



Scope of Practice of Assistant Practitioners

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Summary

Over the past decade, the Scope of Practice of assistant practitioners has been reviewed and revised to incorporate additional modalities and practice settings where assistant practitioner roles have been approved. This guidance brings together in one document the Scope of Practice of assistant practitioners across both diagnostic and therapeutic radiography and across all modalities. It supersedes any previous guidance documents although they may form a useful reference source.

Introduction

The 'Assistant Practitioner' was introduced to the radiography workforce as a result of a study into skill mix in radiography conducted by the Department of Health in 2002¹. The diversity of radiographic practice, coupled with increasing service demand and the introduction of new technologies and techniques, allowed for the exploration of the potential to develop new roles. Within the career progression framework, new roles have emerged that support service delivery by developing individuals in order to undertake specific tasks and activities that improve patient flow and delivery of effective and timely services. There was no suggestion at any point that these new roles would replace radiographers but that they would provide additional capacity in the workforce to allow radiographers to develop and fulfil their own potential. Assistant practitioner roles also fulfilled the need to develop career progression opportunities for the support workforce in clinical imaging and radiotherapy services.

For all new roles there is a need to develop education and training programmes that support the individual in acquiring new skills and extending knowledge. There must be a framework of supervision that allows for development and ensures patient safety during both development and ongoing practice.

Over the past decade, the Scope of Practice of assistant practitioners has been reviewed and revised to incorporate additional modalities and practice settings where assistant practitioner roles have been approved. This guidance brings together in one document the Scope of Practice of assistant practitioners across both diagnostic and therapeutic radiography and across all modalities. It supersedes any previous guidance documents although they may form a useful reference source.

The Assistant Practitioner

The definition of the assistant practitioner appears in the Skill Mix document¹ as follows:

“An Assistant Practitioner performs protocol-limited clinical tasks under the direction and supervision of a state registered practitioner.”

(It should be noted that, at the time of publication, the term “state registered” was still valid).

The Society and College of Radiographers’ policy regarding the practice of assistant practitioners was published in the document “Educational and Professional Development: Moving Ahead”². Assistant practitioners, like general support staff, are likely to be from diverse backgrounds but they will differ from the general support workforce in that, as part of their duties, they will perform limited clinical imaging examinations or treatment procedures in concert with, and under the supervision of, registered radiographers. The range of such examinations or treatments will vary in accordance with locally identified need but is likely to be confined to standard examinations or treatments carried out on adult patients who are conscious, co-operative and communicative, and conducted in accordance with locally agreed protocols.

This guidance document is intended to support service managers, radiographers and assistant practitioners by stating clearly the rationale for the Scope of Practice of Assistant Practitioners in all aspects of imaging and radiotherapy and clarifying the responsibilities of all concerned. Service managers may wish to use this document to create local guidelines which best suit their own service needs.

It is intended that the Scope of Practice for the entire radiography workforce continues to be kept under review and research evidence used to support future developments in the Scope of Practice, such that services to patients continue to be improved.

Regulation and the Voluntary Register

The NHS (England) White Paper³ outlining the Health and Community Care Bill was followed by a Command Paper entitled “Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff”.⁴ This indicated that wholesale regulation of the support workforce would not be pursued. It proposed instead that a system of assured voluntary registration be introduced. The Command Paper also suggested that the public and patients who want to gauge whether the support worker meets appropriate standards should be able to access such information, and it placed responsibility for ensuring competence of the workforce with the employer. In Scotland, there are already codes of conduct⁵ for both employers and employees in respect of the support workforce.

In order to carry out its responsibilities with regard to public safety and professional practice, the Society and College of Radiographers developed an accreditation scheme and a public voluntary register for assistant practitioners to reassure patients and employers that these registrants had been appropriately educated and trained for their role. It is possible that the SCoR voluntary register may become part of a system of “voluntary assured registration”.

The public voluntary register for assistant practitioners has operated since 2005 but of those members that claim assistant practitioner as their membership status, only a small proportion have sought accreditation and have their name entered on the voluntary register. The implication is that, for the remainder, we do not know their scope of practice and the training that underpins it nor do we know if they engage in continuing professional development (CPD) to maintain their skills and competence.

Additionally, as members of the Society of Radiographers (SoR), assistant practitioners are entitled to benefits of membership such as professional indemnity insurance. However, if they are not accredited then the SoR and possibly their supervising radiographers do not know whether they have been “adequately educated and trained” for the tasks they are delegating to them. Therefore from January 2013, all members who claim to be assistant practitioners will be asked to apply for

accreditation. In due course, those who do not seek accreditation will be informed that their membership status will be annotated as “support worker” or “radiography department helper”. They will not be subsequently recognised by the SoR for any clinical activity relating to imaging or treatment.

As part of a professional workforce the expectation is that assistant practitioners like any other healthcare practitioner should be willing to place themselves on a voluntary register to signify that they accept the SCoR’s professional standards and its Code of Conduct and Ethics ⁶ just as radiographer members are required to maintain their registered status with the Health Professions Council (HPC).

Supervision, Accountability and Delegation

It must be remembered that the underlying role of the assistant practitioner is to perform protocol limited clinical tasks under the direction and supervision of a registered practitioner, usually a radiographer. The assistant practitioner is not a registered healthcare professional (a situation that is unlikely to change for the foreseeable future) and therefore cannot take overall responsibility for the “episode of care”. The person in overall charge of the radiographic, radiotherapy or ultrasound procedure is usually a registered radiographer or other registered healthcare professional. Within a framework of supervision they may be able to delegate appropriate tasks to the assistant practitioner.

Radiographers who themselves are undergoing considerable professional development or preceptorship should not be expected to undertake the additional burden of supervision of assistant practitioners. It is expected that those radiographers providing supervision are themselves employed within roles for which the job description includes responsibilities for teaching and assessing in the workplace.

The SCoR has published a Statement ⁷ and a Framework ⁸ related to clinical supervision. It should be recognised that clinical supervision is a quality assurance framework and not a quality control process. Clinical supervision is a two-way process between an individual and his/her mentors, supervisors and peers and is intended to ensure that safe, effective practice is carried out at all times.

