Medical Radiation Practice Board of Australia

Re:- "November 2011 Registration Standards"

Thank you for the opportunity to comment on proposed registration standard – Supervised Practice Standard.
I have listed below the professional experience from which these observations are drawn;

Immediate Past President - Australian Institute of Radiography (AIR)	–2011
President – Australian Institute of Radiography	2009 - 2010
Board Member - Australian Institute of Radiography	2006 - present
Member - MRTBQ Supervised Practice Program Committee (SPPC)	2002 - present
Chair - Combined AIR/ SPP Sub Committee	2003 - 2010
Member - National Registration Steering Committee	2008 - 2011
Chair - Queensland Branch (AIR)	1999 - 2004
Member - Queensland Branch (AIR) Committee	1997 - present
Clinical Practice Coordinator - Medical Imaging, PAH	1995 - 2008

The views expressed in this submission are a personal professional view derived from more than 35 years of diagnostic radiography experience and involvement in Supervised Practice.

Timothy Way

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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

Graduates of academic programs of 3 year duration are registered with provisional conditions requiring successful completion of a Supervised Practice Program(SPP) to have conditions removed.
The profession (AIR) also requires successful completion of the National Professional Development Program (NPDP) to meet the Competency Based Standards (CBS) set by the profession and achieve Accredited Practitioner status.
Graduates completing these programs can provide the objective evidence to demonstrate they have the necessary skills to practice independently. The term of the SPP / NPDP is 48 weeks.

ii. A four year course of study

It is acknowledged that university programs participate in the profession's accreditation process. While 4 year programs are promoted by the universities conducting them as having the answer to the Professional Development Year "By us incorporating that professional development year into our formal course….."[i], I am yet to be convinced that graduates from these programs can demonstrate that they are safe to practice as independent professionals or are able to be placed in solo practices on qualification. Students in these programs participate in "professional practice" placements of around 24 weeks. In some programs, these placements are unassessed. Graduates are not required to demonstrate, to the same rigour as those who participate in a supervised practice program, how they meet the requirement of independent practice.
My views on this are evidenced through the employment of practitioners from 4 year programs and the additional time and resources needed to orientate them to the workplace in order to undertake independent safe practice.

Clinical practice hours and experience as a student should not be confused with the time and experience gained following graduation, from a Supervised Practice Program / NPDP. It is misleading to think that the NPDP / SPP is "embedded" or part of any university program. Any practice undertaken by a student is a learning experience as they do not have a professional qualification. As a student, one is applying a series of newly learned skills in the clinical arena. As a graduate, one has these skills and is developing them into competent practice and acquiring the professional knowledge, reasoning and judgement required to practice independently.

*I believe that there is a need for Graduates of all programs to undertake a period of **48 weeks supervised practice after graduation** to demonstrate competence in practice and work readiness as independent professional practitioner. If a variation for Graduates of 4 year programs is to be made, I believe that at the very least, the successful completion of a partial 26 weeks supervised practice program after graduation (registration with probationary conditions) should be*

required to demonstrate that they are competent and ready to work as independent professional practitioners. A progress report at 13 weeks (equivalent to 24 week progress report - with sign off for "on call" and shift work) and final report at 26 weeks (equivalent to 48 week final report) should be successfully completed prior to removal of conditions. Should the required clinical and professional attributes still not be evident at this point, then the period of supervision should be extended to 48 weeks with further reports at corresponding (3 monthly) time intervals.

If a Graduate of a 4 year program has not practiced for 12 months from time of qualification, they should be required to successfully complete a 48 week SPP prior to having conditions removed.

I believe this would provide safe environment for the patient, Graduates and supervisors concerned and provide the assurance of a safety net for the public.

