Q1. [redacted]

Q2.

Supervised practice framework: public consultation

Introduction
National Boards (excluding Pharmacy and Psychology) and the Australian Health Practitioner Regulation Agency (AHPRA) are seeking feedback about the proposed *Supervised practice framework* (framework).

Please ensure you have read the public consultation papers before taking this survey, as the questions are specific to the proposed framework and supporting documents.

Thank you for taking this short survey.

Q26.

Privacy

Your responses will be anonymous unless you choose to provide your name and/or the name of your organisation.

Privacy notice

This consultation is being conducted by AHPRA and is hosted on a third-party website, provided by Qualtrics. The information collected will be used by AHPRA to evaluate the proposed framework. The information will be handled in accordance with the privacy policies of AHPRA accessible here and Qualtrics here.

Q45.

Contact details

We may contact you about your response.
Please write your name and contact details.

(Skip if you wish to be anonymous)

Q28.

Publication of responses

National Boards and AHPRA publish responses at their discretion. We generally publish responses on our

websites to encourage discussion and inform the community and stakeholders.

We will not publish responses that contain offensive or defamatory comments or which are outside the scope of the consultation. Before publication, we may remove personally-identifying information, including contact details.

We can accept responses made in confidence. These responses will not be published. Responses may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential response will be determined in accordance with the Freedom of Information Act 1982 (Cth), which has provisions to protect personal information and information given in confidence.

You must let us know if you do **not** want us to publish your responses.

Published responses will include the names (if provided) of the individuals and/or the organisations that made the response unless confidentiality is requested.

Q23. Publication of responses

Please select the box below if you do **not** want your responses to be published.

- [ ] Please do **not** publish my responses

Q3. About your responses

Q33. Are you responding on behalf of an organisation? (optional)

- ( ) Yes (please write the name of organisation) [ ]
- (•) No

Q35. Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q4.

Which of the following best describes you?

- (•) I am a health practitioner
- ( ) I am a member of the community
- ( ) I am an employer (of health practitioners)
- ( ) Other [ ]

Q5.
Which of the following health profession/s are you registered in, in Australia?

You may select more than one answer.

- [ ] Aboriginal and Torres Strait Islander Health Practice
- [ ] Chinese Medicine
- [ ] Chiropractic
- [ ] Dental
- [ ] Medical
- [ ] Medical Radiation Practice
- [ ] Midwifery
- [ ] Nursing
- [ ] Occupational Therapy
- [ ] Optometry
- [ ] Osteopathy
- [x] Paramedicine
- [ ] Pharmacy
- [ ] Physiotherapy
- [ ] Podiatry
- [ ] Psychology

Q9.

About supervised practice.

The following questions will help us to gather information about supervised practice and the proposed framework and supporting documents.
Please ensure you have read the public consultation papers before responding, as the questions are specific to the proposed framework.

Q44.

National Boards and AHPRA have developed the *Supervised practice framework* (the framework) and supporting documents to enable a responsive and risk-based approach to supervised practice across the National Registration and Accreditation Scheme (the National Scheme). The National Boards' preferred option is to adopt the proposed framework and supporting documents.
How helpful and clear is the content and structure of the proposed framework? Please explain your answer.

How helpful and clear is the content and structure of the proposed framework? Please explain your answer. I am a qualified paramedic employed by a major state government ambulance service. I have experience in delivering education in both clinical and non-clinical settings. This includes supervision and preceptorship of paramedicine graduates in various ambulance services. In these responses, I will contend that more clarity is required for paramedic supervision requirements. Specifically, my responses will focus on the perspective of graduate paramedics who have supervision requirements imposed on their registration due to non-recency of practice or similar matters. After reviewing both the 'Supervised practice framework for paramedics – Interim' dated September 2018 and the 'Proposed Framework', I recommend that the Board: • Creates an individualised approach to supervision requirements for paramedic practice, or; • provides more clarity within this framework of how it can be applied to paramedicine, or; • Creates a profession-specific document that clarifies matters of paramedicine supervision. I will discuss the rationale for this in the following responses. Education of paramedic graduates is inherently different to other health fields, particularly supervision practices. Direct supervision is undertaken by a single preceptor/clinical instructor (CI) at a time, with organisational service delivery and rostering requirements influencing the duration and frequency of change of individual CI's. In the service I work for, a graduate will be supervised by a CI for at least 6 months. Each roster period is 4 weeks, and a CI may change each roster cycle due to operational demand and to diversify the education of the graduate. Following this they will be rostered with a qualified paramedic with no less than 2 years experience in the role, for another 6 months. Supervision reports are required each roster cycle, and these time frames may be extended if required. A significant problem with the proposed framework and the previous interim arrangements for paramedicine, are that they are prohibitive of employment of persons with supervision requirements by state emergency ambulance services. This is due to the potential impact on ambulance service provision. I will discuss this in more detail in the following responses to questions Where profession-specific material is mentioned – these documents should be listed and hyperlinked under this to improve flow and ensure clarity of requirements, or at least direction on where this can be located once published.

