Ahpra Board
Accreditation Committee

Guidance on embedding good practice in clinical placements, simulation-based learning and virtual care in initial student health practitioner education

April 2024

Statement of advice

Context

This paper provides good practice guidance on three elements of learning in initial student health practitioner education: clinical placements, simulation-based learning and virtual care. These are important and necessary components of every health practitioner's initial education as they help ensure graduates are equipped with the capabilities required for safe and contemporary practice.

Clinical placements provide students with opportunities to turn theoretical learning into practice, and to experience a range of workplace settings. They help students practise their skills and meet required learning outcomes in a supportive environment, with levels of supervision appropriate to the stage of their professional education. Clinical placement is defined by the Accreditation Committee (the committee) as 'the component of a program of study, undertaken with supervision, in a clinical or professional practice environment, which assists students to put theoretical knowledge into practice'[1].

Clinical placements can maximise student learning in a range of ways, including through placements in diverse geographic locations (such as metropolitan, regional or rural locations); a variety of practice settings (such as public/private hospitals, university clinics, primary and community health care, and overseas volunteer programs), and by using different models such as block placements, collaborative placements, and longitudinal integrated clerkships, among others. Exposing clinical placement students to a variety of patients and patient presentations ensures they are well prepared before the placement starts (e.g. travel, accommodation, etc) and experiencing a positive workplace culture is also beneficial to student learning. Clinical placements may influence a student's future choices about professional specialisation, location and area of practice, and can be an opportunity for students to learn and demonstrate cultural safety and inclusivity in a real-world environment.

All health practitioners have an important role to play in supporting the development of the health workforce[2]. Clinical placement supervisors are critical in this regard, and need the knowledge, skills and professional attributes to support good clinical practice as well as the ability to provide teaching, supervising and mentoring to students.

Like clinical placements, simulation-based learning can add significant value to learning for student health practitioners. Simulation-based learning, also called simulation-based education and training, enables students to practise their learning in a safe environment. It is defined by the committee as 'interactive educational methods or clinical experiences that evoke or replicate real-life characteristics of an event or situation as the basis for developing skills, confidence, and problem-solving abilities in a safe, controlled and monitored environment'.

[1] Clinical placements are often called different terms, including work-integrated learning (WIL), work-based learning, professional experience placement (PEP), professional placement, professional experience, work placement, midwifery practice experience (MEP), clinical experience, clinical attachments, practice placements, clinical internship, clinical rotation, clinical observation or experiential learning. For the purpose of this guidance the term clinical placement is used to encompass all of these. For definitions of terms included in the committee's guidance, see the committee's glossary of accreditation terms

[2] Ahpra and National Boards Code of Conduct. June 2022.

Similarly, the evidence shows the importance of including content on virtual care in initial student health practitioner education curricula. Virtual care is defined by the committee as 'any interaction between consumers/patients/clients and members of their care team occurring remotely, using technology with the aim of facilitating or maximising the quality and effectiveness of consumer/patient/client care'.

Health care is rapidly evolving. Health practitioner education must also evolve to reflect changing community needs and expectations. Clinical placements, simulation-based learning and education in virtual care are central to a student health practitioner's education to ensure they have the capabilities required for future practice.

Development of the guidance

The role of National Scheme entities (National boards, accreditation authorities and the Australian Health Practitioner Regulation Agency (Ahpra)) is to help protect the public by regulating Australia's registered health practitioners and setting standards and policies they must meet.

This guidance was developed by the independently-chaired Accreditation Committee (the committee), which was established by Australian health ministers in 2021. As outlined in the Ministers' Policy Direction, the committee was established to give expert advice on accreditation reform and other National Scheme accreditation matters to National Scheme entities (National Boards, accreditation authorities and the Australian Health Practitioner Regulation Agency (Ahpra)).

At the time of its creation, one of the priority issues referred to the committee by ministers was the development of advice to support good practice, in clinically-relevant placements in a variety of settings, geographical locations and communities; evidence-based technological advances; and pedagogical innovations in the delivery of programs of study.

