AUSTRALIAN COLLEGE OF PHYSIOTHERAPISTS

Australian College of Physiotherapists Specialisation Training Program Registrar Manual

(Version 2: May 2024)

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Contents

1. Introduction to the Australian College of Physiotherapists

The Specialisation Training Program (STP) is delivered by the Australian College of Physiotherapists (ACP), supported by both College staff as well as members of the College via Committees, Boards, and Working Groups.

The Specialisation Training Program is an integral component of the Specialisation process and aims to assist the registrar to achieve an appropriate level of performance across all four elements in a specific field of physiotherapy practice.

Registrars will be facilitated during this training period by a physiotherapist nominated by the College. In most instances, the facilitator will be a Fellow of the College.

In the case of a discipline with insufficient specialists to facilitate registrars, the College will appoint, a senior physiotherapist with relevant experience to be a facilitator. In such a situation, support will be provided by the discipline specific member of the Board of Censors, as required. An 'associate facilitator', who is a Fellow of the College and has experience in this role, may be appointed to support the 'novice facilitator' and ensure the registrar is provided with appropriate guidance as to the general standards expected at Fellowship level.

In certain circumstances, the role of facilitator may be shared between two Fellows of the College. The College will determine whether such a situation is in the best interests of the registrar and facilitators. Please see Appendix 5 for further information.

This manual is intended to provide guidelines for registrars and facilitators in all Specialisation disciplines of physiotherapy. The words 'patient' and 'clinical' are used in this document, however, in some disciplines these terms may also be interpreted to mean a client, a community setting, a work site or the built environment under assessment.

College Support

The Specialisation Training Program is supported by the College team, in particular:

- Head of the Australian College of Physiotherapists
- Training and Assessment Lead
- Training and Assessment Coordinator

As a Registrar, your first point of contact within the College will be the Training and Assessment Lead. Once you move to your final examination, your main staff support will be the Training and Assessment Coordinator. If you are unsure which member of staff to contact, you can contact the whole College team via acp@australian.physio, where your queries will be directed to the most appropriate member of staff.

Governance/Committee Support

Board of Censors

The Board of Censors (BOC) has a discipline specific member responsible for each cohort, who will liaise with both facilitators and Registrars. Communication between the facilitator and BOC discipline specific member occurs on a regular basis, in line with progress report deadlines and BOC meetings. Facilitators and Registrars may contact their BOC discipline specific member for guidance or assistance at any stage during the training program. Facilitators and Registrars may also contact a member of the College team for queries and support.

Board of Examiners

The Board of Examiners (BOE) is the Advisory Panel responsible for the oversight, monitoring, ratification, and development of the Specialisation Final Examination. The BOE reports to the Assessment and Credentialing Standing

Committee (ACSC). The panel is responsible for coordinating Specialisation Training Program (STP) examinations and makes recommendations on matters regarding the examination and ratification of examination results. The Board of Examiners comprises the Chief Examiner, a Deputy Chief Examiner and one discipline specific representative from each area of Specialisation.

Fellowship Pathways Standing Committee

The Fellowship Pathways Standing Committee (FPSC) provides strategic and operational oversight of all College Titling and Fellowship pathways. The responsibilities of the FPSC are to engage with all College Standing Committees and to confer recommendations made by the BOC.

Assessment and Credentialing Standing Committee

The role of the Assessment Credentialing Standing Committee (ACSC) is to provide strategic and operational oversight of all assessment and credentialing requirements for Titling and Fellowship pathways, including the appointment, training, and education of examiners and assessors. The ACSC members monitor and review assessment moderation and validation, including objectivity, transparency, consistency, and equivalence in criteria across Titling and the Fellowship training programs.

Appeals, Complaints, and Grievances Standing Committee

The Appeals, Complaints, and Grievances Standing Committee (ACGSC) reviews alleged appeals, complaints, and grievances pertaining to admissions, programs, courses, or professional development offered by the Australian Physiotherapy Association and the Australian College of Physiotherapists. The ACGSC maintains confidentiality of all parties and promotes fairness, consistency, and transparency for all stakeholders in education, professional development, and other activities of the College through risk identification.

College Council

College Council representatives provide strategic oversight on education programs and professional development activities. The College contributes to the lifelong learning needs of physiotherapists. The role of College Council is to assist the Association to achieve its objectives, through the provision of leadership, communication, representation, and services to all its Members; and to provide strategic direction for the Australian College of Physiotherapists cognisant of all stakeholders, the changing healthcare environment, and community expectations.

Examination Working Party

The Examination Working Party (EWP) is comprised of the Chief Examiner and the Exam Coordinator from each specialisation discipline with exam candidates. The EWP is responsible for supporting College staff in the preparation and delivery of the final specialisation examinations.

Additional Wellbeing Support

As part of our ongoing commitment to health and wellbeing of College members, Titling Applicants, and Specialisation Training Program and Original Contribution Registrars, the ACP has partnered with EAP ASSIST. EAP ASSIST provides confidential, independent phone counselling and/or support to resolve personal and professional issues. If you need assistance, please do not hesitate to contact EAP ASSIST on **0407 086 000** between 9.00am - 5.00pm AEST Monday to Friday or visit their website https://eapassist.com.au/ to complete a booking form. Please state the company code: **Australian Physiotherapy Association.**

2. Introduction to the Specialisation Training Program

On entering the Specialisation Training Program (STP), applicants will become Registrars of the Australian College of Physiotherapists. Registrar status will be conferred for the duration of the training period.
Fellowships by Specialisation are awarded in the following disciplines of physiotherapy:

- Cardiorespiratory
- Gerontology
- Musculoskeletal
- Neurology
- Occupational Health
- Paediatric
- Pain
- Sports and Exercise
- Women's, Men's, and Pelvic Health

Costs

Specialisation Training Program

The STP will cost $9,900, paid in two instalments, payable:

- on acceptance into the program ($4950);
- before commencement of the second year of the program ($4950).

Final Examinations

Final examinations for specialisation will cost $3300, paid in one instalment on acceptance to sit the final examination. Candidates are advised that final examinations may be held in a different state to the one in which they reside. All costs associated with travel and accommodation will be the responsibility of the candidate and are not included in the examination fees.

Repeat Final Examinations

Re-sitting of the final examinations for specialisation incurs an additional cost dependent on the components of the examination that are being repeated:

- Practical Component (Clinical Cases x2): $2200
- Viva Voce Component: $1100
- Full Examination: $3300

As per the initial examination attempt, all costs associated with travel and accommodation will be the responsibility of the candidate and are not included in the examination fees.

Additional Costs

The College will endeavour to notify Registrars of any additional costs as soon as practicable and will aim to minimise these costs whenever possible. Note that in some cases, these costs will be tax-deductible.
Registrars are expected to meet all personal travel and accommodation costs during the program, including costs associated with:

- Attending face to face sessions with their cohort,
- Attending Conferences,
- Participating in other courses or training,
- Visiting clinical Specialists located in other states,
- Completing mock exams,
- Attending final examinations.

Registrars are also expected to:

- Provide all equipment and other resources required for their training sessions,
- Provide their own internet, computer access and telephone and meet these costs throughout the STP,
- Maintain their APA, College, and appropriate national group membership.

Membership Costs

Upon completion of the STP, Registrars will be required to pay their Australian College of Physiotherapists Membership fee in order to use the Fellow title and FACP post nominal. The membership fee is $220 and is required annually to maintain Fellowship.

3. Structure of the Specialisation Training Program

Cohorts

Every Registrar in the training program is allocated to a cohort. Cohorts are groups of 1 – 4 Registrars within the same specialisation discipline who have entered the training program at the same time. Each cohort will be assigned a facilitator and a discipline specific Censor and is required to meet face to face eight times across the training program. These meetings may be conducted in the workplace of the facilitator and/or Registrars or using virtual platforms if circumstances arise where a cohort cannot meet face to face. Where possible, a cohort will be based in a single geographical area. A schedule of times and locations for face to face or virtual meetings will be negotiated between the facilitator and the Registrar cohort. Registrars are expected to take an active role in the organisation and planning of cohort meetings, whether virtual or face to face.

Correspondence between Registrars in different cohorts (from all specialisation disciplines) are encouraged and will be promoted through workshops and events, online learning through PebblePad, and other virtual platforms.

Facilitators

The role of the Facilitator is to advise and guide their cohort through the training program, supporting them with their learning and ensuring they are working to the expected standard through each part of the training program. They are required to work with their Registrars to produce SWOT analyses and Learning Contracts and will monitor each Registrar's progress through the program against these. Facilitators will also support the scheduling and content of the eight (8) face-to-face cohort meetings. Facilitators are Fellows of the College and in most cases will be from the same specialisation discipline as the Registrars in their cohort.

Censors

The role of the Censor is to provide an overview of Registrar progression to the BOC and to provide support and guidance to the Facilitator.

Timeline

The STP is delivered by the ACP in four 6-monthly blocks, designed to be completed over two years. A detailed timeline with specific deadlines and event dates will be provided to each cohort.

Training Block	Key Events and Activities
Block 1: Months 1 – 6 April → September	• Orientation • 2x Cohort Meetings • PEDro Information Session • SWOT Analysis • Learning Contract • 4x Clinical Reflections • Case study 1 • Additional self-guided learning activities
Block 2: Months 7 – 12 October → March	• 2x Cohort Meetings • Updated SWOT Analysis • Updated Learning Contract • 4x Clinical Reflections • 1x Marked Mock Examination • Registrar Day (held every second year) • Additional self-guided learning activities
Block 3: Months 13 – 18 April → September	• 2x Cohort Meetings • Updated SWOT Analysis • Updated Learning Contract • 4x Clinical Reflections • Case Study 2 • Additional self-guided learning activities
Block 4: Months 19 – 24 October → March	• 2x Cohort Meetings • Updated SWOT Analysis • Updated Learning Contract • 4x Clinical Reflections • Oral Presentation of Case Study • Professional Issues Essay • 2x Marked Mock Examination • Registrar Day (held every second year) • Additional self-guided learning activities

Year Three Deferred Program

The Year Three Deferred Program is an additional training period offered to Registrars who are not ready to sit their final examination at the 24-month point in the program, have not yet completed all components of the program prior to their final examination, or who are not yet at the expected standard of a new Specialist in their discipline. The program runs from April until the examination in November. Registrars may choose to enter the program if they do not feel prepared to sit their examination in June.

Extensions and Deferrals

The program can be undertaken over a longer period with part time completion plans or through extensions and deferrals. The BOC will consider variations to the two-year timeline on a case-by-case basis. In all cases, the STP must be completed within a maximum of four (4) years, including any period of deferment. If a Registrar's situation does not permit this, they will be required to withdraw from the STP and commence a new STP when circumstances allow. A transition to part time or a deferral will be implemented at the commencement of a new training block once the Registrar has satisfied all learning requirements and standards for the previous block.

4. Elements of Training Program and Learning Activities

Training progression and performance for Registrars will be measured against four key elements:

- Element 1: Development of Specialist Skills in Area of Practice
- Element 2: Participation in Education of The Profession
- Element 3: Commitment to Lifelong Learning and Professional Development
- Element 4: Participation in Research Activities

The Registrar will be required to participate in direct training with their cohort and facilitator, in addition to participating in other activities as well as successful completion of the formal Marked Mock Examinations (MMEs) and written components of the STP, to achieve the required entry level standard in each of the four elements. Progress in each Element will be reflected in the facilitator reports provided to BOC at quarterly intervals. This information will be considered by Facilitators, BOC, and College Staff when deciding whether the Registrar is ready to move on to the next six-months of the STP.

Element 1: Development of Specialist Skills in Area of Practice

Registrars will continue practicing in their field to develop high level specialist skills in the context of their discipline specific Curricula. Registrars will develop their skills through weekly clinical contact, cohort meeting activities, and individual learning activities. During these activities, Registrars will individually and collaboratively reflect upon experiences with scenarios / case presentations and management, and clinical reasoning and review of other theoretical background relevant to the area of specialty practice. Registrars are also encouraged to develop relationships with current Specialists and other STP cohorts across disciplines, geography, and years and to meet with them formally and informally.

Expected level of achievement in Element 1 will be assessed against the nine standards of practice. By the end of the STP the Registrar will be expected to demonstrate achievement in the nine standards of practice, commensurate with an entry level Specialist physiotherapist and Fellow of the College in the context of the discipline specific Curricula. Skill development activities undertaken as part of the STP are logged in the PebblePad Workbook under each Training Period Learning Contract. Associated with these logs should be reflections on the learning activity undertaken and how the activity has addressed aspects of the Learning Contract.

Nine Standards of Practice

1. Highly advanced professional behaviours
2. Highly advanced communication skills
3. Highly advanced knowledge in the field of the physiotherapy specialty and related sciences, advanced skills in information retrieval and analysis, highly advanced skills in the application of evidence-based practice
4. Highly advanced skills in physiotherapy assessment
5. Highly advanced skills in clinical reasoning
6. Highly advanced skills in development and application of an optimal physiotherapy management
7. Highly advanced skills in the evaluation of effectiveness, efficiency, and cost effectiveness of physiotherapy management
8. Ability to contribute to multidisciplinary heath care team management, where appropriate
9. Highly developed skills in service delivery and quality improvement processes.

Element 2: Participation in Education of the Profession

Registrars will demonstrate significant contributions to education of the profession during the STP. Education and teaching activities undertaken as part of the STP are logged in the PebblePad Workbook under each Training Period Learning Contract. Associated with these logs should be reflections on the activity undertaken and how the activity has addressed aspects of the Learning Contract.

Teaching activities should include examples of at least two of the following:

- Delivery, at an advanced level, of continuing professional development courses within a national group program or delivery of other teaching as approved by the BOC
- Delivery, in long term capacity, of undergraduate/graduate entry student education
- Delivery of postgraduate student education
- Delivery, at an advanced level, of staff development and training programs
- Presentations at national or international conferences
- Supervision of postgraduate, undergraduate or APC student clinical placements.

Element 3: Commitment to Lifelong Learning and Professional Development Activities

Registrars are strongly recommended to attend conferences, master classes, and advanced courses in their field of specialisation, for professional development and learning opportunities clearly linked to the objectives identified in their Learning Contract. Professional development activities undertaken as part of the STP are logged in the PebblePad Workbook under each Training Period Learning Contract. Associated with these logs should be reflections on the learning activity undertaken and how the activity has addressed aspects of the Learning Contract.

Element 4: Participation in Research Activities

Registrars are required to provide evidence of consistent involvement in research or other academic/scholarly activity across the STP. This may include involvement in research in any capacity, together with at least one of the following:

1. Providing a major contribution as a treating physiotherapist in a clinical trial or supporting research activity through screening and recruitment processes, or in a hospital / university research project.
2. Contribution to research supervision, e.g., co-supervisor of an honours or other research student.
3. Publication of a case study in a peer reviewed journal. Please note: InMotion is NOT considered to be a peer reviewed journal.
4. Reviewing abstracts for a conference or journal.
5. Publication and / or presentation of research at a conference / professional event.
6. Successful completion of a relevant research course (e.g., a university course in Evidence Based Practice or Research Methodology)
7. Accredited reviewer for the PEDro database and evidence of 3 reviews in each six-month period completed and documented in the Registrar's PebblePad Workbook.
8. Other research related activity as approved by the BOC.

Research activities undertaken during the STP should be documented in the PebblePad Workbook under each Training Period Learning Contract. Associated with these logs should be reflections on the activity undertaken and how the activity has addressed aspects of the Learning Contract. Supporting evidence such as manuscript drafts or proof of participation in research data collection or supervision is required for each activity. Research projects undertaken to meet this element must not be solely for the purposes of commercial product development but must contribute to the broader peer reviewed literature knowledge base. Confidentiality will be respected; however, a member of the BOC must be briefed about the nature of the research.

Recognition of Prior Learning

Applicants who believe they have met program requirements for Element 2 and /or Element 4 may be given credit in recognition of prior learning. An application for Recognition of Prior Learning (RPL) must clearly demonstrate a continuum of, and current learning, in relation to the element(s). To be considered current, prior learning must have been attained within three years of the year of admission into the STP. The BOC will consider a written application submitted with a statement providing evidence in support of the request for RPL.

5. Components of Training Program

Registrars are required to complete several components across their time in the STP. These tasks are measured against the four key elements and the nine standards of practice to determine performance of Registrars and progression through the four stages of the training program. Required components of the program are:

- Clinical contact
- SWOT Analysis
- Learning Contract
- Learning Activities (under each Training Period)
- Cohort Meetings
- Clinical Reflections
- Case Studies
- Oral Presentation of a Case Study
- Professional Issues Essay
- Marked Mock Examinations
- Final Examination

Clinical Contact

Registrars will continue to practice in their field of specialty in addition to learning activities and training program assessments and components. Registrars are expected to maintain a minimum of eight (8) hours of clinical contact each week for the duration of the STP.

SWOT Analysis

At the start of the program, Registrars will undertake a SWOT analysis to identify strengths, weaknesses, opportunities, and threats in consultation with their Facilitator and, if required, the discipline specific Censor. A copy of the final SWOT Analysis will be presented to the BOC (via PebblePad) for evaluation and approval in accordance with the cohort timeline. The BOC may require the Registrar to provide further detail or clarification of their SWOT prior to its approval and may provide advice about specific inclusions if considered appropriate. Registrars will be required to review their SWOT Analysis at the beginning of each 6-month block of the program.

Learning Contract

At the start of the program, Registrars will develop a Learning Contract, in consultation with their Facilitator and, if required, the discipline specific member of the BOC. The Learning Contract will identify individual learning needs in the context of the speciality discipline criteria and establish short- and long-term goals (learning objectives) for successful completion of the STP. Learning goals should be established using the SMART goal format (Specific, Measurable, Attainable, Realistic and Timely).

A copy of the Learning Contract will be presented to the BOC (via the Registrar's PebblePad Workbook) for evaluation and approval in accordance with the cohort timeline. The BOC may require the Registrar to provide further detail or clarification of their Learning Contract prior to its approval and may provide advice about specific inclusions if considered appropriate. The Learning Contract is required to be updated at a minimum, before the end of each six-month period of the STP, to reflect current achievements and to document new learning goals and proposed activities.

Learning Activities (under each Training Period)

Registrars will undertake a program of self-guided learning activities to assist in their development across all four key elements of the program. Learning activities should be selected by each Registrar to directly address the weaknesses, opportunities, and threats outlined in the SWOT Analysis and the Learning Objectives established in the Learning Contract. Learning activities may include:

- Conducting literature reviews,
- Attending multidisciplinary conferences,
- Completing short courses or workshops,
- Observing Specialists and experts,
- Private reading,
- Engaging in research and teaching activities,
- Engaging in critical reflection, enquiry in practice, and peer review,
- Increasing the depth and breadth of clinical and theoretical knowledge,
- Engaging in peer teaching and support,
- Accessing experts in the field (physiotherapy and other relevant health professionals or stakeholders).

Relevant evidence of each activity is recorded in PebblePad under each Training Period Learning Contract. Evidence should include commentary from the Registrar justifying the relevance of the activity to the element it has been logged under and to the goals they have set in their Learning Contract for the 6-month period. More than one file can be uploaded as evidence for an activity.

Cohort Meetings

Each cohort is required to meet face-to-face a total eight (8) times across the training program. Cohort meetings should be conducted in person, however, can be completed virtually if circumstances arise where a cohort cannot meet face to face. Meeting frequency will be approximately every three months, as two (2) meetings must occur in each 6-month period. The duration of these meetings is dependent on the cohort size and equates to one half day per Registrar.

Cohort Size	Meeting Duration
1 Registrar	0.5 Days
2 Registrars	1 Day
3 Registrars	1.5 Days
4 Registrars	2 Days

Activities during cohort meetings may include:

- Clinical demonstrations by Registrars, Facilitator, and/or other Specialists,
- Complex case demonstrations or presentations by Registrars, Facilitators, and/or other Specialists,
- Peer observation, feedback, and discussion,
- Engagement in critical reflection, enquiry in practice, and peer review,
- Observation of or being observed by Specialists and experts,
- Presentations delivered by Registrars,
- Facilitated tutorials,
- Mock examinations using the final examination marking schema,
- Other activities negotiated between Registrars and their Facilitator.

Clinical Reflections

Over the two year period, registrars will be required to reflect on cases or clinical / practical experiences which illustrate their progress towards attainment of highly advanced behaviours in the nine standards of practice. Registrars are required to reflect on cases or clinical experiences which illustrate progression towards attainment of highly advanced skills, knowledge, and behaviours in line with the nine standards of practice. A minimum of four (4) clinical reflections must be submitted to PebblePad in each six-month block, totaling to a minimum of 16 clinical reflections over the course of the training program. Each reflection should encompass one or more of the nine standards of practice and be presented in no more than 500 words. The Registrar is welcome to keep some reflections confidential between themselves and their Facilitator, but there must be at least 4 reflections formally

submitted via PebblePad in each six-month period. Several useful articles about reflective practice, reflective learning, and written reflections can be accessed in the resources section of Atlas (available via PebblePad).

Case Studies

Case studies are a formal illustration of clinical reasoning skills. The cases should display evidence of an appropriate level of practice including advanced reasoning and problem solving in assessment and management as well as reflective practice. Registrars will present two case studies over the course of the STP:

- Case Study 1: Case study of a typical non-complex patient/client/workplace.
- Case Study 2: Case study of a novel or complex patient/client/workplace.

The Registrar will submit their case study topic to the BOC at least one month in advance of the completed case study, in accordance with the cohort timeline, to allow time for engagement of an appropriate assessor. It is expected that the Facilitator will approve the case study topic and will oversee the preparation of the written case.

Case studies must be written in an academic style, consistent with the Guidelines for Presentation of Case Studies (available in the resources section of Atlas via PebblePad) and be accompanied by a completed Case Study Cover Page and Checklist (available in the resources section of Atlas via PebblePad). As scientific writing as used in case studies is a complex and iterative process, it is possible that Registrars may need to prepare many drafts to meet the assessment requirements. Accordingly, the Registrar must allow sufficient time for drafting the case study (at least two months) and for feedback from their Facilitator and revision prior to submission for assessment.

The final submitted version of each case study that is deemed 'satisfactory' will be sent to the editor of InMotion to be considered for publication. Registrars must advise College staff in writing if they do not wish for their case study to be published. It is expected Registrars will observe copyright regulations and have obtained all necessary permissions, including consent from the patient, for publication of their case.

Case Study Advisory Group

Registrars requiring additional support to complete their case studies can seek assistance from the Case Study Advisory Group (CSAG). The CSAG is comprised of physiotherapists with an academic background, who assist with preparation and/or revision of the written case study. The Registrar must complete the CSAG application form (available in the resources section of Atlas via PebblePad) which must be co-signed by their Facilitator. Their role is to help Registrars with writing style, deciding where to cut content if they are over the word limit, making sure that referencing is correct, etc. The CSAG will not provide case study content advice. Even if the case study writing has been overseen by the CSAG, the Facilitator must still approve the final copy prior to submission to the BOC.

Oral Presentation

Registrars are required to prepare and deliver an oral presentation on one of their case studies at a relevant conference or education session. The presentation should be no longer 15 minutes, but may be required to be shorter, depending on the forum at which the case is presented. At the close of the presentation there will be an opportunity for questions from the audience, during which the Registrar must be able to provide a rationale for their assessment and management of the case. Unless otherwise advised, there should be no more than five minutes for questions.

Three (3) Fellows of the Australian College of Physiotherapists (FACPs) must evaluate the presentation and provide feedback. Fellows from other disciplines and Fellows by Original Contribution can assess the presentation. Facilitators can be assessors, but it is preferable to have three independent assessors, where possible. Two of the three assessors must score the oral case presentation as 'satisfactory' for this element to be considered completed. Completed assessor reports and a self-reflection by the Registrar will be uploaded to PebblePad as soon as possible after the oral case study presentation under the Case Studies tab.

It is the responsibility of the Registrar to arrange for assessment of their case presentation, including identifying

assessors, providing assessment sheets, and making time and venue arrangements if their presentation is not part of an organised event. Each year Australian Specialist Physiotherapy Education (ASPE) and the Australian College of Physiotherapists co-host a forum where Registrars can present their case study. Registrars can also present their case study to Fellows at an ACP Registrar Day.

Professional Issues Essay

Registrars are required to present a Professional Issues Essay on an issue relevant to the physiotherapy profession within their field of practice. The written paper must clearly describe their selected topic, outlining its importance to the physiotherapy profession, how Specialists may get involved, and how Specialists can influence the chosen area in a maximum of 1000 words. This essay is intended to prepare Registrars for a question in the Viva Voce component of their final examination - "Nominate and discuss major professional and/or ethical issues relating to contemporary (discipline) physiotherapy practice". Registrars will submit the final version of their essay to the Training and Assessment Lead, along with written evidence that their facilitator has deemed it to be satisfactory. Facilitators must also mark the essay as satisfactory on PebblePad.

It is strongly recommended that Registrars discuss potential topics with their Facilitator prior to commencement of writing. Topics which may be considered include, but are not limited to, areas such as:

- Leadership
- Advancement of practice
- Legislation
- Other professional activities or responsibilities

Registrars will submit the final essay in the final 6-month block of their program, at least four months before the finalisation of the training period. The final submitted version of each Professional Issues Essay that is deemed 'satisfactory' by the facilitator, will be sent to the editor of InMotion to be considered for publication. Registrars must advise College staff in writing if they do not wish for their essay to be published. It is expected Registrars will observe copyright regulations and have obtained all necessary permissions, including consent from the patient, for publication.

Marked Mock Examinations

Marked Mock Examinations (MMEs) are used to assess clinical competence and to prepare Registrars for their final examinations. Registrars must complete a minimum of three (3) MMEs during their training program. The first mandatory MME is to be completed in the second 6-month block of the program and does not require a pass outcome, though performance in relation to objectives outlined in the Learning Contract will be considered in determining progression through the program. *Registrars who achieve a score of 0 or 1 (inadequate) for more than half of the criteria assessed may be counselled against progressing into year 2***.** Registrars in this situation may elect to withdraw from the Specialisation Training Program altogether, or to defer for an agreed period (no more than 12 months) to work on a defined program of learning. The remaining two (2) mandatory MMEs are to be completed in the final 6-month block of the program and will be used to determine readiness to sit final examinations. Registrars must pass at least one of the final two MMEs to be deemed ready to sit their examination. In the event of a deferment prior to sitting the final examination or a second examination attempt, two additional MMEs must be completed in the six months preceding the final examination, with at least one pass outcome. All MME marksheets must be uploaded to the Marked Mock Exams tab of PebblePad to evidence satisfactory completion.

