9 January 2012

To: The Medical Radiation Practice Board of Australia

Re: Response to the Proposed Registration Standard – Supervised Practice

Dear MRPBA members

I would like to thank the MRPBA for seeking feedback on the Proposed Registration Standard – Supervised Practice Standards.

My reply reflects my experience of having been a senior supervising practitioner of students and graduates, a member of the Australian Institute of Radiography's (AIR) Professional Accreditation & Education Board (PAEB) from 1991-1998, and again from 2008 to the present, and the experience I have had in accrediting both 3 year and 4 year degrees. My reply also reflects my experience at the University of Newcastle as program convenor of the three medical radiation science (MRS) degrees, and working within a Faculty of Health and School of Health Sciences where there are around 12-15 accredited health professional programs of which some have specific clinical skill and time requirements for graduate practice.

Prior to providing direct answers to the specific items asked about I do wish to comment on a few issues.

The first issue is related to the lack of a definitive document that describes those core competencies/skills required by all radiography, radiation therapy and nuclear medicine general registrants. While there are professional statements and/or standards that describe broad fields of knowledge, attributes and practice, that graduates must obtain during a program of study, there are no clear national guidelines that describe the clinical competencies/skills that all programs and graduates must achieve and have verified for registration. Without this national agreed document the accreditation of programs becomes problematic as unis argue the case for how their programs meet the professions standards, rather than the case of unis demonstrating that the clearly articulated national standards required of new practitioners are imbedded within the program, and the professions and members of the profession argue that the requirements for independent practitioners have not been met citing members comments and feedback. While the MRPBA have asked about the time requirements for training, without this document, one that articulates the range and quality of graduate skills required to be considered as having met the standard, it is difficult to define how much time it takes to develop such skills and confidence to practice independently. Many professions have articulated the core competencies to practice, and their associated programs are required to monitor students against these skill sets, eg physiotherapy. While some MRS programs in Australia have competency evaluation and assessment many do not. This makes the issue of meeting national standards difficult. A priority of effort must be put towards the development of a competency to practice document that clearly described the clinical skills required of a graduating student and a general registrant.

A second issue is the recent development of university based clinical simulation facilities. Universities and governments are funding the development of labs that are able to teach the clinical skills required of practice. Many of these labs have infrastructure that are better than

many clinical sites, and many universities use clinical staff as tutors and assessors in these labs. When discussing development or accreditation of programs, and the time required to train students, consideration should be given to the university's ability to provide simulated clinical teaching and assessment, and the effect on pre-placement clinical skills development of students in that program. It would be hoped that the MRPB and MRSAC support these developments as a means of increasing the clinical skills development of students attending placement and reducing the pressure on clinical sites for teaching the basic skills.

The third issue I wish to address is the current lack of equivalence in the current clinical experience of students in training and those required to complete the current Professional Development Year (PDY) /National Professional Development Program (NPDP) programs. Since the inception of the AIR's and Australian and New Zealand Society of Nuclear Medicine (ANZSNM) PDY/NPDP programs into Australia in the early 1990's, graduates of three year degrees have to complete around 22-25 weeks of clinical placement within their program of study plus the 48 week PDY/NPDP (essentially the supervised practice program SPP) – leading to a total of around 70-73 weeks clinical practice experience. In more recent times the AIR has accredited 4 year DR & RT programs with around 50 weeks (variation somewhere around 46-53 weeks) clinical placement experience with no need for an SPP as the extended placement time was seen to provide extra time and experience to develop accredited practitioners. There is therefore a large difference (some 20-23 weeks) in clinical experience between the two types of programs, with 3 year program plus PDY students completing nearly some 20-23 weeks (around 5 months more clinical experience completed) than 4 year degree students will complete as a student. My comments within this response seeks to make equivalent the amount of experience and time that students and graduates must have when applying for general registration, regardless of whether they complete a 3 year plus PDY program or a 4 year program.