This guidance has been developed in line with the ministers' policy direction. The intent of the policy direction is that all National Scheme entities including Ahpra, National Boards and accreditation authorities are accountable for having regard to the committee's advice when exercising their functions for the purpose of the Health Practitioner Regulation National Law as in force in each state and territory (National Law). The policy direction states Ahpra and the National Boards are to document the outcome of their consideration of the advice and accreditation authorities are to document the outcome of their considerations. The policy direction also states other external entities performing accreditation roles as part of the National Scheme, such as specialist colleges and postgraduate medical councils, must also consider the committee's guidance, where relevant.

Purpose of this guidance

This document presents the committee's draft proposed guidance covering three topics that are part of initial student health practitioner education for professions regulated by the National Scheme[3]. These are:

1. embedding good practice in clinical placements
2. the use of simulation-based learning
3. virtual care learning experiences.

The draft guidance provides an overview of evidence-based strategies for continuous improvement of student learning in these settings and activities. It draws on the best available evidence identified at the time of writing. It reflects recent evidence on contemporary and innovative practice in the health and education sectors globally and leading practice by some accreditation authorities in the National Scheme.

The committee acknowledges that research in some areas is rapidly advancing and there may be some information that would be valuable but has not been possible to include. The document 'Information paper: good practice approaches to embedding clinical placements, pedagogical innovations and evidence-based technological advances in health practitioner education' sets out the evidence the committee has used to develop this guidance and is available on the 'publications' section of the committee's webpage. The information paper may be a valuable resource to support implementation of the guidance.

[3] The National Scheme regulates 16 professions, including Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental, medicine, medical radiation practice, nursing and midwifery, occupational therapy, optometry, osteopathy, paramedicine, pharmacy, physiotherapy, podiatry and psychology.

The primary audience for this draft guidance is National Scheme entities, and in particular the National Boards and accreditation authorities. The committee envisages that accreditation authorities will use this guidance in undertaking their accreditation functions, for example, when developing and reviewing accreditation standards, when assessing education programs against those standards or providing guidance to education providers on good practice in this space. National Boards can also use this guidance when approving accreditation standards and approving accredited education programs.

Some of the statements in the guidance may directly relate to assessing programs, while others are more general ‘good practice’ statements that could, for example, be included in an evidence guide. Accreditation authorities can determine how they best apply this guidance to program assessment.

The committee is aware that, for some professions, the accreditation standards and other guidance documents, and the education providers they apply to, may already meet aspects of the good practice guidance outlined in this document. In other professions, this guidance will assist in achieving the same outcomes. In either case, it is anticipated that all accreditation authorities could use this document in their work with education providers and in guiding continuous improvement in initial student health practitioner education.

Beyond the National Scheme, the committee hopes the guidance will be useful for accreditation authorities and education providers in self-regulating professions.

It is anticipated that this guidance, and the evidence that underpins it, will be reviewed every five years or earlier, if required.

Professor Andrew Wilson AO
Chair

Guidance

This good practice guidance covers three topics that are part of initial student health practitioner education. These are:

1. embedding good practice in clinical placements
2. the use of simulation-based learning
3. virtual care learning experiences.

What is 'good practice'?

The committee considered how best to describe the statements in this guidance, including whether the guidance was 'good practice' or 'best practice', as these terms are often used interchangeably, along with the terms 'evidence-based practice' and 'emerging practice'.

'Best practice' suggests that one strategy/approach, proven by research/evaluation, is most effective at achieving a desired outcome[4]. 'Good practice' is one of many strategies/approaches that has been proven to work well and achieve good results. However, these terms are still being formally defined from a health care perspective[5].

For the purpose of this guidance, when the committee uses the term 'good practice' it means a strategy/approach that is:

Methodology for the development of the guidance

In developing this guidance, the committee has purposely used high-level evidence (such as systematic reviews, meta-analyses, etc) wherever possible, and focused on professions in the National Scheme.

