Medical Radiation Practice Board of Australia

Public consultation on draft registration standards

26 June 2014

Responses to consultation questions

Please provide your feedback as a word document (not PDF) by email to medicalradiationconsultation@ahpra.gov.au by close of business on 30 June 2014.

Stakeholder Details

If you wish to include background information about your organisation please provide this as a separate word document (not PDF).

Organisation name
Australian Institute of Radiography
Contact information *(please include contact person's name and email address)*
David Collier – email removed for privacy reasons

The AIR responses to consultation questions

Registration standard: Professional indemnity insurance arrangements (PII) *Please provide your responses to any or all questions in the blank boxes below*
1. From your perspective how is the current PII registration standard working?
The current PII registration standard is explicit in the requirement for unlimited run off cover. This is equivalent to the cover provided by the AIR which protects members in a fully comprehensive manner ensuring that they are able to practice their profession without the risk of facing an uninsured post retirement claim. It is customary for claims for radiation misadventure to emerge many years post the treating event. Because radiation preferentially depletes rapidly dividing stem cells over the more resistant mature cells, there is typically a latent period between radiation exposure and overt radiation injury. Injury does not manifest until a significant fraction of the mature cells die of natural senescence and, due to loss of stem cells, are not replaced. Therefore the current PII registration standard is essential for practitioner safety and peace of mind.
2. Is the definition of clinical practice suitable or should it include the provision of advice to other practitioners?
Definition of clinical practice should be defined to include advice to both health services users and other professional practitioners. In the circumstances of PII the particulars of this professions clinical practice must be clinically identified. At high enough doses, ionizing radiation can damage molecules such as DNA in cells. Damage to DNA and other important cellular components can result in cell damage or cell death. This can lead to health effects like an increase in cancer risk and, at extremely high doses, death. At the same time, ionizing radiation has many practical applications such as in medical imaging using x-rays and CT (computerized tomography) scans. It is used in radiation therapy to treat tumours and leukaemia.

Registration standard: Professional indemnity insurance arrangements (PII)

Please provide your responses to any or all questions in the blank boxes below

Clinical practice as defined by the draft "practice that involves the provision of professional services direct to health service users." Professional services can be interpreted to mean advice given to the health service user (general community). This can occur at times including outside of the clinical setting, when people can seek advice from you by the nature of your occupation. A clear and unambiguous definition of "professional services" will need to be outlined.

Perhaps the wording as per page 39 of the Recency of Practice guidelines which states "clinical practice has an element of "direct" care associated with it", can be added to the definition?

3. Is the content and structure of the draft revised PII registration standard helpful, clear, relevant and more workable than the current standard?

Content and structure is clearer in this draft guideline. The notion that PII cover needs to cover you whilst in a volunteer capacity (new graduate vs retired consultant) conflicts with the removal of "unlimited" in the run-off cover. If clinical practice includes advice and someone is working as a volunteer, should this still not be unlimited?

Practitioners will be encouraged to take a short term view of their insurance policies, and this document proposes that in order to save money for those not undertaking clinical practice, they can purchase an inferior insurance policy, which will expose the practitioner to greater risk particularly in light of the late term effects claims. The AIR maintains as part of our PII support information, a global data base of claims against insurers arising from the use of ionising radiation in the healthcare environment.

We note run off cover is defined to protect a practitioner. This does not define specifically if this is a registered practicing or non practising individual. The definition of "who has ceased a particular practice? What is the particular practice? Does this include consultancy work post retirement from a clinical workplace?

We are concerned about those staff members who rely on their employers insurance who will be at risk if they work elsewhere as a part-time casual and have their prime employers details on their registration.

This goes back to the argument that if you are not practicing, is the advice you give, in the "consultancy" role deemed to be considered as clinical practice? Irrespective of this distinction, the need for unlimited run off is essential, as even those no longer practicing are not immune from the potential for a late effect claim against their previous actions.

