

Promoting quality in clinical placements: literature review and national stakeholder consultation

Final Report

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•SIGGINS MILLER



An Australian Government Initiative

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Contents

Executive Summary	v
Introduction and background	1
Method	1
Literature Review	1
National stakeholder consultation	2
Literature Review	3
<i>Introduction</i>	3
Description of the literature	3
The clinical learning environment.....	4
Experiential learning	4
Quantitative measures of the clinical learning environment	4
Enabling factors in clinical learning environments	5
Culture for quality	5
Effective supervision	7
Learning opportunities.....	10
Communication and collaboration	11
Resources and facilities.....	13
Barriers in clinical learning environments	13
Occupational stress.....	13
Workplace incivility & aggression	14
Summary	14
Other key issues.....	14
Innovation	14
Modes of supervision	15
Length of placement	15
Inter-professional placement	16
Technology.....	16
Web-based clinical learning programs	16
Teaching and learning resources:	17
Rural and remote considerations	18
Enhanced student outcomes	18
Barriers in the rural and remote setting	19
Enablers for rural and remote placements	19
Diversity in clinical supervision	20
Cultural diversity and clinical supervision.....	20
Culturally sensitive supervision.....	21
Difficulties in providing effective cross-cultural supervision	21
Initiating and encouraging discussion of cultural or racial issues.....	21
Experiences of Aboriginal and Torres Strait Islander students.....	22
Gender	22
Disability.....	22
Summary	22

National stakeholder consultation.....	24
Concerns about the development and implementation of a national framework	24
Terminology	24
Disciplinary differences in supervision	24
Differences in setting or context	24
Acknowledgment of existing frameworks	24
Other concerns.....	24
Flexibility	25
Consultation	25
Collaboration	25
Effective supervision	25
Learning culture	25
Conclusion.....	26
Frameworks for quality clinical placements	27
Description.....	27
Analysis	27
Development.....	31
Implementation	31
Monitoring and evaluation	32
Conclusions	33
Recommendations	34
Elements of a quality clinical placement experience.....	34
References.....	35
Appendix A: Quality in clinical placements – table of frameworks	59
Appendix B: Quality in clinical learning environments – primary research	75
Appendix C: Interview protocols.....	98

Figures and Tables

Table 1 – Complementary and/or Supplementary Frameworks	vi
Table 2 – Search Terms	1
Table 3 – Factors in Chan’s (2002) Clinical Learning Environment Inventory (CLEI)	5
Table 4 – Framework Analysis for Elements Relevant to Quality in Clinical Placements	26

Executive Summary

This report was commissioned by Health Workforce Australia in June 2012 to inform the potential development of a national plan for promoting quality in clinical placements, as part of Health Workforce Australia's *Clinical Supervision Support Program* (CSSP). The CSSP aims to expand the capacity and competence of supervision for all health professions across the educational and training continuum.

A literature and document review of more than 500 records was conducted with a view to: (1) identify elements of quality in clinical placements as cited by peer reviewed research, (2) identify existing quality clinical placement frameworks, and (3) recommend one framework that can be adapted for use in the Australian clinical placement environment. This review covers multiple perspectives, including those of clinical supervisors, students, health organisations, and education providers. These perspectives were further explored in a national consultation with 19 informants representing all States and Territories and all stakeholder groups.

Identify elements of quality in clinical placements

Based on the review and consultation, a framework of elements relevant to quality clinical placements was developed consisting of enablers, barriers, and other key issues.

Enablers are factors known to improve the quality of the clinical placement experience and include:

1. *A culture for quality*, comprising relationships, learning, and best-practice
2. *Effective supervision* founded on a good supervisory relationship
3. *Learning opportunities* largely supported participation in direct patient care
4. *Effective communication and collaboration* between students, academic institutions, and placement sites to ensure adequate placement preparation
5. *Resources and facilities* to conduct placement activities.

Barriers are factors known to reduce the quality of the clinical placement experience and include:

1. *occupational stress* which induces states of anxiety that inhibit learning, impair performance, and compromise health and wellbeing, and
2. *workplace incivility and aggression* which threatens the socio-emotional and physical safety of students in the placement environment.

Other issues that affect the quality of clinical placements were identified:

1. *Innovation* to increase placement quality and capacity, in areas such as mode of supervision, length of placement, inter-professional placements, and learning technologies;
2. *Rural and remote considerations*, including a recognition of the unique enablers and barriers in rural and remote placements; and
3. *Diversity*, where the needs of culturally and linguistically diverse groups, the experience of Aboriginal and Torres Strait Islander students, and the impact of gender and disability on the placement experience are considered.

Identify existing quality clinical placement frameworks

The search yielded 23 frameworks (10 international and 13 Australian) frameworks – that is, documents, guidelines and handbooks offering guidance to placement sites, educational institutions, clinical supervisors and students about quality clinical placements and effective supervision. Of the 23 frameworks identified as relevant to quality clinical placements, only five were specifically about clinical placement: the majority (14) focused more narrowly on clinical supervision for registered health practitioners. Each framework was analysed using the elements of quality outlined above.

One framework that can be adapted for use in the Australian clinical placement environment

The Victorian Department of Health’s *Best Practice Clinical Learning Environments* (BPCLE) was identified as an evidence-based, piloted, and evaluated framework suitable for adaptation to the Australian context. It features six elements: (1) organisational culture, (2) best-practice clinical practice, (3) a positive learning environment, (4) an effective health service-training provider relationship, (5) effective communication, and (6) appropriate resources and facilities. Review of each of these elements reveals sufficient evidence of all enablers of quality except supervision. Like most frameworks, it does not address barriers in the clinical placement environment and pays limited attention to issues of innovation, rural and remote considerations, and diversity. However, given the material available in existing frameworks and the literature, there is an opportunity to expand the core elements of the BPCLE to capture the full spectrum of factors influencing quality clinical placements. Frameworks that would complement or supplement the BPCLE are listed in Table 1 as sources relevant to developing, implementing, monitoring and evaluating a national plan.