The majority of this evidence comes from the largest professions – medicine and nursing. However, in some cases the committee has used moderate level evidence (such as scoping and literature reviews) to ensure the guidance reflects the evidence available for other professions in the National Scheme. Low level evidence, such as single qualitative studies or case studies, has not been included.

[4] World Health Organization. Guide for documenting and sharing" best practices" in health programmes. InGuide for documenting and sharing" best practices" in health programmes 2008 (pp. 9-9)

[5] Fauci AJ, D'Angelo D, Coclite D, Napoletano A, Gianola S, Ferrara C, Di Nitto M, Gensini G. Exploring the definition and methodology of "best practice" in the health care literature: a scoping review protocol. JBI Evidence Synthesis. 2023 Oct 1;21(10):2134-41.

1. Guidance on embedding good practice in clinical placements

Context

Clinical placements help students translate the theoretical knowledge and skills they learn into practical skills and professional attributes they can apply safely in the workplace. Students value learning experiences in clinical placements that allow them to immerse themselves in the clinical environment, spend time with patients, perform patient assessments, observe other health practitioners at work and develop an understanding of real-world clinical practice and their role within it. They also value placements that enable them to gain independence and confidence and develop skills in communication, critical thinking and reflective practice.

Clinical placements should help students meet their learning outcomes such as clinical skills, communication skills and student confidence and resilience[6]. Providing placements in diverse settings, using a placement model that suits the work context and longer, more continuous placements may enhance student learning from clinical placements.

Clinical placement governance and arrangements should encourage healthcare providers and education providers to collaborate when developing and delivering clinical placements. The quality of clinical supervision, and supporting student health and wellbeing while on placement, are key to enhancing student learning while on clinical placement.

Guidance

Student learning from clinical placements is likely to be maximised when students:

1. experience variety in their placements, including:
    - diverse practice settings (such as primary care, private and public hospitals, residential aged care, prisons etc.)[6,7,8]
    - a diverse range of patients and patient presentations (clinical issues, populations, ages, cultures, etc.)
    - in diverse geographic locations (rural, regional and metropolitan), where possible.[6,7,8]
2. are provided with extended clinical placements in the same setting to allow them to experience continuous patient care and observe the outcomes of treatment, where possible and if benefits to student learning outcomes are likely[9]
3. are provided enough time to participate in clinical placements throughout their program of study to achieve the capabilities they need for safe practice[10]
4. are prepared for their clinical placements, e.g. they receive orientation and induction to the workplace, receive pre-clinical placement information sessions that provide key information on university contacts, clinical environment expectations, resources, etc.
5. are well-supported by, and well-connected to their peers, clinical placement supervisors and colleagues during their placement
6. are provided with opportunities to participate in clinical placement learning activities that:

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[6] Hanna H, Jordan Z, Stern C, Pearce J. Experiences of learning, development, and preparedness for clinical practice among undergraduate paramedicine students, graduate/intern paramedics, and their preceptors: a qualitative systematic review. JBI Evidence Synthesis. 2021 Sep 1;19(9):2052-154.

[7] Brooke J, Rybacka M, Ojo O. 'Nursing student's lived experience of a clinical placement in prison healthcare: A systematic review'. Nurse Education in Practice. 2022:103463.

[8] Keeping-Burke L, McCloskey R, Donovan C, Yetman L, Goudreau A. Nursing students' experiences with clinical placement in residential aged care facilities: a systematic review of qualitative evidence. JBI evidence synthesis. 2020 May 1;18(5):986-1018.

[9] Bonnie LH, Cremers GR, Nasori M, Kramer AW, van Dijk N. Longitudinal training models for entrusting students with independent patient care?: a systematic review. Medical Education. 2022 Feb;56(2):159-69.

[10] Edward KL, Ousey K, Playle J, Giandinoto JA. Are new nurses work ready–the impact of preceptorship. An integrative systematic review. Journal of professional nursing. 2017 Sep 1;33(5):326-33.

