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A WORK-BASED EDUCATION PACKAGE TO ENABLE RADIOLOGY ASSISTANT PRACTITIONERS TO UNDERTAKE AP ERECT CHEST X-RAYS WITH RADIOGRAPHER SUPERVISION

Contents

Document Information

This document has been developed during a NHS Education for Scotland (NES) Expression of Interest undertaken by

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This has then gone through rigorous review with all comments and suggestions discussed and implemented where appropriate by

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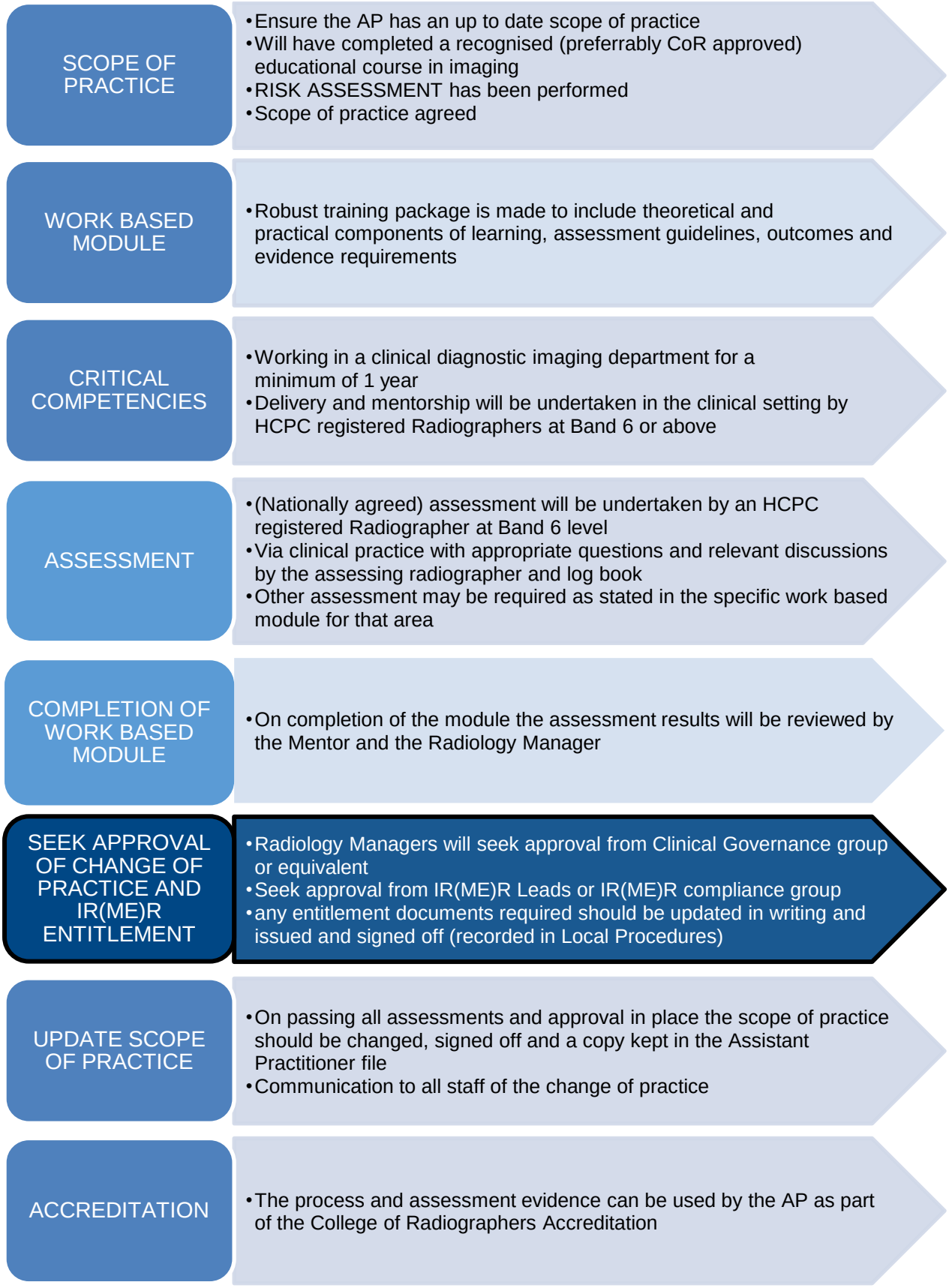
A local pilot is recommended in the first instance.
Please feedback information to: nss.scin@nhs.scot

Flowchart: Method of implementing changes to Assistant Practitioner (Radiology) Scope of Practice Flowchart



Introduction

Aim

The National Health Service supports Radiology Assistant Practitioners (AP's) in delivering high quality care based on a blend of knowledge and practice skills. As Assistant Practitioners currently work within a defined scope of practice, it is proposed within this EOI to extend this scope of practice for AP's to undertake Anterio-Posterior Erect Chest X-rays (AP Erect CXRs) in Radiology departments to support the service demand. The purpose of this education package would be to deliver a new skill set to extend their scope of practice to perform AP Erect CXR in chairs, trolleys or beds under the direct supervision or delegation of a Radiographer.

Risk Assessment

The trainee APs must be supported by a clinical diagnostic radiographer registered with the Health and Care Professional Council with clinical experience at an assessor or supervisor level. Documentation of policies such as Manual Handling, Infection Control and Health and Safety must be reviewed and up to date on the trainee's records. These policies will underpin the APs ability to be able to work within their defined scope of practice in regard to the patient's condition, manual handling, and equipment requirements.

Assistant Practitioners are responsible for the tasks they undertake and should alert the supervising radiographer if the situation arises that they are unfamiliar with or which they consider is out with their competency to practice (SoR 2012).

