It is amazing how quickly time has gone, by the end of June 2015, we will complete our 5 year term of office; yet I can still remember writing my welcome note! It has been a privilege for me to serve as Chairman of this dynamic and strong Board. The collective knowledge, experience, expertise and maturity of the members of the Board have contributed significantly to the general advancement of the emergency care profession. This Board has made great strides working together tirelessly within the HPCSA noble ethos of “Guiding the profession and protecting the public” in a professional, collegial manner for the betterment of our profession.

During this term, the Board established two additional Committees; i.e. the Clinical Advisory Committee and the Research Committee. These respective Committees will play a major role in developing and monitoring clinical practice and research within our profession. In line with its mandate, the education and training standards of all the qualifications for the respective registration categories were also reviewed. The recent promulgation of the Emergency Care Assistant, Emergency Care Technician and Emergency Care Practitioner regulations by the honourable Minister of Health, Dr Aaron Motsoaledi endorses the National Emergency Care Education and Training (NECET) Policy, which makes provision for a 3 tiered service provision within Emergency Medical Services (EMS).

For reasons beyond our control, the review of the scope of practice has been delayed, however, the matter is at hand. The revision of all scopes of practice will be based on the patients’ needs, be evidence based, in line with international best practice and locally relevant. The scope will also be compliant with the 2015 ILCOR resuscitation guidelines and cognisant of the desired 3-tiered EMS service provision.

Stakeholder meetings were held in all nine provinces with a second round of meetings commencing in 2014. These public stakeholder meetings have proven to be extremely informative, giving the Board the opportunity of engaging with its members within their respective provinces. Several stakeholder meetings were held with the National Department of Health, the Department of Higher Education and Training, the South African Military Health Services, the National Committee on EMS, public and private EMS education and training providers, as well as with other major role players.

The recognition of some of the registration categories by the Medicines Control Council as authorised prescribers was a major step towards professional practice.

Towards the end of 2014, I had the opportunity of presenting a paper at The College of Paramedics Conference, United Kingdom. Much
to my surprise, many of the issues we are grappling with in the South African context are the same as in other parts of the world, like USA, Canada, Switzerland, Austria, UK and Australia. Internationally, it does appear as though our profession is reaching a point where EMS is consolidating, critically reviewing and challenging its regulations, policies, systems and practices. Even more surprising, but encouraging, was that in many aspects we are actually ahead.

On behalf of the outgoing Board, I wish the incumbent Board every success as they take the profession forward especially, with regards the operationalisation of the NECET Policy and the review of the scopes of practice. We pledge our continued support, if and when called upon to do so. While the future will no doubt be challenging, it is also full of promise with exciting opportunities for the profession and the patients we serve in the prehospital environment.

Mr Raveen Naidoo
Chairman

PEDIATRICS GROUP OFFERS ADVICE ON EVALUATING FRACTURES FOR SIGNS OF CHILD ABUSE (JOURNAL WATCH)

The American Academy of Pediatrics has published a guide to assessing whether childhood fractures are the result of abuse.

The most recent publication of its kind, its claim of relevance lies in the evidence that fractures are the second most common injury caused by child physical abuse whereas bruises are the most common injury.1,2 "Failure to identify an injury caused by child abuse and to intervene appropriately may place a child at risk for further abuse, with potentially permanent consequences for the child."1,3-5

According to Journal Watch, the article, published in ‘Pediatrics’, notes that a fracture should be suspicious for child abuse in the following circumstances:

- There is no history of injury, or the history described is not consistent with the injury sustained.
• The caregiver provides inconsistent or changing histories.
• The fracture is in a nonambulatory child.
  o “Approximately 80% of all fractures caused by child abuse occur in children younger than 18 months.”1
• The fracture has a high specificity for child abuse; in infants and toddlers, these include classic metaphyseal lesions of long bones and rib, scapular, sternal, and spinous process fractures.
  o “Rib fractures are highly suggestive of child abuse. Most abusive rib fractures result from anterior-posterior compression of the chest. For this reason, rib fractures are frequently found in infants who are held around the chest, squeezed, and shaken. Rib fractures have high probability of being caused by abuse.”
• There are multiple fractures or fractures of different ages.
• The child has other suspicious injuries.
• The caregiver delayed seeking medical treatment.