The principle of supervision means that there must be a designated supervisor and the assistant practitioner will know clearly who is supervising them for all tasks that they undertake and that their supervisor will be working with them in the imaging or treatment room, or will be immediately accessible for support and advice. Legal opinion has advised that “adequate supervision” for assistant practitioners cannot be provided by telephone and therefore the Society and College of Radiographers does not support this practice.

It must be agreed by both the assistant practitioner and the supervising radiographer that the assistant practitioner is competent to undertake the task required, whether they are working under direct supervision or under indirect supervision. If they carry out the task under direct supervision ie working alongside a registered radiographer or other registered practitioner, legal responsibility for the task remains with the supervising radiographer as the autonomous, regulated practitioner. Indirect supervision occurs when the supervising radiographer, having ascertained that the examination for a particular patient is appropriate, delegates the task to the assistant. The radiographer may not actually oversee the procedure being undertaken, however they retain the responsibility for the act of delegation.

Where a supervising radiographer judges that the assistant practitioner being supervised is not able to undertake the allocated task, the supervising radiographer is directly responsible and accountable for ensuring that the task is re-allocated, or for carrying out the task personally. It is also the responsibility of the assistant practitioner to alert the supervising radiographer to situations where

they do not have the competence or confidence to undertake the allocated task.

The Law and the Assistant Practitioner

All healthcare practitioners have a duty of care and therefore a legal liability with regard to the patient. They must be able to perform competently and to inform their supervisors when they are unable to perform competently. In order for anyone to be accountable they must:

- have the ability to perform the task
- accept the responsibility for the task
- have the authority to perform the task within their job description and the policies and protocols of the organisation

For the assistant practitioner to act as an Operator under IR(ME)R 2000 ⁹ they must be entitled by their employer and be able to evidence “adequate education and training” for that role.

The radiographer has a duty of care and a legal liability with regard to the patient. If they have delegated a task, they must ensure that the task has been “appropriately delegated”.

Appropriate delegation means that:

- the task is necessary and delegation is in the patient’s best interest. This comes within the elements of consent and justification. Justification cannot be undertaken by the assistant practitioner as they are not registered healthcare practitioners
- the assistant practitioner understands the task and how it is to be performed
- the assistant practitioner has the skills and abilities to perform the task
- the assistant practitioner accepts the responsibility to perform the task competently.

NHS Wales have published the following statement:

“Delegation is the process by which you (the delegator) allocate clinical or non-clinical treatment or care to a competent person (the delegate). You (the delegator) will remain responsible for the overall management of the service user and accountable for your decision to delegate. You will not be accountable for the decisions and actions of the delegate”

This principle is upheld by the SCoR in that assistant practitioners must not be working in areas remote from the supervising radiographer as the radiographer may not be in a position to intervene or provide advice to prevent an adverse incident. The process of delegation will help to establish the circumstances in which advice should be sought from the supervisor and confirm the availability of the supervisor should they be required for advice and support.

Principles of delegation

- Delegation must always be in the best interest of the patient and not performed simply in an effort to save time or money.
- The assistant practitioner must have been suitably trained to perform the task.
- The assistant practitioner should always keep full records of training received, including dates. In roles requiring them to act as an Operator under IR(ME)R, such record keeping is a legal requirement.
- There should be clear guidelines and protocols in place so that the assistant practitioner is not required to make a clinical judgement that they are not competent or authorised to make.
- The role should be within the job description.
- The person who delegates the task must ensure that an appropriate level of supervision is available. The level of supervision must be appropriate to the task being delegated. In complex examinations or treatment or with patients who are severely injured, ill or

incapacitated, this will require the assistant practitioner to work alongside the radiographer (direct supervision).

- The whole process must be assessed for the degree of risk.

Professional responsibilities of the supervising radiographer

The “Episode of Care”

When a patient/client presents for imaging or treatment they are entitled to receive the highest standards of care. The responsibility for ensuring the quality and standards of the episode of care therefore remains with the registered practitioner (radiographer). The “episode of care” begins with the referral for imaging or treatment using ionising (or non-ionising) radiation. All exposures involving ionising radiation must be justified before they are made and the justification must be undertaken by someone recognised and entitled by the employer as a ‘Practitioner’ under IR(ME)R 2000. Following the publication of The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2006¹⁰, the ‘Practitioner’ must be a registered health care professional whose profession is regulated by a body as detailed within Section 25 (3) of the National Health Service Reform and Health Care Professions Act 2002.¹¹ For this reason, an assistant practitioner is legally not allowed to take on the role of ‘Practitioner’. The assistant practitioner as an IR(ME)R ‘Operator’ is, however, legally responsible for the tasks they are entitled by the employer to undertake in relation to ionising radiation medical exposure.

Each episode of care ends when the patient/client is discharged from the imaging or radiotherapy department either back into the primary care environment or onwards to another hospital department. The satisfactory discharge of patients is the responsibility of the supervising radiographer.

Adverse Incidents

In the event of an adverse incident arising from the actions of the assistant practitioner, the act and appropriateness of delegation may be challenged. If the delegation was deemed inappropriate then it is the radiographer who may have this aspect of their professional conduct investigated and may risk losing their registered status with the Health Professions Council (HPC). The HPC cannot take action against the assistant practitioner as they are not a registered healthcare practitioner.

Even if the employer offers vicarious liability for actions undertaken outside the Scope of Practice or an individual’s competence, the supervising radiographer is not protected from any action that may be taken against them by the HPC. Put simply, even if the employer indemnifies the radiographer against litigation by a patient, the radiographer can still lose their registration to work as a radiographer.

The Society of Radiographers’ Professional Indemnity (PII) Scheme

The policy of confining the Scope of Practice of the assistant practitioner forms the basis upon which the Society’s professional indemnity insurance is based. The insurance premium is based on an assessment of risk and limitation of practice reduces that risk. Professional indemnity insurance provided by the Society of Radiographers does not cover the assistant practitioner or the supervising radiographer if the assistant practitioner is acting outside the Scope of Practice determined by the Council of the Society of Radiographers and for which the individual is accredited.

The Society and College of Radiographers gives advice on all aspects of radiographic practice and does so in the best interests of patients and the public. This includes advice on the Scope of Practice for those individuals who practise radiography. It is expected that members of the Society of Radiographers and those accredited by the Society and College of Radiographers adhere to the relevant Scope of Practice, whether as an assistant practitioner, or as a supervising radiographer.

