document, complete electronically, and email to us (Lesley.Siegloff@flinders.edu.au)
  We will upload the de-identified document to a secure platform and delete the email once received so that your anonymity is maintained
- ❑ Contact us to complete the audit over the phone or as an on-line videoconference
  Via email: Lesley.Siegloff@flinders.edu.au) Via phone: 0400 682 165;
- ❑ Exit the audit now (go to Question 87)

2. Consent to Participate

Completing the survey is voluntary and you can change your mind and decide not to participate at any time, right up until the survey is submitted electronically. It will take you approximately 30 minutes to complete.

Your participation is anonymous unless you wish to participate in a follow-up interview. If you identify yourself on the survey by providing your details to participate in a follow-up interview, your survey data will be de-identified by the project team. The project team are the only people who have access to the survey data, which will be stored in password protected computer files or locked up until it is destroyed in 5 years' time.

All information gained from the survey will be presented as aggregate data in the report preventing anyone identifying you or your individual responses. You don't have to give a reason if you choose not to participate.

Participating, or deciding not to participate at any time will not affect your relationship with your manager, or your employment status, or future employment.

The review team have considered the potential risks of participating, or deciding not to participate in the survey and considers risks to be minimal. There may be the potential for the survey to remind you of Gayle's tragic death, or threats to your own, or others' safety or security. Should you experience any distress, please contact the relevant psychological service provided by your employer, or you may like to contact CRANA*plus* Bush Support Services on 1800 805 391, which provides free confidential 24/7 telephone psychological support for all rural and remote health workers and their families.

There is no direct benefit to you personally as a participant, but by participating you will contribute to evaluating the implementation of the Act and Regulations. You may also contribute to identifying any future changes that may be required to improve the safety and security of health professionals working in remote areas and the health and wellbeing of people living in remote Australia.

The review is a commissioned evaluation and follows the NHMRC Ethical considerations in quality assurance and evaluation activities which does not require the review to be submitted to, or be approved by a Human Research Ethics Committee.

If you would like further information please contact:

Associate Professor Lesley Siegloff at Lesley.siegloff@flinders.edu.au or 0400 682 165;

or

Professor Robyn Aitken at robyn.aitken@flinders.edu.au or 0417 276 112

❑ Yes, I agree to participate (please continue to Q2)

❑ No, I would like to exit the survey now (Please go to Question 87)

3. Have you read any of the following?
   (select all that apply)

   ❑ Gayle's Law Legislation

   ❑ Gayle's Law Regulations

   ❑ On-line information about Gayle's Law (including overview & fact sheets)

   ❑ None of the above

4. Does your organisation provide an unscheduled and/or out of hours call-out health service?
   (select one)

   ❑ Yes, please continue

   ❑ No, please exit audit (go to Question 81)

5. Does your organisation have a Health Service Policy(s) and Procedure(s) for unscheduled and/or out of hours call-outs?
   (select one)

   ❑ Yes

   ❑ Don't know

   ❑ No

6. Is information about unscheduled and/or out of hours call- outs s documented in a special registered kept for this purpose?
   (select one)

   ❑ Yes, please describe

   _____

   ❑ No, Please explain

   _____

7. In an average week, how often would your staff respond to an **unscheduled** (during business hours) call out?

   ❑ Never

   ❑ Please indicate the number of times per week

   _____

   ❑ Please comment/describe _____

8. In an average week, how often would your staff respond to an **out of hours** call out?

   ❑ Never

   ❑ Please indicate the number of times per week

   _____

   ❑ Please comment/describe _____

9. How many staff (headcount, not FTE) are employed in your service to cover business hours and unscheduled call out and/or out of hours on-call duties?

   ❑ Business hours _____

   ❑ Unscheduled call out _____

   ❑ Out of hours on call _____

10. Of the **STAFF** below, who would routinely respond to an unscheduled and/or out of hours callout?
(Select all that apply).

- ❑ Registered Nurse
- ❑ Registered Midwife
- ❑ Enrolled Nurse
- ❑ Aboriginal Health Practitioner
- ❑ Aboriginal Health Worker
- ❑ Medical Officer
- ❑ Allied Health Staff (please specify discipline)
  _____
- ❑ Health Services Assistant (or other non-registered health workers)
- ❑ Support Staff (administrative officers, drivers, gardeners)
  _____
- ❑ Security Officers
- ❑ Someone who speaks the local language
- ❑ Other (Please specify) _____

11. Of these staff, who would routinely perform the role of a second responder?
(Select all that apply)

- ❑ Registered Nurse
- ❑ Registered Midwife
- ❑ Enrolled Nurse
- ❑ Aboriginal Health Practitioners
- ❑ Aboriginal Health Workers
- ❑ Medical Officer
- ❑ Allied Health Staff (please specify discipline)
  _____
- ❑ Health Services Assistant (or other non-registered health workers)
- ❑ Security Officer
- ❑ Support Staff (administrative officers, drivers, gardeners)
- ❑ Someone who speaks the local language
- ❑ Other (please specify) _____

12. Are there **OTHER PEOPLE** located in your community who do not work at your health service but perform the role of designated second responder?
(Select all that apply)

- ❑ No - we only have employed second responders (please go to Q17)
- ❑ Community members
- ❑ Paramedics
- ❑ Volunteer ambulance
- ❑ Family members of employed health staff
- ❑ Police
- ❑ Aboriginal Community Workers
- ❑ Someone who speaks the local language
- ❑ Emergency services personnel
- ❑ Health staff employed at other health services
- ❑ Security officers

❑ Other (please specify) _____

13. What is the status of other people (from the last question) who are available as designated second responders for an unscheduled and/or out of hours call-out? (select all that apply)

❑ Employed specifically for on-call

❑ Volunteer specifically for on-call

❑ Other (please describe) _____

14. What are the requirements for persons to be approved by your health service before they can be identified as designated second responders? (select all that apply)

❑ An Australian Driver's license

❑ A Current Police Check

❑ A current Working with Children's check (within the last five years)

❑ Are not prohibited from working with children

❑ Other (please describe) _____

15. Do the above requirements impact on the pool of second responders available to health services? (select one)

❑ Never

❑ Some of the time

❑ Most of the time

❑ All of the time

❑ Other (Please comment) _____

16. How do you ensure that second responders meet the requirements of the legislation? (select all that apply)

- ❑ There is a prescribed recruitment process
- ❑ There a register that identifies approved second responders
- ❑ People cannot be rostered as second responders if they do not meet the requirements
- ❑ Other (please describe) _____

17. How do **staff on-call** for an unscheduled and/or out of hours call-out know who is available as a designated second responder for a particular day? (select all that apply)

- ❑ There is a roster of second responders
- ❑ They are on a list and may/may not be available when they are asked to accompany the health staff
- ❑ They are on a list and know that they must accompany the health staff when asked
- ❑ Other (please describe) _____

18. How do **designated second responders** for an unscheduled and/or out of hours call-out know when they are required?
(select all that apply)

- ❑ There is a roster of second responders
- ❑ They are on a list and may/may not be available when they are asked to accompany the health staff
- ❑ They are on a list and know that they must accompany the health staff when asked
- ❑ Other (please describe) _____

19. How are designated second responders recruited?
(select all that apply)

❑ Community members respond to a health service recruitment initiative

❑ A health service staff member volunteers

❑ A community member volunteers

❑ Recruited by word of mouth

❑ It is a requirement of their employment

❑ Other (please describe) _____

20. Is there an adequate number of people available to perform the role of second responder?
(select one)

❑ Never

❑ Some of the time

❑ Most of the time

❑ All of the time (Please go to Q24)

21. Have you experienced any difficulties in having adequate people to act as a designated second responder?
(select one)

❑ Yes

❑ No (Please go to Q24)

22. What are the barriers to having adequate people to act as second responders? (select all that apply)

- ❑ The eligibility requirements for non-staff responders
- ❑ A small pool of non-staff to draw upon/roster
- ❑ A small pool of people available/willing to participate in out-of-hours work
- ❑ Competing demands for non-staff member's time (i.e. cannot commit to being available)
- ❑ Insufficient financial resources to cover employment of enough staff to cover additional roster requirements (salaries)
- ❑ Insufficient financial resources to cover call-out costs (overtime cost, additional hours)
- ❑ Insufficient financial resources to pay non-staff members
- ❑ Insufficient equipment to ensure safety and security of second responders
- ❑ Other (please comment) _____

23. Can you provide some information about **solutions** to/ how barriers could be addressed?
(select one)

- ❑ Yes, (please describe) _____
- ❑ No

24. What are the consequences if you have an inadequate number of designated second responders? (select all that apply)

- ❑ Not applicable
- ❑ Staff can only attend on-call out of hours sometimes
- ❑ We have to use health service staff and this may mean we cannot offer a service the next day
- ❑ Health service staff may decide to attend on-call out of hours without a second responder
- ❑ We may ask health service staff to attend on-call out of hours without a second responder
- ❑ Staff use an alternative second responder
- ❑ Other (please comment) _____

25. In the past 12 months have there been any occasions when staff have **NOT** attended an unscheduled and / or out-of-hours call-out ?
(select one)

- ❑ Yes (please enter the number of times recorded)
  _____
- ❑ I don't know, our service does not record the number of times this has occurred (Please go to Q26)
- ❑ No (Please go to Q26)

26. What was the reason that staff did not attend?
(select one)

- ❑ I don't know, our service does not record a reason
- ❑ I don't know, the staff did not record a reason
- ❑ Please tell us about the reason(s) _____

27. In the past 12 months have there been any occasions when staff **HAVE** attended an unscheduled and / or out-of-hours call-out **WITHOUT** a designated or alternative second responder?
(select one)

- ❑ Yes, please enter the number of times_____
- ❑ I don't know, our service does not record the number of times this has occurred (Please go to Q29)
- ❑ No (Please go to Q29)

28. Was any of these call-outs at a prescribed site?
(select one)

- ❑ Yes (please enter the details of the prescribed site(s)
  _____
- ❑ I don't know what a prescribed site is (please describe the location(s) staff went to)
  _____
- ❑ No (please describe the location(s) staff went to)
  _____

29. If not a prescribed site/or you don't know, was the call-out approved by the relevant supervisor?
(select one)

- ❑ Yes (please tell us the reason) _____
- ❑ I don't know, our service does not record this information
- ❑ No (please tell us the reason) _____

30. Does your organisation permit staff to attend a location for an unscheduled and/or call out of hours **WITHOUT** a second responder when there are emergency services personnel in attendance?
(select one)

❑ Yes

❑ Don't know (Please go to Q33)

❑ No (Please go to Q33)

31. If your organisation permits staff to attend a call out when an **emergency services personnel** attends the location **in the place of** a second responder the person, which of the following emergency services personnel would be expected to be in attendance?
(select all that apply)

❑ Police Officer

❑ Special Constable

❑ Fire and Emergency Officer

❑ Ambulance Officer

❑ Other health care worker (please specify discipline)

_____

32. When an **emergency services personnel** attends the location in place of a second responder the person:
(select all that apply)

❑ is present at all times

❑ remains at the same premises/location within hearing of the health professional during the entire call-out

❑ is physically present during the provision of health services

❑ ensures that the on-call staff return safely to their nominated destination

❑ ensures the second responder is called if they cannot meet any of the above

❑ None of the above (please comment) _____

33. The regulations allow engagement of an ***alternative second responder*** if a designated second responder (someone who meets all the required criteria) is not available.

