ANZCA
FPM

Australian College of Rural & Remote Medicine

RACGP
Royal Australian College of General Practitioners

Rural Generalist Anaesthesia

Handbook for training

Table of contents

Introduction

The Australian and New Zealand College of Anaesthetists (ANZCA), the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) are the professional organisations in Australia that, together, are responsible for the education, training, and assessment of rural general practitioners and rural generalists providing anaesthesia services in rural locations.

The Rural Generalist Anaesthesia training program is governed by the Tripartite Committee of Rural Generalist Anaesthesia ("tripartite committee"). ANZCA, RACGP and ACRRM are all members of this tripartite committee.

The aim of the Rural Generalist Anaesthesia (RGA) training program is to produce competent rural generalist anaesthetists (RGAs) who can deliver safe and timely anaesthesia, perioperative care and critical care to rural and remote Australians.

Since 1994, the training and standards for RGAs has been defined and certified by the Joint Consultative Committee on Anaesthesia (JCCA). The JCCA has served rural and remote communities exceptionally well, however it needed a structural and educational overhaul, hence the new qualification.

The RGA training program is a contemporary qualification using up to date educational methods designed to provide standardised training so that jurisdictional credentialing bodies and rural patients can be assured of a minimum standard of quality anaesthesia care by RGA holders. The RGA training program is a fit-for-purpose, Australian Medical Council accreditable qualification focussed on delivering a quality, standardised level of care for rural and remote Australians.

1. Getting started

1.1. Registering for RGA training

1.1.1. Recommended prior learning and experience

It is recommended that potential RGA trainees complete 2 years of their primary fellowship training and at least 6 months non-anaesthesia experience in rural practice prior to commencing RGA training. Ideally, RGA training will be completed toward the end of primary fellowship training or post fellowship to ensure currency of skills continues into specialist practice. Recommended experience includes:

- Experience in rural generalist practice.
- Knowledge and skills in managing paediatric patients (refer to RACGP or ACRRM primary Fellowship requirements).
- Knowledge and skills in the management of critically ill patients such as:
    - 10 weeks FTE clinical experience in intensive care medicine; or
    - 10 weeks FTE clinical experience in emergency medicine and completion of a course which covers essential and fundamental aspects of Intensive Care; or
    - a combination of clinical experience and education which demonstrates achievement of intensive care medicine learning.

To be eligible for registration into the Advanced Certificate of Rural Generalist Anaesthesia Training Program, applicants may be trainees of ACRRM and/or RACGP or have completed their fellowship with their primary college.

1.1.2. Registration for current trainees of RACGP or ACRRM

Medical practitioners who are current trainees of RACGP or ACRRM wishing to undertake the rural generalist anaesthesia (RGA) training program must:

- have obtained a position suitable for RGA training through their primary college. The primary college will then notify ANZCA of these individuals. (Do not apply directly to ANZCA.); and
- have current advanced life support 2 (ALS2) certification prior to commencing RGA training; and
- have completed at least one year of their primary fellowship training.

The primary college will send ANZCA a list of prospective trainees and all documentation required for registration as a RGA trainee. ANZCA will send confirmation of registration to trainees once this process is complete.

1.1.3. Registration for medical practitioners who have completed fellowship of their primary college

To register for training, applicants must:

- register for RGA training directly with ANZCA
- have completed their fellowship with RACGP and/or ACRRM; and
- have obtained a position approved for RGA training; and
- have a current ALS2 certification.

1.2. Trainee selection

ANZCA does not appoint trainees to accredited RGA training positions. Appointment is undertaken by the employer. Refer to your primary college website for information about selection criteria and processes.

1.3. Change of name

If the doctor's name has been changed from that on the documents, a certified copy of the evidence of change of name must be provided.

1.4. Recording training

During training, trainees are required to log their training experiences in ANZCA training ePortfolio system ("the ePortfolio"). The ePortfolio is an online portfolio system for the RGA training program which allows trainees and supervisors of training (SOT) to record and track progress throughout training. RGA workplace-based assessment (WBA) assessors will also have access to complete WBAs.

Trainees can access the ePortfolio from the start of RGA training and are responsible for ensuring information within it is kept up to date and accurate. Trainees should enter their training experiences within four weeks of completing the experience. Any experiences not recorded may be marked as leave or interrupted training.

Once an Entrustable Professional Activity (EPA) has been signed off, no training event recorded in that EPA can be altered.

The ePortfolio support resources are available on ANZCA website. Queries regarding the ePortfolio can be sent to ANZCA via rga@anzca.edu.au.

Data privacy on the ePortfolio

Collecting patient information has important implications:

- Trainees and SOT should be familiar with relevant privacy legislation. Appropriate consent must be obtained or approved.
- Patient data recorded in the ePortfolio must be de-identified.
- Any patient information recorded in the cases and procedures section must comply with the individual's or hospital's privacy statement, or the patient must have given their consent.

It is also important to note that any reflective comments in the ePortfolio may have potential medico-legal implications.

Time spent completing mandatory courses may be recorded as clinical anaesthesia time in the ePortfolio. Time spent travelling to and from mandatory courses and time spent completing non-mandatory courses should be recorded as leave in the ePortfolio.

1.5. Fee structure

The RGA training fee structure is outlined in regulation 44.18.

For active trainees of RACGP or ACRRM, all training fees for the first 52 weeks FTE, except the examination fees, will be paid to ANZCA by the primary college. Any additional training fees must be paid directly to ANZCA by the trainee.

Medical practitioners who are not active trainees of RACGP or ACRRM should refer to ANZCA website for information on fees.

1.5.1. Examination fees

The multiple-choice question (MCQ) examination fee must be paid at the time of application to sit the examination. This is a one-off fee that allows multiple attempts at the MCQ examination.

The Rural Generalist Anaesthesia Standardised Structured Scenario-based Assessment (RGA-SSSA) fee must be paid at the time of application to sit the examination.

RGA trainees are responsible for paying all examination fees.

The examination withdrawal fee will apply to trainees withdrawing from an examination, as specified in regulation 44.13.2.8.3 and regulation 44.13.3.9.

1.6. Recognition of prior learning and experience

Recognition of prior learning and experience (RPLE) is a process to acknowledge previously completed anaesthesia training that is comparable and relevant to RGA training and the required competencies. This may then be used to gain credit towards the requirements of RGA training.

1.6.1. Principles and eligibility

The RGA is a qualification for rural GP anaesthetists. As such, RPLE applications will only be accepted from fellows or trainees of RACGP or ACRRM who are registered as RGA trainees.

Earlier preliminary assessment is also available for those not yet registered as RGA trainees but are applying or considering applying for RGA training.

Any training performed more than 3-years previously must have had the knowledge and skills gained from the training maintained via ongoing caseload, upskilling attachments, and continuing professional development (CPD).

Rural context is an important part of RGA training, so this will also be assessed before any credits are awarded. Rural context is defined as working in a location as defined by Modified Monash Model 3 -7.

Training submitted for RPLE consideration must meet the following prerequisites:

- Completed in a recognised anaesthesia training department and been part of a recognised anaesthesia training program. Other non-anaesthesia critical care specialty training, such as intensive care medicine, emergency medicine and retrieval medicine, will not be considered for RPLE.
- Performed at anaesthesia registrar/principal house officer or above level. Resident terms, within Australia or New Zealand, will not be considered.
- Comparable with RGA training and the competency outcomes (ACRRM core training anaesthesia requirements will not be considered).

1.6.2. Applying for a preliminary assessment

Medical practitioners who are fellows, trainees or intending trainees of ACRRM or RACGP and are considering applying for RGA training may apply for a preliminary RPLE assessment of their previous experience. This provides an indication of likely RPLE approvals, which can be useful for planning RGA training time. A non-refundable preliminary assessment fee will apply. Upon subsequent registration as a RGA trainee, the preliminary RPLE is formalised, and the remainder of the recognition of prior learning fee will be charged.

1.6.3. Application Process

To apply for RPLE, applicants must:

- Complete the RPLE application form.
- Provide the required documentation and evidence to support your application:

- Copy of any qualifications achieved.
- Training time – a supporting letter on hospital letterhead.
- Volume of practice and workplace-based assessments – extract of your electronic logbook or certificate/letter stating training or experience completed.
- Courses - certificates for advanced life support, early management of severe trauma, effective management of anaesthetic crises, advanced paediatric life support, can't intubate, can't oxygenate, neonatal resuscitation.
- Multiple-choice question (MCQ) examination – certificate of completion of appropriate examination e.g., ANZCA initial assessment of anaesthesia competence MCQ exam, primary examination or equivalent.
- Entrustable professional activity (EPA) equivalents sign off – A supporting letter from the clinical supervisor of the training confirming competence achieved meets expectations of any RGA EPAs that RPLE is being applied for. If applying for RPLE for the paediatric and obstetric analgesia EPAs where there is a volume of practice requirement, paediatric numbers identifying those in the 5 to 10-year-old age group and epidural numbers must be included in the logbook or the clinical supervisor's letter.

- If the training was more than three years previous, evidence that the knowledge and skills acquired during the training have been maintained, for example:
  - logbook of cases in the last two years
  - anaesthesia relevant CPD for the last three years
  - evidence of any upskilling attachments.
- Evidence of any anaesthesia training or anaesthesia experience in a rural context as defined by Modified Monash Model 3-7.
- Pay the RPLE application fee.

1.6.4. Outcomes

RPLE applications will be assessed on an individual basis by ANZCA Director of Professional Affairs (DPA) assessor.

Possible credits include:

- Time credits: a maximum of 26 weeks credit. In exceptional circumstances additional credit may be considered.
- Credits for EPAs: credit for all EPAs is possible with appropriate evidence.
- Credit for multisource feedback (MsF): evidence for a MsF in anaesthesia must be provided.

- Examination credit: credit for the MCQ will be considered with evidence. Credit for the RGA standarised structured scenario-based assessment will not be considered.

1.7. Academic honesty and plagiarism

ANZCA upholds the highest standards of academic integrity. Academic dishonesty will not be tolerated. Substantiated academic dishonesty will result in referral to the primary college.

1.8. Privacy

As outlined in the training agreements, ANZCA collects and holds personal information from individuals when it is reasonably necessary for the performance of college functions and activities. This information is used for administering registration, training and examinations. De-identified information may be used for internal monitoring, evaluation and audit purposes. The information collected and held will not be disclosed to third parties except as required by law.

The reasons for collecting the information and how it is used are outlined in ANZCA's privacy policy.