4. Is there any content that needs to be changed or deleted in the draft revised PII registration standard?

The AIR strongly recommends that the word unlimited remains in the runoff cover.

Note that practitioners generally do not pay that much attention to their insurance covers. They are aware of the requirements; however do not understand the policies. This is evidenced when a situation does arise and the practitioner requires assistance.

5. Does the proposed five year maximum period within which to undertake a review of the standard provide a reasonable balance between stability and the flexibility required to revise and update the standard if necessary?

Given that the recency of practice is limited to a three year period, then so should documents be revised on a three year period, to prevent things going out of date and maintain the currency for that period of time? Insurance policies also change rapidly, so three years is ideal.

Registration standard: Professional indemnity insurance arrangements (PII) *Please provide your responses to any or all questions in the blank boxes below*
6. Is there anything missing that needs to be added to the draft revised PII registration standard?
The definition of ionising radiation in the healthcare setting
7. Do you have any other comments on the draft revised PII registration standard?
Need to have clarity on the definition of Clinical Practice and all the variations associated with this. Should this not be the same as the current definition of “Practice”? When defining the word practitioner, it needs to state registered practitioner, as those who retire may choose to relinquish their “protected title” status and not be aware of the implications if there are any. Perhaps the wording as per page 39 of the Recency of Practice guidelines states “clinical practice has an element of “direct” care associated with it can be added to the definition?

Registration standard and Guidelines: Continuing professional development (CPD)

Please provide your responses to any or all questions in the blank boxes below

1. From your perspective how is the current registration standard working?

The current registration standard for CPD was a little ambiguous and did not give clarity to practitioners.

2. Are the proposed requirements for registrants to undertake specified CPD activities appropriate?

The AIR agrees that it is important that registered MRP's undertake CPD to maintain currency in the rapidly moving technological environment and to establish best practice.

3. Is the change to who is required to meet the standard appropriate?

The AIR supports that the addition of provisional registrants is a natural progression from the university environment into the real clinical environment. This will enable them to understand and appreciate the requirements that they will need to fulfil once they become a general registrant.

4. Is the content and structure of the draft revised registration standard helpful, clear, relevant and more workable than the current standard?

Item 4 in the registration standard states "You don't need to meet this standard when you apply for registration in Australia for the first time as a medical radiation practitioner."

- This does not consider practitioners that are from overseas that have been working previously and are able to demonstrate this aspect.

Item 8 on the same standard then states "when a person registers for the first time, or applies for registration after it has lapsed; the number of CPD hours to be completed will be calculated on a pro rata basis according to a formula published by the Board in its CPD guideline."

- This is inconsistent with item 4. The recommendation would be to clarify item 4 with the addition of the words "graduates exiting from an approved MRPBA accredited program do not need to meet this standard....."
- This will cover new Australian graduates and those overseas practitioners who have just exited their degrees and have not undertaken any post graduate clinical experience prior to registration.
- Also with item 8, if a person registers after their registration has lapsed, they may also not meet recency of practice, or they may have been on maternity leave or working in another field. How will these practitioners be able to demonstrate CPD? If these practitioners are recommended an SPP, then this will be covered with the introduction of CPD to provisional practitioners.

5. Is there any content that needs to be changed or deleted in the draft revised registration standard?

Clear definition of the audit process, On the registration standard under item 4 "During the registration period, your compliance with this standard may be audited from time to time."

In the summary of guideline item 3 it states that "to ensure that satisfactory records of CPD undertaken are maintained and available to be submitted to the Board during its annual CPD audit"

Registration standard and Guidelines: Continuing professional development (CPD)

Please provide your responses to any or all questions in the blank boxes below

- Given that the guidelines stipulate that the board will be auditing annually, we recommend in the registration standard that this reads "your compliance with this standard may be audited. x% of practitioners will be randomly chosen to be audited on a yearly basis.

For dual division registrants, their substantive CPD hours must include activities for each division of their registration. Is dual division defined as a practitioner who is registered as a radiographer and then limited to MRI for example?