    Please tell us about your experience with alternative second responders
    (select one)

    ❑ We know about the option, but do not make this option available to our staff (please go to Q34)

    ❑ I did not know about alternative second responders (please go to Q34)

    ❑ Alternative second responders are included in our policy but have never been used (please go to Q34)

    ❑ Alternative second responders are included in our policy and are used

34. What were the circumstances when staff used an alternative responder?
    (select all that apply)

    ❑ Staff had taken all reasonable steps to engage a designated responder

    ❑ There was a high risk to the health of the person who staff were being called out for

    ❑ The alternative second responder was known to the staff and they considered them suitable in the circumstances

    ❑ Other (please describe) _____

35. Is there a Police station in the community that can be used as a prescribed site (as defined by the legislation)?

    ❑ Yes, a police officer resident at all times

    ❑ Yes, a police officer will come from another location

    ❑ No, there is a police station, but no resident or on-call police officer

    ❑ No, there is no police station

    ❑ Please include any other options below _____

36. What are the locations where an unscheduled and/or out of hours call-out may be requested?
(select all that apply)

- ❑ Person's home
- ❑ Road accident scene
- ❑ Camp site
- ❑ Community facility
- ❑ Health clinic
- ❑ Health worker's home
- ❑ Police Station
- ❑ Others (Please comment/ describe) _____

37. What is the **MOST COMMON** location **REQUESTED?**
(select one)

- ❑ Person's home
- ❑ Road accident scene
- ❑ Camp site
- ❑ Community facility
- ❑ Health clinic
- ❑ Health worker's home
- ❑ Police Station
- ❑ Other (please comment/describe) (8) _____

38. What is the **MOST COMMON** location where an unscheduled and/or out of hours call-out is **ATTENDED**?
(select one)

- ❑ Person's home
- ❑ Road accident scene
- ❑ Camp site
- ❑ Community facility
- ❑ Health clinic
- ❑ Health worker's home
- ❑ Police Station
- ❑ Other (Please comment/describe) _____

39. Does your organisation **preclude** unscheduled and/or out of hour attendance at any of the above locations?

- ❑ Yes (please specify) _____
- ❑ No

40. What is the expectation for **STAFF** to complete orientation to call-out policy/procedure and/or what to do for call-outs?
(select one)

- ❑ It is mandatory for all employed staff
- ❑ It is only mandatory for staff who will be rostered for a call-out
- ❑ It is voluntary for all employed staff
- ❑ There is no expectation
- ❑ Other (please describe) _____

41. What is the expectation for **DESIGNATED SECOND RESPONDERS** to complete orientation to call-out policy/procedure and/or what to do for call-outs?
(select one)

- ❑ It is mandatory for all designated second responders
- ❑ It is voluntary for all designated second responders
- ❑ It is only mandatory for employed designated second responders
- ❑ There is no expectation
- ❑ Other (please describe) _____

42. How is orientation provided for call-out policy/procedure and/or what to do for call-outs?
(select one)

- ❑ There is an orientation program
- ❑ Employees/second responders are expected to orientate themselves
- ❑ Other (please describe) _____
- ❑ There is **NO** orientation (Please go to Q46)

43. When are staff or second responders who are not staff orientated to health service policy/procedure and/or what to do for unscheduled and/or out of hours call-outs?
(select all that apply)

- ❑ When they commence as new staff or volunteers
- ❑ When they are added to the on-call roster
- ❑ Immediately before they are required to participate on-call out of hours
- ❑ Existing staff were orientated when the regulations were enacted
- ❑ Other (please specify) _____

44. What resources are available for orientating **staff** to call-out policy/procedure and/or what to do for call-outs?
(select all that apply)

❑ There are no resources

❑ Supervisors or staff provide an orientation

❑ Face-to-face orientation

❑ On-line orientation package

❑ Paper-based orientation

❑ Other (please describe) _____

45. What resources are available for orientating **people other than staff** to call-out policy/procedure and/or what to do for call-outs?
(select all that apply)

❑ There are no resources

❑ Supervisors or staff provide an orientation

❑ Face-to-face orientation

❑ On-line orientation package

❑ Paper-based orientation

❑ Other (please describe) _____

46. How often are staff and second responders required to review their knowledge of the call-out policy and procedure and/or what to do for a call-out?
(select all that apply)

❑ There is no requirement after orientation

❑ Staff and second responders decide when they need to refresh/update

❑ Before each out of hours 'call out'

❑ Annual education update

❑ Other (please specify) _____

47. How do **staff** provide feedback on the practical implementation of the policy and procedure relating to unscheduled and/or out of hours call-outs at your health service? (select all that apply)

- ❑ We don't have a policy/procedure
- ❑ Written feedback
- ❑ Verbal feedback to their supervisor
- ❑ Team meetings
- ❑ Incident reporting system
- ❑ Other (please describe) _____

48. How do people who are **not staff** provide feedback on the practical implementation of the policy and procedure relating to unscheduled and/or out of hours call-outs at your health service? (select all that apply)

- ❑ We don't have a policy/procedure for non-staff responders
- ❑ Written feedback
- ❑ Verbal feedback to someone at the clinic
- ❑ Team meetings (4)
- ❑ Community meetings (5)
- ❑ Other (please describe) (6) _____

These next questions relate to equipment available in **BUILDINGS**

49. What communication equipment is available and in working order at **the HEALTH CLINIC/SERVICE CENTRE** to manage risks associated with the safety and security of personnel attending unscheduled and/or out of hours call-outs?
(select all that apply)

- ❑ Mobile phone (3-5G service)
- ❑ Mobile phone (satellite)
- ❑ Two-way radio
- ❑ Internet/wifi access
- ❑ Duress alarm
- ❑ Mobile duress alarm
- ❑ Landline
- ❑ CCTV
- ❑ Security alarm
- ❑ Other (please specify) _____

50. Are the above options enough?
(select one)

- ❑ Yes
- ❑ I don't know
- ❑ No (Please comment/suggest any additional equipment)
_____

51. Is the same communication equipment available and in working order in the **ACCOMMODATION** of on-call staff members to manage risks associated with the safety and security of personnel attending unscheduled and/or out of hours call-outs?

❑ Yes
❑ No (please specify) _____

52. Are the above options enough?(select one)

❑ Yes
❑ I don't know
❑ No (Please comment/suggest any additional equipment)
_____

The next questions relate to equipment available in **VEHICLES**

53. What communication equipment is available and in working order in health service **VEHICLES** used for unscheduled and/or out-of-hours call-outs?
(select all that apply)

❑ Mobile phone (3-5G service)
❑ Mobile phone (satellite)
❑ Two-way radio
❑ GPS locator
❑ Duress alarm
❑ Mobile duress alarm
❑ Landline
❑ Dashboard/in-car camera
❑ Security alarm
❑ External lights
❑ Other (please specify) _____

54. Are the above options enough?
(select one)

❑ Yes

❑ I don't know

❑ No (Please comment/suggest any additional equipment)

_____

55. Is the same communication equipment available and in working order in **ALL** health service **VEHICLES** that may be used by on-call staff members?
(select one)

❑ Yes (Please go to Q58)

❑ No (please specify) _____

56. Where is the most equipped vehicle located for an out of hours call-out?
(select one)

❑ At the first on-call person's accommodation

❑ At both the first on-call and staff second responder's accommodation

❑ At the health service clinic

❑ There is no vehicle for out of hours use

❑ Please comment _____

57. How often is the **MOST** equipped vehicle available for unscheduled and/or out of hours call outs?
(select one)

❑ Never

❑ Some of the time

❑ Most of the time

❑ All of the time

❑ Other (please comment) _____

58. Does the staff member ever use their own vehicle for unscheduled and/or out of hours call-outs?
(select one)

❑ Never (Please go to Q60)
❑ Some of the time
❑ Most of the time
❑ All of the time
❑ Other (please comment) _____

59. What communication equipment is available and in working order in staff owned **VEHICLES** used for unscheduled and/or out-of-hours call-outs?
(select all that apply)

❑ Mobile phone (3-5G service)
❑ Mobile phone (satellite)
❑ Two-way radio
❑ GPS locator
❑ Duress alarm
❑ Mobile duress alarm
❑ Dashboard/in-car camera
❑ Security alarm
❑ External lights
❑ Other (please specify) _____

60. Do the staff member on-call and the second responder travel together to the location of the call-out?
(select one)

❑ Never
❑ Some of the time
❑ Most of the time
❑ All of the time (Please go to Q65)
❑ Please comment) _____

61. When they **do not travel together** what is the procedure?

_____

62. Does the second responder use their own vehicle?
(select one)

❑ Never (Please go to Q65)
❑ Some of the time
❑ Most of the time
❑ All of the time
❑ Please comment _____

63. What equipment, safety and security measures are available to the second responder? (select all that apply)

- ❑ Mobile phone (3-5G service)
- ❑ Mobile phone (satellite)
- ❑ Two-way radio
- ❑ GPS locator
- ❑ Duress alarm
- ❑ Mobile duress alarm
- ❑ Landline
- ❑ Dashboard/in-car camera
- ❑ Security alarm
- ❑ External lights
- ❑ Other (please specify) _____