Ultimately, it is the employer's responsibility to ensure that its employees are adequately educated and trained for their role. It is strongly advised that clinical governance guidelines are followed and that a thorough risk assessment is undertaken in order to develop protocols for assistant practitioners and that the employer is aware of these new practices and accepts vicarious liability for its employees.

Local variations in the Scope of Practice and Professional Indemnity Insurance

It is accepted that assistant practitioners will develop their skills and will become experienced in defined aspects of practice. Over time, it may be possible for an individual assistant practitioner who has undergone further relevant and College of Radiographers' approved, education and training to be accredited for additional competences. The Society and College of Radiographers will consider such requests for accreditation on an individual basis using the standards and procedures of the Approval and Accreditation Board. However, it should be noted that assistant practitioners cannot be responsible for a complete episode of care. This remains the domain of the registered radiographer.

Assistant Practitioners and IR(ME)R 2000 and 2006

The definition of Operator is stated in IR(ME)R as:

"any person who is entitled, in accordance with the employer's procedures, to carry out practical aspects...".

The following guidance is intended for radiography education providers and clinical services managers about the entitlement of trainee assistant practitioners as IR(ME)R Operators during their education and training and while undertaking practice based learning.

Under IR(ME)R 2000 and 2006 Regulation 4(4)a and (4)b, the Employer has a responsibility to ensure that all entitled Operators are adequately trained to perform the tasks within their defined scope of practice and, similarly, Operators should not carry out a medical exposure or any practical aspect without having been adequately trained (Regulation 11(1)). The Employer must specify the scope of practice and the tasks for which an individual can act as an Operator and be able to demonstrate that he/she is adequately trained.

Persons entitled to act as an Operator must have undergone training in those subjects in Schedule 2 of IR(ME)R which are relevant to their functions and area of practice. The Society and College of Radiographers recognises that the education programmes for assistant practitioners that it approves and/or the SCoR accreditation process address the requirements of Schedule 2 of IR(ME)R. Hence, these may be used as the benchmark by which the Employer defines 'adequate training' as an individual moves from being a trainee to qualified and accredited assistant practitioner. Additional local training will be required for new equipment or modalities.

While undergoing training, the requirements of Schedule 2 are unlikely to be fully met prior to qualification and in these cases Regulation 11(3) of IR(ME)R is relevant, where supervision still applies. Trainee assistant practitioners should be directly supervised by a radiographer whilst in the clinical environment. The supervising radiographer will be responsible for the practical aspects carried out by the trainee and therefore is the "Operator" for that medical exposure.

It should be noted, however, that for trainee assistant practitioners, education providers and clinical services managers are advised that the College of Radiographers considers it inappropriate for Employers to entitle them as an "Operator" to act in their own right.

If an Employer is satisfied that evidence of assessment and an up-to-date training record of the assistant is held by the relevant clinical imaging or radiotherapy services department, it is possible for a trainee assistant practitioner to be deemed competent in a specific task and entitled as an

Operator within a very limited scope of practice.

If an Employer entitles a trainee assistant practitioner to act as an “Operator”, there must be a robust local entitlement process within the clinical department which satisfies the relevant sections of Schedule 2. As part of the entitlement process, the necessary information surrounding the individual’s scope of practice, the theoretical and practical training given as well as an assessment of competence must be clearly documented in the individual’s training record in line with the IR(ME)R Employer’s Procedures.

Once an Employer has entitled a trainee as an Operator, that employer assumes responsibility for ensuring that adequate and up-to-date local training of the entitled Operator is delivered and recorded and is consistent with the tasks the individual is entitled to carry out. It is the Employer’s responsibility to maintain documented and up-to-date evidence of adequate training for all entitled IR(ME)R duty holders including all assistant practitioners and trainees that the Employer decides to entitle as Operators.

Clinical Governance

It is the responsibility of the employer, the supervising healthcare practitioner and the assistant practitioner to ensure that the quality of care is delivered and maintained to a high standard. The following must therefore be observed and implemented:

- Outcomes of care, especially adverse events and service failures are monitored in order to analyse and improve services.
- Clear lines of responsibility and accountability are established for the overall quality of clinical care.
- Skill mix is considered when planning and developing workforces in imaging and radiotherapy services.
- Risk assessments are undertaken before new roles and working practices are developed and introduced.
- Protocols are developed and agreed locally (with the employer, as appropriate) before skill mix initiatives are implemented.
- Evidence based practice is supported and applied routinely in everyday practice.
- Continuous professional development programmes are in place to identify and meet the developmental needs of the individual health professional.

It is important that the work of assistant practitioners is subject to the same clinical audit processes as for other members of the workforce. Extension of the role and scope of practice of the assistant practitioner will be considered by SCoR on the basis of robust research and audit data to support such a proposed change.

Assistant Practitioners and the Supply and Administration of Medicines and Contrast Agents

This statement is published to clarify the role of assistant practitioners in the supply, administration and prescribing of medicines (including contrast agents) within imaging and radiotherapy departments.

Assistant practitioners are not permitted, by law, to use Patient Group Directions (PGDs).

A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before arrival in the department. PGDs are a legal requirement when supplying or administering 'prescription only medicines' (POMs), and if the drug is a different category (pharmacy or general sales list), PGDs are also considered good practice.

PGDs can be used by certain registered practitioners including radiographers, but assistant practitioners are not registered and regulated practitioners and therefore they are NOT permitted to use PGDs.

It is advised that where the initiation of an exposure also initiates the administration of a contrast agent eg automatic pump injectors, these devices are neither loaded by an assistant practitioner, nor do they initiate the exposure in their role as an Operator under IR(ME)R.

It is understood that some assistant practitioners are trained to insert "Venflon"™ and similar devices. We advise that the patency of the device is again checked by the radiographer or other registered healthcare practitioner before initiating administration of contrast agents or other substances.

Assistant Practitioners Verifying Patient Identification and Seeking Consent

Assistant practitioners and trainee assistant practitioners are part of the non-registered workforce and must work under the supervision of a registered healthcare professional (normally a radiographer). Assistant practitioners, do not practise autonomously and must work effectively and safely within their defined area of practice, within relevant legal and ethical frameworks, and in accordance with agreed protocols.