Assistant Practitioners must be aware of their surroundings regarding radiation protection. Assessing the situation with regards to carers, the safety of the public and other staff members. Radiation protection will be included in the theory aspect of the education package and must be implemented in all AP chest x-ray imaging.

NHS bodies are vicariously liable for the negligent acts and omissions of their employees and are responsible for ensuring that the appropriate governance processes are in place to support the AP scope of practice. (SoR 2023 Supervision and Delegation guidance). CoR accreditation demonstrates publicly that applicants have met the professional body's standards for APs, promoting the consistent education and development of the support workforce. Those awarded CoR accreditation will be eligible to be listed on the SCoR's Public Voluntary Register of Accredited Assistant Practitioners (PVRAAP) providing managers with quality assurance of their staff, and public reassurance. APs who are SoR members will be eligible to participate in the SoR's professional indemnity insurance (PII) scheme. The PII scheme will cover APs for their accredited scope of practice. The SoR and CoR must be informed of any changes to an AP's scope of practice at the time of change or the PII cover may be affected. This may require application for re-accreditation of the new scope of practice (CoR AP Accreditation: Guidance for Applicants 2023).

A local risk assessment for service change should be completed prior to the start of this work-based education package.

Purpose

To provide evidence of training of knowledge and skills to allow assistant practitioners to perform Anterior-Posterior erect chest x-rays using X-ray equipment within a radiology department.

On completion the trainee should be able to:

- Evaluate the clinical and physical condition of the patient to undertake an AP Erect CXR
- Demonstrate the ability to perform an AP Erect CXR using modified techniques whilst patient is in a bed, chair or trolley.
- Understand scenarios where an AP Erect CXR would not be appropriate to answer the clinical question.
- Critically evaluate AP Erect CXRs to a diagnostic standard.

A logbook will be provided to record all practical training where AP Erect CXR's have been observed, performed Aided and Unaided.

Theoretical assessment questions to be completed.

Staged Assessments will be conducted to demonstrate trainees' competence in performing AP Erect CXR's on chairs, trolleys and beds.

Finally, a reflective report to be completed and filed along with logbook and staged assessment sheets.

INCLUSION & EXCLUSION CRITERIA

INCLUSION CRITERIA

There should be a clear understanding of the inclusion criteria to perform AP Erect CXR's which are detailed below.

- Children 16 years and above
- Refer to department's protocols on AP Erect Chest X-rays.
- Mobility criteria- wheelchair, chair, trolley or bed
- A patient that is conscious, cooperative and communicative

EXCLUSION CRITERIA

The APs should alert the supervising radiographer if they consider the examination has gone out with their scope of practice.
Other exclusion criteria:

- Intubated patients
- Supine patients
- Patients with major or complex injuries
- Unconscious patients
- Portables x-rays on wards
- The use of a Grid. Refer to department's SOPS if a grid is required as a standard.
- Monitored patients i.e., those patients with more complex needs where the clinical review of a radiographer is needed.
- Patients connected to apparatus such as drains, monitors, or intravenous drips.
- Modified techniques such as apical view, lateral.

EXPECTATIONS OF THE RADIOLOGY MANAGER

The Radiology Manager should be responsible for agreeing and understanding how to support APs during the work-based education package, providing appropriate support for the demands required to complete this learning and development. The manager should encourage staff to develop their skills by continuous personal development plans, allowing staff time to complete reflective work and evidence-based learning. The Radiology Manager should also have Quality Assurance plans in place to provide CPD support incorporating regular Clinical supervision sessions to provide ongoing support for the AP. To facilitate continued learning and the audit cycle, audits of examinations undertaken will be completed annually to evidence competency has been maintained and form part of the annual appraisal discussion. When new equipment is installed or upgraded ensuring all staff levels competent in operating this equipment has had the relevant training and documented.

METHOD OF SUPERVISION

The trainee AP will be under the direct supervision of a supervising Radiographer. Radiographer must be Health and Care Profession Council registered with at least two years' clinical experience. The Radiographer will take full responsibility of the supervision of the assistant practitioner undertaking the training education package.

Radiographer must have undertaken appropriate training to fulfil this role as mentor, such as with the online training module NHS Education for Scotland (NES) Clinical Supervision on Turas.

Resource: https://learn.nes.nhs.scot/3580/clinical/supervision
Supervising Radiographers are also expected to have undertaken assessor training to be competent in filling out staged assessment examinations. This type of training may be in house training or as part of a Higher Education training programme.

Supervising Radiographers are also expected to have undertaken assessor training to be competent in filling out staged assessment examinations. This type of training may be in house training or as part of a Higher Education training programme. Supervising Radiographer must be able to provide the knowledge and practical skills to support the assistant practitioners throughout their training. Where there is any urgent or unexpected findings on the resultant radiograph, the trainee AP should escalate their concerns to the supervising radiographer who will be able to take this forward.

Any communication of urgent findings should be done so by the supervising radiographer (SoR, 2023).

EXPECTED OUTCOMES

During the APs training for this work-based education package, the AP is expected to observe, and participate in examinations of AP erect CXR examinations. The number of clinical exams completed is not critical, but the AP must demonstrate that they can work unassisted through a range of examinations. Completion of the work-based education package will provide evidence that the learning outcomes have been met.

