Webinar transcript

March 2019

Revised professional capabilities for medical radiation practice

AUTOMATED VOICE:

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ADAM REINHARD:

Hi everyone. OK, welcome to today's webinar, which is hosted by the Medical Radiation Practice Board Of Australia on the revised capabilities for the profession. My name is Adam Reinhard and I'm the executive officer on medical radiation practice. We'll be starting the webinar shortly, but before we do, I wanted to go through a few things. This will just be handy particularly if you haven't participated in the webinar before.

So just looking at the slide in front of you, there's a few things you can do to make your webinar experience a good one. You should be able to see the control panel in the top right of your screen. Clicking the arrow in the red box expands or minimises the control panel. You'll see that your microphones are muted so we won't hear your voices. We are happy to take questions on today's presentation. If you have a question, please type it into the chat box and we'll get it to you when we break to the question and answer session at the end of the presentation. Just a quick tip, remember to click Send. If we don't get to your question today, we'll email you to address it directly or provide it in an FAQ document in the coming weeks.

Just next slide, there we go, good. So we are going to be recording the webinar today. We will keep a log of your chat questions and refer to you by name if you ask a question. If you wish to ask a question anonymously, please state that at the start. OK. So now I'll start today's presentation. The professional capabilities for the professional are first published by the board in November 2013. Since then, there had been developments in technology and changes in practice. This impacts on what minimum professional capabilities a board expects of a registered medical radiation practitioner. Next slide. Yep, good. Today's presenter is Mark Marcenko, the chair of the board and a registered medical radiation practitioner based in Tasmania. Mark is a nuclear medicine scientist. So I'll hand you over to Mark now for the presentation. Thanks, Mark.

MARK MARCENKO:

So, thanks, Adam. Before we start today, I'd like to... We might go to the next slide, please? So, before we begin, we like to acknowledge the Traditional Custodians of the land we are meeting on for the continuing connection to the land, sea, community, and culture. We pay our respects to their elders, past present, and emerging. Next slide please. So hello everyone. Thank you for joining us for this webinar to hear about some of the changes in our capability document. But more important, for us to get your feedback and thoughts as well. So I'll start with some introductions. I'm Mark Marcenko, as Adam said, the chair of the national board.

And you've already heard from Adam Reinhard, he's the executive officer for the medical radiation practice board. Today is about providing you with information about the board's proposed changes to the professional capability for medical radiation practice. We know that

the professional capabilities are an interest to most registered practitioners, which is a pretty great thing because they apply to all the registered medical radiation practitioners.

Two weeks ago, we published a public consultation document on the board's website, and my aim today is to give you some of the context for the proposed changes to the professional capabilities. So to start with briefly, I'm going to go over the process of public consultation. It's a little dry, but it provides some context. Next I'll provide some background which should include some of the policy directions. And the bulk of today's discussions will look at more substantive changes. I'll also touch on the concept of capability and its relationship with competence. And towards the end, I'll provide an opportunity for a few questions. We'll go to the next slide. The board is required to undertake public consultation on any proposed or revised regulation before we submit it for approval. Public consultation is a very useful process to go through. It allows the board to test this proposal with a range of stakeholders. And the benefit of this is we can refine the professional capabilities before they're approved for use.

Now as I mentioned earlier, the board started public consultation on professional capabilities a few weeks back. The consultation will remain open for approximately ten weeks closing on the 26th of April at around midday. So to assist the stakeholders, we held two information sessions already. We had one in Brisbane and one in Melbourne, and as well as today's webinar. So the feedback that you provide, there's two ways you can do it. You can send your written feedback by email - so the email address in the consultation paper. And this email address is also on our website. And we do ask that you use the response template that is in the consultation webpage and provide feedback to some of the specific questions along with any of the general feedback you have. Well, we're trying something a little bit new this year, and you can choose to provide your feedback online, if that actually suits you more. So the online feedback is intended for enabled quick directed feedback based on the questions in the consultation paper.

As in a survey style feedback method, there's limited opportunity for detailed responses, although you can give short responses. So you can access the online consultation feedback using your phone. But I have to tell you, there is a limit of 300 characters. So if you feel that you wanted to have a little bit more in your questions, the other way is probably better for you. And also noting that you must use the length in the board's website, and this helps us maintain the integrity of the consultation feedback. So go to the next slide. The professional capabilities is a thread that runs through many aspects of regulation and practice in the profession. The board uses the professional capabilities for regulatory decision making, including decisions on registration, and assessing complaints about performance. Practitioners use their professional capabilities to guide their work and as a reference point for supervising practitioners and students in clinical training. Education providers use the professional capabilities to guide the development of course content, and program outcomes.