64. Is this equipment enough?
(select one)

- ❑ Yes
- ❑ I don't know
- ❑ No (Please comment/suggest any additional safety equipment)
  _____

65. Are there any barriers to having adequate equipment in working order for responders, accommodation, and vehicles?

(select one)

- ❑ Yes
- ❑ No (Please go to Q67)

66. What are the barriers to having adequate equipment in working order for responders, accommodation, and vehicles?
(select all that apply)

- ❑ Competing demands for equipment
- ❑ No replacements available for equipment requiring repair
- ❑ Equipment has to be sent off-site for repair
- ❑ Unreliable equipment
- ❑ Fit for purpose equipment is not available
- ❑ Fit for purpose equipment is not available at an affordable price
- ❑ Insufficient financial resources to cover enough equipment (quantity)
- ❑ Insufficient financial resources to cover fit for purpose equipment (quality)
- ❑ Other/please comment _____

67. What is the expected time for the second responder to arrive at the location of the call-out?
(select one)

- ❑ 0-5 minutes
- ❑ 10-15 minutes
- ❑ 20-30 minutes
- ❑ >30 minutes
- ❑ Other, (please comment) _____

68. On average, how often is this time frame achieved?
(select one)

- ❑ Never
- ❑ Some of the time
- ❑ Most of the time
- ❑ All of the time
- ❑ Other (please comment) _____

69. What is the expectation for the second responder during the call-out?
(select all that apply)

- ❑ Must be present at all times
- ❑ Must remain at the same premises within hearing of the health professional during the entire call-out
- ❑ Must be physically present during the provision of health services
- ❑ Other/please comment _____

70. On average, how often is the above expectation achieved?
(select one)

- ❑ Never
- ❑ Some of the time
- ❑ Most of the time
- ❑ All of the timer
- ❑ Please comment _____

71. After the call-out has finished, what is the procedure to ensure that the **second responder** arrives safely at an agreed destination?
(select one)

❑ I don't know
❑ Please describe the procedure _____
❑ There is no procedure

72. After the call-out has finished, what is the procedure to ensure that the **on-call staff** has arrived at their agreed destination?
(select one)

❑ I don't know
❑ Please describe the procedure _____
❑ There is no procedure

73. Are any of the following tools, guidelines or protocols available to manage risks associated with the safety and security of personnel attending unscheduled and/or out of hours call-outs?

(select all that apply)

- ❑ There are no tools, guidelines or protocols to manage risks
- ❑ Staff, Work Health and Safety risk assessment tool for out of hours call-outs
- ❑ Triage protocol for determining the need for out of hours attendance
- ❑ Clinical risk assessment tool
- ❑ Register, to document out of hours call-outs
- ❑ Protocol, to document out of hours call-out in client record/medical record
- ❑ Staff call out roster
- ❑ Incident reporting protocol for out of hours call-out
- ❑ Protocol to ensure that all personnel attending the out of hours call-out return safely to their place of residence or other designated place
- ❑ Other (please describe) _____

74. Are you able to quantify the investment that your health service has made in order to implement Gayle's Law legislation/regulations?

- ❑ Additional human resources please describe/comments (1) _____
- ❑ Financial cost please describe/comments (2) _____
- ❑ Other/please describe/comments (3) _____

75. Has COVID-19 had any impact on implementation of the procedures relating to Gayle's Law/Regulations in your health service?
(select one)

- ❑ Yes (please comment) _____
- ❑ Don't know
- ❑ No

76. Is there anything else that you would like to tell us?

For example:

- examples of how the legislation has worked to improve the safety and security of staff responding to unscheduled and/or out of hours call-outs,
- barriers to implementation and/or
- improvements that could be made.

Please feel free to forward a copy of the related policies, guidelines, tools, and procedures to Assoc Professor Lesley Siegloff at lesley.siegloff@flinders.edu.au

❑ Yes (please describe) _____

❑ No

77. **Demographic Information**

We understand that there may be concerns about remaining anonymous, but we would appreciate if you could provide some demographic information so that we can report the breadth of health services that have provided data for this review.

Data will be aggregated so your privacy is maintained

78. What is the best description of your health service?
(select one)

❑ I would prefer not to respond to this question

❑ Public (Government health service)

❑ Non-Government Organisation

❑ Aboriginal Medical Service

❑ Health services on a mine site

❑ Other (please describe) _____

79. What is the size of the population served by your health service?
(select one)

- ❑ I would prefer not to respond to this question
- ❑ < 50 people
- ❑ 51- 100 people
- ❑ 101 - 300 people
- ❑ 301 - 500 people
- ❑ 501 - 1000 people
- ❑ >1000 people

80. Thank you for completing this survey, your contribution is highly valued.
We would also like to invite you to a follow up interview.
Please indicate if you are interested in being interviewed.

- ❑ Yes, I would like to volunteer to participate in a follow-up interview. My contact details are below (telephone/email) _____
- ❑ Yes, I will forward my contact details separately to lesley.siegloff@flinders.edu.au or phone Assoc Professor Lesley Siegloff on 0400682165
- ❑ No, I don't want to volunteer to participate in a follow-up interview.

END OF AUDIT – IF YOU HAVE PARTICIPATED, THIS IS YOUR LAST QUESTION

Please save and email the audit to Lesley.Siegloff@flinders.edu.au

THIS PAGE IS FOR PEOPLE WHO DID NOT WANT TO PARTICIPATE
OR
DID NOT MEET CRITERIA TO PARTICIPATE

81. We understand that you may not meet the criteria for completing this survey, or may not want to complete the survey, but is there anything that you would like to tell us?

    For example

    - including examples of how the legislation has worked to improve the safety and security of staff responding to unscheduled and/or out-of-hours call outs,
    - barriers to implementation and/or
    - improvements that could be made

    ❑ Yes (Please describe)

    _____

    ❑ No

END OF AUDIT – THIS IS YOUR EXIT QUESTION
Please save and email the audit to Lesley.Siegloff@flinders.edu.au

APPENDIX 11: Health practitioner survey

College of Medicine & Public Health

Gayle's Law Review - Health Worker Survey

REVIEW OF THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SOUTH AUSTRALIA) (REMOTE AREA ATTENDANCE) AMENDMENT ACT 2017 AND THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SOUTH AUSTRALIA) (REMOTE AREA ATTENDANCE) (No 2) VARIATION REGULATIONS

The South Australian Parliament passed the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act, which is more commonly referred to as 'Gayle's Law', in response to the tragic death of Gayle Woodford, a dedicated nurse who was murdered while working in a remote community in South Australia. The Law and associated regulations were enacted on 1 July 2019. The intention is that health service providers who employ health practitioners in a remote area must ensure that a second responder accompanies the health practitioner when attending an out of hours callout or unscheduled callout.

Professor Robyn Aitken has been commissioned by the South Australian Department of Health and Wellbeing to undertake the review of Gayle's Law to establish whether it has been implemented as intended; the impact that the Act and Regulations have had on health services, the safety of health practitioners and persons providing health services, and communities in the remote areas of South Australia. The review will also consider whether any amendments to the Act or Regulations would improve their operation. A/Professor Lesley Siegloff is working alongside Professor Aitken to complete the review.

You are invited to participate in this voluntary and anonymous survey to provide information relevant to the review.

We appreciate that health staff are very busy, so there are four ways that you can respond to our request. You can:

- ❑ Complete the on-line survey – click on this link
- ❑ Download this document, proceed to the next page, complete the survey, and email to us (Lesley.Siegloff@flinders.edu.au)
  We will upload the de-identified document to a secure platform and delete the email once received so that your anonymity is maintained
- ❑ Contact us to complete the survey over the phone or as an on-line videoconference
  Via email: Lesley.Siegloff@flinders.edu.au) Via phone: 0400 682 165;
- ❑ Exit the survey now (go to Question 88)

2. Consent to Participate

Completing the survey is voluntary and you can change your mind and decide not to participate at any time, right up until the survey is submitted electronically. It will take you approximately 30 minutes to complete.

Your participation is anonymous unless you wish to participate in a follow-up interview. If you identify yourself on the survey by providing your details to participate in a follow-up interview, your survey data will be de-identified by the project team. The project team are the only people who have access to the survey data, which will be stored in password protected computer files or locked up until it is destroyed in 5 years' time.

All information gained from the survey will be presented as aggregate data in the report preventing anyone identifying you or your individual responses. You don't have to give a reason if you choose not to participate.

Participating, or deciding not to participate at any time will not affect your relationship with your manager, or your employment status, or future employment.

The review team have considered the potential risks of participating, or deciding not to participate in the survey and considers risks to be minimal. There may be the potential for the survey to remind you of Gayle's tragic death, or threats to your own, or others' safety or security. Should you experience any distress, please contact the relevant psychological service provided by your employer, or you may like to contact CRANA*plus* Bush Support Services on 1800 805 391, which provides free confidential 24/7 telephone psychological support for all rural and remote health workers and their families.

There is no direct benefit to you personally as a participant, but by participating you will contribute to evaluating the implementation of the Act and Regulations. You may also contribute to identifying any future changes that may be required to improve the safety and security of health professionals working in remote areas and the health and wellbeing of people living in remote Australia.

The review is a commissioned evaluation and follows the NHMRC Ethical considerations in quality assurance and evaluation activities which does not require the review to be submitted to, or be approved by a Human Research Ethics Committee.