Table 1: Complementary and/or Supplementary Frameworks

Phase	Element/Topic	Framework
Development	Supervision	<i>Super guide: A handbook for supervising allied health professionals</i> developed by Health Education and Training Institute in New South Wales
	Innovation	<i>The Inter-Professional Capability Framework</i> (Walsh, Gordon <i>et al</i> 2005)
	Rural & remote considerations	<i>Optimising Rural Placements Guidelines - Draft</i> (2012), National Rural Health Students’ Network (NRHSN)
	Diversity	<i>Diversity- Clinical supervision handbook: a guide for clinical supervisors for Addiction and mental health</i> (Centre for Addiction and Mental Health 2008)
Implementation	Resources	<i>Super guide: A handbook for supervising allied health professionals</i> developed by Health Education and Training Institute in New South Wales <i>Foundation Programme: Reference Guide</i> (UK Foundation Programme Office 2012) <i>Foundations to Supervision</i> (WA Department of Health 2008)
Monitoring & evaluation	Measurement and Quality Assurance	<i>Indicators of Practice Education Quality in Health Care Organisations</i> (Newberry 2007) <i>Education Commissioning for Quality: Guidance for Education Providers</i> (NHS West Midlands 2010) <i>Placements in Focus: Guidance for education in practice for health care professions</i> (UK Department of Health and English National Board of Nursing, Midwifery and Health Visiting 2001)

Quality Clinical Placements: Literature Review and National Stakeholder Consultation

Introduction and background

This report contains a literature and document review designed to inform the potential development of a national plan for promoting quality in clinical placements, as part of Health Workforce Australia's *Clinical Supervision Support Program* (CSSP). The CSSP aims to expand the capacity and competence of supervision for all health professions across the educational and training continuum. The CSSP's three areas of focus are:

- 'clarity' - achieving agreement and accountability across professions, jurisdictions and educational institutions in relation to the role and function of a clinical supervisor;
- 'quality' - improving the quality of clinical supervision, building local capacity, reducing tension between service delivery and teaching and making the most effective use of clinical supervisors' time; and
- 'culture' - recognising and reinforcing the value and contribution of clinical supervisors and enabling collaboration within and across professions.

The strategies developed under the CSSP will focus on underserved areas and new settings which may include rural and remote, primary care, mental health, aged care and dental services.

Health Workforce Australia (HWA) has developed the *National Clinical Supervision Support Framework* to guide and support clinical education activity in the health sector. It also informs and underpins all the projects and activities undertaken as part of the CSSP.

As one component of the CSSP, this project includes a systematic literature review and consultation with selected participants in each State and Territory. The literature and document review identifies the elements of quality clinical placements, the conditions necessary to implement them, and frameworks in Australia and overseas designed to achieve these goals.

The report offers conclusions and recommendations to inform a potential national plan for promoting quality in clinical placements.

Method

Literature Review

The search strategy encompassed both peer-reviewed and grey literature. Peer-reviewed literature was sourced from health databases including PubMed, OVID PsycINFO, ProQuest, and EBSCO's Cumulative Index of Nursing and Allied Health (CINAHL). Each search was limited to peer reviewed records from 2000 – current, and in the English language. Table 2 lists the search terms applied across three tiers relevant to the research question.

Table 2 – Search Terms

Tier 1: Experience	Tier 2: Descriptor	Tier 3: Product
Clinical learning environment Placement environment Clinical placement Clinical clerkship Preceptorship Clinical supervision	Quality Effective Best practice	Frameworks Guidelines Models

Search terms used title, abstract and keyword fields where possible. Tier 1 search terms were used first. Where hits exceeded 250, Tier 2 and Tier 3 combinations were added to refine the search. Including specific disciplines as a tier was trialled in piloting of the search strategy and did not assist in refining the strategy. Records were included or excluded based on the title. The records most commonly excluded were simply descriptions of how to conduct research on clinical placements. The results were supplemented by inspecting the reference lists of seminal works, and by literature recommended in stakeholder interviews.

The breadth of the search strategy was cross-checked using pilot searches in two library catalogues (Griffith University and University Queensland), Google Scholar, and the Scopus database, which confirmed that the search strategy had captured the most relevant records, and a small number of additional papers were located. After screening for duplication, the search strategy yielded 581 peer reviewed records. Perusal of the abstracts of each record, or the article where abstracts were absent, resulted in 95 exclusions and 69 inaccessible records. The resulting peer reviewed literature set was 417 records. During review, seminal works published prior to 2000, were identified and obtained for inclusion, as well as other relevant works. This increased the literature set to 468 records.

Several methods were used to access grey literature. Databases, library catalogues and search engines known to include government and non-government literature were searched, including: OVID PsycEXTRA, World Catalogue, University of Queensland, Griffith University, and Google. Australian stakeholder websites were reviewed, including each State and Territories' health agencies. The websites of stakeholder counterparts in New Zealand, the United Kingdom and Canada were also reviewed. Unpublished but relevant information was accessed through stakeholder consultation. The grey literature data set included 53 records.

National stakeholder consultation

An initial set of 15 stakeholder contacts was developed in consultation with HWA. These stakeholders represented four groups:

- members of Integrated Regional Clinical Training Networks
- staff members of health departments' central offices who had portfolio responsibility for the relevant issues
- consultants working on other HWA projects, or
- others with expertise relevant to this project, including clinical education providers, clinical supervisors, and students,

Stakeholders were invited by telephone and email to participate in a 20-30 minute telephone interview. Interview protocols were designed to encompass the needs of all stakeholders and were forwarded to participants before the interview (Appendix C). Conversations with the initial stakeholder group revealed some absences due to leave, and referral to a more appropriate informant was made. The final respondent list appears in exceeded the initial target of 15. In sum, 19 stakeholders were consulted through 14 telephone interviews and two written email responses. Stakeholder representation was drawn from all States and Territories, and each of the four stakeholder groups was represented. The perspectives of these informants are detailed in the second section of this report.

Literature Review

Introduction

A quality clinical placement is one that successfully achieves the aims of clinical education in the practice environment. These aims include but are not limited to: (1) the quantity and quality of learning that is experienced by students, (2) the degree to which the experience is individualised to meet student needs (Rodger *et al* 2011), (3) adequate preparation for professional practice, and (4) efficient use of resources to achieve this (Newberry 2007). Quality clinical placements are for the most part defined in terms of student learning outcomes, and accordingly occur in high quality environments for clinical learning. The most commonly cited definition of the clinical learning environment states it is “an interactive network of forces influencing student learning outcomes in the clinical setting” (Dunn & Hansford 1997, p.1299). Researchers have attempted to identify these forces, and this literature review synthesises that effort.

Quality placements provide students with opportunities for skill development, socialisation into the profession, and a bridge between academic and workplace learning (Chan 2001; Newton *et al* 2010; Rodger *et al* 2011). It follows that clinical placements have been identified by students and health professionals alike as the most influential learning experience in a student’s journey to becoming a competent health professional (Kilminster & Jolly 2000; Chan 2001; Koontz *et al* 2010). Despite consensus about the importance of the clinical learning experience, issues about the quality of the placement process persist.

Across almost 30 years of research, the literature is rife with reports of continuing and complex problems surrounding the clinical placement experience, accompanied by concerns about students’ competence and confidence to practice (Levett-Jones & Lathlean 2008). The last decade has seen these concerns echoed beyond academia into the public health arena, shown in a surge of government reports investigating the issue across health jurisdictions globally (Levett-Jones & Lathlean 2008). It is not surprising, then, that while clinical experience is “undisputed as a key to professional competence” (Courtney-Pratt *et al* 2011, p.1381); it has been argued to be the most difficult to manage (Levett-Jones *et al* 2006).