- In this case with a new definition of more than 30 hours substantive CPD – does this mean that dual division registrants must undertake substantive activities in both divisions that culminate in a total of 30 hours?
- An example here would be ideal so that there is no ambiguity.
- Is this dual division inclusive of MRP's who undertake ultrasound?

Is reflection a requirement for <u>all</u> substantive activities undertaken? What is the minimum requirement?

Item 9 in the guidelines state that those practitioners participating in a CPD program approved by the Board are able to "use evidence of completion of the requirements of that program to meet the requirements of the CPD standard."

There is no mention of the requirement to provide evidence of participation such as certificates etc. Will this be a requirement? If so, this will need to be articulated. The Current standard seeks five years of evidence to be retained for a three year triennium, this requires explanation.

CPD pro rata formula

- In the example provided, the nearest whole number calculated does not match the definition of rounding to the nearest whole number. I.E. 12 months x 1.67 hrs = 20.04 hours therefore the CPD hours pro rata equals 20 hours. The document stipulates 21 hours.

Under item 12 exemptions

- Is parental leave considered as an exemption? The definition under parental leave reads as though parental leave will be issued, as 12 months not undertaking CPD "will not materially affect a practitioner's ability to practice in a safe manner." However, parental leave can be extended for a period of 24 months in a workplace under certain agreements. Will parental leave be issued for a maximum of 12 months given the description, with the extended parental leave considered on a case by case basis?

6. Does the proposed five year maximum period within which to undertake a review of the standard provide a reasonable balance between stability and the flexibility required to revise and update the standard if necessary?

The Board has stipulated a triennium. It would only be a natural progression that the registration standards also follow this triennium and be reviewed every three years.

7. Is there anything missing that needs to be added to the draft revised registration standard?

The AIR has no additions.

Registration standard and Guidelines: Continuing professional development (CPD) *Please provide your responses to any or all questions in the blank boxes below*
8. Do you have any other comments on the draft revised registration standard?
The AIR has no other comments to make.
9. What specific requirements in addition to those listed in 'what must I do' should the Board require to approve a CPD program?
Specific requirements for Board approval as a CPD program • Clear transparent, unambiguous documentation. • Processes • Mechanisms for recording for practitioners. • Maintenance of privacy of all practitioners. • Clearly defined auditing process to maintain the standard of the approved CPD program.
10. Is the information provided in the guidelines clear and useful?
Information has been expanded and appears to be clearer.

Registration standard and guideline: Recency of practice (RoP) *Please provide your responses to any or all questions in the blank boxes below*
1. From your perspective how is the current RoP registration standard and guideline working?
Currently the standard and guidelines are a little ambiguous and there are inconsistencies. As there is no minimum limit set on the requirement of specific hours, practitioners are finding it difficult to understand the requirements for resumption of clinical practice when they do not meet the recency of practice.
2. Is the definition of clinical practice appropriate for the purpose of demonstrating recency of practice?
The definition of Clinical practice may need to be reviewed as per the PII document.
3. Is the requirement for 450 hours of practice in the past three years sufficient for practitioners to competently and safely provide services to the public?
The number of hours stated, although is a good starting level, does not take into consideration the experience of the practitioner. Will there be any specific modalities or techniques that the practitioner be required to demonstrate during these 450 hours? There needs to be clarity in this number of hours, as these can all be achieved in one year. So if a practitioner undertakes the 450 hours of practice in year one, then goes off on two years leave, will this still be acceptable? Alternatively will the 450hours be split evenly over a period of three years ie 150 hours per year ie 3 hours per week? It is reported to the AIR that DR Chiefs would have reservations rostering practitioners to the areas of DSA or MRI with only this amount of time and expect them to perform to a reasonable standard. Clarification that this is related to clinical practice or the definition of practice itself? Definition of practice incorporates all types of skills or knowledge in the profession. Will the recency of practice guidelines take into consideration the “practice” that a registered practitioner may have undertaken? These practitioners may be undertaking practice, but not “clinical practice” per se. In Appendix 1, where the time since last practiced was 0-3 years, Would it also be advantageous to ensure that when the 450 hours clinical practice are undertaken, that these practitioners also have the minimum requirement of CPD? This amount of clinical practice could equate to a part time person – who is also required to undertake mandatory CPD. This would then meet the Board’s standard for minimum requirements for CPD.
4. Is the content and structure of the draft revised RoP registration standard and guideline helpful, clear, relevant and more workable than the current standard?
This new registration standard has more detail and has some structure which would assist those returning to practice a little more of a guideline on what to demonstrate. Clarification is sought on “each division of practice”. Does this refer to a practitioner who is registered with dual qualifications ie medical imaging and radiation therapy, or is it referring to practitioners who register as a radiographer and is limited to a specific scope of practice eg radiographer limited to mammography? Will these practitioners need to demonstrate 450 hours in radiography and 450 hours in mammography practice?