Identification of the patient

Under a process of supervision, the assistant practitioner or trainee may identify the patient in accordance with local policies and protocols. Typically this would be using the well established three-point patient identification procedure:

- first name
- last name
- date of birth.

This procedure was developed as a requirement for employers under IR(ME)R regulations [Regulation 4 (1) Schedule 1 (a)].

The assistant practitioner or trainee should ensure that the patient actively responds to identification questions. They should confirm with the patient that the requested examination corresponds with the patient's clinical history ie check symptoms in case the wrong patient identifier has been attached to the request form.

Where possible, the NHS Number should always be used in conjunction with other verifiers when identifying a patient.

There may be exceptions where it may not be possible or may be difficult for the patient to be directly identified such as mute or non-English speaking. The employer will have clearly documented

procedures in place to cover these eventualities.

As long as consent to investigation or treatment has been gained from the patient, it is not necessary in law to seek additional consent to treatment which will be undertaken by an assistant practitioner or trainee as the nature and purpose of the procedure remains the same whoever undertakes the task.

The SCoR reaffirms its statement that from an ethical perspective, a patient must be made aware that the examination will be undertaken by an assistant practitioner or trainee and not a registered health professional and permission to proceed must be sought from the patient through his/her explicit verbal agreement.

The task of gaining consent may be delegated by a supervising radiographer to an assistant practitioner or trainee who is proven competent to do so following education and training. The radiographer retains the overall responsibility for the task and accountability for the decision to delegate. The person who has been delegated the task is responsible for their own actions.

Assistant practitioners in clinical imaging undertaking limited protocol-driven standard imaging examinations on the co-operative, communicative and conscious adult patient may take responsibility for obtaining patient consent in these limited contexts provided s/he is proven competent to do so.

Obtaining consent for radiotherapy is deemed to be beyond the scope of practice and role of the assistant practitioner in radiotherapy.

Presence of trainees during examinations

Whenever trainees are working with a radiographer or observing as part of their training, it is a requirement that their presence is explained to the patient and the patient's permission is sought for the trainee to be present during the examination.

For trainee observation of intimate procedures (eg transrectal/transvaginal ultrasound, mammography, prostate brachytherapy, etc) as part of their training requirement, the patient's explicit verbal consent for a trainee to be present must be sought prior to entering the examination room. Patients must be made aware of the type and number of students who will be present and be advised that they can decline without fear of offence or of compromising their examination or treatment.

Scope of Practice of Assistant Practitioners in Specific Areas of Practice

ASSISTANT PRACTITIONERS IN RADIO THERAPY

The original Scope of Practice of assistant practitioners in radiotherapy was defined as performing limited treatment procedures which will vary in accordance with locally identified need and in consideration of the relative risk associated with the activity.

Scope of Practice related to specific radiotherapy procedures

Assistant practitioners must have a sound knowledge of the basic concepts of a defined area of practice as described in the Learning and Development Framework (2007).¹²

Within Radiotherapy Centres, assistant practitioners work as members of the team and in describing their scope of practice, it is important to recognise two distinct roles:

First, there are elements of the work traditionally performed by the radiographer which may be

undertaken by the Assistant Practitioner who is trained and competent to carry out that element (ie the assistant practitioner takes responsibility for the tasks delegated to them).

Second, assistant practitioners may work alongside the radiographer helping with aspects of an episode of care under the direct supervision of the radiographer. This may include elements which would be outside the normal scope of practice for an assistant practitioner if working alone. The radiographer retains both professional and legal responsibility for the episode of care. The SCoR recommends that there should always be two Operators involved in each treatment activity. This means that a radiographer should not work alone with trainee assistant practitioners who are not yet entitled as Operators under IR(ME)R.

The assistant practitioner will work within a scope of practice under the supervision (direct or indirect depending upon the task) of a registered practitioner (radiographer) within relevant legislation and departmental protocols. Elements which may be delegated may include:

- elements of pre-treatment processes such as imaging
- elements of treatment delivery; those treatments defined by protocol and simple megavoltage treatments
- elements of daily machine quality assurance tasks
- elements of patient support and information within a clearly defined protocol.

All areas of practice of the assistant practitioner require robust training and education and an appropriate assessment of competence. It is the responsibility of the Radiotherapy Services Manager to define the details of the scope of practice for their assistant practitioners in response to their own service needs (and in line with guidance from this professional body) in agreement with the employer, who entitles the assistant practitioner to carry out the defined scope of practice. However, the safety of the patient is always paramount and therefore the scope of practice is limited. Assistant practitioners can never replace a radiographer where a registered practitioner of this level is required.

Listed below are clinical situations where assistant practitioners can work but where they can only take responsibility for the core elements of set-up and for which they are assessed as competent. Assistant practitioners are able to contribute to the set-up of patients within the clinical situations listed below however they must be under the direct supervision (ie working alongside) of a registered radiographer and cannot take responsibility for the total treatment. This means that they cannot work alone and therefore must always be directly supervised for the more complex elements of the set up requirements.

These activities include:

- complex and non-protocol defined radiotherapy including apposition techniques superficial, orthovoltage and electron techniques and, for example, multi-field/phase complex head and neck treatments.
- patients with complex needs including children.

Practices outside the Scope of Assistant Practitioners

Listed below are a number of situations in which the responsibilities related to radiation protection, patient care and treatment planning and delivery are considered to be beyond the Scope of Practice and role of the assistant practitioner in radiotherapy:

- obtaining consent for radiotherapy
- decision making regarding treatment complications
- on-treatment patient review/patient follow up
- administration and supply of medicines under Patient Group Directions - **NB** assistant practitioners are not permitted, by law, to use Patient Group Directions (PGDs).

ASSISTANT PRACTITIONERS IN CLINICAL IMAGING

(i) Radiographic imaging

The Department of Health project that examined skill mix in clinical imaging¹³ concluded that the activity of the assistant practitioner would be restricted to undertaking plain film radiography (standard radiographic imaging) under the supervision of a registered health care practitioner (radiographer). There was also the possibility that other activities that would provide support for radiographers where assistant practitioners would be working under direct supervision could be explored.

The Scope of Practice in standard radiographic imaging includes:

- appendicular skeleton
- axial skeleton excluding skull and cervical spine (see below)
- chest and thorax
- abdomen and pelvis.