This difficulty has been attributed in part to the tension created when clinical learning occurs in environments designed for clinical service rather than education (Berntsen *et al* 2010; Henning *et al* 2011). There is a need to recognise clinical practice and learning environments as one thing, rather than dissociated entities that make the transition from student-learner to learner-worker more difficult (O’Brien & Teherani 2001; Newton *et al* 2009; Koontz *et al* 2010; Gallagher *et al* 2012).

The review begins with a description of the literature in terms of the disciplines, countries, and organisations it is drawn from, and the research methods used. A thorough account of elements of quality in the clinical learning environment is presented, and factors known to enable or impede the placement experience are discussed. Enablers include (1) a culture for quality, (2) effective supervision, (3) learning opportunities, (4) communication and collaboration, and (5) resources and facilities. Barriers include (1) occupational stress, and (2) workplace incivility and aggression. Other key issues explored include the importance of innovation as a way to enhance quality, considerations for quality in rural and remote placements, and diversity issues as they relate to a quality placement experience.

Description of the literature

The peer reviewed literature informing this paper included 470 records, mostly published since 2000. Consistent with previous reviews (e.g. Brown *et al* 2011), the great majority of research on issues relevant to quality clinical placements has been done in nursing, followed by medicine, and a smaller literature for the allied health disciplines. Occupational therapy was the most published allied health discipline, but dentistry, social work, paramedics, audiology, physiotherapy, speech pathology, radiography, radiation therapy, psychology and physical therapy have also been captured

in this review. An international perspective has been obtained, encompassing research from across the globe; United States, Canada, United Kingdom, Europe, the Netherlands, Norway, Sweden, Finland, Australia, New Zealand, China, Cyprus, South Africa, and Malta. A selection of primary research studies representing this distribution appears in table form in Appendix B, with a combination of qualitative and quantitative methods. Primary research has predominantly used cross-sectional surveys or qualitative interviews or focus group methods with student and non-student stakeholders (e.g. clinical supervisors, clinicians, academics). The various methods produce generally consistent results across studies. A limitation of the research methodology is the paucity of research conducted on placements in community settings - the focus is largely on hospital environments (Berntsen *et al* 2010).

The review has also been informed by grey literature records; including articles, research reports, guidelines, frameworks, and handbooks. Consistent with the disciplinary distribution of peer-reviewed literature, the grey literature has been generated predominantly by nursing agencies, followed by general health services, medicine and allied health. The types of organisations publishing this material include academic institutions, state and federal departments of health or health services, medical councils, statutory and regulation bodies, and private consultants contracted by one of these agencies.

The clinical learning environment

Experiential learning

Learning in quality clinical placements is what experiential learning theory calls ‘situated’ – that is, it transforms theory into practice (Yardley *et al* 2012). Students must be provided opportunities to transfer classroom learning to the context where this learning applies. There is much empirical research to show that the clinical learning environment predicts clinical learning outcomes (Dunn & Hansford 1997; Lofmark & Wikblad 2001; Andrews *et al* 2006; Levett-Jones & Lathlean 2008; Plack 2008). Simply, real learning comes from real environments, and is a necessary component of clinical education (Brown *et al* 2011; Yardley *et al* 2012). This has been acknowledged in practice. For example, based on a comparison of student preparation to begin practice in three UK medical schools, Illing *et al* (2008) recommended to the General Medical Council that experiential learning openings be increased to improve preparedness for practice. However, the clinical learning environment is starkly different from the controlled academic settings that students are familiar with. Skaalvik *et al* (2011) say the learning environment includes everything surrounding the student in the placement setting. There are elements of unpredictability in the attitudes and behaviours of staff members and patients and their family members, which give rise to unplanned events during placement (Koontz *et al* 2010; Brown *et al* 2011). Indeed, this lack of control in the environment is what makes it a valuable and critical learning experience, but it also creates risks to quality.

Dunn and Hansford (1997) defined the clinical learning environment (CLE) in terms of the interacting forces that influence student learning. Researchers have attempted to identify and understand those forces further. Nursing researchers have tried to quantify these forces by developing valid and reliable survey tools.

Quantitative measures of the clinical learning environment

There is a significant relationship between students’ perceptions of the learning environment and their satisfaction and success (Van Hell *et al* 2009). Dunn & Hansford’s (1997) study of nursing students demonstrated that the relationship between student satisfaction and a positive learning environment was bidirectional. As a result, several measures have been developed across health disciplines. Two commonly cited examples include the Clinical Learning Environment Inventory (CLEI) (Chan 2002) and the Clinical Learning Environment Supervision and Nurse Teacher evaluation scale (CLES+T) (Saarikoski & Leino-Kilpi 2002).

Chan (2002) developed the CLEI based on a theoretical framework in psychosocial education. It measures six aspects of the CLE (defined in Table 3).

Table 3: Factors in Chan's (2002) Clinical Learning Environment Inventory

Factor	Description
Individualisation	Extent to which students are allowed to make decisions and are treated differently according to ability or interest.
Innovation	Extent to which clinical teacher/clinician plans new, interesting, and productive ward experiences, teaching techniques, learning activities, and patient allocations.
Satisfaction	Extent of enjoyment of clinical placement.
Involvement	Extent to which students participate actively and attentively in hospital ward activities
Personalisation	Emphasis on opportunities for individual student to interact with clinical teacher/clinician and on concern for student's personal welfare.
Task Orientation	Extent to which ward activities are clear and well organised.

The CLEI is administered using two forms: one measures students' perceptions of the real environment, and the other assesses their ideal environment. Chan & Ip (2007) found significant differences between students' perceptions of the actual clinical learning environment and the ideal clinical learning environment they desired. Significant gaps between students' ideal and real environments have appeared internationally: students often have experienced placements they perceive as poor quality (Chan 2002b 2004a; Ip & Chan 2005; Brown *et al* 2011).

The CLES+T was derived from a content analysis of 87 empirical studies, six audit instruments, and five systematic literature reviews published between 1980 and 2006 (Saarikoski & Leino-Kilpi 2002). It consists of (1) pedagogical atmosphere, (2) supervisory relationship, (3) leadership style of the ward manager, (4) premises of nursing on the ward, and (5) role of nurse teacher in clinical practice (Saarikoski & Leino-Kilpi 2002). Both measures have made a considerable contribution to the field in evaluating learning environments, but they do not produce the complete picture. Moreover, such measures tend to be student focused, and may not capture the perspectives of the other stakeholders, such as placement site personnel and academic staff. It is useful to look beyond such measures to identify factors that optimise clinical learning environments.

Enabling factors in clinical learning environments

A thorough review of the literature yielded five elements critical to enhancing the clinical placement experience. First, a culture for quality is required. Such a culture values positive relationships, supports learning, and promotes best-practice in education and service delivery. It is argued that all other elements are underpinned by a culture for quality. Secondly, effective supervision of students is a necessary condition of quality placement. Thirdly, learning opportunities characterised by supported participation in patient/client care are needed. Fourthly, quality clinical placements are facilitated by good communication and productive collaboration, within and between placement sites and academic institutions. Finally, quality placements require sufficient resourcing and facilities to conduct learning in the workplace.