2. Training program requirements

Duration	Competency-based. Minimum duration 52 weeks FTE anaesthesia time (including up to 8 weeks leave). Maximum duration for completion is 2 years (excluding any period of interrupted training).			
Approximate timing	**1-3 months**	**4-6 months**	**7-9 months**	**10-12 months**
Curriculum – Primary Focus	RGA Roles in Practice			
	Airway Management Perioperative Medicine Obstetric Analgesia	GA and Sedation Pain Medicine Regional Anaesthesia	Paediatrics Obstetric Anaesthesia and Analgesia	
		Resuscitation, Trauma and Crisis Management Safety and Quality in Anaesthesia Practice		
Targeted Learning (within EPAs)		Can't Intubate, Can't Oxygenate (CICO) Cardiac Arrest	Paediatric Life Support Neonatal Resuscitation	
Formative workplace-based assessment	Patient Consultation Observation (PCO) Direct Observation of Procedural Skills (DOPS) Mini Clinical Evaluation Exercise (Mini CEX) Case based Discussion (CbD)			
		Multi Source Feedback		
Entrustable Professional Activities (EPAs)	EPA 1 – Assess patients for elective surgery EPA 2 – Provide epidural analgesia for patients in labour	EPA 3 – Provide general anaesthesia to stable ASA 1 and 2 patients	EPA 5 – Anaesthetise or sedate adults in the rural or remote context, including emergencies EPA 6 – Anaesthetise children 5 years and over in the rural or remote context, including emergencies EPA 7 – Provide obstetric analgesia and anaesthesia	
		EPA 4 – Provide perioperative pain relief for patients		
Summative Assessment		Successful completion of MCQ Examination		Successful completion of RGA-SSSA
Monitoring and Review	Interim Review (approx.6 weeks) Progress Review and Plan EPA completion	Progress Review and Plan EPA Completion and MSF	Progress Review and Plan Progress with remaining EPAs	Progress Review and Plan EPA Completion Completion of training Review

2.1. Clinical experience

Trainees must complete a minimum of 52 weeks full time equivalent (FTE) training in clinical anaesthesia in a unit accredited for ANZCA RGA training. This may include up to 8 weeks FTE leave. Clinical anaesthesia time may include preadmission clinic, acute pain rounds, and perioperative medicine clinics or rounds. Time spent in retrieval medicine, outpatient pain clinic work, allergy clinic, clinical support time, administration sessions and intensive care sessions should be recorded as leave or interrupted training.

All reference to duration is FTE which is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours.

Trainees are encouraged to gain clinical anaesthesia experience in a rural hospital not accredited for RGA training. Ideally this should be a cumulative period of 2 – 4 weeks. Arrangements should be made with the supervisor of training (SOT) to ensure trainees continue to work towards the requirements of the training program and have appropriate supervision during this time. If this experience is to be completed in a hospital that is not accredited for RGA training, the trainee must inform ANZCA.

2.2. Leave

Leave consists of all time not spent in clinical anaesthesia training and includes annual leave, bereavement leave, sick leave, parental leave, study leave, examination leave, industrial action and any non-anaesthesia time (including intensive care medicine). Leave taken in excess of that allowed will not count towards training time.

Leave from RGA training for longer than 13 calendar weeks requires that the trainee participates in a trainee re-entry to practice program as outlined in section 3.2.

2.3. Progress Review and Planning

It is each trainee's responsibility to ensure that Progress Review and Planning occurs as part of their training.

There are three types of review and planning:

- **Training Plan**: must be completed within the first two calendar weeks of starting training.
- **Progress Review and Plan Meeting**: Conducted approximately every 13 calendar weeks.
- **Interim Progress Review**: as required. Suggested within the first six calendar weeks.
- **Final Progress Review:** conducted once all RGA training program requirements are completed.

Time management is an essential component of training. This includes allocating appropriate time to acquire the knowledge, skills and attitudes associated with the training program. Trainees should take into account their abilities and the opportunities available to them.

All progress review and plan meetings are mandatory. Trainees who do not complete these within 4 calendar weeks of the end date of the period will be deemed to be in interrupted training. If it is anticipated that leave may make one of these reviews difficult or impossible an alternative plan to ensure feedback and progress should be worked out before the due date.

2.3.1. Training Plan

The training plan must be completed by the trainee in consultation with their supervisor in the first 2 weeks in the program. It is intended as a guide for completion of the training program:

When developing the training plan the trainee and their supervisor should:

- be familiar with the learning outcomes of the RGA training program.
- identify the trainees learning needs including the specific knowledge, skills and attitudes they need to acquire.
- focus on the workplace-based assessments and volume of practice the trainee will complete during each entrustable professional activity (EPA).

The plan should be based upon the trainee's current practice and learning style. Trainees should consider their plan and revise it as necessary. Revisions can be added in subsequent progress reviews.

2.3.2. Progress Review and Plan Meetings

The progress review and plan meetings must occur every 13 calendar weeks. These meetings are to review the trainee's progress in the training program, identify barriers to completion of requirements and set goals for the next period. This is the opportunity for the trainee to receive regular structured feedback on their performance.

Trainees must ensure all compulsory reviews are scheduled and the relevant form completed. The review of performance and progress is an important part of ensuring trainees can achieve the qualification.

Preparation for the 26-week review meeting is particularly important as trainees need to ensure they have met the requirements of EPAs 1-3, as well as having completed the multisource feedback (MsF) and multiple-choice question (MCQ) exam. It should include an assessment of their ability to complete the program in 52 weeks as this may have employment considerations.

Self-assessment is an essential skill for effective medical practitioners. Self- assessment is periodic self-review by the trainee in order to improve their ability as an RGA. It is extremely valuable for trainees to develop this skill during training as it is a critical part of continuing professional development. In its simplest form, self-assessment requires the trainee to ask:

- What were my goals for the last 13 weeks?
- Which goals did I achieve?
- What goals did I not achieve? why? how could i address this in the future?
- What are my strengths?
- What areas do I need help with?
- What are my goals for the next 13 weeks?

With practice, self-assessment becomes intuitive and can be performed more effectively.

2.3.3. Interim Progress Review

During training, interim progress reviews can occur at any point for trainees who require additional support or who are seeking further feedback. This may be initiated by either the trainee or supervisor of training.

An interim progress review should be conducted at 6 calendar weeks. This is to ensure the trainee is engaging with workplace-based assessments and demonstrating some progress. The training plan may be updated, and other actions agreed to should be documented in the ePortfolio.

2.3.4. Final Progress Review

The final progress review is an assessment conducted by the supervisor of training at the end of RGA training. This is to confirm that the trainee has completed all requirements of the RGA training program.

Depending on the timing of completion of training, the final progress review may coincide with the entrustable professional activity sign off.

2.4. Time limit on training completion

All training requirements must be completed within 104 weeks FTE of the date of commencement of training. Any time spent in interrupted training will not count towards the 104 weeks FTE to complete. The qualification will not be awarded until the pre-requisite fellowship has been awarded, see section 2.9.

2.5. Clinical supervision in the workplace

Any FANZCA, RGA holder, credentialed rural generalist anaesthetists or ANZCA provisional fellow within a department can supervise RGA trainees' clinical work. The role of the supervisor of training is outlined in section 4.2.

Four levels of supervision are recognised for RGA training:

Level 1 - the trainee needs the supervisor to be able to intervene immediately

Requires the trainee to:

- Negotiate with the supervisor what role they will have in the case
- Know the location of the supervisor and how to get their immediate help
- Only undertake significant interventions with the supervisor's knowledge

All trainees must be supervised at level 1 in any area in which they are unfamiliar.

Requires the supervisor to be:

- Exclusively available to that trainee, with no other duties, and immediately able to provide assistance or assume direct patient care
- Usually present, remains physically close so able to attend and intervene within 1-2 minutes if briefly absent
- Fully aware of the details of the case or procedure and the anaesthesia plan, its progress and the dynamic situation

Level 2 - the trainee needs the supervisor to be able to intervene quickly

Requires the trainee to:

- Know how to contact the supervisor for assistance or advice
- Be able to initiate management of a complication or change in patient condition
- Be aware of their limitations and the need for help

Requires the supervisor to be:

- Available without delay, undertaking other duties only if it is anticipated that they can be immediately abandoned
- In relatively close proximity so can attend and intervene within 5 minutes
- Fully aware of the details of the case or procedure and the anaesthesia plan
- Level 2 supervision can be provided to one or two trainees

Level 3 – the trainee needs the supervisor to be available on site

Requires the trainee to:

- Know who the supervisor is and how to contact them
- Know how to manage a complication or change in patient condition and be able to commence and continue treatment until help arrives
- Recognise patient, anaesthetic and surgical factors that increase risk to inform decisions about planning and the need for help

Requires the supervisor to be:

- Available to a trainee after only a short delay and always available for consultation
- Within the same institution so no travel is required to attend and intervene
- May be unaware of the case or procedure
- Level 3 supervision can be provided to more than 1 trainee

Level 4 – the trainee can manage the case with the supervisor available off-site

Requires the trainee to:

- Know who the supervisor is and how to contact them
- Be able to manage a complication or change in patient condition, direct others to assist if needed, and continue until the issue is resolved or supervisor help is provided
- Be able to accurately anticipate risk or deterioration

Requires the supervisor to be:

- Always available for consultation and free of commitments that would prevent their attendance if needed
- Exclusively on call for the institution and able to attend within a reasonable travel time, (usually 30mins, dependent on local guidelines)
- May be unaware of the case or procedure

As trainees progress, it is important to encourage greater levels of independence i.e. at supervision levels 3 and 4. Where there is concern about trainee performance the supervisor of training must advise the head of department on appropriate levels of supervision. Please see the *RGA trainee support: a guide for supervisors*, for further information on handling concerns about trainee performance.

Supervision levels, consultation and attendance by consultants must also comply with local department guidelines.

2.6. Assessments

Assessments include skills based and knowledge-based assessments.

Skills are assessed via Direct Observation in the clinical setting using Workplace-Based Assessments (see section 2.6.1) and include Entrustable Professional Activities (see section 2.6.10).

Knowledge is assessed by the multiple-choice question examination (see section 2.6.7.1) and the RGA standardised structured scenario-based assessment (see section 2.6.7.2).

2.6.1. Workplace-based assessments

Workplace-based assessments (WBAs) must be completed as outlined in the RGA training program curriculum ("the RGA curriculum") and The Rural Generalist Anaesthesia Handbook for Training ("the RGA training handbook").

A range of assessors, including FANZCAs and RGAs, should be used to complete WBAs throughout the program.

WBAs provide trainees with regular, structured and actionable feedback to aid learning and development as they progress toward unsupervised practice. WBAs also inform the progress review and plan process and assist supervisors of training (SOTs) to provide meaningful suggestions to trainees, for their progression through training. WBAs foster a culture of feedback and support, while providing transparency for trainees and supervisors of training.

Assessment tools have been matched specifically to the types of learning outcomes (knowledge, skills and attitudes/behaviours). The learning outcomes are mapped to the assessment to ensure trainees engage in the breadth of practice articulated. This promotes learning and ensures that graduates of the program have all the necessary attributes for practice.

The following five WBA tools each have a different focus. They guide trainees to competence in key clinical tasks and assist supervisors of training in monitoring trainee performance and progress:

- patient consultation observation (PCO)
- direct observation of procedural skills (DOPS)
- mini clinical evaluation exercise (Mini CEX)
- case based Discussion (CbD)
- multisource feedback (MsF)

For a WBA (excluding the MSF), a case is defined as any observed interaction with a patient that can be assessed, however short or long. This may focus on a specified component and does not have to cover the complete anaesthetic.

As part of the WBA process, the supervisor will complete an assessment of the level of supervision required by the trainee for a similar case in the future. Using this feedback and their reflections, trainees document specific actions to improve their future anaesthesia practice.

2.6.2. Patient consultation observation

Patient Consultation Observation (PCO) assesses and provides structured feedback about proficiency to communicate with the patient and conduct a structured comprehensive pre-operative assessment of the patient. In developing an appropriate plan, the trainee must seek consent and consider the patient, facility, surgical and personal factors. The trainee then needs to reflect on how these influence planning and the need for transfer to an alternate centre for care and demonstrate provision of cultural competency for cultural safety.