A fourth issue is the current requirement that the PDY/NPDP must be completed in Australia. There are many countries and clinical centres that can offer the experience and support required of supervised practice. Many students and graduates would like to be able to complete their supervised practice overseas. Consideration should be given to the idea that supervised practice can be completed outside Australia if the required clinical experience and assessment can be provided.

The MRA has specific comments in the following areas:

a. The number of clinical practice hours required to be completed by a recent graduate for the purposes of general registration from

i. A three year course of study, and

ii. A four year course of study

In providing a comment on the number of clinical practice hours required in programs, I wish to consider the issue of clinical skill development (competencies) and clinical confidence development. Whilst they are obviously intertwined (students do development confidence as they practice) I believe that in terms of this discussion the two can be thought of differently. I do believe that students can develop a level of confidence and competence to practice safely within the confines of their university and clinical training experience, however that clinical confidence, ie the confidence to display those qualities of an independent practitioner, requires clinical time practicing those skills.

There are two places competencies can be taught and assessed: one is in labs at university and one is on clinical placement. Effective simulation labs at university can teach and assess skills prior to placement and most universities are starting to develop effective simulation labs that can teach core skills. The Federal Government is also starting to support the purchase and development of simulation training centres at universities (eg the Vert Linac system at all Australian Unis offering radiation therapy). As part of program accreditation, universities should have to demonstrate how they teach and assess those fundamental and underpinning clinical skills required of students at different years of study attending placement prior to the placement. Core skills or competence must also be demonstrated and assessed during clinical placement by practitioners under real working conditions against the national clinical skills criteria discussed earlier in this submission.

Clinical confidence, the ability to make effective decisions in real life professional situations and feel confident in your ability to perform clinical tasks independently, can only be developed while working in clinical centres with real patients and with the support of practitioners who can offer mentoring in difficult and non-standard situations.

Without drawing out this discussion too much further I offer the following:

For 3 year degrees I believe all programs should have to demonstrate:
1. The development and assessment by universities of the required foundation clinical skills required by the student attending placement, prior to the placement.
2. At least 25 weeks of placement to be dedicated towards the development and assessment of clinical skills within the 3 years of the program. The 25 weeks comprises around 1000 hours - 25 weeks x 40 hours/week – the 40hr week includes time for university reports to be written.
3. Where a university can demonstrate well developed simulation labs the 25 weeks of clinical skill development may include a period of not more than 5 weeks of on-campus clinical skills development and assessment in well developed simulation laboratories.

To allow for the development of clinical confidence graduates of these programs (provisional registrants) should then have to undertake a period of not less than 24 weeks (6 months) of supervised practice to develop the confidence required of an independent practitioner (general registrant). Note: The 24 week period allows for two periods of SPP to be run each year, a first half of year and second half of year - with a few weeks removed at the beginning and end of each year due to New Year and Christmas start and finish times.

In total this represents for a graduate of a 3 year program a period of not less than 49 weeks of professional supervised development.

For 4 year degrees I believe that all programs should have to demonstrate during the program:
1. The development and assessment by universities of the required foundation clinical skills required by the student attending placement, prior to the placement.
2. At least 25 weeks of placement to be dedicated towards the development and assessment of clinical skills within the first 3 years of the program. The 25 weeks comprises around 1000 hours - 25 weeks x 40 hours/week – the 40hr week includes time for university reports to be written.
3. Where a university can demonstrate well developed simulation labs the 25 weeks of clinical skill development may include a period of not more than 5 weeks of on-campus clinical skills

development in well developed simulation laboratories.
4. To allow for the development of clinical confidence graduates of these programs should then have to undertake a period of not less than 24 weeks of supervised practice in the 4th year of the program to develop the confidence required of independent practitioners. This final 24 weeks should be deemed the "supervised practice program", and students during these 24 weeks should be required to meet national SPP requirements, as well as any other university program requirements.

In total this represents for a graduate of a 4 year program a period of not less than 49 weeks of professional supervised development.