Culture for quality

Organisational culture includes the values, beliefs and assumptions about the appropriate ways to think and behave within an organisation. Therefore the culture of the clinical learning environment to which students are introduced, has a powerful influence on what is learned and how this is expressed as professional behaviour. Three aspects of organisational culture are clearly related to quality in clinical placements, (1) relationships, (2) learning, and (3) best-practice.

Students often identify relationships in the clinical learning environment as the most important factor influencing the quality of a placement, illustrating they need to be supported both pedagogically and psychologically (Saarikoski & Leino-Kilpi 2002). Students report the absence of psychological support to reduce quality of life and increase the risk of compassion fatigue and vicarious trauma (Henning *et al* 2011). Part of the problem may rest in the relative importance of relationships as viewed by students and clinical educators. Rodger *et al* (2011) found that while students identified a welcoming learning environment as an indicator of quality, clinical educators tended to focus more on operational requirements. Professional stakeholders involved in the placement process must be informed about the importance of relationships to student learning outcomes and student satisfaction.

Placement experiences characterised by supportive relationships in positive learning environments have been shown to improve learning outcomes significantly (Fenton 2005; Hartigan-Rogers *et al* 2007; Morris 2007). There are several explanations for this. First, positive working relationships can increase opportunities to practise in the placement setting, whereas negative relationships can restrict the student to routine tasks (Newton *et al* 2009). Secondly, a culture of support offers students the psychological safety necessary to ask and respond to questions, make and learn from mistakes, and initiate additional opportunities for learning (Lofmark & Wikblad 2001; Healey 2008; Plack 2008). Thirdly, environments characterised by mutual respect and positive regard reduce student anxiety, thereby enhancing cognitive function (James & Chapman 2009). Fourthly, trusting relationships increase the capacity for open and honest feedback that encourages self awareness and reflective learning (Fenton 2005; Chesser-Smyth 2005 as cited by James & Chapman 2009). Given the benefits to student learning, it is not surprising that students identify relationships as critical to their satisfaction with the placement experience.

Researchers using Chan's (2002) CLEI have consistently found personalisation as the most important element from the student perspective, indicating the importance of the interaction with clinical educators and the concern shown for student welfare (Chan & Ip 2007; Smedley & Morey 2010; Brown *et al* 2011). Relationships are important to students because of the support and sense of belonging they provide (Skaalvik *et al* 2011; Gallagher *et al* 2012). Regardless of health discipline or country, students consistently report they need to feel respected, appreciated and part of a team (Papp *et al* 2003; Klang 2005; Newton *et al* 2009; Ralph *et al* 2009; Brown *et al* 2011; Rodger *et al* 2011). These concepts are captured in the research within discussions about communities of practice and belonging.

Skaalvik *et al* (2011, p.2301) captured the importance of culture focused on relationships - "a pedagogical atmosphere characterised by positive engagement and supervision in a supportive and trusting atmosphere." Research using the CLES (Papastavrou *et al* 2010) identified "premises of learning on the ward" as an important determinant of student satisfaction with the placement experience in the hospital setting. Henderson *et al* (2011) developed a framework to help health facilities build a learning culture. Integral to the effort are positive partnerships, effective management, and inspirational leadership. These three examples illustrate how the "forces influencing student learning outcomes" (Dunn & Hansford 1997) are interconnected.

Ideally, the clinical learning environment is a community of practice where learning processes are underpinned by a culture in which "social interaction is a vital component...place of cooperation, kinship, caring, support, understanding, unity and inclusiveness" (Lave & Wenger 1991, cited by Smedley & Morey 2010, p.76). Research has demonstrated that when students feel part of the community of practice, their satisfaction is increased (Smedley & Morey 2010). A community of practice is characterised by a sense of belonging, whereby "an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group" (Levett-Jones & Lathlean 2008, p.104). More than 50 years of psychology research has demonstrated that an absence of belongingness reduces self esteem, well-being and happiness, while increasing stress,

anxiety, and depression (Levett-Jones & Lathlean 2008). The same body of research illustrates that the need to belong can induce conformity behaviours. In the placement context, this has been observed in students who engage in behaviour they know is not best practice, in an effort to be accepted (Levett-Jones & Lathlean 2008). This highlights the importance of culture of positive relationships, together with one that supports learning and promotes best-practice.

An organisation's culture is inextricably linked to its leadership. The values, beliefs, and assumptions of an organisation's leadership are displayed in the attitudes and behaviours that communicate to members the professional behaviours that are rewarded, and those that are punished. This is also the case in the clinical learning environment. Ward leadership that demonstrates a positive attitude to students' and supervisors' learning and teaching needs is consistently found to be critical in promoting a learning culture (Dunn & Hansford 1997; Saarikoski & Leino-Kilpi 2001; Andrews *et al* 2006; Newberry 2007; Skaalvik *et al* 2011). Livsey (2009) found a direct relationship between leadership and either an empowering or in a disempowering work environment. Leaders demonstrating that they valued learning were associated with students with higher motivation, confidence and self-directed learning. Further, Andrews *et al* (2006) found the quality of leadership was reflected in the quality of care provided, and therefore the quality of the learning experiences students could observe or participate in.

While there is important attention to the supervisor's contribution on the learning environment, the student clearly has a significant role to play. Individual factors that influence the quality of the placement include students' prior knowledge and experience, preparation for placement, personality, person-job fit, and self-directedness (Lofmark & Wikblad 2001; Papp *et al* 2003; Gallagher *et al* 2012). Mature age learners tend to be more self-directed (Dornan *et al* 2007). Mature age learners also tend to be more experienced with workplaces in general, which can reduce anxiety and increase their coping capacity (Brown & Edelmann 2000). Professionals in the placement context need to be alert to the additional support younger, less experienced students may require.

The limited research that does exist on patients as contributors to the learning environment suggests they are generally treated as passive in the learning process (Kauffman 2003). Consistent with effective learning principles, it has been suggested that patients be allocated to students as appropriate to their level of competence, whereby more challenging cases are assigned as the student develops (Parsell & Bligh 2001). This practice would also contribute to patient safety, a core objective of best practice.

The term 'best- practice' as used here means both quality in teaching and quality in patient care. A best practice culture promotes "doing things smarter, practices which lead to superior performance, achieving consistent quality in what is done and evidence-based practice" (NZ Hospital and Health Services Knowledge Network, cited by Perleth 2001, p.237). Students have identified best-practice environments as important to their satisfaction with placements. In addition to satisfaction, student learning is improved, since opportunities for learning and the quality of teaching are both enhanced by a best practice focus. Klang's (2005) student sample identified quality of care as an indicator of quality. Cole and Wessell (2008) thought the learning experience could be improved when staff displayed their own professional behaviour characterised by evidence-based practice and continuing education.