PCO includes the following components:

- **Initial Discussion:** regarding relevant anatomy, indications, contraindications, complications and side-effects, equipment required, patient positioning and monitoring, and consent. It is useful to ask the trainee to outline the relevant factors that will affect the perioperative management of the case. The trainee should be able to articulate and justify an additional investigations or tests ordered and their management plan. Consideration should be given as to whether this discussion should occur in the presence of the patient.
- **Observation:** of the pre-operative assessment.
- **Global assessment:** The supervisor will need to make a global assessment on the level of supervision they believe the trainee requires when conducting a pre-operative assessment. This decision should be based on questioning and direct observation of the trainee's performance. It does not depend on how many times the trainee has completed an assessment or the level of training of the trainee.
- **Feedback:** This is the most important aspect of the process. Feedback conversations should be held between the trainee and WBA assessor as soon after the observation as possible. The setting should be private and free from interruption.

- **Documentation by the supervisor of their observations:** Comments should include sufficient specific detail to allow for later reflection by the trainee and provide SOTs with an understanding of the trainee's performance. Items to provide written feedback on for the PCO include history taking, examination and investigation, risk assessment, patient-centred care and management plans. Identification of good performance as well as areas for improvement is important.

  If the trainee is assessed as still requiring direct supervision, the supervisor is required to provide feedback to the trainee on what they need to do in order to conduct pre-operative assessments without direct supervision.

- **Trainee reflection and comments with development of an action plan:** This will assist the trainee to progress towards independent practice by incorporating feedback and develop their skills for self-reflection and continuous improvement.

2.6.3. Direct observation of procedural skills

Direct observation of procedural skills (DOPS) assesses and provides structured feedback about both knowledge and technical proficiency regarding a discrete procedural skill. The procedure may be done as part of usual clinical work or by simulation (for example, on a part task trainer).

DOPS includes the following components:

- **Initial Discussion:** Regarding relevant anatomy, indications, contraindications, complications and side-effects, equipment required, patient positioning and monitoring, and consent. It is useful to ask the trainee to outline how they will perform the procedure and what precautions they will take, before they start the procedure. Consideration should be given as to whether this discussion should occur in the presence of the patient.

- **Observation:** Of the consent process and the procedure.

- **Global assessment:** The supervisor will need to make a global assessment on the level of supervision they believe the trainee requires when performing the procedure. This decision should be based on questioning and direct observation of the trainee's performance. It does not depend on how many times the trainee has performed the procedure or the level of training of the trainee.

- **Feedback:** This is the most important aspect of the process. Feedback conversations should be held between the trainee and WBA assessor as

soon after the observation as possible. The setting should be private and free from interruption.

- **Documentation by the supervisor of their observations:** Comments should include sufficient specific detail to allow for later reflection by the trainee and provide SOTs with an understanding of the trainee's performance. Items to provide written feedback on for the DOPS include consent and preparation, technical ability, insight and rural context and documentation and post procedure management. Identification of good performance as well as areas for improvement is important.

  If the trainee is assessed as still requiring direct supervision for the procedure the supervisor is required to provide feedback to the trainee on what they need to do in order to do the procedure without direct supervision.

- **Trainee reflection and comments with development of an action plan:** This will assist the trainee to progress towards independent practice by incorporating feedback and develop their skills for self-reflection and continuous improvement.

2.6.4. Mini-clinical evaluation exercise

The mini-clinical evaluation exercise (mini-CEX) provides supervisors and trainees with a structured assessment and feedback format for clinical knowledge (including reasoning and understanding), skills (technical and non- technical) and behaviours related to the trainee's management of a single clinical case.

The trainee and the supervisor should agree on an appropriate case before the assessment starts. The case should be one that the trainee is able to comprehend and manage reasonably without direct intervention by the supervisor (this is referred to as being at the trainee's 'learning edge'). Trainees should be mindful of the need to ask for help as required, and that appropriate guidance seeking will be viewed positively in the assessment. The supervisor should clarify their role, including the circumstances in which they would intervene in the case.

The mini-CEX has six components:

- **Initial Discussion:** Regarding relevant clinical knowledge, understanding and reasoning related to the case. The trainee should be able to articulate and justify a management plan. Consideration should be given as to whether this discussion should occur in the presence of the patient.

- **Observation:** Of the trainee managing the case. It is important that the trainee is ‘in the driver’s seat’. The supervisor may need to intervene from time to time for reasons of safety and work efficiency. The supervisor should record what supervisory interventions were required and why. This forms the basis of the constructive feedback to assist the trainee attain greater autonomy. The supervisor should also note when no intervention was required and discuss this in the feedback.
- **Global assessment:** The supervisor will need to make a global assessment on the level of supervision that the trainee requires when managing the case. This decision should be based on questioning and direct observation of the trainee's performance. It does not depend on how many times the trainee has performed the procedure, or the amount of training completed.
- **Feedback:** This is the most important aspect of the process. Feedback conversations should be held between the trainee and WBA assessor as soon after the observation as possible. The trainee should be encouraged to share their perspectives on their performance. The setting should be private and free from interruption.
- **Documentation by the supervisor of their observations:** This should include specific detail and examples of observations to allow for later reflection by the trainee and provide SOTs with a clear idea of the trainee’s performance. Identification of good performance as well as areas for improvement is important. Items to provide written feedback on for the Mini CEX include planning and preparation, patient interaction, vigilance and decision-making, team interaction and risk minimisation and application to rural contexts.
- **Trainee reflection and comments with development of an action plan:** This will assist the trainee to progress towards independent practice by incorporating feedback and develop their skills for self-reflection and continuous improvement.

2.6.5. Case-based discussion

The case-based discussion (CbD) is primarily designed to assess and coach trainees in the skill of reasoning through discussion of decision-making, interpretation and application of evidence to real clinical cases. It assesses self- reflection and the ability to verbally present a case. It is also an opportunity to assess and give guidance on relevant clinical knowledge, understanding and documentation.

A CbD is particularly useful for cases that the trainee has managed under level 3 or 4 supervision and is a powerful tool for assessing decision-making, particularly during the later stages of training. It is not mandatory for the case to have been managed at level 3 or level 4 supervision as this may not always be possible and there is still value in assessing the trainee's understanding of why the patient was managed in a particular fashion. However, cases done with closer supervision are more appropriate for a mini-CEX.

The CbD has two components:

- **Case selection and de-identification**. The trainee brings copies of the anaesthetic records of at least three cases they have dealt with reasonably independently (ideally at level 3 or 4 supervision) and the supervisor chooses the most appropriate one for discussion.

  Occasionally the SOT may direct a trainee to have a particular case assessed and in this case the trainee needs to take a copy of that specific anaesthetic record along to the assessment.

  All anaesthetic records should be de-identified for privacy and confidentiality reasons.

- **Presentation, discussion, assessment, feedback.**
  - **Presentation:** the trainee presents the case to the supervisor.
  - **Discussion:** the trainee provides the rationale for the decision-making around aspects of the case. This is also an opportunity to explore how the trainee would manage the patient if events unfolded differently, or what issues they might have anticipated for this patient during the procedure.
  - **Global assessment:** the supervisor rates the trainee according to how much prompting is required to demonstrate adequate reasoning and other skills for safe care.
  - **Feedback:** this should be provided at the time of the assessment. It should be specific and constructive in order to guide the trainee on areas they should focus on in future study, and structures they may find helpful for approaching tasks such as formulating plans. Items to provide written feedback on for the CbD are patient assessment, management, reasoning and insight and risk minimisation and rural context.
  - **Trainee reflection and comments with development of an action plan:** this includes what the trainee plans to do in the future as a result of the discussion and feedback that has occurred.

The CbD should only require 10 to 20 minutes of discussion, and the whole process should take 30 to 45 minutes.

Trainees are encouraged to seek both FANZCAs and credentialed RGAs who are external to their training site as assessors for CbDs. CbDs can be conducted virtually. After organising a suitable assessor, the trainee sends de-identified patient notes at least one week in advance of the assessment. Discussing how the case may have been managed differently at an alternate site provides a valuable learning opportunity for the trainee.

2.6.6. Multi-source feedback

The multi-source feedback (MsF) is a formative assessment, which is undertaken at least once during training. A MsF must be completed during the first 6 months FTE of training. The feedback received in the MsF should be considered with feedback included on other WBAs.

The MsF should be completed by both specialist anaesthetists and other team members (for example, surgical registrars and specialists, nursing staff and anaesthesia assistants) with whom the trainee has worked. A minimum of seven feedback forms are required for a reliable assessment.

The trainee is responsible for co-ordinating the distribution of the MsF forms to feedback providers, allowing sufficient time for them to be returned to the supervisor of training (SOT). The SOT can make recommendations on specific supervisors and/or the roles of supervisors (surgeon, theatre nurse, and so on) that must be invited to provide feedback. While the SOT cannot request responses directly from the supervisors, they can delay the collation of feedback until the specified supervisors have been included.

To ensure the minimum seven feedback forms are returned, the trainee should use their judgement on how many forms to circulate, perhaps assuming a response rate of 50 per cent.

The feedback forms are returned to the SOT who reviews and collates the information into summary response for discussion with the trainee. This process ensures confidentiality and allows the SOT to give the trainee a global assessment rather than focusing on individual comments. To ensure validity the supervisor must consider the content of the feedback and the extent to which it represents the desired range of professional / patient groups and their relationship with the trainee. The SOT can also exclude responses that they deem inappropriate but must provide a justification for not including the feedback, for example, inappropriate supervisor such as a fellow registrar who has not worked with the trainee.

It is recommended that the mandatory MsF is undertaken between the 3 and 6 month Progress Review and Plan Meeting. This allows enough time for the feedback providers nominated by the trainee, to have observed them in training and to be able to comment on various aspects of their performance. The MsF outcomes are then discussed with the SOT at the 6-month Progress Review and Plan Meeting.

2.6.6.1. Monitoring of workplace-based assessments

SOTs can monitor performance by reviewing WBAs with the trainee at each Progress Review and Plan Meeting. This will enable the SOT to provide appropriate assistance with the aim of guiding the trainee to complete each EPA.

If trainee performance is not progressing toward Level 4, additional workplace-based assessments (WBAs) should be undertaken to reach that goal. The SOT can request that the trainee completes extra WBAs to assist them in addressing areas where improvements can be made. If the trainee is repeatedly receiving the same feedback in the same area(s) and is unable to demonstrate improvement despite this feedback, it may indicate that they are experiencing difficulty and intervention may be required, see section 3.4.

2.6.7. Examinations

Trainees are required to successfully complete the multiple-choice question examination and the RGA standardised structured scenario-based assessment.

Dates and venue requirements for examinations are available on ANZCA website.

2.6.7.1. Multiple-choice question examination

The purpose of the multiple-choice question (MCQ) examination is to drive early learning on quality and safety in anaesthetic practice. Trainees will have access to have practice questions.

The MCQ examination is mapped to the learning outcomes within the RGA curriculum.

Trainees are permitted a maximum of three attempts at the MCQ examination. Trainees who do not successfully complete the examination within the first 26 weeks FTE of training will be removed from the training program.

Eligibility to sit the MCQ examination

Trainees must be in approved RGA training position at the time of the examination.

Once trainees have submitted an application and paid the examination fee, they will be given access to the MCQ examination platform.

Any trainee seeking exceptions relating to the above examination rules should contact ANZCA DPA assessor via email rga@anzca.edu.au.

Preparation for the MCQ examination

Once registration as an RGA trainee is completed trainees will be able access a practice question bank. Trainees can work through as many of the questions in the question bank, as they wish.

Results

Candidates are advised of their examination results at the completion of the examination via the online examination portal.