The pediatric fractures article1 as a cue to child abuse also provides a framework for the medical exam, lab work, imaging, sibling evaluation, and diagnosis. Emergency Care relevance is to maintain a high index of suspicion for child abuse under the circumstances listed above and to document and report such observations. The EMS system must be strengthened so that every EMS provider becomes an advocate against child abuse and for child safety.

Link(s): Pediatrics article (Free PDF) http://click.jwatch.org/cts/click?q=27%3B67952074%3Bc5PFFc89Zp9A6QcsoxUXMCeezyq85I9CEXAAfEPnE%3D

By Navin Naidoo

References
DOMESTIC VIOLENCE INTERVENTION IN RSA

DOMESTIC VIOLENCE SCREENING

PREPARED BY PROFESSIONAL BOARD FOR EMERGENCY CARE

1. Preamble

The mortality associated with Domestic violence becomes apparent when one considers that one woman is killed every 6 hours by an intimate partner (Mathews et al., 2004). Domestic Violence survivors “express a strong desire for compassion, trust and understanding from health care professionals” (Joyner, 2009). A public health study of attitudes and beliefs of emergency care providers elicited a poor level of understanding of the problem of domestic violence (Naidoo, 2007). Only 49% of respondents could define domestic violence. Provider qualification was associated with domestic violence definition in that basic providers were more likely to define incorrectly than their advanced counterparts. Eighty-one percent of respondents recognized less than thirty (30) domestic violence calls in six months. Considering the high incidence and prevalence of domestic violence (WHO, 2006), this suggests a probable low detection rate amongst the majority of emergency care providers.

There are harbouring myths that necessitate the implementation of a pre-hospital protocol for domestic violence management. There is an inadequacy of current emergency care practice with respect to domestic violence crisis intervention with regards to screening, management and referral. The majority of emergency care providers (89%) experienced no special handling of domestic violence victims. No significant correlation could be found between qualification and knowledge of domestic violence laws. Qualification is not a predictor of legal knowledge about abuse. Qualification could also not be positively correlated with the referral of victims, although the majority of all qualifications (78%) had only sometimes referred victims or not at all (Naidoo, 2007).

This poor response by and lack of preparedness of ECP’s is counterproductive to the HPCSA’s motto and legal obligation to “Protect the public and guide the professionals”. The lack of direct ethical obligations and operational guidance (in the form of protocols) has potential to render the HPCSA complicit in not enabling healthcare professionals to respond to domestic violence and its health-related consequences. The proposed ethical and protocol guidelines below serve to contextualise the clinical discretion practitioners enjoy in the interest of universal (routine) screening for domestic violence.
2. Definition of terms

2.1. Domestic violence

“Any controlling, abusive, fear inducing act that threatens to harm the health, well being or safety of a person in a domestic relationship” (The Domestic Violence Act, No 116 of 1998). “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life” (United Nations, 1993). This is contextualised within a past or present relationship. It is generally perpetrated by a male partner, but not exclusively, and is experienced by the woman as harmful and destructive to herself, physically, emotionally, socially and psychologically (Family Violence Prevention Fund, 1999). Domestic Violence is a form of Gender-based violence or interpersonal violence and does not preclude men and children as victims.

2.2. Gender Based Violence

“Gender-based violence is any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Around the world, GBV has a greater impact on women/ girls than on men/boys. “Gender-based violence” is interchangeable with “violence against women.” It highlights the relationship between the subordinate status of women in society and their increased vulnerability to violence. Men and boys may also be survivors of gender-based violence, especially sexual violence. The nature and extent of specific types of GBV vary across cultures, countries, and regions. Examples of GBV include: sexual violence, including sexual exploitation/abuse and forced prostitution; domestic violence; human trafficking; forced/ early marriage; harmful traditional practices such as female genital mutilation, honour killings, and widow inheritance” (United Nations, 2005).

3. PROFESSIONAL/ETHICAL REQUIREMENTS OF THE HPCSA:

Health care professionals must be responsive to domestic violence by the following actions

3.1. Screening: Ask gently about violent and/or controlling behavior and believe response
3.2. Assess Risk: Conduct a risk assessment to identify imminent danger
3.3. Supportive care: Provide supportive bio-psycho-social care
3.4. Document: Document any evidence of abuse
3.5. Inform: Inform patients of their rights, services and the legal remedies. Talk through the implications of domestic violence, including the risk of HIV (Joyner, 2010).
3.6. Refer responsibly: Referring clients to appropriate resources and to identify her support system

DOMESTIC VIOLENCE SCREENING PROTOCOL (ADULT AND CHILD)

PREMISE:

There is evidenced under-detection of domestic abuse in South Africa. There is evidenced insufficient training regarding a health sector response to domestic violence.

