Australian and New Zealand Society of Nuclear Medicine Limited

ABN: 35 133 630 029

22 July 2013

Mr Adam Reinhardt
Executive Officer
Medical Radiation Practice Board of Australia
GPO Box 9958
Melbourne VIC 3001

Dear Mr Reinhardt

Proposed Supervised Practice Guidelines for Medical Radiation Practice

On behalf of the Australian and New Zealand Society of Nuclear Medicine (ANZSNM) we wish to provide comment and feedback on the proposed Supervised Practice Guidelines for Medical Radiation Practice and responses to the questions for consideration by interested parties.

Regards

Liz Bailey
President
ANZSNM

Regards

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Submission on behalf of the Australian and New Zealand Society of Nuclear Medicine (ANZSNM)

Draft Supervised Practice Registration guidelines for medical radiation practitioners of the Medical Radiation Practice Board of Australia (MRPBA)

Introduction:

The ANZSNM is the national professional organisation representing professionals from all disciplines involved in the field of Nuclear Medicine. It is the current professional body for Nuclear Medicine Technologists/Scientists in Australia, with approximately 80% of working practitioners being members, and these form the ANZSNMT.
For over 20 years, the ANZSNM has provided a supervised practice program for practitioners prior to being granted full accreditation as a Nuclear Medicine Technologist/Scientist. With the transition to a National Board, the ANZSNM and ANZSNMT recognize the need for greater transparency and the issues outlined in the draft standard. Although our preferred option is for things to remain "As is", we understand this may not be possible. With this in mind, the ANZSNM would be happy to continue work with the MRPBA to provide a Supervised Practice Program that helps to produce fully qualified Technologist/Scientists with world's best practice.

Answers to Supervised Practice Guidelines:

Question 1

Are the principles of supervised practice suitable?

There are two areas of the principles which we have concerns about:

a) Practitioners are expected to determine the parameters for their learning through their supervised practice year. We understand that in an adult learning environment the practitioners should be able to take some responsibility in working with their supervisor to create a structured program. However for the new graduate to take full control or ownership of this process could be quite a daunting thought and is inappropriate for them to advise staff senior to them on how they want to learn, what they want to achieve and when. Limits of their competence should be set by the workplace supervisor by developing a departmental training plan and not by the individual;

b) This relates to point 5: '*The principal supervisor accepts a professional responsibility to the Board to properly supervise the supervised practitioner. The supervisor remains responsible for the clinical care or oversight of the clinical care, provided by the supervised practitioner'.* This clearly implies that the supervised practitioner does not take any responsibility for any actions and shows no accountability for unprofessional or inappropriate behaviour, especially in regards to patient care, and that the principal supervisor is ultimately responsible for their actions. This goes against the expectation that on successful completion of the university course that the graduate has been provided the skills and knowledge base to be responsible for the clinical care of a patient. Has the MRPBA considered the implications to Professional Indemnity Insurance for Principle Supervisors if they are taking professional responsibility for the actions of a junior practitioner, even if that practitioner does not follow the correct protocols or specific instructions.

Question 2

Do the principles provide sufficient capacity to supervise and assess practitioners in a range of clinical settings?

The great flexibility in the principles of the supervised practice program will allow capacity to supervise in a wide range of clinical settings. It is this flexibility however that does not allow for control, structure and standardisation of training across departments and the states.

Question 3

Are the levels of supervision adequate?

Overall we feel that the levels of supervision are adequate. However we are more troubled by the lack of definition of timelines where a provisional practitioner would progress to the next level. Also by having no form of timeline to follow it is hard to determine what justification would be required to progress the provisional practitioner to the next level.

Time lines that we suggest are as follows:

Level 1 – 2-4 weeks
Level 2 - 6-8 weeks
Level 3 – 6 months
Level 4 – 9-10 months

Clarity is required on the definition of Providing Clinical Care. Does this relate to roles that do not specifically involve patient contact, such as preparation of radiopharmaceuticals?

Question 4

Do the guidelines adequately describe the responsibilities of the supervised practitioners?

Below is highlighted the responsibilities and our major concerns:

a) *'Identify a suitable position and principal supervisor to enable them to undertake and complete a supervised practice program'* - It is not an acceptable option to take the responsibility of determining the supervision structure away from the departments. This allows for the provisional practitioner to choose someone that they would like to be their supervisor rather than someone who has a suitable level of experience and expertise in supervising. If this method of determining supervisors is used, it could potentially impact on the skill set of the workforce as new graduates will not be exposed to the same level and variety of procedures as currently required in the existing PDY program run by the ANZSNM. Assessments should be performed by an appropriately skilled supervisor with a structured timeline of training and exposure to specific procedures. This would include *establishing at the outset, in conjunction with the principal supervisor:*
    i. *their learning needs;*
    ii. *the context relevant to the need for supervision, and*

iii. *any other issues that may affect an effective supervisory arrangement*

These should have set standards which should need to be followed.

b) *If trained overseas, participate in an orientation or introduction to the Australian healthcare system and be informed on culturally appropriate care.*

What is the level of knowledge required? Each state has different structures to their Health Care Systems which then fall under the Medicare system. There are also significant differences to the structure of Public versus Private healthcare systems. Do they need to know both? Is there a specified course that they can participate in or a specific syllabus to follow?

c) *Notify the National Board within seven days if a principal supervisor is no longer able to fulfill their obligations and report on whether an approved alternative supervisor can take on the principal supervisor role. Supervised practitioners are required to* ***immediately cease practice*** *if a supervisor cannot fulfill his or her responsibilities and alternative arrangements are not available.*

The process of finding replacement supervisors should not be left up to provisional practitioners as supervisory structures should be dictated by departmental hierarchy and be assigned to specific position specification in department. If that position is vacated, it will be filled by another person. The provisional practitioner will need to notify AHPRA of the change however making them cease practice immediately if no supervisor has been nominated is detriment to the practitioner and department, both financially and professionally. And is this an inappropriate expectation.

