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:	Associate Professor Catherine Kamphuis
Organisation Name:	Victoria University, Melbourne, Australia

Your responses to the public consultation questions

1. **Does any content need to be added?**

2. **Does any content need to be amended?**
Standard 1: Criterion 1.3- This is problematic for any tertiary institution as they are reliant on the industry partner to provide the WIL clinical placements. There are limitations around aligning industry placements with prerequisite capabilities. The clinical placements may at times be asynchronous with the curriculum timetable due to operational and logistical constraints of the industry partner. This means students may have to attend clinical placement without having yet achieved the new information scheduled to be taught for that semester. This is mitigated at each higher year level of an undergraduate degree as students will still bring the information, knowledge and practical ability from previous years into their clinical placement experience. This is further mitigated by the teaching approach of some educational providers where paramedic theory and practice units are taught continually each semester throughout the degree. Some educational providers have a clinical skills matrix document (for preceptors and students), which details the students expected scope of practice and clinical capabilities at the end of each semester of study. In a situation where a student is required to undertake clinical placement before undertaking the relevant practical unit of study, that student would be limited to the previous semesters scope of practice. Students carry this document and in order to maintain theirs' and the public safety can identify to their WIL supervisor whether or not they are able to observe or participate in a particular course of clinical action. Suggest the language in this criterion is amended accordingly. Standard 1: criterion 1.5 - (Dot point 2) This is currently unclear as is worded. Can the Board please provide an example of how the educational provider monitor the currency and licence of an industry partner? The education provider has no jurisdiction to monitor currency and licence of the industry provider. The education provider does usually have a clinical learning agreement or letter of intent they have made with the industry provider which they could provide as evidence of the agreement that the industry partner will maintain its currency required of its jurisdiction. The education provider creates clinical agreement with industry partners for WIL. Part of these clinical agreements includes statements by the industry partners that accreditation and licencing is appropriate and current. Would this suffice as "an example/s of implementation of a formal mechanises that show facilities and health services used for WIL maintain relevant accreditation and licences"? Can the Board please provide examples of how this could be further met? Further to this, every clinical agreement is reviewed and renewed at various intervals as needed. Would this suffice as "an example that the education provider monitors the currency of accreditation and licencing"? Can the Board please provide examples of how this could be met? The definition of WIL is interpreted to includes International study tours. However, the situation

may arise where the relationships with health care providers in developing nations, such specific documentation of “accreditation” and licencing” may not exist. Can the Board please provide information about what documents and process may suffice instead?
Currently VU ensure a safe student experience by utilising induction sessions, safety training days prior to departure, regularly debriefs, adheres to department of foreign affairs safety travel advise, ensures students fitness to travel (including immunisation status) and provides insurance for all staff and students.

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

Standard 1: criterion 1.5 - The requirement to meet this criterion may exclude the use of providers who operate in a manner different to Australian standards and who may not require accreditation or licences in the same way in which Australian providers do. The wording of criterion may unintentionally reduce the rich learning experiences we can offer to students to undertake WIL clinical experiences in countries where the emergency services are emerging, developing or are not mandated by law to keep such licenses. Suggest this criterion be reworded to allow for other forms of documentation other than accreditation/licences as is relevant for the provider.

Standard 2: criterion 2.8 – (Dot point 6) - Unclear what the “example reports” are about? This may be interpreted as if there is there an expectation that education providers survey/ring/ask for reports from employers about their graduates/courses? This is not a feasible request. Graduates move into a great many areas of employment around the globe and gathering relevant and meaningful information would not be possible.

Currently no such survey or report exists of graduates that would be granular enough to elicit feedback that could be used to implement course changes. There is a Graduate destination survey and a Good Universities guide survey but these would not elicit specific relevant information to contribute to meeting criterion 2.8. Suggest that education providers ensure representation of graduate(s) on Program/Course Advisory board to elicit such feedback and input.

Standard 3: Criterion 3.8- Can the Board clarify how such legislation and regulatory requirements would be assessed during periods of WIL in the program? Assessment per se does not occur in WIL placements/situations. Students are observed and reported upon by their supervisor which is currently captured in the Clinical log book but assessment does not occur. Further, the WIL is not controlled in so far as case presentation is concerned. There is no certainty student have exposure to patients/clients whose condition(s), presentation or situation may evoke said Legislation and Regulations. Suggest criterion include language that says “ legislative and regulatory requirements relevant to the profession are taught and their application to practice is assessed in the WIL, simulated or clinical practice setting (which we understand to include the university clinical laboratory setting)”

Standard 3: Criterion 3.8 - Dot point 1 be reworded to include “ ...are taught and assessed during WIL, simulation and or the clinical practice setting”.

Standard 3: Criterion 3.10 - Education providers are not able engage with practitioners who provide instruction and supervision to students during WIL nor can the education provider ensure that formal mechanisms exist for the training of these supervisors. The supervisors are employees of the industry provider not of the education provider. For example, it is Ambulance Victoria's responsibility to provide training and monitoring of their staff. As an education provider we understand that our industry partners provide online training modules around supervision to their supervising WIL staff. The education provider cannot mandate, control or monitor this directly. In discussion with the industry providers we provide feedback about quality of supervision in response to feedback we receive from students after undertaking WIL either directly or as is captured in the student's clinical logbook.