PURPOSE

1. To protect victims of abuse from a lack of responsiveness from emergency care providers and in so doing perpetuate the cycle of abuse.
2. To guide emergency care providers in the universal screening of health care users for the early detection of abuse and to enable early and appropriate referral.

DUTIES OF THE ECP

Ensure that all who have experienced violence are not stigmatised or blamed when they seek help from health institutions such as emergency services (public or private).

1. Ensure that victims of abuse will receive appropriate medical attention and other assistance.
2. Ensure confidentiality and security.
3. ECP’s should aim, to ensure that providers are appropriately sensitised to issues of abuse, treat women and children in particular with respect, maintain confidentiality and do not reinforce women’s / children’s feelings of stigma or self-blame, as well as being able to provide appropriate care and referral as needed.
4. Support research on the causes, consequences, and costs of violence against women and effective prevention measures.

WHO SHOULD BE SCREENED FOR DOMESTIC VIOLENCE?

All females aged fourteen years and older should be screened for domestic violence. Men of any age may also be screened, based on the emergency care provider’s index of suspicion. Abuse and neglect of children may also suggest incidence of domestic violence.

WHO SHOULD SCREEN FOR DOMESTIC VIOLENCE?

Screening should be conducted by an emergency care provider who has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency. The emergency care provider must have been trained on how to ask about abuse and to intervene with identified victims of abuse. Of course, the emergency care provider must also secure the opportunity to speak to the patient in a private setting to maintain trust and confidentiality. The emergency
care practice should emphasize the particular nature and treatment of domestic violence, as concertedly as it does myocardial infarctions and CPR. Educational facilitators and managers in Emergency Services need to be sensitised to the magnitude of the problem. At the service level, responses to violence against women should be integrated into all areas of care (e.g. emergency services, reproductive health services such as antenatal care, family planning, and post-abortion care, mental health services, and HIV and AIDS-related services) [WHO, 2006]. The emergency medical system should no longer undermine its life-saving role in primary prevention and early detection. To this end, paradigm shifts in regulation, management and education of emergency care providers towards domestic violence intervention must occur and should include the content detailed below.

HOW SHOULD SCREENING OCCUR?
The universal screening protocol (Figure 1) is a tool to guide screening and management. Screening for abuse over the past year should occur at every trauma emergency call. For non-trauma calls, patients should be screened for any domestic violence that occurred anytime in their lives (or recent past). Screening should occur as part of routine health history taking or during a review of systems. It should be a standard part of a health assessment, but particularly important in cases of new chief complaints and new intimate relationships. During a face-to-face health care encounter, the emergency care provider must be direct and non-judgmental. Screening must take place in private, where no friends or relatives of the patient are present. Preferably, no children over two should be present as they pose a risk to confidentiality. Patients should be told of the confidentiality of the conversation and also told of the limits of that confidentiality. Ideally, screening for domestic violence should also be included as part of a written health questionnaire and in the patients primary language. The emergency medical system’s communication centre has the technology to facilitate telephonic screening, more appropriate dispatch, appropriate referral, and even telephonic crisis intervention. The call centre operators, however, do need capacity-building in terms of domestic violence crisis intervention skills.

DOCUMENTING DOMESTIC VIOLENCE
As a result of routine screening, patients may disclose domestic violence. These patients must be assessed as soon as possible and the findings documented. Emergency care providers must remember to believe victims testimony and to
respond correctly and with dignity. Failure to do so may result in further non-disclosure, mistrust, shame and guilt. The examination form is a confidential medical record and must be treated as such. Where applicable, the exact words of the patient must be documented, as must be the identity of the offender and his relationship with the patient. All history of abuse as well as the presenting complaint must be documented, even if in cases of pre-hospital discharge.