In sum, a positive learning environment conducive to student learning and satisfaction is underpinned by a culture that values positive relationships, supports learning, and promotes best practice in teaching and patient care.

Effective supervision

Clinical supervisors are charged with a dual role of ensuring patient safety while promoting students' professional development (Kilminster & Jolly 2000). This requires three primary functions commonly referred to in the literature as educational (formative), supportive (restorative) and managerial/administrative (normative) (Kilminster & Jolly 2000). A clinical supervisor attempts to fulfil these

functions in an increasingly challenging service environment characterised by health workforce shortages and heightened patient demand. The supreme significance of the supervisor role to the quality of the clinical learning environment has been illustrated in a rigorous longitudinal nursing study demonstrating a 20% improvement in the quality of hospital based clinical learning environments over a 25 year period largely due to improvements in supervision (Chan 2002).

This section begins by setting out how supervision is defined for this review, and discusses the critical importance of the supervisory relationship to student satisfaction and learning outcomes. Characteristics of the supervisor and attempts to develop them through education and training are discussed. The importance of reward and recognition of supervisors as an enabler of effective supervision is outlined. Finally, common barriers to effective supervision are identified.

Terminology used to describe supervision and other supportive relationships lacks consensus in both health and education (Cottrell *et al* 2002; MacDonald 2002; Mills *et al* 2005; Kilminster *et al* 2007; Milne 2007; HWA 2011; O'Donovan *et al* 2011). This review takes a generic approach where the term 'supervisor' includes health professionals engaged in clinical supervision of students of medicine, nursing, or allied health. This definition includes preceptors, clinical or practice educators, and mentors. It excludes clinical supervision of registered practitioners. It also excludes non-clinical supervisors (for example, line managers of students who have no clinical supervisory responsibilities would not be defined as a supervisor in this context).

An influential definition of clinical supervision was proposed by Bernard & Goodyear (1998):

“an intervention that is provided by a senior member of a profession to a junior member or members of that profession. This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to clients she, he or they see(s) and serving as a gatekeeper for those who are to enter the particular profession” (Bernard & Goodyear 1998)

Health Workforce Australia's *Clinical Supervision Support Framework* (HWA 2011) recommends that each discipline interpret the term as applicable to their discipline. It defines 'clinical supervision' as:

‘the oversight – either direct or indirect – by a clinical supervisor of professional procedures and/or processes performed by a student or a group of students within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each student’s experience of providing safe, appropriate and high-quality patient care.’ (HWA 2011, p.4)

Students have reported the supervisory relationship to be the single most important factor (Saarikoski *et al* 2002; Saarikoski & Leino-Kilpi 2002; Henzi *et al* 2006; Saarikoski *et al* 2008; Papastavrou *et al* 2010; Warne *et al* 2010), or one of the most important factors influencing their satisfaction with the clinical learning environment (Rolfe & Sanson-Fisher 2002; Fenton 2005; Sheehan *et al* 2005; McCall *et al* 2009; Koontz *et al* 2010; Henning *et al* 2011; Rodger *et al* 2011). This research has been conducted across countries and health disciplines. The supervisory relationship has also been shown to have a direct effect on student self-efficacy and learning outcomes (Saarikoski *et al* 2002; Warren & Denham 2010).

Good supervisory relationships maintain a balance between the challenges posed to the student and the support provided through constructive dialogue and feedback (O'Donovan *et al* 2011; Våågstool & Skjøien 2011). They are characterised by open and honest communication (Bonello 2001; Rodger *et al* 2011) which includes frequent and constructive feedback (Bonello 2001; Lofmark & Wikblad 2001; Cole & Wessell 2008; Rodger *et al* 2011). They also require a significant time investment. Students persistently report they require more time with their supervisor (Fenton 2005; Sheehan *et al* 2005; Henzi *et al* 2006; Happell 2008c). The quality of time is also important, as students tend to be more satisfied if they have access to uninterrupted one-on-one supervision (Fenton 2005; Young *et al* 2009). These student concerns are consistent with frequently reported concerns from

supervisors that they are time poor and overworked (Leners *et al* 2006; Thompson *et al* 2012). The association between time and relationship is also highlighted by research investigating the duration of placement, where longer placements are related to stronger supervisory relationships (Happell 2008c). Another factor contributing to a successful relationship is a shared perspective in clinical background and approach (Haggerty *et al* 2012).

Poor supervisory relationships have included abuse of the supervisor's power, unreasonable work demands and criticism, and violation of ethical codes prescribed by professional bodies (O'Donovan *et al* 2011). Ineffective communication also characterises poor relationships. Students have reported condescending and insensitive manner, negative and humiliating comments, and failure to listen as having an adverse impact on their learning and wellbeing (Bonello 2001; Lew *et al* 2007; Morris 2007; Anderson *et al* 2011). The prevalence of incivility in clinical learning environments is discussed further in the barriers section.

Perhaps the friction within the supervisory relationship is partly explained by each party's expectations of it. Students tend to characterise effective supervision to include a consistent approach, supervisor availability, routine supervision sessions, balanced feedback, fair and transparent assessment processes and a respectful and judgement free relationship (Fernald *et al* 2001; Sheehan *et al* 2005; Rodger *et al* 2011; Pack 2012). Conversely, supervisors perceive supervision as a way of ensuring patient safety and mitigating risks to the organisation (Pack 2012). Evidently, expectations of the supervisory relationship influence its effectiveness. Similarly, characteristics of the supervisor and learner contribute to the supervisory relationship.

Several characteristics of supervisors have been identified as desirable to facilitating supervision across a range of disciplines (Levy *et al* 2009; HWA 2010). Attributes most commonly thought to enable effective supervision include (1) the ability to form positive relationships and rapport with students, (2) the ability to demonstrate clinical competence, (3) being organised, (4) being a good communicator, (5) possessing strong leadership and management skills, (6) acting as a role model who displays enthusiasm and a passion for learning, and (7) consistent and transparent assessment procedures (Lee *et al* 2002; Kilminster *et al* 2007; Levy *et al* 2009; Rudland *et al* 2010; Rodger *et al* 2011; Vågstool & Skoien 2011).

Undesirable characteristics may be regarded as a lack of these desirable attributes, and the research supports this assertion. Specifically, students report as undesirable inability to build rapport, disorganisation, incompetence, ineffective communication, disinterest in or dislike for students and teaching, and inconsistent and unfair assessment procedures (Bonello 2001; Fenton 2005). Supervisor education and training attempt to address these issues.