On completion of the work-based education package module the assistant practitioner will:

- be able to explain and understand the clinical need for an AP Erect Chest X-ray patient in relation to mobility or condition.
- Discuss the different views: Posterior- Anterior Vs Antero- Posterior Erect Chest x-rays.
- Have an understanding of patient positioning and how to correct patient positioning to produce a diagnostic image.
- Know how to position detector/ cassette and align X-ray Tube.
- Have an awareness of oxygen tubing, other attachments, and potential artefacts.
- Apply appropriate radiation protection techniques for the AP Erect CXR examination.
- Have a systematic approach to evaluate AP Erect CXR images.
- Have completed and passed the practical learning assessment:
  - Have completed 15 unaided AP Erect CXRs consisting of on 5 chairs, 5 trolleys and 5 on beds under direct supervision of a Radiographer.
  - 3 unaided AP Erect CXRs are to be completed under staged assessment conditions to be performed 1 in a chair, 1 in a trolley and 1 in a bed.

  - Once logbook is completed, this will be signed off and appropriately documented in staff records ready for governance approval.
- Evaluate AP Erect CXR image.

RECOMMENDED PRIOR KNOWLEDGE AND QUALIFICATION STATUS

- Must have a Certificate of Higher Education (CertHE) in Radiographic Studies (1 year) or Diploma of Higher Education (DipHE) (2 years). The Education and Career Framework (CoR 4th Ed, 2022) now requires graduating APs to have a DipHE. APs with CertHE qualifications may require additional support and training to achieve completion of the work-based education package but should be seen as a role development opportunity.
- Be performing PA chest x-rays while employed as a Radiology Assistant Practitioner for a minimum of one year.
- Recommend Assistant Practitioner accreditation with the College of Radiographers.

DELIVERY: Teaching methods & Assessment process

This Work Based Educational Package will be undertaken within a clinical setting in a Radiology Department.

A blended approach of in-house training, clinical practice and theoretical learning will be provided by the manager and supervising Radiographer. Ideally, the theoretical aspects should be linked to an accredited education programme at SCQF8. Assistant practitioners are to be encouraged to complete the examinations in radiology areas in which they will be working.

One to one session with a Radiologist/ Senior Radiographer on AP chest evaluation must be included in the practical aspect of this education package. A session with a chest reporting practitioner (Radiologist/radiographer) is recommended to appreciate the limitations of the Antero-Posterior technique.

Theory

a) Assistant Practitioner will then be assigned a mentor to support them in the theoretical and practical aspects of the education package.
b) Following teaching of the theory of AP Erect CXR's the trainees would be expected to complete the theoretical education package with assessment questions. On completion this will be signed off by the department manager.

Practical

c) The practical aspect of the education package would be to initially shadow a Radiographer and observe AP erect chest x-rays involving chairs, trolleys and beds. Next step will be working towards performing AP Erect CXR aided or assisted with a supervising Radiographer.
d) A logbook will be provided to document all AP Erect CXRs that have been observed, performed aided and unaided with a supervising radiographer.
e) Under regular review the Assistant Practitioner will complete 15 unaided AP Erect CXRs
f) To ensure the trainee is competent in their new scope of practice they are expected to complete 3 AP Erect CXRs one in a chair, one in a trolley and one in a bed, under assessment conditions using the staged assessment forms. This would complete the practical aspect of the education package.

Once the theory workbook and practical logbook are complete a reflective report is required to demonstrate and collect the reflection of the assistant practitioner on their progress and continuous development.

Where the AP is accredited by the College of Radiographers, as in on the public voluntary register of accredited assistant practitioners PVRAAP they will have access to the CPD Now programme, which can be used to document any CPD undertaken in support of their training and extended scopes of practice.

Annual Audit of Practice should be devised locally to ensure continued compliance and competence.

IR(ME)R 2017 ENTITLEMENT

For the Assistant Practitioner to act as an Operator under IR(M)ER they must be entitled by their employer and be able to evidence adequate training and education to perform the tasks within their defined scope of practice.

“An operator usually will carry out a range of functions as part of their employment and Schedule 2(1)(b) requires entitlement and the scope of practice of operators to be clearly defined within the employer’s written procedures.” Department of Health and Social Care (2018).

The Radiographer has a duty of care and a legal liability regarding the patient. If they have delegated a task to the Assistant Practitioner, they must ensure that the task has been appropriately delegated (Lamb, B 2015). It is essential that all new training records are updated and stored on file by the manager.

Where there is any urgent or unexpected findings on the resultant radiograph, the AP should escalate their concerns to the supervising radiographer who will be able to take this forward.

Any communication of urgent findings should be done so by the supervising radiographer (SoR, 2023).

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APPENDIX

WORK BASED EDUCATION PACKAGE WORK BOOK

A Work-Based Education Package to enable Radiology Assistant Practitioners to undertake AP ERECT Chest X-rays (AP Erect CXR) with Radiographer supervision

This education and record of learning is split into 2 areas for assessment: theory and practical

Expected outcomes

On completion of the work-based education package the assistant practitioner will:

- be able to explain and understand the clinical need for an AP Erect CXR patient in relation to mobility or condition.
- Discuss the different views: Posterior- Anterior Vs AP Erect CXRs.
- Have an understanding of patient positioning and how to correct patient positioning to produce a diagnostic image.
- Know how to position detector/ cassette and align X-ray Tube.
- Have an awareness of oxygen tubing, other attachments, and potential artefacts.
- Apply appropriate radiation protection techniques for the AP Erect CXR examination.
- Have a systematic approach to recognise normal/abnormal AP Erect CXR images and escalate abnormal findings to a radiographer for appropriate action.
- Have completed and passed the practical learning assessment:
  - Have completed 15 unaided AP Erect CXRs consisting of 5 on chairs, 5 on trolleys and 5 on beds under direct supervision of a Radiographer.
  - 3 unaided AP Erect CXRs are to be completed under staged assessment conditions to be performed 1 in a chair, 1 in a trolley and 1 in a bed.
  - Once logbook is completed, this will be signed off and appropriately documented in staff records ready for governance approval.
- Evaluate AP Erect CXR image.