**SAFETY ASSESSMENT**

A safety assessment must be done for all patients who disclose domestic violence. Continued exposure to the violence may place the patient in grave danger. If the patient feels unsafe, referral to the South African Police Services may be crucial. If the patient is uncertain, establish the following and then facilitate the development of a safety plan:

- Has the violence increased?
- Does the perpetrator use alcohol and drugs?
- Has the perpetrator threatened to kill her/him?
- Does the perpetrator have access to weapons?
- Is the patient afraid to go home?
- Has the patient/perpetrator thought about killing herself/himself?

*By Navin Naidoo*

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**Figure 1: Screening Protocol for Abuse (Martin and Jacobs, 2003)**

Abbreviations: DVA- Domestic Violence Act 116 of 1998, SAPS- South African Police Service
An important component of most health care education and training programmes involves supervised student interaction with real patients in the authentic clinical environment. It is a requirement of the professional board that any student who engages in clinical / experiential learning or interacts with patients is registered with the professional board as a student in the relevant category.

A number of instances have recently emerged wherein persons not registered as students with the HPCSA have been found to have participated in clinical / experiential learning shifts allegedly under the mentorship and supervision of paramedics, emergency care practitioners and medical doctors registered with the HPCSA. This practice is not permissible and opens both the participant and the mentor or host in a position where disciplinary action may be initiated.

Registered persons and their employing services are hereby advised to ensure that all students they host are duly registered as such with the HPCSA. This would include persons who have enrolled for distance learning programmes offered by training providers based abroad and wish to complete their clinical learning in the local pre-hospital environment.

By Craig Lambert
Are you up to the task?

If you are clinically up-to-date, feel confident about your skills, have an educational / teaching / instructor qualification, and are keen to contribute to the profession by maintaining excellent standards of emergency medical care, then you are a potential candidate. The PBEC would like to invite interested and suitably experienced Emergency Care Practitioners (ECPs) to apply to be considered for the elite PBEC external moderator team.

The PBEC external moderator’s function is vital and constitutes one of the few quality touch points available to the PBEC to verify appropriate qualification benchmarks. Successful candidates will be responsible inter alia to confirm and assure the integrity, credibility and standard of the examination processes.

Functions, roles and responsibilities

An external moderator is expected to:

- independently verify that the required standards have been adhered to, and that assessors have conducted a fair assessment that is consistent, valid and reliable, and practicable;
- ensure that sufficient, recent, authentic, accurate evidence is collected to support the assessment decisions taken;
- assist, mentor and support examiners to develop skills and capacity via collaborative means;
- be sufficiently confident to make decisions regarding the assessments and to either support or refute the judgement decisions made by the assessors; the external moderator is the co-custodian of the final decisions about whether students are passed or failed, and whether the passing candidates should be registered on the relevant HPCSA register. It is a huge and extremely important responsibility, and one not to be taken lightly. You need to be ready to defend your decisions and willing and able to be firm and ethically resolute.

The moderator, as objectively as possible, should:

- form part of the quality assurance, peer review process
- identify the need to redesign assessments if required
- confirm that there is an appeals/re-assessment procedure in place for dissatisfied learners and facilitate that process
- monitor and evaluate performance of assessors, to ensure that assessments are conducted in a consistent, accurate and well-designed manner.
- ensure that all assessors are employing standardised, well controlled assessment methods and instruments, and are making similar and consistent judgments about candidates’ performance
- provide feedback to the PBEC on learning outcomes and evaluation processes & policy, and on the performance of the candidates
- provide a cogent and well-written report to accurately document findings around quality and compliance of HPCSA assessment policy.

Moderators should be registered ECPs who are competent in the emergency medical care profession. Successful candidates will be experienced assessors who are respected and regarded highly by their peers. They should be willing to participate in relevant training in assessment and moderation, peer review, and must be skilled communicators.

The external PBEC appointed moderator plays a significant role in quality audit and improvement. Meaningful moderation requires a blend of support, advice and guidance to the examiners, and strict and unwavering adherence to the required standards. The responsibility to ensure that only competent candidates pass the assessment process is pivotal to patient safety and development of our EMS profession. What’s more, it is a fundamental and practical way we can “protect the public, and guide the profession”.

You are invited to apply if you believe you can contribute in this way. Your profession needs you!

By Martin Botha
Registered Emergency Care Practitioners (ECPs) who are interested and would like to get more involved in the Board moderation of examinations are invited to apply in writing to the Professional Board for Emergency Care.