The skull and cervical spine are excluded if they are to be imaged as a result of trauma. Best practice suggests that computed tomography is the most appropriate modality and technique to be employed. Imaging of the cervical spine in trauma poses a specific risk and therefore should be carried out by experienced radiographers.

Imaging of the orbits prior to magnetic resonance imaging (MRI) to exclude the presence of metal foreign bodies is acceptable provided that additional training has been given. Similarly, following additional acceptable training, assistant practitioners can be accredited for undertaking dental radiography in adults.

Dual energy x-ray absorptiometry (DEXA) imaging

The use of DEXA equipment by assistant practitioners is growing, however this should be under the supervision of a registered radiographer. We are aware that some nurse practitioners supervise DEXA services and in those circumstances we expect the nurse practitioner to be entitled as an Operator under IR(ME)R. Standard operating procedures must identify how to obtain advice regarding radiographic practice or radiation protection issues. The scope of practice of the assistant practitioner is limited to image and data acquisition. The assistant practitioner must not interpret the data or convey an interpretation of that data to the patient or another healthcare practitioner.

Supplementary projections, repeat imaging and discharge

A qualified and accredited assistant practitioner can assess their images for their technical acceptability. Any repeat imaging must be agreed by the supervising radiographer. If supplementary projections are required, the assistant practitioner must have been additionally trained in these techniques and only then authorised to undertake them by the supervising radiographer and in accordance with local protocols.

When the examination is deemed to have been completed, then the supervising radiographer will view the images and discharge the patient. Local schemes of work have been developed where, if the patient is returning to another department in the hospital such as an outpatient clinic and the images will be immediately reviewed by the referring clinician, the supervising radiographer can make the decision not to review the images. However the supervising radiographer still remains responsible for the act of delegation and the episode of care. In no circumstances should a patient be discharged from the department to return home or leave the hospital unless the images have been reviewed by a radiographer, radiologist or referring clinician. Further information pertinent to breast screening can be found in the relevant section.

Practices outside the scope of assistant practitioners in radiographic imaging

There are a number of situations in which the responsibilities related to radiation protection and

patient care are considered to be beyond the Scope of Practice and role of the assistant practitioner.

The examination of patients with major trauma

The scope of practice is limited to the “adult, ambulant patient” who is “conscious, co-operative and communicative”. For the severely injured, it is likely that modifications to projections or techniques may be required. This requires that an experienced radiographer undertakes these examinations. The role of the assistant practitioner is restricted to working under the direct supervision of the radiographer undertaking the examination. This applies equally to working within the main department or within the accident and emergency department.

Mobile x-ray units in areas remote from the main department

The primary concern of all involved in an imaging procedure is that the patient is treated effectively, within ALARA principles and following best practice. There have been suggestions that assistant practitioners undertake imaging procedures on wards and remote locations and without the direct supervision of a radiographer. There are a number of reasons why this is unacceptable and outside the recognised scope of practice of assistant practitioners:

- As best practice and to achieve dose limitation to both the patient being imaged and other patients, staff and visitors, patients should be examined within the main imaging department wherever possible. If the patient’s condition precludes this then, by definition, the patient’s condition is complex and likely to require adaptation of standard technique. Justification of the individual exposure will also be required, given the needs of the patient and the requirement to adapt technique and, under IR(ME)R, this cannot be undertaken by the assistant practitioner. It is also inappropriate and not in the patient’s best interests that imaging should be delayed while the assistant practitioner finds a radiographer to provide supervision. It is unacceptable, in these circumstances, for advice to be given by telephone.
- The application of radiation protection measures to limit dose to other patients, staff and visitors is the subject of the Ionising Radiations Regulations 1999. The Society and College of Radiographers states unequivocally that this level of responsibility to monitor the environment and exposure of staff is beyond that of an assistant practitioner.
- The supervising radiographer who has delegated the task and is responsible for the episode of care would be placed in a difficult position if she/he is held responsible for the activities of another person or situation over which they have no direct knowledge or control. It is unacceptable to the SCoR to expect a radiographer to accept this liability.

(ii) Mammography

Assistant practitioners have become a well established element of the workforce in the NHS Breast Screening Programme. The focus of their activity is with non- symptomatic well women. It is becoming evident that, as breast care services are re-aligned, there may be the opportunity for them to expand their Scope of Practice to include symptomatic patients. However, this must be on the understanding that they have undertaken the additional education and training necessary for them to fulfil this role and that they continue to work under protocol and the supervision of a radiographer. In addition, the employing authority must be advised of their additional duties and expanded Scope of Practice and the justification for projections additional to the standard cranio-caudal and medio-lateral projections must be made by a registered health care practitioner.

Assistant practitioners have been employed to work alongside radiographers on mobile breast

screening units. This is considered acceptable as the radiographer remains responsible for the episode of care. In no circumstances does the Society and College of Radiographers accept that the mobile screening service can be delivered entirely by assistant practitioners working without the supervision of a radiographer who is also available to act as a Practitioner under IR(ME)R if required. Before working on a mobile unit, the assistant practitioner must have been assessed as fully competent in the use of mammography equipment in a breast screening centre.

In the event that a woman presenting for screening can only have a “partial examination”, this is deemed to be a variation from protocol and must be justified by a Practitioner (under IRMER). The assistant practitioner cannot act as a Practitioner and the examination requires justification by the supervising radiographer.

With the implementation of digital imaging equipment on mobile units, it is now possible for the images to be viewed at acquisition. Therefore the same procedures regarding repeat imaging and discharge in respect to standard radiographic imaging are acceptable. Repeat imaging should be agreed with the supervising radiographer. However these arrangements are for local agreement and implementation. The rationale for discharge remains the same as for analogue equipment. The care pathway for breast screening dictates that images are reviewed and technical recall instigated if appropriate. Supplementary projections would not be undertaken in mobile units and therefore the technical acceptability of the images can be judged by an experienced assistant practitioner and the woman informed that the examination is complete.

Additionally, the same considerations must be given to the assistant practitioner in respect of health and safety matters as to radiographers undertaking mammography, ie there must be proper attention to rest periods and rotation of duties to minimise the risk of work related musculo-skeletal disorders.