Examination failure

The SOT will be notified of trainees who fail on their first attempt. For trainees who fail on their second attempt, a trainee support process will be initiated, as per section 3.4. Trainees who fail the examination for the third time will be removed from the training program.

2.6.7.2. Rural generalist anaesthesia standardised structure scenario-based assessment

The focus of the Rural Generalist Anaesthesia Standardised Structure Scenario-based Assessment (RGA-SSSA) is on the practical integration and application of knowledge in clinical practice, with a focus on RGA practice in the rural and remote context. RGA-SSSA is mapped to the learning outcomes within the RGA curriculum.

The RGA-SSSA is normally held twice a year. Examiners will be centrally located, and trainees will be invigilated at their location.

The RGA-SSSA consists of 8 scenarios which assess knowledge and clinical judgement.

Trainees are permitted a maximum of three attempts at the RGA-SSSA as per regulation 44.13.3.6.

Eligibility to sit the RGA-SSSA

Trainees are eligible to sit the RGA-SSSA once they have successfully completed:

- at least 26 weeks FTE of approved clinical anaesthesia time.
- EPAs 1 – 4 and have commenced the remaining entrustable professional activities (EPAs).
- successfully completed the multiple-choice question examination.

Trainees must be in an approved training position at the time of their first examination attempt.

Trainees must submit an application form and pay the examination fee prior to the closing date.

Trainees who have had one unsuccessful attempt at the RGA-SSSA may apply for a second or third attempt if they will have completed all EPAs at the time of their second or third attempt.

Any trainee seeking exceptions relating to the above examination rules should contact ANZCA DPA (assessor) via email rga@anzca.edu.au.

Preparation for the RGA-SSSA

Trainees are strongly advised to have a structured approach to exam preparation and to pay particular attention to time management, study skills and study environment.

Many trainees benefit from participation in formal or informal study groups with other examination candidates. The formation of these groups can be facilitated by local supervisors of training and may include trainees from different hospitals to ensure sufficient numbers to form an effective study group.

Trainees are encouraged to discuss their exam preparations with their supervisor at the progress review and plan meetings.

RGA-SSSA withdrawal

Any candidate who withdraws their application in writing, before the closing date of the RGA-SSSA, is entitled to a full refund of their application fee.

Candidates who withdraw from an RGA-SSSA during the interval between the closing date for applications and up to 15 days before the date of the RGA-SSSA will incur a withdrawal fee and the balance of the RGA-SSSA fee may be refunded.

Candidates who withdraw from an RGA-SSSA 14 or fewer days before the RGA-SSSA will not receive a refund of the RGA-SSSA fee, unless ANZCA determines otherwise.

A candidate may also withdraw on medical or compassionate grounds before the RGA-SSSA date by making a written application.

Results

To achieve a pass in the RGA-SSSA the candidate must meet the minimum standards required by the examination.

All candidates will be notified of their results as soon as possible after the examination.

Examination failure and feedback process

Trainees who are unsuccessful at their first attempt at the examination will trigger a trainee support process. Trainees who are unsuccessful on their third attempt at the examination will be removed from the training program.

Examination reports will be made available after each RGA-SSSA. Trainees are encouraged to review the exam reports and the exam feedback received with their supervisor of training (SOT).

It is strongly recommended that trainees who are close to completing other requirements but have not yet passed the examination should discuss their situation with their SOT and seek mentorship.

2.6.8. Special consideration at examinations

Refer to Special Consideration Policy. This policy applies to formally scheduled summative assessments (including examinations) and mandatory scheduled workshops that can't be altered.

Any candidate may withdraw his or her examination application in writing, before the date of the examination (regulation 36.17.4). A candidate may withdraw on medical or compassionate grounds before the examination. If, on medical or compassionate grounds, a candidate is unable on the day to present for the examination, he or she must submit a written notice and provide evidence of cause.

Candidates should not be disadvantaged as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken that might be held to be unfair to other candidates. If an examiner or invigilator becomes aware that a candidate is ill, he or she should notify the chair of the court, who will determine whether the illness is incapacitating and, if appropriate, will reschedule the candidate's program within the examination or advise the candidate to withdraw. No special consideration will be given to a candidate who elects against advice to continue with the examination.

2.6.9. Entrustable Professional Activities

Completion of an Entrustable Professional Activity (EPA) requires a trainee to demonstrate the required competency to independently perform an activity unsupervised. They are a method of translating the competencies from various sections of the curriculum into clinical practice.

EPAs:

- combine with workplace-based assessment as evidence of ability to complete specific clinical activities.
- guide trainees and supervisors on the skills and knowledge needed to demonstrate competency.
- assess trainees' ability to apply knowledge and integrate the RGA Roles in Practice.
- provide a measure of progress.

During the training program, trainees must complete a total of seven EPAs:

EPA 1 - Assess patients for elective surgery

A portfolio of evidence demonstrating competence must include the following:

- Patient Consultation – preoperative assessment of an ASA 1 or 2 patient
- Case based Discussion – anaesthesia management plan for a patient with comorbidities who requires low risk elective surgery

EPA 2 - Provide obstetric epidural analgesia

A portfolio of evidence demonstrating competence must include the following:

- DOPS – epidural analgesia for labour and delivery
- Case based Discussion – initial management of complications (e.g. inadequate block, dural puncture)

EPA 3 - Provide general anaesthesia to stable ASA 1 and 2 patients

A portfolio of evidence demonstrating competence must include the following:

- DOPS – bag-mask ventilation and insertion of an LMA
- DOPS – airway intubation
- Mini-CEX – GA / RSI in ASA 1 or 2 patient
- DOPS – anaesthetic machine check
- Completed a CICO course

EPA 4 - Provide perioperative pain relief for patients

A portfolio of evidence demonstrating competence must include the following:

- Patient Consultation Observation - assessment of a patient with acute pain in the perioperative context
- Case based Discussion – development and implementation of a perioperative pain management plan with pre-existing chronic pain, opioid tolerance and/or addiction.

EPA 5 - Anaesthetise or sedate adult patients in the rural and remote context, including emergencies

A portfolio of evidence demonstrating competence must include the following:

- Mini-CEX – procedural sedation for an adult patient
- DOPS – spinal anaesthesia for a non obstetric adult patient
- Case based Discussion – the three cases provided by the trainee must include
    - GA for a stable ASA 3 patient (Assessor can use this case to discuss a hypothetical perioperative crisis); and
    - GA a critically ill patient unfasted patient requiring emergency surgery.

EPA 6 - Anaesthetise children 5 years and over in the rural and remote context, including emergencies

A portfolio of evidence demonstrating competence must include the following on paediatric cases with patients aged 5-10 years:

- Patient Consultation Observation – preoperative assessment
- Mini CEX – gas induction and insertion of airway
- Mini-CEX – IV induction on an emergency case
- Case based Discussion – the three cases provided by the trainee must include:

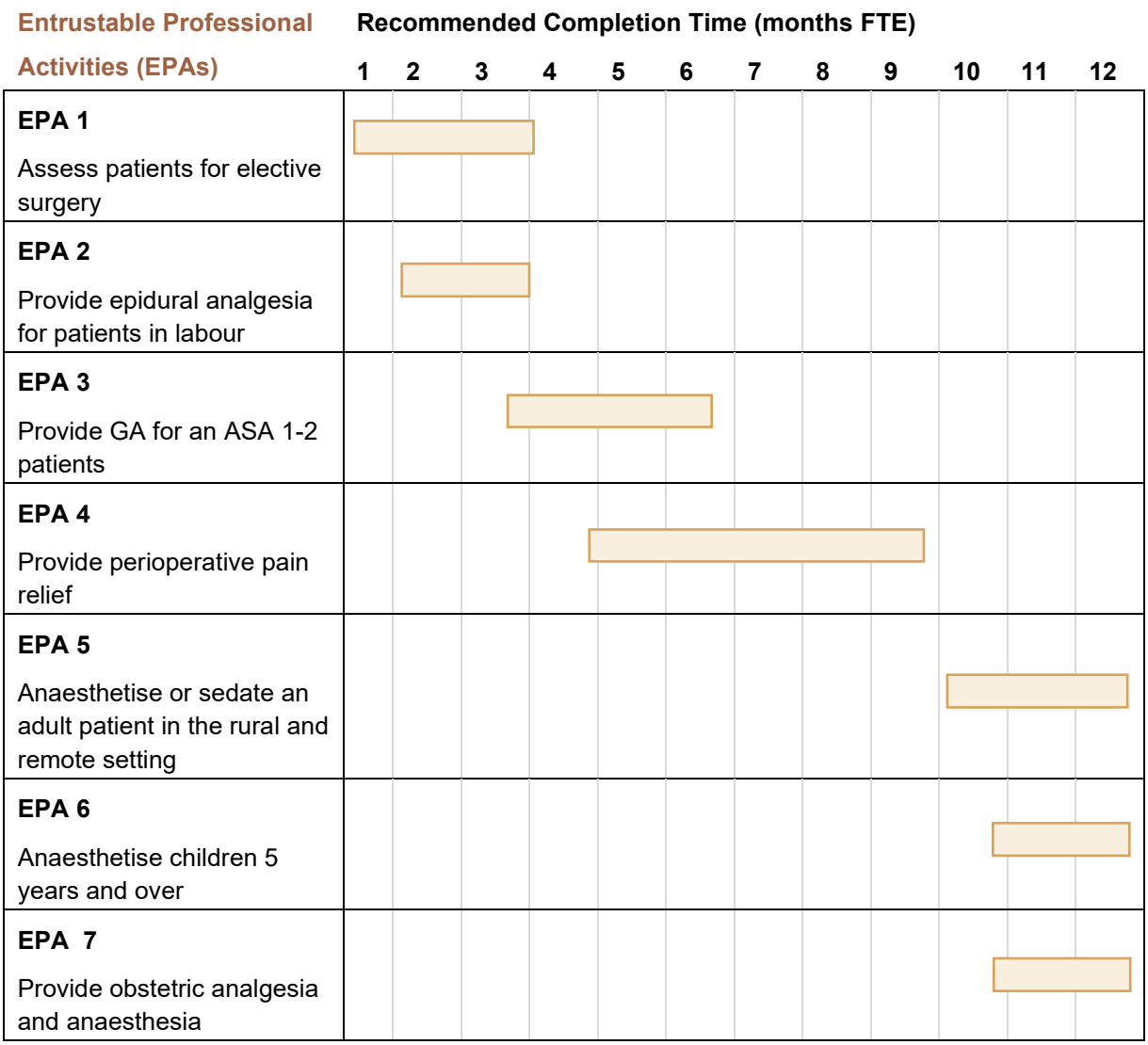
    - management of anaesthesia for elective surgery for a paediatric patient
    - emergency surgery or procedure for a paediatric patient.
- Logged 30 paediatric anaesthetic cases with patients aged 5-10 years
- Completed a paediatric life support course

EPA 7 - Provide obstetric anaesthesia and analgesia

A portfolio of evidence demonstrating competence must include the following:

- Mini-CEX – neuraxial block for a caesarean birth
- Case based Discussion - general anaesthesia for caesarean birth
- Case based Discussion – the three cases provided by the trainee must include:
    - an obstetric emergency case (or one which would have normally been transferred to a larger facility)
    - an elective obstetric case that may have had complications
- Logged 30 labour epidurals subsequent to completing EPA 2
- Completed a neonatal resuscitation course

The recommended timing for completion is provided in the following figure.