1. Applications should include a letter of motivation, references, a comprehensive CV and a portfolio of all formal experience in assessment and moderation to date;

2. Applicants must be registered as an Emergency Care Practitioner with the HPCSA for at least two (2) years.

3. Applicants must have at least 2 years education/training experience in emergency medical care field.

4. Successful applicants will be required to-
   a. Sign a confidentiality agreement and a conflict of interest disclosure;
   b. Participate in workshops and competence/review/verification mechanisms;
   c. Commit to peer review, CPD and a quality assurance program.

The Education Committee of the Professional Board for Emergency Care will consider the applications and appoint suitably qualified and experienced moderators.

The Board reserves the right to change the criteria if and when the Board found it necessary, and to appoint moderators at its own discretion.
INTRODUCTION

Ethical practice of the health professions requires consistent and on-going commitment to lifelong learning to update and develop the knowledge, skills and ethical attitudes that underpin competent practice. This perspective protects the public and promotes the health of all members of the South African society. Guided by the principle of beneficence, health professionals aspire to standards of excellence in health care provision and delivery. The Health Professions Act, 1974 (Act No. 56 of 1974) (as amended) endorses Continuing Professional Development (CPD) as the means for maintaining and updating professional competence, to ensure that the public interest is promoted and protected, as well as ensuring the best possible service to the community. CPD should address the emerging health needs and be relevant to the health priorities of the country. ¹

CPD is an international trend, crucial and necessary to ensure that healthcare professionals remain current and competent at all times. Initial certification of qualification undertaken as a healthcare professional does not guarantee that the competence and proficiency of an individual will be maintained for the rest of their professional life. Health professionals should select activities at any level of learning that meet their particular needs and the demands of their practice environments.

PROFESSIONAL BOARD FOR EMERGENCY CARE (PBEC) INITIATIVE TO PROMOTE CPD COMPLIANCE

Mandatory CPD for the registered PBEC providers was instituted on 1 January 2007 in terms of section 26 of the Health Professions Act, 1974 (Act No. 56 of 1974), which requires all registered providers to comply with the conditions of CPD as a prerequisite to retain registration in terms of the Act. Reports from the HPCSA CPD office however continue to reflect poor compliance amongst EMS providers.

Recently the PBEC hosted a meeting where both CPD providers and accreditors alike were provided a platform to discuss CPD issues, to raise concerns, to reflect on common challenges and to share ideas and solutions, to improve CPD activities and compliance, and ultimately patient care. Despite a disappointing turnout, stakeholders who did attend were able to comfortably exchange thoughts and suggestions on improving the current CPD system.

Discussion primarily focused on the following:

1. Accreditation of CPD activities inconsistent

Despite the process of accreditation of CPD activities being clearly defined in the HPCSA CPD guidelines (published on the HPCSA website²), discussion revolved around the varied interpretation of these prescripts by accreditors. The PBEC appointed accreditors are ultimately responsible for CPD accreditation, in accord with these guidelines, thus the responsibility rests on all accreditors to ensure compliance and to allocate CEUs in a standard and consistent manner.

The inconsistency in awarding of CEUs was intensely debated during the meeting. In general, the different levels of CPD activity appear to be poorly understood, leading to accreditors allocating disparate CEUs for similar activities. This is an untenable situation, and mechanisms to control and standardize these decisions were discussed.

Accreditation processes are not standardised or universal, and outcomes for formal refresher training are not prescribed resulting in dissimilar benchmarks for re-registration. More collaboration amongst the accreditors is vital to achieve comparability and consistency.

CPD accreditation should accurately be aligned to the appropriate level of CPD activity, i.e. Level 1 or Level 2, with Level 3 activity being reserved for formal, tertiary level training where the candidate successfully completes or shows suitable progress in the course. The amount of CEUs awarded should also be congruent with the actual contact learning time, generally one point per hour. Although reliant on provider ethics, trust and professional integrity,
this should be monitored and non-compliance should be identified and dealt with appropriately. Registered persons attending CPD activities should also be made aware of the fact that CPD providers are only accredited to offer certain activities, perhaps via a CPD license certificate or PBEC website information.

The aim of CPD is to improve patient care and thus registered providers should ideally only get credit for CPD activities directly related to their scope of practice. Accreditors are responsible to ensure CPD content falls within the ambit of the emergency care profession. While not intending to be overly prescriptive, the PBEC and its accreditors are mandated to regulate the scope and quality of CPD, to ultimately promote patient safety.