- resemble activities they would perform in the workplace as registered practitioners[6]
- are appropriate to their level of knowledge and skill[6]
- address their personal needs (e.g. family/religious requirements, childcare requirements, are culturally safe, etc.)
- align with the learning outcomes of their education program[6]
- are scaffolded to enable the monitoring of student progress from novice to competent practice
- support students to develop resilience[6]
- support students to develop their communication skills, including communicating with patients/families/guardians and carers, as well as interprofessional communication skills[6]
- allow students to collaborate with health practitioners, patients, families, guardians and carers as well as students from other professions

7. are provided with opportunities to consider the feedback they receive from clinical placement supervisors, reflect on their practice and improve their skills[11]
8. participate in peer-assisted learning activities that complement their clinical placement learning/activities[12]
9. learning outcomes and clinical placement performance measured and assessed using clear, fair and equitable assessment criteria, rigorous and consistent assessment methods, and validated assessment instruments, where these are available for the relevant health profession[11,13]
10. attend placements with organisations and in facilities that have the appropriate accreditation, licensing and/or registration for the services they provide, where required by relevant government authorities
11. attend placements with organisations that can facilitate support for their personal needs (e.g. family/religious requirements, childcare requirements, are culturally safe, etc.) as much as possible
12. attend placements where the training facilities, clinical assessor training programs and clinical assessors are quality assured, where relevant
13. participate in clinical placements that align to relevant national, state and territory guidelines and reflect best practice clinical learning environment (BPCLE) frameworks

All health practitioners have an important role to play in supporting the development of the health workforce. Clinical placement supervisors are critical in this regard, and therefore need to be suitably qualified and experienced, both in providing good clinical practice to patients, and in teaching, supervising and mentoring students. Their professional behaviours, attitudes, and attributes, as well as their clinical knowledge and skills, are key in shaping student learning from clinical placements as well as student attitudes towards the placement and their future profession.

To support student learning, clinical placement supervisors should:

1. be trained in clinical teaching, mentoring, assessment and professional behaviours, attitudes and attributes of successful clinical supervisors (where applicable). This includes having the training made available to them, and being able to undertake the training without unreasonable impost on their workload and current responsibilities[6,10,11,14]

[11] Immonen K, Oikarainen A, Tomietto M, Kääriäinen M, Tuomikoski AM, Kaučič BM, Filej B, Riklikiene O, Vizcaya-Moreno MF, Perez-Canaveras RM, De Raeve P. Assessment of nursing students' competence in clinical practice: a systematic review of reviews. International journal of nursing studies. 2019 Dec 1;100:103414.

[12] Sevenhuysen S, Thorpe J, Barker LA, Keating J, Molloy E, Haines T. Education in peer learning for allied health clinical educators: A mixed methods study. Focus on Health Professional Education: A Multi-Professional Journal. 2017 Aug 4;18(2):4-18.

[13] Leighton K, Kardong-Edgren S, McNelis AM, Foisy-Doll C, Sullo E. Traditional clinical outcomes in prelicensure nursing education: An empty systematic review. Journal of Nursing Education. 2021 Mar 1;60(3):136-42.

2. have the capacity to be, and be trained in/familiar with the clinical placement provider and education provider policies, procedures and systems
3. be provided with allocated time, resources, and teaching support to ensure they can be successful clinical placement supervisors to students and support student learning needs and outcomes[15]
4. demonstrate a willingness and ability to support students by[7]:
    - establishing positive, personable and interactive relationships with students[10,14 15]
    - showing respect, patience, kindness and understanding towards students[10,14,15]
    - working closely with education providers, where required
    - being a positive role model to students
    - maintaining professional and ethical standards of practice.
5. provide teaching and mentoring that aligns to both the students' learning goals[15] and program learning outcomes
6. provide progressive and structured learning opportunities that appropriately challenge the student and encourage suitable levels of independence[15]
7. understand external pressures that might impact the student during their placement, e.g. work, study, culturally unsafe environments, caring responsibilities, family responsibilities, cultural and religious responsibilities, financial pressures, etc.[15]
8. be prepared and organised to support the student, where required (e.g. providing information ahead of time, including schedules and structured rotations, and participating in cultural safety training where relevant, providing/directing students to learning resources, etc.)[15]
9. support the same student throughout an entire clinical placement experience where possible, and provide students with opportunities to work with other clinical placement supervisors[6]
10. understand the expectations for student assessment and evaluation[15]
11. provide constructive, regular and timely feedback to students[15]
12. foster a collaborative learning environment between themselves, students and other staff, to create an environment that encourages interprofessional learning opportunities[15]
13. not have any conditions on their registration, either currently or in the preceding twelve months.

