The Medical Radiation Practice Board of Australia is seeking feedback on the draft registration standard:

SUPERVISED PRACTICE

Background Of This Submission

The following submission represents the consensus views from a number of Imaging Operations Managers, Chief Diagnostic Radiographers and Tutor Diagnostic Radiographers from the Melbourne Metropolitan and Victorian Regional Public Hospital System.

Since 1986, Victorian graduates of undergraduate Medical Radiation Science (MRS) courses, and those who have graduated from interstate MRS courses, who wished to practice in the State of Victoria, have been required to complete the twelve (12) month Victorian Intern Program, as defined by the Victorian Professional Accreditation Education Committee (PAEC). This state based Intern Program has since been replaced by the Australian Institute of Radiography's (AIR) National Professional Development Program (NPDP).

Since 2000, undergraduates of Monash University's four (4) year MRS course, have been required to complete a twenty-four (24) week Professional Clinical Placement (PCP) in the final year of their course, in order to be professionally accredited, and registered as a practitioner by the Medical Radiation Practitioner's Board of Victoria (MRPBV).

In 2011, the first class completed a twenty-four (24) month post-graduate Masters Degree in MRS from the Royal Melbourne Institute of Technology. They will obtain provisional registration to practice in the State of Victoria in 2012, and at that time start a twelve (12) month NPDP for general registration.

This represents over 25 years of experience in mentoring, training and assessing diagnostic radiography undergraduates and graduates.

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,

It is our opinion that these under-graduate programs require a post-graduate 48 week supervised practice period and it has been the experience of this group that these clinical skills and professional responsibilities are required of the contemporary diagnostic

radiographer to ensure competency of the individual practitioner, and above all, safety to the general public.

ii. A four year course of study

In Victoria, under-graduates of the four year Monash University MRS course are required to complete a 24 week Professional Clinical Placement (PCP), in their fourth year, in order to obtain general registration to practice in this state.

It is clear that clinical hours are the foundation on which quality supervised clinical practice is based upon. Having experienced the individuals who have undergone both types of under-graduate working within the same clinical imaging environment, it would generally considered that the structure of a 24 week PCP within the four year degree prepares the under-graduate for a mediated entry into the workforce as well as the three year under-graduate, with a structured NPDP.

iii. **A two year post-graduate course of study**

In Victoria, students from Royal Melbourne Institute of Technology (RMIT) have completed this form of diagnostic radiography program, with the initial group graduating at the end of 2011. It is our opinion that these post-graduate programs require a **mandatory** 48 week of supervised practice period **after** graduation.

Whichever course is being undertaken the Medical Radiation Practice Board of Australia (MRPBA) will need to be satisfied that the registrants have achieved the level of skill required of a beginning independent practitioner as defined by the Board. This must be achieved by a **post-graduate** 48 week of supervised practice for a three year course, or two years Master's course of study, or a **minimum** of a 24 week placement in the final year of a four year under-graduate MRS course.

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

Given that the profession is moving from state based registration boards or no registration in some states, to mandatory national registration, the term "fitness to practice" will need to be defined by the MRPBA. The major issue for the Board is that there are inconsistencies across the country. Beginning practitioner's skill will vary from state to state and different standards apply to "return to work" practitioners, as well as required criteria for assessment of overseas qualified practitioners. The other issue which will need to be considered is mutual recognition, pertaining to the Trans Tasman Mutual Recognition Treaty.

Once these issues have been addressed, it is our opinion that mandatory clinical competence, professional conduct and compliance should be assessed during the supervised practice, by the following methods.

- Three, six, nine and twelve months assessment reports conducted by supervising practitioners / Tutor Radiographers. The assessments should cover all the prescribed competencies and professional conducts in a clear and concise manner, to enable administration time to be kept to a minimum.

- There should be a prescribed portfolio of evidence / events which shows compliance with both professional conduct and regulatory standards, with face-to-face discussion on general professional conduct and development.
  .
- There should be regular monitoring pertaining to the attainment of prescribed competencies, with direct feedback on the clinical competencies achieved.

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

This can only be achieved by having a set national standard of clinical evaluation. The Board in conjunction with the profession need to establish what the clinical practice expectations of the beginning practitioner.

To achieve consistency within a supervised practice program, there needs to be a well structured system in place with accurate and defined criteria which will need to be met. There will need to be core areas (imaging modalities and tasks) that are required for mandatory participation, and the subsequent assessment criteria. This will ensure that no matter what clinical setting the supervised program takes place in, core minimum requirements are met. The accredited supervising practitioner / Tutor Radiographer needs to be available to oversee the program at each site. They should be able to receive feedback on the participant's progress throughout the program, and make any changes or recommendations as required.

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

While the level and extent of supervision will depend on the skill level of the provisional registrant, (and we include the fourth year of a four year MRS under-graduate in this category), the system should allow for very direct supervision early, but offers the flexibility to relax the level of supervision as the provisional registrant develops during the period of supervised practice.

Supervision needs to be dynamic, as the needs of the provisional registrant in a supervised department change. It is our opinion that they must be supernumerary within an imaging environment.