Registration standard and guideline: Recency of practice (RoP) *Please provide your responses to any or all questions in the blank boxes below*
5. Is there any content that needs to be changed or deleted in the draft revised RoP registration standard and guidelines?
Clarification is sought regarding the information required to demonstrate competency to practice. Evidence of Supervised Practice Completion of Education courses – Will these be a specific type of program recommended by the Board, or can this include short courses etc? Will there be a list of approved "short courses"? The AIR remains deeply concerned about the practice of requiring deficient practitioners to find a course and then seek accreditation of that course. Completion of an examination / assessment – Will there be policies and procedures surrounding this type of examination. What resource material will be provided regarding this? How will it be determined which candidates will be required to undertake this form of assessment? Will the examinations / assessment be similar to an Objective Structured Clinical Examination (OSCE)? The AIR stresses that there is a big difference between an examination and an assessment.
6. Does the proposed five year maximum period within which to undertake a review of the standard provide a reasonable balance between stability and the flexibility required to revise and update the standard if necessary?
To keep all documents consistent, a three year period for review is recommended.
7. Is there anything missing that needs to be added to the draft revised RoP registration standard and guidelines?
Will there be a transition phase for this introduction? Will there be education seminars and materials and resources provided on the website regarding this? The requirement for a statement of service from the employer and a letter stating the number of clinical hours would mean a lot of work to maintain the database over a long period of time. Surely consideration could be given to requesting a percentage of time spent in individual modalities would achieve the same outcome.
8. Is the information provided in the guideline clear and useful?
Appendix one is provided in a tabulated format which details the requirements. There are difficulties with this, as although the Board has attempted to delineate the various "times since last practiced", it is still a little confusing and can be misinterpreted. In the category of 4 years or less can place you into any of the other preceding categories. Lots of the categories also overlap each other for the variations. This categorisation needs to reflect definitives not an ambiguous sliding scale. Needs to be one category only and have no overlapping years. In the section 10 years of more, the mitigating action of having "completed an approved program of study" needs to read "completed an approved program of study in the past xxx years". Currently it reads as though if you have completed this program within the past 10 years, then you meet the mitigating actions. Perhaps a further explanation of the Australian Qualifications Framework can be referred to, as listing the requirement of having undertaken an (AQF9) postgraduate program may be confusing unless you are an academic. Clarification on "relevant" postgraduate is sought. Is this in reference to a Graduate Entry Masters program, or a Masters qualification in MRI or ultrasound for instance. Is there a requirement for clinical practice within this relevant PG program when this AQF 9 postgraduate is undertaken?

Registration standard and guideline: Recency of practice (RoP) *Please provide your responses to any or all questions in the blank boxes below*
Clarification is also sought on the recommended hours of directed CPD. Ratio of additional directed CPD is inconsistent between the different categories of time since last practiced.
9. Do you have any other comments on the draft revised registration standard?
The AIR has no additional comments to make