Assessment 1

Complete theory based workbook covering Antero- Posterior versus Posterior-Anterior; assessing the patient; radiation protection and image evaluation. This must be complete prior to moving to Assessment 2

Assessment 2

Complete practical assessment of

- Assessment of patient condition.
- Demonstrate the ability to perform an AP Erect CXR by positioning the patient, detector and X-ray Tube.
- Patient immobilisation specific to chair, trolley or bed.
- The use of appropriate radiation protection techniques.
- Undertaking the examination and risk assessment within the policy framework of Manual handling, Health and Safety and Infection control.

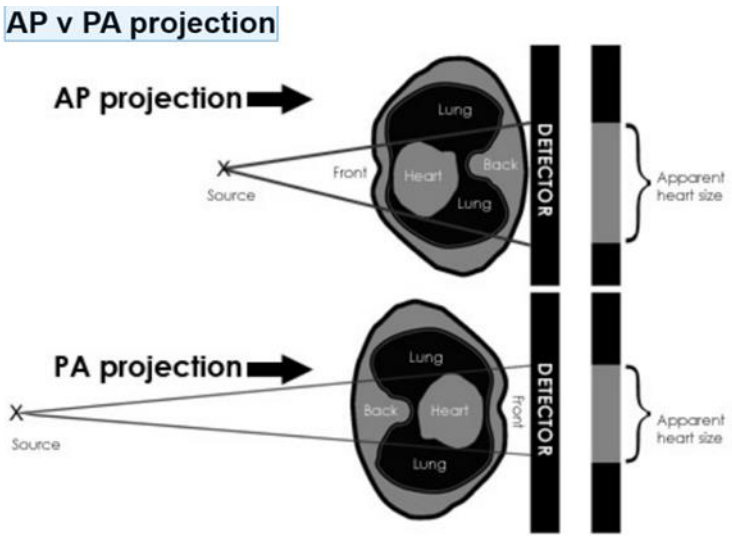
- Demonstrate competency in Image Evaluation of the Antero-posterior chest view

It is expected that the trainee Assistant Practitioner to have completed 15 unaided AP Erect Chest X-rays including 3 staged assessments using chairs, trolley and bed, within a time frame of two months. (Can be agreed flexible time frame however if extended due to low volume then must evidence that competence is achieved and can be maintained.)

THEORY

Outcome 1: Postero-Anterior (PA) versus Antero-Posterior (AP) projection

An Antero-Posterior (AP) projection is often considered the alternative to a Postero-Anterior (PA) Chest X-ray if the patient's condition or mobility limits them to safely perform a PA chest X-ray. The understanding of the difference between the two projections is vital for patient safety and answering the clinical question.
In an Antero-posterior position X-rays pass from the anterior to the posterior of the patient with the Image receptor behind the patient. The heart is an anterior structure within the thorax cavity resulting it being magnified by an AP projection (Radiology masterclass 2017). An AP projection can reduce the accuracy in the assessment of the cardiothoracic ratio. Magnification of the cardiothoracic structures can also be exaggerated further by a shorter distance between the x-ray source and the patient (Clarks 2017).



Outcome 2: Assessing the patient

PA projection is classed as 'gold standard' (Evans, D 2017) however, if the patient's mobility or condition limits them to perform this view than an AP projection can be used as alternative technique. A patient's condition must be considered prior to performing an AP chest X-ray.

Assess your patient

- Communication
- Conscious
- Are they able to stand safely?
- Are they able to sit off the trolley for a PA projection?
- Do they have any exclusion criteria that would extend out with the Assistant Practitioner's scope of practice?
- Patient notes/request which may indicate the patient would not be able to tolerate a PA projection.

Outcome 3: Radiation protection

Under IRR17 all radiology staff using ionising radiation should complete training in the basics of radiation physics, radiation effects and the legislation.

It is recommended that these resources found in TURAS are completed:

1. **Radiation Protection: The Ionising Radiation Regulations 2017 (IRR2017)**
2. **Radiation Protection: Biological effects, dose and risks**
3. **Radiation Protection: Introduction to Radiation Physics**

The fundamental principles of radiation protection are:

As Low as Reasonably Achievable (ALARA) regulatory guidelines reduce workers to exposure to radiation through 3 main principles.

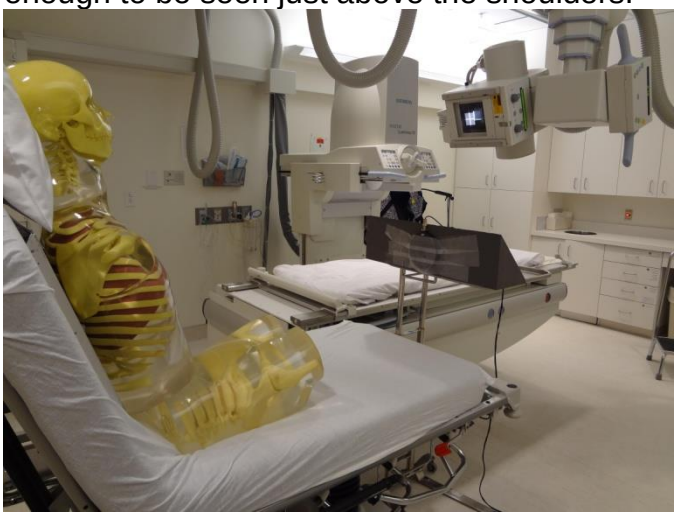
- Time – Limit time spent near the source.
- Distance – scatter radiation reduces the further away you are the patient and source. The Inverse square law is used to calculate the intensity of any given radiation or distance. “The intensity of the radiation is inversely proportional to the square of the distance” (BYJU’s 2023).
- Shielding – PPE such as lead apron, thyroid collar, protected eye wear, lead shields, table drapes are used to minimise radiation exposure.

