**Ionising Radiation (Medical Exposure) Regulations: Guidance for compiling training records for clinical oncologists**

**Appendix**

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| --- |
| **This Appendix contains an example of a clinical oncologist training record. The content can be adapted to reflect local practice and the individual’s scope of practice. This might include anatomical sites (for example, breast and skin disease) and/or techniques (for example, Intensity Modulated Radiotherapy or Proton Beam Therapy) and/or types of exposures (for example, planning, verification or treatment). These are sometimes referred to as practice privileges.** |

**Sample Clinical Oncologist IR(ME)R training record**

|  |  |
| --- | --- |
| Document reference | XXX V0.1 |
| Policy Name | Clinical Oncologist training record |
| Author(Name and Job title) | XXXXXXXXXXXXSAMPLE |
| Reviewer:(Name and Job title) | XXXXXXXXXXXX |
| Date of issue | XX/XX/XXXX | Review date | XX/XX/XXXX |

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# Scope and responsibility

The Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) require the employer to keep up-to-date training records for all practitioners and operators and make these available for review.

Clinical oncologists may be entitled to act in one or more of the duty holder roles as referrers, practitioners and operators.

Clinical oncologists must have a clearly defined scope of practice, and training and competency records to support their roles as operators and practitioners. While not explicitly required under IR(ME)R, it is considered best practice that referrers complete local referral awareness training prior to being entitled – that is, making, amending and cancelling referrals.

Training records should be available to support competency sign-off and link to the individual’s scope of practice for which they are entitled to act.

Staff must read and understand reference documents such as employer’s procedures, local departmental procedures and protocols specific to the work undertaken.

It is the responsibility of each individual to recognise and work within the limitations of their own scope of practice.

Locally-entitled IR(ME)R operators, practitioners and referrers should be listed, with their scope of practice, within the quality management system (*reference specific document here*).

# Aim

The aim of this document is to evidence training, competency and continued professional development for individuals to be entitled as IR(ME)R duty holders.

SAMPLE

# IR(ME)R General and Annual Review

**Name: …………………………………………………. Job Title: …………………..…………………...**

**Registration body and number: ………………… Checked by and date: ………………………..**

**For brachytherapy practice confirm: ……………………………………………..……………………..**

**Practitioner licence reviewed: …………………… Checked by and date: .….……………………**

|  |  |  |
| --- | --- | --- |
| **Nature of training** | **Oncologist signature/ date**  | **Trainer signature/ date** |
| Radiation protection e-learning training (ESR) – annually  |  |  |
| Review IR(ME)R employers procedures – annually*(reference local procedures)* |  |  |
| Review ionising radiation policy– annually*(reference local procedure)* |  |  |
| Referrer scope of practice and entitlement record reviewed*(reference specific document here)*SAMPLE |  |  |
| Operator scope of practice and entitlement record reviewed *(reference specific document here)* |  |  |
| Practitioner scope of practice and entitlement record reviewed(*reference specific document here)* |  |  |
| Brachytherapy - HDR Local Emergency Training update |  |  |
| Additional training needs identified |
|  |  |  |
|  |  |  |

In signing this record the individual named above confirms they have received and understood the training provided, and read and understood the reference documents.

**Signature of individual / date:**

**………………………………………………**

**Signature of assessor / date:**

**………………………………………………...**

Completed copies of this document should be kept in the employee personnel file.

This document should be submitted as part of annual appraisal.

# IR(ME)R Referral awareness training record

**Name: …………………………………………. Job Title: ……….……………………………..**

**Confirmation individual is a registered healthcare professional: …………………………**

(*e.g. GMC number*)

|  |  |  |
| --- | --- | --- |
| **Nature of training** | **Oncologist signature/ date** | **Trainer signature/ date** |
| Induction only |
| Access to local referral guidelines *(reference local procedure in Quality Management System and consider on-site and off-site access as required*) |  |  |
| Access and overview to local referral system (*consider access on-site and from off-site clinics*) |  |  |
| How to submit a referral(*reference local work instruction*)SAMPLE |  |  |
| How to amend a referral(*reference local work instruction*) |  |  |
| How to cancel a referral(*reference local work instruction*) |  |  |
| Awareness and access to view individual scope of practice for entitlement*(reference local procedure)* |  |  |
| CPD / update / refresher training |
| *e.g. return to practice refresher* |  |  |
| *e.g. software update training* |  |  |
| *e.g. significant changes to local practice* |  |  |

In signing this record the individual named above confirms they have received and understood the training provided, and read and understood the reference documents.

On completion of training the named individual will be deemed competent to be entitled as an IR(ME)R referrer in the (*local radiotherapy department*) for the tasks listed above for the practices listed in their scope of practice.

**Signature of individual / date:**

**………………………………………………**

**Signature of assessor / date:**

**………………………………………………...**

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# IR(ME)R Practitioner training record

**Name: ………………………………………….. Job Title: .………………………………………**

**Confirmation individual is a registered healthcare professional: …………………………**

(*e.g. GMC number*)