So, the public, too, use the professional capability to assess what they can expect from medical radiation practitioner. Professional associations, unions, and other health professions, and even journalists reference the professional capabilities in the work that we do. So, the reach and impact of the professional capabilities is significant. Importantly, the professional capabilities can be used to meet a number of government policy objectives with respect to the medical radiation practice workforce. I'm going to touch on that a little bit later. So, we got to change professional capabilities, we can't happen in a vacuum. As the board, we must be conscious of all various interests and stakeholders to use this document. So, there are a number of policy directions the board has applied and has revealed the professional capabilities.

Now these include the national law objectives that the regulation, one, facilitate health, access to health services, and enables the continuous development of a flexible, responsive, and sustainable workforce, and enables innovation and the education (INAUDIBLE) service delivered by registered health practitioners. Governments, employers, and, indirectly, practitioners had advised the board that to the extent possible, the regulation of health profession should have the same requirements where possible. Now one of the more

significant considerations in this review is the effect that current and future technological changes will have on practice. I think we've seen this lull of hybrid imaging over the last few years. And as effect, I know nuclear medicine, there's procedures we're doing now that weren't even invented when we did the last capability document, which I think we started about five years ago. So, we've also tried to ensure that the professional capabilities are flexible enough to adapt to change over the next few years with the new technology that's coming in. Now a significant policy from all levels of government to Australia is the focus on improving Indigenous health outcomes.

To give you a sense of how slow this change has been, it's been on a federal government objective since 2008 - or as like to say, approximately five prime ministers ago. And it's only starting to enter mainstream health practice now. So, in the professional capabilities, we strengthen requirement for cultural competence in a way that aims to focus on improving health outcomes for Indigenous Australians. All registered practitioners should be respective of all cultures, Indigenous health outcomes are priority, and the cultural capability with respect to Indigenous Australians is a way we can all contribute to improving health outcomes. Another driving force in our considerations has been the agreement the board has with New Zealand. The Australian and New Zealand boards have agreement principle that practice in both countries is basically the same. And the goal for both boards is to find a common way of describing the commonality and practice. So that agreement is to work together to develop cooperative regulation.

Recently, the New Zealand board reviewed their capabilities, and they aligned them significantly with the Australian capabilities. And now in this revised version, the Australian board has relied upon the experience of New Zealand with respect to the capabilities for MRI and ultrasound. Next slide. So, let's jump right in. The first change you'll notice is that we've changed the structure. It's not a particularly big thing, but it's important in terms of consistency with other health professions. Now it follows closely what is generally considered best practice when it comes to describing capabilities in health professions. So, the structure of the capabilities now is premised on the CanMEDS model of practitioner competency. So, this model is developed by the Royal College of Physicians and Surgeons of Canada and it starting to be used all around the world. The CanMEDS framework groups abilities under a number of practitioner roles. So, you have the expert practitioner, the communicator, the collaborator, the manager, the health advocate, scholar, and the professional.

So, by using practitioner roles as the main titles emphasises that many of the capabilities required a practice integral to the practitioner and not just the practice. So, as you see on this slide, some of the changes that we will go over tonight. And can I also say that some of these changes have been driven by notifications we see from the last seven years. - and that's specially I suppose if you look at the last two. So, when something goes wrong and practitioners throw up their hands and say that's not my job, well, we disagree. We'd use this opportunity to beef up some of the areas, especially in the last two slides, as I was saying. And we did that basically to better provide protection to the public. So, we'll go to the next slide. The draft revised professional capabilities are organised in five domains common to all medical related practitioners, and three domains that are specific to each of the three division, domains from 1A through 1C.

So, each domain consists of key capabilities and corresponding enabling components. So, the structure the revised capabilities reflects the current version, their five domains of practice. The main change, however, is in the order that the domains follow. The revised capabilities place the medical radiation practitioners at the top, much the same as the CanMEDS model. The rest of domains reflect what is essentially the same domains that was in the current version of capabilities. We'll go to the next slide. The revised domain 1 has the same structure as the current domain 5. So, in the first part, domain 1, describes elements of practice that are common to all medical radiation practitioners, or can be common to all medical radiation practitioners.

Now what's important here is 1A, 1B, and C must exist to meet the requirements of the national law. We still have to have the three different divisions. So, we still have to have a diagnostic radiographer, radiation therapist, or nuclear medicine technologist. So, we still have those three streams within our medical radiation practice. We'll go to the next slide. So, the domains describe the practitioner's role but its key capabilities that describe what the medical radiation practitioners must be able to do to succeed in that role. So, the key capabilities describe the key features that safe and competent practice in a range of context and situations of varied complexity and uncertainty. So, during any one procedure or treatment, practitioners are expected to demonstrate key capabilities from various domains. So, this recognises that competent professional practice is more than just a sum of each discrete parts and requires an ability to draw on all the capabilities to practise safely. So, in the new revised capabilities, we've evolved the language a bit too so that we can use terms such as use, perform, or apply as capability descriptors.