Once an AP Erect CXR has been established as the X-ray projection, appropriate exposure factors, collimation and authorisation under guidelines should be considered. Positioning of the patients’ bed or chair needs to be appropriate to room design.

Under an AP projection there is an increase radiation dose to the patient’s eyes, thyroid due to the tube being positioned facing the patient. The radiation dose to the more radiosensitive organs can be reduced by collimating and correct positioning.

Outcome 4: Positioning of the patient and x-ray tube

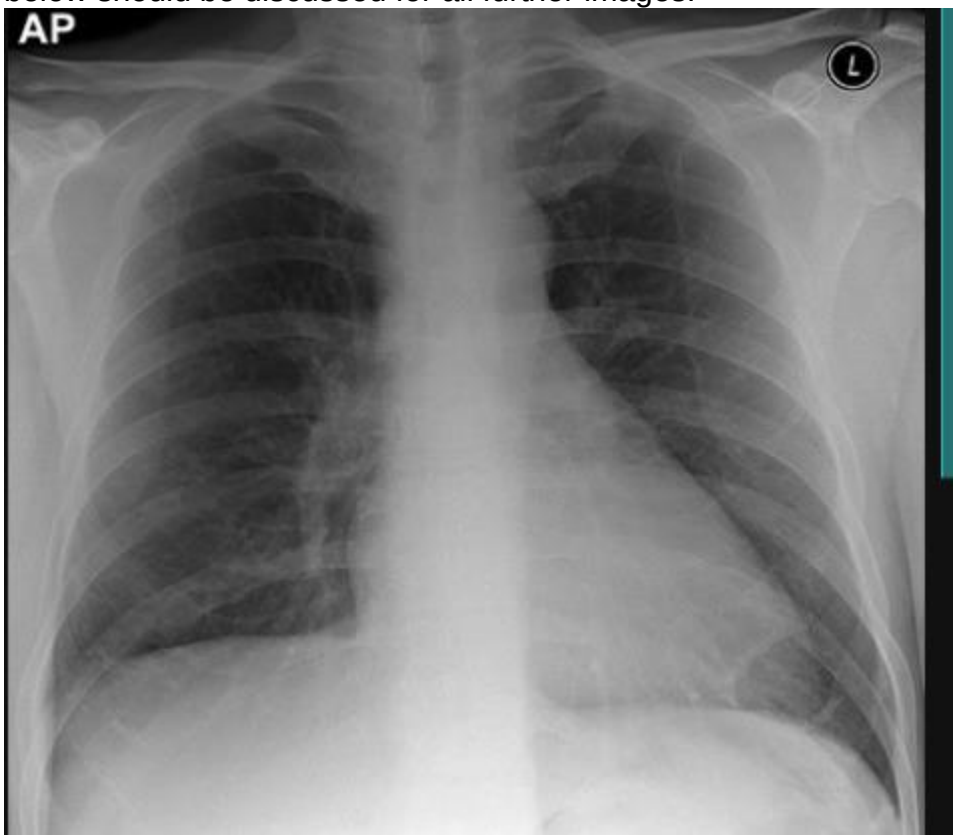
1. When the patient arrives in the X-ray room the room environment should be considered. SID needs to be considered so push the bed as far away from the x-ray tube to achieve this distance.
2. Patient preparation prior to the x-ray should include remove of bras, clothing which may cause artefact. Oxygen tubing to be placed above the shoulder and image receptor. Jewellery to be removed such as necklaces and long earrings.
3. The patient's arms, if clinically possible, should be internally rotated at the shoulders until the thumbs are facing the floor this is to minimise the superimposition of the scapulae on the lung fields (Whitley 2017). Ensure the patient's hips are not rotated as this can result in the chest x-ray image to appear rotated (Evans, D 2017). The patient's head should be raised off the chest to visualise the apices of the lungs.
4. Ensure the patient is sitting erect in the chair or trolley the Image receptor can be placed in an erect holder or large pad to support the patient upright. The patient may require repositioning in the chair or trolley to achieve an erect position.
5. The patient is seated as upright as possible with either Image Receptor or cassette directly behind them. The upper edge of the Image receptor is raised enough to be seen just above the shoulders.



6. The direction of the x-ray tube is angled caudally until it is at right angles to the sternum and centred midway between the sternal notch and xiphisternum (Whitley 2017). A caudal angle is used to reduce the effect of lordosis. The source-image distance (SID) should be 180cm to reduce the magnification of cardiothoracic structures (Whitley 2017). Collimate laterally down to the patient's lateral chest wall, apices of the lungs to the patient's costophrenic angles.
7. X-ray exposure is taken on full inspiration with close observation of the patient to assess the optimum timing of the exposure as full inspiration can be inhibited by sitting due to abdominal pressure.

Outcome 5: Image Critique

Critical Evaluation of technique for the Antero-posterior chest x-ray – the information below should be discussed for all further images.



- ID – ID check name, date of birth & address
- Projection- AP Erect Chest X-ray Projection
- Positioning - Rotation medial end of clavicles to be equidistance to the spinous processes
    - Scapulae is within the lung fields
    - Clavicles projected over the apices, either patient leaning back or not enough angle of the X-ray tube.
    - chin high off the chest.
- Collimation – apices of the lungs, lateral borders of the thorax cavity, costophrenic angles of the lungs
- Image Annotations – Legend marker placed on the Image receptor.
- Inspiration - The 5-6 anterior ribs, lung apices, both costophrenic angles and the lateral rib edges should be visible.
- Exposure – Good penetration to visualise vertebrae body, good contrast, density, resolution.
- Artefacts – clothing, oxygen tubing, jewellery,
- Distinguish normal from abnormal – e.g. pneumothorax, consolidation, infection, malignancy
- Additional views/ repeats – Is the X-ray image to a diagnostic standard?