The need for supervisor development is clear if one acknowledges that a good clinician is not automatically a good supervisor (HWA 2010). Often the core skills required of a supervisor are not clearly articulated, and supervisors are selected based on seniority or availability rather than suitability (Bonello 2001; HWA 2010). Clear description of the supervisor role supported by education and training are ways to increase supervisor competence (Milne & James 2002; Kirke *et al* 2007; HWA 2010). Training increases supervisor competency includes teaching, assessment, appraisal, feedback, and interpersonal skills (Kilminster *et al* 2007; Kraemer *et al* 2011).

In addition to training, supervisors argue that appropriate reward and recognition could contribute to building supervisor capacity. In a study of nurse supervisors, Leners *et al* (2006) found that financial compensation and reduced workload were necessary rewards according to supervisors. Occupational therapists agree, arguing that a culture of appreciation is required, and it should come not just from the placement setting, but from the academic institution as well. In Kirke *et al* (2007) research, occupational therapists suggested that universities provide acknowledgement and thanks, in addition to tokens of appreciation such as free professional development, and administrative support for orientation, tutorials and placement paperwork. Reward and recognition of desirable supervisory behaviours would be consistent with a culture that values learning. Furthermore, the

organisational psychology literature clearly shows reward and recognition as a powerful psychosocial variable that influences performance. Education and training, and reward and recognition initiatives can serve to enable supervision, but there are some common factors which impair it.

These common barriers include high supervisor workload, lack of confidence and/or ability to assess student competence within clinical placements, and undesirable learner characteristics. Through occupational stress and exhaustion, high supervisor workloads contribute to high staff turnover and burnout, all of which will inhibit effective supervision (Hautala *et al* 2007; Haggerty *et al* 2012). Lack of time and competing demands mean that most supervisory activity occurs during patient care activities, with little opportunity to reflect and debrief with the student (Hautala *et al* 2007; Iedema *et al* 2010; Walters *et al* 2011). In some instances, students are seen to affect the supervisor's own duties as interruptions by questions from students can potentially compromise both the supervisor's patient care and the student's supervision (O'Donovan *et al* 2011; Wearne 2011). Managing an underperforming student or multiple students is also identified as a cumulative toll on a supervisor's time (HWA 2010; O'Donovan *et al* 2011; Wearne 2011).

Several authors say a core challenge to effective supervision has been supervisors' belief that they cannot effectively evaluate student knowledge and competence (McCarthy & Murphy 2010; Kelly 2011; O'Donovan *et al* 2011; Sturman *et al* 2011). This is certainly a concern expressed by students as well (Bonello 2001; Rodger *et al* 2011). Supervisors may also be reluctant to fail or have difficulty in failing underperforming students (O'Donovan, Halford *et al* 2011). O'Donovan *et al* (2011) concluded that contextual issues may play a role in influencing supervisors' ability to evaluate students effectively. Specifically, lines of accountability (an invitation to supervise from a university while clinical placement is overseen by the employer); potential lack of experience in supervising students; and the lack of information about what student competence is expected (O'Donovan *et al* 2011). This reinforces the concern about the lack of training and guidelines to assist supervisors fulfil their role (Williams & Irvine 2009).

Some student characteristics can influence effective supervision. When students display poor interpersonal skills, lack enthusiasm, or fail to develop the competence to perform their role, challenging them can make teaching hard work (Rudland *et al* 2010; Sturman *et al* 2011). The possibility that some students make mistakes or lack capacity sometimes leads to a refusal to accept students on placement because the workload of the supervising practitioners would increase (Liu *et al* 2010).

In sum, the supervisory relationship benefits from agreed expectations of the supervision process, effective communication, quantity and quality time, and common clinical interests. It is enabled by supervisor characteristics which are amenable to development through education and training, and by reward and recognition initiatives. Common obstacles to effective supervision include high supervisor workload, problems with consistent and accurate assessment of student competence, and undesirable learner characteristics.

Learning opportunities

A fundamental aim of the clinical learning environment is to bridge academic and workplace learning. Students in one study identified reducing the gap between theory and practice as the most positive aspect of the placement experience (Ralph *et al* 2009). The nature of the opportunities for learning is repeatedly raised by students as a key factor influencing satisfaction with the clinical learning environment. Smedley and Morey (2010) found that together with personalisation, student involvement (the extent to which students participate actively and attentively in hospital ward activities) was the most important aspect of students' preferred clinical learning environment. The importance of active participation has been replicated in several countries across disciplines. Generally students want more opportunities to:

- actively participate and observe patient care (Saarikoski *et al* 2002; Dornan *et al* 2007; Hartigan-Rogers *et al* 2007; Morris 2007; Newton *et al* 2009; Van Hell *et al* 2009; Henning *et al* 2011; Gallagher *et al* 2012;)
- teach their peers (Gallagher *et al* 2012)
- observe a range of role models (James & Chapman 2009; Koontz *et al* 2010; Rodger *et al* 2011)
- reflect on learning experiences (Koontz *et al* 2010)
- build confidence and competence to practice independently (Newton *et al* 2009)
- explore clinical interests (Hartigan-Rogers *et al* 2007)

Conversely, students want fewer:

- lectures (Henning *et al* 2011)
- unproductive tasks or non-educational tasks such as billing or patient scheduling (Henzi *et al* 2006; Ralph *et al* 2009)
- situations where staff were indifferent to their presence or restricted participation (Morris 2007; Newton *et al* 2009a)
- unreasonable expectations and responsibility beyond the student status (Morris 2007)

Similar to culture and supervision, learning opportunities influence both student satisfaction and learning outcomes. Students have reported that a lack of active participation in direct patient care impedes their development (Henderson *et al* 2007) and confidence (Lofmark & Wikblad 2001), while increased participation characterised by experiences of patients in their entirety, promotes initiative, confidence, learning, and understanding of the professional role (Lofmark & Wikblad 2001). Given the importance of direct patient contact, Van Hell *et al* (2009) findings are interesting. They found medical students across eight hospitals on average spent 40% of the time observing, 12% independently participating in consultations, and 6% involved in directly supervised activities. Students listed 7% of the time as unproductive. Blended learning has been suggested as a way to improve learning opportunities within operational requirements.

Blended learning combines traditional face-to-face teaching with computer-based learning opportunities such as discussion boards, webinars, or online mentoring. It can be an effective way to work within the time constraints of settings that cannot allow face to face teaching all of the time (Young *et al* 2009). Other innovations which improve opportunities for learning are discussed in the innovation section, including the structure and duration of placements.

In sum, students benefit from a diverse range of learning experiences, but supervised direct patient contact is required to build professional confidence and competence.

Communication and collaboration

Early research noted that good collaboration between stakeholders contributed to a positive clinical learning environment and in turn better learning outcomes (Dunn & Hansford 1997). More recent research indicates that a need for closer collaboration still exists (Kirke *et al* 2007). This section focuses on communication between the student, placement site, and academic institution as an antecedent to adequate preparation for the placement experience.