Once the trainee feels competent and has completed all requirements they can request 'sign off' for the EPA. Two supervisors of training must review the evidence and confirm entrustment. If there is only one SOT in the department, the trainee may seek an SOT from another hospital for EPA sign off. The trainee needs to meet with each supervisor of training to sign off the EPA. This can occur at any time, or during a Progress Review and Plan meeting. Further information on the requirements to complete each EPA can be found on the ANZCA website.

2.7. Courses

Trainees are required to complete the following courses:

- management of Can't Intubate, Can't Oxygenate (CICO)
- Paediatric Life Support
- neonatal resuscitation
- ANZCA online Perioperative Anaphylaxis Response

The following guidelines are provided:

- so that local courses/workshops can be developed
- so that a Supervisor of Training, ANZCA Fellow or RGA holder can create an individual learning session in accordance with stated learning objectives
- to determine whether a hospital course is appropriate, and attendance and participation may be used for sign-off (for example, one conducted by another hospital department)
- to determine if an external course the trainee has completed is suitable for sign off.

2.7.1. Management of Can't Intubate, Can't Oxygenate

A Can't Intubate, Can't Oxygenate (CICO) course or equivalent must be completed during RGA training, prior to the completion of enstrustable professional activity 3.

This course is designed to meet the learning outcomes of the RGA curriculum in relation to CICO situations. Alternatively, trainees may complete an ANZCA CICO practical simulation session or workshop that has been recognised as a valid activity for satisfying the CPD requirement for the management of 'can't intubate, can't oxygenate'.

2.7.1.1. Definitions and terms

No universally agreed definitions exist for much of the nomenclature around CICO. For the purposes of clarifying terms that are used below, the following definitions are provided. Alternative definitions may be used in CICO sessions however, providers should make note of the equivalent meaning.

2.7.1.2. Can't Intubate Can't Oxygenate (CICO)

Where airway obstruction exists in the upper airway (including the larynx) that cannot be relieved by airway management interventions delivered above the point of obstruction (i.e.: supraglottic), and which results in an inability to oxygenate the patient with low or falling oxygen saturations.

2.7.1.3. Infraglottic airway access / Front-of-neck access

Airway management techniques performed below the larynx via the anterior surface of the neck aimed to maintain or restore airway patency. This includes techniques such as needle or surgical cricothyroidotomy or tracheostomy.

- Lead Facilitator:

  The doctor who conducts the CICO course. Needs to be appropriately skilled and experienced to deliver the content of the session. Ideally the lead facilitator will have medical education experience and/or credentials. A lead facilitator should be present for the full duration of a course.

- Instructor:

  A doctor with relevant anaesthesia skills and experience who conducts the individual “hands-on” skills stations/scenario rehearsals with guidance from the lead facilitator. Ideally the instructors will have medical education experience and/or credentials.

2.7.1.4. Recognised emergency algorithms

ANZCA does not endorse any one emergency algorithm for CICO situations but recognises the need for clinicians to be familiar with at least one. The following algorithms are recommended as being suitable for use in infraglottic airway access / front-of-neck access and should be read in conjunction with the accompanying background articles:

- Frerk C, Mitchell VS, McNarry AF, Mendonca C, Bhagrath R, Patel A, O’Sullivan EP, Woodall NM, and Ahmad I, Difficult Airway Society intubation guidelines working group. Difficult Airway Society 2015 guidelines for management of unanticipated difficult intubation in adults. British Journal of Anaesthesia. 2015 115 (6): 827–848.
- CICV Algorithm. Heard AM, Green RJ, Eakins P. The formulation and introduction of a 'can't intubate, can't ventilate' algorithm into clinical practice. *Anaesthesia*. 2009; 64(6):601-8.
- Greenland KB, Acott C, Segal R, Goulding G, Riley RH and Merry AF. 2011. Emergency surgical airway in life-threatening acute airway emergencies – why are we so reluctant to do it? *Anaesthetic Intensive Care* 39(4): 578-584
- Heard A. Percutaneous Emergency Oxygenation Strategies in the “Can’t Intubate, Can’t Oxygenate” Scenario.
- Canadian Difficult Airway Focus Group. Law J et al. The difficult airway with recommendations for management – Part 1 – Difficult tracheal intubation encountered in an unconscious/induced patient. *Canadian Journal Anaesthesia*. 2013 (60): 1089-1118.
- Chrimes N, Fritz P. The vortex approach: management of the unanticipated difficult airway http://vortexapproach.com
- Transition from supraglottic to infraglottic rescue in the “can’t intubate can’t oxygenate” (CICO) scenario. Report from

ANZCA Airway Management Group, Nov 2014. http://anzca.edu.au/Front-page-news/Transition-to-CICO-report

- ANZCA professional document – PS61 Guidelines for the Management for Evolving Airway Obstruction: Transition to the Can't Intubate Can't Oxygenate Airway Emergency. April 2016. http://www.anzca.edu.au/Resources/Professional-documents

2.7.1.5. Learning objectives

The primary purpose of this course is to teach the technical skill of infraglottic airway access/front-of-neck access. As a minimum, courses must provide the opportunity for participants to meet the learning objectives listed below.

By the end of the course, participants will be able to:

- describe the location and type of available equipment required for a CICO situation specific to the area in which they are working.
- explain the steps and decision-making points in one of the recognised difficult airway algorithms that addresses CICO (refer to list of recognised algorithms above).
- be fluent with equipment and procedures relevant to the preferred algorithm.
- implement the chosen emergency CICO algorithm including demonstration of infraglottic airway access / front-of-neck access.
- discuss the 'human factors' that have a negative impact in evolving CICO crises, and strategies to overcome them.

Optional

- Course providers may elect to expand the focus of teaching to include additional objectives if deemed that this would facilitate more effective teaching for the particular target audience. Suggestions for consideration include:
- Recognise the relationship of CICO to anaesthesia related mortality, and the major risk factors for CICO.
- Recognise the arguments for and against scalpel or needle cricothyroidotomy techniques.

- Recognise when awake intubation or tracheostomy is indicated.
- Consider how management of acute airway obstruction would differ in patients with a tracheostomy.
- Lead the team or actively participate in an emergency response for CICO simulation, including transition to CICO.
- Recognise the dangers of transport and extubation of the difficult airway and discuss strategies that may mitigate this.

2.7.1.6. Structure of the course

- Provide pre-course reading that refers to the selected CICO algorithm used in the session and provides relevant foundation knowledge of the session content.
- Be delivered as a continuous session.
- Provide a small group teaching strategy to ensure key non-technical learning objectives are met.
- Provide knowledge of local equipment.
- Provide familiarity with the chosen CICO algorithm.
- Provide stations to familiarise with technical skills relevant to the chosen algorithm.
- Be conducted by a lead facilitator and provide at least one instructor per four participants. Facilitators need to observe each participant and provide verbal feedback to ensure they are achieving the objectives of the session.

If the trainee has completed an external CICO course, they must provide a detailed outline which shows the learning objectives of the program, and certificate of completion of the course. The SOT must be provided with sufficient evidence to confirm that the trainee had the opportunity to demonstrate and obtain feedback on the minimum skills required.

2.7.2. Paediatric Life Support Course

A paediatric life support course or equivalent must be completed during RGA training, as part of enstrustable professional activity 6.

RGA trainees who hold a current paediatric life support course may be exempt from completing the same course during RGA training, if the certificate will remain valid at the time of RGA training completion.

This course is designed to meet the learning outcome of the RGA curriculum: 'Demonstrate advanced life support in paediatric patients consistent with Australian Resuscitation Council guidelines'.

2.7.2.1. Definitions and terms

As per the Australian and New Zealand Committee on Resuscitation (ANZCOR) guidelines, the term 'infant' is used to refer to ages zero to 12 months (up to their first birthday), and 'child' to refer to ages one (after their first birthday) to 18 (up to their 18th birthday).

2.7.2.2. Recognised emergency algorithms

The ANZCOR guidelines released in November 2021, replace earlier Australian Resuscitation Council /New Zealand Resuscitation Council guidelines.

Guideline 4 – Airway, including foreign body airway obstruction (choking) algorithm.

Guidelines 12.1-12.5 – Paediatric Advanced Life Support.

Participants should be familiar with these guidelines prior to attending the course.

Highly recommended pre-reading for participants:

Bhananker SM, et al. Anesthesia-Related cardiac arrest in children: update from the Pediatric Perioperative Cardiac Arrest Registry. *Anesthesia & Analgesia,* 2007 105(2): 344-350.

2.7.2.3. Learning objectives

As a minimum, courses must provide the opportunity for participants to meet the learning objectives listed below and to actively engage in hands-on activities to practise skills during the session.

By the end of the course, participants will be able to:

- recognise clinical features of cardiac arrest in a (simulated) child.
- institute Basic Life Support (BLS) according to ANZCOR guidelines and apply the foreign body airway obstruction (choking) algorithm.
- institute Advanced Life Support (ALS) according to ANZCOR guidelines.
- demonstrate and practice paediatric cardiac massage (compression) with correct technique(s) as per the size of the particular paediatric patient.

- demonstrate simultaneous non-intubated bag mask ventilation and cardiac compression according to the recommended ratio.
- recognise ventricular fibrillation (VF), pulseless electrical activity (PEA) and asystole in different paediatric scenarios.
- recognise the need for early defibrillation in a shockable rhythm.
- demonstrate the safe use and correct voltage of a defibrillator on a (simulated) child.
- demonstrate the appropriate selection, timing and administration of drugs in paediatric cardiac arrest. Where possible, emphasise dosing and dilution of drugs commonly used in paediatric emergency.
- state the appropriate timing and role of endotracheal intubation in APLS (successful intubation need not necessarily be demonstrated).
- demonstrate ventilation and cardiac compression according to the recommended ratio in an intubated (simulated) child.
- describe reversible causes of cardiac arrest in any setting: 4Hs and 4Ts.
- recognise causes of cardiac arrest that are relatively more specific to the perioperative and paediatric setting, including but not limited to: massive haemorrhage, anaphylaxis, local anaesthetic toxicity, gas embolism and high-spinal (reference may be made to peri-operative cardiac arrest data).
- recognise the return of spontaneous circulation in a child.
- describe the fundamentals of post-resuscitation care in a child.

Optional

Course providers may elect to expand the focus of teaching to include additional objectives if deemed that it would facilitate more effective teaching for trainees. Suggestions for consideration include:

- demonstrate intraosseous cannulation.
- demonstrate leadership, including clear instruction of resuscitation priorities to a team.
- explain ventilation strategies, including need to recognise life-threatening auto-PEEP.

- recognise and manage peri-arrest rhythms. This may include recognition of critically unstable child, management of SVT, prolonged QT and VT, and external pacing.
- discuss the appropriate time and manner in which to cease resuscitation efforts.
- discuss non-technical factors that contribute to poor outcome during management of arrests and strategies to manage.

2.7.2.4. Structure of the course

It is recommended that a suitable number of facilitators are available to conduct the session so that all participants can be observed while they are working through scenarios. Verbal feedback should be provided to ensure all participants will achieve the learning objectives of the session. A guideline is a minimum of one facilitator for every five participants.

- A facilitator must observe each trainee demonstrating activities and provide confirmation of their ability to demonstrate the required skill or corrective instruction to improve performance.
- Various age and weight ranges should be practiced.
- Where numbers permit, a variety of team-based scenarios, including shockable and non-shockable rhythms, should be included to allow demonstration of 2-4 person resuscitation.
- It is expected that the session will provide trainees with the opportunity to utilise the following equipment:
- A mannequin that can:
    - be ventilated via bag-mask.
    - be intubated.
    - have CPR performed on it.
    - be defibrillated.
- a self-inflating bag plus face mask.
- an endotracheal tube plus laryngoscope.
- a defibrillator.
- ability to display relevant arrhythmias, either on a monitor or in hard copy.