An accreditor refers to an institution appointed by the PBEC to review applications by, and accredit, non-accredited service providers for provision of once-off level one continuing professional development activities and to monitor these activities for compliance with the rules and CPD guidelines. The current PBEC accreditors are the higher education institutions: UJ, DUT, CPUT, NMMU and CUT.

2. Quality assurance

Quality assurance is the responsibility of all stakeholders but is specifically within the CPD accreditor’s remit. This should include inter alia proactive audits on CPD providers under their jurisdiction. The quality of the CEUs that have been designated to a particular provider should be verified, and a formal QA/QI policy and process should be in place with monitoring, reporting, audit and follow-up to ensure that providers are compliant with all the requirements. Adopting a laissez-faire approach will not assure the quality of CPD activity, nor verify that CPD Providers are adherent to the HPCSA professional guidelines. Accreditors acknowledged that they lacked the resources to operationalise this QA function. The onus falls upon the registered individual to confirm the activities attended are indeed accredited, that CEUs are in line with the CPD guidelines, and that correct certification is issued timeously. Each registered provider is obliged to report providers who fail to adhere to the CPD policy.

3. Refresher Courses

These are a valuable platform to share new evidence and best-practice. They also provide an opportunity for skills practice and evaluation of current proficiency, and to normalize the standards of initial training undertaken. Attendees suggested that refresher courses be standardized for each category of HPCSA registration, and further proposed that all must include compulsory components in ethics/medico-legal/human rights, and skills competence.

Standardising and regulating refresher training would require CPD providers to comply with minimum training standards and assessment outcomes, ensure suitable training aids were available, etc. Standardisation would also mean that providers would not be able to award more than the annual CEUs to a successful candidate, e.g. a maximum of 15 CEUs for the BAA refresher course provided it entails at least 15 hours of contact time, and 30 CEUs for a week long refresher course (ILS and ALS).

It is PBEC policy that only institutions registered with the Board are entitled to run BAA, AEA and ALS CPD refresher training. This approach is inconsistent amongst accreditors and should be regulated more strictly.

CPD activity reporting

Both CPD accreditors and providers are required to submit accurate and sufficient data in their annual reports, to allow the PBEC to monitor CPD. Reporting affords the opportunity to analyse and address problems identified, and forms the foundation of QA/QI. Moreover, since CPD compliance will in future constitute a continuous requirement to obtain the annual license to practise, the quality and integrity of CPD needs to be measured and maintained.

Audit and QA needs to be formalised. Annual CPD submissions are scant, sometimes erroneous, and reflect no focus on educational QI. CPD programs are arguably more important than the initial qualification courses, which are relatively well audited. More attention should thus be focused on the quality of the education and training offered via CPD, current expertise of the presenters, etc.

More information is required to meaningfully assess the reports; this might include numbers of attendees who participated, numbers who passed the assessment (if applicable), course summary, synopsis of participant feedback, etc. All attendees should complete a confidential course feedback form, with an email contact for the CPD office to offer direct feedback if preferred. These documents should be filed, and should be available at HPCSA re-accreditation visits. Furthermore, the cost of activity ought to be reported in the interests of transparency – CPD should not be an expensive exercise, and may not be a commercial enterprise.

More robust, standardised reporting, perhaps on-line and monthly, might promote more useful information analysis. From the current reporting format, it is not clear how many attendees finally participated in the courses. It may be that the current

1QA / QI – quality assurance / quality improvement
reporting framework over-estimates the amounts of courses, as it is possible that courses were planned but never conducted. A more realistic picture of the CPD status is required.

The PBEC should require more formal and comprehensive and structured reporting from the accreditors to track and trend CPD activities: duration, topics covered, presenters, number of attendees, numbers passed assessments (if applicable), cost, target audience, assessments, skills proficiency included, ethics, etc.

**Recommendations and Conclusion**

One national accreditors’ workshop per annum and several regional workshops should be held for CPD representatives around the country, to standardize accreditation, discuss issues, common problems, how to quality assure, etc. Assessments should be externally moderated if refresher courses fulfil re-registration purposes.