**Confirmation of attainment of FRCR Part 1 date: ….…………………………………………**

**Confirmation of attainment of FRCR Part 2 date: .……………………………………………**

**Other relevant qualification/ name and date: ….………………………………………………**

|  |
| --- |
| **For brachytherapy practice confirm:** |
| **Practitioner licence number** |  |
| **Expiry date** | SAMPLE |
| **Procedure codes from the licence** |  |

|  |  |  |
| --- | --- | --- |
| **Nature of training** | **Oncologist signature/ date**  | **Trainer****signature/ date** |
| Induction only |
| Understand local site-specific planning guidance*(reference local procedure)* |  |  |
| Access agreed dose/fractionation regimes*(reference local procedure)* |  |  |
| Use of local e-prescribing system*(reference local procedure)* |  |  |
| Prescription approval*(reference local procedure)* |  |  |
| How to amend a prescription(*reference local procedure)* |  |  |
| How to stop a treatment(*reference local procedure)* |  |  |
| Introduction to authorisation of a deviation from protocol *(reference local procedure)* |  |  |
| Participation in peer review meetings*(reference local procedure)* |  |  |
| Brachytherapy – Practitioner Licence management process*(reference local procedure)* |  |  |
| Brachytherapy – Employer Licence awareness*(reference local procedure)* |  |  |
| Awareness and access to view individual scope of practice for entitlement*(reference local procedure)* |  |  |
| CPD / update / refresher training |
| *e.g. Successful completion of ESTRO - Falcon Online Course - Breast Cancer (certificate of attendance available)* |  |  |
| *e.g. Attendance at ESTRO Multidisciplinary Management of Breast Cancer (certificate of attendance available)* |  |  |
| *e.g. Invited speaker at RCR study day on radiotherapy in breast cancer*  |  |  |
| *e.g. Contributed to RCR consensus guidance on breast radiotherapy* |  |  |
| *e.g. Led local review of breast clinical protocol*SAMPLE |  |  |
| *e.g. Completed literature review as evidence basis for local breast protocol* |  |  |
| *e.g. Participation in peer review* |  |  |
| *e.g. Appointed local lead breast consultant clinical oncologist* |  |  |

In signing this record the individual named above confirms they have received and understood the training provided, and read and understood the reference documents.

On completion of training the named individual will be deemed competent to be entitled as an IR(ME)R practitioner in the (*local radiotherapy department*) for the tasks listed above for the practices listed in their scope of practice.

**Signature of individual / date:**

**………………………………………………...**

**Signature of assessor / date**:

**………………………………………………**

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# IR(ME)R Operator training record

**Name: ………………………………………… Job Title: ..………………………………………...**

|  |  |  |
| --- | --- | --- |
| **Nature of training** | **Oncologist signature/ date** | **Trainer signature/ date** |
| Induction only |
| Access and overview of Quality Management System(*reference local procedure*) |  |  |
| Access to and use of local incident learning system*(reference local procedure)* |  |  |
| Access and use of local oncology management system(*reference local procedure)* |  |  |
| Access and overview of treatment planning system (TPS)*(reference local procedure)*SAMPLE |  |  |
| Overview of image fusion tools*(reference local procedure)* |  |  |
| Use of contouring tools in TPS*(reference local procedure)* |  |  |
| Use of expansion tools in TPS*(reference local procedure)*  |  |  |
| Approval processes in TPS*(reference local procedure)* |  |  |
| Plan review in TPS*(reference local procedure)* |  |  |
| Awareness of local Image Guided Radiotherapy (IGRT) protocols*(reference local procedure)* |  |  |
| 2D IGRT image matching tools*(reference local procedure)* |  |  |
| 3D IGRT image matching tools*(reference local procedure)* |  |  |
| 4D IGRT image matching tools*(reference local procedure)* |  |  |
| IGRT image approval tools and processes*(reference local procedure)* |  |  |
| Awareness of local patient review protocols*(reference local procedure)* |  |  |
| Use of patient review recording systems*(reference local procedure)* |  |  |
| Brachytherapy – prostate seed insertion*(reference local procedure)* |  |  |
| Brachytherapy – gynaecological applicator insertion*(reference local procedure)* |  |  |
| Brachytherapy – use of ultrasound for verification*(reference local procedure)* |  |  |
| Brachytherapy – access and use of TPS*(reference local procedure)* |  |  |
| Brachytherapy – use of contouring tools*(reference local procedure)* |  |  |
| Brachytherapy – approval processes*(reference local procedure)* |  |  |
| Brachytherapy - HDR local emergency training*(reference local procedure)* |  |  |
| *(Include other specialist equipment e.g. MR Linac, superficial as appropriate)* SAMPLE |  |  |
| Awareness and access to view individual scope of practice for entitlement*(reference local procedure)* |  |  |
| CPD / update / refresher training |
| *e.g. return to practice refresher* |  |  |
| *e.g. software update training* |  |  |
| *e.g. significant changes to local practice* |  |  |

In signing this record the individual named above confirms they have received and understood the training provided, and read and understood the reference documents.

On completion of training the named individual will be deemed competent to be entitled as an IR(ME)R operator in the (*local radiotherapy department*) for the tasks listed above for the practices listed in their scope of practice.

**Signature of individual / date:**

**………………………………………………..**

**Signature of assessor / date**:

**……………………………………………**

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# Peer review records

**Name: ……………………………………….. Job Title: …..………………………………………**

In addition to the training records outlined previously in this document, staff should complete a minimum of 10 clinical cases for peer review as part of induction and then annually thereafter. This document is for keeping a record of completed cases and should be submitted at annual appraisal.

|  |  |  |
| --- | --- | --- |
| **Clinical competencies:** Target outlining record, body site specific – minimum of 10 cases per anatomical site over a 12-month period**.** An exception may be made for rare and less common tumours. | **Oncologist signature / date** | **Peer reviewer signature / date** |
| Number | Date | Body site | Pt No. | Peer review/volume |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  | SAMPLE |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Evidence in this document provides evidence of training and competence. In signing this record the individual named confirms they understand local requirements and the peer reviewer is satisfied as to their competence.

**Signature of individual / date:**

**………………………………………………**

**Signature of assessor / date:**

**....................................................................**

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