Practices outside the scope of assistant practitioners in mammography

The role of the assistant practitioner is primarily to acquire the standard images for screening. Some centres may wish to involve assistant practitioners in the imaging of symptomatic women or of biopsy samples. The accreditation of an assistant practitioner to undertake the imaging of symptomatic women requires evidence of additional education and training to support this activity. Additional training can be given for the imaging of biopsy specimens if this is a locally agreed procedure.

Advice from the NHS Breast Screening Programme considers that the imaging of the augmented breast (women with implants) is not a routine procedure. These women often have concerns about the appearance or feel of the implant that need to be discussed in detail possibly through referral back to their surgeon. To adequately image the augmented breast may require adaptation of technique. The SCoR therefore supports the view expressed by the NHSBSP and advises that these examinations are undertaken by the radiographer.

It is not within the scope of practice for assistants to assess images for the purpose of technical recall or recall to assessment. We do not accept that assistant practitioners can extend their practice to the examination of the breast by ultrasound.

(iii) Assisting in fluoroscopy

The role of the assistant practitioner during investigations involving fluoroscopy is to support the registered health care practitioner. Therefore, in these situations, the provisions of direct supervision prevail. The assistant practitioner having been adequately trained in fluoroscopy may assist a radiographer or radiologist in undertaking fluoroscopic examinations. To fulfil the condition of direct supervision for fluoroscopic procedures, the radiographer or radiologist will be present in the examination room and leading the procedure.

Practices outside the scope of assistant practitioners in fluoroscopy

Fluoroscopy in operating departments and locations remote from the clinical imaging department

The requirement for fluoroscopy in operating departments and similar locations remote from the main department poses particular challenges. It may involve the use of mobile equipment and thus require the establishment of a temporary controlled area or it may be in a purpose built facility such as a cardiology suite. The examination may be complex and the patient may be unconscious requiring the Operator (under IR(ME)R) to continuously monitor the radiation exposure in order to determine and communicate that prolonged or continued exposure may not be justified. Justification is the responsibility of an entitled Practitioner under IR(ME)R 2000 and the assistant practitioner cannot undertake this role .

The education and training prescribed by the Society and College of Radiographers and the non-registered status of assistant practitioners does not equip them for this activity and level of responsibility. Additionally, it is considered that to prolong the patient's exposure to anaesthesia while advice or assistance is sought from the supervising radiographer may compromise the patient's wellbeing. Therefore it is the view of the SCoR that the responsibility for undertaking imaging in these situations is that of a registered radiographer.

Some centres may hold the view that the medical practitioner leading the operation or investigation is the Practitioner under IR(ME)R 2000 and can therefore fulfil the requirements for justification as well as maintain a safe radiation environment for staff. This view is not supported by SCoR in that it believes that the medical practitioner's role should be focussed on the clinical procedure being undertaken. Where the medical practitioner is undertaking the role of Practitioner under IR(ME)R 2000, it is imperative that the employer has carried out and documented a thorough risk assessment including the radiation safety aspects for both patients and staff relative to the anticipated episodes of care. This includes ensuring that the Practitioner has been adequately trained to act in that capacity as required by IR(ME)R 2000, specifically Regulations 4 (4) and 11.

Both the Practitioner and the Operator have a duty to adhere to the ALARP (as low as reasonably practicable) principles of dose reduction and the maintenance of a safe radiation environment.

SCoR has considered and supported individual cases where the examination is non complex and is undertaken with radiographer support immediately available. Advice must be sought from SCoR by departments and individual accredited assistant practitioners before such an extension to the scope of practice can be accepted. However it remains that, for many operations, procedures and investigations the potential for significant dose accumulation is high. The individual responsible for monitoring dose accumulation, the radiation environment and for challenging prolonged exposure has a responsibility beyond that of an assistant practitioner. In these situations it must be the responsibility of a registered radiographer.

As in the case of using mobile imaging equipment on wards, the radiographer who is nominally responsible for supervision is placed in a difficult position if an adverse incident or 'exposure that is greater than intended' results from the examination.

Children

As discussed in the recent Society and College of Radiographers' publication 'The Child and the Law: The Roles and Responsibilities of the Radiographer',¹⁴ the responsibilities of the radiography workforce to children are both critically important and complex. They include such issues as:

- child protection
- confidentiality and consent
- non-accidental injury and skeletal survey
- co-operation, distraction and immobilisation.

The radiographer has a clear duty of care to safeguard and promote the welfare of children including responsibility for child protection. The Society and College of Radiographers believes that because of the complexity of issues and the possible serious consequences of any mistakes, the interests of children are best served by radiographers taking the responsibility for the imaging procedure. Any actions taken by assistant practitioners with regard to children should be under the direct

supervision of the radiographer.

The imaging of children frequently requires adaptation of technique and therefore this would preclude the assistant practitioner from independently undertaking the examination.

Where no modification of technique is required and where children may be deemed to be 'Gillick competent', (a term used to describe when a minor may be able to consent to his or her own medical treatment despite their young age), it may be possible for an experienced and accredited assistant practitioner to undertake some standard examinations provided that the welfare interests of the child are being overseen by a registered healthcare practitioner who is trained in this aspect of care.

(iv) Computed Tomography and Magnetic Resonance Imaging

The initial Scope of Practice of the assistant practitioner was limited to the acquisition of standard radiographic images. The role of an assistant practitioner in computed tomography (CT) and magnetic resonance imaging (MRI) is related to providing support for other registered healthcare practitioners, eg radiographers and radiologists, and for aspects of patient care. Therefore, in these situations, the provisions of direct supervision prevail. Accredited assistant practitioners should apply for an extension to their individual scope of practice stating the additional education and training they have undertaken to support this role.

(v) Nuclear Medicine and Radionuclide Imaging

Assistant practitioners can be involved in these procedures as Operators provided that they have undergone adequate education and training as required by IR(ME)R 2000. In this role they may position equipment and select image acquisition parameters. At all times they should be working under the direct supervision of a registered radiographer, healthcare scientist or qualified nuclear medicine technologist.

As non-registered healthcare practitioners, they may not administer radiopharmaceuticals under Patient Group Directions. However they may be entitled by their employer to administer radiopharmaceuticals under Patient Specific Directions. In these instances, the SCoR recommends that this be for oral administration only and not intravenous administration. In all cases, the dose to be administered must be checked by a second Operator before it is given to the patient.