It should fall to the profession, in conjunction with the Board, to make a determination of the clinical expectation of the provisional registrant, which could then in turn lead to a common denominator for clinical experience and supervision.

The Board must also give explicit definitions of both "Direct Supervision" and "Indirect Supervision", and where they apply in the areas of advanced imaging modalities.

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

As mentioned in the previous answer, the Board must define the concept of both “Direct Supervision” and “Indirect Supervision”, as these statements will essentially define these supervision ratios.

It is our opinion that these ratios, will also directly depend on the modality the supervised practitioners are being exposed to. For example, more supervision is required in the modality of Magnetic Resonance Imaging, or Digital Subtraction Angiography, as compared to plain film radiography.

In essence, a direct ratio of 1:1 would be acceptable for plain film radiography, with at least three qualified practitioners in the imaging department at all times.

If the modality is considered more sophisticated, then a workable ratio of two (2) supervising practitioners to one (1) supervised practitioner, would be considered suitable.

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

All major public hospitals within Victoria, are required to provide a 24/7 imaging service, which will consist of dedicated “out-of-hours” shifts, as well as the provision of an “on-call” services, for a variety of procedures.

It should be noted that diagnostic radiographers are one of a handful of health professionals who are required to provide imaging services in areas of sole practice either in rural areas, or small suburban practices.

Within a dedicated “out-of-hours” shift environment, if a supervised provisional registrant has met all the requirements in the core imaging areas, within a six month period, then they should be able to be rostered on to “out-of-hours” shifts, alongside two (2) qualified / supervising practitioners.

It is our opinion that there is no “Direct or Indirect Supervision” provided for the supervised practitioner, within an “on-call” environment. As a consequence, there are no circumstances where a supervised practitioner should be placed in this situation. There is a distinct possibility that this practice can be open to abuse and used to alleviate operational / staffing issues, rather than providing a quality clinical experience.

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

It could be argued that an appropriately registered, newly qualified practitioner should have sufficient knowledge and skills to supervise otherwise they should not be registered. They will however need to have a good understanding of the teaching program, the clinical competencies, and assessment methods required to supervise these provisional registrants.

As mentioned, in previous answers, there are imaging modalities of varying sophistication. It is our opinion, that the more sophisticated the modality, such as MRI and DSA, will require the supervising radiographer to have to have significant clinical experience, potentially combined with a post-graduate qualification.

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

Supervised practice is essential for a mediated entry into the workforce, and it is the concept of supervised practice requirements that prepares the individual for general registration. These requirements demand the achievement of competencies in all core areas of diagnostic imaging.

It is a fact that over the years, feedback from recently registered graduates indicate, that supervised practice requirements significantly improve the transition from the MRS under-graduate course to the realities of the workplace.

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

The main advantage of a supervised practice program is the ability for participants to put into practice the theory they have learnt whilst at university. A structured, supervised program, allows for consolidation of clinical skills for participants. Clinical placements throughout the course allow for some practice within the course, but the supervised program will consolidate all skills and prepare participants for entry.

Other advantages include the following;

- Provides a “safety net” for new graduates that address any clinical skills omissions that may have occurred during undergraduate course.
- Allows for “face to face” learning.
- Provides the opportunity for graduates to learn suitable patient engagement skills and multidisciplinary communication techniques
- Provides opportunities for remedial action with progressive assessment
- Potentially increases the retention of valued participants of supervised practice
- Introduces graduates to a structured form of Continuing Professional Development at beginning of career
- Enhances standards of professional practice
- Ensures graduates meet public protection obligations of the National Bill.
- Formalises and provides direction for employers
- Accreditation of centres provides employers with a competitive recruitment advantage
- Improves radiation safety standards for patients
- Reduces potential for litigation
- Enhances engagement of experienced workforce in the education and training of new graduates

The main disadvantages of implementing and maintaining a supervised practice program is as follows:

Within Victoria, it is seen that a successful supervised program does require a dedicated clinical educator / Tutor Radiographer, who in turn would require time to carry out administrative and supervisory tasks of the specific program. This requirement may be seen a disadvantage to some, as there will be a financial or cost factor associated with this.

Other disadvantages include:

- Results of a supervised practice program may be subjective due to human factors.
- General registered staff have to constantly supervise provisional registrants.
- Difficult and / or unresponsive provisional registrants.
- There is a cost in time resources and in service delivery to each imaging department.
- Funding will need to be found to run such a supervised practice program.

One option is to have the required supervised practice period included in the four (4) year undergraduate program, where it is regulated by an external accrediting authority. This would need to be a minimum of 24 weeks in the final year and have prescribed competency milestones. There would need to be contractual obligations between the university, the workplace and the accrediting authority. This would enable the Board to be reassured that a minimum set of clinical skills have been obtained by the graduate. This graduate should then be given provisional registration for that period determined by the Board to ensure the public protection elements of the legislation are met and that the practitioner is ready to accept the professional and ethical responsibilities of sole practice.

j) Alternative structures of supervised practice that address:

i. Reducing costs on healthcare and workforce

Alternative structures of supervised practice largely depend on if all of the educational institutions are going to collectively move to a four (4) year under-graduate course or if they remain with a three (3) year under-graduate course.