Q11.

The word "consult" is used to describe the interaction between a supervisee and supervisor in the levels of supervised practice (see Section 5 Levels in the framework and the *Fact sheet: Supervised practice levels*). The word "consultation" is often used to describe the interaction between a patient/client and a health practitioner.

Is the meaning of "consult" clear for the purpose of the supervised practice levels? Why or why not?

Yes it is clear

Q13.

Is there any content that needs to be changed, added or removed in the proposed framework and/or supporting documents? If so, please provide details.

The Board should create a supervision plan in consolation with each state ambulance service, rather than each individual registrant creating a plan, given the majority of these supervision plans will be highly similar. This reduces the workload for AHPRA staff having individual plans reviewed, when the vast majority of registrants with supervision requirements are likely applying to work for a state service, of which there are only seven. Not least, a standardised supervision plan could be developed with the largest employers, such as the state ambulance services of NSW, QLD and Victoria etc. This streamlines the process of supervision and approval process for employers and the Paramedicine Board, creating a clear and consistent process of supervision. The Board should consider the inclusion of “What if urgent lifesaving care is needed?” and the following paragraph as its meaning is unclear for paramedic practice. For example, a supervisee is employed as a paramedic and works in conditions where they provide emergency care. Therefore, if their supervisor is absent, should they continue to respond to emergency cases, then retrospectively advise the board, only not responding to non-emergency calls? How will the board define urgent lifesaving care in paramedic practice? Further examples of this could be a call to a patient with shortness of breath – this patient may require emergency medications to treat this, who would otherwise deteriorate into a respiratory arrest without these medications. Or is the intention to limit this to patients in full cardiac arrest?

Q14.

Are there any other ways that the Board can support supervisees, supervisors and employers involved in the supervised practice arrangement?

Yes, see next response.

Q15.

Is there anything else the Board should consider in its proposal to adopt the framework and supporting documents, such as impacts on workforce or access to health services?

As it stands in both the existing interim supervision framework and the proposed framework do not support a state ambulance service in their provision of care. Whilst it is reasonable to require direct supervision, the Board must remain cognisant of the fact that this is already undertaken by all graduate ambulance paramedics employed by state ambulance services', regardless of AHPRA imposed supervision requirements. Specific issues arise in the requirement for named supervisors, and the requirement to cease practice when a named supervisor is unavailable. Whilst primary and secondary supervisors can be named, it is often not plausible to have a secondary supervisor on stand-by to cover unplanned absence of the primary supervisor in paramedicine, due to the 24 hour nature of shifts. Staff are moved from various ambulance branches or called in on overtime to cover unplanned absence. One could not predict the specific staff member and provide their details to the Board prior to that time. It therefore follows that in the absence of a named supervisor, a supervisee can no longer respond to cases, and the service now has to staff 2 vacancies. This poses a number of issues; 1. This is against public expectations of ambulance provision and response, that when a paramedic of equal standing would be available to fill a position, they would expect it would be filled and the ambulance staffed. This is particularly pertinent for rural and outer metropolitan communities, who would experience a significant increase in response times if their local ambulance was not staffed. 2. This creates a significant challenge for resourcing, having to find 2 staff to fill a single vacancy. Again, a particular challenge in rural communities, though nonetheless still challenging in metro regions. 3. This poses added strains on budgeting and government funding, potentially paying an employee who is unable to undertake their duties. 4. From a business perspective, it does not make sense to employ someone with this potential liability, when someone with general registration could be employed providing more stability. Therefore, the named supervisor requirements are prohibitive to employment of registrants requiring supervision. Without employment, a registrant is unable to meet their conditions. Essentially, this means registration with conditions of supervision imposed is comparable to a refusal to grant registration, as the conditions are unable to reasonably be met by an employer. It is therefore reasonable that an ambulance service excludes registrants with supervision requirements from employment due to the potential detriment of service provision and patient care. However, it is unfair that the Board imposes conditions on registrants with the knowledge it precludes them from practicing as a paramedic, given the unique employment market, where registrants have one employment option per state if wishing to work as an emergency paramedic. In summary, named supervision requirements pose a unique challenge that would not be experienced in other health professions. The ability to name more than one supervisor provides little benefit in paramedicine, due to the unpredictability of staffing.