Registrars are required to make all arrangements for their MMEs in consultation with their Facilitator. This includes arranging venues, patients, consent forms, and examiners. MMEs can be completed in person or can be recorded and shared as a video for assessment. Completed patient and Registrar consent forms will need to be held by the Registrar, as part of the patient medical record. The MMEs will follow the same format as the final examination, with treatment of a new patient that includes:

- Initial Assessment (60 or 90 minutes)

- Follow Up Assessment (30 or 45 minutes)
- Post Assessment Discussion (up to 30 minutes)

For the purpose of mandatory, formal MMEs, an experienced examiner is someone who has participated in an ACP Final Specialisation Examination round using the ACP exam mark sheet (2018), or who has conducted at least one MME (formal or not) with an experienced examiner using the post 2018 marking schema. Further information is available in Appendix 8 Procedure for Marked Mock Exams, and in Appendix 10 Video Submission for Marked Mock Examinations.

Using a smartphone or similar device is acceptable, provided the quality (sound and picture) is of a standard that can be assessed. It is recommended to use a tripod for video recording if using a phone. A third party can be used to take the video, if the patient consents to this, to ensure that suitable views of the interaction with the patient are obtained. The video date and time stamp must be continuous. Stopping and re-starting the video is not permitted. Registrars will be responsible for the secure storage of the video files.

Final Examination

The examination is the final step in meeting the requirements of the STP. On successful completion of the Specialisation Training Program the registrar becomes a 'candidate' and moves to the examination program. Each candidate will be required to successfully complete oral (viva) and practical examinations to complete the program and be awarded Specialisation and the Fellow of the Australian College of Physiotherapists (FACP) post nominal title. The examination is delivered in physiotherapy practices, hospitals, or community health facilities with real patients to create an authentic clinical scenario to be assessed. It runs over two days to allow initial and follow up assessments of patients. Examinations typically occur two months after the last 6-month block of the program. Registrars are given a maximum of two (2) attempts at the final examination. A third attempt may be considered in some circumstances at the discretion of the Facilitator, BOC, and/or College staff.

The final examination is made up of the following components:

1. Case / Patient 1
2. Case / Patient 2
3. Viva Voce
4. Patient notes
5. Post Examination Self Reflection

Clinical Cases

Registrars are required to complete two cases within their examination in which they treat real patients or clients to demonstrate their practical skills and knowledge. The cases are separated into three sessions – the initial assessment which occurs on day one of the examination and the follow up assessment and post assessment discussion which occur on day two. To pass the practical component of the examination, candidates must receive a pass mark from three of the four examiners across their two cases.

The practical component will have different timing based on discipline, as per the following table:

Component	CRP	GERO	PAEDS	PAIN	MSK	NEURO	OHPA	SPEX	WMPH
Reading Time	10 mins	10 mins	10 mins	10 mins	10 mins	10 mins	10 mins	10 mins	10 mins
Initial Assessment	60 mins	90 mins	90 mins	60 mins	60 mins	90 mins	60 mins	60 mins	60 mins
Follow Up Assessment	30 mins	45 mins	45 mins	45 mins	30 mins	45 mins	30 mins	30 mins	30 mins

Post Assessment Discussion	30 mins	30 mins	30 mins	30 mins	30 mins	30 mins	30 mins	30 mins	30 mins

Viva Voce

The Viva Voce component is allocated 60 minutes across all disciplines. It is structure as an interview between the Candidate and Examiners that aims to consider all the cognitive domains of Bloom's taxonomy i.e., knowledge, comprehension, application, analysis, synthesis, and evaluation. Examiners will be evaluating a Candidate's theoretical knowledge and application of that to clinical practice and their capacity for reflection and synthesis across of research with due regard for gaps in the evidence, an understanding of the quality of the research, and application of the evidence to a specific clinical practice scenario. Current Viva Voce questions for each discipline are available through Pebble Pad, in Examination Information Packs, or via College staff.

The oral examination is designed to assess:

- Advanced knowledge in basic, applied, and medical sciences relating to the specialty field.
- Advanced knowledge relating to specific conditions, clinical situations, or settings relevant to the area of specialisation.
- Advanced knowledge of the role of the physiotherapist within the multidisciplinary and/or multiservice construct of management and prevention for the field of specialty.
- Attributes of professional leadership and responsibility.
- Attributes of professional, ethical, and socially responsible conduct.

Further information is available in Appendix 8 and Appendix 9.

Patient Notes

Candidates will have a maximum of three (3) hours allocated after their final post assessment discussion to complete their patient notes, including letters to the referring physiotherapists. These summaries form part of the examination record and must be handed to relevant venue staff prior to leaving the examination venue. Any letters written on behalf of the patient to the referring physiotherapist, medical officer, or other relevant health professional, must be included with the treatment notes. In some cases, patient notes and letters to the referrer may be used by Examiners when determining a Candidate's examination outcome.

Post Exam Self-reflection

All candidates are required to prepare a reflection on both cases, to be written as soon as possible after the examination. Formal submission is required within two weeks of the examination date. The reflection will be used if a feedback session is required. At that time, it is released to the feedback panel, to be used in addition to case notes and the examiners' report, to guide the feedback session. Details of all self-reflections will remain confidential unless required by a feedback panel.

6. Registrar Status and Progression through Program

Progression Through Six-Month Training Blocks

In each six-month report, Facilitators will provide a status determination on each of their Registrars that will indicate if the expected standard in each of the elements has been 'met' or 'not yet met'. This status is based on progress against the Learning Contract and SWOT Analysis, completion of program components for that period (including Case Studies, MMEs, and/or Professional Issues Essay), and Learning activities and evidence logs across all four elements.

Registrars who obtain a 'Met' status on all four elements will progress to the next training period of the program. Registrars who obtain one 'Not yet met' status will progress to the next period with detail provided on remedial steps and improvements they need to make over the next six-month period to achieve a 'Met' status. This will be

addressed by the Registrar in their updated Learning Contract and SWOT Analysis. If the Registrar has not yet met the same element in a subsequent 6-monthly report or has received a 'not yet met' status on more than one element in a single report, the matter will be discussed by the Registrar, Facilitator, BOC, and College staff as required, to determine whether the Registrar be referred for progression review.

If it is found that progression is not in line with the STP requirements, then the Registrar will be required to withdraw from the program.

A Facilitator may, in instances where the Registrar's performance has not been satisfactory, make a recommendation for progression review. In such an instance, the Facilitator is required to clearly outline the areas in which performance is unsatisfactory, what remedial steps and actions have been advised/put in place to address these areas prior to the report cycle and the Registrar's response to those steps and/or actions. The Facilitator must provide justification for the recommendation for progression review. If the Registrar wishes to refute the recommendation for progression review, they are required to provide evidence which might explain the finding of unsatisfactory progress and outline evidence of steps taken, and/or intended to be taken, to address the areas of concern. Final decisions on progression will be determined between the Registrar and the Facilitator, BOC, and College staff as required.

Progression to Final Examinations

If a 24-month report indicates a Registrar has not yet met one or more elements or have not completed all required components of the program, they will be deemed not yet ready to sit their final examination. In this instance, the Registrar will move into the Year Three Deferred Program, in which they will complete all outstanding components of the program and continue to build on their skills until they achieve 'met' status on all elements, to be deemed ready to sit their final examination.

7. Specialisation Training Program Resources

Pebble Pad and Atlas

Pebble Pad and Atlas are the platforms used for submission of work during the program. They are both accessed using the same login details via the Pebble Pad login page, https://v3.pebblepad.com.au/login/Login/ChooseInstall. Registrars will submit all required work into their Pebble Pad workbook, which is set up with a different tab for each component of the program. Facilitators and Censors have access to these workbooks to assess submissions and review Registrar progress through the program.
Atlas also contains a Resources section that includes:

- Exemplar Pebble Pad workbooks from previous Registrars
- Detailed instructions on each component of the program
- Marking rubrics and marking guides for assessments

Pebble Pad access and training is provided to new Registrars by the College at the commencement of the training program.

Website

The APA website provides Registrars with access to general information regarding the College, STP, College membership, competence framework, and use of College titles as well as details on College governance, policies, and procedures. You can access the College page of the APA website directly here: https://australian.physio/pd/australian-college-physiotherapists

APPENDICES

Appendix 1

SWOT Analysis template

Registrar Name:	
Specialist Discipline:	
Facilitator:	
Projected Completion Date:	

Identify your **S**trengths, **W**eaknesses, **O**pportunities & **T**hreats in relation to your ability to undertake and complete each element of the Specialisation Training Program. You should consider your analysis in the context of the discipline curricula (Appendix 13) and include the written components of the Specialisation Training Program. You should also consider and include personal strengths, weaknesses, opportunities and threats. (eg: family commitments).

When presenting your Learning Contract below, please identify your goals in the context of SMART goals – i.e. goals that are:

Specific

Measureable

Achievable

Realistic

Timely

Element 1: Development of specialist skills

Strengths	Weaknesses	Opportunities	Threats

Element 2: Participation in education of the profession

Strengths	Weaknesses	Opportunities	Threats

Element 3: Professional development activities

Strengths	Weaknesses	Opportunities	Threats

Element 4: Participation in research activities

Strengths	Weaknesses	Opportunities	Threats

Written components

Strengths	Weaknesses	Opportunities	Threats

Marked Mock Exams

Strengths	Weaknesses	Opportunities	Threats

Learning Contract template for Training Periods 1-4

Element 1 Development of specialist skills

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed?

Element 2 Participation in education of the profession

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed?

Element 3 Commitment to lifelong learning and professional development activities

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed?

Element 4 Participation in research activities

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed?

Appendix 2
Sample SWOT Analysis

Element 1: Development of specialist skills

Strengths	Weaknesses	Opportunities	Threats
• Strong Clinical Reasoning • Good communication with patients • Open to constructive feedback • Strong functional assessment and modification procedures • Holistic treatment planning	• Can compartmentalise patients into dominant classification only • Moderate capacity to communicate neurophysiological changes to patients • Potentially biased towards conservative management options being utilised first over medical/surgical • Prefer simple, uncomplicated manual therapy techniques • Unsure of sensory testing for set dermatome patterns (conjecture in the literature) and myotome testing levels	• Senior physiotherapist at a clinic whereby I am allowed first and second 30 minute 'initial' consultations, replicating the hour long initial consultations in the final specialisation exams • Fortnightly 90 minute mentoring with Specialist Physiotherapist	• Young child and my partner are the top priorities in my daily and weekly schedule • Full work schedule including 32 hours of physiotherapy employment and 12 hours of my own personal physiotherapy consultancy business, as well as 3- 5 weekly 3 hours post-graduate physiotherapy student tutoring sessions per year • Personal trait and bent towards perfectionism meaning I can spend more time than necessary on work and Specialisation assignments

Element 2: Participation in education of the profession

Strengths	Weaknesses	Opportunities	Threats
Currently supervising students at a hospital outpatients' clinic	Lack of access to post-graduate students	Personal connections with university lecturers, researchers and Specialist Physiotherapists	Affording time off work to travel to participate in un-funded education
Participating in regular education sessions at local inter-practice professional development.		3- 5 weekly 3 hours post-graduate physiotherapy student tutoring	

Element 3: Professional development activities

Strengths	Weaknesses	Opportunities	Threats
• Willingness to attend regular weekend courses. • Good contacts with local professional development run by specialists	Most professional development has been tailored towards my interest in cervical spine/ whiplash conditions and persistent pain	Clinical Coordinator. I organise monthly Professional Development, including Specialist Physiotherapists, Sports Physicians and Medical Consultants	• Limited financial resources to travel interstate. • Young children and husband involved in fly in fly out employment • Taking time off to participate in unfunded PD
		Fortnightly Professional Development with Specialist Physiotherapists	

Element 4: Participation in research activities

Strengths	Weaknesses	Opportunities	Threats
Interest in reading and applying research to daily practice University access to research databases	Limited understanding of principles of research design and implementation.	Personal connections with university lecturers, researchers and Specialist Physiotherapists	Limited time to dedicate.

Written components

Strengths	Weaknesses	Opportunities	Threats
Strong writing skills through participation in post-graduate education.	Never prepared or considered physiotherapy case report writing.	Use CSAG	Family pressures and availability of uninterrupted time

Marked Mock Exams

Strengths	Weaknesses	Opportunities	Threats
Work well under pressure	No experience in clinical exams	Practice	Nervous about being observed

Sample Learning Contract: first 6 month period

Element 1: Development of specialist skills

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed
To acquire specialist level skills in the assessment, education and management of the dominant pain mechanisms in patient's presentation: - Peripheral neuropathic/neuropathic pain - Peripheral sensitisation - Central sensitisation and brain plasticity	1) Attend interstate weekend Pain specific course 2) Review lecture on classification system for the neural system 3) Observe Specialists assess and manage patients at 2 major public hospitals 4) Review literature on testing pressure-pain, thermal pin thresholds, 2-point discrimination 5) Read X 2 major texts 6) Apply specialist level assessment/education/management in 10 patients over 6 months	Certificate of attendance Certificate of attendance Reflection on clinical practice Prepare 1-2 page summary Prepare 1-2 page summary Case Study/series	Portfolio of evidence Portfolio of evidence Portfolio of evidence Present to cohort Present to cohort Case study presentation/ submission Achieve at least 4/5 mark in mock-exams within my cohort	
To acquire specialist level knowledge and understanding of the non-physiotherapeutic management (pharmacological, psychological procedural) of persistent pain problems	1) Observe pain specialist and neurologist at a major hospital 2) Observe clinical psychologist's session with a chronic pain patient 3) Attend/observe a day of multi-disciplinary pain clinic, attend STEPS program	Reflection/ Experience Prepare 1-2 page summary/5x5 slide	Portfolio of evidence Present to cohort	
To acquire specialist level skills in the specific area of…, with current best theory and management options for physiotherapeutic and medical management for these disorders	1) Attend specific lecture 2) Observe Sports Physician's assess and manage a group 3) Review current literature on specific pathophysiology, pathoanatomy and management	Certificate of attendance Reflection/ Experience Prepare 1-2 page summary	Portfolio of evidence Portfolio of evidence Present to cohort	
To consolidate specialist level skills in the knowledge of motor control conditions, at an advanced level	1) Observe specialists manage patients 2) Attend courses to review lecture material and case presentations by specialist 3) Apply specialist level assessment /education /management in 3 patients, supervised by a specialist physiotherapist	Reflection/ Experience Reflection/ Experience Case Study/series	Portfolio of evidence Portfolio of evidence Case study presentation / submissionAchieve at least 4/5 mark in mock-exams within my cohort	
To consolidate specialist	1) Attend Certificate in Advanced	Certificate of	Portfolio of evidence	

level skills in the diagnosis and management of complex shoulder, NSAP, wrist/hand disorders and knee pain	Sports Rehabilitation and review lecture 2) Observe Specialist manage a complex shoulder patient 3) Observe Medico manage a complex NASP, wrist/hand patient 3) Apply specialist level assessment/education/management in 3 patients, supervised by specialist physiotherapist 4) Completion of training as a Certified Mulligan Practitioner and teacher through examination by Specialists	Attendance Reflection Reflection Case Study presentation/ series Certificate of Attendance	Portfolio of evidence Portfolio of evidence Case study presentation/ submission Portfolio of evidence Achieve at least 4/5 mark in mock-exams within my cohort	
To acquire specialist level skills in the differential diagnosis of the dizzy patient and incorporate accurate management of sensorimotor dysfunction in the cervical spine Headache	1) Observe Senior Physiotherapist 2) Review literature on CAD Vestibular dysfunction Cervicogenic dizziness Craniovertebral instability 3) Apply specialist level assessment/education/management in 3 patients, supervised by specialist physiotherapist 4) Pebble Pad discussions with other Registrars from other states Attend courses to review lecture material and case presentations	Reflection Prepare 1-2 page summary Case study presentation Reflection/ Experience	Portfolio of evidence Present to cohort Case Study presentation Achieve at least 4/5 mark in mock-exams within my cohort Portfolio of Evidence	
Red Flags	Review APA presentation by Specialist Musculoskeletal Physiotherapist	Reflection/ Experience	Portfolio of Evidence	
Mechanisms of actions of manipulative/exercise therapy	Review post-graduate lecture and pre-reading material for this topic	Reflection	Portfolio of evidence	
Advanced Clinical Reasoning	1) Attend workshop or view webinar on Advanced Clinical Reasoning 2) Read 3 articles/text book chapters authored by …	Certificate of Attendance	Portfolio of evidence	

Element 2: Participation in education of the profession

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed
To enhance the clinical reasoning and skill of post-graduate physiotherapists studying the Masters of Clinical Physiotherapy and completing the Clinical units	1) Supervision of students at a hospital outpatients' clinic on the first and second semester 5 weeks clinics 2) Utilise simple strengths/weaknesses forms with these students, and create a reflective form for them to fill out at the end of their placement	Student reflective form Student reflective form	Portfolio of evidence	
To enhance the physiotherapy skills, clinical reasoning and knowledge of new and recently graduated physiotherapists at the Life Ready group	1) Weekly, fortnightly and monthly mentoring sessions with review of past and current patients 2) Regular assessment and treatment of particularly complex patients of these physiotherapists 3) Dissemination of relevant literature to these physiotherapists 4) Create simplified, evidence-based clinical reasoning form for physios to complete	Life Ready day sheets Completed simple clinical reasoning form Customer satisfaction survey	Portfolio of evidence	
Delivery, at a specialist level, of staff development (lectures/tutorials) at Physio Practice and other health professional workplaces	1) Delivery of lectures/tutorials at these workplaces 2) Creation of customer satisfaction surveys	Lecture/tutorial material Customer satisfaction survey	Portfolio of evidence	

Element 3: Professional development activities

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed
Demonstrate my passion and commitment to lifelong learning	Actively participate in the specialisation training over the next 2 years, to include: • Attend one weekend course • Attend Certificate sessions • Attend fortnightly professional development run by specialists • Attend training nights conducted for tutors on the postgraduate Master of Clinical Physiotherapy • Travel to other states to attend workshops with Specialists Observation of patient examinations by other Specialists recorded on video on the APA website	Attendance certificates, reflections on changes to clinical practice	Portfolio of evidence	

Element 4: Participation in research activities

What are your learning objectives?	How are you going to meet your learning objectives?	What evidence will you gather?	How are you going to prove your learning?	Timeframe? When will this be completed
Undertake sufficient participation in research activities to meet the requirements of the specialisation Training Program, and to enhance my knowledge and understanding of the process required to undertake research in a clinical setting	1) Support research activity of Dr. X through screening and recruitment of patients. Possibly also with a Paediatric Rheumatologist	Emails, competed literature	Portfolio of evidence	

Written Components: SWOT Analysis and Learning Contract, 4 X Reflections

	SWOT Analysis	Learning Contract	Case Study 1 topic	Reflections 4 X
Due date				
Draft 1				
Draft 2				
Final				

Appendix 3

Guidelines for presentation of case studies

Two case studies will be presented over the course of the Specialisation Training Program.

- Case Study 1: Case study of a typical non-complex patient/client/workplace.
- Case Study 2: Case study of a novel or complex patient/client/workplace.

The cases should display evidence of an appropriate level of practice including advanced clinical reasoning in assessment and management, as well as reflective practice. Scientific writing as used in case studies is a skill that will need to be developed to varying degrees in individual registrars. As it is a complex and iterative process, it is possible that registrars may need to prepare many drafts to meet the assessment requirements. Accordingly, the registrar must allow sufficient time for drafting the case study (at least two months) and for feedback from their facilitator and revision prior to submission for assessment.

The following outline should serve as a guide only to the presentation of the case, as different cases will present different opportunities for discussion.

The purpose of the case study is to describe, in reasonable detail, the evaluation and management of a patient/client/workplace presenting to a physiotherapist in the relevant field of practice. While presenting a case study at a level and in language suitable for publication in a peer-reviewed journal is the ultimate goal for an author of a case study, the College does not require the case study to be at this highest level of submission. The requirement of the case study from the Board of Censors is that it must be at a standard and depth suitable for presentation at a conference. In addition to the guidelines outlined below, it is recommended that registrars familiarise themselves with resources and examples available in PebblePad (Atlas Resources) to assist in the development of their case study and to ensure it meets the standard. The CARE checklists and guidelines, which are a consensus statement from a group of journal editors, are primarily relevant *should you wish to pursue publication options in a peer reviewed journal. (Not InMotion).*

All registrars are also advised to study the Case Study Assessor Report and the Case Study Cover Sheet and Checklist (below) to ensure that their final submission meets the guidelines against which it will be assessed. All final case studies are submitted to the APA Publications Editor, who will consider them for publication in APA journals and magazines. Registrars who prefer their work not be automatically submitted must advise the Training and Assessment Lead, ACP, by email.

Written report

Case study reports must be submitted electronically using standard word processing software (e.g. MS Word) on A4 layout using a font size no smaller than 11, line spacing of 1.5, and with margins of no less than 2cm. Text should be left justified. Registrars must include their APA member number in the footer of the case study. This will enable identification for administrative purposes, whilst enabling the assessor to be blinded to the identity of the author. The case study, and any subsequent drafts must be submitted with a completed Case Study Cover Page and Checklist.

The case study is to be no more than 2500 words in length excluding abstract (maximum of 250 words) illustrations, and tables (maximum of 4 figures with captions plus 3 tables, maximum of 80 words per table) and references (maximum of 30). These limits must be strictly adhered to or the case study will be rejected by the assessor. It is expected registrars will observe copyright and have obtained all necessary

permissions.

Reference Tools and Citation styles

Registrars are recommended to choose one citation style (e.g. APA) and to consistently use this style throughout the case study. Free reference management tools such as Zotero and Mendeley are available online and contain guidance material on use. These reference management tools may assist with more consistent citation styles and reference list compilation and formatting of case study manuscripts.

The assessor uses the following categories to evaluate the case:

1. Writing Style

- Scientific
- Concise
- Unambiguous
- Grammatically correct
- No/minimal spelling errors

2. Appropriate structure of the case

Abstract (maximum of 250 words, *not included in the word count*)

The abstract (on a separate page at the beginning of the report) should provide an overview of the whole case study including background, assessment and intervention/management, main outcome(s), brief discussion of issues arising and conclusion.

Introduction (Guide: 250-450 words):

The introduction should 'set the scene' for the topic under consideration, providing summaries of relevant contemporary literature related to the topic in general and particularly the assessment and management of the chosen case. The purpose of submission (e.g. typical case or complex /novel case and why you chose it) should be stated.

Presentation of the case (Guide: 1,000-1,400 words).

A clear and concise description and illustration (see below) as appropriate of:

- The reason for referral or presentation (if appropriate), subjective assessment findings, relevant patient/client features including psychosocial presentation or situation (as appropriate)
- The goals of management/intervention
- Appropriate and evidence-based choice of pre/ post assessment tools
- A clear description of, and rationale for, management /intervention(s)
- Outcomes of management /intervention(s)
- Declaration of patient consent for use of information.

There should be clear documentation of the clinical reasoning processes guiding the evaluation of the client, establishment of the hypothesis(es) /diagnosis(es) and clear documentation of the outcome measures used, the rationale for their use and the relationship of outcome measures chosen to the goals of the intervention.

The management/intervention program should be described with reference to the literature to support

an evidence informed approach to management. The clinical reasoning process for progression or modification of intervention or referral to other health practitioners should be provided. The role of other members of the health care team should be described if appropriate.

Any changes in outcome measures over the intervention period should be provided (graphs or tables). In addition, and as relevant to the case, a post-intervention follow-up evaluation of primary outcomes (e.g. 3 months post discharge) would be highly regarded.

Discussion/conclusion (Guide: 600 words) should overview issues arising from the case, management and outcome with reference to the literature. There should be evidence of reflective practice, particularly in relation to existing literature and indications for any modification in management of similar clients in the future. In addition, an understanding of any limitations should be demonstrated (eg why guidelines were not able to be followed in this case or any restrictions on the use of best practice assessment/management, client personal/environmental factors limiting outcomes etc.).

Discussion includes:

a. Justification for assessment, management/ intervention(s)
b. Implications of outcomes and potential modification of further management
c. Issues raised by treatment effects / confounding effects of the intervention
d. Limitations (if any)
e. Reflection on what might have been done better or differently and why

Conclusion(s): main finding(s) from case, evidence based and related to previous literature

References: (Maximum of 30, *not included in the word count*. Consistent formatting - no style is mandated – see 'reference tools and citation styles,' above.)

a. Accurate
b. Relevant
c. Predominantly from peer-reviewed literature
d. Up to date

3. Appropriate use of good quality figures and tables

No more than four figures with captions and no more than three tables, (maximum of 80 words per table). *Figure captions and tables are not included in word count.*

Tables and figures must:

- Present relevant outcomes /data
- Add to / clarify report and do not repeat information in text
- Include captions which are concise and relevant

Please note:

Make sure that the case study is carefully proof-read prior to submission. If it demonstrates extensive spelling, typographical, grammatical or formatting errors, it will be returned to the registrar for correction prior to distribution to an assessor. Equally, a case study that does not meet the guidelines will also be returned for amendment prior to assessment.

Management of case studies

Initial process of selection of topic & submission of case study

- Registrars must discuss the topic for their case study with their facilitator and review the instructions regarding format for presentation of the case study provided above. They must also review the various documents provided in PebblePad (ATLAS Resources) to assist with their preparation of the case study, and to indicate standards required for the written submission. PebblePad resources section has several case studies written by previous registrars. The CARE guidelines for writing case studies are primarily relevant *should you wish to pursue publication of your case study in a peer reviewed journal (i.e. not InMotion).* Registrars are advised not to commence work on their case study before these two steps are completed.
- The final topic must be submitted to the Board of Censors in accordance with the cohort timeline. This is approximately one month before the submission date to allow identification of suitable assessors. Once a topic has been selected, the registrar should work in conjunction with their facilitator through a process of presentation of draft documents to the facilitator for review, advice and subsequent revision prior to reaching a final version that both registrar and facilitator agree is at a satisfactory standard to submit for evaluation. The registrar must allow sufficient time for drafting the case study (at least two months).
- If the facilitator does not have expertise in writing skills to support the registrar, and/or wishes to seek further advice, the registrar may request the assistance of the 'Case Study Advisory Group' (CSAG) for assistance with guiding the registrar through the writing process. The registrar must contact the Training and Assessment Lead, ACP for an application form, which must be co-signed by the facilitator. The appointed CSAG member will communicate directly with the registrar. It is the responsibility of the registrar to report to their facilitator on the progress of the case prior to submission. The facilitator must approve the completed case study prior to it being submitted, or re-submitted, for evaluation.
- Following submission of the case study, the Training and Assessment Lead, ACP (or proxy) will send the written case study to an independent assessor for evaluation. In the first instance, the assessor will be blinded to the identity of the registrar.
- Once the assessor report is provided, the registrar will be notified, via the Training and Assessment Lead, ACP, of the outcome of the case study evaluation, and the report and any comments will be forwarded. If the case study has been determined to be satisfactory, the registrar and facilitator will receive a letter from the Chief Censor formally advising of the outcome.