Placement preparation is one of the most challenging tasks for universities (Redding & Graham 2006). Students often say that how well the placement was organised had influenced their experience of the placement (Leners *et al* 2006; Morris 2007; Gallagher *et al* 2012). This often depended on the communication between the university and the placement site (Papp *et al* 2003). In a study of paramedic students, McCall *et al* (2009) found students frustrated when supervising staff were unaware of their impending arrival, the student's role, and their learning requirements. Levett-Jones *et al* (2006) said clinicians were concerned about the poor communication between them and universities. It was characterised by limited knowledge about what students had learned

prior to placement, trouble contacting academic staff, untimely provision of information about placement details, unclear clinical objectives, and absence of orientation processes to clinical venues. Several studies have identified the need for clearer communication about what supervisors can expect of students (Henning *et al* 2011) and what students can expect of supervisors (Rodger *et al* 2011). Formal channels of communication between the placement site and academic institution need to be established so that orientation procedures can be agreed on, and processes for addressing emerging issues developed (Fenton 2005; Andrews *et al* 2006; Kirke *et al* 2007; Newberry 2007; Rodger *et al* 2011). Redding and Graham (2006) provide some practical advice for ensure all stakeholders are prepared for the placement experience:

“Best practice centers on knowing students fully and understanding their needs. The planning process should be deliberate, integrated, and specifically focused on course objectives. Contacts with clinicians and clinical agencies need to be cultivated and maintained through networking. Coordination is an ongoing consideration to meet the challenges of change. Flexibility on the part of faculty and clinical agencies is helpful” (Redding & Graham 2006, p.177).

There are examples of successful collaboration in the Australian context.

The Princess Alexandra Hospital in Brisbane instigated strategic partnerships with tertiary institutions to address clinicians’ needs for support to fulfil student and university expectations, where each party identified its needs and capacity for involvement (Henderson 2009). Strategic partnerships between the Hospital and tertiary institutions ensured that Hospital staff that facilitated student learning in the clinical setting were well supported by tertiary education faculties. The Hospital had earlier reached a collaborative arrangement with university and ward staff where a ward staff member was paid by a university to be free of a clinical workload to supervise students in a team of nurses in a ward providing patient care, in contrast to the standard model where students were placed with registered nurses in different localities (Henderson *et al* 2006). The challenge for the Hospital was to build appropriate processes and a culture that promoted continuous dialogue and active management of student issues. This entailed the form and nature of communication, roles and responsibilities of staff involved in the partnership, and feedback measures that would inform future changes (Henderson 2009).

Page *et al* (2008) described examples of collaboration among Australian medical schools. Traditional interaction among medical schools has been competitive, not collaborative, and accounts of joint educational ventures between them are uncommon. However, several collaborative initiatives are under way in regional and rural Australia to address the rural workforce gap. They include:

- the North Coast Medical Education Collaboration between the medical schools at the University of Western Sydney, University of Wollongong and University of Sydney
- the Joint Medical Program of the University of Newcastle, the University of New England, and Hunter New England Health
- the Northern Victoria Regional Medical Education Network between the University of Melbourne and Monash University, and
- the Rural Clinical School of Western Australia, collaboration between the University of Western Australia and the University of Notre Dame.

The research indicates communication and collaboration are in need of a focused effort, and evidently there is some appreciation of this in the Australian context.

A final consideration in placement preparation is the support provided to students to participate. Placements requiring travel and incurring a financial cost are particularly difficult for students (Morris 2007; Ralph *et al* 2009). Issues such as these are particularly relevant to the rural and remote context, and discussed in that section.

Resources and facilities

Physical resources and facilities are a necessary but not sufficient aspect of the clinical learning environment. Review of the research clearly demonstrated that students and other placement stakeholders consider the psychosocial aspects of the placement experience to be the most influential on satisfaction and learning outcomes (Anderson *et al* 2011). In fact, if a supportive culture exists, it can override concerns about the physical work environment (Fenton 2005). Where resources and facilities are mentioned, it is in regard to updating facilities, providing more space and equipment for teaching and learning, increased access to learning materials, providing lockers and change rooms, access to the Intranet and Internet, and increase human resources to address shortages (Papp *et al* 2003; Anderson *et al* 2006; Newberry 2007; Magobe *et al* 2010). Interestingly, Newberry (2007) notes that current systems for gathering data to inform distribution of resources are poor. This is most likely exacerbated by ineffective communication and collaboration between universities and placement sites. It is difficult to plan resourcing when details of placements are not known to the health service.

Barriers in clinical learning environments

Two factors that clearly obstruct satisfaction and success in the clinical learning environment are occupational stress and workplace incivility and aggression. The adverse impact of both of these phenomena on individuals, teams, and organisations is well documented in the organisational psychology literature. They are discussed here in the context of the clinical placement experience.

Occupational stress

Health service environments can be particularly challenging even for the most seasoned health professional. Psychosocial stressors such as high workload, low levels of control, high role ambiguity and/or conflict, problematic working relationships, lack of supervisor and co-worker support, poorly managed change, perceived organisational injustice, and low levels of recognition and reward are all too commonly reported themes in health service delivery environments. For many students, this environment is their first encounter with life and death decisions (Newton *et al* 2009b), and their first engagement with professional culture (the good and the bad). The nature of clinical work is emotionally laborious, and unlike more physical or cognitive work roles students have encountered. Clinical education is certainly stressful for students (Lincoln *et al* 2004; James & Chapman 2009; Moscaritolo 2009; Anthony & Yastik 2011). This section outlines common stressors identified by students, the impact of stress on the individual, and strategies to manage stress in the placement environment.

Commonly cited stressors include (1) the first clinical experience, (2) lack of adequate preparation for the placement, (3) poor supervision and conflict with supervisor, (4) the amount of knowledge to be acquired and speed at which to do so, (5) the lack of support from co-workers and the academic institution, (6) fear of making mistakes, (7) fear of competence assessments, (8) a feeling of not belonging, (9) feeling intimidated by staff, and (10) difficult or critical patients (Mason 2006; Levett-Jones & Lathlean 2008; Moscaritolo 2009; Kanno & Koeske 2010; Pinnock *et al* 2011). In addition, students have reported being used as workers to respond to staff shortages, at the expense of their role as learners (Koontz *et al* 2010).

The impact of stressors on individual learning, performance, and wellbeing can be profound. The anxiety created by occupational stress can inhibit learning and reduce performance of professional behaviours (Moscaritolo 2009). Using an experimental design, Cheung and Au (2011) demonstrated anxiety reduced technical proficiency in a treatment procedure. Anxiety is also associated with a lack of confidence to ask questions and fear of making mistakes (Levett-Jones & Lathlean 2008). Lofmark and Wikblad (2001) found stress caused students to question their career path, and invoked feelings of losing control. At its' most damaging, stress can have serious long-term consequences for physical

and psychological health, as students can suffer psychological strain common to health service roles such as emotional exhaustion and burnout (Kanno & Koeske 2010; Magobe 2010).