If you would like further information please contact:

Associate Professor Lesley Siegloff at Lesley.siegloff@flinders.edu.au or 0400 682 165;

or

Professor Robyn Aitken at robyn.aitken@flinders.edu.au or 0417 276 112

❑ Yes, I agree to participate (please continue to Q3)

❑ No, I would like to exit the survey now (Please go to Question 88)

3. Have you read any of the following?
(select all that apply)

- ❑ Gayle's Law Legislation
- ❑ Gayle's Law Regulations
- ❑ On-line information about Gayle's Law (including overview & fact sheets)
- ❑ None of the above

4. Have you worked as a health practitioner/health service provider in a remote area of South Australia as shown on the map below?
(select one)

- ❑ Yes, after 7 November 2019 – (Please continue to Q5)
- ❑ Yes, but not after November 2019. Please exit the survey (go to Question 88)
- ❑ No. Please exit the survey (go to Question 88)

5. Does your service provide an unscheduled and/or out of hours call-out health service?
(select one)

- ❑ Yes, please continue to Q6
- ❑ No, Thank you - please exit the survey (Please go to Question 88)

6. What is the best description of your role in unscheduled and/or out of hours call-outs? (select one)

   ❑ Yes, I participate in call-outs – (please continue to Q7)

   ❑ I am a second responder - please exit this survey and click on this link to go to the second responder survey

   ❑ I do not participate in call-outs - please exit this survey (go to Question 88)

7. When you participate in unscheduled and/or out of hours call-outs what is your role? (select all that apply)

   ❑ I am a first responder for unscheduled (during business hours) call outs

   ❑ I am a second responder for unscheduled (during business hours) call outs

   ❑ I am first responder for out of hours call outs

   ❑ I am a second responder for out of hours call outs

8. In an average week, how often would you respond to an **unscheduled** (during business hours) call-out?
   (select all that apply)

   ❑ Never

   ❑ Please indicate the number of times per week
   _____

   ❑ Please comment / describe _____

9. In an average week, how often would you respond to an **out of hours** call-out?
   (select all that apply)

   ❑ Never

   ❑ Please indicate the number of times per week

   _____

   ❑ Please comment / describe

   _____

10. Does your organisation have a Policy(s) and Procedure(s) for unscheduled and/or out of hours call-outs
    (select one)

    ❑ Yes

    ❑ I don't know

    ❑ No

11. What is the expectation for staff to complete orientation to call-out policy/procedure and/or what to do for call-outs?
    (select one)

    ❑ It is mandatory

    ❑ I don't know

    ❑ It is voluntary

    ❑ There is no expectation

12. How is orientation provided for call-out policy/procedure and/or what to do for call-outs?
    (select one)

    ❑ There is an orientation program

    ❑ Employees are expected to orientate themselves

    ❑ Other (please describe)

_____

13. What resources are available for orientation to call-out policy/procedure and/or what to do for call-outs?
(select all that apply)

- ❑ I don't know
- ❑ There are no resources
- ❑ Supervisors or staff provide an orientation
- ❑ on-line orientation package
- ❑ face-to-face orientation
- ❑ Paper based orientation
- ❑ Other (please describe)

_____

14. Have you been orientated to call-out policy/procedure and/or what to do for call-outs?
(select one)

- ❑ Yes (go to Q16)
- ❑ No (please answer the questions below)

15. Why have you not been orientated/orientated yourself to call-out policy/procedure or what to do for call-outs?
(select all that apply)

- ❑ Orientation is not mandatory
- ❑ There are no resources for orientation
- ❑ There is orientation resources but I have not participated
- ❑ Other (please describe)

_____

16. When were you orientated/orientated yourself to information about call-out policy /procedure **and/or what to do** for call-outs?
(select all that apply)

- ❑ I have not been orientated/orientated myself
- ❑ Within the first week of employment
- ❑ Immediately prior to the first time I was rostered for out of hours call-out
- ❑ Immediately prior to each call-out
- ❑ I orientated myself prior to being rostered for out of hours call-out
- ❑ When Gayle's Law was first introduced
- ❑ Other (please describe)

_____

17. How often are staff required to review their knowledge of the policy/procedure or what to do for call-outs in your community?
(select all that apply)

- ❑ I don't know
- ❑ There is no requirement
- ❑ There is no requirement after orientation
- ❑ They decide when they need to refresh/update
- ❑ Before each out-of-hours call-out
- ❑ Annual education update
- ❑ Other (please specify)

_____

18. Please identify who (other than yourself) is orientated to call-out policy/procedure and/or how to respond to call-outs in your community?
(select all that apply)

- ❑ I don't know
- ❑ There is no orientation
- ❑ All staff employed by the health service
- ❑ Only staff employed by the health service who will be rostered on-call out-of-hours
- ❑ All designated second responders
- ❑ Only employed designated second responders
- ❑ Other (please specify)

  _____

19. If other staff/second responders are orientated to call-out policy/procedure and/or how to respond to call-outs, is it the same type of orientation?
(select one)

- ❑ Yes
- ❑ Other people are not orientated
- ❑ I don't know
- ❑ No (please describe e.g. it is not mandatory)

  _____

20. What are the locations where you may be **ASKED** to attend an unscheduled and/or out-of-hours call-out?

    (select all that apply)

    - ❑ Person's home
    - ❑ Road accident scene
    - ❑ Camp site
    - ❑ Community facility
    - ❑ Health clinic
    - ❑ Health worker's home
    - ❑ Police station
    - ❑ Other / comments / please describe _____

21. Does your organisation preclude unscheduled and/or out-of-hour attendance at any of these locations? (select one)

    - ❑ Yes (please specify)
      _____
    - ❑ I don't know
    - ❑ No

22. What is the **MOST COMMON** location **REQUESTED**?

(i.e. you are asked to go to that location most often)
(select one)

- ❑ Person's home
- ❑ Road accident scene
- ❑ Camp site
- ❑ Community facility
- ❑ Health clinic
- ❑ Health worker's home
- ❑ Police station
- ❑ Other / comments / please describe

_____

23. What is the **MOST COMMON** location where an unscheduled and/or out-of-hours call-out is **ATTENDED**

(i.e. a request is made and you most often go to that location)?
(select one)

- ❑ Person's home
- ❑ Road accident scene
- ❑ Camp site
- ❑ Community facility
- ❑ Health clinic
- ❑ Health worker's home
- ❑ Police station
- ❑ Other / comments / please describe

_____

A designated second responder is a person who has met specific criteria as specified in Gayle's Law regulations 11D(2):

- They hold a current Australian driver's license
- They have undertaken a Child Safety check within the last 5 years and
- Are not prohibited from working with children

24. Who is available to accompany you on an unscheduled and/or out of hours call-out in the role of **designated second responder**?
(select all that apply)

❑ Registered Nurse
❑ Registered Midwife
❑ Enrolled Nurse
❑ Aboriginal Health Care Worker/Practitioner
❑ Medical Officer
❑ Paramedic
❑ Allied Health Practitioner (please specify category)
_____
❑ Transport Personnel (e.g. employed Driver)
❑ Maintenance / Gardening Officer
❑ Administration Officer
❑ Volunteer ambulance
❑ A member of my family
❑ Family members of other employed health staff
❑ Police
❑ Aboriginal Community Worker
❑ Emergency Services personnel
❑ Health staff employed at other health services
❑ Security Officer
❑ Nominated Community Member (please specify)
❑ Someone who speaks the local language
❑ Other (please specify)
_____

25. What is the status of community members who act as designated second responders for an unscheduled and/or out of hours call-out?
(select all that apply)

- ❑ I don't know
- ❑ Employed specifically for on-call
- ❑ Volunteer specifically for on-call
- ❑ Other (please describe)

_____

26. Who is the person who is **MOST** likely to accompany you on an **OUT OF HOURS** call-out in the role of designated second responder?
(select one)

- ❑ Registered Nurse
- ❑ Midwife
- ❑ Enrolled Nurse
- ❑ Aboriginal Health Care Practitioner
- ❑ Aboriginal Health Care Worker
- ❑ Medical Officer
- ❑ Paramedic
- ❑ Allied Health Practitioner (Please specify discipline/s)

  _____
- ❑ Transport Personnel (e.g. employed Driver
- ❑ Maintenance / Gardening Officer
- ❑ Administration Officer
- ❑ Volunteer Ambulance Officer
- ❑ Family member of employed health staff
- ❑ Police
- ❑ Aboriginal Community Worker
- ❑ Emergency Services personnel
- ❑ Health staff employed at other health services
- ❑ Security Officer

_____

❑ Nominated Community Member (please specify)

_____

❑ Other (please specify)

_____

27. Is this the same for unscheduled (business hours) call-outs?

❑ Yes

❑ No (please describe the difference) _____

28. How do **YOU** know who is available as a designated second responder for a particular day? (select all that apply)

❑ There is a roster of second responder

❑ There is a list or register that provides the contact details of a second responder

- and I call around until I find someone

❑ I don't know, I just contact someone I know on an ad hoc basis according to their

- capability

❑ Other (please describe)

_____

29. How do **THEY** (on-call designated **SECOND RESPONDERS)** know when **THEY** are required for an unscheduled and/or out of hours call-out ?
(select all that apply)

- ❑ I don't know
- ❑ There is a roster of second responders
- ❑ They are on a list and may / may not be available when they are asked to accompany the health staff
- ❑ They are on a list and know that they must accompany the health staff when asked
- ❑ They don't know, they are contacted on an ad-hoc basis according to their known capability
- ❑ Other (please describe)

_____

30. How are designated second responders recruited?
(select all that apply)

- ❑ I don't know
- ❑ Community members respond to a health service recruitment initiative
- ❑ A health service staff member volunteers
- ❑ A community member volunteers
- ❑ Recruited by word of mouth
- ❑ It is a requirement of their employment
- ❑ Other (please describe)

_____

31. Are there any barriers to having adequate people to act as designated second responders? (select all that apply)

- ❑ I don't know
- ❑ Not that I know of
- ❑ The eligibility requirements for non-staff responders
- ❑ A small pool of non-staff to draw upon/roster
- ❑ A small pool people available/willing to participate in out-of-hours wor (4)
- ❑ Competing demands for non-staff member's time (i.e. cannot commit to being
- ❑ available)
- ❑ Insufficient financial resources to cover employment of enough staff to cover
- ❑ additional roster requirements (salaries)
- ❑ Insufficient financial resources to cover call-outs costs (overtime cost, additional
- ❑ hours)
- ❑ Insufficient financial resources to pay non-staff members
- ❑ Insufficient equipment to ensure safety and security of second responders
- ❑ Other (please comment)
- ❑ _____

32. Do you have feedback on how these barriers could be addressed?

(select one)

- ❑ There are no barriers
- ❑ No, I don’t have any feedback
- ❑ Yes (please comment)

_____

33. What are the consequences if there is an inadequate number of second responders ? (select all that apply)

- ❑ Not applicable - there are enough second responders
- ❑ Non-staff members get tired or have competing responsibilities and are not available
- ❑ Non-staff members are called too often and decide not to be a second responder anymore
- ❑ I am always the person who is on-call for an unscheduled call-out
- ❑ I am always the person who is on-call out of hours
- ❑ It is always two staff who attend an unscheduled and/or out-of-hours call-out
- ❑ If I attend an unscheduled call out with a non-staff member the health service has to be closed
- ❑ If two staff members attend an unscheduled call out the health service has to be closed
- ❑ If I attend an unscheduled call out with another member of staff the health service has to be closed the next day
- ❑ I may decide to attend an unscheduled or out-of-hours call-out without a second responder
- ❑ I may be asked by my supervisor to attend an unscheduled or out-of-hours call-out without a seconder responder
- ❑ I feel the pressure by the community to attend an unscheduled or out-of-hours call-out without a seconder responder
- ❑ Other/comments

_____

34. Have you experienced any difficulties in a designated second responder being **available at the time when you need them** to accompany you on an unscheduled and/or out-of-hours call-out?

