



Submission from the Australian Institute of Radiography to the Medical Radiations Practice Board of Australia on Supervised Practice

Introduction

The Medical Radiations Practice Board of Australia has called for submissions on Supervised Practice. In this call they outlined the background contained in the national law (the Health Practitioner Regulation National Law Act 2009) which is summarised below and then asked for submission on each of ten key questions. For the purposes of clarity this submission, first, sets out the call for submission as it was received and then, second, addresses each of the key questions.

What the National Law requires

For the purposes of being eligible for general registration under s.52 of the National Law, amongst other requirements, an applicant must be;

1. qualified for general registration, and
2. have completed any period of supervised practice required by an approved registration standard.

An applicant is eligible for provisional registration for the purpose of enabling an individual to complete a period of supervised practice that the individual requires to be eligible for general registration (section 62 National Law).

Background

When an individual has met the qualification requirements for general registration, the National Law allows the Board to specify, where the Board considers necessary, a period of supervised clinical practice. Prior to commencement of the National Scheme for Partially Regulated professions on 1 July 2012 the requirement for general registration mandated graduates of an Australian 3 year courses of study to undertake a period of 48 weeks of supervised practice. At the time of consultation, graduates of 4 year courses of study undertake sufficient clinical practice hours that meet the requirements for general registration with existing State and Territory Boards.

Specifically, the Board seeks feedback on:

- 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
- b. How “fitness to practice” (clinical competence, professional conduct and compliance with regulatory standards) should be assessed during supervised practice.
- c. How to achieve consistency in implementation of supervised practice and consistency in clinical evaluation.

- d. The level or extent of supervision for provisional registrants – i.e. direct supervision and indirect supervision.
 - e. What ratio, if any, should exist between Supervising practitioners and those practitioners being supervised?
 - f. At what point, and under what conditions, is it appropriate for a practitioner being supervised to undertake On Call duties.
 - g. The level of training or experience required of a Supervising Practitioner.
 - h. The impact of supervised practice requirements on the transition of graduates into the workforce.
 - i. The advantages and disadvantages of implementing and maintaining a supervised practice program
 - 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
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Response from the Australian Institute of Radiography (AIR)

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;

A three year course of study leading to a Provisional Statement of Accreditation (PSoA) upon graduation and then requiring a further 48 weeks of National Professional Development Program (NPDP) with successful completion to achieve Accredited Practitioner status is offered at the following universities;

- Charles Sturt University BMRS MI
- QUT BAppSc MI & RT
- RMIT BMRS MI & RT
- Uni of Newcastle BSc MI & RT
- Uni of Sydney BSc MI & RT, MDR and MRT

Minimum number of clinical hours leading to PSoA; 714hrs (MDR, Uni of Sydney)

Maximum number of clinical hours leading to PSoA; 1085hrs (BMRS, Charles Sturt University)

Graduates of these academic programs of 3 year duration are registered with provisional conditions requiring successful completion of the NPDP to have conditions removed. Graduates completing these programs must provide objective evidence to demonstrate they have the necessary skills to practice independently. The term of the NPDP is 48 weeks, or in hours, 1824 hrs (based on a nine day fortnight). The average combined total of clinical hours of both kinds would be 2,432hrs.

ii. A four year course of study;

The four year university program imbeds the clinical hours into the completion of the academic qualification and therefore these students do not participate in the profession's NPDP accreditation process post-graduation. The following universities offer the four year programme leading directly to a Validated Statement of Accreditation so as to achieve Accredited Practitioner status with the profession.

- Curtin University MMIS and BSc MIS
- Monash BRMI & MRT
- UniSA IBRS MI & RT proposed
- Central Queensland Uni

Minimum number of clinical hours leading to VSoA; 1815hrs (proposed IBRS MI & RT, University of South Australia)

Minimum number of clinical hours leading to VSoA; (currently accredited programme) 1925hrs (MMIS, Curtin University)

Maximum number of clinical hours leading to VSoA; 2450hrs (BRMI, Monash University)

There is an argument that clinical practice hours and experience as a student should not be confused with the time and experience gained following completion of a supervised practice program such as the NPDP. As a student pre-graduation, it is argued, one is applying a series of newly learned skills in the clinical arena. As a graduate immersed in clinical practice, one is developing these skills into competent practice and, developing the professional knowledge, reasoning and judgement required to practice independently.

Graduates of all currently accredited Australian programmes meet the international benchmark for average number of clinical hours for professional entry (1823 hours).