The level of capability for safe and competent practice requires practitioners to apply detailed knowledge and perform practice-related tasks in the practice setting, but not in isolation. In other words, practitioners should be capable of doing rather than simply knowing. And this will often be best demonstrated in the clinical education setting which includes simulation. So, part of the consultation question asks you whether these key capabilities are appropriate. And we're keen to know what you think about that. So, go to the next slide. The enabling components describe the essential and measurable characteristics of the corresponding key capabilities and facilitate assessment of performance in the practice setting. Medical radiation practitioners must be able to demonstrate all enabling components for all key capabilities for safety competent practice. So, this includes applying, adapting, and synthesising new knowledge from experience to continually improve their performance. In the example above, the key capability is delivering patient care.

The enabling component - that is the elements that ensure the practitioner can deliver safe and effective care to the patients are listed there. So on this one, one of the enabling components is being able to recognise and response to the deteriorating patient. And for some of the enabling components, we have provided further information on guidance on what is expected in order to meet that enabling component. Again, an example that we have here, there's the additional information at the bottom. So, when we talk about capability and competence, we're talking about the minimal level of skills, knowledge, and attributes and behaviours that are expected on medical radiation practitioner. These minimum capabilities are expected of the newly recognised practitioner on their first day just like the practitioners that's practising for 20 years. So, if we go to the next slide...

So, if you have a look at the red dot, there's the student. So, you can see the line that shows minimum capability, that line actually should probably be slightly sloping upward because we have continuing professional development in order to practise. So, you can see on the red line, the student, when they first start out in the red, look, they don't know at all, but they know some of it already. Then if you see the green circle there, that's the registered practitioner, and that's where these capabilities come in. That's the minimally capable practitioner. And a lot of people think, well, does it just stop there? Well, no it doesn't. So, if you look at the blue circle, you can see that's the experienced practitioner. And so, people are continuing to grow and gain their knowledge as they're practising along. So professional capability is the ability to take appropriate and effective action, to formulate solve problems, both in a familiar, unfamiliar, complex, and changing setting. Professional capability reflects how a practitioner uses their professional judgement, decision-making skills, experience, and knowledge to apply in any given situation.

So, confidence refers to the knowledge and skills being applied consistently to the standard of performance required in the workplace. So, the definition of competence required for the job will change, the job role evolves. Threshold professional capability is the point of which the minimum level of confidence required to perform the job safely and competently is reached. And I guess that's what we're seeing on that line there. Capability does not preclude the expression of competence nor is capability a higher level than competence. Rather

competence is viewed as an essential part of being capable. So, it stands the reason that the professional capability develops over time. For students, we can expect that as they progress through their program of study, they will gradually be able to demonstrate an increasing number of key capabilities. Knowing that's the completion of the course, they're required to meet all the professional capabilities. Similar to a registered practitioner's capability will expand and improve as, again, professional experience. It's over time their skills and knowledge works can be on demand with capability enabling them to work in a broader scope of practice. We'll go to the next slide, please.

So medical radiation practitioners must be able to demonstrate all enabling components for all key capabilities for safe and competent practice. This includes applying, adapting, and synthesising new knowledge from experience to continually improve performance. The enabling component includes different levels of demonstration requirements. So, you have to apply knowledge, apply principles, indicate the practitioner is expected to apply detailed knowledge to the practice setting. Understand indicates the practitioner is expected to apply broad knowledge and understanding of information for safe practice. But may not be required to understand or interpret detailed information, or may not be required to use their knowledge and understanding to perform certain procedures.

Performance - for example, perform, identify, respond, operate - are used for the majority of the enabling components. And these are the abilities required in the practice setting. So, go to the next slide. So, one of the things we changed on that, and we got kind of an example on how it works, but also one of the things we thought was important to change, in the revised capabilities, we made changes in the requirement for practitioners' respect to using and managing information systems. I think before we had it, it was in two lines. It was like knowing how to do respects. And we just thought, we've actually had notifications about some of these issues too. So, we thought we would beef that one up a little bit. So, the key capability, as described above, in enabling components require so, understanding the legislative responsibilities for managing and handling patient identification, data privacy, ownership, storage, retention, and destruction of patient clinical records and other practice documentation.

Then we have using clinical information management systems to accurately record patient-client history, and any examination treatment provided, and having that associated with the correct patient. Then we have to know and ensure that the stored clinical information - information and images - is associated with the correct patient, client, and examination/treatment. And then we also identify and respond appropriately when clinical information is incorrectly associated with the identity of the patient/client, and/or examination/treatment. And we have managed clinical information - so information and images - appropriately and consider the workflow between the different clinical information management systems and respond appropriately to data errors and, or system failures, and to ensure clinical information is made available to the appropriate persons involved in the care of the patient. So responding to data errors and, or system failures includes troubleshooting, fixing errors where possible, or reporting errors and fails to the system administrator in a timely manner. So, I think you can see from going from two lines, we've certainly beefed up the risk (INAUDIBLE) part of things. OK, I'm just going to hand over to Adam now.