Cultural safety in clinical placements

Ahpra, the National Boards and accreditation partners are committed to a health system that is both culturally safe and free from racism[16]. Cultural safety is a fundamental objective of the National Scheme. The National Law now includes the objective 'to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples'[17].

Cultural safety is not new. There is already content in accreditation standards and in health practitioner education. Cultural safety must be embedded in clinical placements to ensure all students have culturally safe experiences that are free from racism. This will help students understand the foundations of providing culturally safe care to Aboriginal and Torres Strait Islander Peoples.

Clinical placements demonstrate cultural safety and elimination of racism when:

1. students receive cultural safety training and support before and during their clinical placement

[14] Tuomikoski AM, Ruotsalainen H, Mikkonen K, Kääriäinen M. Nurses' experiences of their competence at mentoring nursing students during clinical practice: a systematic review of qualitative studies. Nurse education today. 2020 Feb 1;85:104258.

[15] Gibson SJ, Porter J, Anderson A, Bryce A, Dart J, Kellow N, Meiklejohn S, Volders E, Young A, Palermo C. Clinical educators' skills and qualities in allied health: a systematic review. Medical education. 2019 May;53(5):432-42.

[16] Joint statement: Aboriginal and Torres Strait Islander health and cultural safety at heat of National Law changes

[17] Section 3(2)(ca) of the National Law

2. culturally appropriate communication is delivered to health care providers before student placement starts
3. supervision provided to students is culturally safe and inclusive, free of racism and other forms of discrimination
4. clinical placement supervisors understand their influence on students and use this influence in a respectful, measured and fair manner
5. students are believed when they raise concerns about cultural safety, racism, and other forms of discrimination and the placement host takes decisive action to resolve these issues[18]
6. they foster collaborative and culturally safe learning environments that are free of racism and other forms of discrimination

[18] Joint statement: Aboriginal and Torres Strait Islander health and cultural safety at heat of National Law changes

2. Guidance on the use of simulation-based learning

Context

Simulation-based learning has become a common pedagogical tool used in health practitioner education, driven by advances in technology and increasing awareness of patient safety. Simulation-based learning can help prepare students for real-world practice and provide consistent learning experiences in a safe environment. It may also be more convenient for students and can enable them to play an active role in their learning.

Simulation-based learning can enhance students' clinical and non-clinical knowledge[19,20,21] and skills, critical thinking[20,22], psychomotor skills[20], self-confidence[19,20,21] and self-efficacy[20]. In addition, it can support the development of pre-clinical skills and may be more valuable to students if they already have some real-world clinical exposure.

Evidence suggests that simulation-based learning activities for students can be enhanced by a number of factors. These include faculty education and engagement[23,28]; briefing, debriefing and evaluation of student performance[21,23,28] providing realistic and active learning experiences in a safe, high-quality environment[21,24,28]; opportunities for repeated practice and student satisfaction with simulation-based learning experiences[21].