Failure of the case study

- If the case study is deemed unsatisfactory, the registrar and facilitator (or CSAG member, where relevant) must revise and resubmit the case study, within the specified timeframe. The facilitator/CSAG member and registrar must work together to review and discuss the feedback provided and plan a course of action for the registrar to work on addressing issues raised in the feedback in preparation for re-submission. The registrar may include with the re-submission a letter outlining the amendments made to the text and commenting on/ justifying where recommendations made have not been addressed.
- The assessor may offer to discuss corrections directly with the registrar. If this discussion occurs, the assessor will be 'unblinded' to the registrar.

- If at this stage of the process, the facilitator or registrar wish to seek advice from the CSAG, whether they have previously sought advice/ input or not, this option is available to them, with the same requirements as outlined in relation to the initial submission.
- Once the facilitator and registrar are satisfied that they have addressed all feedback/comments provided by the reviewer, the case study must be re-submitted for second assessment, undertaken wherever possible, by the same assessor as for the first submission. The registrar is generally given two weeks to re-submit their revised case. The same processes of reporting the outcome of the second review will be followed as for the first review.
- If, following revision and second submission, the case study is still deemed not to have reached satisfactory standard, it will be returned to the facilitator and registrar with the report and feedback provided by the reviewer.
- At this stage, the registrar must request input from the CSAG, if they have not already done so. The Board of Censors will nominate a specific member of the CSAG, which may be a different person to the CSAG member previously involved, to assist the registrar further with preparation and final amendments to the case study to ensure that it does reach a satisfactory standard.
- If, following this extensive process, the case study is still deemed unsatisfactory, the registrar will be advised by the Chief Censor of an appropriate path, which may include submission of a completely new case study, for completion of the case study requirement.
- If this is the case, the registrar will *remain on conditional status* until such time as a new case study is completed and deemed satisfactory. The registrar may be advised to focus on other areas within their Learning Contract for a period of time deemed appropriate by the member of the CSAG and/or the Board of Censors before attempting a new case study.

Both case studies must be deemed satisfactory for the registrar to achieve good status and be eligible to sit for final examinations.

Case Study cover page and checklist

Please complete and submit this page with your Case Study.

Title of Case Study:

Author:

The author's APA Member Number:

- ☐ The author's APA member number appears in the footer of each page.
- ☐ The author's name appears **on this page only**.
- ☐ ***The author's facilitator has read this case study and approved it for submission***

Please complete the checklist below.

The author has:

- ☐ Read and understood the Case Study Guidelines (Appendix – TP Manual)
- ☐ Read and understood the Case Study Assessor's Template (Appendix – TP Manual)

Obtained the patient's consent for:

- ☐ Use of patient's information in this Case Study
- ☐ Publication of the final version of this Case Study
- ☐ Used a spell checker to minimise errors.
- ☐ Indicated the 'purpose' of the case (typical or complex case) in the introduction.
- ☐ Checked that the overall word count of the case study **DOES NOT EXCEED** 2500 words.

Checked that the case study meets the following requirements.

- ☐ Abstract on a separate page – Maximum of 250 words (not included in overall word count)
- ☐ Figures - Maximum of 4 (four) figures with captions (not included in overall word count)
- ☐ Tables - Maximum of 3 tables, maximum of 80 words each (not included in overall word count)
- ☐ Figures and tables are referred to in the text (eg. Symptom location is illustrated in Figure x).
- ☐ References – Maximum of 30 references (not included in overall word count)

A note about the Case Study Advisory Group (CSAG)

The CSAG comprises academic physiotherapists who are appointed by the Board of Censors to assist registrars in the preparation and / or revision of their case study. Each registrar is encouraged to seek the input of CSAG during the preparation of their case studies if their facilitator indicates that they not able to assist with this task. Further information about the role of CSAG is available in the TP Manual or via the Training and Assessment Lead, ACP.

AUSTRALIAN COLLEGE OF PHYSIOTHERAPISTS

AUSTRALIAN COLLEGE OF PHYSIOTHERAPISTS

Assessor's Report: case study

Registrar	
Subspecialty area	
Case Study Title	

Reviewer	
Reviewer email	
Review Due Date	Please return completed report to acp@australian.physio by:

Please note: the marking template is written on the assumption that the case study refers to assessment and management of a patient in a clinical environment. For OH registrars, the term 'patient' and 'clinical' may need to be replaced by 'client', 'work site' or 'the built environment under assessment'.

Abstract (Max 250 words) *Not included in the word count*)	**Structured abstract** includes: ○ Background to case topic ○ Assessment ○ Management/Intervention ○ Outcomes/results ○ Discussion ± Conclusions	

Introduction (Guide 250-450 words)	**Introduction** describes: ○ The case and condition / pathology ○ Relevant literature ○ The purpose of submission (e.g. typical case or complex /novel case)	

Presentation of the case (Guide 1,000-1,400 words)	○ The Case Study includes: ○ A clear and concise description and illustration (see below) as appropriate of: ○ Declaration of patient consent for use of info. The reason for referral (if appropriate), subjective assessment findings, relevant patient/client features including psychosocial presentation or situation (as appropriate) ○ The goals of management/intervention ○ Appropriate and evidence-based choice of pre/ post assessment tools ○ A clear description of, and rationale for, management /intervention(s) ○ Outcomes of management /intervention(s)	

Discussion/conclusion (Guide 600 words)	**Discussion** includes: ○ Justification for assessment, management/ intervention(s) ○ Implications of outcomes and potential modification of further management ○ Issues raised by treatment effects / confounding effects of the intervention ○ Limitations (if any) ○ Reflection on what might have been done better or differently and why **Conclusion(s)** – main finding(s) from case, evidence based and related to previous literature	

References Maximum of 30 *Not included in the word count*.	○ Accurate ○ Relevant ○ Predominantly from peer-reviewed literature ○ Up to date ○ Consistent formatting (no style is mandated)	

Figures and Tables Limited to up to four figures with captions plus three tables, (maximum of 80 words per table). **	Appropriate use of good quality figures and tables ○ Present relevant outcomes /data ○ Add to / clarify report and do not repeat information in text ○ Captions are concise and relevant ***Figure captions and tables are not included in word count*	

Writing Style	Scientific ○ Concise ○ Unambiguous ○ Grammatically correct ○ No/minimal spelling errors	

Is the report consistent with the guidelines provided in the Training Program Manual and reported in a suitable academic style?	YES or NO? *(please specify)*	YES ☐ NO ☐
	If NO, what changes are required?	

Has the candidate demonstrated advanced knowledge in the presentation of the case and relevant literature, moderate to high level clinical reasoning and critical reflection skills in this case study report	YES or NO? *(please specify)*	YES ☐ NO ☐
	If NO, what changes are required? (You may choose to annotate the actual case report to indicate recommended changes).	

General Comments (both constructive critique that would enhance the report and any general feedback); **If a re-submission - has candidate addressed previous feedback (please add an additional page if required).**

Please indicate if there is any necessity for direct contact between the assessor and registrar to discuss the feedback YES ☐ NO ☐

Case Study Assessor Signature: _____ Date: _____

Appendix 4

Oral presentation of a case study

Registrars are required to prepare and deliver a verbal presentation of one of their case studies at a College Discussion evening or relevant conference/session where three Fellows will evaluate the presentation and provide feedback using a standard assessment form. FACP's from other disciplines/Original Contribution are able to evaluate the presentation. Facilitators can be assessors, but it is preferable to have three independent assessors. It is the responsibility of the registrar to arrange for evaluation of their case presentation.

The presentation should be no longer 15 minutes, but may be required to be shorter, depending on the forum at which the case is presented. At the close of the presentation there will be an opportunity for questions from the audience, during which the registrar must be able to provide a rationale for their assessment and management of the case. Unless otherwise advised, there should be no more than five minutes for questions.

Two of the three assessors must score the oral case presentation as 'satisfactory' in order for this element to be considered completed. Completed assessor reports and a self-reflection (see below) written by the registrar will be submitted by the registrar to the Training and Assessment Lead, ACP, as soon as possible after the oral case study presentation.

Some advice for successful oral case presentation

1. Slides

- You should aim to have *no more than one slide per minute* (fewer if some are complex and will take time to explain). Consequently for this presentation you should only have about 15 slides, fewer if the time allocation is less
- Structure your presentation similarly to the written case – intro/background, assessment findings and interpretation, management, outcomes of treatment and brief discussion/conclusion. You should finish with a reflection on what could have been done better/differently (what you have learned)
- Pick an easy to read font and consistently use the same type of font and size on all slides (literature citations may be in a smaller font, but should still be legible)
- Dark text on a pale background will always be the best choice. Whatever colour scheme you chose, keep the design/background very basic and simple
- Remember that your slides are there to support your presentation - if you simply read all of the content of your slides, the audience will get bored and stop listening
- Keep the content of each slide simple. Make good use of keywords to highlight your main points. Avoid long sentences or lots of bullet points on one slide
- 'A picture is worth a thousand words'. Slides with more images than text help the audience to listen to you, and not get distracted reading the slide

2. Presentation

- In addition to a well-prepared talk, it is important that you present yourself professionally
- An enthusiastic and confident manner will maintain your audience's attention
- A little humour can help to engage the audience but avoid gimmicks (such as excessive animation!)
- Practice, practice aloud, practice - know your slides inside out. Use timed practice to make sure that you can cover all your material without having to rush
- Attend to the warning signal that indicates that you only have a few minutes left
- Speak with confidence – loud and clear, but don't speak too fast. Although there will be number of Fellows in the room, they may not have expertise in the topic of your case, and YOU are the expert on your client – so be confident in your knowledge
- Talk to your audience, not to the screen. Try to maintain eye contact with the audience as much as possible
- If you are using a laser pointer, anticipate that you might be a bit shaky. It is acceptable to rest your forearm/hand on the lectern (if there is one). Ensure that you don't point the laser at the audience!
- Anticipate the sorts of questions you might be asked so that you can be prepared to answer them (you can even plant a few easy ones in the audience with a friend/colleague or get someone to ask about things that they know you didn't get a chance to cover if you run out of time).

Oral presentation assessment forms

Case Study Oral Presentation Evaluation Form: Assessor

Candidate's Name	Comments (please turn over if more space required)
Content 50% weighting • Important information about the case is presented • Differential diagnosis and management are clear • Evidence of high level clinical reasoning • Evidence of advanced reflective practice • Sound use of relevant literature • Conclusions are appropriate	
Presentation 20% weighting • Information is well organised for presentation • Stimulates and maintains interest • Highly competent manner of delivery • Completed presentation in allocated time	
AV material 10% weighting • Clear and well-constructed • Used appropriately to enhance the presentation.	
Discussion/ question answering ability 20% weighting • Consistently able to reply spontaneously with a logical and concise answer that demonstrates a thorough understanding of the case and relevant literature	
ASSESSMENT (please tick)	☐ SATISFACTORY ☐ UNSATISFACTORY
Assessor's name	Signature Date

Australian College of Physiotherapists

Case Study Oral Presentation Self -Evaluation Form

Registrar Name: _____

Date: _____ Venue: _____

City: _____ Approximate number in audience: _____

Title of Conference/Event: _____

Title of Case Study presented: _____

Names of ACP assessors

1. _____

2. _____

3. _____

Please use dot points to summarise the main changes that you would make to your presentation, based on the feedback which you have received, should you present this material again to another audience.

Please complete this form, collect the three completed and signed assessment forms and send to acp@australian.physio within one week of your presentation.

Appendix 5

Shared facilitator role

If the role of facilitator is shared between two individuals, the following considerations must be made:

- If both facilitators are Fellows of the College, in most instances, they will be drawn from the same discipline and from the discipline of the registrar. In exceptional circumstances, appointment of one facilitator from outside the discipline of the registrar may be considered and implemented by the Board of Censors
- In the situation of discipline areas with small numbers of Fellows, one facilitator may be a titled member of the relevant special group, but the other must be a Specialist Fellow of the College, ideally with experience as a facilitator
- All requirements of facilitators as described in the Specialisation Training Program manual must be shared between co-facilitators. Co-facilitators will develop a contract including details of the specific roles and responsibilities to be fulfilled by each facilitator. While it is expected that the day to day roles of co-facilitators will adapt to the needs and dynamics of the cohort, responsibilities in relation to reporting will be clearly stated
- One facilitator will be nominated as the 'senior' member who holds ultimate responsibility for all reporting processes to the Board of Censors
- All reports to the Board of Censors must be co-signed by both facilitators
- In the event of a dispute between facilitators in relation to standing of a registrar in their cohort, process outlined in the *College Dispute Resolution Policy* will be followed.

Appendix 6

6-Month Facilitator Report Template

SPECIALISATION TRAINING PROGRAM
6-MONTHLY FACILITATOR REPORTING

6-Month Facilitator Report

Registrar:		**Discipline:**	
Censor:		**Training Period:**	1: 0 – 6 Months
Report completed by Facilitator:			

Required Components of Training Period 1		
Component	**Feedback for Registrar on component**	**Final Status**
Learning Contract	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
SWOT Analysis	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Cohort Meetings	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Clinical Reflections	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Case Study 1	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Clinical Contact - 208 hours	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Is a Registrar Support Plan required to address any of the above components for the next training period?		
☐Yes ☐No Component/s:		

Learning Activities and Supporting Evidence		
Element	**Feedback for Registrar on Pebble Pad uploads and evidence**	**Final Status**
Element 1	*Provide feedback on the quantity and quality of all Element 1 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐ Met ☐ Not Yet Met
Element 2	*Provide feedback on the quantity and quality of all Element 2 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐ Met ☐ Not Yet Met
Element 3	*Provide feedback on the quantity and quality of all Element 3 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐ Met ☐ Not Yet Met
Element 4	*Provide feedback on the quantity and quality of all Element 4 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐ Met ☐ Not Yet Met
Is a Registrar Support Plan required to address any of the above elements for the next training period?		
☐ Yes ☐ No Element/s:		

Signatures			
Please sign and date below before submitting to College staff via email to acp@australian.physio.			
Facilitator Signature:		**Date:**	
Registrar Signature:		**Date:**	

Appendix 7

24 Month Facilitator's Report Template

24-Month Facilitator Report

Registrar:		**Discipline:**	
Censor:		**Training Period:**	4: 19 – 24 Months
Report completed by Facilitator:			

Required Components of Training Period 4		
Component	**Feedback for Registrar on component**	**Final Status**
Learning Contract	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
SWOT Analysis	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Cohort Meetings	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Clinical Reflections	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Oral Presentation of Case Study	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Professional Issues Essay	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
2 x Marked Mock Exams	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Clinical Contact - 208 hours	*Provide commentary on the participation, standard, quality etc. of the component, including details on feedback provided and resubmissions made if applicable. Please detail areas the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Satisfactory ☐Unsatisfactory
Is a Registrar Support Plan required to address any of the above components for the next training period?		
☐Yes ☐No Component/s:		

Learning Activities and Supporting Evidence		
Element	**Feedback for Registrar on Pebble Pad uploads and evidence**	**Final Status**
Element 1	*Provide feedback on the quantity and quality of all Element 1 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Met ☐Not Yet Met
Element 2	*Provide feedback on the quantity and quality of all Element 2 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Met ☐Not Yet Met
Element 3	*Provide feedback on the quantity and quality of all Element 3 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Met ☐Not Yet Met
Element 4	*Provide feedback on the quantity and quality of all Element 4 learning activities and the supporting evidence provided, including relevance to the Registrar's Learning Contract and SWOT Analysis. Please detail the areas where the Registrar will require more focused work in the next 6-Month training period to achieve the required 'entry level specialist' standard.*	☐Met ☐Not Yet Met
Is a Registrar Support Plan required to address any of the above elements for the next training period?		
☐Yes ☐No Element/s:		

Signatures			
Please sign and date below before submitting to College staff via email to acp@australian.physio.			
Facilitator Signature:		**Date:**	
Registrar Signature:		**Date:**	

Appendix 8

Information about conduct of Marked Mock Exams (MME) and ACP clinical exams

This information is taken from the Candidates and Examiners Manual. It is updated annually. The latest version of the Manual is available on the PebblePad resources page. If there is any unintended conflict in procedure between this document and the Exam Manual, the Exam Manual will be the authoritative document.

It is not possible to replicate the final examinations exactly in an MME, however the procedures and processes outlined here should be followed as closely as possible by registrars and examiners undertaking formal mandatory mock exams. 'Candidate' is used to describe a person who has completed the Specialisation Training Program and has progressed to the examination program. In an MME, registrars should endeavour to replicate conditions applicable to candidates as closely as possible, in both the live streamed and face to face formats.

Please note: It is the registrar's responsibility to organise all aspects of their MMEs.

Prior to examinations

Marked Mock Exams (MME)

A formal MME, comprising *at least* a single session with a new patient and a post exam discussion using the ACP examination mark sheet, will be held:

(a) at the end of the first year of the Specialisation Training Program (STP) and
(b) between November and the end of February of the second year of the STP.

Data from these marked mock exams will be used to inform Board of Censors decisions about:

(a) a registrar progressing from first to second year of the TP and
(b) readiness to sit the final examinations.

For the purpose of formal MMEs, an experienced examiner is someone who has participated in an ACP Final Specialisation Examination round using the revised ACP exam mark sheet (2018), or who has conducted at least one MME (formal or not) with an experienced examiner using the post 2018 marking schema.

Number of Exam Attempts

A candidate is allowed to attempt the final examinations a maximum of twice. The Fellowship Pathways Standing Committee, at its discretion, may approve a third attempt at the examinations.
Each subsequent attempt at the examinations will occur in the year immediately following the failed attempt. The Fellowship Pathways Standing Committee, at its discretion, may allow an unsuccessful candidate to defer their next attempt at the examinations for no more than twelve months.

Examining Committee

Great care is taken in the selection of the examination committee for each discipline. Examiners must declare any Conflicts of Interest (CoI) and examination panels for individual candidates are carefully constructed to avoid any CoIs.

The Exam Coordinator's main role is to support the examiners, including answering any queries and identifying and resolving, wherever possible, any issues arising. The ACP Training and Assessment Coordinator, supports the candidates and oversees examination logistics and procedures. The Chief Examiner has oversight of all examinations and supports the patients. These three roles form a committee over the course of the examination weekend to ensure any issues arising are dealt with quickly and fairly.

Examining Panels

Examining Panels report to the Fellowship Pathway Standing Committee through the Chief Examiner. Formation of each Panel may involve consultation with the discipline representatives on the Board of Censors and the Chief Examiner.

Diversity of examiner panels

Selection of exam panels take into account diversity of geography, gender, previous exam experience, and area(s) of clinical expertise.

An examiner will not re-examine a candidate whom they have previously failed. Although it is preferable not to examine a candidate from the same state, there can be exceptions where necessary; however, the examiner must have had limited interaction with the candidate to be examined.

It is preferred that an examiner should not have conducted mock exams with the candidate in the four months immediately prior to the exam round; however it is recognised that flexibility is required within disciplines with fewer potential examiners.

The Examining Panel will examine a candidate in all parts of the final examination (clinical cases and oral viva exam), formulate a report on the candidate's performance and make a pass/fail recommendation.

All examiners award marks independently. Marks from each examiner are only revealed at the end of day 2, immediately prior to the examination panel discussion.

Professional Indemnity Cover

All examination participants must provide documentary evidence of current professional indemnity insurance. Participants are advised to check their professional indemnity cover very carefully to ensure their existing cover is not limited to a particular facility.

Authorisation to practice at the examination venue

The venues in which examinations are conducted may be required to 'authorise' registrars, candidates and examiners (other than those who normally work at the host facility) to practice physiotherapy at that venue.

Examiner and candidate meetings

There will be separate teleconferences for examiners and candidates, where participants can raise any issues, seek clarification and discuss any aspect of the examinations. On site meetings with candidates will be held directly before the exams to ensure familiarity with venue and allow any further questions to be answered.

The Assessment Credentialing Standing Committee, through the Chief Examiner, and Board of Examiners will be responsible for oversight of all examinations including the appointment of the Examination Working Party and Examining Panels.

Structure of the examination

The examination will consist of practical exams on two patients (initial assessment and management of each patient) on the first day, with follow up assessment and management on the second day. Immediately following the follow up assessment there will be a 30 minute 'post exam discussion' between the candidate and examiners. There will also be an oral exam (viva), 60 minutes in duration, scheduled within this two day period.

No examination will extend over the allotted time. Examiners leave at the designated conclusion of the examination.

Examination Duration

Reading time: 10 minutes	All disciplines
Initial Assessment: 60 minutes	CRP, MSK, Pain, SPEX, OHPA, WMPH
Initial Assessment: 90 minutes	Gero, Neuro, Paeds
Follow up Assessment: 30 minutes	CRP, MSK, SPEX, WMPH
Follow up Assessment: 45 minutes	Gero, Neuro, Paeds, Pain
15 minute break	All disciplines
Post Discussion Assessment: 30 minutes	All disciplines
Viva Voce (Oral examination): 60 minutes	All disciplines

Following the second day consultation with each of the two allocated patients there will be post exam discussion with the examiners where the candidate will be offered the opportunity to answer any questions which the examiners may have. The post exam discussion should not be viewed as a 'defence' but rather as an opportunity for the candidate to elaborate their reasoning with regard to their assessment /management choices, to clarify any areas that the examiners wish to explore and to provide further evidence, if required, that they have the knowledge base expected at an entry level specialist level. This will last a maximum of up to 30 minutes for each case.

Use of technology during exam

Recording of the examination, by either the candidate or the examiner, for the purpose of reviewing the candidate's performance is not allowed in final examinations, however, with appropriate patient permission, is acceptable for MMEs. The use of technology to augment the assessment process is allowed (eg. RTUS imaging, video of a movement task). This must be undertaken in the allotted examination time, although allowance for brief 'travel' can be made if the equipment to be used for the assessment (eg. treadmill) is at some distance from the location of the rest of the examination.

Verbal consent must be gained from the patient and noted by the examiners. If the video recording is for feedback to the patient or for educational purposes (eg. a home exercise program), then it is recommended that it be made on the patient's mobile device where possible. If the video is obtained on the candidate's mobile device, the file must be deleted in the presence of the examiners and preferably the patient, at the end of day 2 of the

examination weekend. If electronic notes were taken during the examination, these must also be deleted at the end of the second day, in the presence of the examiners.

Patient does not return on day 2

Unforeseen circumstances may lead to a patient not attending the follow up examination, scheduled for day two. Should this situation arise, the day 2 follow up examination will proceed as follows:
The examiners will discuss with the candidate issues such as:
How the candidate expected the patient to present on Day 2 with respect to findings from the Day 1 history taking and physical examination.
How the candidate would have responded to differences in the patient's presentation on Day 2 to what the candidate described in 1 (for both the history and physical findings).
What management (assessment and intervention) the candidate planned to undertake on Day 2.
How the candidate would have managed various responses to the proposed management on Day 2
What additional information and education they would have provided the patient on Day 2.

The alternative format for Day 2 does not include asking the candidate to explain their overall rationale for patient management, which is included in the usual Post Exam Discussion on Day 2, nor are other usual processes included in the Post-Exam Discussion to be duplicated or examined during the alternative format follow up exam.

An additional 15 minutes is allowed in some disciplines to cover additional time required for communication with and movement of the patient. However, in the event that a patient does not attend on Day 2, the time allowed for the follow up examination will be 30 minutes in length for all candidates, regardless of the usual time allowed.

The remainder of the exam will proceed in accordance with the exam timetable.

It is recommended that candidates prepare for the alternative exam scenario as part of their mock examinations by completing an oral 'follow up' about Day 2 plans, followed by a 15 minute break and then the usual post examination discussion with examiners.

Interaction with relevant others during the examination (ie: patient's family members/guardian)

Currently, in many disciplines, registrars are encouraged to focus exclusively on the interaction with the patient/client, but there are circumstances (eg. where the patient is a minor) when it is appropriate and, indeed important, to include a 'relevant other' in assessment/intervention and discussion about post examination management to ensure that appropriate data are obtained and advice about management is communicated clearly. Assessors should score the relevant criteria according to the clinical scenario.

Timing of the examination

Examiners will leave the room at the expiration of the allotted time. The candidate should finish what they are doing with the patient. This should take no more than 5 minutes. As the examiners will not 'see' this additional activity, they cannot take it into account when they make a judgement about the candidate's performance. Candidates are advised to provide advice or education to the patient only when the examiners are in the room. New information gained during the period after the exam time has elapsed will be deemed inadmissible as part of the examination or as part of the post examination discussion.

Examiners may question or examine the patient at the end of the second day of the exam (once the candidate has left the room). One or both examiners have the right to intervene during an examination or to stop the examination only if they consider the performance of the candidate to be unsafe. Subsequent action is taken based on immediate discussion between examiners and the candidate if required. Careful consideration should

be given to management of the patient in such cases.

Patient referrals and imaging

Examiners and candidates will have access to the patient referral documentation prior to the scheduled start time of the initial assessment for each clinical case. Imaging and/or imaging results, and any other relevant information will be made available where possible.

ePPOC Questionnaires (Pain Discipline)

ePPOC Questionnaires will not be sent to exam patients prior to the exams. If the patient has come from a tertiary pain clinic, where they have completed the questionnaires online, and it has been automatically pre-scored, and a summary of the ePPOC is able to be printed off, this would be part of the pre-reading provided for that patient.

Candidates can give the patient the ePPOC to complete in the waiting room (patients will be asked to arrive 30 minutes prior to the exam commencement), using a paper form or an ipad/laptop provided by the candidate. If the candidate needs to/wishes to score the ePPOC before commencing the treatment, it comes out of the 60 minutes allocated to the initial assessment.