ADAM REINHARD:

Thanks, Mark. OK, so, OK. So cultural capability. In March 2008, Australian governments agreed to work together to achieve equity in health and life expectancy between Aboriginal and Torres Strait Islander people and non-indigenous Australians by the Year 2031. The Council of Australian Governments, COAG, implemented the Closing the Gap strategy setting six ambitious targets across health, education, employment to drive progress. The strategy recognised that closing the gap in for Indigenous peoples who are disadvantaged would require long term and generational commitment with effort to be directed across a range of priority areas and early childhood schooling, economic participation, healthy homes, and a range of other things.

In December 2016, the COAG committed to working together with Aboriginal and Torres Strait Islander people to refresh the agenda with renewed focus on collaborative effort, evaluation, and building on what was working in each jurisdiction. In June 2017, COAG welcomed a strengths-based approach that supported Indigenous advancement. While the focus is on doing more, there is also a focus on enabling as many elements of Australian society that can contribute to Closing the Gap. In 2018, the 11th Closing the Gap report shows that despite the work that's going on, only a little has changed. And so we've still got, you know, sort of significantly divergent rate for infant mortality and overall life expectancy. So we need a paradigm shift. We can't keep relying on the same policies that do not deliver the change that we want to see. Next slide, please.

So equity. In 2018, all national boards committed to the statement of intent, which was developed by the Aboriginal and Torres Strait Islander health strategy group. The statement of intent commits the entities of the national scheme, boards, accreditation bodies, and APRA to work together with Aboriginal and Torres Strait Islander peoples to achieve equity and health outcomes between Indigenous Australians and non-indigenous Australians. To reiterate, it's equity, not necessarily equality, that is being strived for. To ensure that Aboriginal and Torres Strait Islander people can enjoy the same health outcomes as the rest of Australia, we must do more not just what we do for everyone. We recognise that patient safety is inextricably linked to the elements of clinical and cultural safety. If patients do not feel safe in health care facilities, they won't use them. So patient safety for Aboriginal and Torres Strait Islander people must be the norm. What we have learned that it is Aboriginal and Torres Strait Islander people who must lead this work. What defines cultural capability must then be defined by Aboriginal and Torres Strait Islander people, and that work is currently underway. Next slide, please.

The purpose of the statement intent is that all entities of the national scheme work towards requirements that ensure a culturally safe workplace. A culturally safe workplace is one that provides health care that is culturally safe for all patients regardless of their cultural background. The difference here, however, is that there is an identifiable need that we must focus efforts on ensuring that we create equity in health care outcomes, regardless of patient's culture. And of the aims is to increase Aboriginal and Torres Strait Islander peoples' participation in the registered healthcare workforce. The overall effect of these efforts is to provide greater access for Indigenous Australians to culturally safe services delivered by health professionals regulated under the national scheme. Next slide, please. So here we have a definition of cultural safety, noting that it's not just applicable to the individual, but also to organisations - and so to the system of operation. Next slide, please.

Cultural safety is a higher standard than sensitivity or cultural awareness. There's an obligation to ensure that the practice is safe and that patients are safe. Patient-centred care in views and obligation that we practise in a way that places the patient at the centre of care. When we consider patient-centred care, we undertake reflection on not just what we do, but to whom we deliver those health services. In understanding this, we begin to understand the individual needs of each patient and what the safe healthcare services means to them in terms of their understanding their background, history and culture. Back to you, Mark.

MARK MARCENKO:

Thanks Adam. So go to the next slide. So the current professional capabilities in domain 5A - practice and diagnostic radiography - includes capabilities for ultrasound and MRI. But I think we'd all agree that these capabilities are very limited in nature, and only require a superficial level of understanding that's not sufficient for safe and competent practice. So the board seeks to address this issue by clarifying the threshold requirements versus safe and competent practice - including MRI and ultrasound. We've done this by having optional key capabilities and enabling components that you'll see in domain 1. So the proposed threshold requirements are informed by the New Zealand board practice statement for MRI technologist and sonographers respectively.

So basically, they took a lot of our capabilities for the rest of it and we've returned the favour and taken a couple of theirs. The proposed capability for MRI and ultrasound only apply to those practitioners who are registered or applying to be registered as a medical radiation practitioner. So they don't apply to unregistered practitioners. Now I know this can be a bit confusing for some. There's a rather large cohort of unregistered sonographers, and these capabilities do not apply to them. Now, I don't want to veer from the talk too much, but sonographer currently is not a protected title. But we believe there are approximately 2,500 medical radiation practitioners who practise ultrasound, and we've had considerable amount of notifications from the ultrasound practice, so we thought this was one another area that we thought we have to beef up a bit. So in the revised professional capabilities, we've taken some care to be clear that the capability for ultrasound and MRI are optional - and that is, you do not need these capabilities to be registered. But if you are registered and perform either ultrasound or MRI, you must meet these minimum capabilities to practise in those fields.