Practices outside the scope of assistant practitioners in nuclear medicine/radionuclide imaging

The preparation of any radiopharmaceutical prior to administration, including dose calculations, is beyond the scope of practice of an assistant practitioner.

ASSISTANT PRACTITIONERS IN ULTRASOUND

Ultrasound services are multidisciplinary and multi professional in nature and include a range of examinations which play an essential part in the screening, diagnosis and management of patients in primary, secondary and tertiary care settings. The demand for ultrasound imaging is increasing and due to the versatility of the technique, its application in various fields of medicine is also expanding.

The purpose of this section is to indicate where an assistant practitioner, appropriately supervised by a registered healthcare practitioner* (henceforth referred to as a "sonographer"), can contribute to service delivery by being educated and trained to undertake routine, non-complex ultrasound examinations and to recognise when the expertise of a more experienced sonographer is required.

The term "sonographer" in the context of this document does not imply any specific professional background but does imply registration with a statutory regulator (eg the Health Professions Council, the Nursing and Midwifery Council or the General Medical Council), or equivalent*, and education and training at postgraduate level to undertake ultrasound examinations. The SCoR believes that

sonographers must be registered with one of the statutory regulators of medical or non-medical practitioners or, where this is not possible, with the Public Voluntary Register of Sonographers. This upholds best practice in terms of protection of the public and patient safety.

* Some sonographers, usually those trained overseas, are not currently eligible for registration with one of the statutory regulators. These should seek entry to the Public Voluntary Register of Sonographers maintained by the College of Radiographers.

All patients/clients presenting to the ultrasound department are entitled to receive the highest standard of care, therefore the responsibility for ensuring the quality and standard of the episode of care remains with the designated supervising sonographer. The episode of care begins with the referral for an ultrasound scan. All referrals for an ultrasound examination must be confirmed as appropriate by a sonographer before delegating to an assistant practitioner.

The activity of the assistant practitioner in ultrasound should be restricted to undertaking limited, single condition and simple screening ultrasound examinations performed to an agreed protocol and under the supervision of a registered sonographer. The assistant practitioner may undertake other duties such as supporting other sonographers, undertaking examinations and the routine quality control of equipment. Any limitations of the role of the assistant practitioner must be made absolutely clear. It is not appropriate for assistant practitioners to discuss clinical matters with patients or clients and, if unexpected findings arise during any examinations the assistant practitioner is authorised to carry out, they must seek immediate advice from the sonographer supervising their practice.

The Scope of Practice related to specific ultrasound procedures

There are elements of the work traditionally performed by the sonographer that may be undertaken by the assistant practitioner who 'is trained and competent to carry out that element' (ie the assistant practitioner takes responsibility for the tasks delegated to them). The assistant practitioner will comply with relevant legislation and departmental protocols and work within their competence, recognising their limitations and when to seek advice.

Assistant practitioners may also work alongside a sonographer helping with aspects of an episode of care, for example, providing chaperoning services or providing support to patients.

The sonographer retains both professional and legal responsibility for the episode of care.

Elements of ultrasound practice which may be delegated to assistant practitioners include:

- single measurements, single conditions or routine screening examinations; for example
 - obstetric dating scans where the task is limited to making a single measurement followed by recording the associated gestational age that has been automatically calculated by the machine software from standard data charts/tables. N.B. Nuchal translucency measurements are not permitted.
 - Abdominal aortic aneurysm (AAA) screening where a single organ is scanned and measurements taken and recorded.
- calculating bladder volumes and ankle brachial pressure indices using dedicated or specialised single purpose equipment and automatic calculation software.
- routine surveillance examinations to monitor anatomical dimensions where a baseline scan has been performed by a registered healthcare practitioner.
- routine quality control of imaging equipment.

Practices outside the scope of assistant practitioners in ultrasound

Listed below are a number of situations in which the responsibilities related to the practice of ultrasound, patient care and patient management are considered to be beyond the scope of an assistant practitioner.

- Ultrasound examinations on patients with complex needs including children, and hospital in-patients.
- Ultrasound examinations which investigate multiple organs and conditions and may reveal complex pathology.
- Ultrasound examinations which require a differential diagnosis.
- Ultrasound examinations which require specialised image acquisition and interpretational skills, including fetal anomaly screening and nuchal translucency measurements.
- Ultrasound examinations which require high levels of communication skills, for example breaking bad news.
- Ultrasound examinations which require decision making regarding patient management and referral.
- Ultrasound examinations which require decisions for patient review/patient follow up.

Supervision

Where the assistant practitioner is supervised by a radiographer/sonographer, SCoR considers that the supervising practitioner should have completed a CoR/CASE accredited postgraduate training programme such as a Postgraduate Certificate/Diploma/MSc in Medical Ultrasound and have at least two years of clinical experience in this speciality. They should also be able to demonstrate the level of knowledge and skills necessary to supervise others effectively as outlined in the SCoR Practice Educator scheme.

Additionally, it is the responsibility of the manager/employer to ensure that individuals carry out examinations according to current British Medical Ultrasound Society safety guidelines and are “adequately educated and trained for their role”. The assistant practitioner must not undertake tasks for which they have not been trained or entitled to carry out.

Ultrasound service managers and employers are advised to seek advice and clarification with regard to the scope of practice of assistant practitioners in circumstances that they consider may not be covered by this guidance document. Enquiries should be directed, in the first instance, to the Professional and Educational department at SCoR.

Education and Training

The assistant practitioner role developed from support workers who were deemed to have the potential to undertake non-complex clinical tasks within a defined scope of practice. It was, therefore, appropriate to develop these skills through work based learning built on proven vocational education programmes. Relevant National Vocational Qualifications (NVQ) were available that were considered to provide suitable education and training to underpin practice. Additional skills and competences were developed through National Occupational Standards and are accepted as the basis of the learning outcomes for training programmes to develop assistant practitioners.

Assistant practitioners must have a sound knowledge of the basic concepts of a defined area of practice as described in the SCoR’s Learning and Development Framework.

A number of education providers sought to offer training programmes and submitted these for approval by the Society and College of Radiographers. The SCoR upholds the principle that the minimum educational level is one that equates to an NVQ at Level 3. The NVQ in Health has been discontinued. The SCoR will consider work based programmes, including apprenticeships, on an individual basis.