Alternatively, the candidate can give some or all of the questionnaire to the patient to complete overnight and bring with them the next day. If the candidate wishes to score rather than just look at the results, the time would be taken from the 45 minutes allocated to the follow up session.

If a paper version of the ePPOC was completed, examiners will be given a copy. If it was done electronically, examiners would look at the ipad/laptop at the end of day 1 and/or be provided with a copy of the summary sheet if this is possible.

Outcome measures

All examination and treatment procedures undertaken by the candidate should be performed in the allocated examination time. Use of equipment such as US imaging, video analysis etc. is permitted but must be undertaken in the allotted examination time. Candidates may provide paper or electronic questionnaires (on their own device) to the patient, via the Exam Coordinator, once the reading time has commenced. These will be brought into the exam room by the patient once the reading time has concluded. It is permissible for patients to complete questionnaires after the initial assessment (day 1) has concluded, either while they remain in the exam room, or at home, depending on their availability and the judgement of the candidate about whether assistance may be needed to understand the assessment tool. Results will be made available to examiners on Day 2.

Practical examination

The nine standards of practice

The candidate will be expected to demonstrate the nine standards of practice in all areas of the final examination process of Fellowship by Specialisation:

1. Highly advanced professional behaviours
2. Highly advanced communication skills
3. Highly advanced knowledge in the field of the physiotherapy specialty and related sciences, advanced skills in information retrieval and analysis, highly advanced skills in the application of evidence-based practice
4. Highly advanced skills in physiotherapy assessment
5. Highly advanced skills in clinical reasoning
6. Highly advanced skills in development and application of an optimal physiotherapy management plan
7. Highly advanced skills in the evaluation of effectiveness, efficiency and cost effectiveness of physiotherapy management
8. Ability to contribute to multidisciplinary heath care team management, where appropriate
9. Highly developed skills in service delivery and quality improvement processes.

Selection of exam cases

The TP is designed to reflect specialist practice, with a broad base of expertise in a discipline, as well as the potential for recognition of some sub-specialisation within that clinical area. The selection is based on the 'primary presenting disorder' with the understanding that sometimes the focus of assessment and treatment can change during the actual examination.

In selecting cases, the following considerations are taken into account:

- The patient is known to be reliable (will present for the exam or communicate lack of availability in a timely manner)
- The patient is able to communicate effectively (that is, if the person has communication deficits, or English as a second language, an adequate communication strategy is established)
- The patient has a complex presenting condition relevant to the discipline and is representative of the kinds of cases which a specialist in that discipline might typically see
- Wherever possible, basic referral information is available including (at least) imaging report(s), where relevant, and information from the treating health professional, if appropriate.
- Wherever possible, and particularly in a private practice setting, the patient has been reviewed by a physiotherapist.

In selecting cases for MSK exams, at least one case will be a 'spinal' presentation. Any peripheral case should not require specialist knowledge in another field (eg. an athlete with a 'thrower's shoulder') should not be selected for MSK exams.
In selecting cases for the SPEX exams, no areas of sub-specialty are nominated.
In selecting cases for other disciplines, the Chief Examiner will ensure that at least one of the selected cases reflects a 'core' area of specialist practice in that discipline (eg. stroke for neurology, cerebral palsy for paediatrics).

Viva Voce (oral examination)
The Viva Voce is 60 minutes in duration and will be scheduled within the two day examination period. Two of the candidate's examiners will conduct this exam. The oral examination is designed to assess:

- Advanced knowledge in basic, applied and medical sciences relating to the specialty field.
- Advanced knowledge relating to specific conditions, clinical situations or settings relevant to the area of specialisation.
- Advanced knowledge of the role of the physiotherapist within the multidisciplinary and/or multiservice construct of management and prevention for the field of specialty.
- Attributes of professional leadership and responsibility.
- Attributes of professional, ethical and socially responsible conduct.

Exam marking schema
The Assessment of Physiotherapy Practice (APP) tool is used for all MMEs and Exams. The APP schema effectively has two 'fail' grades and then a 'pass' can be graded as adequate, good or excellent, allowing higher quality performance to be acknowledged. The normative reference for the scoring system will be the performance (skills, knowledge and professional behaviours) expected of an 'entry level specialist'. These marking sheets are included in Appendix 2.

The APP rating schema is as follows:
0 = Infrequently/rarely demonstrates performance indicators (fail)
1 = Demonstrates few performance indicators to an adequate standard (fail)
2 = Demonstrates most performance indicators to an adequate standard (pass)
3 = Demonstrates most performance indicators to a good standard ('credit' pass)
4 = Demonstrates most performance indicators to an excellent standard ('distinction' pass)
Not assessed = item was not assessed.

Examiners must record marks as whole numbers. Half marks (.5), ranges (2-3) and other variations must not be used. N/A or the numbers 0, 1, 2, 3, 4, are the only marks that should appear on the mark sheets.

Examiners should apply the 0-4 exam rating scale against the **minimum** competency level expected for an **entry level specialist, regardless of whether it is a Year 1 MME, Y 2 MME or Final exam.** Each examiner must assess the registrar independently. Scores are not combined or averaged across examiners. Examiners should complete the four point Global Rating Scale (GRS) before they add up their marks at the end of the post exam discussion. The GRS is based on the overall impression of the performance of the candidate (not adequate, adequate, good, or excellent).

It is expected that all performance elements in the marking schema will be assessed over the two days of the examination, but if this is not the case, the item is scored as 'not assessed' (N/A). For example, it is possible that the day 2 criterion: 'Able to identify domains of presentation that are outside scope of practice and recommend referral to relevant expert(s)' is not appropriate to the particular case, and so the examiner may choose the N/A mark allocation. In this event, an adjustment is made so that the score allocated is a percentage of the total number of items assessed. ie. the maximum total mark over all three sections of the clinical case examination (25 criteria) is usually 100, but if one criterion is N/A the exam would be marked out of 96.

Global Rating Scale (GRS)

Examiners should complete the four point GRS **before they add up their marks** at the end of the post exam discussion for each case or after the viva (where relevant) on Day 2 of the examinations. The GRS is based on the overall impression of the performance of the candidate for that case/viva (not adequate, adequate, good, or excellent). The GRS enables examiners to review the overall performance of the candidate **prior to focussing on** the individual marks allocated for each section.

Safety

Examiners have the right to intervene or stop the examination if they consider the performance of the candidate to be unsafe for the patient. Subsequent action is taken based on immediate discussion between examiners and the candidate if required. If necessary, the Chief examiner (if available) or the Exam coordinator may be consulted. Time taken for such deliberation is not included in the examination time. If a patient safety issue becomes obvious following an examination, examiners can take it into consideration in determining the candidate's final mark and pass/ fail.

There will be no mark allocation for the 'safety' criteria. This is a dichotomous category, with a section for comments. If a 'no' is allocated, examiners must determine whether the issue was sufficiently serious to constitute an overall fail, or whether it is a matter that they will discuss with the candidate to inform their future practice. It is likely that a concern with the safety and risk criterion will be reflected in other criteria related to clinical reasoning, and this may contribute to the decision whether or not to allocate an overall 'inadequate' score.

A range of circumstances can result in a 'no' grade for the safety and risk criterion. They must all relate to actual harm/risk of harm to the patient, the candidate, the examiners, the College, APA or the profession. A distinction needs to made between immediate risk of harm versus anticipation of a future risk. An example of the former might be unsafe infection control practices for intimate examination or treatment. Some examples of the latter might include: if a patient is given an inappropriate home exercise program which could be harmful; where failure to establish consent or undertake risk assessment for a procedure could expose the candidate (and, indirectly,

the examiners and organisation) to a negligence claim; or where the candidate's inattention to serious physical or mental health flags means that the patient may not receive the most appropriate holistic management including preventative steps to promote their safety. The examination mark sheet safety considerations in assessment states 'Predictive ability ensures safe and wise *conduct of assessment*, execution of intervention(s) and appropriate anticipatory planning'.

Post examination

Post Exam Self-reflection

All candidates are required to prepare a reflection on both cases, to be written as soon as possible after the exam and submitted to the Training and Assessment Lead, ACP, within two weeks of the examination. This is intended to act as an aide de memoir in the event that a feedback session is required. This self-reflection remains confidential until results are provided to candidates and a feedback panel has been formed for any unsuccessful candidates. At that time it is released to the feedback panel, to be used in addition to case notes and the examners' report, to guide the feedback session.

Official ACP 'support person'

Each year, the College will appoint a person who is very familiar with the post exam processes and timelines and the grounds and procedures for an appeal in a support role to candidates while they wait for results. Immediately after the examinations have finished, and before the results are released, s/he will contact all candidates and offer them general support and an opportunity to de-brief.

There is no expectation that this person has discipline specific knowledge, and it is not their role to provide any commentary on the candidate's performance. While some candidates will talk to their facilitator, and many contact the Training and Assessment Lead, ACP, during this period of waiting for results, it is considered that appointing a senior FACP to this role may allow candidates to feel better supported and may prevent/reduce feelings of dissatisfaction and alienation in some unsuccessful candidates.

Awarding of Fellowship

The Examining Panel will provide a result for each candidate, via the Chief Examiner, to Fellowship Pathways Standing Committee and to College Council for noting.

Each candidate will receive an email with an official letter of notification attached from the Chief Censor.
Successful candidates who are financial members of the College are entitled to use the letters FACP and to call themselves Specialist (Discipline) Physiotherapist (as awarded by the Australian College of Physiotherapists in XXX Year). It is essential this exact wording is used. Variations are not permitted under AHPRA regulations.

Feedback to unsuccessful candidates

Each unsuccessful candidate is offered the opportunity to participate in a feedback session. This session will be scheduled no sooner than two months after the appeals period has concluded (notification of an appeal must be received 28 days from the day results are released).

The aim of the feedback session is to provide advice about where the candidate did, or did not, meet the standard expected of an entry level specialist; to identify what behaviours (skills, knowledge etc.) expected at specialist level were not seen; and to give the unsuccessful candidate direction on how to prepare for any subsequent attempt at the examination. It is not the intention of the feedback session to provide a detailed breakdown of the assessment and management of the clinical case(s), although examples of behaviours observed during the examination may be provided, to illustrate where the expected standard was not met.

Appeals, grievances and complaints

Registrars have the right to lodge an appeal, grievance or complaint. Appeals, grievances or complaints must be requested on the ground that the procedure set out in this and other procedural documents of the College has not been followed. For further information and to view the ACP Appeals, Complaints and Grievances Policy and Procedures: Go to the College Governance Page on the APA website.

Appendix 9
Examination assessment sheets

Examination Mark Sheet

Case Details

Examiner:		Candidate:	
Date:		Case:	

Scoring Instructions

- Evaluate the performance against the minimum competency level expected for an entry level specialist.
- Score only one number for each criterion. Half marks (0.5, ½) and ranges (1-2) must not be used.
- If a score falls between numbers on the scale the higher number should be allocated.
- Not assessed – a criterion should only be scored as 'not assessed' when there is a credible reason that the criterion was not seen during the examination. If a criterion is 'not assessed' the total potential score is adjusted for the missed criterion.

Rating Scale

0 = Infrequently/rarely demonstrates the performance indicators (inadequate)
1 = Demonstrates few performance indicators to an adequate standard (inadequate)
2 = Demonstrates most performance indicators to an adequate standard at the level of an **entry level specialist** (pass)
3 = Demonstrates most performance indicators to a good standard (credit pass)
4 = Demonstrates most performance indicators to an excellent standard (distinction pass)
NA = Not assessed – it is acceptable that the criterion was not able to be evaluated.

Day 1: Initial Assessment

Criterion 1: Patient/Client Interview	Rating
Questions patient/client selectively, thoroughly, efficiently and appropriately.	
Is able to pursue assessment according to a highly advanced line of reasoning, which incorporates available medical, radiological or other (including psychosocial), information.	
Identifies most relevant problems including patient/client goals Identifies appropriate screening tools / outcome measures that will form the basis for examination, management and reassessment.	
Criterion 1 Comments:	

Criterion 2: Physical Examination	Rating
Is able to pursue a physical examination according to a highly advanced line of reasoning which extends from the patient/client interview.	
Demonstrates highly advanced assessment skills.	
Uses a range of appropriate assessment domains. Is able to modify assessments as appropriate. Gains targeted information on which to proceed.	
Criterion 2 Comments:	

Criterion 3: Outcome of Examination	Rating
Clearly demonstrates an advanced understanding of the patient/client's presenting problem.	
Criterion 3 Comments:	

Criterion 4: Management Planning	Rating
Identifies intervention options according to a highly advanced line of reasoning which extends from the outcomes of the examination.	

Clearly outlines intervention options to the patient /client and considers their values and preferences in deciding how to proceed.	
Constructs a management plan that is collaborative, comprehensive and targeted towards the individual's goals, needs, and capacity.	
Criterion 4 Comments:	

Criterion 5: Intervention	Rating
Demonstrates highly skilled execution of chosen intervention(s) in an efficient and effective manner. Is highly responsive to changes and patient/client responses concurrent with the intervention implementation.	
Criterion 5 Comments:	

Criterion 6: Ongoing Assessment – Response to Patient / Client	Rating
Demonstrates the ability to be flexible, adaptable and rapidly responsive to patient/client´s expectations, their understanding of the management approach, and reactions to the intervention(s). Notices subtle changes in patient/client´s response and introduces new assessment procedures or interventions appropriately in response to findings.	
Criterion 6 Comments:	

Criterion 7: Communication and Professionalism	Rating
Consistently seeks patient/client´s input, listens reflectively and responds appropriately. Explains the source(s), contributing and causative factors, and mechanisms underpinning impairments, activity limitations, or participation restrictions as required Explains ongoing management and any program to be undertaken by the patient /client clearly and succinctly, ensuring there is complete understanding and acceptance by the patient/client. Displays professional and empathetic consultation and goal setting with patient/client. Demonstrates high level documentation skills including all relevant information and provision of informed consent.	
Criterion 7 Comments:	

Safety Criterion:	Rating

Predictive ability ensures safe and wise conduct of assessment, execution of intervention(s) and appropriate anticipatory planning. Demonstrates consideration of issues related to obtaining informed consent. Implements measures to ensure patient/client safety at all times.	Yes ☐ No ☐
Safety Comments:	

Final Comments:

Total Score – Initial Assessment:	(Maximum 52)
Examiner Signature:	
Date:	

Day 2: Follow Up Assessment

Criterion 1: Assessment: Patient /Client Interview (Reference Standards 1-5)	Rating
Questions selectively, thoroughly, efficiently and appropriately. Is able to pursue assessment according to an advanced line of reasoning. Assesses response to previous intervention(s) against findings and goals. Clarifies any factors from the initial interview. Uses the most appropriate outcome measures.	
Criterion 1 Comments:	

Criterion 2: Physical Examination (Reference Standards 1-5)	Rating
Uses advanced skills of re-assessment to interpret response to previous intervention(s). Uses appropriate assessment domains relevant to the patient/client's main problem and goals.	
Gains targeted information on which to proceed. Is able to modify assessment or add additional assessments if necessary, Shows sensitivity and flexibility in re-assessing the patient/client, including modifying and adapting the assessment according to response to previous intervention(s).	
Criterion 2 Comments:	

Criterion 3: Intervention /Management Plan (Reference Standards 2,3, 5 & 8)	Rating
Develops a collaborative, targeted and comprehensive management plan that is evidence based, highly relevant, and specific to patient/client's problems and achievement of goals. Selects optimum interventions/management relevant to re-assessment findings. Progresses, modifies or adapts intervention(s) based on patient/client's previous response.	
Criterion 3 Comments:	

Criterion 4: Intervention (Reference Standards 5, 6 & 7)	Rating
Demonstrates highly skilled execution of intervention(s) in an efficient manner. Is highly responsive to changes concurrent with the intervention implementation.	
Criterion 4 Comments:	

Criterion 5: Ongoing Assessment and Response to Patient/Client (Reference Standards 2-5, & 7)	Rating
Demonstrates the ability to be flexible, adaptable and rapidly responsive to patient/client's expectations, their understanding of the management approach, and reactions to the intervention(s). Notices subtle changes in patient/client's response and introduces new assessment procedures or interventions appropriately in response to findings.	
Criterion 5 Comments:	

Criterion 6: Communication And Ongoing Management (Reference Standards 1, 2 & 8)	Rating
Communicates future management plan & implications to patient/client, accurately, clearly & succinctly.	
Is able to identify domains of presentation that are outside scope of practice and recommend referral to relevant expert(s).	
Criterion 6 Comments:	

Safety Criterion:	Rating
Predictive ability ensures safe and wise conduct of assessment, execution of intervention(s) and appropriate anticipatory planning. Demonstrates consideration of issues related to obtaining informed consent. Implements measures to ensure patient/client safety at all times.	Yes ☐ No ☐
Safety Comments:	

Final Comments:

Total Score – Follow Up Assessment:	(Maximum 32)
Examiner Signature:	
Date:	

Day 2: Post Exam Discussion

Criterion 1: Clinical Reasoning In Assessment (Reference Standards 1-5)	Rating
Able to provide a succinct, accurate summary of patient/client's problems. Clinical reasoning process is well articulated and reflects a substantial, well organized, knowledge base. Able to link patient/client's problems to pathophysiology and function and to identify the impact of environmental and personal factors at an advanced level.	
Criterion 1 Comments:	

Criterion 2: Clinical Reasoning In Management (Reference Standards 2, 3, 5, 6 & 8)	Rating
Demonstrates an innovative and broad range of actual and possible management approaches. Able to support management decisions with well targeted problem solving and appropriate theoretical background. Decision making reflects a personal model of practice developed from clinical experience and is well integrated with research evidence.	
Criterion 2 Comments:	

Criterion 3: Critical Reflection On Outcomes (Reference Standards 2- 5)	Rating
Understands and is able to discuss the reliability and validity of measurement tools used, including normative values if available. Is able to interpret and critique patient/client outcomes against assessment findings and goals of the intervention. Reflectively critiques own reasoning process in relation to assessment and intervention.	
Criterion 3 Comments:	

Criterion 4: Future Management Planning (Reference Standards 2, 3, 5-8)	Rating
Understands and is able to discuss prognosis. Is able to develop a collaborative, comprehensive, appropriate plan for progression of patient /client management, based on excellent theory & evidence, as well as taking into account the patient/client's values, preference and capacity. Outlines comprehensive and well developed plans for ongoing management (if appropriate).	
Criterion 4 Comments:	

Final Comments:

Global Rating Scale
Please complete this section BEFORE you add up /finalise your detailed marks for this case In your opinion as an ACP examiner, the overall performance of this Candidate in this clinical exam against the **minimum** competency level expected for an **entry level specialist** was: ☐ Not Adequate ☐ Adequate ☐ Good ☐ Excellent
Global Rating Scale Comments:

Total Score – Post Exam Discussion:	(Maximum 16)
Examiner Signature:	
Date:	

Day 2: Final Score

Overall Score		
Total Overall Score:	Initial + Follow Up + Post	(Maximum 100)
Examiner Signature:		
Date:		

Examination Mark Sheet

Viva Voce

Examiner:		Candidate:	
Date:			

Scoring Instructions

- Evaluate the performance against the minimum competency level expected for an entry level specialist.
- Score only one number for each criterion. Half marks (0.5, ½) and ranges (1-2) must not be used.
- If a score falls between numbers on the scale the higher number should be allocated.
- Not assessed – a criterion should only be scored as 'not assessed' when there is a credible reason that the criterion was not seen during the examination. If a criterion is 'not assessed' the total potential score is adjusted for the missed criterion.

Rating Scale

0 = Infrequently/rarely demonstrates the performance indicators (inadequate)
1 = Demonstrates few performance indicators to an adequate standard (inadequate)
2 = Demonstrates most performance indicators to an adequate standard at the level of an **entry level specialist** (pass)
3 = Demonstrates most performance indicators to a good standard (credit pass)
4 = Demonstrates most performance indicators to an excellent standard (distinction pass)
NA = Not assessed – it is acceptable that the criterion was not able to be evaluated.

Examination Mark Sheet Examiner: Candidate: Case: Viva

Viva Voce Examination

Criteria	Rating
Advanced knowledge in basic, applied, and medical sciences relating to the specialty field.	
Advanced knowledge relating to specific conditions, situations, or settings relevant to the area of specialisation.	
Advanced knowledge of the role of the physiotherapist within the multidisciplinary and/or multiservice construct of management and prevention for the field of specialty.	
Attributes of professional leadership and responsibility.	
Attributes of ethical and socially responsible conduct.	
Comments	

Global Rating Scale
Please complete this section BEFORE you add up /finalise your detailed marks for this case In your opinion as an ACP Examiner, the overall performance of this Candidate in this clinical exam against the **minimum** competency level expected for an **entry level specialist** was: ☐ Not Adequate ☐ Adequate ☐ Good ☐ Excellent
Global Rating Scale Comments:

Total Score – Viva Voce:	(Maximum 20)
Examiner Signature:	
Date:	

Appendix 10

Video Marked Mock Exams: Information and consent forms

Registrars have the option of submitting their marked mock exams via video. Registrars should make any paperwork/ reports/ supporting documentation that would be viewed by an examiner in a F2F exam available to their video assessor(s), if possible.

It is the responsibility of the registrar to organise two assessors for each of their mandatory mock exams.

Examiners should be approached before the exam is submitted. Registrars should confirm the file format they are using can be opened and viewed by the assessor. The file transfer method should also be discussed – drop box or similar platform, USB key, the cloud etc.

The most common file format is .mp4. Make sure the video file format produces a video file that is of a size that can easily be transferred.

Using your phone is completely acceptable. It is well worth doing a trial to ensure the quality (sound and picture) is of a standard it can be assessed.

Make sure the camera is set up on a tripod in a position that allows a wide angle view of the treatment space and you treating the patient. You may choose to have a videographer in the treatment room with you.

Check the sound quality. Conversation must be clearly audible with no background noise.

The date and time stamp on the video must be continuous.

Consent forms must be completed by both the patient and the registrar.

Examination mark sheets and consent forms are available in the ATLAS section of PebblePad.

See also the Marked Mock Exam Procedure

PATIENT CONSENT FORM
ACP Clinical Specialisation Examinations

I, _____(print full name)

I understand that physiotherapist, xxxx, will examine me today and that this examination will be viewed by remote examiners. I hereby give consent for my medical / physiotherapy records and any relevant investigations / results of investigations to be released to the treating physiotherapist and participants involved in the assessment process of the purpose of conducting this clinical examination by the Australian College of Physiotherapists on the above dates. The documentation will be retained by the participants only for the purposes of the examination process, after which it will be destroyed.

I understand that the case summary and mark sheets will only be retained in a deidentified format.

I give permission for this examination process to be live streamed and recorded, utilizing zoom web conferencing software. This recording will only be made available to those involved in the assessment process. The recording will be destroyed, once the examination results are ratified.

I understand that there will be a camera person in the treatment room with me to facilitate the recording of the examination.

I confirm that the procedures associated with the examination have been comprehensively explained to me before commencing the examination and that I fully understand and consent to the procedures outlined.

I consent to the information outlined above:

Patient name: _____

Signed: _____ Date: _____

Witness: _____

ACP Exam Role: _____

Signed: _____ Date: _____

CANDIDATE CONSENT FORM

I hereby give consent for my video assessment of

Patient name: ……

Conducted on: …… (date)

To be used for educational and research purposes by the Australian College of Physiotherapists. If the recording was to be used for any external purposes that I would be contacted prior and that my consent would be required.

I have obtained and attached to this document a completed Patient Consent Form, stating that the abovenamed medical / physiotherapy records and any relevant investigations / results of investigations can be released and discussed for educational and research purposes by the Australian College of Physiotherapists.

Information released may include any documents on record and written reports created at the request of outside individuals or agencies.

Preferred contact method (phone/email): ……

Name: ……

Signed: …… Date: ……

Appendix 11

Suggestions for mock examiners to guide feedback to registrars (single day exam)

Patient interview

- Patient perspectives/goals
- Pain/dysfunction type; source of pain /dysfunction, differential diagnosis
- Precautions for management
- Priorities for objective examination

Physical examination

- Physical impairments and source of symptoms
- Contributing (non-physical) factors
- Pain /dysfunction type

Analysis and Management plan

- Assessment/re-assessment
- Use of outcome measures
- Explanation/education

Intervention

- Appropriateness of management choices/ application of intervention
- Modification of program/feedback on performance
- Reassessment post intervention
- Plans for further assessment (day 2)
- Plans for treatment progression/self- management (day 2)
- Views about prognosis

Overall performance (try to provide specific examples)

- What was done well (at level of an entry-level specialist)?
- What could have been done better (performance was not at level of an entry-level specialist)?
- Did the registrar address the patient's main goal(s)/problem?

Recommendations for future development

- What areas of knowledge and which skills do they need to work on over the next six months (try to be as specific as possible)?

Post-exam discussion prompts (30 minutes)

This discussion should provide the registrar with an opportunity to demonstrate their understanding of the patient's presentation and elaborate their clinical reasoning process and the evidence base for their choices of assessment and management.

Keep in mind that the questions should seek to recognise the priorities, reasoning and evidence guiding decisions. There are situations in which very open or highly focussed questions are appropriate. It is important to consider the marking guide and focus on areas in which the registrar has not scored highly – it may be necessary to go to these areas first in the question time.

The language used below might be useful as a guide.

- 'Thank you. There are a few questions we have in order to understand your decision making more clearly. Can you please elaborate…'
- 'Can you tell us what the main issues were in this case?'
- 'What do you feel were the perspectives of this patient in regard to the impairment(s)?'
- 'Can you discuss the pain/dysfunction mechanisms involved? / What do you think was the source of symptoms?'
- 'How did you prioritise the relevance of the symptoms?'
- 'Can you please outline the reasoning behind your choice of intervention(s)? Which information from the examination led you to select this approach? Is there particular evidence which supports this intervention?'
- 'Can you help us to understand the ongoing management plan for this patient?'
- 'Are there any other investigations / objective assessment tests / interventions that you'd like to consider in the future for this patient?'
- 'How will the outcome be measured in this case? What guides you to expect that your management plan will work?'
- 'What do you think the prognosis is in this case? Do you think the patient understands their prognosis?'
- 'What were the patient's goals for the session? Do you feel these were addressed?'
- 'What do you feel that you did well in this exam?'
- 'Were there any areas in which you would like to have done better?'