Question 5

Do the guidelines adequately describe the requirements and responsibilities of supervisors and principle supervisors?

The requirements for supervisors seem adequate. We feel as has been mentioned previously in this response that the following statement puts the supervisor at risk:

'Take responsibility for the practice carried out by the supervised practitioner as well as for their own practice'

At some point during their supervised practice period, the provisional practitioner must take professional responsibility for their own actions and processes.

The requirements for principle supervisors have provided some points of concern, as outlined below:

a) *Have held general registration for at least one year.*

After 1 year of practice, the principle supervisor will not have gained professional maturity that is required to develop a supervised practice program and guide the provisional practitioner as required by AHPRA and the profession. We suggest that this should be a minimum of 3 years. Has the MRPBA developed a checklist of requirements to be a supervisor or is the only requirement that you hold full registration?

b) *Hold a position which is at the same, or higher, classification/remuneration level or responsibility as the supervised practitioner's position.*

A minimum standard should require that the principle supervisor be at least a level higher than the provisional practitioner. The principle supervisor needs the confidence, experience and knowledge base to be able to supervise, they cannot be checking with someone else if they do not know.

c) *If proposing to be responsible for more than one practitioner requiring supervision, identify additional supervisors to ensure that there is at least one supervisor for every supervised practitioner at all times*

This really is defined by the regulations that will set the number of supervised practitioners that are allowed in each department. What would happen in the current PDY program for the ANZSNM is that in particular in a large teaching hospital there would be one principle supervisor which in most cases would be the Chief Nuclear Medicine Technologist / Scientist or Senior Clinical Educator position. Then staff with adequate experience would be in roles as supervisors. The number of PDY's would depend on the number of available supervisors and the specified ratio required. This process has been successful over the years.

d) *Ensure that the supervised practitioner is provided with a practice induction/orientation program which, when necessary (such as overseas qualified practitioners or practitioners returning to practice), includes an overview of the health system in Australia*

The same problem arises as mentioned before, that there needs to be a specified course to teach this or at the very least a minimum syllabus for this to be taught either as a formal training course or informally as part of the induction program for the provisional practitioner.

e) The section on skills and experience of Supervisors is acceptable as they are only recommendations. In order for the society to provide full comments on this regulation, the Clinical Supervision Resources should be provided on the website to allow interested stakeholders to review.

Question 6

Are the requirements of the supervised practice plan appropriate?

Without being provided with the example supervised practice plan, it is difficult to judge the requirements. Please provide the requested document and we will happily provide feedback. From what we can understand the plans will be quite vague and open for interpretation. Outlining well defined examples which are specific for each area should be represented by the MRPBA. These examples should have a minimum requirement to cover the areas included in the Professional capabilities for Medical Radiation Practice Document.

Our concern is that there is too much flexibility in the potential structure of the plan therefore allowing the supervised practitioner to complete their supervised practice year without being exposed to the full range of nuclear medicine procedures and skills required to develop the qualities needed to become a professional, highly valued nuclear medicine technologist/scientist in the workplace.

Question 7

Should supervised practitioners be able to provide on-call services?

Yes. They should be able to provide on–call services after 6 months. Their supervision would be from the Nuclear Medicine Physician or Radiologist on duty. Thus the Nuclear Medicine Physician or Radiologist must be on site throughout the duration of the procedure and they must be fully qualified, not at registrar level.

Question 8

Do the guidelines adequately describe the assessment reporting requirement?

Once again this is hard to judge because we have not been provided with the example reporting structures. It is felt that the assessment reporting requirements should have certain standards, which are as follows:

- Set reporting documents which are stream specific;
- Set times for reporting documents to be filled out and returned to MRPBA;
- The final report clearly shows the progression of the supervised practitioner through the levels defined in this document.

Question 9

Are the definitions appropriate?

Definitions supplied are suitable, however there needs to be a clear definition of what providing clinical care means. There are roles performed in Nuclear Medicine that do not require specific interaction with the patient, for example morning Camera Quality control procedures and Laboratory procedures. However if mistakes are made in these processes they can have a major impact on providing patient care.

Question 10

What are the likely impacts of this proposal on individual registrants?

The effects of this proposal can be felt by all involved in the process of supervised practice. Supervised practitioners could potentially receive inadequate training as a result of a supervised practice plan that has not been designed to cover all the necessary areas to become a competent medical radiation practitioner. The supervisors will need to take on greater responsibility and may potentially be held accountable for incidents which they were not directly involved in and have provided sufficient direction to avoid.

Question 11

Are their jurisdiction-specific impacts for practitioners, or governments or other stakeholders that the national board should be aware of, if these guidelines are adopted?

Those working in rural and remote settings require special consideration. Access to the same level and breadth of nuclear medicine practices may not be possible from a single site. In this circumstance, the practice will need to gain access to larger facilities so as to expose the supervised practitioner to the same broad range of skills as provided in the metropolitan setting.

Question 12

Is 1st November 2013 a suitable date for if these guidelines adopted?

This appears to be a tight timeline as there are still some forms and examples relating to this guideline that don't appear to have been produced. We anticipate there will need to be a consultation process around these forms and examples.

Question 13

Are there implementation issues the National Board should be aware of?

What will happen to provisional practitioners who are currently enrolled in a PDY program for the ANZSNM or AIR that will finish their PDY year after the adoption date? Will the professional associations still be responsible for these trainees or do they have to start a new supervised practice program for the remainder of their supervised practice period?