If there is a significant national move to a four (4) year under-graduate course, then there would be a transition to a supervised practice program to within the undergraduate course which would provide reduced costs, as undergraduates would not be part of the paid workforce but provide significant assistance toward the end of their training.

Please note.
At present in Victoria, under-graduates of the four (4) year Monash University MRS course, who are required to complete a 24 week PCP, in their fourth year, **receive the payment of award rates** as prescribed by the State Enterprise Bargaining Agreement.

There are also other areas of supervised practice that will need to be addressed.

- Clinical practice which will be required for “non-practicing” general registrants who have been out of the workforce for a period of time. The Board will need to decide just how much clinical time, with appropriate evaluation is required, and whether this clinical time should also be associated with some standardised theoretical subjects, to enhance the individual’s knowledge.

- There will need to be a form of clinical practice to assess the competency of foreign radiographers, whose qualifications are not deemed equivalent to the national standard. A structured supervised program will be required to assess if these individuals have or develop clinical skills in keeping with their perceived skills not sometimes apparent by the academic evidence.

ii. Increase workforce access and flexibility

Scholarships could be directed to accredited centres where workforce demand warrants such assistance, and in regional centres around the country, a Viva Voce system via an audio visual environment could be established whereby provisional registrants would have the opportunity to explain what they do and demonstrate their clinical reasoning by simply providing evidence of knowledge, listing facts or recalling protocols.

Graduates are then workforce ready/registrable on completion of their supervised practice program.

iii. Provide consistent, measurable clinical outcomes

It is our opinion that both the profession along with the educational institutions should provide input into the supervised practice model. These types of models have been successfully implemented on a State level, with the Victorian Intern program, and more recently, the supervised practice model, implemented by the Medical Radiation Technologist Board of Queensland

Educational institutions are well versed in developing consistent / measurable outcomes. While the profession is well positioned to measure clinical skill, it is a skill which can be open to inconsistent measurement, given the differing levels of supervised practice models which have traditionally varied in the past, from state to state.

In reality, the Board needs to ensure that **a healthy balance** exists between the number of graduates from universities, and positions available for the supervised practice model.. A healthy model would incorporate a well structured supervised program, with clear core areas and requirements, and ensure that **all** participants of the supervised program have equal opportunities within a medical imaging department. This will ensure a consistent stream of emerging qualified radiographers who have met all requirements and tasks as set by the supervised practice model, and are therefore ready to enter the workforce.

In conclusion, it is our opinion that one of the biggest risks facing the Board will be the tendency that the expected level of clinical skill of the new registrant will sit at the **lowest common denominator**.

It is well recognised that some states still have a very hierarchical approach to clinical practice and the Board risks setting expected clinical practice for new registrants back at the levels before a Professional Development Year was introduced nationally. We believe this will significantly harm the profession in the future.

We would strongly suggest that the present Victorian model would be appropriate. It follows the medical model in that provisional registrants have practical clinical experience in all aspects of their profession. Over this period, and at a point in time, they will need to be independent practitioners in some areas. They will gain the ability to undertake “routine” examinations in more specialised areas (such as CT) and be exposed to advanced clinical practice in areas such as DSA and MR.

We are also of the opinion that within the supervised practice model that presently exists in the State of Victoria, both clinical learning and practice along with staffing supervision ratios above the recommended level provide a stable and supportive environment to undertake clinical practice. However, it is doubtful as to whether the provisional registrant, who then receives general registration, at the end of this program, is able to immediately practice as a sole practitioner, in a one-man department within rural Australia.

We thank you for considering the above submission.

Stuart Baum

Chief Radiographer

Royal Melbourne Hospital

Melbourne Health, City Campus

Mark Burgess

Chief Medical Imaging Technologist

Diagnostic Imaging, Monash Medical Centre, Southern Health

Allen Burton

Radiographer Manager

Austin Health, Melbourne

Brendan Carroll

Tutor Radiographer

Royal Melbourne Hospital

Melbourne Health, City Campus

Ben Grinsted

Tutor Radiographer

The Alfred Hospital, Melbourne

Bruce Harvey

Tutor Medical Imaging Technologist

Barwon Medical Imaging, Geelong Hospital

Stephen Lacey

(Dip. of Education, La Trobe University)

Tutor Medical Imaging Technologist

Royal Children's Hospital, Melbourne

Alan Malbon

Chief Medical Imaging Technologist

St. Vincent's Hospital, Melbourne

Olasunbo Olalere

Chief Medical Imaging Technologist,

Goulburn Valley Health, Shepparton.

Peter Rouse

Director of Operations

Eastern Health Medical Imaging.

Adam Steward

Tutor Radiographer

Western Health, Footscray

Gillian Tickall

Chief Radiographer

The Alfred Hospital, Melbourne

Greg Trypis

(Dip.of Education, Melbourne University)

Tutor Medical Imaging Technologist

St. Vincent’s Hospital, Melbourne