So a radiographer or an RT who does not practise ultrasound or MRI does not need to meet these capabilities. So these capabilities sit within domain 1, and what this means - just to make it even extra clear, I'll repeat it again - is for practitioners who do not practise in the area of ultrasound. The capabilities will not apply. However, for those registered medical radiation practitioners who perform diagnostic ultrasound examinations, the capabilities do apply. By making ultrasound and MRI capabilities optional, it actually provides a flexibility for education providers and the type of program that they ultimately create. So education providers of approved programs of study must produce graduates that are capable of registration in one of the practice divisions. But we think here, this lecture structure provides flexibility for education providers to adapt programs that actually might be required for the workforce. So maybe not with this paper, but further down the road, we may be seeing a few changes with that. We'll go to the next slide.

The current professional capabilities require medical radiation practitioners to identify and respond to a patient/client's deteriorating condition. So in 2013, the professional capabilities were published before the Australian Commission on Safety and Quality in Health Care, released the second edition of the 'National Consensus Statement: Essential Elements for Recognising and Responding to Acute Physiological Deterioration', or this document is basically called the 'National Consensus Statement'. So the 'National Consensus Statement' sets out the agreed practice for recognising and responding to clinical deterioration, and applies to all patients in all acute care facilities in Australia. So one of the objectives is that the statement was developed for registration, regulation, and accreditation agencies. And can I also point out that its scope was for recognition of the deteriorating patient, but, you know, this is quite important, it does not cover the specific clinical treatments or interventions that may be needed to stabilise a patient. So the board recognises that aside from basic life support, these treatments or interventions may be outside the scope of a medical radiation practitioner.

The revised capabilities are now more and closely aligned to the updated edition and reference the 'National Consensus Statement' as a guidance document. So it's important that the professional capabilities for medical radiation practice align with the 'National Consensus Statement'. This statement sets the expectation of all registered health practitioners working in an acute care setting - so not just our practice. The board seeks to address this issue referring the 'National Consensus Statement' in the explanatory notes relating to the key capability 7 in domain 1, and adopting the same language. For instance, recognise and respond in appropriate and timely way. Health systems worldwide acknowledge that when health practitioners recognise and respond in an appropriate and timely way to deteriorating patients, patient/client safety and outcomes are improved.

Medical radiation practitioners practise in a range of health care settings so they're well positioned as part of the overall care team to help with providing and summoning urgent care for patients and clients when they need it most. The 'National Consensus Statement' primarily applies to the acute care setting. However, in some cases, medical radiation practitioners are expected to exercise the same principle of care when practising in private practices or community health care facilities. So in most cases, medical radiation practitioners will apply

clear protocols for managing a deteriorating patient. But in some other cases, medical radiation practitioners will need to apply a high level of professional judgement to provide the best care for the deteriorating patient. Medical radiation practitioners are expected to be able to respond to the deteriorating patient and make a reasonable assessment of a patient's physiological status, understand and interpret abnormal vital signs, observations and other abnormal physiological parameters, initiate appropriate early intervention for patients who are deteriorating, and respond with life-sustaining measures - so basic life support in the event of severe or rapid deterioration pending the arrival of emergency assistance, and when they do, (INAUDIBLE) communicate information about clinical deterioration in an instructive, structured, and effective way to the attending medical officer or team, to the clinicians providing emergency assistance, and to patient's families and carers.

So at a minimum, medical radiation practitioners must be able to interpret and identify abnormalities within the following physiological parameters. So things, for example, like respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, and level of consciousness. So these are things that the vast majority of medical radiation practitioners do on a daily basis. And as the statement says, all clinical members of the workforce should have a local escalation protocol relevant to their position and should know how to call for emergency assistance if they have concerns about a patient and they should know that they should call under these circumstances. So hopefully this capability will stop that very small minority of practitioners who throw up their hands and say that's not my job when something goes wrong, which we have seen some notifications.

So go to the next slide. I'm also going to go to the other one that we concentrated, wanted to beef up. I'm going to move on to the capabilities relating to conveying information when urgent and unexpected findings are identified. The current professional capabilities require medical radiation practitioners to apply knowledge of responsibilities for conveying information when significant findings are identified. The current professional capabilities do not identify to whom the information should be conveyed. So the board seeks to address this issue by clarifying that information must be conveyed in an appropriate and timely way to a health practitioner involved in immediate management of that patient/client. So when there's urgent and unexpected findings that are identified, they must do, as I said before, convey those to a health practitioner involved in the immediate management of that patient. And you'll see this on domain 1 key capability 7, enabling component C.