Guidance

Simulation-based learning experiences demonstrate good practice when:

1. They have a degree of realism. That is:
    - they are realistic[21,24] and prepare students for real world practice
    - the degree of realism of the simulation (also called 'fidelity'[25]) is enough to enable the student to learn the capability being taught (e.g. if the student is to learn suturing a low-fidelity part-task trainer may be sufficient)[24]
    - they increase students' exposure to diverse clinical presentations (e.g. chronic disease, urgent or emergency situations, etc.)
    - they are used to complement traditional teaching methods, such as clinical placements[21]
2. they are tailored and scaffolded to the student's level of knowledge, and appropriate to their learning needs and the expected learning outcomes[21,26,27]
3. they are demonstrated to result in greater student satisfaction in their learning[21]
4. they include several different technologies, techniques, modalities and scenarios across the students' education program, enabling them to progress through more complex and more emergent patient presentations[26]
5. the simulation-based learning integrates briefing and debriefing into the simulation activity[21,28]

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[19] Alanazi AA, Nicholson N, Thomas S. The use of simulation training to improve knowledge, skills, and confidence among healthcare students: a systematic review. Internet Journal of Allied Health Sciences and Practice. 2017;15(3):2.

[20] Cant RP, Cooper SJ. Use of simulation-based learning in undergraduate nurse education: An umbrella systematic review. Nurse education today. 2017 Feb 1;49:63-71.

[21] Mulyadi M, Tonapa SI, Rompas SS, Wang RH, Lee BO. Effects of simulation technology-based learning on nursing students' learning outcomes: a systematic review and meta-analysis of experimental studies. Nurse education today. 2021 Dec 1;107:105127.

[22] Larue C, Pepin J, Allard É. Simulation in preparation or substitution for clinical placement: A systematic review of the literature. Journal of Nursing education and practice. 2015 Jun;5(9):132-40.

[23] Asegid A, Assefa N. Effect of simulation-based teaching on nursing skill performance: a systematic review and meta-analysis. Frontiers of Nursing. 2021;8(3):193-208.

[24] Kim YJ, Yoo JH. Effects of Manikin Fidelity on Simulation-Based Nursing Education: A Systematic Review and Meta-Analysis. Journal of Nursing Education. 2022 Feb 1;61(2):67-72.

[25] 'Fidelity' is the degree to which the simulation replicates the real event and/or workplace; this includes physical, psychological, and environmental elements

[26] Chernikova O, Heitzmann N, Stadler M, Holzberger D, Seidel T, Fischer F. Simulation-based learning in higher education: A meta-analysis. Review of Educational Research. 2020 Aug;90(4):499-541.

[27] Watts PI, McDermott DS, Alinier G, Charnetski M, Ludlow J, Horsley E, Meakim C, Nawathe PA. Healthcare simulation standards of best practiceTM simulation design. Clinical Simulation in Nursing. 2021 Sep 1;58:14-21.

6. they promote active learning experiences. That is:
    - they require students to actively participate[21,26,28]
    - they enable students to collaborate with health practitioners and students from other professions[27]
    - they give students multiple opportunities to practice the same task, if possible[21,28]
7. the simulation is delivered using good quality training, facilities and learning resources, including:
    - they are supported by faculty who are trained and equipped to deliver the simulation-based learning activities[28]
    - they are supported by appropriate facilities (including training rooms and equipment)[27]
    - they provide a safe practice environment[21]

[28] Astbury J, Ferguson J, Silverthorne J, Willis S, Schafheutle E. High-fidelity simulation-based education in pre-registration healthcare programmes: a systematic review of reviews to inform collaborative and interprofessional best practice. Journal of interprofessional care. 2021 Jul 4;35(4):622-32.

3. Guidance on the inclusion of virtual care learning experiences

Context

Virtual care[29] has been a regular part of rural and remote healthcare in Australia for decades. More recently it has been progressively introduced and expanded in other healthcare settings, particularly during the COVID-19 pandemic. Virtual care is now part of mainstream healthcare, and health practitioner graduates are expected to have the skills to deliver care virtually. It is therefore essential that health practitioner education programs equip students with the capabilities required for this type of practice.