2.7.3. Neonatal Resuscitation

A neonatal resuscitation course or equivalent must be completed during RGA training and as part of entrustable professional activity 7.

This course is designed to meet the learning outcome of the RGA curriculum: 'Demonstrate basic and advanced life support of the newborn'.

2.7.3.1. Definitions and terms

As per the Australian and New Zealand Committee on Resuscitation (ANZCOR) guidelines, the term 'newborn' refers to the infant in the first minutes to hours following birth. In contrast, the neonatal period is defined as the first 28 days of life. Infancy includes the neonatal period and extends through the first 12 months of life.

2.7.3.2. Recognised emergency algorithms

The ANZCOR guidelines released in January 2016, replace earlier Australian Resuscitation Council /New Zealand Resuscitation Council guidelines.

Guidelines 13.1-13.10 and the Newborn Life Support algorithm are specifically for the care of infants during the neonatal period, and particularly for newborn infants.

It is expected that all trainees have read and are familiar with the ANZCOR guidelines prior to attending the course.

2.7.3.3. Learning objectives

As a minimum, courses must provide the opportunity for participants to meet the learning objectives listed below and to actively engage in hands-on activities to practice skills during the session.

By the end of the course, participants will be able to:

- describe the circumstances (maternal, foetal and intrapartum) that place a newborn infant at risk of needing resuscitation.
- demonstrate initial assessment of the newborn and recognise the compromised newborn.
- correctly apply the ANZCOR newborn life support algorithm.
- demonstrate the positioning of the newborn for effective ventilation.
- discuss the indications for tracheal intubation and ventilation.
- demonstrate effective airway management and ventilation of the newborn.

- demonstrate use of recommended ratio and timing of ventilations.
- demonstrate bag-mask ventilation.
- demonstrate correct use of the t-piece (neo-puff) and other ventilation devices.
- discuss the indications for starting chest compressions.
- demonstrate the correct position, rate, and technique of chest compressions.
- describe the correct use of medication and fluids in resuscitation of the newborn.
- discuss vascular access in the newborn.
- demonstrate the correct dose and timing of adrenaline.
- discuss the role of blood and fluids in the resuscitation of the newborn.
- discuss the role of other drugs in the resuscitation of the newborn.

Optional

Course providers may elect to expand the focus of the session to include additional objectives if deemed that it would facilitate more effective teaching for trainees. Suggestions for consideration include:

- describe the continuing care and monitoring of the infant once adequate ventilation and circulation have been established.
- discuss the guidelines for resuscitation of the newborn in special circumstances, for example, prematurity.
- discuss ethical issues that may be encountered when initiating or discontinuing resuscitation of the newborn infant.

2.7.3.4. Structure of the course

It is recommended that a suitable number of facilitators are available to conduct the session so that all participants can be observed while they are working through scenarios. Verbal feedback should be provided to ensure all participants achieve the learning objectives of the session. A guideline is a minimum of one facilitator for every five participants.

- A facilitator must observe each trainee demonstrating the activities and provide confirmation of their ability to demonstrate the required skill, or corrective instruction to improve performance.
- It is expected that the session will provide trainees with the opportunity to utilise the following equipment:
- Effective airway management and ventilation:
    - t-piece infant resuscitator (Neopuff) and self-inflating bag.
    - neonatal facemasks (range of sizes from premature to term infants).
    - airway adjuncts (Oropharyngeal airway 00, 0, 1).
    - suctioning equipment (Yankauer suction catheter and tubing).
    - laryngoscope with infant blades (Straight blade 00, 0, 1).
    - endotracheal tubes (sizes 2.5, 3, 3.5, and 4mm ID).
    - endotracheal stylet or introducer.
    - supplies for securing endotracheal tubes (e.g., scissors and tapes).
    - exhaled CO2 detector (colorimetric end-titdal detector).
    - infant oximeter.
- Vascular access:
    - adrenaline solutions.
    - fluids for dilutions and flush.
    - syringes.
    - intraosseous Access Kit^.
    - umbilical vein catheter^.
- Simulation Environment^:
    - newborn mannequin (Sim Baby or ALS Baby)^.
    - pregnant mannequin^ (SimMom).
    - mannequin control module and connected software^.

^ optional

If the trainee has completed an external neonatal resuscitation course, they must provide a detailed outline which shows the learning objectives of the program, and certificate of completion of the course. The SOT must be provided with sufficient evidence to confirm that the trainee had the opportunity to demonstrate and obtain feedback on the minimum skills required.

2.7.4. Anaphylaxis

Trainees must complete ANZCA online Perioperative Anaphylaxis Response course as part of entrustable professional activity 5. Alternatively, trainees may complete an ANZCA Anaphylaxis practical simulation session or workshop that has been recognised as a valid activity for satisfying the CPD requirement for the management of anaphylaxis.

2.8. Completion of training

Once the final progress review is completed (see section 2.3.4) and upon payment of a non-refundable fee (may be waived for part-time trainees or trainees in interrupted training in special circumstances), the trainee may request a letter from the tripartite committee confirming completion of training. The initial letter will be valid for two calendar years. Additional letters may be requested and will require:

- payment of a non-refundable fee (may be waived for part-time trainees or trainees in interrupted training in special circumstances); and
- the support of the primary college; and
- evidence of progress through the primary training program; and
- participation in an appropriate CPD program.

Additional letters will be valid for one calendar year from the date of issue.

Completion of training does not automatically confer the qualification. The trainee must complete their primary qualification before ANZCA will confer the qualification.

2.9. Graduates

Prior to award of the qualification, trainees must have completed all training requirements as outlined in regulation 44.27, ***the RGA Curriculum*** and ***the RGA training handbook*** including having been awarded a prerequisite fellowship acceptable to ANZCA Council. The RGA does not lead to eligibility for the award of ANZCA Fellowship or membership.

Application should be submitted to ANZCA DPA assessor and should include:

- evidence of completion of the primary fellowship (if not already provided to ANZCA)
- evidence of maintenance of anaesthesia competence will be required if there is a gap between completion of training and application or award of the qualification.
- a declaration of fitness to practice

2.10. Removal from training

Trainees who wish to withdraw from training should advise ANZCA and their primary college of this in writing, specifying reasons for withdrawal. Once notification is received, the tripartite committee will be advised.

Trainees who do not complete all training requirements within two calendar years of the date of commencement of training will be removed from training. Any time spent in interrupted training will not count towards the two years to complete.

Trainees who do not pass the examination in the maximum exam attempts will be removed from training.

Trainees who have withdrawn or been removed from training may subsequently re-apply for the program. Applications are considered on an individual basis by the DPA assessor. Trainee cannot reapply if they are removed from the RGA training program due reaching the maximum number of attempts at the multiple-choice question examination or RGA standardised structed scenario-based assessment.

3. Special Circumstances

3.1. Flexible training options

3.1.1. Part-time training

Part-time training is permitted to a minimum of 50 per cent of the commitment of a full-time trainee (i.e., 0.5 FTE). The entire RGA training program may be completed on a part-time basis.

Part-time training should be applied for prospectively and be approved by ANZCA DPA (assessor). Applications should be made to ANZCA.

Trainees should approach their primary college to determine the impacts part-time RGA training may have on their primary fellowship.

3.1.2. Overseas training

All training must be completed within Australia, with the exception of training time approved during recognition of prior learning, as per section 1.5.

3.1.3. Interrupted training

Interrupted training allows a trainee to pause their training. During this time, they remain a registered trainee but cannot sit the multiple-choice question examination or their first attempt at the RGA standardised structured scenario-based assessment (RGA-SSSA), accrue time, volume of practice or workplace-based assessments towards training. Trainees are permitted to undertake mandatory courses and their second or third attempt of the RGA-SSSA during interrupted training.

Trainees wishing to take more than 8 weeks leave, should apply for interrupted training. All periods of interrupted training should, wherever possible, be applied for prospectively and advice obtained from the supervisor of training and primary college. Applications must be submitted to ANZCA DPA (assessor) for consideration and advice on the implications for subsequent training. Trainees may have a maximum of 52 calendar weeks interrupted training.

If the period of interrupted training is greater than 13 calendar weeks a re-entry to training period is required.

If training is interrupted for a continuous period of leave and/or interrupted training of more than 26 calendar weeks, subsequent training must include at least 13 weeks full-time equivalents (FTE) continuous training time, which may include a maximum of two weeks of leave. By having a period of consolidated learning prior to completion of RGA training ensures the trainee is appropriately prepared for independent practice.

3.1.3.1. Application timing

If unforeseeable circumstances make it impossible to submit an application prospectively, an application for interrupted training should be made at the earliest opportunity. Under exceptional circumstances, the supervisor of training may notify ANZCA on behalf of the trainee.

Approved interrupted training

A trainee may apply for a period of interrupted training for reasons such as:

- working in an anaesthetic department not accredited for the RGA.
- working in a non-anaesthesia position.
- taking 8 or more calendar weeks of leave for personal reasons, illness or injury.
- failure to obtain a position suitable for training.

Interrupted training taken for any of the reasons listed above is deemed to have concluded when the trainee re-enters training. The trainee may also seek prospective approval for a further period of interrupted training from ANZCA DPA (assessor). If neither of these occur by the time the initial period of interrupted training elapses, the trainee will be removed from training.

3.1.4. Deemed interrupted training

Training may also be interrupted if the trainee fails to fulfil assessments, fee or documentation requirements by the due date. Interrupted training is deemed to have commenced from Monday of the week when, for example, a trainee:

- fails to complete the required training agreement.
- fails to pay outstanding ANZCA fees.
- fails to record time and assessments in the ePortfolio within four weeks.
- has conditions placed upon their practice by a medical registration authority.

These interrupted training occurrences are deemed to have concluded on the Sunday of the week when the problem is resolved. If the problem is not resolved by the stated deadline, this may result in removal from the training program.

Queries about interrupted training can be directed to rga@anzca.edu.au.

3.2. Trainee re-entry to practice

3.2.1. Overview

RGA trainees who spend more than 13 calendar weeks outside of RGA training must participate in a trainee re-entry to practice program upon returning to training.

3.2.2. Re-entry to training process

The total duration of a formal re-entry into training in RGA process will be determined by a learning needs analysis. The duration of the process and its components may be shortened or lengthened depending on the learning needs analysis and progress with the program.

A re-entry to training program must adhere to the following:

Stage 1 - to be undertaken prior to commencement of or early in the re-entry to RGA training:

- complete a learning needs analysis to identify individual requirements in discussion with the supervisor of training (SOT). This should take into account the trainee's practice to date, assessments and other relevant aspects of training progress prior to the absence from RGA practice. Other important considerations are what the trainee has been doing whilst out of RGA training and the proposed RGA placement on re-entry
- based on the outcome of this analysis, the trainee may not require any further components of the re-entry to practice program.

Stage 2 - to be undertaken on commencement:

- an initial period of one-to-one supervision, followed by an assessment of ability to practice without one-to-one supervision.

Stage 3 - to be undertaken after successfully moving beyond one-to-one supervision and prior to completion of the re-entry into RGA training program:

- a period of oversight by the SOT or nominee; and
- regular discussion with the SOT. During the period of re-entry to training, the trainee should maintain their ePortfolio records, ensuring they are accurate, up-to-date and reflect the entirety of their caseload during the re-entry program.