- ❑ Never
- ❑ Sometimes
- ❑ Always

35. Can you provide some information about any difficulties that you have experienced in a designated second responder being available to accompany you on an unscheduled and / or out-of-hours call-out?

❑ I have not experienced any difficulties

❑ No, I have no comments/information to give

❑ Comments please

_____

36. Can you provide some information about solutions to any difficulties you have experienced with availability of a second responder to accompany you on an unscheduled and / or out-of-hours call-out?

❑ I have not experienced any difficulties

❑ No, I have no comments/information to give

❑ Comments please

_____

37. The regulations allow you to engage an ***alternative second responder*** if a designated second responder (someone who meets all the required criteria) is not available.

Please tell us about your experience with alternative second responders
(select one)

❑ I have used an alternative second responder (please go to the next question)

❑ I know about this option but have not used an alternative second responder (please go to Q39)

❑ I don't know about the option to use an alternative second responder (please go to Q39)

❑ Other - please comment (e.g. what were the circumstances)
_____ (please go to Q39)

38. What were the circumstances when you used an alternative responder?
(select all that apply)

❑ I had taken all reasonable steps to engage a designated responder

❑ There was a high risk to the health of the person who I was being called out for

❑ The alternative second responder was known to me and I considered them

❑ suitable in the circumstances

❑ Other (Please describe)

_____

39. In the past 12 months have there been any occasions when you have **NOT** attended an unscheduled and / or out-of-hours call-out?
(select one)

❑ Yes (please enter the estimated number of times)
_____ (please go to the next question)

❑ I can't remember (please go to Q41)

❑ No (please go to Q41)

40. What was the reason(s) that you did **NOT** attend?

Please tell us about your experience

_____

41. In the past 12 months have there been any occasions when you **HAVE** attended an unscheduled and / or out-of-hours call-out **WITHOUT** a designated or alternative second responder?
(select one)

❑ Yes (please enter the number of times)
_____ (please go to the next question)

❑ No (Please go to Q47)

42. Was any of these call-outs at a prescribed site?
(select one)

❑ Yes (please enter the details of the prescribed site(s)
_____ (please go to Q44)

❑ I don't know what a prescribed site is, please describe the location(s) you went to
_____ (please go to the next question)

❑ No (please describe the location(s) you went to
_____(please go to the next question)

43. If not a prescribed site/or you didn't know, was the call-out approved by your supervisor?
(select one)

❑ Yes (please tell us the reason) _____

❑ No (please tell us the reason) _____

44. Does your health service permit you to attend a location for an unscheduled and/or call out-of-hours **WITHOUT** a second responder if emergency services personnel are in attendance?
(select one)

❑ Yes, and I have attended with emergency services personnel
(please go to the next question)

❑ Yes, but this has never happened to me (Please go to Q47)

❑ I don't know (Please go to Q47)

❑ No (Please go to Q47)

45. If you attended a location for an unscheduled and/or call out-of-hours WITHOUT a second responder who were the emergency services personnel in attendance?
(select all that apply)

❑ Police Officer

❑ Special Constable

❑ Fire and Emergency

❑ Ambulance Officer

❑ Other worker (please specify)

_____

46. When an emergency service personnel attends the location **in place of a** second responder the person:

(select all that apply)

- ❑ Is present with me at all times
- ❑ Remains at the same premises /location and is close enough to hear me during the entire call-out
- ❑ Is physically present while I provide the necessary care
- ❑ Ensures that I return safely to my nominated destination
- ❑ Ensures that a second responder is called as well if they cannot meet any of the above
- ❑ Other (please describe) _____

47. Is there a Police station in your community that can be used as a prescribed site?

(select one)

- ❑ Yes, a Police Officer resident at all times
- ❑ Yes, A Police Officer will come from another location
- ❑ No, there is a police station, but no resident or on-call Police Officer
- ❑ No, there is no police station
- ❑ Other (please describe)

_____

48. Would you like to comment about the role of Police Officers in unscheduled and/or out of hours call-out situations?

(select one)

- ❑ No
- ❑ Yes (please comment)

_____

49. The next questions relate to equipment available in **BUILDINGS**

What communication equipment is available and in working order at the **HEALTH CLINIC** to manage risks associated with the safety and security of personnel attending unscheduled and/or out-of-hours call-outs? (select all that apply)

❑ Mobile phone (3-5G) service
❑ Mobile phone (satellite)
❑ Two-way radio
❑ Internet/WiFi access
❑ Duress alarm
❑ Mobile duress alarm
❑ Landline
❑ CCTV
❑ Security alarm
❑ Other (please specify) _____

50. Are the above options enough?
(select one)

❑ Yes
❑ I don't know
❑ No (Please comment / suggest any additional safety equipment)
_____

51. Is the same communication equipment available and in working order at your **ACCOMMODATION** when you are required to attend an unscheduled and/or out-of-hours call-outs?
(select one)

❑ Yes
❑ I don't know
❑ No (please comment)

_____

52. Are the above options enough?
(select one)

❑ Yes
❑ I don't know
❑ No (Please comment/suggest any additional safety equipment)
_____

53. Is there a difference between the equipment available to you compared to other staff?
(select one)

❑ Yes (please describe/comment) _____
❑ I don't know
❑ No

54. The next questions relate to equipment available in **VEHICLES**

What communication equipment is available and in working order in health service **VEHICLES** used for unscheduled and/or out-of-hours call-outs?
(select all that apply)

❑ Mobile phone (3-5G) service
❑ Mobile phone (satellite)
❑ Two-way radio
❑ GPS locator
❑ Duress alarm
❑ Mobile duress alarm
❑ Dashboard / in-car camera
❑ Security alarm
❑ External lights
❑ Other (please specify) _____

55. Are the above options enough?
(select one)

❑ Yes
❑ I don't know
❑ No (Please comment / suggest any additional safety equipment)
_____

56. Is the same communication equipment available and in working order in **ALL** vehicles that may be used for attending an unscheduled and/or out-of-hours call-outs?
(select one)

❑ Yes
❑ I don't know
❑ No (please comment)

_____

57. How often is the most equipped vehicle for unscheduled and/or out-of-hours call-outs available?
(select one)

❑ Never
❑ Some of the time
❑ Most of the time
❑ All of the time
❑ Other (please comment) _____

58. Where is the most equipped vehicle located for an out-of-hours call-out?

(select one)

❑ At the first on-call person's accommodation

❑ At both the first on-call and staff second responder's accommodation

❑ At the health service clinic

❑ There is no vehicle for out-of-hours use

❑ Other (please comment)

_____

59. Do you ever use your own vehicle for unscheduled and/or out-of-hours call-outs?
(select one)

❑ Never (please go to Q61)

❑ Some of the time

❑ Most of the time

❑ All of the time

❑ Other (please comment)

_____

60. If you use your own vehicle, what communication equipment is available and in working order for unscheduled and/or out-of-hours call-outs?
(select all that apply)

❑ I don't use my own vehicle (please go to Q62)

❑ Mobile phone (3-5G) service

❑ Mobile phone (satellite)

❑ Two-way radio

❑ GPS locator

❑ Duress alarm

❑ Mobile duress alarm

❑ Dashboard / in-car camera

❑ Security alarm

❑ External lights

❑ Other (please specify) _____

61. Is this equipment enough?
(select one)

❑ Yes

❑ I don't know

❑ No (Please comment / suggest any additional safety equipment)
_____

62. Does the staff member on-call and second responder travel together to the location of the call-out?

❑ Never (Please go to Q67)

❑ Some of the time

❑ Most of the time

❑ All of the time

❑ Other (Please comment) _____

63. When they do NOT travel together what is the procedure?

The procedure is:

_____

64. Does the second responder use their own vehicle?

❑ Never (Please go to Q67)

❑ Some of the time

❑ Most of the time

❑ All of the time

❑ Other (Please comment) _____

65. What equipment, safety and security measures are available to the designated second responder?
(select all that apply)

- ❑ I don't know (Please go to Q67)
- ❑ Mobile phone (3-5G) service
- ❑ Mobile phone (satellite)
- ❑ Two-way radio
- ❑ GPS locator
- ❑ Duress alarm
- ❑ Mobile duress alarm
- ❑ Landline
- ❑ Dashboard / in-car camera
- ❑ Security alarm
- ❑ External lights
- ❑ Other (please specify)

_____

66. Is this equipment enough?
(select one)

- ❑ Yes
- ❑ I don't know
- ❑ No (Please comment / suggest any additional safety equipment)

_____

67. Are there any barriers to having adequate equipment in working order in buildings, in vehicles, for responders?
(select one)

- ❑ Yes
- ❑ I don't know (please go to Q69)
- ❑ No (please go to Q69)

68. What are the barriers to having adequate equipment in working order for responders, accommodation, and vehicles?
(select all that apply)

- ❑ I don't know (please go to Q69)
- ❑ Competing demands for equipment
- ❑ No replacements available for equipment requiring repair
- ❑ Equipment has to be sent off-site for repair
- ❑ Unreliable equipment
- ❑ Fit for purpose equipment is not available
- ❑ Fit for purpose equipment is not available at an affordable price
- ❑ Insufficient financial resources to cover enough equipment (quantity)
- ❑ Insufficient financial resources to cover fit for purpose equipment (quality)
- ❑ Other / please comment

_____

69. How quickly do you expect the second responder to arrive at the location of the call-out?
(select one)

- ❑ 0-5 minutes
- ❑ 10-15 minutes
- ❑ 20-30 minutes
- ❑ >30 minutes
- ❑ Other (please comment)

