Response template for providing feedback to public consultation – draft revised professional capabilities for medical radiation practice

This response template is an optional way to provide your response to the public consultation paper for the **Draft revised professional capabilities for medical radiation practice.** Please provide your responses to any of the questions in the corresponding text boxes; you do not need to answer every question if you have no comment.

Making a submission

Please complete this response template and send to medicalradiationconsultation@ahpra.gov.au, using the subject line '*Feedback on draft revised professional capabilities for medical radiation practice*'.

Submissions are due by midday on Friday 26 April 2019.

Stakeholder details

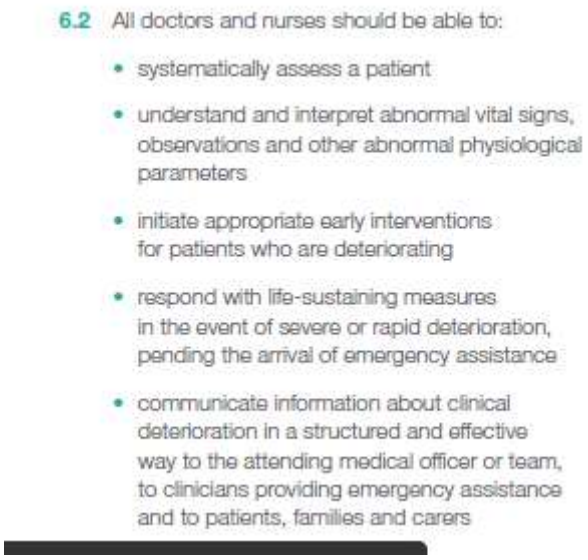
Please provide your details in the following table:

Name:	Carole Brady
Organisation Name:	Radiation Oncology Princess Alexandra Hospital (Raymond Terrace Campus)

Your responses to the preliminary consultation questions

1. Does any content need to be added to any of the documents?

2. Does any content need to be amended or removed from any of the documents?
I believe the National Standard has been misinterpreted and that Medical Radiation Professionals are NOT referred to in the National Standard for the level of what is being presented by the MR Board. Ie. Proposed changes I am referring too. Medical radiation practitioners are expected to be able to respond to a deteriorating patient and: - make a reasonable assessment of a patients' physiological status - understand and interpret abnormal vital signs, observations and other abnormal physiological parameters - initiate appropriate early interventions for patients who are deteriorating - respond with life-sustaining measures (basic life support) in the event of severe or rapid deterioration, pending the arrival of emergency assistance, and - communicate information about clinical deterioration in a structured and effective way to the attending medical officer or team, to clinicians providing emergency assistance and to patients, families and carers. At a minimum, medical radiation practitioners must be able to interpret and identify abnormalities with the following physiological parameters: - respiratory rate - oxygen saturation - heart rate - blood pressure - temperature, and - level of consciousness As written in the National Standards, excerpt from page 15 under the heading of 6. Education (below).



6.2 All doctors and nurses should be able to:

- systematically assess a patient
- understand and interpret abnormal vital signs, observations and other abnormal physiological parameters
- initiate appropriate early interventions for patients who are deteriorating
- respond with life-sustaining measures in the event of severe or rapid deterioration, pending the arrival of emergency assistance
- communicate information about clinical deterioration in a structured and effective way to the attending medical officer or team, to clinicians providing emergency assistance and to patients, families and carers

Please note that there is NO indication that this level of training be mandatory for AH professionals and in particular Medical Radiation professionals. This level of training would require significant training both at university and maintained by the organisations and MRPs once qualified. As the Board is well aware, and based on the same principles for Advanced Practice, skills are maintained through ongoing practice of those skills. The daily routine work of a MRP does NOT include frequent use of these skills and unfairly exposes the MRP to legal action should an incident arise. I am not advocating that MRP's do not have a responsibility to recognise and act promptly to a patient they recognise as acutely deteriorating (CPR/Met call), the point I am making is that the skills and equipment required to determine the patient's state of current health is NOT available to the MRPs in the workplace NOR is it viewed by other disciplines (Doctors and Nurses) to be within our scope of practice. All the MRP has available to them are patient notes (not guaranteed to be timely) and physiological cues that can be observed.

Adding to this issue is that there is currently NO reasonably accessible program that could be accessed annually (like CPR) in order for MRPs to gain and then maintain the skills the Board has listed.

To summarise, it is NOT made clear in the National Standards under *1. Measurement & documentation of vital signs and other observations* which professions/disciplines are required to measure the vital signs of the patient. However, this is made clear in *Section 6. Education* (see excerpt above).