The PBEC should standardise refresher training, in terms of outcomes, duration, scope, assessment, CEUs, ethics, etc., to minimise variation and differing interpretation. Since most non-compliance in the PBEC appears to be due to a lack of ethics CEUs, these activities should be mandatorily offered by all the bigger CPD providers. Reputable online CPD training is another option that should be promoted.

The PBEC, as the ultimate custodian of quality, should require their accreditors, to report on CPD allocations, quality assurance, and monitoring of CPD activities. The CPD learning experience should be reported on. More importantly, the real impact of CPD needs to be measured, to track whether it influences practice and improves patient care or professional practice in any meaningful way – the return on the effort is otherwise unjustified.

There was consensus that most healthcare providers seem to attend CPD activities only in search of CEUs. They are ostensibly motivated more by the mere promise of CEUs, and do not appear to be intrinsically motivated to maintain and acquire new, updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice. The potential to enhance and promote professional integrity, to ultimately benefit the patient is not often the overt motive.

CPD is internationally accepted to promote and indeed to assess continuing personal professional development. Its furthermore a tool used by regulatory bodies to ensure those registered to practice, are doing so in line with current international best-practice, and are adherent to the ethical guidelines of their specific professional scope of practice. Elsewhere, healthcare professionals are required to perform a self-assessment of their own clinical and professional learning needs within their scopes of practice, and then to show how these needs will be met, with timelines, and then to record subsequent progress. CPD compliance also includes formal assessment of competence every few years and peer review; should this not be successfully completed, the provider is deemed to be unable to practice their profession until compliance is demonstrated.

Although these measures may seem overly strict and draconian, the result is improved patient care. The license to practise approach, endorsed by the HPCSA, espouses the guiding principal of “Protecting the Public” by allowing only those healthcare professionals who maintain their annual CPD, to practise.

*by Martin Botha & Wynand van der Net*
The Emergency Care Society of South Africa is a professional society for all professionally registered emergency care workers in South Africa.

What is a Professional Society?

A professional society is an organisation (usually established in the form of a not-for-profit entity, such as a Non-Profit Organisation) that is created with the objective of furthering, growing, representing or developing a particular profession, the interests of members of that profession and the public interest in general.

Who and what does ECSSA represent?

ECSSA advocates for the advancement of pre-hospital emergency care in South Africa and intends to serve as a representative organisation for those in the emergency care profession who subscribe to ECSSA’s vision and values. The Society strives to achieve this ideal by addressing the needs of the profession through engagement with stakeholders at various levels in both the public and private sectors. ECSSA also has a very important role to play in the scientific and Continuing Professional Development (CPD) of pre-hospital emergency care by collaborating with other national and multi-national professional bodies.

What are ECSSA’s vision and mission?

Vision
To be an established Professional Society that strives to advance and represent pre-hospital emergency care in South Africa.

Mission Statement
The Emergency Care Society of South Africa is an organisation of emergency care Professionals who are focused on advancing the practice of pre-hospital emergency care throughout South Africa. By way of Professional advocacy, research, policy development and continuous education, our core focus serves to grow the emergency care Profession with the underlying goal of benefitting all health care users in need of effective and efficient emergency medical services.

What are ECSSA’s strategic goals?

ECSSA’s strategic goals are in line with its vision and include enhancing acknowledgement of ECSSA as a representative organisation by our stakeholders through professional comment and advocacy, promotion of professionalism in emergency care and making ECSSA financially sustainable. The Society will once again be organising a conference to be held in Durban next year and will continue to produce its bi-annual publication Sanguine.

What are the benefits of Society membership?

Benefits of being an ECSSA member include access to online CPD activities (up to 15 Continuing Education Units or the annual membership fee of only R100.00) and other CPD accredited events arranged by the Society’s Special Interest Groups (SIGs) from time to time, including the Society’s bi-annual conference. ECSSA also offers members a platform for direct involvement in and contribution to commentary and advancement of the profession through activities of the Society’s Committees and SIGs.

What ECSSA is not

ECSSA is not a trade union created to protect and enforce the employment rights of emergency care workers. Although the Society certainly has an indirect interest in labour law and employment conditions, norms and standards as they apply to this particular profession, the direct objective is not to provide relief or representation in cases where any such rights or norms have been violated.

ECSSA is not a lobby group or committee in pursuit of a single particular objective or cause. The Society has a long-term strategic vision giving effect to a variety of interests having a bearing on pre-hospital emergency care.