Formal education programmes for assistant practitioners include:

- Certificate of Higher Education
- Diploma of Higher Education
- Foundation Degree
- Higher National Certificate (Scotland)

It is recognised that some assistant practitioners may not be able to offer such qualifications. Student radiographers who have not completed the full degree and have “stepped off” with an award or sufficient credit may be able to be accredited as an assistant practitioner. Assistant practitioners working within the Abdominal Aortic Aneurysm screening programme who have followed the national training programme can apply for accreditation. Those with overseas qualifications may be able to apply for accreditation. Individuals seeking accreditation without SCoR recognised qualifications are advised to contact the Professional and Education department at the SCoR for advice.

Individuals wishing to embark on training to become an assistant practitioner should contact the membership department for an application form. Registering as a trainee enables transition to full accredited status on completion of training.

Accreditation and Recognition of the Practice of Assistant Practitioners

As stated previously, the SCoR believes that individual assistant practitioners practising clinically in the fields of imaging and radiotherapy should be accredited as this process:

- confirms to the employer and colleagues that they have been “adequately educated and trained” for their role, particularly in regard to IR(ME)R legislation
- confirms for the patient, through the Public Voluntary Register, that the examination or treatment is being carried out by a trained and competent person
- recognises the individual’s scope of practice and the potential for extending this, subject to additional education and training
- provides recognition for the individual and their supervisors of the extent of Professional Indemnity Insurance provided by the SoR
- provides access to on-line learning, guidance and support
- supports the individual in progressing their career or transferring employment.

The process for accreditation can be found on the SoR website, under the section Career Progression, in the form of guidance notes and an application form. There are two routes for accreditation:

1. Successful completion of a SCoR approved course
2. Submission of a portfolio detailing the education and training undertaken.

The individual will receive accreditation based on the education and training they have undergone in relation to the SCoR Scope of Practice as described in previous sections of this document. Extensions to the scope of practice of an individual can be considered and will require the submission of evidence related to the additional education and training undertaken.

From January 2013, all members and individuals wishing to be recognised by the SCoR as assistant

practitioners should apply for accreditation if they are not already accredited. Accreditation is a benefit of membership of the SoR and is available to individuals who have been in membership for at least SIX months including any registered training period.

Alternatively, for individuals not wishing to join the Society of Radiographers, accreditation is available on payment of an accreditation fee equivalent to TWO years full membership rate.

Successful individuals will have their name entered on to the Public Voluntary Register of Assistant Practitioners.

CPD and Continued Accreditation

It is expected of assistant practitioners that they will undertake continuing professional development (CPD) in order to demonstrate that they continue to practise safely and competently. The period of accreditation is reviewed at two year intervals from the date of initial accreditation.

Re-accreditation is achieved by recording CPD activities on CPDNow, the SCoR's on-line CPD management tool. CPDNow will automatically produce a summary record and statement of CPD accreditation once 12 activities have been recorded within a TWO year period.

Extension to the Individual Scope of Practice

Where an employer, manager, supervising radiographer(s) and assistant practitioner(s) agree a protocol that extends the Scope of Practice of an assistant practitioner beyond that approved by the Council of the Society of Radiographers it may be possible to gain approval for a local variation to the Scope of Practice that is applicable to the named assistant practitioner(s) involved.

Information regarding the proposed extension to practice and the names of the individual assistant practitioner(s) should be forwarded to the Approval and Accreditation Board at The Society and College of Radiographers for consideration. Should a proposal be approved, the Society of Radiographers' Professional Indemnity Insurance cover would be extended to those individuals and their supervising radiographers. In considering such requests, it must be recognised that the Society will consider them primarily from the perspective of safe practice by the radiographer(s) and assistant practitioner(s) concerned.

Evidence to be submitted

Extensions may be granted to named individuals on receipt of an acceptable proposal that details:

- rationale for extension in terms of the benefit to patients
- risk assessment for the procedure in terms of compliance with legislation, local protocols, dose escalation, patient satisfaction and arrangements for supervision and availability of support for the assistant practitioner
- education and training to support the extension of practice. This can be through formal SCoR accredited training programmes or through work based programmes that can show clearly how the competence, particularly the underlying knowledge, has been assessed. Training records of "numbers of examinations completed" without a theoretical assessment will not be accepted
- agreement of the sponsoring organisation (Hospital Board/Trust or similar) to the extension of practice

- audit procedures to be undertaken in respect of dose monitoring, repeat imaging and patient satisfaction
- evidence from audit or research that supports the proposal
- agreement of radiographers involved in providing supervision.

Submissions must be made in respect of individual assistant practitioners in order that their membership record can be annotated correctly. It is not possible to consider a department- wide proposal as the experience and underpinning education across the assistant practitioner group is likely to be diverse.

Research and Audit of Practice

It is important that the practice of the assistant practitioner is subject to the same clinical audit processes as for other members of the radiographic workforce. Extension of the role and Scope of Practice of the assistant practitioner to meet service demands can be considered and the results of robust research and audit data could be used to support such proposed change.

Assistant practitioners in the NHS Breast Screening Service are required to submit to the same scrutiny of their images for technical recall as radiographers and are expected to meet the same standards.

In other areas of work such as AAA screening or standard radiographic imaging it is expected that the same audit standards will apply irrespective of the qualification status of the practitioner. It is not expected that assistant practitioners will initiate or undertake clinical research although they may support researchers by contributing data or other related activities.

Summary

This document and the policies described within it, supersede all previous Scope(s) of Practice for assistant practitioners published by the Society and College of Radiographers. The sections on IR(ME)R, consent, administration of medicines and accreditation should be read in conjunction with the detailed advice on these subjects available from the SCoR document library.

The document has been developed to provide greater clarity, particularly on practices outside the Scope of Practice of assistant practitioners.

The Society and College of Radiographers recognises that service delivery models continue to evolve and that the imaging and oncology workforce must also continue to develop. This document supports employers and managers in this development but within a safe, effective and evidence-based framework.

Service managers and employers are advised to seek advice and clarification with regard to the Scope of Practice of assistant practitioners in circumstances that they consider may not be covered by this guidance document. Enquiries should be directed, in the first instance, to the Professional and Educational department of the SCoR.

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