So conveying information to appropriate health practitioners is an integral element of safe and competent practice. We've seen several coroner matters that have identified that if a medical radiation practitioner had alerted another health practitioner to an urgent or unexpected finding, the impact on the overall system of patient/client care would have been positive and significant - which I guess translates that they may not have died. Although the focus of enabling component 1.7 C is on conveyance information about urgent and unexpected findings, medical radiation practitioners must be able to recognise abnormalities and identify any urgent and unexpected finding. So medical radiation practitioners are also expected to be more alert of the possibility if you see something like this in a deteriorating patient. So our code of conduct requires that registered practitioners maintain clear and accurate health records. So in most cases, medical radiation practitioners should alert another health practitioner to an urgent and unexpected finding in the quickest way possible - which probably includes verbal communication. The medical radiation practitioners should record that alert in writing as soon as practical.

Now in most cases, the appropriate written record of an alert is in the patient's health records or on the PACS system - or, sorry, the ridge system. But some employees or health services may have specific requirements for recording alert. So this can also just be a note on the referral to the radiologist that you think that he should look at something right away because you're not sure if something looks quite right. So if you're interested, the two coroner inquest that we're looking at were the death of Alice Summer Steer in Queensland, and the death of (INAUDIBLE) Theresa Hamilton in Victoria. So taking appropriate and timely action is a key responsibility when a medical radiation practitioner identifies medically significant findings on

an image. Information must be conveyed verbally or in writing in line with the relevant guidelines. Medical radiation practitioners must ensure information is conveyed to and understood by the appropriate persons who may include the requesting practitioner or other practitioners for the immediate and appropriate management of the patient/client. The patient/client and their family care should also be informed in communications between health practitioners about the clinical status of a patient should be recorded somewhere. Go to the next slide.

So since 2013, the board has steady gained experience with professional capabilities. As part of this consultation, we've developed a number of fact sheets. So this neat symmetry of this quote in this slide and the fact sheets we have developed, namely, they're both about education and experience, and really, we do need both. So go to the next slide. So we have developed two fact sheets - one, relating to education providers, the other, for clinical supervisors. So educational providers develop work-ready practitioners and in doing so, assure Australia's health workforce of a continuing supply of qualified and capable medical radiation practitioners. Their role within the profession is to ensure graduates from an approved program have the knowledge, skills, and professional attributes necessary for safe and competent practice in Australia. So programs that meet the medical radiation practice accreditation standards are accredited by the medical radiation practice accreditation committee and approved by the board as a qualification that, basically, you can get general registration with.

The accreditation standards require the design and implement of a program where learning outcomes and assessment tasks map to all the professional capabilities. So students must demonstrate all enabling components for all key capabilities before they graduate So it's really important. Education providers must be able to show that all students demonstrate all enabling components for all key capabilities for the relevant division of that registration in the clinical setting before they complete the program. So clinical supervisors who teach and assess students from approved, I think there's another slide.

The link between education providers - no, sorry - and clinical supervisors is critical for ensuring safe and competent practitioners. For students to succeed in the clinical training work environment, the expectation of both the education provider and the clinical supervisors must be aligned. Therefore, it's important that both education providers and clinical supervisors have a clear and shared understanding about the goals for any period of clinical training and work integrated learning. So registered practitioners, employers and the public are all entitled to expect that by the end of their final year, a graduating student has demonstrated all enabling components for all key capabilities regardless of the length of program. Thank you very much, and I think we're going to go to a few questions now. So as Adam said before, you can type your questions in. He's going to go through the questions and we'll do as many as we can do.

ADAM REINHARD:

Thanks, Mark. If you haven't already, now's the time to send us your questions. We've already got a few in there. But if you just use the box on the top right of the screen, type the questions in under the area that says questions, and then hit Send. If it's easier, you can also pop that box out onto your screen. So just using where the words questions is, just go along to the right there, there's a little sort of square with a pen in it, pop that, and it pops out for you. All right. So we're just going to start going through some questions. And Mark, I want to see if you can have a read of this one.
MARK MARCENKO:

So Domain 18, capability 2, perform diagnostic imaging states under point of deeper form, spec CT, and PET-CT studies - what does this mean to practising nuclear medicine tech that does not have access to PET-CT equipment and does not perform these studies? Well, if you're currently registered and you don't practise those, it really doesn't really affect you that much. I guess when it does happen to me if you decide to change your scope of practice, so let's say for instance your department puts in a PET-CT scanner. Well, then you have to make

sure that you meet the minimum capabilities. You probably have to do that by either going to another site and learning that or take an additional course. But, you know, because it's in there as a minimum capability, it means students currently coming out have to know those capabilities. But practitioners that have no intention of practising PET-CT, those capabilities are in there. And should you decide to change your scope and include it, then you'll have to do the appropriate training.