This makes the clinical experience for general registration of applicants from 3 or 4 year programs the same ensuring equivalence in clinical experience between the groups.

b. How "fitness to practice" (clinical competence, professional conduct and compliance with regulatory standards) should be assessed during supervised practice.

In terms of supervised practice a nationally agreed form should be developed and utilised within the supervised practice programs that encompasses the concept of fitness to practice.

c. How to achieve consistency in implementation of supervised practice and consistency in clinical evaluation.

In my opening remarks I mentioned the lack of a national document describing those clinical skills thought to be core in terms of new registrant practice. Again this is a vital document to allow for the assessment of clinical and supervised practice outcomes. One way to achieve consistency is to write this document that describes the skills required of registered practitioners, and then having reporting mechanisms that measure these outcomes.

In terms of clinical evaluation the National RT Unis have developed and implemented a national clinical supervisors' assessment which is now in use by all RT Universities. This process has standardised part of the clinical assessment of students, and has been met with much acceptance by clinical staff supervising students. A paper on the development of the form will be published in the March edition of The Radiographer. My suggestion is that DR & NM do the same and develop a nationally agreed clinical assessment form. Universities then will need to show the nationally agreed form embedded within their program.

In terms of supervised practice a nationally agreed form should be developed and utilised within the supervised practice programs.

d. The level or extent of supervision for provisional registrants – i.e. direct supervision and indirect supervision.

Because no definitions have been provided for the terms direct supervision or indirect supervision, I will consider that direct supervision means that supervising practitioner support is available and able to directly supervise if required (ie they are in the dept) and that indirect supervision means that no other supervising practitioner is available to support the provisional

registrant (ie they are not in the dept).

The level of supervision should change during the period of supervised practice in line with the provisionally registrants developing confidence.

All provisional registrants should have access to direct supervision for the first 10 weeks of practice (ie a supervising practitioner support is directly available if required). After this time the provisionally registered practitioner, having been assessed by their supervising practitioner as meeting the ability to work more independently in an area of practice, should be able to participate in shifts (on call etc) under indirect supervision .

e. What ratio, if any, should exist between Supervising practitioners and those practitioners being supervised?

Given my response in item ***d*** (above), I believe that the ratio for direct supervision should be 1:1.

f. At what point, and under what conditions, is it appropriate for a practitioner being supervised to undertake On Call duties.

All provisional registrants should have access to direct supervision for the first 10 weeks of practice. After this time the provisionally registered practitioner, having been assessed by their supervising practitioner as meeting the ability to work more independently in an area of practice, should be able to participate shifts (on call etc) under indirect supervision.

g. The level of training or experience required of a Supervising Practitioner.

It is time for those who wish to be considered professional health providers to assume the responsibility for the support and training of students and provisional registrants. The requirements for the national registration of all practitioners should include the requirement for applicants to agree to take on the responsibilities of supervision and assessment of those requiring such supervision – it should become a normal part of accepted practice in the way it is for some other health professionals, eg medicine. Therefore all registered practitioners would be eligible to be considered as supervising practitioners.

As part of mandatory continuing professional development all registrants should have to complete at least one unit of professional development from a category of study linked to supervision.

h. The impact of supervised practice requirements on the transition of graduates into the workforce.

Students in programs must be made aware of the requirements of the transition to practice. They must be made aware of the requirements of registration and the conditions required to maintain registration. Universities must support the transition of students to supervised by providing to the national regulation agency the names and contact details of all graduates. This will reduce the

impact of supervised practice on practitioners. The impact in the workforce will be minimised by a procedure that is clear and easy to complete.

i. The advantages and disadvantages of implementing and maintaining a supervised practice program

Advantage: clear standards for entry to the registered profession

j. Alternative structures of supervised practice that address
i. Reducing costs on healthcare and workforce
ii. Increase workforce access and flexibility
iii. Provide consistent, measurable clinical outcomes

See all points above

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