Stage 4 - the SOT will confirm that the trainee has satisfactorily completed the program. If the SOT is unable to confirm satisfactory completion of the RGA training re-entry, the re-entry program should be extended until satisfactory completion can be confirmed or the trainee support process (TSP) should be initiated. The re-entry to practice will count as training time.

3.3. Trainees with illness or disability

Trainees have a responsibility to ensure that they are fit to practise and must seek medical advice if they are uncertain about their fitness to practise. ANZCA does not determine fitness to practice; this is a matter for the trainee's treating medical practitioner, their employer, and the relevant regulatory authority granting registration to practise. ANZCA must be notified of any illness or disability that would preclude safe practice. Maintenance of confidentiality and privacy are paramount obligations to trainees with illness or disability; however, in cases where patient safety may be affected, ANZCA reserves the right to notify medical boards, the primary college or other appropriate authorities.

On registration for training, on admission to the examination and on application for the qualification, trainees are required to make a declaration of fitness to practice and an undertaking to notify ANZCA of any future illness or disability that might compromise safe practice.

3.4. Trainee support process (TSP)

There are many situations throughout training when trainees may require more support. The TSP assists trainees during these times. It uses a staged response by providing structured feedback to the trainee.

3.4.1. Identifying trainees requiring support.

Trainees who are not making appropriate progress in training may require more support. This may occur within one or more requirements of the program. Typically, there is a repeated pattern rather than a single incident.

It is important that trainees requiring support are identified early so that issue can be resolved without extending training. Early detection and local intervention increase the likelihood of improved performance and may prevent future problems. Effective completion of this process is often rewarding.

A "RGA trainee support; a practical guide for supervisors" has been developed to assist SOTs to initiate management of a TSP.

When a TSP has been initiated, the supervisor of training (SOT) must advise the state support officer (SSO), primary college and ANZCA as soon as practicable

A TSP will be required in the following circumstances:

- the progress review and plan outcome that indicates that the trainee would benefit from engagement in a TSP.
- the interim progress review outcome that indicates that the trainee would benefit from engagement in a TSP.
- a second unsuccessful attempt at the multiple-choice question (MCQ) examination.

- an unsuccessful attempt at the RGA standardised structured scenario-based assessment (RGA-SSSA).
- unsatisfactory multisource feedback (MSF).

Other triggers may include:

- a trainee is not completing workplace-based assessments (WBAs) at a frequency that will enable them to complete entrustable professional activities (EPAs).
- a trainee has not achieved sign-off of the relevant EPAs at the recommended time intervals.
- personal problems, illness and/or disability that interfere (temporarily or permanently) with training and/or performance of duties.
- mental health issues (for example, depression, anxiety, personality issues) that impair professional communication, teamwork or other aspects of performance.
- a trainee identifying that they are at risk, struggling or requiring additional support.

A TSP must not to be used as a disciplinary measure or where issues relate to employment, misconduct or where patients and/or the trainee are at risk of harm. In these instances, the head of department must be notified immediately and advice sought from the employer's human resources department. The SOT must notify ANZCA and the primary college in these situations.

The processes for dealing with trainees under medical board conditions, suspension or removal from a medical register are outlined in regulation 44.25.

Substance misuse or dependence requires a specific investigation and management process outside the scope of the TSP. See "RGA trainee support; a practical guide for supervisors" resource document. It is essential to seek professional advice and comply with regulatory requirements, especially appropriate reporting requirements, of the Medical Board of Australia.

3.4.2. The TSP meetings

The initial meeting between the trainee and supervisor of training (SOT), should include the following:

3.4.2.1. Before the meeting

- The SOT should schedule a time with the trainee in advance to have the discussion. Adequate time should be allowed to consider all issues, and the meeting should be held in a private place.

- Trainees should be made aware of the concerns to allow them to prepare a self-assessment.
- The trainee should be offered the opportunity to bring a support person.
- The SOT may consider possible solutions and plans of action before the meeting. They should be prepared with all relevant documentation and resources at hand.

3.4.2.2. During the meeting

- The trainee is entitled to, and should be actively encouraged to, contribute to the discussion.
- The SOT will identify barriers to training progress and/or welfare issues impacting on the trainee.
- The trainee should provide a self-assessment, including an explanation about their performance and the issue (or issues) they are experiencing.
- The SOT should outline clear expectations about required performance, training progress and wellbeing.
- The SOT and trainee should develop and implement an action plan.
- The action plan must be documented using the TSP, guidelines and meeting template. The template includes:
- Who was present at the meeting, the date, time and duration?
- The nature of the issues discussed.
- Specific, measurable, attainable, realistic and timely (SMART) goals should be set, together with practical suggestions to achieve them. A timeframe for the trainee to access relevant resources and achieve goals should be agreed.
- Follow-up meeting dates can be scheduled.
- Possible further actions if agreed goals are not met.

3.4.2.3. After the meeting

- Trainees should acknowledge the action plan.
- Completed forms must be forwarded to ANZCA via rga@anzca.edu.au.
- The SOT may consider informing the head of department of the outcome of the meeting.

- The trainee should ensure they have adequate support following the meeting and throughout the TSP process.

3.4.2.4. Monitoring progress

Review meetings need to be set to assess the success of the TSP action plan. It is recommended that these meetings occur at least monthly and possibly more frequently when appropriate. The SOT should look for signs of improvement and give feedback to the trainee.

Further discussions with the trainee must be documented. SOTs can either use the progress review and plan meetings on the ePortfolio, the interim progress review and plan meeting or the TSP meeting template. The SOT should provide regular updates to the state support officer (SSO) and ANZCA.

Monitoring should continue until the trainee's performance returns to a level expected for their stage of training.

Once the trainee has achieved all the set goals, the SOT should advise the trainee, the SSO and ANZCA that the TSP is completed.

If the trainee does not engage with the process or make reasonable improvement during the expected timeframe, the SOT should discuss this with the SSO and must inform ANZCA. The trainee will be placed into interrupted training and referred to their primary college for further remediation.

Trainees who are undertaking a TSP will be required to successfully complete this process prior to completion of training.

3.4.2.5. Advice and support

The TSP can be stressful, and trainees should ensure they are supported professionally and personally throughout. Support may come from many sources including family, friends, the GP, a pastoral carer, colleagues, a mentor or a more senior trainee 'buddy'.

Trainees are strongly encouraged to select a mentor, if they do not already have one. Trainees are free to select their own mentor, although the SOT may assist if the trainee is having difficulty identifying a suitable person.

A mentor or support person should have no formal involvement with the trainee's appointment, reappointment or formal assessment.

Assistance from mentors should be limited to advice and support. Treatment, if required, should be from relevant qualified practitioners in a therapeutic (not a supervisory or mentor) relationship with the trainee.

A spectrum of health professionals from GP, psychologist, physiotherapist, dietician, performance psychologist, life coach and psychiatrist may be considered for assistance. An occupational health physician's advice may also be useful for chronic health problems. The trainee's GP should co-ordinate the management of the trainee's health including referral as appropriate.

Assistance and more information about the trainee support process may be sought from:

- The relevant state support officer.
- ANZCA staff (rga@anzca.edu.au or +61 3 9510 6299).

3.5. Medical registration authority interventions

Medical practitioners may have conditions or undertakings placed on their registration to limit practice or be suspended or removed from registration by the relevant registration authority. This may relate to health-related issues or be the outcome of a disciplinary process.

Trainees subject to agreed undertakings to limited practice, the imposition of conditions, suspension or removal by a relevant registration authority, have an obligation to inform ANZCA.

When ANZCA is advised by the trainee or otherwise becomes aware of registration issues the following will occur:

- if **conditions, undertakings or limitations** are placed on a trainee's practice, the trainee will be placed in ***interrupted training*** from the date the conditions are imposed and the trainees primary college will be notified (regulation 44.25.3.1);
- if a trainee is suspended from the medical register they will be placed in ***interrupted training*** from the date of such suspension and their primary college will be notified (regulation 44.25.3.2). During this time trainees cannot complete assessments or accrue training.

Should the suspension be lifted, or the conditions modified and if the trainee wishes to resume training, they must advise their primary college of this in writing. Training can resume from the date the primary college notifies ANZCA of this in writing.

- If a trainee is **removed** from the medical register they will removed from the RGA training program and not permitted to continue training (regulation 44.25.3.3).

If a trainee has completed RGA training and their primary fellowship and is applying for award of the qualification at the time the regulatory authority's decision is imposed, the following apply:

- the applicant will not be eligible for award of the qualification if they do not hold current registration to practise.
- if the applicant has conditions, undertakings or limitations imposed on their practice by a relevant registration authority, ANZCA Council will determine whether award of the qualification may proceed or be deferred until the agreed undertakings or imposed conditions are lifted.

3.6. Reconsideration, Review and appeal

Any trainee who is dissatisfied with a decision under regulation 44 and this handbook may apply to have the decision reconsidered. Subsequent applications may be made for review and then appeal. All such applications must be made under regulation 30 – Reconsideration, Review and Appeals Policy.

Reconsideration, Review and Appeal for workplace-based assessments

Regulation 30 does not address matters relating to workplace-based assessments (WBA). The supervisor of training (SOT) should address a trainee's concerns about a WBA or clinical placement review locally, and if necessary, involve the education officer. Generally, the WBA should be repeated. It may also be appropriate for local grievance measures or bullying, discrimination and harassment policies to be applied.

The ANZCA policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions.

The ANZCA feedback management policy.

For more information contact the director of professional affairs (assessor) at assessor-requests@anzca.edu.au.

3.7. Grandparenting

Rural generalist anaesthetists may submit an application for grandparenting if they:

- are Fellows of ACRRM or RACGP; and
- hold the Joint Consultative Committee on Anaesthesia (JCCA); and
- are currently credentialed to practice anaesthesia in a rural location (Modified Monash Model 3-7); and
- can demonstrate commitment to rural anaesthesia practice. The expected standard is 12 weeks service in a rural location per year, for each of the preceding 2 years. There will be discretion applied in how commitment to rural practice is assessed; and
- have current relevant CPD.

A non-refundable grandparenting fee must accompany the application.

Applications for grandparenting will close on 31 December 2024. Applicants who completed JCCA training in 2021, 2022, or 2023 have until 31 Dec 2025 to apply for grandparenting. Further information can be found on ANZCA website.

4. Supervisor and other roles

4.1. Departmental roles

Formal RGA supervisor roles

RGA-accredited departments are required to provide trainees with supervisors and tutors to support training and to implement the RGA curriculum in their hospital or other training site.

In any department an individual may fulfil more than one supervisory role. Larger departments may have more than one person in any role. The head of department should not normally be a supervisor of training (SOT) or the state support officer (SSO) due to potential conflicts of interest. Heads of department need to consider workloads in the allocation of these roles.

Supervision of clinical experience and workplace-based assessment assessors

In addition to the formal RGA supervisory roles, any FANZCA, RGA holder, GP anaesthetist or ANZCA provisional fellow within a department can supervise trainees' clinical work and should be encouraged to act as an assessor for workplace-based assessments (WBA assessor).

Extra-departmental roles

At least one SSO will be appointed to each state within Australia. The second and subsequent SSO will have the title deputy SSO.

A list of RGA SSOs and supervisors of training can be found on ANZCA website.

Departments must notify ANZCA about any changes to appointments via email to rga@anzca.edu.au.

4.2. Supervisors of training

Supervisors of training (SOTs) are broadly responsible for anaesthesia training at each RGA-accredited training site. They have a strong understanding of and experience in RGA activities. They oversee each trainee's clinical performance and confirm progression of trainees through the various stages of the training program.

