January 13, 2012

To whom it may concern,

Thank for the opportunity to comment on the proposed registration standards for Supervised Practice:

I have been the Senior Clinical Educator at the Calvary Mater Newcastle (CMN) Radiation Oncology Treatment Centre (ROTC) for 8 years. One of my main roles has been to develop and implement the CMN's Professional Development Year Program (prior to 2011); now referred to as the National Professional Development Program (NPDP).

I am an ardent supporter of supervised practice for graduate Radiation Therapists (RTs). The NPDP, launched by the AIR in 2011, implemented a number of standards which I have found beneficial to our ROTC and graduate RTs; these in general are listed below:

- Accreditation of ROTCs in order to supervise RT graduates
- On-line quarterly assessments of RT graduates
- Assessment criteria in key practice areas

Even though there is scope for improvement of the current system, I believe the core of the NPDP is solid and much of its design should be maintained by the National Registration Board.

In regards to the items the Board has requested feedback on, my personal feedback is as follows:

a. Number of clinical hours accumulated in the current 48 week NPDP is sufficient to ensure graduate RTs are able to demonstrate clinical competence.
    - I have only had experience with those graduates who have undertaken a 3 year course of study. However, I believe for those undertaking a 4 year course of study, if the combined hours of clinical practice during the course of study does not add up to the same number of clinical hours (course + supervised practice) of a graduate from a 3 year course, then the hours need to be made up in a supervised practice component. Logically, it should be expected that there should be some period of supervised practice for those after a 4 year course of study.

b. Assessment of fitness to practice is mandatory, in my opinion. In my experience, there have been some graduate RTs that have slipped through and graduated from university. In their year of clinical practice, gaps in knowledge, skills and attitude were apparent. With a standardized assessment process, these gaps were able to be addressed.

c. Consistency in implementation of supervised practice and consistency in clinical evaluation was addressed well by the A.I.R... And even though there is scope for improvement, the A.I.R. program should be viewed as a good starting point.

    - Direct supervision for the entire period of supervised practice is reasonable. Many graduate RT positions are in addition to the Full Time Equivalent positions

in an ROTC i.e. supernumerary. Hence, graduate RTs should be supervised by two qualified practitioners.

- Even though many graduate RTs have stated working one-on-one with a qualified RT provides them with a sense of achievement and responsibility, I believe we are failing in our duty of care to the patient if this practice is accepted. In our daily work, we do not undertake sole practice in treatment delivery and if we allow only one qualified and a graduate RT to work together, essentially patients are being treated by one qualified RT. The legal position is precarious.

e. As per the preceding item, I believe that there should only ever be on graduate RT in each work area of a department. For example, if an ROTC has two linear accelerators, a planning room and a CT-Simulator, then the maximum of graduate RTs taken on by the centre is four.

f. RTs often are on-call in pairs, and there should be no need to utilise graduate RTs in this area of practice. In a model where graduate RTs must be supervised by two qualified RTs, having a third person would be a costly exercise to an ROTC. There is plenty of time after qualification for on-call practice to be experienced.

g. There should be one supervising RT with at least three years experience. Currently, the CMN has a Senior RT as primary supervisor in each area for those undertaking the NPDP and these people have a minimum of five years experience.
   - As the Clinical Educator, I am responsible to educate, support and guide the Senior RTs in the supervision and assessment of RT graduates; hence all are well verse in the NPDP assessment process. With experience comes maturity, the ability to provide accurate and fair assessment, expertly model professional, ethical and clinical practice and demonstrate a high degree of clinical reasoning.
   - Some form of training should be available in supervision and assessment skills for supervising practitioners.

h. As previously stated, some graduate RTs would like the responsibility of working one-on-one. In my experience, the graduate RTs that have had direct supervision for the full 48 weeks have not been at disadvantage. By the end of the 48 weeks, graduate RTs are generally seen a qualified RTs by their co-workers, even though they still work in a team of three RTs. The transition to the workforce is unimpeded.

i. Advantages and disadvantages to supervised practice:

   a. Advantages –
      i. Australian RTs are well regarded worldwide and I believe this in part due to the supervised practice model that has been used, especially since the implementation of university education programs.
      ii. Supervised practice ensures graduate RTs gain consistent and relatively uninterrupted clinical experience.

iii. I have been an RT for almost 30 years and I know not all students are assessed appropriately when on clinical practice; hence they may pass their clinical blocks and complete their university education. When a graduate RT has slipped through the university system and gained a graduate RT position, if there are any weaknesses in practice, these can be remediated. In the event that a graduate RT may be deemed unsuccessful upon completion of the supervised practice period and not receive qualification, our duty of care to patients is upheld.
iv. The supervised period should be seen as a period of time that the graduate RT has to hone their skills and knowledge without the added pressure and responsibility of double checking other RTs.
v. If the graduate RTs are fortunate move onto qualified positions in their respective ROTC, the investment the ROTC has had in the training and supervision of the graduate has paid off. The ROTC has the knowledge that this new member of staff has a high degree of training and knowledge of their respective centre.

b. Disadvantages
    i. As per the preceding Item v., if positions are not available at an ROTC, then there is little gain in the investment of supervised practice.
    ii. The cost of supervised practice may be onerous on some ROTCs; however some States have seen the value of this practice and have provided funding to ensure the numbers of qualified RTs is at an optimal level.
    iii. Private or smaller ROTCs may not have the adequate numbers of staff or budget to support supervised practice. Unfortunately, some ROTCs see it advantageous to use graduate RTs to boost their qualified workforce. I believe this practice is not optimal.

I hope this feedback is helpful and once again, thank you for this opportunity.

Sincerely,

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