The Monash BRMI is the only programme leading to VSoA in which graduates undertake at least the Australian average number of clinical hours for professional entry arising from a PSoA and NPDP pathway (2432 hours).

The Monash BRMI and the Charles Sturt University BMRS have unusually high clinical hours for their category of programme, sufficiently high to skew the respective averages considerably. If these programmes are excluded from consideration, the average number of clinical hours for VSoA is 1899 and for PSoA is 750.

Graduates of international programmes accredited by the PAEB are required to undertake a year of postgraduate practice for eligibility for VSoA. These practitioners will have completed from 135% to 154% of the average clinical hours expected of an Australian accredited practitioner.

Graduates of NZ programmes accepted under TTA are required to undertake a year of postgraduate practice for eligibility for VSoA. These practitioners will have completed from 164% to 178% of the average clinical hours expected of an Australian graduate practitioner. Currently the Medical Radiation Technologists Board of Queensland is approving graduates of NZ programmes to undertake their Supervised Practice Program(SPP). These graduate practitioners have completed 254% to 294% of the average Australian clinical hours prior to commencing the SPP.

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

The AIR has established a robust reporting mechanism for those graduates completed a supervised practice programme, the NPDP.

Every report, that is those at weeks 12, 24, 36 and 48 (as well as any supplementaries if they happen to be done for whatever reason) are reviewed and confirmed against key benchmarks.

If the report, as a stand-alone document is satisfactory, then it would be the view of the AIR that this showed that acceptable standards are being attained.

For example ‘satisfactory’ would mean that at 12 weeks all the comments indicate everyone is happy, at 24 weeks the AIR would expect to see, at a minimum, predominantly “progressing” ratings and positive comments, at 36 weeks the minimum expectation would be at least predominantly “consolidating” and positive comments and then at 48 weeks the AIR would expect competence and the ability to exercise professional judgement in each of the review areas.

In reviewing the reports, there is a degree of common sense as, for example, a 36 week report with “beginner” in CT would make sense if there was a comment saying the graduate had not yet been rostered there. On the other hand, if there was a 36 week report with “beginner” in general radiography, then there would be serious concerns as this is the key component of a MI graduate’s job.

When a “poor”, “unsatisfactory”, or “unexpectedly low” performance is reported or the comments show elements of concern, or anything that might cause the reviewer to ask questions in their mind about the quality of performance reported, then the AIR would review any previous reports to see if there was a trend or change. Dependent upon the outcome of this review, there is a clear follow up process.

The first step is to contact the supervisor, as most commonly it is a transient issue that passed with some feedback and attention or a wake-up call for the graduate. If it is something ongoing that is not considered by the supervisor to place the graduate at risk, then the AIR would place a ‘watch’ note on this candidate and wait for the next review point. If it is something that places the graduate at risk of “failing” the NPDP, then the AIR will implement the process for graduates-at-risk.

If for any reason the AIR has reason to consider that the supervisor might be giving the graduate a hard time, then contact is made with the graduate. In cases where the AIR has encountered the “wake-up issue”, this is followed by a friendly call or email to the graduate, commending them on improving their attitude - which also gently reminds them that someone cares (or maybe that someone is watching). All these processes are documented and managed from the secretariat of the AIR under the direction of the Professional Academic and Education Board (PAEB) of the AIR.

The AIR would expect that any future assessment of “fitness to Practice” as required by the MRPBA should, as a minimum, meet the current requirements provided by the AIR.

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

For consistency to be achieved, there must be a standardised and benchmarked national programme. This will be achieved through:-

- Every liaison practitioner/supervisor must be able to display evidence of current Continuing Professional Development (CPD) with a clear emphasis on the requirements of supervision as well as the requisite technical aspects.

- Every liaison practitioner/supervisor must undertake a specific education and training programme; in the case of the AIR it is the NPDP Liaison Training Programme. This ensures consistency in reporting, processes and supervision.
- Every site conducting clinical evaluation must meet minimum resource requirements of supervised practice program (equipment, environment, people); in the case of the AIR NPDP programme it is the site accreditation criteria.
- The fundamental premise behind consistency in a Supervised Practice environment is a centralised reporting, review and auditing system, in the case of the AIR this is managed out of the National Headquarters.
- Any programme seeking consistency must conduct regular and on-going review of the process as well as exception management and if possible benchmark externally. These are again features of the AIR programme.

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

The AIR would anticipate that there would be direct supervision at the commencement of the program. Direct supervision is where the supervisor is physically present and observing the graduate in their professional practice. As the period of supervised practice progresses and the graduate demonstrates progression in their practice then some elements of practice may be undertaken without immediate supervision. There would still be access to supervision at all times. It is expected that this supervision would be available on-site, where support, inquiry and review are available as required. It is expected that ongoing mentoring from an appropriate clinical supervisor will also occur during these periods.