Appendix 12
Clinical Reasoning after Physical Examination

History / Subjective

Describe the patient's presenting symptoms / problem list

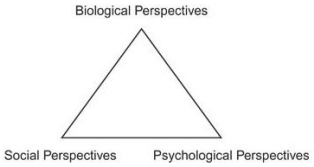
Problem	Contributing Factors

1. Consider three hypotheses for their symptoms / problem list

Hypothesis	Key Feature	Distinguishing Feature
1.		
2.		
3.		

2. Explain why each question was asked and how selective questioning contributed to reprioritising the hypothesis

Hypothesis	Explanation of Questioning
1.	
2.	
3.	



Clinical Reasoning After Subjective

3. List your competing hypotheses including supportive and negating evidence for each

Prioritised Hypothesis	Supporting Evidence	Negating Evidence

4. What are your priorities (in order) to examine in the PE?

1.	
2.	
3.	
4.	

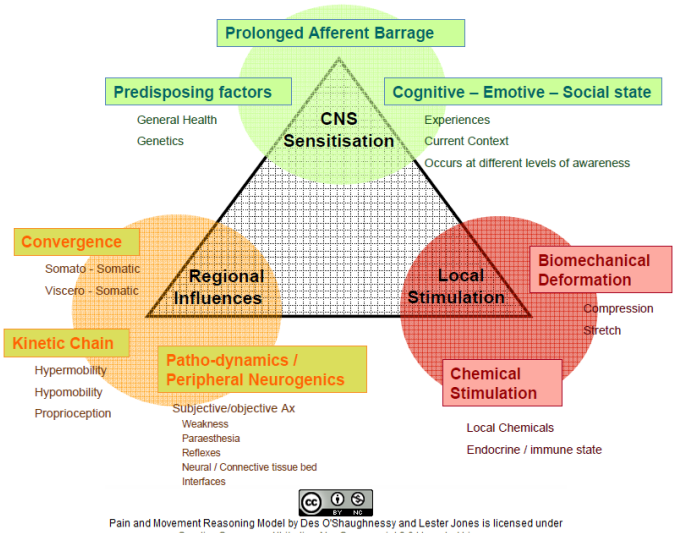
Clinical Reasoning during Physical Examination

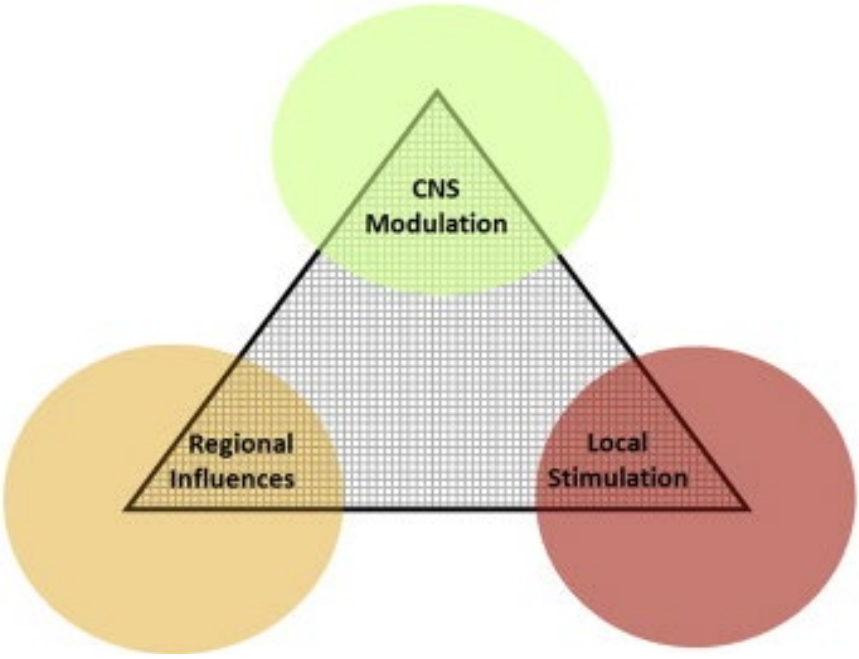
5. What are the key factors in the physical examination that you can identify as 'special'?

1.	
2.	
3.	
4.	

6. If you were allowed one more PE test at the end of the PE, what would it be and why?

Pain and Movement Reasoning Model
(O'Shaughnessy & Jones, 2008)





7. List current hypotheses, do they differ from those listed in Q4?

Hypothesis	Supporting Evidence	Negating Evidence	Differ? How/ Why?

Management

8. What are the three main priorities for management and why?

1.	
2.	
3.	

9. What is the patient's prognosis?

Plan for day 2

10. Your plan for Day 2?

Review Outcome	Further Examination	Physical Treatment	Management Plan
If Better			
If Worse			

11. Management Plan

Overall Reflection

12. Reflecting on what you have learned from this experience, how might you modify your approach to examination and management of a patient in this context?

Adapted by: Hannah Graetz ACP Registrar, WMPH (November 2017) – from clinical reasoning form used at ACP Associate's Day (October 2017) by Trudy Rebbeck, Mike Ryan, Mark Kenna, Mary Magarey and Darren Beales.

Appendix 13: Discipline curricula

Cardiorespiratory

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the cardiorespiratory discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Dyspnoea/pain
2. Exercise in disease states
3. The aging or pregnant cardiorespiratory system
4. The critically ill patient
5. Chronic respiratory disorders
6. Mechanisms of action of cardiorespiratory interventions and advanced understating of outcome measures
7. Examination of any patient from a cardiorespiratory view
8. Safety in cardiorespiratory practice
9. Professional, cultural and ethical issues specific to the scope of practice of cardiorespiratory physiotherapy.
10. Evidence based practice in cardiorespiratory physiotherapy

	Component	Knowledge	Skills
1	Dyspnoea/pain	Mechanisms of dyspnoea in acute, subacute and chronic states Understanding of the interactions between physiological and behavioural drivers of dyspnoea Appreciation of the effect of acute pain on the cardiorespiratory system and current methods of management	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills High level patient explanations of diagnosis and treatment options Multi-professional options for dyspnoea/pain management
2	Exercise in disease states	Contemporary knowledge of disordered exercise physiology and implications for rehabilitation e.g. chronic respiratory diseases, cardiac conditions, metabolic conditions, critical care acquired weakness Changes in peripheral muscle properties in disease states and implications for rehabilitation Advanced level of understanding of respiratory muscle function in health and disease	Highly advanced clinical reasoning and assessment skills Highly advanced treatment options and skills High level patient explanations of diagnosis and management
3	The aging or pregnant cardiorespiratory system	Understanding of implications of aging on the Cardiorespiratory system in both the acute and chronic situations Understanding of implications of pregnancy on the Cardiorespiratory system in both the acute and chronic situations	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Advanced skills in wellness and prevention programs High level patient explanations Multi-professional options for management
4	The critically ill patient	High level understanding of disease processes of common conditions in critical care e.g. ARDS, Sepsis, severe trauma, neurological injury High level understanding of high risk surgical patient, those at risk for respiratory failure or readmission to ICU	Highly advanced clinical reasoning and assessment skills Highly advanced management skills Consideration of the bio-psychosocial aspects of client care

	Component	Knowledge	Skills
5	Chronic respiratory disorders	Appreciation of pathophysiology and implications for management of chronic respiratory conditions e.g. COPD, cystic fibrosis and bronchiectasis.	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills and management
6	Mechanisms of action of cardiorespiratory interventions and advanced understating of outcome measures	Advanced level of understanding of Cardiorespiratory interventions e.g. NIV, airway clearance Advanced level of understanding of all outcome measures	Highly advanced clinical reasoning and assessment skills Highly advanced treatment & management skills
7	Examination of any patient from a cardiorespiratory view	Advanced ability to interpret radiology, pathology & clinical examination tests. Able to appreciate cardiorespiratory effects of disease states in other specialties e.g. neurology (stroke), musculoskeletal and consult with other specialities accordingly	Highly advanced clinical reasoning and assessment skills Highly advanced management skills Consideration of the bio-psychosocial aspects of client care
8	Safety in cardiorespiratory practice	Advanced knowledge of conditions interventions and treatment effects/interactions	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices
9	Professional, cultural and ethical issues specific to the scope of practice of cardiorespiratory physiotherapy.	Leadership in cardiorespiratory physiotherapy and relationships with other health care professionals; policy makers Cultural influences and the receipt of cardiorespiratory management Patient centred influences on management delivery	Highly advanced professional and leadership skills Highly advanced communication skills Consideration of the bio-psychosocial aspects of client care
10	Evidence based practice in cardiorespiratory physiotherapy	Evidence from systematic review and randomised controlled trials Clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management

Gerontology

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the gerontology discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Pain in the elderly
2. Motor control in elders
3. Balance and postural control
4. Activity limitations and participation restrictions in the elderly
5. Exercise and activity in the elderly
6. The aging process and impact on physical health
7. Problems associated with aging with a disability
8. Safety in gerontological practice
9. Professional, cultural and ethical issues specific to the scope of practice of gerontological physiotherapy.
10. Evidence based practice in gerontological physiotherapy

	Component	Knowledge	Skills
1	Pain in the elderly	Mechanisms of pain in acute, subacute and chronic states Differential diagnosis of pain of central and peripheral origin Recognition of psychological reactions and drivers of pain Understanding of the interactions between physiological and behavioural drivers of pain in elders	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and treatment options Multi-professional options for pain management
2	Motor control in elders	Contemporary knowledge of disordered motor control and implications for gerontological physiotherapy Changes in muscle properties with aging and implications for gerontological physiotherapy Advanced understanding of varying frameworks of gerontological physiotherapy management	Highly advanced clinical reasoning and assessment skills Highly advanced treatment options High level patient explanations of diagnosis and management options Highly advanced multi-professional management and referral practices
3	Balance and postural control	Advanced knowledge of the mechanisms of balance and postural control Advanced understanding of the role of the gerontological physiotherapist in falls prevention and risk management	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills High level patient explanations of diagnosis and management options Multi-professional options for falls prevention management
4	Activity limitations and participation restrictions in the elderly	Advanced level of understanding of reasons for and methods of prevention for activity limitations in elders Knowledge of interactions between the biological systems and their interactions with the individual's functional disability and participation limitations.	Highly advanced clinical reasoning and assessment skills Highly advanced treatment options and skills High level patient explanations of diagnosis and management
5	Exercise and activity in the elderly	Advanced level of understanding of the evidence for the physiological, functional and psychosocial benefits of exercise for elders. Advanced understanding of wellness programs for elders	Highly advanced clinical reasoning and assessment skills Highly advanced management skills High level patient explanations and management options

	Component	Knowledge	Skills
6	The aging process and impact on physical health	Advanced knowledge of the impact of aging on body systems and the implications for gerontological physiotherapy practice Advanced knowledge of cognition in elders, the processes that may affective cognitive function and the implications for gerontological physiotherapy practice Differential diagnosis of cognitive impairment and confusional states in elders.	Highly advanced clinical reasoning and assessment skills Highly advanced treatment & management skills Highly advanced multi-professional management and referral practices
7	Aging with a disability	Advanced knowledge of effects of aging on pre-existing disabilities (e.g. TBI, Spinal cord injury, CP) Advanced level of understanding of gerontological interventions for this client group.	Highly advanced clinical reasoning and assessment skills Highly advanced management skills Highly advanced multi-professional management and referral practices
8	Safety in gerontological practice	Advanced knowledge of conditions, interventions and treatment effects/interactions	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices
9	Professional, cultural and ethical issues specific to the scope of practice of gerontological physiotherapy.	Leadership in gerontological physiotherapy and relationships with other health care professionals and policy makers Cultural influences and the receipt of management Patient centred influences on management delivery Opportunities and barriers in residential care facilities	Highly advanced professional and leadership skills Highly advanced communication skills Highly advanced teamwork skills
10	Evidence based practice in gerontological physiotherapy	Evidence from systematic reviews and randomised controlled trials relevant to gerontological physiotherapy practice Advanced knowledge of outcome measures for gerontological physiotherapy practice Appreciation of advantages/disadvantages of clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management

Musculoskeletal

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the musculoskeletal discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Pain and musculoskeletal disorders
2. Motor control in musculoskeletal disorders
3. The aging musculoskeletal system
4. Trauma and overuse injuries of the musculoskeletal system.
5. Classification of musculoskeletal pain states
6. Mechanisms of action of musculoskeletal physiotherapy interventions
7. Radiology for musculoskeletal physiotherapy practice
8. Safety in musculoskeletal physiotherapy practice
9. Professional, cultural and ethical issues specific to the scope of practice of musculoskeletal physiotherapy
10. Evidence based practice in Musculoskeletal Physiotherapy

	Component	Knowledge	Skills
1	Pain and musculoskeletal disorders	Mechanisms of pain in acute, subacute and chronic states Differential diagnosis of pain of central and peripheral origin Recognition of psychological reactions and drivers of pain Understanding of the interactions between physiological and behavioural drivers of pain	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and treatment options Multi-professional options for pain management
2	Motor control in musculoskeletal disorders	Contemporary knowledge of disordered motor control and implications for rehabilitation Changes in muscle properties and implications for rehabilitation Brain plasticity and implications for rehabilitation	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management
3	The aging musculoskeletal system	Prevention of disease progression in peripheral and spinal degenerative disease and other disorders of aging Consideration of presentations in acute, subacute and chronic stages Wellness programs	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Advanced skills in wellness and prevention programs Patient explanation of diagnosis and management Multi-professional options for management
4	Trauma and overuse injuries of the musculoskeletal system	Differential diagnosis of complex spinal and extremity musculoskeletal disorders in acute, subacute and chronic presentations. Knowledge of the interactions between biological systems and their interactions with the individual's functional disability and participation limitations	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management Multi-professional options for management
5	Classification of musculoskeletal pain states	Current classification systems for spinal and extremity joint musculoskeletal disorders Clinical utility of classification systems in acute, subacute and chronic states	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills

	Component	Knowledge	Skills
6	Mechanisms of action of musculoskeletal physiotherapy interventions	Neurophysiological, mechanical and psychological underpinnings of musculoskeletal physiotherapy practice	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills
7	Radiology for musculoskeletal physiotherapy practice	Radiation safety Indications for referral for plain x-rays, CT, US imaging, MRI Clinical Guidelines for radiology use	Highly advanced clinical reasoning and assessment skills
8	Safety in musculoskeletal physiotherapy practice	Advanced knowledge of conditions and drug side effects/interactions that may masquerade as musculoskeletal pain states and their clinical recognition	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices
9	Professional, cultural and ethical issues specific to the scope of practice of musculoskeletal physiotherapy.	Leadership in musculoskeletal physiotherapy and relationships with other health care professionals; policy makers Cultural influences and the receipt of musculoskeletal management Patient centred influences on management delivery	Highly advanced professional and leadership skills Highly advanced communication skills
10	Evidence based practice in Musculoskeletal Physiotherapy	Evidence from systematic review and randomised controlled trials Clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management

Neurology

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the Neurology discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Motor control in neurological disorders
2. Balance and postural control
3. Activity limitations and participation restrictions in neurological conditions
4. Non motor problems in neurological diseases
5. The acute, chronic and degenerative neurological condition
6. Mechanisms of action of neurological interventions
7. Outcome measures in neurological physiotherapy
8. Safety in neurological practice
9. Professional, cultural and ethical issues specific to the scope of practice of neurological physiotherapy
10. Evidence based practice in neurological physiotherapy

	Component	Knowledge	Skills
1	Motor control in neurological disorders	Contemporary knowledge of disordered motor control and implications for neurological physiotherapy Changes in muscle properties and implications for neurological physiotherapy Advanced understanding of varying frameworks of neurological physiotherapy management	Highly advanced clinical reasoning and assessment skills Highly advanced treatment options High level patient explanations of diagnosis and management options Highly advanced multi-professional management and referral practices
2	Balance and postural control	Mechanisms of balance and postural control Advanced understanding of the role of the neurological physiotherapist in falls prevention and risk management	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills High level patient explanations of diagnosis and management options Multi-professional options for falls prevention management
3	Activity limitations and participation restrictions in neurological conditions	Advanced level of understanding of reasons for and methods of prevention for activity limitations Knowledge of interactions between the biological systems and their interactions with the individual's functional disability and participation limitations.	Highly advanced clinical reasoning and assessment skills Highly advanced treatment options and skills High level patient explanations of diagnosis and management
4	Non motor problems in neurological diseases	Contemporary knowledge of non-motor problems and implications for clinical practice. Understanding of the interaction between motor and non-motor problems and their interaction with an individual's functional disability and participation limitations	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills High level patient explanations Multi-professional options for management
5	The acute, chronic and degenerative neurological condition	High level understanding of pathophysiology and associated motor problems and the implications of common conditions in neurology including stroke, Parkinson's disease, spinal cord injury, multiple sclerosis, lower motor neurone lesion and traumatic brain injury	Highly advanced clinical reasoning and assessment skills Highly advanced management skills High level patient explanations of diagnosis and management options

	Component	Knowledge	Skills
6	Mechanisms of action of neurological interventions	Contemporary knowledge of neuroplasticity and its implications for neurological physiotherapy Advanced level of understanding of available neurological interventions. Clinical utility of equipment and aids in neurological physiotherapy.	Highly advanced clinical reasoning and assessment skills Highly advanced treatment & management skills
7	Outcome measures in neurological physiotherapy	Contemporary knowledge of issues related to outcome measurement in neurological physiotherapy. Clinical utility of outcome measurement in acute, sub-acute and chronic patient populations. Advanced knowledge and understanding of the limitations and validity of outcome measures	Highly advanced clinical reasoning and assessment skills Highly advanced management skills
8	Safety in neurological practice	Advanced knowledge of conditions interventions and treatment effects/interactions	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices
9	Professional, cultural and ethical issues specific to the scope of practice of neurological physiotherapy.	Leadership in neurological physiotherapy and relationships with other health care professionals; policy makers Cultural influences and the receipt of neurological management Patient centred influences on management delivery	Highly advanced professional and leadership skills Highly advanced communication skills
10	Evidence based practice in neurological physiotherapy	Evidence from systematic review and randomised controlled trials Appreciation of advantages/disadvantages of clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management

Occupational Health

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the Occupational Health Physiotherapy (OHP) discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Workplace Legislation
2. Causation and contributing factors to occupational health and wellbeing, occupational illness and injury
3. OHP interventions
4. Evaluation
5. Work trauma, diseases of occupation and work related injury
6. Promoting Wellness at Work
7. Work Injury/Illness Prevention
8. Work Injury/Illness Management
9. Evidence based practice in OHP practice
10. Professional and ethical issues in OHP practice

	Component	Knowledge	Skills
1.	Workplace Legislation	Workplace and related legislation in relevant jurisdictions, in a broad national and international context Implications of legislation for all stakeholders including specific implications for OHP	Highly advanced interpretation of workplace related legislation in relation to stakeholders. Highly advanced practice of OHP skills in accordance with legislative framework
2.	Causation and contributing factors to occupational health and wellbeing, occupational illness and injury	Relationship between work history, work practice, work environment, lifestyle and mechanisms of injury and illness. The effects of change in the workplace. Biophysical, psychosocial, organisational and economic factors affecting work health. Highly advanced knowledge base of contemporary views in relation to OHS Key stakeholders' perspective of workplace health and safety, injury prevention and management. Safe systems of work	Highly advanced reasoning skills drawing on the different paradigms of key stakeholders Highly advanced ability to discern safe and unsafe elements and systems of work practice
3.	OHP Interventions	Contemporary knowledge and application of workplace ergonomics Principles of adult learning, education and training Project management of OHS interventions within an organisation including immediate on-site injury management, change management, priority setting and participative ergonomics. Integrated with Safety management Systems	Highly advanced reasoning skills, assessment and management skills. Highly advanced skills in the selection and application of ergonomic tools Highly advanced delivery of appropriate training and education sessions Consultation with employers and employees
4.	Evaluation	Methods of evaluation of OHP interventions in workplace wellness, injury prevention and injury management Evaluation of outcomes and incorporating feedback into the development of subsequent strategies Measurement using lead and lag indicators.	Highly advanced reasoning skills Explanation of benefits and weaknesses of different evaluation methods to key stakeholders Able to critically interpret both qualitative and quantitative work illness and injury data

	Component	Knowledge	Skills
5.	Work trauma, diseases of occupation and work related injury system	Commonly encountered occupational related conditions (in depth knowledge of MSDs and also including knowledge of other conditions for example stress, NIHL dermatitis, respiratory conditions and cancer) Evidence for work relatedness of musculoskeletal disorders in acute, subacute and chronic presentations. Interactions between work systems and human factors, (e.g. biological systems and their interactions with the individual's functional ability and participation limitations)	Highly advanced reasoning and assessment skills Highly advanced management skills Explanation to stakeholders of diagnosis and management Multi-professional options for management
6.	Promoting Workplace Wellness	Principles and practice of the workplace as a setting for health promotion Environmental factors to create a healthy workplace: physical, psychosocial, and economic Setting appropriate work duties for individual and groups of staff including those with special needs e.g. older workers, workers with physical or intellectual restrictions Barriers to workplace wellness and how to overcome them Measurement tools for health promoting activities at work	Explanation to relevant stakeholders about healthy workplace settings and practices Highly advanced skills in the promotion, delivery and management of workplace wellness Highly advanced appropriate evaluation skills
7.	Work injury prevention	Principles and practice of contemporary work injury prevention Ergonomic and other tools to identify hazards and conduct risk assessments Risk management (including control hierarchy) and priority setting Accident and incident investigation Communication strategies to facilitate change The role of stakeholders in injury prevention	Sound theoretical principles underlie interventions Highly advanced observational and interpretive skills Highly advanced management skills Appropriate communication and explanation (verbal and written) to all stakeholders involved in work injury prevention

	Component	Knowledge	Skills
8.	Work injury management	Principles and practice of contemporary work injury management Multiple issues leading to chronicity and prevention/early detection/management thereof, including management both at the workplace and within the compensation system Multidisciplinary collaboration Barriers to successful return to work and how to manage them Role of the Union in the workplace Knowledge of industrial processes and needs including work rates, chain of command, direct and indirect labour, Australian Standards and return on investment into OHP in the workplace.	Highly advanced skills in workplace injury management interventions Appropriate communication and explanation to all stakeholders involved in work injury management Multi professional options
9.	Evidence based practice in OHP	Evidence from systematic reviews and randomised controlled trials Clinical practice guidelines and their relevance to work injury management Outcome measures and their use within OHP practice Limitations of evidence in OHP Practice	Highly advanced reasoning and assessment skills Highly advanced management skills Stakeholder explanation of management and reasoning
10.	Professional and ethical issues in OHP practice	Leadership in OHP practice and relations with other stakeholders including employers, employees, health care professionals, insurers and policy makers Barriers to communication and how to overcome them Ethical issues in occupational health Cultural influences within the workplace and OHP practice Promoting OHP to relevant stakeholders	Highly advanced communication with all stakeholders. Highly advanced professional and leadership skills Highly advanced understanding of ethical issues in OH physiotherapy practice

Paediatrics

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the paediatric discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Pain and paediatric disorders
2. Motor control in paediatric disorders
3. Peri natal paediatric conditions
4. Developmental paediatric disorders
5. Chronic and complex paediatric conditions
6. Mechanisms of action of paediatric physiotherapy interventions
7. Radiology for paediatric physiotherapy practice
8. Safety in paediatric physiotherapy practice
9. Professional, cultural and ethical issues specific to the scope of practice of paediatric physiotherapy
10. Evidence based practice in Paediatric Physiotherapy

	Component	Knowledge	Skills
1	Pain and paediatric disorders	Mechanisms of pain in acute, subacute and chronic states from early infancy to adolescence Differential diagnosis of pain of central and peripheral origin Recognition of psychological reactions and drivers of pain Understanding of the interactions between physiological and behavioural drivers of pain	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient and caregiver explanation of diagnosis and treatment options Multi-professional options for pain management
2	Motor control in paediatric disorders	Contemporary knowledge of disordered motor function/control and implications for treatment and rehabilitation Changes in muscle properties and implications for rehabilitation Brain plasticity and implications for rehabilitation	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient and caregiver explanation of diagnosis and management Highly advanced diagnostic skills of movement disorders
3	Peri natal paediatric conditions	Differential diagnosis, assessment and management of peri natal conditions Consideration of clinical presentations in neurological, musculoskeletal and cardiothoracic conditions in acute and subacute stages	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Advanced skills in management Patient and caregiver explanation of diagnosis and management Multi-professional options for management
4	Developmental paediatric disorders	Knowledge of normal and abnormal neuromotor and biomechanical development Knowledge of the interactions between biological systems and the individual's functional disability and participation limitations Understanding of the role of physiotherapy in a multidisciplinary team management of developmental disorders	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient and caregiver explanation of diagnosis and management Multi-professional options for management

	Component	Knowledge	Skills
5	Chronic and complex paediatric conditions	Knowledge of the progression of congenital and acquired childhood conditions and their impact on function and activity participation Knowledge of the role of physiotherapy and the multidisciplinary team in management of ongoing and complex congenital conditions Consideration of transitional arrangements into adult care	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Modification of management priorities with changing clinical, educational, social and environmental circumstances
6	Mechanisms of action of paediatric physiotherapy interventions	Neurophysiological, mechanical and psychological underpinnings of paediatric physiotherapy practice Advanced understanding of the cognitive and developmental level of the child as it relates to physiotherapy intervention	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Highly advanced skills in age and developmental stage appropriate interventions Family Centred Practice
7	Radiology for paediatric physiotherapy practice	Radiation safety Indications for referral for plain x-rays, CT, US imaging, MRI Clinical Guidelines for radiology use	Highly advanced clinical reasoning and assessment skills
8	Safety in paediatric physiotherapy practice	Advanced knowledge of conditions and drug side effects/interactions that may masquerade as paediatric pain states and their clinical recognition	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices
9	Professional, cultural and ethical issues specific to the scope of practice of paediatric physiotherapy.	Leadership in paediatric physiotherapy and relationships with other health care professionals; policy makers Cultural influences and the receipt of paediatric management Patient centred influences on management delivery	Highly advanced professional and leadership skills Highly advanced communication skills Family Centred Practice
10	Evidence based practice in Paediatric Physiotherapy	Evidence from systematic review and randomised controlled trials Clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced clinical reasoning and assessment skills Highly advanced treatment skills Patient explanation of diagnosis and management

Pain Discipline

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the paediatric discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Biopsychosocial approach
2. Communication and collaboration – inclusive of interdisciplinary, written, verbal and non-verbal aspects
3. Concepts in pain
4. Assessment of person with pain
5. Treatment and management of pain
6. Leadership and advocacy in pain physiotherapy
7. Pain conditions across the breadth of society
8. Safety in pain practice
9. Professional, cultural and ethical issues in pain practice
10. Evidence based practice in physiotherapy

The pathway to clinical specialisation in pain management will develop in registrars a highly advanced knowledge base and skill set of the following components.