_____

70. On average, how often is this time frame achieved?

(select one)

- ❑ Never
- ❑ Some of the time
- ❑ Most of the time
- ❑ All of the time

❑ Other (Please comment)

_____

71. What is the expectation for the second responder during the call out?

(select all that apply)

- ❑ Must be present at all times
- ❑ Must remain at the same premises within hearing of the health professionals during the entire call-out
- ❑ Must be physically present during the provision of health services
- ❑ Other /please comment _____

72. On average, how often is the above expectation achieved?

(select one)

- ❑ Never
- ❑ Some of the time
- ❑ Most of the time
- ❑ All of the time
- ❑ Other please comment

_____

73. After the call-out has finished, what is the procedure to ensure that the **SECOND RESPONDER** has arrived safely at an agreed destination?
(select one)

- ❑ I don't know
- ❑ Please describe the procedure _____
- ❑ There is no procedure

74. After the call-out has finished, what is the procedure to ensure that **THE ON-CALL STAFF MEMBER** has arrived safely at their agreed destination following the call-out?
(select one)

- ❑ I don't know
- ❑ Please describe the procedure _____
- ❑ There is no procedure

75. Are any of the following tools, guidelines or protocols available to manage risks associated with the safety and security of personnel attending unscheduled and/or out-of-hours call-outs?
(select all that apply)

- ❑ I don't know (please go to Q76)
- ❑ There is no tools, guidelines or protocols available to manage risks
- ❑ Staff, work health and safety risk assessment tool for out-of-hours call-outs
- ❑ Triage protocol for determining the need for out-of-hours call-outs
- ❑ Clinical risk assessment tool
- ❑ Register to document the out-of-hours call-outs
- ❑ Protocol to document the out-of-hours call-out in client record/medical record
- ❑ Staff call-out roster
- ❑ Incident reporting protocol for out-of-hours call-out
- ❑ Protocol to ensure that all personnel attending the out-of-hours call-out return safely to their place of residence or other designated place
- ❑ Other (please describe) _____

76. What are the options for staff, designated or alternative second responders to provide feedback on the practical implementation of the policy and procedure relating to unscheduled or out-of-hours call-outs in your community?
(select all that apply)

- ❑ I don't know
- ❑ Written feedback
- ❑ Verbal feedback to their supervisor
- ❑ Team meetings
- ❑ Incident reporting system
- ❑ Community meetings
- ❑ Other (please specify) _____

77. Have you ever provided any feedback?
(select one)

- ❑ No (please go to Q79)
- ❑ Yes

78. Can you tell us about the feedback that you provided?
(select all that apply)

- ❑ Please describe the feedback that you gave
  _____
- ❑ Please describe the outcome of your feedback
  _____

79. Has COVID-19 had any impact on implementation of the procedures relating to unscheduled and/or out-of-hours call-out in your role?
(select one)

❑ Yes, please comment _____

❑ I don't know

❑ No

80. Is there anything else that you would like to tell us?

For example

- including examples of how the legislation has worked to improve the safety and security of staff responding to unscheduled and/or out-of-hours call outs,
- barriers to implementation and/or
- improvements that could be made

❑ Yes (Please describe)

_____

❑ No

Demographic Information

We understand that there may be concerns about remaining anonymous, but we would appreciate if you could provide some demographic information so that we can report the breadth of health services that have provided data for this review.

Data will be aggregated so your privacy is maintained.

81. What is your profession and what are your qualifications?

- ❑ I would prefer not to answer this question
- ❑ Registered nurse (please put your qualifications below)

  _____
- ❑ Registered Midwife (please put your qualifications below)

  _____
- ❑ Enrolled nurse (please put qualifications below)

  _____
- ❑ Aboriginal Health Care Worker (please put your qualifications below)

  _____
- ❑ Allied Health Practitioner (please put your qualifications below)

  _____
- ❑ Medical Officer (please put your qualifications below)

  _____
- ❑ Primary Health Care Practitioner (please put your qualifications below)

  _____
- ❑ Public Health Practitioner (please put your qualifications below)

  _____
- ❑ Administration (please put your qualifications below)

  _____
- ❑ Other (please describe and put your qualifications below)

  _____

82. How long have you worked at the health service where you are currently employed?

❑ I would prefer not to respond to this question (4)

❑ I have worked at the health service where I am currently employed? (insert length of time)

_____

83. How long have you worked in a remote location?
(anywhere in Australia, or areas covered by Gayle's Law)

❑ I would prefer not to respond to this question

❑ I have worked in a remote location for (insert length of time)

_____

84. How are you employed by the health service?

❑ I would prefer not to respond to this question.

❑ I am an employee

❑ I am employed by an agency and assigned to the health service

❑ Other (please describe)

_____

85. What is the best description of the health service where you currently work?

❑ I would prefer not to respond to this question

❑ Public (government health service)

❑ A non-government organisation

❑ Aboriginal Medical Service

❑ Health Services on a mine site

❑ Other (please describe)

_____

86. What is the size of the population served by your health service? (approximately)

- ❑ I would prefer not to respond to this question
- ❑ <50 people
- ❑ 51-100 people
- ❑ 101-300 people
- ❑ 301-500 people
- ❑ 501-1000 people
- ❑ >1000 people

87. Thank you for completing this survey, your contribution is highly valued.

We would also like to invite you to a follow up interview.

Please indicate if you are interested in being interviewed.

- ❑ No, I don't want to volunteer to participate in a follow-up interview.
- ❑ Yes, I would like to volunteer to participate in a follow-up interview. My contact details are below (telephone/email) _____
- ❑ I will forward my contact details separately to lesley.siegloff@flinders.edu.au or phone Assoc Professor Lesley Siegloff on 0400682165

END OF SURVEY – IF YOU HAVE PARTICIPATED, THIS IS YOUR LAST QUESTION

Please save and email the survey to Lesley.Siegloff@flinders.edu.au

THIS PAGE IS FOR PEOPLE WHO DID NOT WANT TO PARTICIPATE

OR

DID NOT MEET CRITERIA TO PARTICIPATE

88. We understand that you may not meet the criteria for completing this survey, or may not want to complete the survey, but is there anything that you would like to tell us?

For example

- including examples of how the legislation has worked to improve the safety and security of staff responding to unscheduled and/or out-of-hours call outs,
- barriers to implementation and/or
- improvements that could be made

❑ Yes (Please describe)

_____

❑ No

END OF SURVEY – THIS IS YOUR EXIT QUESTION

Please save and email the survey to Lesley.Siegloff@flinders.edu.au

APPENDIX 12: Second responder Survey

Flinders UNIVERSITY
College of Medicine & Public Health

Gayle's Law Review – Second Responder Survey

REVIEW OF THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SOUTH AUSTRALIA) (REMOTE AREA ATTENDANCE) AMENDMENT ACT 2017 AND THE HEALTH PRACTITIONER REGULATION NATIONAL LAW (SOUTH AUSTRALIA) (REMOTE AREA ATTENDANCE) (No 2) VARIATION REGULATIONS

The South Australian Parliament passed the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act, which is more commonly referred to as 'Gayle's Law', in response to the tragic death of Gayle Woodford, a dedicated nurse who was murdered while working in a remote community in South Australia. The Law and associated regulations were enacted on 1 July 2019. The intention is that health service providers who employ health practitioners in a remote area must ensure that a second responder accompanies the health practitioner when attending an out of hours callout or unscheduled callout.

Professor Robyn Aitken has been commissioned by the South Australian Department of Health and Wellbeing to undertake the review of Gayle's Law to establish whether it has been implemented as intended; the impact that the Act and Regulations have had on health services, the safety of health practitioners and persons providing health services, and communities in the remote areas of South Australia. The review will also consider whether any amendments to the Act or Regulations would improve their operation. A/Professor Lesley Siegloff is working alongside Professor Aitken to complete the review.

You are invited to participate in this voluntary and anonymous survey to provide information relevant to the review.

We appreciate that you may be very busy, so there are four ways that you can respond to our request. You can:

- ❑ Complete the on-line survey by clicking on this link
- ❑ Download this document, continue to the next page, complete electronically, and email to us (Lesley.Siegloff@flinders.edu.au)
  We will upload the de-identified document to a secure platform and delete the email once received so that your anonymity is maintained
- ❑ Contact us to complete the survey over the phone or as an on-line videoconference
  Via email: Lesley.Siegloff@flinders.edu.au) Via phone: 0400 682 165;
- ❑ Exit the survey now (go to Question 43)

2. Consent to Participate

Completing the survey is voluntary and you can change your mind and decide not to participate at any time, right up until the survey is submitted electronically. It will take you approximately 15 minutes to complete.

Your participation is anonymous unless you wish to participate in a follow-up interview. If you identify yourself on the survey by providing your details to participate in a follow-up interview, your survey data will be de-identified by the project team. The project team are the only people who have access to the survey data, which will be stored in password protected computer files or locked up until it is destroyed in 5 years' time.

All information gained from the survey will be presented as aggregate data in the report preventing anyone identifying you or your individual responses. You don't have to give a reason if you choose not to participate.

Participating, or deciding not to participate at any time will not affect your relationship with your manager, or your employment status, or future employment.

The review team have considered the potential risks of participating, or deciding not to participate in the survey and considers risks to be minimal. There may be the potential for the survey to remind you of Gayle's tragic death, or threats to your own, or others' safety or security. Should you experience any distress, please contact the relevant psychological service provided by your employer, or you may like to contact CRANA*plus* Bush Support Services on 1800 805 391, which provides free confidential 24/7 telephone psychological support for all rural and remote health workers and their families.

There is no direct benefit to you personally as a participant, but by participating you will contribute to evaluating the implementation of the Act and Regulations. You may also contribute to identifying any future changes that may be required to improve the safety and security of health professionals working in remote areas and the health and wellbeing of people living in remote Australia.

The review is a commissioned evaluation and follows the NHMRC Ethical considerations in quality assurance and evaluation activities which does not require the review to be submitted to, or be approved by a Human Research Ethics Committee.