Pathologies / Artefacts

1. Pleural effusion

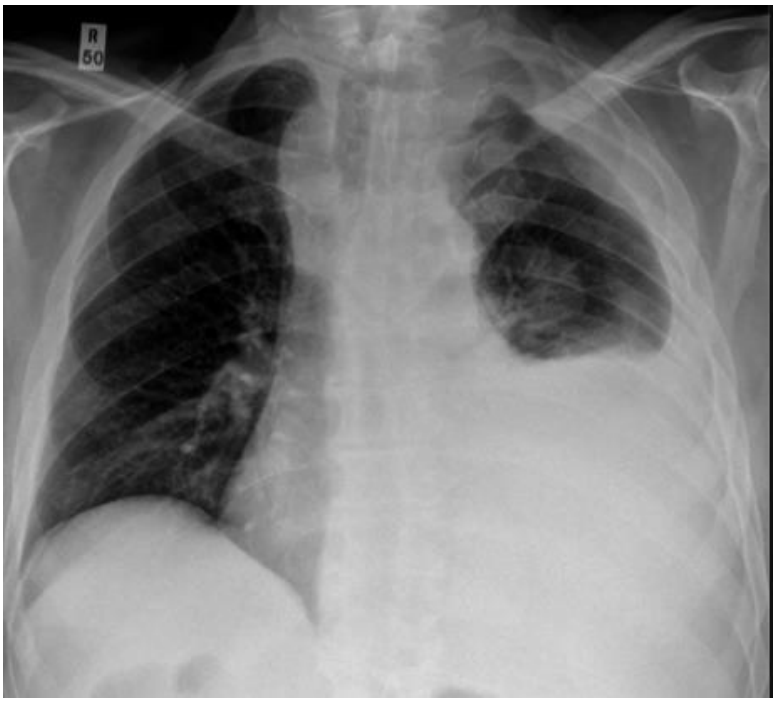


Image A demonstrates a large pleural effusion which has pushed the mediastinum to the right.

2. Tension Pneumothorax

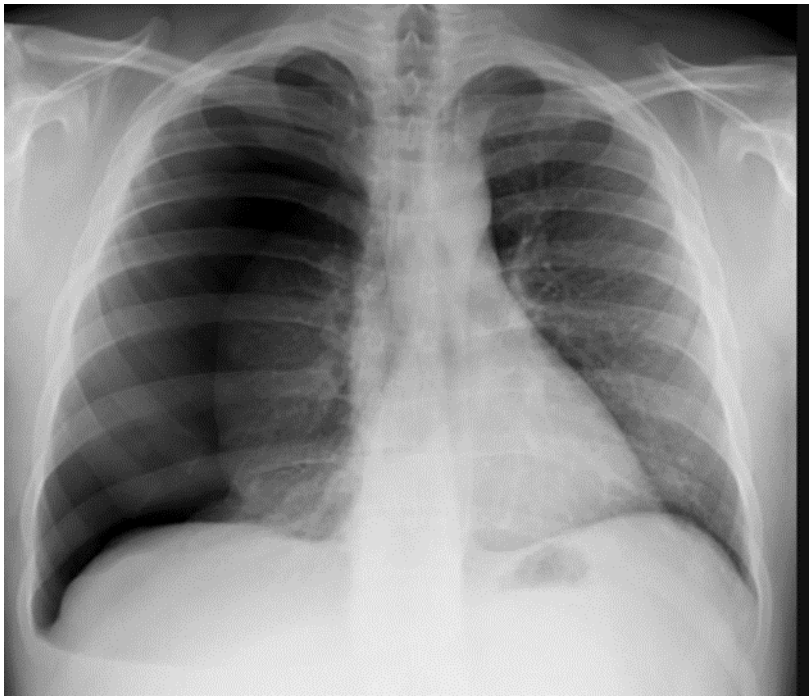


Image B demonstrates a tension pneumothorax, Heart border shifted to the left, Right hemi diaphragm slightly depressed on the right.

3. Mass & Pleural Effusion

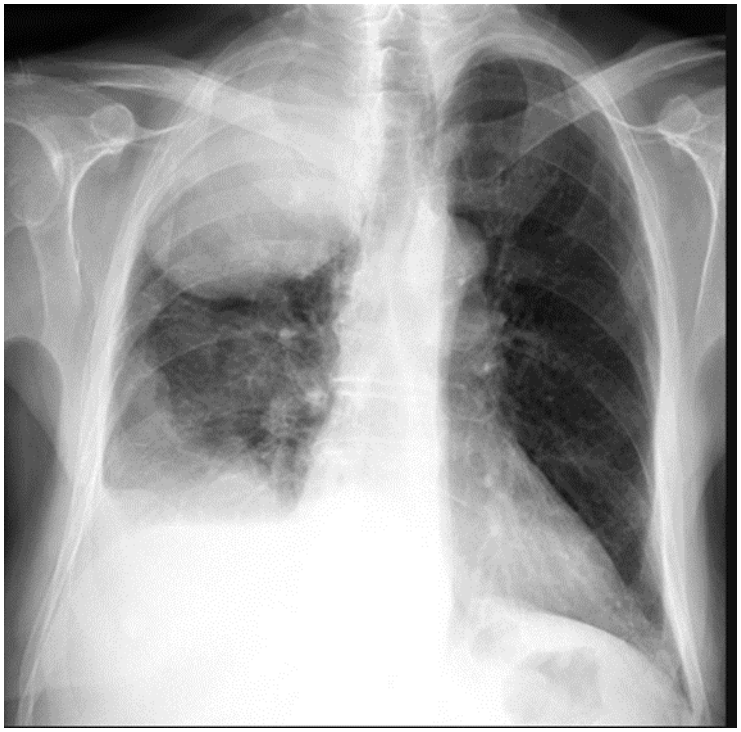


Image C demonstrates a large mass right apices of the lung and pleural effusion right base of the lung