1. Biopsychosocial and person centred approach to pain care

Objectives

1. Understand in a biopsychosocial context the dynamic, complex, multidimensional, and individual-specific experience of pain, including the significant impacts of pain on a person's life and potential for recovery
2. Understand how various biological, psychological and social factors can stimulate and modulate the body's neuro-immune protection responses, and their influence on the assessment, management and response to treatment
3. Understand the intersection of multiple personal facets - age, gender, religious and spiritual beliefs, development opportunities, psychological factors, family, cultural changes over the life course, work, physical and mental health comorbidities, spirituality, sexuality, educational achievement, and personal physical and social environment histories
4. Understand the special history of Aboriginal and Torres Strait Islander peoples impacts on their current health status, education and communication

Competencies

Pain specialists will demonstrate:

- Respect of a person's autonomy and a non-discriminatory approach to a person's capacities, needs, preferences and values with consideration of the differences in pain beliefs, expression and choices in treatment across society
- Culturally safe care being mindful of personal biases, bridging any differences to the views and values of the client
- The ability to gather appropriate information across biological, physical and psychosocial domains, interpret their impact in a clinical reasoning framework and discern those that are relevant and modifiable
- An awareness of the impacts on physical, psychological, social and spiritual aspects of people experiencing pain, including the loss of social roles, stigma in society, and emotional distress such as anxiety or depression
- Recognition of risk factors for limited recovery including, yellow flags (relating to a person's psycho-social state) and blue and black flags (relating to the work environment)
- Care delivery that facilitates empowerment of the client, and when appropriate, their care giver
- Assessment and management that is mindful of the tension of achieving holistic health and well-being gains which may either align or conflict with addressing pain in a person's life

2. Communication and collaboration

Objectives

1. 1 Understand communication theories as applied to clinical pain practice, in particular the use of language that is empowering, accurate, respectful and inclusive

2. Understand the use of communication strategies to facilitate behaviour change at individual and group levels
3. Develop advanced levels of written and verbal communication skills to all service stakeholders
4. Value the role, scope of practice, and contribution of the different professions within interdisciplinary pain-management care, underpinned by collaborative client centred goals

Competencies

Pain specialists will demonstrate:

- Empathic listening and compassionate engagement to promote disclosure that elicits the expectations, beliefs, concerns, aspirations and values from a client
- Expert communication skills which are person-centred, trust building, sensitive, validating, non-reactive and respectful to clients and their significant others
- Ability to modify preferred communication styles to match:
  - Different individuals' needs and preferences
  - Limitations in comprehension or expression exist relating to: cognitive impairments; development age; low self-confidence; disturbed mood states (eg angry, anxious, distressed); language (including interpreter use); cultural norms and mental health conditions
  - Varying contexts, such as the presence of other family members or stakeholders in the room, or client group programs
- The ability to recognise non-verbal cues of people demonstrating aroused emotions or a high level of distress, and facilitate a non-judgemental environment which enables care processes
- The ability to gain consent based on an individual's informed choice
- The provision of education to a variety of people in a way that is tailored, empowering, interactive and meaningful, and is supplemented appropriately with printed and online information resources
- High quality writing skills in reports to other health professionals, and other stakeholders such as insurance companies, legal parties and health policy makers
- Expert collaborative communication skills when providing feedback to colleagues and other stakeholders, in particular when managing difference and conflict resolution with differing opinions of stakeholders
- Clinical documentation that is clear, and captures care processes in line with local policies, professional standards and legal requirements
- Skills of the key components in the conduct of successful group programmes involving multiple disciplines, including modification of personal practice when developing shared clinical goals and responsibilities, and facilitation of cohesion within the group

3. Concepts in pain

Objectives

1. To understand concepts of pain including the scientific paradigms, the nomenclature, the experience of pain, and pain's impact on the individual and society
2. To recognise pain as a protective mechanism in response to threat and the capacity for modulation into greater or lesser sensitivity

3. To understand the role of neuroplasticity in both the modulation of nociception and in recovery from chronic pain
4. To have an awareness of the evolution of pain care in recent decades, and to recognise the strengths and challenges of contemporary pain management at all levels of the health care system
5. To understand the roles of all stakeholders, including the patient and family

Competencies

Pain specialists will demonstrate

- A comprehensive working knowledge of the mechanisms and paths that underlie specific biopsychosocial aspects of pain experiences, including the roles of:

Natural history of tissue healing	Brain construction of pain/neuromatrix
Nociception	Radiculopathies and entrapment neuropathies
Disease and inflammatory states	
Afferent transmission	Motor outputs/control
Primary hyperalgesia	Neurogenic inflammation
Protective cognitions/mood states/behaviours	CNS responses to pain management techniques
Spinal cord modulation	Immune and endocrine systems
Glial cells	Placebo and nocebo
Central sensitisation	Genetic phenotypes

- The ability to recognise and harness the beneficial effects of pain when it is functioning to prevent potential tissue damage, to promote healing or to communicate distress in order to garner social support
- Knowledge of the magnitude of pain as a public health problem
- The social, ethical, and economic considerations of persistent pain
- The roles for primary, secondary and tertiary prevention strategies in reducing the burden
- An understanding of the complexities of compensable systems and the unhelpful impacts on people in chronic pain
- An understanding of the various professional, system, patient, family, and community enablers and barriers to effective pain assessment and management
- Critical appraisal of the clinical classification of pain mechanistic descriptors for - nociceptive, neuropathic, and nociplastic
- Care which is mindful that although cognitive and emotional factors are known to increase a simple acute pain episode being refractory to treatment, living with persistent pain and its sequelae are likely to create low mood, anxiety, anger and cognitive losses

4. Assessment of the person experiencing pain

Objectives

1. Develop advanced skills in the identification of dominant pain mechanisms and moderating factors utilising hypothetical-deductive clinical reasoning processes
2. To recognise the biological, psychological and social aspects of a complex pain presentation

3. To identify and analyse patient, provider and system factors that can facilitate or interfere with effective pain assessment and management, including social, work, home, third party funders and institutional factors
4. To be able to identify risk factors that may contribute to the development and maintenance of pain states, and identify subgroups of responders/non-responders in the transition from acute to chronic pain
5. Knowledge of the use and limitations of appropriate subjective and objective outcome measures at initial and ongoing assessment stages, including the use of the ePPOC measures to be used to benchmark therapists' outcomes with their patient groups

Competencies

Pain specialists will demonstrate

- The ability to undertake a respectful, thorough and sensitive assessment process that is timely, engaging and closely matching the person's expectations and needs. This includes the ability to modify the assessment procedures according to a person's age, development, psychological state and ability to engage in the assessment tests, and when unexpected clinical information presents.
- A comprehensive subjective assessment with advanced skills in the identification of the vast array of factors causing, modifying and contributing to the persistent pain state, for example:

the time period of the pain condition	expectations
the cause of onset	coping strategies
iatrogenic factors	social supports
functional limitations	previous care plans and investigations
attitudes	comorbidities
beliefs	history of trauma
emotional state	the role of third-party funders

cultural influences

- The appropriate use of screening tools to assess and monitor progress of pain, function and disability and the role and impact of psychological and social factors
- The ability to perform a complex physical (musculoskeletal, neurological or pelvic) examination
- Discerning if the predominant pain mechanism arises from inflammatory, peripheral neuropathic, central nervous system, or immune physiology
- The ability to assess psychophysical or autonomic response measures
- The ability to discern enablers and obstacles to behaviour change management
- The ability to recognise the utility and risks involved in various radiological investigations and pathology tests
- The ability to build trust and therapeutic alliance utilising patient centred communication thus empowering the person to take control and embrace a goal orientated recovery pathway

5. Treatment and Management of Pain

Objectives

1. To be able to implement a psychologically informed, person-centred and evidence based approach, applying SMART goals that reflect meaningful shared decision making with the person and relevant others

2. To develop the capacity to apply a range of physiotherapy techniques which may address mechanical and nociplastic aspects of pain as required
3. To understand the impact and evidence for the use of education and self-management as key strategies in person-centred treatment
4. To identify the benefits and risks of multi-modal pain management e.g. pharmacology and intervention procedures
5. To value the strengths and weaknesses of differing clinical reasoning paradigms to apply to pain management care

Competencies

- Pain specialists will demonstrate:
- The ability to synthesise and justify management options based on evidence and the context in which the patients experience of pain occurs
- Skilled treatment planning that takes into account the differences between acute pain, acute-on-chronic pain, chronic/persistent pain, and pain at the end of life. Ongoing care plans should remain flexible and responsive to contextual and patient change and involve principles of managing flare-ups and long term self-management.
- The skill of being able to clear when to focus on tissue healing, biomechanics and the alleviation of pain, when to facilitate health behaviour changes, and when to target increased meaningful living in the presence of pain
- Care delivery that works to optimise a person's confidence in their physical, psychological, and social capacities
- The ability to provide appropriate exercise prescription that is individualised to the person and their context, and is accompanied with appropriate motivation techniques and tools
- The ability to provide psychologically informed physiotherapy care. This may include but is not limited to:
    - targeting learned fear/protection-avoidant attitudes and behaviours
    - fostering confidence in the body's capabilities
    - modifying catastrophising thoughts
    - developing self-efficacy
    - socratic and motivational interviewing
    - cognitive behavioural therapy
    - graded exposure
    - acceptance and commitment therapy
    - mindfulness and relaxation
    - counselling skills
    - sleep hygiene
    - developing collaborative communication in work, family and social settings and case meetings when appropriate, with key stakeholders
- The ability to Identify the indications and evidence for, and the proposed mechanisms underlying physiotherapy techniques specific to persistent pain states
- Skilled application of these techniques such as graded motor imagery, somatosensory training, graded reintroduction of preferred activities and exercise when prescribed according to contextual factors

- Tailored educational strategies, as appropriate to the individual's preferred learning style, when providing pain science knowledge
- The ability, when applicable, to address key barriers to returning to work, and strategies to address each of these, including engagement of other stakeholders in case planning meetings
- A detailed knowledge of the strengths and difficulties with inter-disciplinary pain care models
- The ability to successfully facilitate key aspects of pain management group programmes, eg: setting agreed ground rules; sharing expectations; managing group dynamics and inappropriate behaviours; encouraging disclosure without dominating; smooth transition between modules, and; flexible delivery, including telehealth
- Awareness of the role, and appropriate referral to partnering health professionals - eg substance misuse, psychiatry, neurology, neurosurgery
- An extensive knowledge of the indications, evidence, proposed mechanisms and risks for the wide array of potential pharmacologic agents for pain management, and relevant legislation
- A knowledge of the indications, evidence, proposed mechanisms and risks for procedures including different injections, infusions and implanted devices
- Knowledge of how physical dependence, substance misuse, tolerance, addiction, and non-adherence may be recognised and addressed

6. Leadership / advocacy

Objectives

1. To develop the capacity to foster a culture that inspires high quality care, personal improvement, service development, openness to diversity, and self-care
2. To develop the role of the clinician as an advocate in assisting patients to meet treatment and life goals
3. To set a clear vision with a supporting rationale for change, to support system change, and to articulate the outcomes of change
4. To promote best practice pain management to consumers at a community level, with education to empower them to make change
5. To promote the development of highly skilled physiotherapists in pain management via the career pathway and culminating in specialisation.

Competencies

Pain specialists will demonstrate:

- An ability to advise service stakeholders, legal bodies, government departments and engaged agencies on:
    - The principles, benefits, resources and costs of high quality pain management care
    - How limitations depend on the intersection of individual skill level; team capacity; care pathways; health economy resources; competing demands; society
- An ability to assist individuals to change their beliefs and behaviours relating to their pain condition
- A working knowledge of the processes for appraising strengths and weakness of care delivery in a local context as well as within a broader health economy, and principles of modernisation and redesign

- Implementation of key elements of successful supervision and peer mentorship, for associated health care practitioners of varied levels of expertise in pain.
- The ability to develop the team's capacity to provide professional and individualised high-quality care based on biopsychosocial principles
- The ability to collaborate and facilitate the integration of the views of various parties with different aspirations and needs in order to generate shared goals and responsibilities
- The ability to self-reflect, including monitoring own leadership style and abilities to influence individual clients, practitioners, services and health system stakeholders
- Modelling of personal critical reflection, appraisal of personal biases, identification of own limitations, management of conflicts of interest and adherence to guidelines and standards, while accessing relevant others for feedback and opportunities for development as appropriate
- Involvement in the development of clinical standards, locally and nationally
- Commitment to lifelong learning and to the education of Australian College of Physiotherapy registrars, and when appropriate contributing to initiatives to embed best practice pain assessment and management across the breadth of the profession.
- Supporting the community to evolve a contemporary understanding of pain perception and experience, and the principles of high quality care
- Promote the role of specialist pain physiotherapist in advocating to improve access for management of patients with pain

7. Pain conditions across the breadth of society

Objectives

1. In the areas of pain practice, to have a detailed knowledge of the pathologies and relevant assessment and management components across a breadth of various pain conditions, which may stand alone, or co-exist with other conditions
2. To identify individuals, conditions (eg musculoskeletal, neurological, cancer) and specific populations at risk for under-treatment of their pain (eg individuals who are unable to self-report their pain, neonates, indigenous, cognitively impaired, adolescents, older age groups, elite forces, elite sports people, veterans, cultural minorities, socially disadvantaged, those with a mental illness) and develop an appropriate plan of care to mitigate the issues that exist

Competencies

Pain specialists will demonstrate:

- The ability to assess and manage pain across a variety of settings, particularly where disparities exist regarding access to high quality pain care, and demonstrate efforts to redress these disparities, including challenging individual practice and service process discrimination
- Knowledge of pathology and evidence for management of pain conditions, in line with the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD 11). The focus of pain physiotherapy specialisation, including examination, will be:

Chronic primary pain:

- Musculoskeletal pain conditions eg. Chronic Non-Specific Low Back Pain; Whiplash Associated Disorder; Hypermobility Syndromes; Headaches including migraine
- Chronic widespread pain / Fibromyalgia
- Complex Regional Pain Syndrome
- Chronic Primary Visceral Pain including abdominal (eg Irritable bowel syndrome) and pelvic pain conditions

Registrars may choose to develop particular expertise in:

- Chronic cancer related pain
- Chronic postsurgical and post-traumatic pain including phantom limb pain
- Chronic neuropathic pain: eg related to post-CVA, spinal cord and traumatic brain injuries, multiple sclerosis, post-polio syndrome, diabetes
- Chronic secondary headache or orofacial pain
- Chronic secondary visceral pain
- Chronic secondary musculoskeletal pain, arising from inflammatory arthropathies, autoimmune disorders e.g. Systemic Lupus Erythematosus, or neurological disorders

Knowledge of other conditions commonly presenting with pain conditions e.g. Chronic Fatigue Syndrome, Functional Neurological Disorder, Restless legs syndrome, Benign vertigo

8. Safety in practice – Identification and Management of the Clinical Risks

Objectives

1. To ensure safety for the person in pain and the therapist at all times
2. To recognise the inherent risks in assessment processes, radiological investigations, interventional procedures, pharmacology, peripheral tissue focussed care and psychologically informed physiotherapy approaches
3. To identify and address risks of worsening clinical outcomes, which may arise from serious pathologies, from incomplete care, or from client's attitudes and behaviours
4. To recognise limitations of scope of practice and when necessary, refer to a more appropriate clinician(s) eg psychologist, musculoskeletal specialist, with expertise to manage the identified problems

Competencies

Pain specialists will demonstrate:

- The ability to use questioning and testing to identify red flags suggestive of pain arising from serious pathology which requires onward referral and/or immediate investigation eg vascular compromise, metastases, neurological compromise, visceral pathologies
- The ability to recognise the over-protective attitudes and behaviours of a person (in either acute or chronic pain states) that indicate risk of delayed improvement, prolonged physical disability, psychological distress and social loss. This includes being able to identify the source as being either self-generated or arising from their social context, beliefs in the community, or from other health care professionals

- The ability to identify the person experiencing personal risk arising from suicidal ideation, exposure to family and domestic violence, substance and medication misuse, social isolation, history of trauma, changes in family or work circumstances, and facilitate referral to an appropriate health care professional
- Recognition of signs of emotional and/or physical abuse at the hands of a partner, parents, carer or family member and an awareness of processes involved in notification for people experiencing abuse and how to engage appropriate social services
- Recognition of inadequate pain care arising from the therapists own limitations, from service delivery processes or from broader health economy constraints
- Practice of cultural safety principles in all clinical interactions
- Self-care principles to manage the personal strains for physiotherapists providing empathic and compassionate clinical care for a client load with a high proportion experiencing distress
- The development of team environments that support all staff to manage the emotional pressures associated with supporting a cohort of clients experiencing distress
- Knowledge and practice of relevant Occupational Health and Safety regulations
- Cessation of care when a person presents with uncontrolled aggression or intoxication

9. Professional cultural and ethical issues

Objectives

1. To practice in accordance with the APA and ACP Code of Conduct
2. To understand the value and integration of appropriate professional networks
3. To provide care that is mindful of potential diagnoses, breadth of clinical skills, evidence base, patient choice, professional ethics and current health policy

Competencies

Pain specialists will demonstrate:

- Respect for the autonomy of the person, even when there exists conflict with the practitioner's health behaviour beliefs
- The professional qualities of transparency, respect, self-awareness, accountability and integrity
- Awareness of clinical biases and personal prejudices, and make attempts to minimise the effect on clinical care
- Accountability towards service users, professional ethics, team principles, funding sources and society
- Ability to identify and manage conflicts of interest
- Awareness of personal limitations and professional scope of practice, as well as the need for referral to other APA specialists as appropriate and other organisations for guidance and support if required
- The practice of expert level physiotherapy assessment and management that is conducted in line with professional standards and legislative requirements including secure storage of treatment records.
- High level time management skills, including balancing the demands of personal and professional priorities

10. Evidence based practice(EBP)

Objectives

1. To develop a deep learning and critical appraisal of the research literature and recognised clinical guidelines across a variety of relevant musculoskeletal conditions/pelvic pain conditions/paediatric pain conditions, pain science, and psychologically informed physiotherapy
2. To appraise the limitations of processes that generate evidence and translate that evidence into clinical practice

Competencies

Pain specialists will demonstrate:

- The ability to articulate the indications and evidence for, and the proposed mechanisms underlying commonly used interventions in pain management
- A working knowledge of quality improvement processes including the critical reflection skills to develop more effective approaches in pain management, for individual practitioners, physiotherapy teams and multi-disciplinary services
- An awareness of their own personal strengths and weaknesses for the variety of professional development tools including: critical reflection; mentoring; case presentations; accessing clinical guidelines; courses; supervision; observation of others; online learning, and; involvement in quality improvement processes
- Promotion of the translation of new knowledge to service care by benchmarking, engaging service users as appropriate, service redesign (being aware of the efficacy, cost efficiency and risks of potential service improvements) and re-appraisal
- Development of a positive learning environment for the team in order to develop all aspects of pain care
- Able to create or interpret new knowledge to the level of publication in a peer reviewed journal
- Continuous commitment to accessing new published EBP guidelines and the integration in their clinical practice

This Curriculum and Competency document has been based on other guidelines and competencies in the field of pain physiotherapy:

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Pain Australia, 2019. Talking about pain - Language guidelines for chronic pain. Available at: https://www.painaustralia.org.au/static/uploads/files/talking-about-pain-lgfcp-16-07-2019-wfsumqrbtavy.pdf.

Deloitte Access Economics, 2019. The cost of pain in Australia. Pain Australia. Available at: https://www.painaustralia.org.au/static/uploads/files/the-cost-of-pain-in-australia-final-report-12mar-wfxbrfyboams.pdf.

Sports and Exercise

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the sports and exercise physiotherapy discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Musculoskeletal pain states in the context of the active population
2. Motor learning and motor control in the context of the active population
3. The body's response to trauma and overuse injuries of the musculoskeletal and neural systems in the context of sport and the active population
4. The role of Sports Physiotherapy in prescription of exercise in the context of sport and the active population
5. Medical investigations relevant for Sports Physiotherapy practice and use of sports related performance evaluation instruments
6. Safety in Sports Physiotherapy practice
7. Evidence based practice in Sports Physiotherapy
8. The role of the Sports Physiotherapist and pre-season/competition/activity screening, and wellness monitoring in the performance plan for athletes and the active population
9. The role and responsibilities of the Sports Physiotherapist in the context of the Sports Health and Sports Performance Team.
10. Professional, cultural and ethical issues related to contemporary sports physiotherapy practice

	Component	Knowledge	Skills
1	Musculoskeletal pain states in the context of the active population	Mechanisms of pain in acute, subacute and chronic states Differential diagnosis of pain of central and peripheral origin Recognition of psychosocial reactions and drivers of pain Understanding of the interactions between physiological and behavioural drivers of pain	Highly advanced bio-psychosocial approach to patient assessment and management Highly advanced clinical reasoning and assessment skills Highly advanced recognition of when response to pain has become counter-productive to recovery Highly advanced communication and educative skills Multi-professional options for pain management
2	Motor learning and motor control in the context of the active population	Contemporary knowledge of the theories of motor learning and implications for Sports Physiotherapists Contemporary knowledge of normal and disordered motor control and implications for rehabilitation Changes in muscle properties and implications for rehabilitation Brain plasticity and implications for rehabilitation	Highly advanced ability to integrate motor learning strategies into skill development, injury prevention and injury management Highly advanced clinical reasoning skills Highly advanced evaluation and management skills for impaired motor control
3	The body's response to trauma and overuse injuries of the musculoskeletal and neural systems in the context of sport and the active population	The physiological, mechanical and neurological response to trauma and overuse in all tissues of the neural, musculoskeletal and fascial systems	Highly advanced clinical assessment skills Highly advanced clinical reasoning skills Highly advanced clinical management skills, all in the context of the athletic and active population.
4	The role of Sports Physiotherapy in prescription of exercise in the context of sport and the active population	The physiology of exercise The evidence in support of integration of exercise in performance enhancement, injury prevention and injury management of the athletic and active population	Highly advanced assessment skills in relation to evaluation of physical capacity in the context of the athletic and active population. Highly advanced skills in exercise prescription in the context of performance enhancement, injury prevention and injury management of the athletic and active population.

	Component	Knowledge	Skills
5	Medical investigations relevant for Sports Physiotherapy practice and use of sports related performance evaluation instruments	Radiation safety Indications for referral for plain x-rays, CT, US imaging, MRI Clinical Guidelines for radiology use Indications for referral for relevant haematological tests Knowledge of sports performance evaluation instruments and their use in performance enhancement, injury prevention and injury management	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices Highly advanced sports evaluation skills
6	Safety in Sports Physiotherapy practice	Advanced knowledge of conditions and drug side effects/interactions that may masquerade as musculoskeletal pain states and their clinical recognition	Highly advanced clinical reasoning and assessment skills Highly advanced multi-professional management and referral practices
7	Evidence based practice in Sports Physiotherapy	Advanced knowledge of the evidence behind key aspects of Sports Physiotherapy assessment and management Advanced understanding of the role of evidence based practice within Sports Physiotherapy Evidence high quality research in the field of Sports Physiotherapy and Sports Health Clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced critical thinking skills Highly advanced clinical reasoning skills Highly advanced ability to read and interpret relevant literature and integrate different levels of evidence as appropriate in the context of Sports Physiotherapy practice
8	The role of the Sports Physiotherapist and pre-season/competition/activity screening, and wellness monitoring in the performance plan for athletes and the active population	Reliability and relevance of test selection. Monitoring systems and application Influence of screening on injury prevention and performance enhancement	Highly advanced clinical assessment skills Highly advanced management skills

	Component	Knowledge	Skills
9	The role and responsibilities of the Sports Physiotherapist in the context of the Sports Health and Sports Performance Team.	The role of all participants in the Sports Health and Sports Performance team The science and clinical utility associated with each of the participants in the Sports Health and Sports Performance team	Highly advanced communication skills Highly advanced skills in collaboration Highly advanced multi-professional management and referral practices
10	Professional, cultural and ethical issues related to contemporary sports physiotherapy practice	Leadership in Sports Physiotherapy and relationships with other health care professionals; policy makers Cultural influences and the receipt of musculoskeletal management in the context of the athletic and active population Patient centred influences on management delivery	Highly advanced professional and leadership skills Highly advanced communication skills

Women's, Men's and Pelvic Health

The following discipline specific components will be addressed at an advanced level during the Specialisation Training Program by registrars in the Women's, Men's and Pelvic Health discipline stream.

Learning objectives that will form the program of knowledge development for each registrar will be framed in terms of these components.

Assessment of registrars will measure both the generic performance standards and the specialist level knowledge and skills specific to these components.