If you would like further information please contact:

Associate Professor Lesley Siegloff at Lesley.siegloff@flinders.edu.au or 0400 682 165;

or

Professor Robyn Aitken at robyn.aitken@flinders.edu.au or 0417 276 112

❑ Yes, I agree to participate (please continue to Question 3)

❑ No, I would like to exit the survey now (Please go to Question 43)

3. Have you read any of the following?
(select all that apply)

- ☐ Gayle's Law Legislation
- ☐ Gayle's Law Regulations
- ☐ On-line information about Gayle's Law (including overview & fact sheets
- ☐ None of the above

4. Do you help health staff for call-outs?
(select one)

- ☐ No (Please go to Q43)
- ☐ Yes, I am a second responder only - please continue

5. What is the best description of your role as a second responder?

(select all that apply)

- ☐ I am a second responder for unscheduled (during business hours) call outs
- ☐ I am a second responder for out of hours call outs

6. In an average week, how often would you respond to an **unscheduled** (during business hours) call-out?

- ☐ Never
- ☐ Please indicate the number of times per week _____
- ☐ Please comment / describe _____

7. In an average week, how often would you respond to an **out of hours** call out?

   ☐ Never

   ☐ Please indicate the number of time per week
   _____

   ☐ Please comment / describe _____

8. How do you know what to do for a call out?

   (select all that apply)

   ☐ I don't know

   ☐ I follow instructions

   ☐ Someone from the health centre told me what to do

   ☐ Someone from the health centre asked me to read what to do

   ☐ Someone form the health centre asked me to read what to do on the computer

   ☐ Other (please comment) _____

9. When did you do this?

   (select all that apply)

   ☐ I haven't done it yet, I don't know about a policy or procedure

   ☐ Within the first week

   ☐ Just before the first time I was rostered for a call-out

   ☐ Just before every call-out

   ☐ Other/more information (please describe)
   _____

10. Who is normally the first responder to a call-out?

(select all that apply)

- ☐ Registered Nurse
- ☐ Registered Midwife
- ☐ Enrolled Nurse
- ☐ Aboriginal Health Care Practitioner
- ☐ Aboriginal Health Care Worker
- ☐ Medical Officer
- ☐ Paramedic
- ☐ Allied Health Practitioner (please specify category) _____
- ☐ Other (please specify) _____

11. Are you?
(select one)

- ☐ Employed specifically for on-call
- ☐ Volunteer specifically for on-call
- ☐ Other (please specify) _____

12. How do **YOU** know when you are required as a second responder for a particular day?
(select all that apply)

- ☐ I am on a roster of second responders
- ☐ I am on a list and may/may no be available when I am asked to accompany the health staff
- ☐ I am on a list and know that I must accompany the health staff when asked
- ☐ I don't know, I am contacted on an ad-hoc basis according to my skills
- ☐ Other (please describe)) _____

13. How were you recruited?

(select all that apply)

- ☐ There was an advertisement
- ☐ I just volunteered
- ☐ Someone asked me to be a second responder
- ☐ It is a requirement of my employment
- ☐ Other (please describe) _____

14. Have you had any difficulties being a second responder?

Please describe and/or move to next question if no difficulties

_____

_____

_____

_____

_____

15. Can you tell us anything that would be helpful?

Please describe and/or move to next question if no difficulties

_____

_____

_____

_____

_____

16. In the past 12 months/ or in a time that you can remember have there been any occasions when you have **NOT** been able to attend when you have been asked?

- ☐ Yes (please state the reason/s) _____
- ☐ No

17. Are there enough people to act as second responders in your community?

(select all that apply)

- ☐ I don't know
- ☐ I think that there are enough people
- ☐ There are not enough people to do this job
- ☐ No, the process is too hard for people to become a second responder
- ☐ No, people have too many other responsibilities (i.e. cannot commit to being available)
- ☐ No, people don't want to do this job without being paid
- ☐ No, people want more training to do this job (8)
- ☐ Other (please comment) _____

18. Do you have any ideas about on how to get more second responders?

(select one)

- ☐ Yes (please comment) _____
- ☐ No

19. What happens if there are not enough second responders?

(Select all that apply)

- ☐ There is always a second responder
- ☐ I am always the person who is a second responder
- ☐ I am always the person who is on-call out of hours
- ☐ I feel pressured by the health person even if it is difficult for me
- ☐ Other/comments _____

20. What places are you **ASKED** to go as a second responder?

(select all that apply)

- ☐ Person's home
- ☐ Road accident
- ☐ Camp site
- ☐ Community building
- ☐ Health clinic
- ☐ Doctor, Nurse, Midwife or Health worker's home
- ☐ Police station
- ☐ Other / comments / please describe_____

21. Is there any place that you would not go to?

(select one)

- ☐ Yes (please specify) _____
- ☐ No

22. What is the **MOST COMMON** place that you are asked to go to?

(select one)

- ☐ Person's home
- ☐ Road accident
- ☐ Camp site
- ☐ Community building
- ☐ Health clinic
- ☐ Doctor, Nurse, Midwife or Health worker's home
- ☐ Police station
- ☐ Other / comments / please describe

_____

23. What is the **MOST COMMON** place that you **HAVE** gone to?
(select one)

- ☐ Person's home
- ☐ Road accident
- ☐ Camp site
- ☐ Community building
- ☐ Health clinic
- ☐ Doctor, Nurse, Midwife or Health worker's home
- ☐ Police station
- ☐ Other / comments / please describe

_____

24. How can you tell somebody what it is like to be a second responder in your community? (select all that apply)

- ☐ Write about it
- ☐ Tell someone my story
- ☐ At a meeting with health staff
- ☐ At community meetings
- ☐ I don't know
- ☐ Other (please describe) _____

25. Have you ever told/written to anyone about being a second responder? (select one)

- ☐ No
- ☐ Yes
- ☐ Please describe what you wrote or said _____
- ☐ What happened after you did this? _____

26. Do you travel to the place of the call-out with the health staff? (select one)

- ☐ Never
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time
- ☐ Other please comment _____

27. When you travel on your own what is the procedure?

- [ ] I don't travel on my own
- [ ] The procedure is: _____

28. Do you ever use your own car/truck/troopie?
(select one)

- [ ] Never
- [ ] Some of the time
- [ ] Most of the time
- [ ] All of the time
- [ ] Other please comment _____

29. What equipment, safety and security measures are available to you?
(select all that apply)

- [ ] Mobile phone (3-5G) service
- [ ] Mobile phone (satellite)
- [ ] Mobile phone with pre-programmed emergency numbers
- [ ] Two-way radio
- [ ] GPS locator
- [ ] Duress alarm
- [ ] Mobile duress alarm
- [ ] Landline
- [ ] Dashboard / in-car camera
- [ ] Security alarm
- [ ] External lights
- [ ] Other (please describe) _____

30. Are these enough options?

- [ ] Yes
- [ ] I don't know
- [ ] No
- [ ] Please comment / suggest any additional safety equipment (4)

_____

31. How quickly do you expect to arrive at the location of the call-out?

- [ ] 0-5 minutes
- [ ] 10-15 minutes
- [ ] 20-30 minutes
- [ ] >30 minutes
- [ ] please comment _____

32. On average, how often do you arrive in this time?

- [ ] Never
- [ ] Some of the time
- [ ] Most of the time
- [ ] All of the time
- [ ] Please comment _____

33. What are you expected to do when you are at the call out?
(select all that apply)

- [ ] Stay with the health staff at all times
- [ ] Act as an interpreter
- [ ] Stay at the same location within hearing of the health staff during the entire call-out
- [ ] Being physically present when health staff are doing something to the patient
- [ ] Other /please comment _____

34. After the call-out has finished what is the procedure to ensure that **YOU** arrive safely at home/an agreed place?
(select one)

- [ ] The procedure is _____
- [ ] There is no procedure

35. After the call-out has finished what is the procedure to ensure that **HEALTH STAFF** arrive safely at home/an agreed place?
(select one)

- [ ] The procedure is _____
- [ ] I don't know
- [ ] There is no procedure

36. Has COVID-19 had any impact on your role as a second responder?
(select one)

- [ ] No
- [ ] Don't know
- [ ] Yes (please comment) _____

37. Is there anything else that you would like to say, about the role of the second responder including any improvements that could be made?

_____

_____

38. We understand that there you may not want to answer the next questions, but it will help us describe in general (without giving your name) who has helped us with this review.

How would you describe yourself?
(select one)

- ☐ I would prefer not to respond to this question
- ☐ I am a community person
- ☐ Registered Nurse
- ☐ Midwife
- ☐ Enrolled Nurse
- ☐ Aboriginal Health Care Practitioner
- ☐ Aboriginal Health Care Worker
- ☐ Medical Officer
- ☐ Allied Health Practitioner/s (please specify category/ies)
  _____
- ☐ Paramedic
- ☐ Transport Personnel
- ☐ Maintenance/Gardening Officer
- ☐ Administration Officer
- ☐ Volunteer Ambulance
- ☐ Family member of employed health staff
- ☐ Police
- ☐ Emergency Services Personnel
- ☐ Health Staff Employed at other health services
- ☐ Security Officer
- ☐ Other (please describe) _____

39. How long have you been a second responder?

_____

_____

_____

_____

_____

40. How long have you lived in a remote location?

_____

41. How many people live in your community? (approximately)

☐ I would prefer not to respond to this question

☐ <50 people

☐ 51-100 people

☐ 101 -300 people

☐ 301-500 people

☐ 501-1000 people

☐ >1000 people

42. Thank you for completing this survey, your contribution is highly valued. We would also like to invite you to talk to us. Please tell us below if you would like to do this.

☐ No, I do not want to talk to anyone.

☐ Yes, I would like to volunteer to talk to you about being a second responder. I have included my telephone number and email below

_____

☐ Yes, I will write to Lesley Siegloff at lesley.siegloff@flinders.edu.au or phone her on 0400682165

END OF SURVEY – IF YOU HAVE PARTICIPATED, THIS IS YOUR LAST QUESTION

Please save and email the survey to Lesley.Siegloff@flinders.edu.au

THIS PAGE IS FOR PEOPLE WHO DID NOT WANT TO PARTICIPATE
OR
DID NOT MEET CRITERIA TO PARTICIPATE

43. We understand that you may not meet the criteria for completing this survey, or may not want to complete the survey, but is there anything that you would like to tell us?