4. Hilar Mass

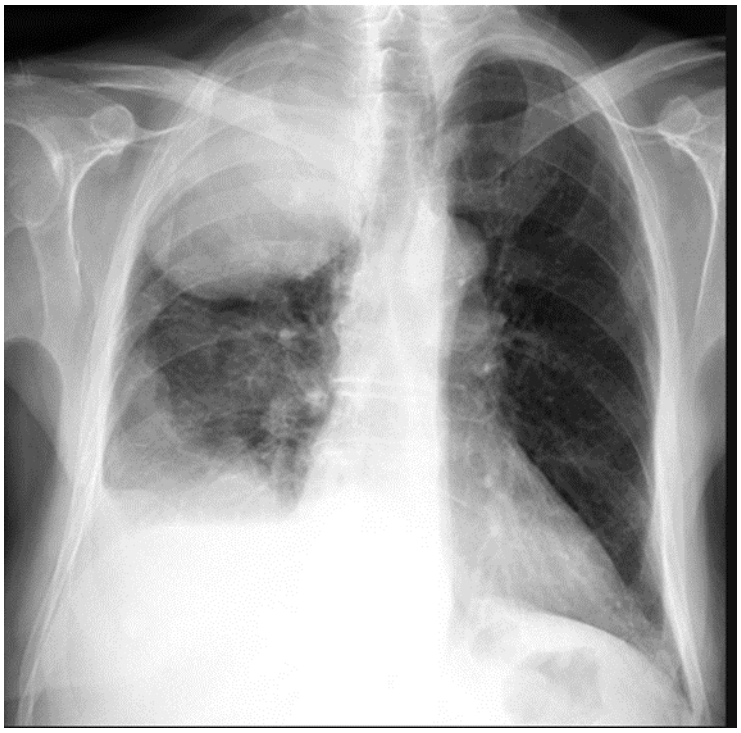


Image D shows the right hilar is abnormal compared with the left. The mediastinum is enlarged. Blunting of the right costorphrenic angles.

5. Metastasis

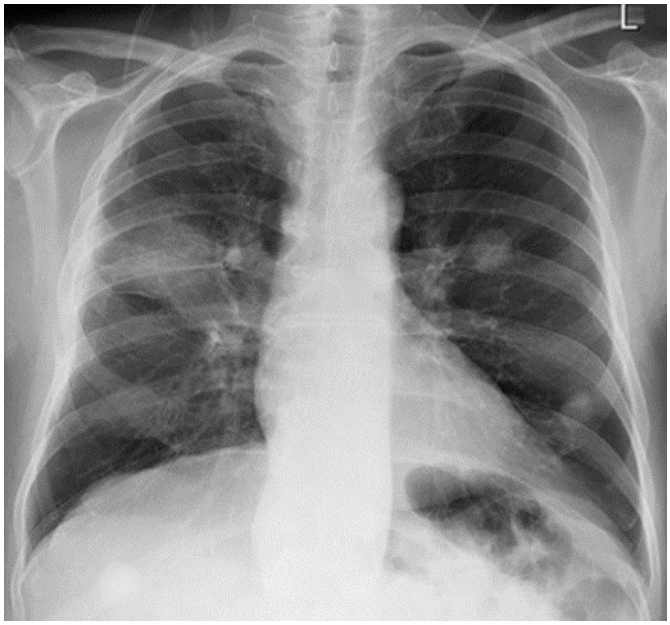


Image E demonstrates a large right middle lung mass with several metastasis in both lungs.

6. Jugular line for chemotherapy

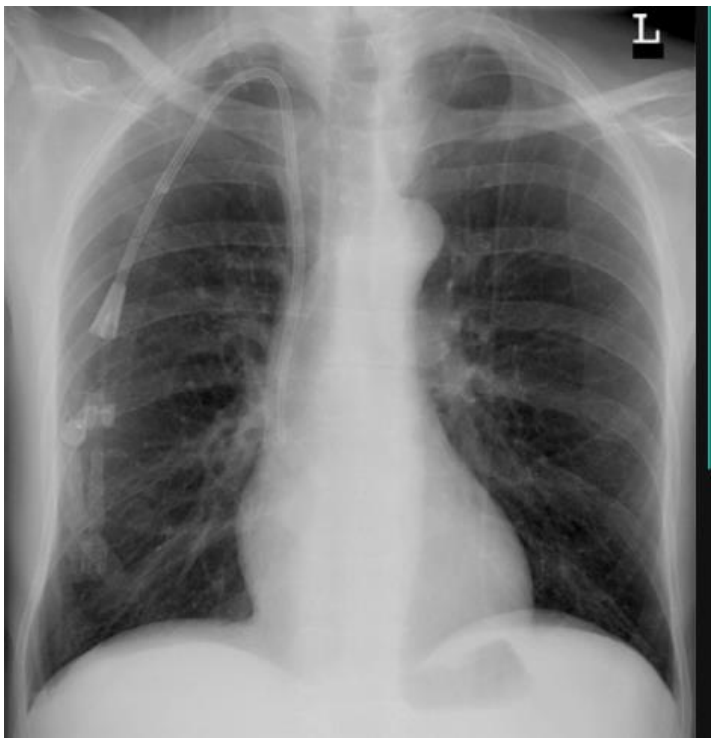


Image F demonstrates a placement of a jugular line for chemotherapy.