ADAM REINHARD:

OK, thanks, Mark. The next question is from Andrew. Andrew asks about the privacy laws. And he says that these are fairly extensive. Is there any reference that spells out what students and practitioners need to know? Thanks, Andrew, good question. The privacy laws across Australia, unfortunately, vary from state to state, and they also differ from the Commonwealth privacy laws. So when we talk about that, it's always going to be the law that kind of applies to the practitioner in the state that they're working in. And so that kind of, because there is difference, the practitioners will need to sort of be aware of what those differences might be or what the local requirements are. But I suppose on a broader level, really, a lot of the privacy arrangements sort of around sort of making sure that, you know, obviously, if you have patient information that you're protecting it. that you're not sort of, you know, using it in inappropriate way, and things like that. So that's, in fact, what the privacy laws are asking or requiring of medical radiation practitioners. Alright. OK, so we're just going to screen down here. Oh, sorry. Maybe Mark, sorry.

There's a question here from Christine and that is how do practitioners know what their current scope of practice is? Thanks, Christine, great question. Someone's scope of practice is essentially defined by what they're trained and competent to perform. So if you've never done, say, something like MRI, and you've never done any training around it, then MRI is not part of your scope of practice. If, however, you have done training in that area and you do regularly practise in the area, then clearly that forms a part of your scope of practice. And equally, if you only do MRI and then you've decided to maybe come back out into sort of you know, diagnostic radiography or nuclear medicine technology - to go to a more fulsome scope, you would need to make sure that you are confident to perform, I suppose, the range of practice that you're going to be involved in. So I hope that helps. All right. We're going to move on to another question now. Sorry, my screens just stopped.

MARK MARCENKO:

So we've got a question from Karen. Thank you, Karen. Is CT an essential component? So as you look through the capability, CT is essential on all three streams - 1A, B, and C - but to a different level. So if you, you know, for nuclear medicine for instance, if you're just using CT for anatomical localization and for attenuation correction, well, it's not quite the same level as someone giving diagnostic contrast. So you can see that we've actually expanded it, and they say nuclear medicine or NRT, they both can do diagnostic CTs with contrast but then they have to meet the same capabilities that are required and that those are put into the radiographer section. So although it is essential now for all three, it does take it to a slightly different level if you're performing diagnostic CTs with contrast.

We got a question from Christopher Edwards.

(INAUDIBLE)

So just a question in relation to the optional (INAUDIBLE) capabilities. As it currently stands, the diagnostic imaging accreditation stream requires that where practice provides ultrasound service, each of the sonographer - student or otherwise - needs to be verified on the ASAR registrar. If the board gets notification against the radiographer/sonographer in relation to performing ultrasound service, do you first check the sonographer in question is actually on the ASAR registry? Well, probably for us, if they're registered with us, that would be the first thing that we would check. If they're, you know, if there's a medical radiation practitioner

number that they would have, if it went to be investigated, and I suppose if it was a case where we're wondering what their competency, that would probably be a step that the investigators would probably go down and assess that. So thanks for that question.

Here's a really good one. What are the consequences for not conveying information re medically significant findings? There seems to be a culture but it's not my job out there to do that, and has medical radiation practice board considered a way to overcome this culture? Well, as I said, when we had our policy writing in this committee, I walked into the room and that was one of the things. Now there's the two things that I outlined that we've had notifications on where there's been significant bad outcomes for patients. One was the deteriorating patient, and one of the other ones was not identifying medically significant findings.

Both of those, what did come back is the practitioner saying it's not my job. So I guess the way we're changing the culture is by changing the capabilities. I think we've beefed it up a bit in the capabilities saying that you must tell somebody. You should write it down at some place or other. So that's basically, I think, we are beefing it up, and hopefully, the culture is changing. And I believe when you're seeing some of the students coming out, they enjoy that aspect of the job, and I think they're quite happy to tell somebody what they think on an image. So I think that culture is going to shift slowly as time goes by, but it might be just, they might actually take a little bit of time. Although I suppose, if there's a few notifications of people said they saw something but didn't bother saying it, well, that'll probably change the culture fairly quick too.

OK, so someone said, Karen Thomas said sorry, they're still confused about diagnostic. Are we required to be able to perform diagnostic CT or not? So I think as I was saying... I think as I was saying earlier in, like, if you're currently taking a diagnostic CT course - I believe that that's embedded in the course - so you would be required to understand how to do that. The other two course, and that's what where we're trying to get CT out of there, because currently, there's a large percentage of nuclear medicine technologist that are now performing, they've taken additional courses and they're performing diagnostic CT courses, And I guess what we're saying as a board, if you have the appropriate credentials or appropriate training, then you can do it. So we're trying not to say that only diagnostics can do it, and that's why we've changed the capabilities a little bit in saying that all three can do it. So I guess to answer your question, in order to pass probably a new diagnostic radiography, of course, yes, you would have to know how to do it, but I understand some of the other courses, (INAUDIBLE) courses, some we're actually embedding that in and they're doing the same components. Some of the institutions or universities are having the same components required for nuclear med as well. And I'm not sure about the RT. So Adam wanted to do one. Adam?