I believe *Domain 1, Point 7 – Deliver patient/client* care note below should be removed or clarified to reflect competency in basic life support and skills and knowledge of rapid response and escalation protocols and nothing more.

Domain 1, Point 7 note 1:

Recognising and responding to a patient's/client's deteriorating condition must be consistent with the *National consensus statement: essential elements for recognising and responding to clinical deterioration.*

In addition to this, the following excerpt below (Domain 1, Point 7, note 2) requires clarification as the knowledge required to cover the extent of possible abnormal changes is well in excess of knowledge of common abnormal changes. Remembering that this is document if for the Threshold level, please consider that it is not reasonable at Threshold level to identify urgent and unexpected findings when the patient has undergone a neck dissection or surgery to remove or remodel

abdominal organs after a Whipple procedure, or identifying urgent findings in a patient with extensive disease as a result of systemic metastases. The wording below seems simple but has far reaching implications if this is not addressed. The statement below is far outside the scope of a Threshold practitioner and should not be included as it stands.

Domain 1, Point 7 Note 2:

Identifying urgent and unexpected findings includes recognising and applying knowledge of normal from abnormal imaging appearances and relating appearances to the patient/client's clinical history.

Domain 1, Point 8 Apply knowledge of safe and effective use of medicines to practice. Subpoints a-e would require extensive knowledge of pharmaceuticals and MRPs are not trained pharmacists nor do we have the facility to upskill ourselves with all new medications that come onto the market. In radiation therapy a lot of this knowledge is obtained in practice over much time and even though I have 30+ years of practice and hold a Masters, I believe I would fall sadly short of the expectations of the Board as it is currently written. Point c should not be included in RT in particular. It may be relevant for Nuc Med and MIT. It may be better to remove it from the General list and put it into each of these discipline specific capabilities instead.

Domain 3, Point 1 – Communicate clearly, sensitively … I do not understand the purpose of this note within this domain. Are you saying it is OK if these barriers exist? I hope not, as we all have to be mindful how these can influence our actions and to act on the patients behalf irrelevant of our own beliefs. This statement needs clarification as it is just a statement and does not indicate what to do about these barriers or what the Board expects of the practitioner in these cases.

Note:

Communication barriers may arise due to the medical radiation practitioner's own culture and experience affecting their interpersonal style, or due to the patient's/client's or family's/carer's culture and experience. The patient's/client's or family's/carer's capacity to understand may be influenced by English language skills, health literacy, age, and health status.

3. Do the key capabilities sufficiently describe the threshold level of professional capability required to safely and competently practise as a medical radiation practitioner in a range of contexts and situations?

No, I believe that there are points already raised in this document that I believe are expectations that are well above the level of threshold capabilities knowledge and skill.

Not sure how the below statement can be met by overseas trained MRPs looking to have their qualifications evaluated so they can work in Australia.

Also not sure how this can be measured in the workplace if, during an SPP or clinical placement, there are NO Aboriginal or Torres Strait Islander peoples on treatment.

> **Cultural safety** is defined by the National Scheme's Aboriginal and Torres Strait Islander Health Strategy as the individual and institutional knowledge, skills, attitudes and competencies needed to deliver optimal healthcare for Aboriginal and Torres Strait Islander Peoples.

I believe if the above statement is to be included, that the MRPBA ensure that some mechanism is in place for an overseas applicant to meet this aspect of the threshold capabilities.

4. Do the enabling components sufficiently describe the essential and measurable characteristics of threshold professional capability that are necessary for safe and competent practice?

5. Is the language clear and appropriate? Are there any potential unintended consequences of the current wording?

Not always. See previous notes in other sections.

6. Are there jurisdiction-specific impacts for practitioners, or governments or other stakeholders that the National Board should be aware of, if these capabilities are adopted?

I believe that there are capabilities within this document that the medical, nursing and pharmaceutical professions would consider to be well outside of an MRPs scope of practice the way it is currently written. Refer to my previous entries.

The largest implication is for all the MRPs currently working under the current set of capabilities. There are no easily accessible CPD activities that could upskill the workforce in a timely manner or assist the MRP maintain the new level of skill and knowledge the Board is proposing. This will expose the entire workforce to personal legal suits that would not otherwise be forthcoming. I appreciate that the profession needs to maintain currency however I do not believe the changes, especially to my first point (ie. Medical radiation practitioners are expected to be able to respond to

a deteriorating patient ….) is required as it does not reflect the sentiment or wording of the National Standards.
7. Are there implementation issues the National Board should be aware of?
8. Do you have any other general feedback or comments on the proposed draft revised professional capabilities?