Assessment 1: THEORY ASSESSMENT BOOK

OUTCOME 1: Antero-Posterior (AP) versus Postero-Anterior (PA) projection

1.1 Describe the difference between an AP projection and a PA projection with regards to magnification.

OUTCOME 2: Assessing the patient.

2.1 What patient mobility or condition may prevent the patient from be able to tolerate a PA projection?

2.2 What steps would you take if the examination went out with your scope of practice?

OUTCOME 3: Radiation protection

3.1 Describe the 3 practical radiation protection principles.

3.2 Identify which tissues and organs are most radiosensitive

3.3 List radiation protection PPE

OUTCOME 4: Positioning of the patient and x-ray tube

4.1 Describe patient positioning for an AP chest X-ray.

4.2 What is the centring of an AP chest X-ray?

4.3 How would you alter the tube if the patient was leaning back?

Assessment 2: PRACTICAL LOGBOOK

Unit Title: A Work-Based Education Package to enable Radiology Assistant Practitioners to undertake AP ERECT Chest X-rays (AP Erect CXR) with Radiographer supervision.

Radiology Assistant Practitioner Name	
Radiographer Mentor Name	
Hospital	
Health Board	
Date Started	

Notes: Technical Evaluation of Image should include patient identification, name of projection, and region of interest, centring, collimation, marker, exposure, artefact, repeat, anatomy and abnormalities demonstrated

To be completed by AP and Supervising Radiographer, adding comment for further learning opportunities

AP ERECT CHEST XRAY

CASE	DATE	AP ERECT CHEST	Technical evaluation Outcome 1: Antero-Posterior (AP) versus Postero-Anterior (PA) projection Outcome 2: Assessing the patient. Outcome 3: Radiation protection Outcome 4: Positioning of the patient and x-ray tube					Post processing: Outcome 4: Positioning of the patient and x-ray tube –resultant image Outcome 5: Image Critique						Supervising Radiographer: Initial and comment
		Mobility: Chair Trolley Or Bed/ Assisted/ unassisted	ID check complete Yes/ No	Correct use of AP Erect CXR Projection Yes/ No	Positioning of patient Yes/ No	Positioning of x-ray tube/ centering Yes/ No	Collimation Yes/ No	Anatomical marker placed within primary beam Yes/ No	Adequate inspiration Yes/ No	Adequate exposure Yes/ No	Pathology recognised. Yes/ No	Artefacts Yes/ No	Additional / repeat view? Yes/ No	
1														
2														
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CASE	DATE	AP ERECT CHEST	Technical evaluation Outcome 1: Antero-Posterior (AP) versus Postero-Anterior (PA) projection Outcome 2: Assessing the patient. Outcome 3: Radiation protection Outcome 4: Positioning of the patient and x-ray tube					Post processing: Outcome 4: Positioning of the patient and x-ray tube –resultant image Outcome 5: Image Critique						Supervising Radiographer: Initial and comment
		Mobility: Chair Trolley Or Bed/ Assisted/ unassisted	ID check complete Yes/ No	Correct use of AP Erect CXR Projection Yes/ No	Positioning of patient Yes/ No	Positioning of x-ray tube/ centering Yes/ No	Collimation Yes/ No	Anatomical marker placed within primary beam Yes/ No	Adequate inspiration Yes/ No	Adequate exposure Yes/ No	Pathology recognised. Yes/ No	Artefacts Yes/ No	Additional / repeat view? Yes/ No	

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RECORD/ TALLY OF COMPLETE AP ERECT CXR EXAMINATIONS

MOBILITY	OBSERVED	ASSISTED	UNASSISTED	STAGED ASSESSMENT
CHAIR				
TROLLEY				
BED				

ASSISTANT PRACTIONER AP ERECT CXR STAGED ASSESSMENT FORM

PREPARATION	YES/ NO
Understanding of medical terms and clinical questions on CXR request?	
Checked for recent imaging	
PATIENT CARE	**YES/ NO**
3 point identification check	
LMP (if appropriate)	
Verify correct examination requested	
Removal of clothing/ jewellery artefacts for this view	
Consideration of patient mobility	
Adhere to moving and handling procedures	
Adhere to infection control protocols	
Maintain patient dignity throughout the examination	
PROCEDURE	**YES/ NO**
Appropriate selection of exposure factors, making adjustments where required?	
Positioning- optimal erect patient position?	
Appropriate caudal angulation of x-ray tube for AP Erect CXR	
Radiation protection considerations/ ALARP?	
Communicated appropriately with patient	
Communicated appropriately with family members/ carers	
Communicated appropriately with other staff?	
Provided correct post examination information?	

RADIOGRAPHIC TECHNIQUE	YES/ NO
Patient ID present and correct	
Correct radiographic markers and other necessary annotation?	
Appropriate region of interest and collimation?	
Artefact present?	
Accurate position of x-ray tube?	
Need for additional or repeat projections?	
GENERAL PERFORMANCE	**YES/ NO**
Professional manner	
Sought additional assistance when necessary?	
Compliance with IR(ME)R 2017?	
Automatic fails indicated with asterisk (*)	
Collation: Total number of Yes / 27 X 100 = ___ % for example, 23 / 27 X 100 = 85% **Pass rate = 80% or greater**	
Result:	
Outcome (Pass/Fail):	
Signature of Assessor:	
Signature of Assistant Practitioner:	
Date:	

A PASS IS REQUIRED IN ALL 3 STAGED ASSESMENTS TO COMPLETE THE PRACTICAL ASSESMENT

REFLECTIVE REPORT FOR ASSISTANT PRACTITIONER

What did I learn that I can put into clinical practice?	
What went well in the training module to perform AP Erect Chest X-rays?	
What could have been done differently?	
Feedback from supervising Radiographer	
Assistant Practitioner Name/ date	
Supervising Mentor Name/ date	