ADAM REINHARD:

Yep, OK. Thanks, Mark. The next question, from Greg. The presentation gives the impression that the Australia and New Zealand has similar capabilities, and specifically that the new MRI capabilities are adopted from the New Zealand documents, but the draft text is very different to the current New Zealand text, why? The answer starts off with that Australia and New Zealand operate under different legislative requirements. So New Zealand must, I suppose, adapt how they describe capabilities to the way that their legislation works. For the Australian board, we've worked to capture what is in effect the essence of what New Zealand have. But again, the Australian capabilities and the way that they're structured, they work just a little bit differently. So yes, it's not a word-for-word, I suppose, comparison, but, I suppose, the essence and the intent is there.

MARK MARCENKO:

OK, I'm going to just jump one question from Karen again. What does the impact on staff whose employer does not provide basic life support training? Well, I think that's something probably working in the field that's the CPD thing that people take that on themselves if they're not getting it from their employer. So I think you would probably have to do that yourself.

So here's another question. I think it's slightly related to ultrasound. What are your thoughts re IVF nurses performing follicle tracking scans with no formal training other than learning from another nurse? I'm assuming that's an ultrasound position, and I think basically that if there was issues with that, it would go back to the nursing board.

ADAM REINHARD:

Yeah, that's right.

MARK MARCENKO:

Once again, we're mainly, and I try to make that clear, and I know that's a really tricky spot with ultrasound because there's doctors performing ultrasound, there's nurses performing ultrasound, and sonographer not being a protected title. But I guess what we're looking at - and I keep reiterating back and forth - it's the sonographers that are, actually, medical radiation practitioners as well. We got another question here Adam wants to do. What are the medical radiation practice requirements basic life support training now? Adam?

ADAM REINHARD:

Thanks, Mark. Yeah, it's a question from Nina, thanks, Nina. Yeah, in effect, yes that's what's going to be required. In order to meet the capabilities, yes, practitioners need to be able to respond to the deteriorating patient. And, you know, if the patient goes into arrest, the practitioner would need to, one, call the medical team, or the ambulance if you're in private practice, and yes, you would need to start CPR. You're trying to provide life-sustaining measures. Which I guess...

MARK MARCENKO:

So we'll go down, keep looking up through the questions.

ADAM REINHARD:

We've covered most of them, I think.

MARK MARCENKO:

There's a couple other questions that I think we're going to take on notice and probably get back to you.

Is that a question then? So I think someone wrote, it was raised at the Brisbane meeting, in order to change it, you need 1,000 to 1,500 practitioners write back. Well, I think I just used those numbers. I said, if we had 1,000 practitioners all say the same thing, we'd probably say oh well, maybe we don't quite have it right. So there's actually no number. And I think that's really points, and thanks for that question, what we need is to hear feedback. You know the people that are dialling in today, you're engaged practitioners, you're interested in the capabilities - that's the ones we want. Well, we want to hear from everybody, but you especially are the people that we want to hear about. If you think we don't have it quite right or if you think, oh, it's right but, you know, the education required, tell us that. Just say, you know, we're confused about this, we want to know exactly, you know, what about, and that's what the whole feedback area's for. And I think we'll gain a lot out of it, you'll gain a lot out of it as well, and hopefully, all working together on this document, we can basically get something that everyone's happy with and that's safe for the public.

ADAM REINHARD:

So just going to scan through to see if there's any more questions.
So just checking with everyone. Any more questions to come through?

MARK MARCENKO:

You have about another nine minutes so if anybody had anything else...

And I think there's another one from Karen also asking, what about staff - I'm assuming that are currently working but are not trained in CT. And once again, if you're not performing CT, if it's outside your scope of practice, you know, those are the capabilities that are there for people who are actually performing CT. And should they decide to change their scope of practice, so then they'd have to, you know, gain the appropriate, you know, skills, training, and attributes in order to perform it.

Thanks, Adam, for saying that you thought it was thorough. (CHUCKLES)

ADAM REINHARD:

All right. OK, so unless there's any more questions, we might call the webinar to a close. I'm going to give everyone just one more minute if there's any last questions. I will start... Hold on, wait. No more questions. All right, so that brings us to the end of today's webinar. Thank you for participating. The questions you've asked have been very helpful and will assist the board in developing better regulation for the profession. And thank you, Mark, for talking to us today about the revised capabilities. A recording of this webinar will be published on the board's website in a couple of weeks. More information about the revised professional capabilities under the consultations tab on the board's website. Thank you very much.

MARK MARCENKO:

And thank you Adam, and thanks everyone for helping me out today. And I look forward to getting your feedback. Thank you.