Indirect supervision is where the supervisor is present in the department and available to provide assistance and support to the Graduate in their practice as required but there is not a need for direct physical presence.

By the time following a successful 36 week report it could be anticipated that much of the supervision may be indirect. However in those circumstances where advanced imaging modalities were in use direct supervision is standard practice. The AIR provides these guidelines in the Education Policies.

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

The AIR requires specific standards of supervision for both diagnostic radiography and for radiation therapy. A diagnostic practice must always have the capacity to provide 1:1 supervision. The practice must have two fully credentialed practitioners able to provide support to the graduate when they are working. A therapy practice will always have 2:1 supervision.

On occasion these ratios may vary depending on the complexity of the technique and the modality being used. Such variations would however always be to increase the ratio in favour of greater supervision.

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

In the therapy environment no practitioner under supervision would be placed On Call. It is the view of the AIR that no practitioner under supervision would be placed On Call independently. There may be opportunity as part of the clinical training programme for the practitioner under supervision to accompany a fully credentialed practitioner who is On Call.

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

The AIR Education Policy defines a suitable clinical supervisor is a practitioner who holds a Validated Statement of Accreditation issued by the AIR and who conforms to the AIR Guidelines for Professional Conduct. Irrespective of this the AIR would argue that any fully credentialed practitioner wishing to be a supervising practitioner must be required to complete a current supervisor training program.

The AIR runs workshops of this nature and has an online module available for this purpose. The AIR NPDP Guide outlines the requirements for the NPDP Liaison and the MRPBA should take this as a minimum expectation.

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

Supervised practice provides a realistic and safe entry into clinical practice. The practitioner under supervision benefits from a broad range of experiences which translate the academic learnings' and philosophy of the profession into real world practice and experience as well as develop and enhance those essential skills fundamental to best practice healthcare

Through observation and involvement, supervised practice strongly contributes to the development of professional judgement, reasoning and the overall competence in the transition into practice of the graduate into the workforce.

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

A rigorously structured supervised practice program incorporates many elements from which the practitioner under supervision may gain benefit. The continuity of practice experience and the breadth of professional opportunity are obvious. The potential for the practitioner under supervision to develop professional judgement, to translate the textbook learning into a 'hands on' environment and so enhance the understanding and competence is to be highly valued.

The sites offering supervised practice inevitably can use the opportunity to introduce the practitioners' under supervision to the full range of professional expectations such as ongoing professional development, structured in-service activities, and a broad range of communication and mentoring opportunities. All of these can only build on the professional skills of the graduate.

There are disadvantages, but these are more generally around the administrative and supervision workloads that having a supervised practice program brings with it. The AIR recognises this as an issue and is working to make the reporting requirements as flexible and well-supported as possible. Given the pressure to manage health workforce costs that face governments and departments there is a need for a strong statement about the benefits of such a programme so as to attract sufficient funding.

There are some arguments brought forward about those practitioners under supervision who do not meet the challenges of the workplace and the simple answer is that it is better to find this out earlier rather than later.

j. Alternative structures of supervised practice that address

i. Reducing costs on healthcare and workforce

For the AIR the most obvious mechanism for reducing costs on healthcare and the workforce is to redefine the relationship between the university and the clinical centres. This may well involve some degree of cost sharing, of role extension on the part of the academics for those environments where there is not a clinical tutor in place. There is clearly greater scope to involve the professional bodies and incorporate their skills and knowledge. A collaborative approach with the professional bodies should be considered.

Given the imperatives from government to enhance workforce functionality and encourage greater skill experience there should also be a concerted approach for supplementary funding to support supervised practice.

ii. Increase workforce access and flexibility

The AIR has commissioned significant bodies of work which are currently pending release which addresses the issue of workforce flexibility and access and from the AIR experience with the NPDP we would argue that there is a solid track record of national delivery of an effective and robust supervised practice programme.

iii. Provide consistent, measurable clinical outcome

As described above and throughout our submission the AIR has a working model of supervised practice in the NPDP which ensures a rigorous process, increasing quality of supervision and measurably competent and capable practitioners entering the workforce. The quality of centralised information which has now been gathered and the ability to review individuals against national benchmarks is only benefitting the community, and the ability to recognise and incorporate all elements of supervised practice into one scheme should that be developed would be a highly desirable extension of a sound scheme.