4.2.1. Duties of supervisors of training

SOTs have a range of responsibilities. Some duties must be directly undertaken by the SOT themselves while other duties may be performed by fellows in other roles with oversight from the SOT.

Trainee supervision and management

- Advocate for trainees in matters related to organisation of clinical duties.

- Ensure that rosters for trainees comply with PS43 Statement on Fatigue and the Anaesthetist.
- Timely submission of data into the ePortfolio. SOT resources will be available.
- Perform progress review and planning reviews, see section 2.3.2.
- Oversee trainee progression and performance:
    - confirm the trainees' time entered into the ePortfolio.
    - oversee the progression of the entrustable professional activities (EPAs) and work with other relevant clinical supervisors to assist trainees who are having difficulties achieving these within the required time.
    - oversee trainee progression towards workplace-based assessments (WBAs) and review WBAs to ensure trainees are meeting training requirements.
    - while it is the responsibility of the trainee to complete the requirements of the training program in the required time, each SOT can monitor and facilitate acquisition of volume of practice and WBAs for trainees as they progress through the training program.
    - complete feedback and interim progress review and plan meetings:
    - these are opportunities for the SOT to review trainee progress and note any outstanding elements that need to be addressed.
    - based on all this information, provide a feedback summary and assessment indicating whether the trainee has met the expectations.
    - complete EPAs. A meeting is held with the trainee to confirm that all components of the EPA have been completed and feedback is provided.
    - if the decision is unclear, the SSO may be approached for further advice.
    - if the trainee is identified as underperforming the Trainee_experiencing_difficulty_processTSP should be considered.

4.2.2. Managing and assisting trainees requiring more support

- If a trainee is found to be underperforming or experiencing other difficulties at any stage during training, then a process of remediation should be initiated.
- If required, initiate and implement a TSP, which may include the need to:
    - perform additional interim reviews. These are encouraged for trainees who require additional support and may be initiated by either the trainee or SOTs. They should be arranged in a timely manner to allow for issues to be explored and resolved.
    - assign additional WBAs for a trainee to further investigate any perceived issues and provide structured feedback and guidance.

4.2.3. Education

- Facilitate training of new RGA trainees in the department in the performance of WBAs and giving feedback.
- Assist trainees in locating suitable courses within the local area to meet course requirements. The SOT will need to ensure that the course chosen meets the requirements of that course.

4.2.4. General

- Appoint WBA assessors in consultation with the head of department.
- Attend training courses for SOTs.
- Oversee the following:
    - orientation of trainees
    - monitoring of staffing levels and workload changes, which may impact on training
    - monitoring availability of cases and procedures in their hospital and providing advice to trainees
    - advising current and potential trainees on training requirements, registration, fees, exam dates, support resources and courses.
- Liaise with others in supervisory roles:
    - advise head of department regarding trainee duties, required supervision levels, rest and study time
    - notify the SSO of any trainee requiring more support
    - liaise with the SSO regarding staffing or workload changes likely to impact on training.

4.2.5. Selection, appointment, tenure and reappointment

Selection criteria

- Must be an RGA holder or FANZCA.
- Have an interest in education and demonstrates a commitment to acquiring and maintaining necessary skills in teaching and feedback.
- Have a good understanding of the current training program.
- Must not be the head/director of the department. Deputy directors may undertake dual roles as supervisors of training. However, conflicts of interest should be declared and appropriate steps to manage them must be taken where required.
- There is no minimum amount of post-fellowship experience required before taking on the role of SOT.

Appointment process

- Prospective SOTs for each RGA-accredited training site are nominated by the head of department to the SSO for formal approval. The SSO will then notify ANZCA Training and Assessments team of the appointment (rga@anzca.edu.au).
- On appointment, and re-appointment, SOTs are required to sign an agreement that outlines mutual obligations between ANZCA and the SOT.
- Initial appointment is for a three-year term.

Reappointment

- SOTs may be reappointed for a total of four three-year terms.
- ANZCA will notify the SSO when a SOT is nearing the end of a three-year term, for review and consideration regarding reappointment for a further three years.
- Reappointment will usually be automatic. However, this may be an opportunity for the supervisor of training to move on to other roles within their department, the broader hospital environment or ANZCA.
- It is anticipated that this process of review will also provide an opportunity to consider succession planning and ways to encourage and assist other members of the department to take on supervisory roles.
- In extenuating circumstances, SOTs may be appointed for more than 12 years.

4.2.6. Resources and support for supervisors of training

Departmental requirements

As a condition of RGA accreditation, SOTs must be provided with appropriate clinical support time, physical facilities and other resources to undertake their roles. These include:

- regular, scheduled clinical support time for the duties outlined in section 4.2.1.
- access to appropriate facilities, a private space to meet with trainees with internet and computer access to enable regular (daily) updates to the ePortfolio and ANZCA website.
- support from other departmental members for WBAs, other supervisory and tutor functions, and the TSP.

College resources and support

ANZCA provides resources for those undertaking supervisory roles.

The SSO for the region is available for assistance as necessary to enable SOTs to fulfil their duties. This is recommended if remediation is required for a trainee. For more information see the TSP, see section 3.4.

4.2.7. Access to trainee information via the trainee portfolio system

Supervisors of training are provided with online access via the ePortfolio to the training records of all trainees at their training site.

4.3. Workplace-based assessment assessor

Workplace-based assessments (WBA) are formative assessments (assessment for learning). They involve an assessor providing structured, actionable feedback to the trainee after observing them perform procedural skills and providing care to patients. WBA assessors can complete four types of WBAs for RGA trainees: mini-clinical evaluation exercise (mini-CEX), direct observation of procedural skills (DOPS), case-based discussion (CbD) and patient consultation observation (PCO).

WBA assessors should work regularly in the subject area appropriate for that WBA.

Any FANZCA, RGA holder, credentialed rural generalist anaesthetists or ANZCA provisional fellow within a department can complete WBAs for RGA trainees.

RGA, FANZCA and ANZCA trainees in their provisional fellowship year will automatically be given access to the ePortfolio to complete WBAs. Supervisors of training (SOTs) must forward the name of credentialed rural generalist anaesthetists who assess WBAs to ANZCA to enable access to the ePortfolio.

4.3.1. Duties of workplace-based assessment assessors

The WBA assessor is responsible for observing the trainee at work, and providing formative, contemporaneous and actionable feedback to the trainee about their performance.

The WBA assessor should identify areas where the trainee can improve, highlighting how they might access that experience and suggesting ways they can increase their knowledge in the area.

They will also need to enter feedback for the WBA into the ePortfolio in a timely manner, to allow the trainee an opportunity to reflect and comment on the assessment while it is still fresh in their mind.

4.3.2. Resources and support

Departmental requirements

All WBA assessors must be provided with appropriate time, physical facilities and support to conduct their roles. These include:

- physical facilities including a private space for meetings with trainees, secure document storage and a computer with internet access.
- support from other departmental members for their role.

ANZCA resources and support

Information about the different types of assessment and how to give feedback is available in the WBA section.

The SOT, head of department and state support officer (SSO) will be available for guidance, assistance and any input necessary to enable a WBA assessor to fulfil their duties.

4.3.3. Access to trainee information via the ePortfolio

No specific access to online trainee information is required. However, WBA assessors will be able to lodge WBA via the ePortfolio.

4.4. State support officer

The state support officer (SSO) occupies an important position within the educational framework, overseeing training within an Australian state or territory.

If workload or geography requires, more than one SSO may be appointed, but a lead SSO must be identified and will be responsible for overall co-ordination. All second and subsequent SSO within a training region will have the title ‘deputy state support officer’ (Deputy SSO).

4.4.1. Duties of SSO

Co-ordination and liaison

- To act as a central co-ordinator of RGA training and education within a state.
- To act as a liaison between trainees, supervisors of training (SOTs) and head of departments with the central administration of ANZCA.
- To fully understand the training program, the regulations that govern it and this handbook.
- To understand the processes to be followed by supervisors of training and WBA assessors.
- To provide advice and guidance to supervisors, head of departments, administrators, trainees, and prospective trainees, as required.
- To be aware of college examinations dates.
- To resolve disputes between supervisors during entrustable professional activity (EPA) sign-off and other assessments.

Facility monitoring

- To assist SOTs to monitor staffing and supervision in each RGA-accredited hospital.
- To provide advice to new training sites in the region seeking accreditation.

Trainee management

- To manage disputes between trainees and supervisors where inter-departmental relationships have broken down.
- To provide advice and assistance to trainees if they have concerns or issues that cannot be raised with the supervisor of training.
- To provide advice and assistance to supervisors of training regarding the assessment of trainees.
- To assist the supervisors of training in the management of trainees in the trainees support process.

The role of the SSO does NOT include:

- Representing ANZCA, RACGP, the ACCRM or the tripartite committee in the selection and appointment of trainees to a training program. However, the SSO may be a member of a selection committee or panel.
- Matters involving employment issues, rostering or leave unless these also relate to training or trainee welfare.

4.4.2. Selection, appointment, tenure and reappointment

Selection criteria

- Must be an RGA holder or FANZCA.
- Must have significant experience in a departmental supervisory role or equivalent.

SSOs are appointed by the tripartite committee.

On appointment, and re-appointment, SSO are required to sign an agreement that outlines mutual obligations between ANZCA and the SSO.

4.4.3. Resources and support

All SSOs must be provided with appropriate time, physical facilities and support to undertake their roles. These include:

- clinical support time for duties specified in section 4.4.1.
- access to appropriate facilities including a private space for meetings with trainees and information technology to allow regular ePortfolio access and access to ANZCA website.
- support from other departmental members for their role.

4.4.4. Access to trainee information via the ePortfolio

SSOs can view the ePortfolio training records of all trainees within their state or territory.

4.5. Accreditation of rotations for training

During the 2023 and 2024 training years, accreditation will be automatic for sites accredited by the JCCA. A process for accreditation beyond 2024 is being developed.

5. Definitions

Trainee refers to people undertaking training in the RGA training program. ACRRM uses the term registrar and RACGP uses the term doctors in training.

Primary college refers to the college in which the trainee is undertaking their primary fellowship. This will be RACGP and/or ACRRM.

Rural context is defined as working in a location as defined by Modified Monash Model 3-7.

The RGA training agreement is a legally binding formal statement of the mutual obligations and expectations of ANZCA and the trainee. This document must be signed by the trainee in order to register with ANZCA and then annually acknowledged in order to maintain training registration.

Change control register

Version	Author	Approved by	Approval date	Sections modified	Next review
1.0		Council	September 2022		2023
1.1	Education unit		February 2023	Course link updated - Networks to Learn@ANZCA	-
1.1	Education unit	Council	December 2023	The term 'diploma' removed throughout the document	2024
1.2	Education Unit	EEMC	As part of the 2024 update	Added: Section 1.1.1 – Recommended prior learning and experience Section 1.1.2 – Registration for current trainees of RACGP or ACRRM Updated: Section 1.1 – Registering for rural generalist anaesthesia training Section 1.5 – Fee structure Section 2.4 – Time limit on training completion Section 2.6.8 – updated to reflect updates to the Special Consideration Policy Section 2.7.2 – Updated to reflect changes to the Paediatric Life Support Course requirements	2025
1.3	Education Unit	EEMC	October 2025	Section 2.6.9 – addition of specific requirements of each EPA Section 2.8 – clarification regarding fee waivers and administrative processes	2026