1. Gender health through the life stages
2. Bone health in females and males
3. Reproductive and sexual health
4. Pelvic and breast oncology in women and men
5. Pelvic floor function and dysfunction in women, men and children
6. Continence and elimination disorders in women, men and children
7. Pelvic pain in women and men
8. Safety in women's, men's and pelvic health physiotherapy practice
9. Evidence based practice in women's, men's and pelvic health physiotherapy
10. Professional, cultural and ethical issues specific to the scope of practice of women's, men's and pelvic health physiotherapy

	Component	Knowledge	Skills
		Highly advanced understanding of the	
1	Gender health through the life stages		
	1.1 Promotion of health, prevention of ill-health and management of conditions related to the sex and/or gender of people	Impact of sex and gender on health Impact of sex and gender on the development of conditions that are unique, more common, more serious or require different interventions in women or men or people with other sexual or gender identities/manifestations Role of physiotherapy in the promotion of women's and men's health through the life stages Role of physiotherapy in preventing or minimising the risk of women's health and men's health conditions through the life stages Physiotherapy and multi- disciplinary options for management of women's health and men's health conditions Unique and changing exercise needs of women and men through the life stages. Options for promotion, prescription and delivery of individual and group exercise programs appropriate to specific life stages and/or women's or men's health conditions	Advanced skills in health promotion Advanced skills in development and delivery of wellness and prevention programs Highly advanced clinical reasoning and assessment skills High level client explanations of risk factors, diagnoses and individual and group management options Highly advanced individual and group treatment/management skills Highly appropriate referral and/or participation in multi-professional prevention and management of WMPH conditions Highly appropriate advocacy to promote the health of women and men and minimise gender-related barriers to accessing health care
	1.2 Prenatal, infancy, childhood and adolescence	Factors contributing to development of primary and secondary sexual characteristics and gender identity in the prenatal period, infancy, childhood and adolescence Changes in production, distribution and response to sex hormones at puberty and the impact on bone health, reproductive and sexual health, and pelvic health Role of WMPH physiotherapy in the promotion of gender-related health in childhood and adolescence Role of physiotherapy and WMPH physiotherapy in the prevention and multidisciplinary management of gender-	Highly advanced clinical reasoning and assessment skills Highly appropriate patient and caregiver explanation of diagnosis and management Advanced treatment skills Intra, inter and multi-professional options for management Appropriate advocacy for promotion of gender-related health and minimisation of gender-related health risk factors in childhood and adolescence

		related health conditions in childhood and adolescence	
	1.3 The childbearing years	Biopsychosocial impacts of conception, pregnancy, birth and parenting on health Role of physiotherapy in the promotion of knowledge and health in the peripartum client and their family and community Role of physiotherapy in the prevention and multi-disciplinary management of pregnancy, birth, lactation and parenting related conditions Role of physiotherapy and WMPH physiotherapy in the management of musculoskeletal, neurological, and/or cardiorespiratory conditions, clients bring to the childbearing year	Highly advanced clinical reasoning and assessment skills High level patient explanation of diagnosis, prognosis and treatment options Highly advanced skills in the development and delivery of group exercise and education classes relevant to clients in the CBYs Highly advanced WMPH treatment/management skills Advanced skills in client/physiotherapist, interprofessional and multi-professional collaboration Highly appropriate participation in intra, inter and multi-professional management of pain and/or dysfunction in the childbearing year
	1.4 Menopause, andropause, and healthy aging	Factors contributing to changes in production, distribution and response to sex hormones Biopsychosocial impacts of menopause/andropause and aging on women's, men's and pelvic health Role of physiotherapy and WMPH physiotherapy in the prevention and management of disorders associated with menopause/andropause and aging	Highly advanced clinical reasoning and assessment skills High level patient explanation of diagnosis, prognosis and treatment options Highly advanced treatment/management skills Highly appropriate participation in intra, inter and multi-professional management of pain and/or dysfunction in mid-life and the senior years Advanced skills in development and delivery of wellness and prevention programs

	Component	**Knowledge**	**Skills**
		Highly advanced understanding of the	
2	Bone health in females and males	Impact of genetics, hormones, diet, physical activity, and co-morbidities on	Highly advanced clinical reasoning and assessment skills

		bone health through the life stages Role of physiotherapy in the promotion of bone health through the life stages Investigations and Interventions relevant to the multidisciplinary assessment, diagnosis and management of osteopenia and osteoporosis	High level patient explanation of diagnosis and management options Highly advanced treatment/management skills Highly appropriate participation in intra, inter and multi-professional management of osteopenia and osteoporosis Advanced skills in development and delivery of wellness and prevention programs

	Component	Knowledge	Skills
		Highly advanced understanding of the	
3	Reproductive and sexual health	Mechanisms of sexual function and dysfunction Differential diagnosis of disorders of sexual function Role of physiotherapy in the promotion of sexual health and the multi-disciplinary management of disorders of sexual function	Highly advanced clinical reasoning and assessment skills High level patient explanation of diagnosis and treatment options Highly advanced treatment/management skills Highly appropriate participation in multi-professional management of sexual dysfunction

	Component	Knowledge	Skills
		Highly advanced understanding of the	
4	Pelvic and breast oncology in women and men	Impact on women's and men's health of pelvic and/or breast oncology and its treatment Role of physiotherapy in the multi-disciplinary management of the sequelae of treatment of breast and pelvic oncology conditions	Highly advanced clinical reasoning and assessment skills High level patient explanation of diagnosis and treatment options Highly advanced treatment/management skills Highly appropriate participation in intra, inter and multi-professional management of the sequelae of treatment for pelvic and/or breast oncology

	Component	Knowledge	Skills
		Highly advanced understanding of the	
5	Pelvic floor function and dysfunction in women, men and children	Myofascial properties of the pelvic floor, abdominal wall and respiratory diaphragm and implications for function, dysfunction and rehabilitation Differential diagnosis of pelvic floor and abdominal wall disorders/dysfunctions in females and males (including disorders of abdominal and pelvic organ support) Application of exercise physiology and motor control principles to pelvic floor and abdominal wall muscle rehabilitation Role of electro-physical agents and splinting/supports in the assessment and management of pelvic floor and abdominal wall dysfunction	Highly advanced clinical reasoning and assessment skills High level patient explanation of diagnosis and treatment/management options Highly advanced treatment/management skills Highly appropriate referral and participation in inter and multi-professional prevention and management of pelvic floor and abdominal wall dysfunction

	Component	Knowledge	Skills
		Highly advanced understanding of the	
6	Continence and elimination disorders in women, men and children	Mechanisms of urinary and anorectal continence and elimination in females and males Impact of musculoskeletal, neurological, cardiovascular, respiratory and/or developmental disorders on bladder and bowel function Differential diagnosis of continence and elimination disorders in females and males Role of physiotherapy in the multi-disciplinary management of continence and elimination disorders Role of physiotherapy in pelvic health promotion and the prevention of continence and elimination disorders	Highly advanced clinical reasoning and assessment skills High level patient explanations of diagnosis and treatment /management options Highly advanced treatment /management skills Highly appropriate participation in inter and multi-professional management of continence and elimination disorders Advanced skills in continence promotion and prevention programs

	Component	Knowledge	Skills
		Highly advanced understanding of the	
7	Pelvic pain in women, men (+/- Adolescents)	Mechanisms of pain in acute, subacute and persistent states Differential diagnosis and classification of pain of central and peripheral origin Differential diagnosis of pain of visceral and somatic origin Psychological reactions and drivers of pain Interactions between physiological and behavioural drivers of pain Role of physiotherapy in the multi-disciplinary management of pelvic pain disorders	Highly advanced clinical reasoning and assessment skills High level patient explanation of diagnosis and treatment options Highly advanced treatment/management skills Highly appropriate participation in intra, inter and multi-professional management of pelvic pain

	Component	Knowledge	Skills
		Highly advanced understanding of the	
8	Safety in women's, men's, and pelvic health physiotherapy practice	Informed consent in intimate and non-intimate examination and management of WMPH clients Infection control and other safety risks and procedures in WMPH physiotherapy practice	Highly advanced clinical reasoning and assessment skills Highly advanced communication skills

	Component	Knowledge	Skills
		Highly advanced understanding of the	
9	Evidence based practice in women's, men's and pelvic health physiotherapy	Evidence from systematic review and randomised controlled trials Clinical practice guidelines Clinical utility of the evidence in an EBP framework	Highly advanced clinical reasoning and assessment skills High level patient and colleague explanation of diagnosis, prognosis and options for management Highly advanced and evidence informed treatment/management skills Highly appropriate and evidence-informed participation in inter and multi-professional promotion and management of WM&PH

	Component	Knowledge	Skills
		Highly advanced understanding of the	
10	Professional, cultural and ethical issues specific to the scope of practice of women's, men's and pelvic health physiotherapy.	Leadership in WMPH physiotherapy and relationships with other health care and exercise professionals and policy makers Cultural influences and the receipt of WMPH promotion and management Patient centred influences on management choice and delivery in WMPH	Highly advanced professional and leadership skills Highly advanced communication skills

Appendix 14
Guidelines and Procedures

Recognition of prior learning

Introduction

The Specialisation Training Program is based on an expectation that registrars will be committed to lifelong learning. Due to the advanced nature of the Specialisation Program, a registrar will usually not have the prior learning needed to be exempted from any aspect of the program. However, the College does recognise that individual registrars may have specialised knowledge or skills in some areas relevant to the Specialisation Training Program which then enables them to apply for consideration of recognition of prior learning. This is the basis of the College's Recognition of Prior Learning (RPL) policy.

Exemption of Part of the Specialisation Training Program

Training and performance in the Specialisation Training Program is measured against four elements. However, only two of these elements may be the subject of an Application for RPL.

Element 1 - Development of specialist skills in the area of practice - cannot be subject to RPL. This is in recognition of the individualised nature of the Specialisation Training Program, which involves development of an individual Learning Contract and ongoing assessment and formative feedback provided to the registrar. As the delivery of training will be based on the experience and learning needs of the registrar, there are no structured components of any individualised program from which to seek exemption.

Likewise, Element 3 - Commitment to lifelong learning and professional development - is based on the experience gaps and training needs of an individual registrar, identified in their Learning Contract. Areas in which the registrar is already proficient are identified by the registrar and their facilitator, and further learning/development in these areas is acknowledged as not being required. This does not require a formal application for RPL.

The elements for which a current or prospective registrar may apply for RPL are:

- Element 2. Participation in professional education.
- Element 4. Participation in research activities.

The Board of Censors will consider a written application submitted with evidence to support significant prior learning

in these two elements. Any training (for instance a research degree) or experience (for instance an academic teaching role) that is proposed to exempt the registrar from participation in that element during the Specialisation Training Program must have been undertaken in the previous three years. Following an evaluation of the evidence provided, the Board of Censors may grant exemption from the relevant component(s) of the Specialisation Training Program.

Financial Outcome

There is no deduction of fees based on successful application of RPL for any exemption of any part of the training program.

Approved (ACP Council): August 2010; revised September 2017
Due for review: January 2019 .

Conflict of Interest (CoI)

Wherever possible, College members must avoid being placed in a situation where they are taking action, making a decision or have the ability to influence any action or decision of the College that involves a Conflict of Interest (CoI), or the reasonable perception of a CoI. Likewise College members must avoid conflicts of commitment that impair their ability to fulfil their duties to the College.

As soon as a College member becomes aware that s/he has a CoI or a potential CoI in the process of making a decision or other action in their capacity as a College member, they must immediately declare it and, unless it is resolved, take no further part in any interaction with the relevant individual, negotiation or decision on the subject.

Purpose

The purpose of this document is to define required actions of College members with respect to conflicts of interest (CoI) as defined in the Australian College of Physiotherapists' Policy on Conflict of Interest and is to be read in conjunction with that document.

These procedures apply to any defined person.

Definitions

Close personal relationship:
Family relationships (siblings, parent, child, spouse including de facto spouse, partner, relations by marriage, grandchild and grandparent), business arrangements (business partners, employees, employers) and emotional relationships (including sexual relationship and close friendships).

Conflict of interest: Occurs when professional duty is in conflict with professional or private interests potentially restricting an individual's objectivity, leading to unfair advantage or disadvantage for one or a number of parties. A conflict of interest may be actual, perceived or potential.

Defined person: Any office bearer of the College, registrar, candidate, examiner/assessor, supervisor or staff member.

Financial interest: Any right, claim, title or legal share in something having a monetary or equivalent value over which the member has control.

Perceived conflict of interest: The appearance to a reasonable person that the member's personal/professional interests could improperly influence the performance of the member's duties, may be actual or perceived.

Personal interests: Interests that can bring a benefit or disadvantage to the member or to others they may wish to benefit or disadvantage. Personal interests include financial interests and those arising from close personal relationships or involvement in cultural, sporting, religious or social activities and interests that may lead to a tendency or predisposition to favour or to be prejudiced against a person or an organisation.

Potential conflict of interest: Arises where a member has personal/professional interests that could conflict with his or her College duties in the future.

Conflict of commitment: Arises when a member of the College is unable to perform their duties for a prolonged period of time as a result of other commitments that may be related to paid employment, family commitments, or other circumstances that are not readily defined.

Associate of the College: A person who has committed, by signing an agreement and paying the relevant fees, to undertake either the Training Program for Fellowship by Specialisation or the process of preparation for Fellowship by Original Contribution.

Candidate: 1. A member of the College who has been accepted by the College to undertake the final examinations in the process of Clinical Specialisation.

2. A member of the College who is undertaking the preparation towards Fellowship by Original Contribution.

Registrar: A member of the College who is undertaking the Training Program for Fellowship by Specialisation.

Procedure

The primary obligation of any defined person is to disclose the potential CoI in advance or as soon as practical. Failure to disclose a potential CoI may result in an individual being removed from their position within the College until such time as the CoI is resolved.

Defined person

If a College member believes, or suspects they have a real or potential CoI, they must immediately disclose such CoI to the President of the College or Chief Censor, as appropriate, by completing a Disclosure of Conflict of Interest Form. Verbal disclosure is only sufficient if occurring in a recordable (minuted) circumstance.

College Staff

If a College staff member is in doubt as to whether a conflict exists, they should seek advice from the President of the College and/or Chief Censor as appropriate.

President of the College or Chief Censor

If the President of the College or Chief Censor believes a potential CoI exists, they must direct the defined person to complete a Disclosure of Conflict of Interest Form. Alternatively they should disclose such a potential CoI at the beginning of a formal minuted meeting of the relevant body of the College.

Management of conflicts of interest

Once a CoI is identified and the individual concerned has either completed and submitted the Disclosure of Conflict of Interest form, or such conflict has been declared and minuted in an official meeting, an appropriate person*-must devise a suitable plan to resolve or manage the CoI.

** An appropriate person is a disinterested party holding an Executive position within the BoC or the ACP. In most instances, this person will be either the College President or Chief Censor.*

A management plan states matters including the:

- Nature of the member's situation and how it might constitute a CoI
- Decisions or actions that the member agrees to take or do.

A management plan must be:

- Signed by all parties and placed on file;
- Reviewed annually or on an 'as needs' basis.
- Marked "confidential" and access strictly limited to those people who need access for official purposes.

If a CoI has been noted and minuted, in most instances the individual(s) will be asked to take no part in any issues related to the CoI situation – for example, leave the meeting for the period of discussion to which the CoI applies

Management of perceived/potential conflicts of interest

Requests for consideration of a perceived/potential conflict should:

- Outline (either verbally or in writing) all the relevant facts, including the parties concerned, the nature of the CoI and the reason(s) for requesting advice; and
- Be forwarded to the appropriate person.

The appropriate person should attempt to resolve the issue or refer it to another suitable disinterested party to provide direction on how the CoI should be managed.

Failure to comply with conflict of interest procedure

If a member fails to comply with this procedure, action may be taken to remove him/her from his/her position within the College until such time as the CoI is resolved.

Explanatory notes

The following explanations are for illustrative purposes only and are not intended to include or define all situations.

When a CoI is not considered to be present

In certain circumstances a relationship may exist between individuals within the College that is not considered to lead to a CoI. Such situations include but are not limited to:

Interaction between a College official and registrars/candidates in the Specialisation Training Program

- A College official observing a registrar assessing and managing a patient/client or equivalent situation relevant to the particular discipline and providing feedback on the situation, as part of the registrar(s)' participation in the Specialisation Training Program;
- A College official providing interactive workshop activities to registrar(s) as part of their participation in the Specialisation Training Program;
- A College official providing advice on presentation or content of a written assignment that forms part of the registrar's participation in the Specialisation Training Program;
- A College official providing reference material to registrar(s) of value to their participation in the Specialisation Training Program.

Interaction between a College official and Facilitators of the Specialisation Training Program

- A College official providing advice to a College facilitator in the context of a particular registrar in the Specialisation Training Program;
- A College official providing advice to a Facilitator on presentation or content of a written assignment that forms part of a registrar's participation in the Specialisation Training Program;
- A College official providing reference material to facilitator(s) of value to registrar(s) as part of the registrar(s)' participation in the Specialisation Training Program.

Interaction between a College official and candidates in the Fellowship by Original Contribution Program

- A College official providing advice, or reading material associated with the submission for consideration of Fellowship by Original Contribution to either the candidate or the Supervisor of a Candidate in the Fellowship by Original Contribution Program;
- A College official providing reference material to the Candidate or Supervisor of a Candidate for Fellowship by Original Contribution.

Such activities can be considered part of normal practice within the Training Program for Fellowship by Specialisation or Fellowship by Original Contribution. In such situations, a CoI is only considered where a situation arises that has put the relationship between the College member and candidate/registrar in a compromising position, such as outlined above. In addition, the following situations should be considered:

- Where there has been disagreement between registrar/candidate and the College member;
- Where the College member has been a member of a previous examination panel in which a candidate has failed.

Except in unavoidable circumstances, the following situations should be considered:

- A member of the Board of Censors should not act as facilitator for a registrar in the Training Program for Fellowship by Specialisation;
- A registrar's Facilitator should not serve in the role of examiner for that registrar at Final Examination;
- A member of the College who has acted in the role of examiner for a candidate at a previous Final Examination in which the candidate was not successful should not, except in extraordinary circumstances, act as an examiner in any subsequent Final Examination for that candidate;
- A member of the Board of Censors should not act as Supervisor for a Candidate in the program for Fellowship by Original Contribution;
- A member of the Board of Censors should not act as an examiner for the thesis of a candidate in the program for Fellowship by Original Contribution.
- Any official of the College should not provide a reference for an applicant to the Training Program for Fellowship by Specialisation or Fellowship by Original Contribution.

Consideration of cases of impairment at assessment

Introduction

The College's training and examination processes aim to provide candidates with conditions that allow and encourage performance to the best of their ability.

Illness, accident or disability has the potential to compromise performance. The general principles governing this situation are as follows:

- Candidates should not be disadvantaged unnecessarily as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which could be construed to be unfair to other candidates.
- Some guidelines can be formulated for the procedures to be followed in some cases of illness or disability however, it is impossible to foresee every eventuality.
- Where a problem arises which is not covered in the Regulations, instructions to examiners, or these guidelines, advice should be sought from the Manager - Australian College of Physiotherapists and the Chief Censor or Exam Coordinator.

Acute Illness occurring at the time of examination

In the event that an examiner becomes aware that a candidate is ill, s/he should notify the Chief Examiner (or delegate) who will determine whether, in his/her opinion, the illness is incapacitating and then if appropriate, advise the candidate to withdraw and notify the Chief Examiner and Exam Coordinator in writing of this action. The Chief Examiner (or delegate) needs to ensure patient safety is maintained at all times.

In the event of illness or disability occurring prior to or during any part of the examination, no special consideration will be given to a candidate who elects to continue with the Examination.

Sudden illness or accident which precludes a candidate from attending all or part of an examination may provide grounds for a rescheduling of the exam. Application for this consideration must be made by the candidate and supported by a medical certificate or any other relevant documentation.

Further action is at the discretion of the Fellowship Pathways Standing Committee, on the advice of the Exam Coordinator.

Chronic Illness or Disability

Candidates with a chronic illness or disability will not normally be granted any concession with respect to any part of an examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Exam Coordinator at least four weeks prior to the advertised closing date for applications. Further action is at the discretion of the Fellowship Pathways Standing Committee.

Related Documents

Patient Safety

Deferment of Training Program

Introduction

A registrar, having been offered a place in the Specialisation Training Program, may apply to the Board of Censors to defer entry to the program either prior to commencement or at any stage during the Specialisation Training Program. Deferment will only be considered under exceptional circumstances and is granted at the discretion of the Board of Censors. A fully documented case for deferment should be submitted to the Chief Censor for consideration by the Board of Censors as soon as practicable. Individual circumstances will be considered on a case-by-case basis. Decisions made by the Board of Censors are final.

Deferment at Commencement of Specialisation Training Program

A registrar, having been offered a place in the Specialisation Training Program, may defer entry to the program. The registrar will be offered a place in the next intake, subject to availability of a suitable cohort.

Deferment during Specialisation Training Program

A registrar may defer only once. If deferment is granted, the registrar will re-enter the Specialisation Training Program at the point of their last satisfactory result across all four elements or Elements 1 and 3 if accepted for RPL for 'registrar status indicative of progress towards sitting for Final Exams' on their facilitator's report (6, 12 or 18 months), subject to availability of a cohort and facilitator willing to take on an additional registrar, a situation that cannot be guaranteed. In the event of deferment, Specialisation Training Program fees received will be held until recommencement of the program.

Withdrawal

If a registrar chooses to withdraw, they cannot enter the Specialisation Training Program without reapplication and payment of relevant fees.

Refunds

Any fees paid by registrars who are subsequently granted deferment from either entry to, or continuation of, the Specialisation Training Program will be retained by the College pending the registrar's recommencement.

Registrars withdrawing from the Specialisation Training Program prior to the first face to face meeting (approximately three months into the first year of the program) will be entitled to a full refund of fees paid. Withdrawal after that date will entitle the registrar to a partial refund on a pro rata basis.

Related Documents

Timeframe for completion of Training Program and Exams

Dispute resolution

Introduction

The College's training and examination processes aim to provide registrars and candidates with conditions that allow and encourage performance to the best of their ability. This includes an approach to open lines of communication between all participants, staff, committee members and Board of Censors, facilitators and examiners and the provision of sufficient information for decision making. Should a dispute arise between any of the parties it will be resolved as follows:

Dispute Resolution

If a dispute arises between a facilitator and a registrar, this will be reported to the Board of Censors by both the facilitator and the registrar.

The Board of Censors will advise on a process to resolve the dispute.

If the matter cannot be resolved, then it will be referred to the Fellowship Pathways Standing Committee.

If a dispute arises between a registrar and a member of staff, another educator or the organisation, this will be reported by the relevant party(s) to the General Manager, Education.

The General Manager, Education will advise on a process to resolve the dispute.

If the matter cannot be resolved, then it will be referred to the Appeals, Grievances and Complaints Standing Committee.

All dispute matters will be treated as confidential and will not prejudice assessment outcomes.

Appeals, grievances and complaints

Registrars and candidates have the right to lodge an appeal, grievance or complaint. Appeals, grievances or complaints must be requested on the ground that the procedure set out in this and other procedural documents of the College has not been followed. For further information and to view the ACP Appeals, Complaints and Grievances Policy and Procedures: Go to the Governance Page on the APA website.

Related Documents

Poor performance

External practitioner

Introduction

The College's Specialisation Training Program will be delivered predominantly by Fellows of the College. The program delivery is designed with a mentoring, action-learning approach which will provide high calibre facilitation to registrars. It will engage Fellows and additionally support them to maintain and develop their own skills and experience through the training of others.

External practitioners

When additional expertise is required, the College will engage appropriately skilled and experienced external practitioners either as educators, facilitators or examiners.

In the case of a sub-discipline with an insufficient number of specialists to facilitate the Specialisation Training Program, the Board of Censors will appoint, in consultation with the APA National Groups, a senior physiotherapist to be a facilitator.

Practitioners from other health disciplines may also be engaged as required, at the discretion of the Board of Censors, to participate in the program delivery or assessment.

Rules of engagement

External practitioners will be advised of the educational objectives relevant to the section of the program with which they are involved.

External practitioners will be advised of all College policies relevant to their participation with the program.

External practitioners providing facilitation will receive induction, a facilitation manual and be required to meet the same expectations as College facilitators.

The expectations of external practitioners will be outlined for them in a position description form specific to their role and which includes accountabilities, selection criteria, requirements and remuneration.

Related Documents

Candidate and Examiner Manual

Facilitator Manual

Flexible arrangements

Introduction

The College's training and examination processes aim to provide registrars with conditions that allow and encourage performance to the best of their ability.

To meet the required standards for all elements of the Specialisation Training Program, registrars will be required to contribute to and participate in various activities.

The Specialisation Training Program builds on postgraduate masters level specialty coursework degrees (or equivalent post professional training), and is considered appropriate to support the professional and personal development required for practice as a specialist physiotherapist.

For the duration of the Specialisation Training Program registrars will continue to practice in their field of specialty.

Part Time Practice

Registrars are permitted, on approval from the Board of Censors and in consultation with their facilitator, to complete the practice requirements through part-time equivalent practice for a maximum of four (4) continuous years.

Special Circumstances

Special circumstances of an unexpected nature such as illness, injury, pregnancy or change to employment will also be considered on a case by case basis.

Variations

Any variations to the period of training must be negotiated between registrar and facilitator and approved by the Board of Censors.

If agreement cannot be reached between facilitator and registrar advice should be sought from the Manager - Australian College of Physiotherapists and the Chief Censor.

In all cases, the Specialisation Training Program must be completed within a maximum of four (4) years.

Non-compliance

If a registrar's situation does not permit this, they will be required to withdraw from the Specialisation Training Program and may be permitted to commence a new Training Program when circumstances allow.

Mandatory marked mock exams

Introduction

Since August 2017, the Australian College of Physiotherapists (ACP) has required mandatory marked mock exams (MMEs) to be conducted in order to inform the following decisions:

(a) approval by the Board of Censors (BoC) for a registrar to progress from first into the second year of the Specialisation Training Program (STP) and,
(b) approval by the BoC to allow someone to progress to the final Specialisation examinations, at which point registrars become 'candidates'.
As these MME's are undertaken at different stages of the STP, the BoC will interpret results differently for Year 1 and Year 2 registrars as set out below:

(a) The MME *at the end of the first year of the STP* must be completed and mark sheets submitted by the registrar to the Training and Assessment Lead, ACP, prior to the due date for the 12 month Facilitator's report. This assessment will be considered a 'signpost' of performance, rather than a 'hurdle' exam that results in a pass/ fail outcome. Following input from the facilitator and the registrar (where indicated), the decision taken by the BoC to allow the registrar to progress into year 2 of the STP, will not be based solely on performance at this MME, but on all aspects of the registrar's commitment and progress over the previous period of the TP against their Learning Contract. However, as a reference point, registrars will be expected to be *working towards* the expected performance of an 'entry level specialist', as evidenced by the end of Year 1 MME's. **Specifically, the focus of examiner feedback will be on any criteria where the expected standard was not met. Registrars who achieve a score of 0 or 1 (inadequate) for more than half of the criteria assessed may be counselled against progressing into year 2.** Registrars in this situation may elect to withdraw from the TP altogether, or to defer for an agreed period (no more than 12 months) to work on a defined program of learning.

(b) By 1st March in the year of the examination round, those who are *completing the second year* of the STP, or those who *deferred/were unsuccessful at the previous examination round*, must submit to the ACP Manager (cc Facilitator into submission email) a pdf of mark sheets from two formal MMEs held between November and the end of February. This will allow results to be discussed at the BoC's March meeting when decisions about examination candidates are made. **The BoC expects that the MME exam results will clearly reflect the performance of an entry level specialist on *at least one of these two mandatory mock exams (see also point 4 below)*.** The BoC's decision regarding 'Readiness to Sit' will be informed by the results achieved in these MME's, as well as the facilitator's final (24 month) report, and all other relevant aspects of the registrar's commitment and progress across the last six months of the TP, or during year 3, whichever is appropriate. Registrars who are deemed not ready to sit, but who wish to do so, will be required to provide a rationale in writing in time to be considered at the BoC's March meeting to support their request to sit in that examination round. Candidates will be approved, or denied, the opportunity to undertake the final Specialisation examinations based on careful consideration of all the available information, including these MME results. The Fellowship Pathways Standing Committee's decision is final.