ECSSA is not a recruitment agency. Although we will in future be advertising career vacancies within the EMS sector, our goal is not to place individuals and serve in the capacity of a recruitment agent.

ECSSA is not a statutory authority like the Health Professions Council of South Africa. The role of the Society is not to enforce law or standards, nor is it to regulate the Profession but rather to advance and represent pre-hospital emergency care.

The ECSSA emblem

ECSSA’s emblem is a Baobab tree with a torch in the background and a star of life. The Baobab tree is a tropical African tree, reaching up to 25 meters tall and known to live for several thousands of years. In the wet months water is stored in its thick, corky and fire-resistant trunk for the dry months ahead. The Baobab symbolises strength, endurance and life. The star of life has a well-known association with pre-hospital emergency care, and the torch represents knowledge and light, bringing pre-hospital emergency care workers together under one Society.

Where do I get more information?

From the ECSSA website: www.ecssa.org.za. You can also follow ECSSA on Twitter @ECSSAZA and Facebook (https://www.facebook.com/pages/Emergency-Care-Society-of-South-Africa-ECSSA/558491457552572).
ORBITUARY: MR PETER DENNIS FUHRI

18/11/1951 – 14/11/2014

It is with sadness that we bid farewell to a fellow member of the Board, Peter Dennis Fuhri. Peter died on Friday, 14 November 2014 after contracting malaria in Nigeria where he was heading the Health Cluster tasked with the repatriation of the injured and deceased South Africans following the building collapse in Lagos.

Peter Fuhri was appointed as the Ministerial representative on our Board where he served for 17 years, making him the longest serving member on the Board. During this period, Peter also served as a member on the Health Professions Council of South Africa. As a member of the Board and Council he carried out his duties diligently, bringing his experience and expertise and always placing the interests of the public and the profession first. Peter was known for his calm and professional disposition even under trying circumstances, and will be remembered for always having a pleasant smile.

Peter Fuhri was born Durban and while in school joined the Naval Cadets and post school enlisted with the S A Navy in Simons Town. In the mid 70’s joined the Durban Metro City Police and thereafter worked for Umhlanga Protection Services in the mid 1970. His long illustrious career in EMS was born then as while out patrolling he came across a mother that was in the process of delivering her baby. The ambulance service was not immediately available and all he had was a first aid book which he used to assist the young lady to safely deliver the baby. This led him to joining the KwaZulu-Natal Emergency Medical Services (EMS) in 1985 where he served as the Regional Manager of the then Northern KwaZulu-Natal EMS. He was thereafter appointed as the Principal of the College of Emergency Care for 4 years and in 1991, appointed Chief Operations Officer for the KwaZulu-Natal EMS until 1997. Peter then joined the National Department of Health (NDOH) in 1997 as the National Coordinator for Emergency Medical Service and Disaster Medicine. Peter initiated many significant improvements and changes within the profession in the various portfolios that he held during his EMS career. The most notable of which was the establishment of the EMS Directorate in the National Department of Health, a platform he used effectively to drive changes within EMS towards professionalization.

Peter had several hobbies which included leather work, hiking, camping, building models, gadgets, abseiling, reading, pen crafting, wood work and was a keen motorcyclist. He rode with a team of 3 motorcyclists, including Mr Richard Hussey, to the four corners of South Africa in a ‘bucket list’ trip over a period of eleven days. He had planned to ride all the way to Egypt before his retirement.

As a Board and profession, we express our heartfelt gratitude to our friend, mentor, colleague and leader for all that he did for our profession and country. May his soul rest in peace.

The HPCSA is an autonomous organisation and does not receive grants or subsidies from Government or any other institution. The HPCSA is funded entirely by income generated from registered practitioners. These include income generated from annual, registration and other fees payable by practitioners.

The Council together with the twelve Professional Boards operating under its jurisdiction are committed to the promotion of the health of the South African population, determining standards of professional education and training as well as setting and maintaining of fair standards of professional practice.

The annual fees are used to fund the administrative activities of the Board in terms of the conducting of meetings for the Board, Executive Committee, and Education Committee.

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Account number: 405 00 33 481 (Annual fees ONLY)
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Emergency Care Providers are encouraged to forward their contributions to Ludwe Matanzima at ludwem@hpcsa.co.za

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