It is interesting to note that following the 2010 Australian & New Zealand Association for Medical Educators (ANZAME)[1] Conference, some government employer groups have implemented an NHS type "Flying Start" mentored program for new Graduates[ii] of other professions (Allied Health) in order to develop confident and capable health practitioners.[iii]

In research conducted into adequacy of educational preparation of Graduates for initial employment by Dr J Hummell and Prof Joy Higgs[iv], results indicated that

> *"Allied health graduates in this study reported that their first year of employment involved intense learning, multiple challenges and work stressors, achievements and satisfaction. They perceived that their university courses had adequately prepared them for their first year of employment with two key exceptions, the complex realities of their work roles and the multiple work stressors experienced."*

These are many of the attributes that an SPP provides through a mentored entry into professional practice.

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

Fitness to practice should be assessed during supervised practice through:-

Regular assessment points throughout the duration of the supervised practice program.

Include patient centric attributes addressed through the types of behaviours and actions in competent performance.

Multi level assessment matrix - addressing elements such as degree of independence, time efficiency, professional reasoning, focus and reflective practice

Reports at these assessment points from both supervisor and the practitioner.

Dedicated supervisors

A positive supported environment

The NPDP of the AIR has 4 review points where both graduates and supervisors submit independent progress reports and provides evidence of fitness to practice for graduates of 3 year programs.

For me, this raises the question - How is evidence of fitness of practice assessed for graduates of 4 year programs at qualification?

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

Consistency can be achieved through:-

Uniform reporting mechanisms and processes,

Uniform supervision standards, supervision training availability,

Sites meeting resource requirements of supervised practice program (equipment, variety of presentations to meet required practice experiences, environment, people),

Centralised reporting mechanisms,

Regular process review and audit of all processes.

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

Registrant with restrictions – Direct supervision at the commencement of the program.

As the Graduate progresses through the period of supervised practice, the level of direct supervision is reduced and indirect supervision is possible.

Direct supervision is where the supervisor is present and observing the graduate at practice.

Indirect supervision is where the supervisor is present in the department and available to provide assistance and support to the Graduate at practice as required.

Once there has been sign off of progressing competence at the mid point assessment (24 week), and for the purposes of evening shift work and on call scenarios, the supervisor may be offsite but must be available to provide assistance and support as required.

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

A practice must always have the capability to provide 1:1 supervision during the SPP. In essence, a solo practice site can not support a Graduate. The practice must have at least 2 registrants without restriction available to provide support when the Graduate is working.

[1] From 2011, ANZAME is known as Australian & New Zealand Association of Health Professional Educators (ANZAHPE)

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

After successful completion of the mid point assessment (24 week) supervised practice report, with approval and sign off from designated supervisor and line manager.

For the purposes of evening shift work and "on call" scenarios where there is no onsite support available, the Graduate must have access to a designated supervisor offsite who must be available to provide assistance and support as required.

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

Primary supervisor - Clinical educator with certificate IV training & assessment, or

Registered practitioner with no restrictions with more than 5 years FTE experience.

Both of the above should 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.

Similarly, other persons who provide supervision for Graduates (and students) should attend a workshop or complete the online program.

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

In my experience the impact has been positive for all stakeholders.

Patients have the benefit of a safety net provided by a mentored entry for new Graduates into professional practice.

Graduates get support through mentored entry into professional practice. Supervised practice provides demonstration of an individual's clinical competence and the progressive development of professional judgement and reasoning in the journey to independent practice. Graduates have a measurable pathway to independent or solo practice.

Employers benefit from having a motivated, confident and capable workforce providing best practice patient care at all levels.

Regulators, including licensing authorities, have a measurable pathway that demonstrates safe independent practice

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

Advantages – Provides greater assurance that Part 1 Health Practitioners Regulation National Law Section3 Objectives and guiding principles 2(a) of the will be met. ie

(2) The objectives of the national registration and accreditation scheme are:-

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered.[v]

Employment of all new Graduates on NPDP / SPP for their first year of practice would provide the benefits of a safety net for quality practice.

Provides a motivated and engaging work force fostering best clinical practice in a welcoming learning environment.