Q16. Do you have any other comments on the proposed framework and/or supporting documents?

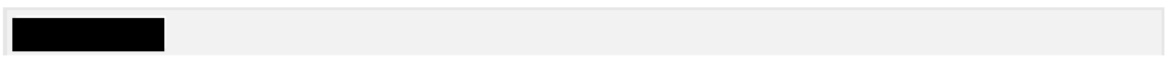
The Board should consider a more individualised approach to supervised practice for Paramedicine. The provision of ambulance services in relation to paramedicine supervision is unique given in comparison to other health fields. Existing supervision requirements create a barrier to employment for graduate paramedics with conditional registration stipulating named supervisor requirements. I recommend the Board reconsider these arrangements and I propose the following: 1. The board takes an individualised approach to supervision requirements for the paramedicine profession. 2. The Board work with state ambulance services, developing a standardised approach to supervision requirements that are able to be met by employers. To achieve this the Board may consider some of the following options; 1. The Board lists a category of persons; i.e. A 'Paramedic Clinical Instructor' as a direct supervisor, rather than an individual named supervisor, and; The Board lists a primary named supervisor, such as a Team Manager who oversees the supervisees' progression and ensures they are rostered with an appropriate direct supervisor. 2. The Board requires a named direct supervisor, providing a clause that allows someone of equal standing to fill the vacancy of the supervisor in periods of short notice absence (0-7 days) and retrospectively advise the Board of this. This enables the supervisee to continue practice and an operational ambulance response to be maintained. 3. The Board could consider an instant online or telephone approval process, available 24 hours a day, providing immediate verification and approval of a supervisor in periods of absence between 1-7 days. This enables the supervisee to continue practice and an operational ambulance response to be maintained. 4. The Board considers a standardised period of direct named supervision for a short period, say 150 hours. This enables the supervisee to be placed in a metropolitan location, where if they are required to cease practice due to supervisor absence, there is a lesser impact on service provision. Following this, a primary supervisor meeting level 4 (remote) is listed for remaining hours, with the knowledge direct supervision would continue for the duration of the graduate training. 5. The Board stipulates a clearer approach to the requirement of the type of supervisor they expect, rather than a named person. For example; an appropriate supervisor may be listed on a supervision plan as 'A Paramedic who has practiced at said level for X number of years full time in the current ambulance service they work for, with full AHPRA registration'. 6. The Board accepts the supervision plans in place by a specific employer, and details this as the condition of registration, for example the condition reads something like; Mr/Ms X must undertake a period of supervised practice for X number of hours in accordance with the Graduate Paramedic Program with [insert state ambulance service name]. They must only practice in this role with this employer. In summary, applicants to an ambulance service currently cannot gain employment due to the service being unable to meet the supervision requirements. The ambulance service is able to meet the hours imposed by AHPRA on all applicants, it is however the specific terms of these conditions that currently make these applicants unemployable. Employment as a paramedic is highly competitive, and takes in excess of 12 months to gain a position. Therefore, if an applicant is unsuccessful for their first round, by the time they reach their second time, they may no longer meet the recency of practice requirements, and have conditions imposed. It is unfair for paramedicine graduates to have one opportunity to gain employment, then if unsuccessful, have conditions imposed that will never be met, meaning they will never work as a paramedic following their study. This is particularly relevant given that Paramedicine Registration and recency of practice requirements are new. I hope the Board can consider the gravity of this small yet hugely significant detail in the supervision requirements for paramedicine, that would unlikely pose such significance in other health professions. Whilst the Board should continue to provide a safe approach to supervision, consideration should be given to existing supervision practices within ambulances services', and the ability of employers to meet these new requirements.

Q24.

Thanks!

Thank you for participating in the consultation.

Your answers will be used by the National Boards and AHPRA to improve the proposed framework and supporting documents.



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