Evidence suggests several strategies that support student education in virtual care, including:

- having an evidence-based, standardised and staged curriculum
- using a variety of teaching methods and technologies
- providing active learning experiences, opportunities for 'hands-on' practice and experiences with real patients
- providing virtual care training to educators, and
- ensuring education and healthcare providers work collaboratively to design virtual care learning activities for students.

Guidance

Virtual care learning experiences demonstrate good practice when:

1. they are provided to students throughout their clinical education program, where relevant[30]
2. they expose students to a variety of virtual care technologies and processes across their clinical education program[35]
3. they align to the Ahpra and National Boards' Telehealth Guidance for Practitioners and state and territory legislative and policy requirements[31]
4. they are delivered through a standardised and staged curriculum[32,33,34] that includes learning modules on:
    - the fundamentals of virtual care
    - virtual care technology and equipment
    - legal and ethical requirements of virtual care
      analysis of data[35]
    - professionalism[35]

[29] Although the term 'telehealth' is sometimes used interchangeably with the term 'virtual care', it refers to one type of virtual care only, involving a telephone or video-enabled patient consultations. It does not encompass the broader nature of virtual care. For the purpose of this guidance, and unless otherwise specified, the term 'virtual care' is used as it is the most current and all-encompassing term.

[30] Wetzlmair LC, O'Carroll V, O'Malley AS, Murray S. Teleconsultation in health and social care professions education: A systematic review. The Clinical Teacher. 2022 Oct;19(5):e13519.

[31] Australia Health Practitioner Regulation Agency and National Boards. Telehealth guidance for practitioners 2020 [Available from: https://www.ahpra.gov.au/Resources/Telehealth-guidance-for-practitioners.aspx.

[32] Grafton-Clarke C, Uraiby H, Gordon M, Clarke N, Rees E, Park S, Pammi M, Alston S, Khamees D, Peterson W, Stojan J. Pivot to online learning for adapting or continuing workplace-based clinical learning in medical education following the COVID-19 pandemic: A BEME systematic review: BEME Guide No. 70. Medical teacher. 2022 Mar 4;44(3):227-43.

[33] Hart A, Romney D, Sarin R, Mechanic O, Hertelendy AJ, Larson D, Rhone K, Sidel K, Voskanyan A, Ciottone GR. Developing telemedicine curriculum competencies for graduate medical education: Outcomes of a modified delphi process. Academic Medicine. 2022 Mar 30;97(4):577-85

[34] Martin R, Mandrusiak A, Lang R, Russell T, Forbes R. A telehealth curriculum: A pre-post study of physiotherapy students' perceived knowledge, self-efficacy and intentions for future use. Focus on Health Professional Education: A Multi-disciplinary Journal. 2022 Aug 1;23(3):56-72.

- developing rapport with remote patients and staff and taking into account people's culturally, socially and linguistically diverse needs[35]
- translating physical clinical skills to virtual care[35]
- coordinating the patient journey through the health system[35]

5. they use participative and interactive virtual care learning activities[35]
6. they provide opportunities for students to collaborate virtually with other professions and practise delivering virtual interprofessional collaborative care to patients[36,37]
7. they incorporate all available healthcare resources, including experiences in virtual interprofessional collaborative practice, where appropriate
8. educators receive training in the delivery of virtual care learning experiences[30]
9. education providers work collaboratively with health care providers to design virtual care learning activities[35,37]
10. they incorporate online and simulation-based learning activities to reinforce student learning and support integration of theoretical knowledge/skills, where possible[36]

[35] Nowell L, Dhingra S, Carless-Kane S, McGuinness C, Paolucci A, Jacobsen M, Lorenzetti DL, Lorenzetti L, Oddone Paolucci E. A systematic review of online education initiatives to develop students remote caring skills and practices. Medical Education Online. 2022 Dec 31;27(1):2088049.

[36] Ahpra's independently-chaired Accreditation Committee. Interprofessional Collaborative Practice Statement of Intent.

[37] TEQSA Guidance note Work-integrated learning (version 2.0 May 4 2022)