Some argue that cost is a disadvantage, however, clinical education and support for these types of programs is now part of core business and seen as a benefit to practice sustainability in both the public and private sector.

Employment of all new Graduates on NPDP / SPP for their first year of practice would provide cost savings for departments.

An SPP can be utilised as one of the tools for a Competency Based Assessment (CBA) for those practitioners returning to practice as required and, in some scenarios, assisting with assessment qualifications of people wishing to work in Australia from overseas.

Disadvantages – Some may argue cost is a disadvantage.

j. Alternative structures of supervised practice that address

i. Reducing costs on healthcare and workforce

A collaborative approach with the professional bodies should be considered.

Redirection of HWA funding to support additional places at sites participating in SPP / NPDP.

ii. Increase workforce access and flexibility

The AIR NPDP is an existing national model demonstrating ease of access and suitability with a proven track record. It is available to members and non members.

iii. Provide consistent, measurable clinical outcome

The AIR NPDP is an existing national model that provides:-

Measured review throughout the period of practice.

Independent feedback from graduates supervisors and a central coordinator.

Feedback through state based branch committee if required.
Sites that are audited (desk top).
A program that demonstrates achieved competence in all areas of professional practice (Appendix A).

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Appendix A

(Extract from AIR NPDP Guide[vi])

Professional practice requirements during your NPDP

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Demonstrates an approach to patient care, including patient advocacy, that is sensitive to the patient and fulfils their needs.

Demonstrates effective and culturally sensitive communication with patients, carers and colleagues and engages as an effective member of the health care team.

Demonstrates an approach to professional practice that conforms to the AIR Guidelines for Professional Conduct and an awareness of medico-legal obligations to the patient, the health care team and as a health professional.

Demonstrates competent performance in professional practice experience areas

For medical imaging, core practice experiences are mandatory and include:

- General radiography, including the genitourinary, cardio respiratory, musculoskeletal and gastrointestinal systems across a broad range of patient age groups and presentations
- Contrast media preparation, administration and contraindications, in the context of minor contrast procedures or contrast for CT but excluding cannulation.
- Fluoroscopic procedures
- Mobile radiography (including image intensification)
- Routine CT, specifically non/post-contrast brain CT, contrast chest/abdominal CT and excluding angiography

For medical imaging, recommended practice experiences include:

- Trauma radiography (including emergency)
- Radiography in the operating theatre
- Paediatric radiography

For radiation therapy, core practice experiences are mandatory and include:

- Simulation for external beam megavoltage treatment (including CT simulation)
- Routine patient immobilisation and stabilisation, including quality assurance of ancillary treatment accessories
- Key Steps to complete NPDP
- External beam megavoltage treatment planning
- External beam megavoltage treatment delivery

For radiation therapy, recommended practice experiences include:

- Brachytherapy treatment & planning
- Superficial radiation therapy treatment & planning
- Orthovoltage radiation therapy treatment & planning
- Stereotactic radiation therapy/radiosurgery

Demonstrates commitment to lifelong professional learning, evidence-based practice and the education of others.

- Provided satisfactory evidence of commitment to continuing professional development (CDP)
- Provided satisfactory evidence of proficiency in the English language

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[i] Jones, A , "Radiography gets second professor", The Weekend Australian, 22 Jan 2011.
[ii] Allied Health New Starter Project, 2010, Allied Health Clinical Education and Training Unit, Qld Health.
[iii] Flying Start NHS, Learning Program, 2011, www.flyingstart.scot.nhs.uk
[iv] Hummell, Dr J, Higgs, Prof J, 2010, "Educational Preparation of Allied Health Graduates for transition into their Initial Employment", presented at ANZAME 2010, ID 958.
[v] Health Practitioner National Law Act 2009, 1 July 2010, Part 1, Section 3, 2(a), p 25
[vi] National Professional Development Guide, Australian Institute of Radiography, August 2011, pp 8-9