To the Medical Radiation Practice Board of Australia.

I would like to provide feedback on you Draft revised professional capabilities document.

The Board's original draft document stated that:

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.*

However, I notice that has recently been changed to

a. *Identify and respond to a patient/client's deteriorating condition, or inability to undergo a procedure or treatment, consistent with duty of care and statutory requirements*

Which statutory requirements would you be referring to there? And does this mean that your newsletter from June 2017 regarding the deteriorating patient has now been replaced by the new draft capabilities document?

In fact, the National consensus statement does not actually give any *detail* of what this would involve for Radiographers, or in fact, any Allied Health.

Whilst not specific in detail, I agree point 6.1 from the consensus statement would however apply to radiographers: "All clinical and non-clinical members of the workforce should receive education about the local escalation protocol relevant to their position". This is appropriate, and would be covered by our annual Basic Life Support training which we all receive, and is commonly taught in hospitals and private workplaces around Australia.

Under 'Application' the consensus statement states *'These systems will need to be tailored to the setting, the risks and needs of the population, and available resources and personnel, while being in line with relevant state, territory or other programs.*

This is precisely what Radiology departments around Australia have done, and subsequently they provide MRP's with Basic Life Support training (BLS).

However, when I asked the MRPBA to elaborate of what that meant for radiographers, the official response I received (dated 15 October 2018) stated:

The Board clarified its position that registered medical radiation practitioners should be able to:

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

Actually, this list appears in the Second Edition consensus statement, (Education 6.2), and it appears immediately below the phrase: "**ALL DOCTORS AND NURSES** should be able to... "

Nowhere else, is there even a suggestion that this level of assessment and interpretation, should apply to Radiographers or other MRP's.

I agree that the points 3-5 above are appropriate for Radiographers, as they describe our annual Basic Life Saving training. Points 1-2 *could* also describe BLS, and if this were the case I would not be objecting. However the devil is in the detail, as described by the 2017 newsletter MRPBA's letter, the first two are in fact *completely inappropriate* for Radiographers and that is why they are not covered by Universities, nor any public hospital training for radiographers. For the record, I also asked Radiographers from the UK, Canada and NZ and several from Interstate, and none of them covered more than BLS either. I also asked a number of Doctors and Nurses at our large tertiary referral hospital and they were actually horrified that anyone was considering Radiographers doing systemic patient assessment, particularly at the level detailed in the MRPBA's letter to me. The common reaction I got was disbelief, followed by a statement like "but that's ridiculous, that's not your job!".

As per the Australian Resuscitation Council, and our current training, here is what **is** covered in Basic Life Support (BLS).

D-Danger - is there any danger that might impact the patient or rescuer
R-Response - is the patient responding at all?
S-Send - Send for help
A-Airway - is the patient's airway clear, and if not, attempt to clear it
B-Breathing - is the patient breathing at all
C-Circulation - does the patient have a pulse at all, if not start CPR immediately
D-Defibrillation - apply a defibrillator if available, and follow it's instructions

I believe that the board originally misinterpreted the National Consensus Statement. Particularly in applying systemic assessment and the biometric parameters as listed, what is especially alarming is that in their letter, they have stated these are *minimum* requirements.

The Board has indicated that, at a minimum, medical radiation practitioners should be able to understand and interpret

- *respiratory rate*
- *oxygen saturation*
- *heart rate*
- *blood pressure*
- *temperature*
- *level of consciousness*

In actual fact, these parameters are only listed in the consensus statement in point 1.6, under the heading "*Monitoring plans* should include measurement of: "
Monitoring plans are a Medical decision, and are carried out by Nurses (and sometimes doctors). In no circumstances are MRP's involved in monitoring plans. Only fully qualified Registered Nurses (who have done at least a three year degree) are qualified to monitor a patient.

I want to make it clear that this is not a case of radiographers requiring a bit more education or an In-service, this level of assessment and interpretation is *completely outside our scope*. It is in fact, at the level of a full nursing or medical degree, and even an EN (Enrolled Nurse) who has completed at least 18 months of nursing degree is **not** qualified to *interpret* vital signs. Furthermore, an EN is not qualified to receive clinical handover for any patient. As radiographers we receive dramatically less training than an EN in patient assessment (ie. only what is covered in Basic Life support). Again, this is *completely outside the scope of MRP's.*

When I spoke to Adam Reinhart on the phone, he was of the opinion the we could receive a one off In-service to tell us which maximum/minimum figures would be appropriate for each parameter. However, this simply *cannot* be the case. For example, heart rate; some patients have a normal heart rate as low as 30bpm, whereas for others if they dropped to 30, we would be initiating a full code blue. This is the case for all the parameters, and the point it that you cannot know, unless you have had clinical handover of the patient, what is normal for that particular patient, and at what level you would therefore initiate an alarm, this is done at a nursing (RN) and medical level. As radiographers we see many of our patients for a period of 5 minutes or less, you cannot possibly have full handover for every patient, *even if* we had done a full nursing degree to understand it.

I want to be clear, that **IF** a radiographer happened to notice a significant drop in one of these parameters, and thought that the patient was deteriorating, of course they should raise the alarm. But to state that a radiographer should *at a minimum* be able to *interpret all* these parameters is a completely different, and inappropriate level of assessment. Most worryingly it leaves us in a very dangerous position legally, where we could be liable if we did not notice one of those signs, despite not being trained to recognise them.

When I spoke to Adam he said that the board would not pursue us if we didn't happen to notice a patient deteriorating, particularly if it were subtle. However this is cold comfort. In the event that a patient or their family decided to sue, the patients lawyers would be using the MRPBA's policy to prove the responsibility of the radiographer involved.

Next, the Board stated in their letter that:
Recognising the difference I practice roles, the Board identified that it was not usual practice for medical radiation practitioners to
6. discuss treatment arrangements with other clinicians or families
7. be involved in decision about substitute decision maker
8. discuss end-of-life care, or
9. broadly communicate comprehensive care plans

Again, these are listed in the consensus statement under the heading "Doctors and Nurses should be able to:" and the words "not usual practice" should be replaced with never, as they are so far outside my scope that I would be criminally negligent if I had anything to do with them at all. I cannot imagine any scenario where radiographers would be involved in these at all. If RT's or other MRP's might be involved in one of these then you should specifically state that if applies only to them.

The letter from the MRPBA also stated that I had mentioned *some* final year students did not have knowledge of the above parameters. This is incorrect, NONE of them (from any of the three universities I asked students from) had any knowledge, and neither do ANY of my colleagues, including ones who trained in other hospitals, or any of our locums.

Does the MRPBA still stand by the original wording of the policy in the June 2017 newsletter, and their subsequent more detailed explanation in the letter to me?
Either way, you need to clarify if Basic Life Support training is considered sufficient for MRP's regarding deteriorating patients, and communicate this formally to all MRP's.

I look forward to the Board's response to all my feedback points.

Regards, Angela Small.

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