For example

- including examples of how the legislation has worked to improve the safety and security of staff responding to unscheduled and/or out-of-hours call outs,
- barriers to implementation and/or
- improvements that could be made

❑ Yes (Please describe)

_____

❑ No

END OF SURVEY – THIS IS YOUR EXIT QUESTION
Please save and email the survey to Lesley.Siegloff@flinders.edu.au

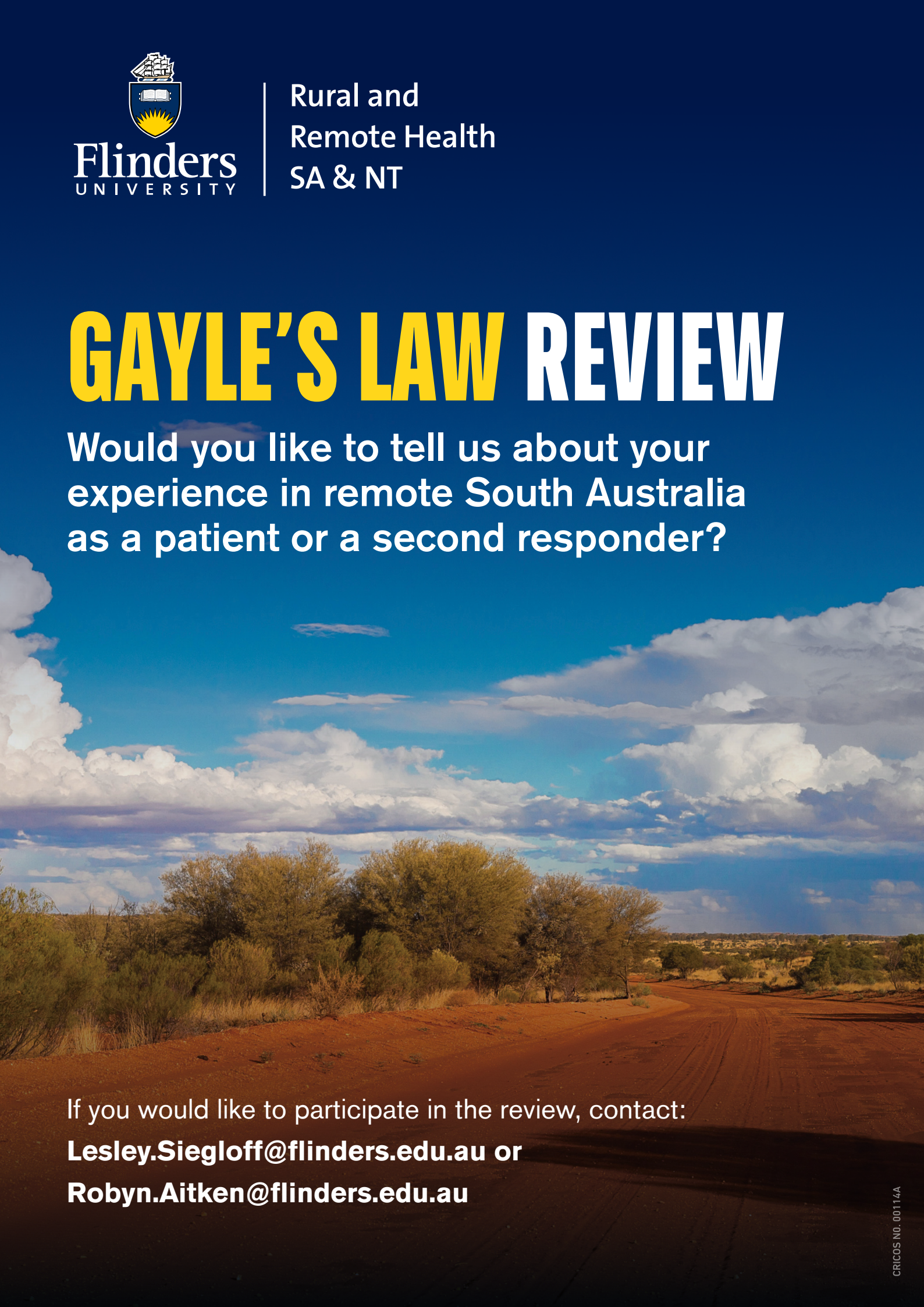
APPENDIX 13: Gayle's Law Review recruitment advertising

Flinders UNIVERSITY

Rural and Remote Health SA & NT

GAYLE'S LAW REVIEW

Would you like to tell us about your experience in remote South Australia as a patient or a second responder?



If you would like to participate in the review, contact:

Lesley.Siegloff@flinders.edu.au or

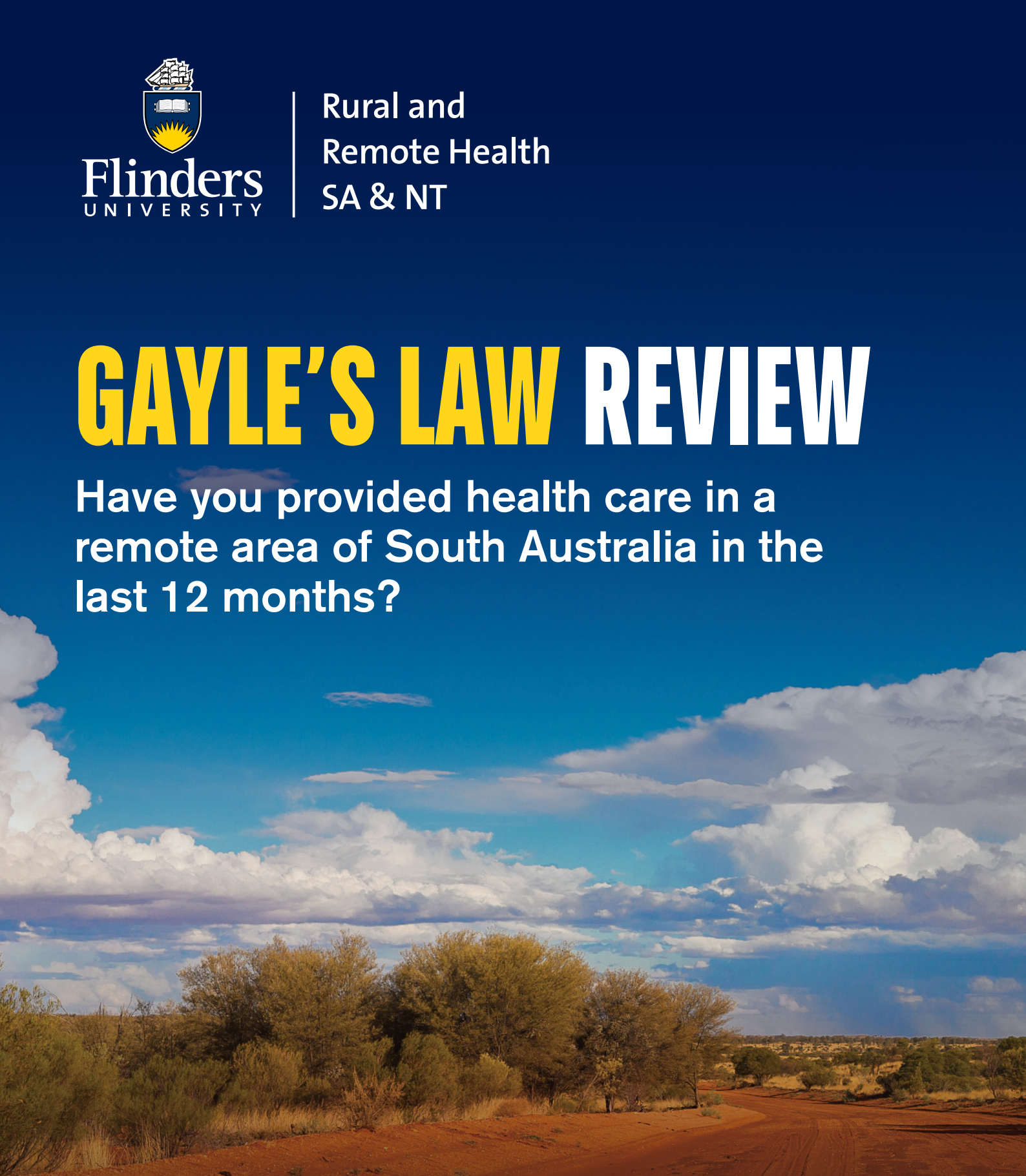
Robyn.Aitken@flinders.edu.au

Flinders UNIVERSITY

Rural and Remote Health SA & NT

GAYLE'S LAW REVIEW

Have you provided health care in a remote area of South Australia in the last 12 months?



If you would like to participate in the review, contact:

Lesley.Siegloff@flinders.edu.au or

Robyn.Aitken@flinders.edu.au

Flinders UNIVERSITY

Rural and Remote Health SA & NT

GAYLE'S LAW REVIEW

Have you provided health care in a remote area of South Australia in the last 12 months?

Click here to watch the introductory video

Click here to participate in an on-line survey

Click here to download a pdf survey

Contact **Lesley.Siegloff@flinders.edu.au** or **Robyn.Aitken@flinders.edu.au** to participate in an interview

Closes 30 March 2021

The review is commissioned by the SA Department of Health & Wellbeing as required under legislation

Email – health practitioner

Email – second responder

Email – Health Services Provider

Click here to watch the introductory video
Click here to participate in an on-line audit
Click here to download a pdf audit
Click here to participate in an interview
Closes 30 March 2021
For further information please contact
Lesley.Siegloff@flinders.edu.au or Robyn.Aitken@flinders.edu.au
The review is commissioned by the SA Department of Health & Wellbeing as required under legislation

Executive Update - Gayle's Law review

19 March 2021

Have you provided health care in a remote area of South Australia in the last 12 months?

The *Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017*, more commonly referred to as 'Gayle's Law', was passed by Parliament to provide better protection for health practitioners working in remote areas of South Australia.

Under Gayle's Law, health practitioners in remote areas of South Australia must be accompanied by a second responder when attending an out of hours or unscheduled callout.

When the law was written, it included a requirement that the implementation be reviewed within 12 months. The implementation of Gayle's Law is now being independently reviewed by Flinders University. If you have provided health care in a remote area of South Australia in the last 12 months, I encourage you to participate in this review.

Please complete this online survey by 30 March 2021, or contact Robyn Aitken at Flinders University to participate in an interview.

Prue Reid
Executive Director
Corporate Affairs