AHPRA | Paramedicine Board of Australia
Accreditation Committee

Response template for providing feedback to public consultation – draft proposed accreditation standards for paramedicine

This response template is the preferred way to provide your response to the consultation on the **Draft proposed accreditation standards for paramedicine.** Please provide your responses to all or some of the questions in the corresponding text boxes. You do not need to respond to a question if you have no comment.

Making a submission

Please complete this response template and send to accreditationstandards.review@ahpra.gov.au using the subject line '*Feedback on draft proposed accreditation standards for paramedicine.'*

Submissions are due by COB on 13 March 2020.

Stakeholder details

Please provide your details in the following table:

Name:	James Pearce – [redacted] In this submission, Red identifies the wording in the consultation document, green identifies a suggested change, with the change underlined.
Organisation Name:	This is a personal response.

Your responses to the public consultation questions

1. Does any content need to be added?
There should be a requirement for education providers to support students while on clinical placement with a 'paramedic facilitator' – a dedicated resource who ideally is associated with both the education provider (university) and health service (ambulance service or other health provider). This model has been successfully piloted and resuled in increased placement quality. [redacted]
2. Does any content need to be amended?
Standard 1.4: Health practitioners who supervise students in the program during work-integrated learning hold current registration in Australia for the clinical elements they supervise This standard requires some clarification. As noted in the draft standards on page 10/11, paramedic students often attend part of their work-integrated learning (WIL) on clinical placement with health practitioners (often ambulance service patient transport service staff) who are not required the be registered to perform their role. These staff are directly supervising students. Suggest: Standard 1.4: Health practitioners from regulated professions who supervise students in the program during work-integrated learning hold current registration in Australia for the clinical elements they supervise Standard 2.13: The education provider appoints academic staff at an appropriate level to manage and lead the program. The expected information for accreditation is very heavily weighted towards leadership/management qualifications, but there is no mention of the teaching/educational qualifications of the academic staff. Experience and proficiency in paramedic technical skills and patient care are quite separate to pedagogic expertise. This standard should set a benchmark that academic staff who manage and lead the program should hold (or be studying towards) a Graduate Certificate in Higher/Tertiary Education or higher. This should not include vocational training qualifications (e.g. Certificate IV in Training and Assessment) which are quite different to tertiary education. Any academic staff engaged in coordinating topics/courses/units should also hold (or be studying towards) a Graduate Certificate in Higher/Tertiary Education or higher.

Standard 2.6: Formal mechanisms exist to evaluate and improve the design, implementation and quality of the program, including student feedback, internal and external academic and professional peer review, and other evaluations.

This is essentially the definition of the phrase 'Scholarship of Teaching and learning' (SoTL), and the standards should include this important phrase.

Standard 3.3: Unit/subject learning outcomes in the program address all the professional capabilities for paramedics.

This standard requires some clarification. It is not possible for the education provider to link learning outcomes to every single one of the professional capabilities for registered paramedics. For example, capability 4.3: 'Respond to urgent and non-urgent requests for assistance in a low risk manner in accordance with relevant road safety legislation, organisational directives, policies, procedures and guidelines.' It is not currently normal practice to teach paramedic students to demonstrate urgent responses in accordance with road rules. Paramedic students studying at university generally are not allowed to drive university or ambulance service vehicle at all. Suggest:

Standard 3.3: Unit/subject learning outcomes in the program address the relevant pre-employment professional capabilities for paramedics.

3. Are there any potential unintended consequences of the current wording?

Standards 3.11: The quality, quantity, duration and diversity of student experience during work-integrated learning in the program is sufficient to produce graduates who have demonstrated the knowledge, skills and professional attributes to safely and competently practise across a broad range of paramedicine settings.

Due to a number of factors, including difficulty accessing ambulance service placements, education providers will/do take the path of least resistance and require the minimum number of WIL/clinical placement hours possible. This standard is too weak. While the general approach of a descriptive, outcomes focussed set of accreditation criteria is good, this standard needs a definitive number of WIL hours, both emergency ambulance and alternative types of clinical placement. Important, this standard specifically should cover the clinical placement aspect of WIL, as simulations are no substitute for the clinical environment. Suggest:

Standard 3.11: The quality, quantity, duration and diversity of student experience during the clinical placement aspect of work-integrated learning in the program is sufficient to produce graduates who have demonstrated the knowledge, skills and professional attributes to safely and competently practise across a broad range of paramedicine settings. As a minimum, this is expected to be least 2000 hours clinical placement in an emergency operational ambulance environment over 3 FTE years. Students should also complete at least 200 hours clinical placement in alternative operational clinical placement environments (e.g. general practice, nursing home, emergency department, RDNS, mental health facility, labour and delivery ward, mine site clinic etc). These clinical placement hours are not to be substituted with simulated practical workshop type environments.

Standard 3.9: The education provider ensures work-integrated learning experiences provide students in the program with regular opportunities to reflect on their observations of practice in the practice setting.

Standard 3.10: The education provider engages with the practitioners who provide instruction and supervision to students during work-integrated learning, and formal mechanisms exist for training and monitoring those supervisors.

Standard 3.11: The quality, quantity, duration and diversity of student experience during work-integrated learning in the program is sufficient to produce graduates who have demonstrated the knowledge, skills and professional attributes to safely and competently practise across a broad range of paramedicine settings.

A large and increasing body of evidence demonstrates that the quality of clinical placements is often poor. Students often have negative experiences including bullying and a lack of support. Suggest mandating the use of a 'paramedic facilitator model', where paramedic students on clinical placement must be supported by a dedicated facilitator who ideally is associated with both the education provider (university) and health service (ambulance service). A similar model is often used in nursing undergraduate clinical placement. This model has been successfully piloted and resulted in increased placement quality. See the pre-print of the study published here: https://doi.org/10.35542/osf.io/nma5d

4. Do the proposed accreditation standards, associated criteria, expected information and explanatory notes indicate clearly what is required for education providers to demonstrate they are producing safe and competent graduates?

5. Do you think education providers will have difficulty in providing evidence (expected information) to meet any of the criteria?	
6. What do you think should be the Accreditation Committee's minimum expectations for education providers to demonstrate adequate quality, quantity, duration and diversity of a student's experience during paramedicine work-integrated learning? (related to standard 3.11)	
Education providers should provide, as a minimum, 2000 hours clinical placement in an emergency operational ambulance environment over 3 FTE years. Students should also complete at least 200 hours clinical placement in alternative operational clinical placement environments (e.g. general practice, nursing home, emergency department, RDNS, mental health facility, labour and delivery ward, mine site clinic etc). Students should be supported while on clinical placement by a 'paramedic facilitator' – a dedicated resource who ideally is associated with both the education provider (university) and health service (ambulance service or other health provider). This model has been successfully piloted and resulted in increased placement quality.[redacted]	
7. Do you have any other general feedback or comments on the proposed standards?	