Mandatory marked mock exams

1. Facility approval process for MMEs

Registrars/facilitators and specialists/clinicians involved in the organisation of MMEs are reminded to be aware of approval processes that might be required, particularly for mock examinations held at Health Department facilities, and to ensure that adequate time is allowed to gather appropriate documentation, and receive the necessary approvals, for the examination to occur at that site.

2. Exam duration

Each exam should involve (at a minimum) a single session with a new patient (no longer than 60– 90 minutes - dependent upon the specialist discipline) AND a 15 minute post exam discussion where the registrar can elaborate their reasoning about assessment and management. *It is recommended that MMEs submitted under the 'Readiness to Sit Policy' are conducted over two days wherever possible*.

3. Examiners

At least two examiners must be involved in these formal MMEs, *one of whom has experience as an ACP Examiner*. For instance, the examination panel may comprise the facilitator and one experienced ACP Examiner, or one experienced ACP Examiner and a 'trainee examiner'. Where possible, the examiners in each exam should be different from those used in any previous 'formal' MME submissions. Potential exam candidates are reminded that, in the final examination, they will not usually be examined by a FACP from their own state, nor (if they are a re-sit) will they be examined by someone who has examined them previously. Consequently, it is advisable to use examiners in these categories in the MMEs in the months before the final examinations. An examiner in the final examination round should not have conducted a mock exam, or had contact, with potential candidates in the previous four months (preferably not for six months).

A videoed MME can be used if arrangements are unable to be made for a face to face MME to be conducted. It is the responsibility of the registrar to arrange assessors for the video exam. The College Manager can assist with identifying suitable examiners and providing examiners access to the video via a secure platform. The registrar must provide all the relevant documentation to examiners, and arrange for the post exam discussion to take place.

4. Consent

'Informed consent' is a person's agreement to allow something to happen to them based on a full disclosure of risks, benefits, alternatives and consequences of refusal. 'Implied consent' is consent which is not explicitly given by the individual, but is inferred from the person's actions or inactions (ie. they indicate their wishes, without necessarily stating them). Much of what a clinician does each day is based on an understanding of implied consent.

It is the responsibility of the registrar to get appropriate written consent from the patient to participate in the MME. In the case of a videoed examination, additional consent documents will be required (available on PP). The patient should be advised prior to signing the consent form that the examiners may wish to question them, and/or perform some additional physical assessment procedures, at the end of the MME. Some physical assessment procedures may require additional verbal consent to be provided. For example, although consent may be implied for a physical assessment at the start of the MME, verbal consent should be obtained prior to any internal examination. If ever there is any doubt whether the actions or inactions of a patient imply consent or not, verbal or written consent must be obtained. It is the responsibility of the person undertaking the assessment to ensure that such consent is obtained prior to proceeding with the examination and that the patient has had adequate opportunity to ask questions in order to provide informed consent.

5. Exam marking system

The scoring system of the Assessment of Physiotherapy Practice (APP) tool is used in ACP examinations (Appendix 1). The APP schema has two 'fail' grades (score of 0 or 1). A 'pass' can be graded as adequate, good or excellent, allowing higher quality performance to be acknowledged. The normative reference for the scoring system will be the performance (skills, knowledge and professional behaviours) expected of an 'entry level specialist'. In many cases, registrars will meet (score of 2) or exceed these expectations (score of 3 or 4) in some criteria at the end of the first year of the TP. A score of 1 should not be allocated just because the registrar has not yet completed the TP. Examiners must record marks as whole numbers. Half marks (.5), ranges (2-3) and other variations must not be used.

Each examiner must assess the registrar independently. Scores are not combined /averaged across examiners. Examiners should complete the four point Global Rating Scale (GRS) *before they add up their marks* at the end of the post exam discussion. The GRS is based on the overall impression of the performance of the candidate (not adequate, adequate, good, or excellent).

Examiners should apply the 0-4 exam rating scale against the *minimum* competency level expected for an *entry level specialist, regardless of whether it is a year 1 or year 2 MME.*

At the end of second year of the TP, or the deferred year, the potential exam candidate must achieve an 'adequate' score *in at least one MME* which indicates that they are close to the level expected of an entry level specialist. This means that, if a one day exam plus post exam discussion is conducted (maximum 17 criteria assessed), at least 9/17 criteria must be scored at an adequate level (score of 2 or more). If a two day exam plus post exam discussion is conducted (maximum 25 criteria assessed) then at least 13/25 criteria must be at an adequate level (score of 2 or more).

For exams conducted at the end of second year of the STP, if there is a GRS discrepancy between examiners (not adequate/adequate), the BoC will take into account the assessment provided by the more experienced ACP Examiner when considering the outcome. If both examiners are reasonably experienced, the same procedure will apply as with the final examination, which is that the result will be determined by the majority of examiners (in this case the rating allocated by 3 of the 4 MME examiners, over the two MMEs, will determine the overall outcome). If there is a split decision, (ie. one examiner *in each MME* recorded a GRS of not adequate), then the BoC will make a determination on how to assess the registrar's readiness to sit, based on a range of evidence from across the TP.

The scoring for the safety and risk criterion is dichotomous. If a 'no' is allocated, examiners must determine whether the issue was *sufficiently serious to constitute an overall fail*, or whether it is a matter that they will discuss with the registrar to inform their future practice. It is likely that a concern with the safety and risk criterion will be reflected in other criteria related to clinical reasoning, and this may contribute to the decision to allocate an overall 'not adequate' GRS.

Examiners may question or examine the patient *at the end of the MME (once the registrar has left the room*). One or both examiners have the right to intervene *during an examination* or to stop the examination only *if they consider the performance of the candidate to be unsafe.* Subsequent action is taken based on immediate discussion between examiners and the registrar, if required. *Careful consideration should be given to management of the patient in such cases.*

A range of circumstances can result in a 'no' grade for the safety and risk criterion. They must all relate to actual harm/risk of harm to the patient, the candidate, or even to the examiner(s). In documentation related to this criterion, distinction needs to made between immediate risk of harm versus anticipation of a future risk. Some examples of the latter might include: if a patient is given an inappropriate home exercise program which could be harmful, failure to establish consent or to undertake risk assessment for a procedure which could expose the candidate (and, indirectly, the examiners) to a negligence claim, and/or where the candidate's inattention to serious physical or mental health flags means that the patient may not receive/have received the most appropriate holistic management, including

preventative steps to promote their safety.

6. Post exam discussion

A template to guide the Post exam discussion with the registrar has been developed (see Appendix 2). The post examination discussion is not intended as a 'defence' but rather as an opportunity for the registrar to elaborate their reasoning about assessment and management of the case, and to clarify any areas which the examiners feel need to be addressed.

7. Feedback to registrars

The process of writing brief individual examiner's reports following the MME is encouraged wherever possible to assist examiners to become more familiar with what is expected in the final examination, and to increase the value of the MME feedback to registrars and facilitators. See Appendix 3 for some prompts to guide the provision of feedback.

Occupational health and safety

Introduction

The College has a legal and moral responsibility to ensure it provides a workplace that is safe and without risks to health, as far as is reasonably practicable. The College is committed to the health, safety and welfare of all employees, registrars, facilitators, educators and examiners involved in College operations.

Staff

Staff members will refer to and comply with the APA Occupational Health and Safety Policy.

Practice and Examination Sites

All registrars, facilitators, educators and examiners will have access to and comply with the Occupational Health and Safety policies and procedures as well as the Emergency procedures of the host organisation.

This information will be provided as part of the Specialisation Training Program induction and exam orientation.

Key Risk Areas

All registrars, facilitators, educators and examiners need to ensure they are aware of all policies and protocols in the key risk areas related to their practice which may include but are not be limited to:

- Manual Handling
- Infection Control
- Equipment safety including use of electrophysical agents
- Hydrotherapy and Pool Safety
- Resuscitation and life support
- Stress management

Adverse Events

In the event of an injury to a registrar, candidate or staff member in the course of training or assessment, appropriate injury management and follow up will be conducted and documented by either the facilitator or chief examiner. Adverse events will be reported to the Manager, ACP.

Responsible Officer

The Manager, ACP is responsible for the implementation, monitoring, compliance and review of this policy. The Manager will consult with staff examiners, candidates and registrars on these matters before reporting to the General Manager, Education regarding the policy and any adverse events.

Related Documents

APA Occupational Health and Safety Policy.

Guidelines for the Clinical Use of Electrophysical Agents 2001

Guidelines for Physiotherapists Working in and/or Managing Hydrotherapy Pools 2002

Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting. DOHA 2008 Available at : http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm

Patient safety

Introduction

A high level of professional conduct and safe and ethical practice is expected of registrars, all of whom are entering the program as very experienced clinicians. As registered practitioners and members of the Australian Physiotherapy Association (APA), registrars are expected to practice according to the Australian Standards for Physiotherapy and the APA Code of Conduct, both in the workplace and during training sessions.

Supervision

Patient safety is an absolute priority of the College. All those involved in face to face sessions will act to ensure patient safety. Facilitators will ensure that registrars are well prepared before attempting any new and /or high risk assessment or treatment techniques and ensure that these are only executed at an appropriate stage of the training. When a registrar is experiencing difficulty or performing below an expected and defined level, the facilitator may intervene as appropriate.

Assessment

During the clinical examination process, an examiner is obliged to intervene if they consider that patient safety is likely to be compromised.

Ethical Practice

Registrars, in practising according to the Code of Conduct, will be conscious of all ethical issues related to their scope of practice.

Formal written consent will be obtained from all patients volunteering to be assessed and treated by registrars either during training or at examination and will form part of the patient record.

Professional Indemnity

All registrars and facilitators are required to have Professional Indemnity Insurance Arrangements (PII) in place that cover all practice during training. Registrars are advised to check with their insurer that their level of cover is appropriate for all anticipated activities. Registrars who have PII arrangements through their employer may find that they are not covered for training or exams outside the workplace or in another jurisdiction. It is the registrar's responsibility to ensure their arrangements are adequate and take out additional cover as required.

The College does not provide professional indemnity insurance.

Complaints Management

Should a patient wish to make a complaint following assessment or treatment by a registrar or candidate, they will have the opportunity to speak confidentially with either the facilitator, if it is during training or with an examiner, if the complaint arises out of the final examinations.

If the patient is not satisfied that their complaint has been addressed, they will be advised to report it to the appropriate statutory authority in that jurisdiction e.g. Health Complaints Commissioner or Physiotherapy Registration Board.

Reporting

Facilitators and examiners are obliged to report any concerns regarding patient safety to the Board of Censors or the Chief Examiner.

The Board of Censors will refer any matters that require consideration with regard to curriculum or program delivery to the Fellowship Pathways Standing Committee.

Details of all complaints will be recorded and reported to the Fellowship Pathways Standing Committee and if appropriate to the Appeals Complaints and Grievances Standing Committee.

Any instances of perceived professional misconduct will be reported directly to the Physiotherapy Registration Board.

The Fellowship Pathways Standing Committee will, in keeping with APA complaints management policy, report any concerns they have regarding injurious or prejudicial conduct to the Association's National Professional Standards Panel.

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Related Documents

Australian Standards for Physiotherapy

APA Code of Conduct

What to do if a complaint is made against you – Information for APA members

Poor performance

Introduction

The College's training and examination processes aim to provide registrars / candidates with conditions that allow and encourage performance to the best of their ability.

Early Identification

Facilitators are responsible for early identification of poor performance.

The structure in place to assess and provide feedback to registrars facilitates this requirement.

The facilitator will provide formal formative feedback to registrars on:

- Their clinical and practical performance in the eight face to face sessions. This feedback will relate to achievement of the standards of practice for specialisation and the registrar's progression towards the final examination.
- The reflective exercises in the portfolio at 6 monthly intervals.
- The professional issues paper - within one month of submission.

The facilitator will provide reports at 6 monthly intervals to the Board of Censors on the registrar's progress and activities undertaken to fulfil the four elements and written components of the Specialisation Training Program. Areas of concern will be reported.

Ultimately, the facilitator will provide to the Board of Censors a final report on the readiness of the registrar to sit for the final examinations for specialisation. The Fellowship Pathways Standing Committee is the body responsible for granting approval to sit final examinations.

Performance Management

Remediation of poor performance and learning will be proposed by the facilitator, agreed by the registrar and approved by the Board of Censors.

Mechanisms may include repetition or augmentation of learning experiences.

Extension of the training period will also be considered up to the maximum period of 4 years.

The Board of Censors reserves the right to discontinue the Specialisation Training Program of a registrar who has demonstrated poor compliance with an agreed remediation plan and consistently poor performance, particularly where such poor performance impacts negatively on the other members of the cohort.

Related Documents

Patient Safety

Dispute Resolution

Provision of ongoing support beyond the two year Training Program for Fellowship by Specialisation

Introduction

Situations may arise where registrars for Fellowship by Specialisation having completed the Specialisation Training Program are deemed not ready to sit final examinations, or chose not to sit for personal reasons, at the normal scheduled time. Additionally, occasions also arise when candidates fail the examinations and express a desire to re-sit. Registrars or Candidates in these situations may be classified as follows:

Condition A

A registrar who has completed the two year training program but has not fulfilled all the requirements of the training program and is therefore ineligible to sit the final examination.

Condition B

A registrar who has been advised by their facilitator, and accepted the advice, that they are not ready to sit the final examinations, who chooses to defer and sit the following year, or who chooses not to sit the exams for personal reasons (to be read in conjunction with the deferment policy).

Condition C

A candidate who has failed the final examination and wishes to re-sit the following year.

A registrar who fulfils the criteria for Conditions A, B or C must apply to the Board of Censors (BoC) for consideration for ongoing contact with the College and the Training Program to retain access to various defined components of the Training Program. Such application should be made on the appropriate form.

The Board of Censors (BoC) has a number of options available for consideration in relation to opportunities for registrars who fulfil the criteria above.

The BoC will review the individual registrar's situation and determine which of the options may be offered to the registrar to allow them to proceed in the training program and prepare for the examinations.

While the BoC, in most instances, will draw from the following options, each situation will be reviewed individually.

All options are subject to availability of resources and appropriate payment of fees commensurate with the option that is pursued. Registrars are therefore encouraged to complete the 2-year training program within the allotted 2-year time and then proceed to exams or consider their options to defer as per the deferment policy.

A decision by the BoC that none of the options is available will lead to termination of candidature.

The BoC's decision is final.

Options

Irrespective of which of the following options is deemed to be appropriate, the registrar would be required to complete a revised Learning Contract at the beginning of the 3rd year. They would also be required to organise a minimum of two marked mock exams, one in November (6 months) and one in March (12 months) of the 3rd year, each involving at least one experienced examiner who is a Fellow of the College. The results of these marked mock exams would be used by the BoC to gauge the registrar's progress at the appropriate 6 and 12 month submission times. The BoC will also utilise these data to inform their decision to allow a registrar an opportunity to sit/re-sit.

Option 1

If available and acceptable to the cohort, the registrar may join another cohort for that cohort's 'unfacilitated' meetings. The registrar would have no contact with a facilitator; therefore, no reports would be provided on the registrar's progress to the BoC through the year except for the outcome of marked 'mock' exams, organised by the registrar. Payment of a full year College membership fee would be required.

Option 2

If available and acceptable to the facilitator and cohort, the registrar may join another cohort in full training capacity. The facilitator would provide reports and marked 'mock' exam results to the BoC at the 6 and 12 month scheduled times in the extra year. A fee commensurate with the fee for one year of the training program would be required for Option 2.

Option 3

If available and acceptable to the facilitator, the registrar may meet with a facilitator on one or two occasions over the year for a facilitated half-day to assess their progress. Following the facilitated half day, the facilitator would provide reports and marked 'mock' exam results to the BoC at the scheduled times in the extra year. A fee commensurate with half the yearly training program fee would be required for Option 3.

Option 4

Should the BoC determine that none of the above options apply to a particular registrar and/ or the BoC determines that special circumstances demand a more tailored option, it may choose to enact Option 4. This option provides for a combination of any or all of the above training resources listed in options 1-3 (i.e. access to facilitator face to face, access to registrar cohorts in full or limited training capacity, access to electronic training resources). The specific combination of available resources chosen by the BoC will be influenced by an analysis of the registrar's needs and circumstances.

The constituent parts of the 3rd year learning package will be determined by the BoC and will be influenced by feedback provided to the registrar by their facilitator during their training period and/or by their examiners where relevant, and consideration of a revised Learning Contract. If a facilitator is unavailable, the registrar will be expected to provide monthly submissions to a discipline specific BoC member, or a College appointed mentor, for ongoing appraisal of progress. Payment for a full year Associate Membership of the College would be required. Additional fees will also be charged commensurate with the learning resources package determined by the BoC.

Commencement of any of the Options at a time other than at the beginning of the training year will require payment of the equivalent fee on a pro rata basis.

Related Documents

Timeframe for completion of Training Program and Exams
Deferment of Training
Readiness to sit final exams for Fellowship by Specialisation
Timeframe for Completion of Training Program and Exams

Approved (ACP Council): August 2010; revised September 2017
Due for review: January 2019
Australian College of Physiotherapists Training Program Manual (v. January 2019)

Readiness to sit final exams

Introduction

The Australian College of Physiotherapists' (ACP) Specialisation Training Program (STP) is an individualised, self-directed learning program facilitated by an ACP appointed Specialist from the same discipline. At the end of the STP, facilitators submit a final report to the Board of Censors (BoC) which includes their opinion with regard to their registrar's readiness to sit the final examinations for Fellowship by Specialisation. The BoC review a range of data (as set out below) and make a recommendation about each registrar who completes the STP to the Fellowship Pathways Standing Committee (FPSC). The FPSC is responsible for issuing invitations to sit this final examination. Once a registrar has successfully completed the STP, they are referred to as an 'exam candidate'.

Some candidates, having deferred their first attempt at the end of the STP, or having been unsuccessful in a previous exam attempt (year 3 registrars) may also be applying to the FPSC to sit final examinations. Oversight of candidates in this situation sits directly with the FPSC. Candidates will be required to submit two MMEs conducted in accordance with the procedure for determining readiness to sit final examinations, and within the timeframe specified by the FPSC.

Conduct of the final specialisation examinations requires a considerable investment on behalf of all involved. It is not in the best interest of registrars, facilitators, examiners, or the College to allow candidates who have not demonstrated a suitable quality of submitted work across all elements of the STP and an appropriate level of clinical ability at the standard of an entry level specialist to undertake the final examinations for Fellowship by Specialisation.

Procedure for determining readiness to sit final examinations

Several formal marked mock exams (MMEs), using the ACP examination mark sheets, will be held in the last four months prior to application to sit the final examinations. At least two examiners must be involved in these mock exams (this could be the facilitator and one independent experienced ACP Examiner or one experienced ACP Examiner and an inexperienced examiner. Out of discipline examiners may also be used). Marks must be available for *at least* two MMEs each involving a single session with a new patient (no longer than 60–90 minutes - dependent upon the specialist discipline), and a 15 minute post exam discussion with the examiners where the registrar can elaborate their reasoning about assessment and management. Please see the ACP Policy and Procedure for ACP Marked Mock Exams (APRIL 2020) for further information.

The recommendation made by the facilitator (where appropriate) to the BoC, and by the BoC to the FPSC regarding 'readiness to sit' the specialisation exam will be informed by the marks achieved and the overall standard of performance in MMEs undertaken during the last few months, as well as a range of data across the last six months of the STP, or year three, whichever is appropriate, including evidence logged in the registrar's virtual Workbook, of progress against the individual registrar's learning plan.

Registrars who wish to sit in that exam round, but are not recommended to sit by their facilitator, or who are deemed to be not ready to sit by the BoC (if they are in a year three situation), will be required to provide a written rationale to the FPSC for consideration. A recommendation to be invited to undertake

the final specialisation examinations (or not) will be made to FPSC by the BoC based on careful consideration of all the available information. The FPSC is responsible for approving registrars to sit the final examination and their decision is final.

Related Documents
Procedure for ACP Marked Mock Exams APRIL 2020
Timeframe for completion of SpecialisationTraining Program and Exams
Deferment of Training
Provision of ongoing support beyond the two Year Training Period for Fellowship by Specialisation

Approved (ACP Council): August 2010; Revised
September 2017, February 2022

Due for review: January 2024

Registrar support

Introduction

The College's Specialisation Training Program is designed to be supportive of registrars. The facilitator will be a role model and adviser to assist the registrar to develop highly advanced knowledge and skills in the field of specialisation. This will include guidance in independent and facilitated life-long learning through practice and reflection and career guidance.

Registrars will also receive peer support through the small study groups formed.

It is anticipated that individuals will, through these strategies, have adequate support to develop both personally and professionally to achieve their educational goals during the two year program.

Referral

Where a registrar considers that they require personal or professional support beyond the capacity of the facilitator and the College, they will be offered access to a limited number of counselling sessions. The sessions will be provided by an accredited counselling service external to the College.

Support of this kind may be proposed by a facilitator in discussions with the registrar. Registrars may alternatively initiate a request for additional support.

Process

Requests must be directed to the Training and Assessment Lead, ACP who will facilitate the referral process.
All requests will be strictly confidential and will have no bearing on assessment outcomes.

Sitting exams outside the designated period

Introduction

The College's examination periods aim to provide candidates with a clear endpoint to their Specialisation Training Program. As such, they are provided to each candidate two years in advance.

Except in cases of acute illness occurring at the time of examination, there is limited possibility of deferring or rescheduling an examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Exam Coordinator as soon as practicable (at least four weeks prior to the examination date if circumstances allow). The decision to defer or reschedule an examination will be made at the discretion of the Fellowship Pathways Standing Committee.

The general principles governing this situation are as follows:

- Candidates should not be disadvantaged unnecessarily as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which could be construed to be unfair to other candidates.
- Some guidelines can be formulated for the procedures to be followed in some cases of personal issues such as hospitalisation or the passing of a family member; however, it is impossible to foresee every eventuality.
- Where a problem arises that is not covered in the Policies and Procedures, instructions to examiners, or these guidelines, advice should be sought from the Manager - Australian College of Physiotherapists and the Exam Coordinator.

Successful Deferment / Rescheduling of Examination

If the Fellowship Pathways Standing Committee decides to reschedule an examination for a candidate, the candidate will usually be allocated the next available examination period. To ensure maintenance of their specialist-level skill base, the candidate will need to extend their candidature (at least one 3 month period) and pay any required fees.

Any rescheduled exam will be charged on a cost recovery basis. This will mean that the candidate will have to pay for all associated costs for the rescheduled exam; which, without the economy of scale available to a full training cohort, may result in the candidate incurring a higher fee.

A candidate is allowed to attempt the examinations a maximum of twice.

The Fellowship Pathways Standing Committee, at its discretion may approve a third attempt at the examinations. A candidate will be required to apply in writing to the Fellowship Pathways Standing Committee and to submit a Learning Contract (TP format) that clearly addresses all areas of concern raised by examiners as part of their application. The candidate will submit progress reports as required. The Fellowship Pathways Standing Committee has the right to rescind the offer of a third attempt at the examinations at any time if the candidate fails to make satisfactory progress towards fulfilling the requirements of the Learning Contract.

Each subsequent attempt at the examinations will occur in the year immediately following the failed attempt. The Fellowship Pathways Standing Committee, at its discretion may allow an unsuccessful candidate to defer their next

attempt at the examinations for no more than twelve months.

A Registrar must complete the Training Program within four (4) consecutive years.

A candidate must complete all attempts at the examinations within four (4) consecutive years.

Related Documents

Consideration of cases of impairment at assessment

Timeframe for completion of Specialisation Training Program and exams

Introduction

The Specialisation Training Program can be considered as a 3 phase process consisting of the first year of training (phase 1), the second year of training (phase 2) and the final examinations (phase 3). A registrar may choose to exit the Specialisation Training Program at the completion of either phase 1 or 2, without going on to complete the examination phase. A registrar may make this decision for many reasons – some examples include a change in personal circumstances, a change in career direction or the simple recognition of having gained sufficient knowledge from the program and the registrar seeing no need to go through the examination process to achieve Specialisation.

A registrar may also choose to defer candidature through either phase 1 or phase 2. However, a registrar must complete the Specialisation Training Program within four (4) consecutive years. A registrar may attempt the examinations a maximum of twice. The second attempt must occur in the year immediately following the failed first attempt.

A registrar is usually allowed to attempt the examinations a maximum of twice. However, the Fellowship Pathways Standing Committee, at its discretion, may approve a third attempt at the examinations. A candidate will be required to apply in writing to the Fellowship Pathways Standing Committee and to submit a Learning Contract (TP format) that clearly addresses all areas of concern raised by examiners as part of their application. The candidate will submit progress reports as required. The Fellowship Pathways Standing Committee has the right to rescind the offer of a third attempt at the examinations at any time if the candidate fails to make satisfactory progress towards fulfilling the requirements of the Learning Contract.

Each subsequent attempt at the examinations will occur in the year immediately following the failed attempt. The Fellowship Pathways Standing Committee, at its discretion may allow an unsuccessful candidate to defer their next attempt at the examinations for no more than twelve months.

A registrar must complete the Training Program within four (4) consecutive years.

A candidate must complete all attempts at the examinations within four (4) consecutive years.

Re-entry to the Training Program

Registrars granted deferment are required to re-enter the Training Program at the point of their last satisfactory facilitator's report (6, 12 or 18 months), subject to availability of a cohort and facilitator willing to take on an additional registrar, a situation that cannot be guaranteed. If no suitable cohort or facilitator is available, the registrar may be required to wait a further twelve (12) months for a suitable training situation. The College will make every endeavour to ensure that a suitable cohort is available at this time, even if the registrar is required to work in a cohort of one (1).

Extraordinary Consideration

In exceptional circumstances, the Board of Censors may, at its discretion, give extraordinary consideration to vary the timeframe for completion of the Training Program. If a registrar believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Chief Censor as soon as practicable. Individual circumstances will be considered on a case-by-case basis. Decisions made by the Board of Censors are final.