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?**

Standard 1: Criterion 1.6 - Can the Board clearly indicate the specific guidelines that are relevant to safe practice? Can we seek clarification about what the Board would like to be made available to students, what specific documents should be shared with students and how will the board notify the education provider of changes to said guidelines that need to be shared with students on an ongoing basis.

Standard 1: Criterion 1.7: Can the Board clarify what is meant by "the education providers obligations" under the Health Practitioner Regulation Act. Require more guidance on what the relevant legislation is. Require guidance on what the Board requires as evidence of compliance with relevant legislation in the context of being the education provider.

5. **Do you think education providers will have difficulty in providing evidence (expected information) to meet any of the criteria?**

Standard 3: Criterion 3.11 - Request the Board provide definitions and evidence based ways in which to measure what is meant by "sufficient, quality and diversity" as currently there is no research that has adequately addressed this. Education providers cannot ensure the quality and diversity of the student WIL learning experience with the current system. Education providers can control quantity and duration, but in the absence of quality and diversity, these terms are somewhat meaningless. The educational providers are aware of gaps and to this end can provide simulations to ensure students are exposed to specific presentations. Suggest wording is changed to reflect recognition of these activities that occur in the simulated environment as evidence to meet this criterion.

Standard 5: Criterion 5.2: Educational providers are not able to "evaluate through direct observation the students in the practice setting", unless the Board expands the definition of "practice setting" to include the simulated and clinical laboratory environment.
The WIL learning experience occurs remote from the university and the supervision is undertaken by WIL supervisors usually employed by an industry partner. The WIL supervisor supports and guides the student within the student's scope of practice over the course of the placement. The WIL supervisor observes and reports upon the clinical skills, knowledge and behaviours of the student within the clinical log book. The WIL supervisor does not assess the student as such. The current wording of criterion 5.2 needs to reworded as it cannot currently not be met by the educational provider.
What is the definition of the practice setting? The attached glossary indicates "Practice setting' refers to the types of organisations, as well as types of geographical locations, students may carry out paramedicine work-integrated learning activities within. The characteristics that define each type of organisation and/or geographical location vary and, consequently, affect the care a student can provide. A practice setting may sometimes be referred to as a 'clinical setting".
Does this include the classroom settings where clinical practice assessments occur? Or is this solely referring to WIL clinical placement outside of the class room.
If the later then the term "assessment" is problematic. Students are not assessed by paramedics on clinical placement outside of the classroom environment. Paramedics supervise, provide feedback and report on the clinical placement experience, of the students however are not qualified to assess them. The clinical placement log book serves as a third party report which is then assessed by qualified academic staff.

Standard 5: Criterion 5.4 states "Details of arrangements to monitor staff who assess students during work-integrated learning". Please refer to the above information (5.2). Students do not undertake formal assessment during WIL clinical placements. Instead are supervised, given feedback and are reported on about performance. These are recorded in the clinical placement log book which subsequently serves as a third party report which is then assessed by qualified academic staff.

Standard 5: Criterion 5.5 states "Examples of guidance provided to work-integrated learning supervisors on how to use assessment tools to improve the validity and reliability of their assessments". It is the responsibility of the industry partner providing placements to give guidance to the supervision paramedics (who are not assessors) as to how to use the reporting

tools (not assessment tools). As has been explained previously, no formal assessment is being undertaken at this time.
The industry partner seeks to ensure that supervising Paramedics have all completed the Graduate Ambulance Program and ideally where possible, will provide Paramedic Clinical Instructors or Paramedic Educators as supervisors.

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)**

7. **Do you have any other general feedback or comments on the proposed standards?**

Definition of WIL on page 23 appears to differ from that provided in pg 36. The definition on page 36 allows by our interpretation to include (or not exclude) learning that occurs in the simulated environment and this is favourable for allowing us as education providers to meet with evidence many of the criteria under the standards. The definition of WIL on page 23 as per TEQSA explicitly states that it is "any arrangement .....outside of their higher education provider". This definition is restrictive and will result in education providers not being able to meet many of the criteria in the draft standards with the evidence requested. Throughout the draft standards there are several criterion that require formal mechanisms of assessment in the WIL environment in a manner that is not achievable. The WIL environment (outside of the university) requires the educational provider to rely on the provision of supervision of the student by a range of people who do not necessarily know the Learning objectives of the course nor are they qualified to assess the student as per the university assessment standards. They can however provide valuable feedback that the education provider can read, consider and act upon if required.

Similarly the term "practice environment" as per the definition can be interpreted to include (or not exclude) the clinical laboratory and the simulated environment. *Recommend this definition be expanded to explicitly include these environments (the clinical laboratory and the simulated environment).

Recommendation is to include reference to the practice environment (with its expanded definition * in all criteria where currently only the WIL based evidence will be acceptable (Criterion 3.8, 3.10, 3.11, 5.1, 5.2, 5.4, 5.5). The definition of practice environment to include recognition of simulated and clinical laboratory environment as environments where required assessments can be made.