Stress management begins at the organisational level. A culture that provides social, emotional, and professional support acts to reduce anxiety and create positive learning experiences (Berntsen *et al* 2010; James & Chapman 2009). Such cultures promote effective supervision, and provide training in stress management; both of which are proven effective in reducing student anxiety (Mason 2006; Moscaritolo 2009). This support increases social inclusion and self efficacy, and in turn facilitates demonstration of clinical competence (James & Chapman 2009).

Workplace incivility & aggression

Co-workers and supervisors can be a source of stress. In nursing there is a telling expression that “nurses eat their young” (Anthony & Yastik 2011, p.140). This section discusses the prevalence of workplace incivility and aggression in clinical learning environments before offering recommendations for practice.

In a study exploring nursing students’ experiences of incivility in clinical education, it is defined as intimidating and disruptive behaviours that are “low intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (Andersson & Pearson, 1999 cited by Anthony & Yastik 2011, p.141). Anthony and Yastik (2011) note that clinical students are relatively powerless in health care settings and therefore vulnerable targets. This was demonstrated by students who reported ostracising, hostile or rude, and dismissive behaviours from staff. More than half of students in an Australian study reported feeling disrespected, devalued, ignored, and invisible during placements (Curtis, Bowen & Reid 2007). Students felt particularly persecuted by non-university trained nurses who espoused the belief that university-trained nurses did not know much about real nursing. Students felt pressured to perform duties as shown, which sometimes contradicted the best practice taught in the university setting. As a result, many students reported an adverse impact on their future career and employment decisions. In a cross-disciplinary study across education, medicine, nursing, and social work, Myrick *et al* (2006) found conflict was experienced on placement across disciplines.

Recommendations for practice include (1) educating students on workplace incivility and aggression, assertiveness and conflict, (2) seeking agreement from the placement site to emphasise the code of conduct in the professional setting, and (3) debriefing placement experiences within the safety of the university environment (Curtis *et al* 2007; Anthony & Yastik 2011).

Summary

The transition from student to practitioner is difficult as the values and practices preached in university courses are challenged by the realities of practice and workplace processes, procedures and requirements (Newton *et al* 2009). As degree completion rates continue to be significantly less than commencing numbers, and do not meet the future demands of the health workforce (James & Chapman 2009) a focus of improving quality in the placement experience is critical to contemporary healthcare. This review has identified five factors that enable clinical learning environments; culture, supervision, learning opportunities, communication and collaboration, and resources and facilities. Two barriers to a quality clinical placement experience were identified: occupational stress, and workplace incivility and aggression. The review highlighted three additional issues that merit consideration: innovation, rural and remote placements, and diversity.

Other key issues

Innovation

To cope with the challenges inherent in the placement process and environment, a variety of innovative clinical education methods have emerged with the goal of increasing both the capacity

and quality of clinical placements. This section outlines the contribution of the following to quality in clinical placements: (1) innovative modes of clinical supervision, (2) placement structure and length, (3) inter-professional placements, (4) technological advances, and (5) new teaching and learning resources.

Modes of supervision

There has been a general increase in the use of non-traditional modes of supervision (Hoe-Harwood *et al* 2009), and the research employed to evaluate their effectiveness. Research investigating group supervision has been mixed with some students in some studies rating it as less favourable when compared to individual supervision (Zeira & Schiff 2010; Sheepway *et al* 2011), and other studies reporting cluster models of eight students in one shift with one supervisor as increasing learning, satisfaction, and placement capacity (Bourgeois *et al* 2011).

However, peer supervision appears more promising. In its simplest form, peer supervision involves two students paired together throughout placement. This approach facilitates learning by easing the transition from the classroom to the clinical learning environment (Ruth-Sahd 2011). Du Plessis (2004) evaluated a system of peer supervision where fourth-year nursing students provided first-year nursing students with learning opportunities, and at the same time gained skill and experience in the process of assessing another student's practice. Evaluations of this model found that students experienced peer supervision and guidance positively, saying that it made their first clinical experience more rewarding and less threatening. They generally felt the supervision integrated theory and practice, offered an effective support system, increased their ability to acquire new skills, and increased their self-confidence (du Plessis 2004). Another peer supervision model proposed that two students are paired with one supervisor. The students changed peer partners and supervisors every three weeks during a nine week placement (Roberts *et al* 2009). Evaluations of this method demonstrated the potential to achieve efficiencies in the supervisors' involvement by coordinating the skill development activities of students as a group, and promoting peer assisted learning. In combination with the mode of supervision, some research has evaluated the effectiveness of different learning modalities. Watt *et al* (2011) developed a structured three-day pilot program to trial learning modalities chosen for their potential to reduce student anxiety. These included a mixture of group learning, peer mentorship, reflective activities, low-fidelity simulations in medication administration, interpreting and documenting patient charts, and typical clinical scenarios. The program succeeded in reducing student anxiety, increasing self-efficacy, and enhancing the overall quality of the placement.

Length of placement

Innovations in the length of placements are well-documented, and longer placements in particular have been evaluated as more effective (Hirsh *et al* 2007; Norris *et al* 2009; Kevin *et al* 2010; Hudson *et al* 2011; Sheepway *et al* 2011). For example, weekly clinical placements have been proposed, where students attend their clinical placement for two to three days a week, and spend the remaining days attending lectures, tutorials and skill laboratories. This approach was found to narrow the gap between theory and practice and gave students continuity and consistency in clinical practice (Kevin *et al* 2010). A twelve-month community-based clinical placement in a rural or remote setting increased GP supervisors' morale and improved the quality of the student's clinical experience (Hudson *et al* 2011). Smedts and Lowe (2008) investigated the effects of duration of clinical training placements in the Northern Territory on the rate of medical students who returned to the Northern Territory for an internship. Their results showed that clinical placements where students spent more than 20 weeks were more efficient and increased the likelihood of students returning to the Northern Territory, compared with students who spent less than 20 weeks at a placement (Smedts & Lowe 2008). Similar results have been found in other studies, which show that longer placements increased students' patient responsibility, examination-driven learning, program flexibility to address educational gaps and a strong and positive perception of educational continuity (Mihalynuk 2008). Students from Harvard

Medical School evaluated their experience in a longitudinal integrated clinical placement lasting six to eight months (Ogur 2009). They reported that the placement structure created a dynamic learning environment that helped them to more broadly learn about their patients' diseases and experiences of illness. They also felt that the placement increased their connectedness to patients and enhanced their self-reflection and developmental skills (Ogur 2009).

Inter-professional placement

Recent literature has proposed inter-professional collaboration in clinical placements, suggesting that the clinical environment is an ideal setting for developing students' collaborative practice skills (Hilton & Morris 2001; Yu *et al* 2009; Dubouloz *et al* 2010). An evaluation conducted by Hilton and Morris (2001) assessed physiotherapy students' experience of the availability and quality of inter-professional learning opportunities, and found that case conferences, team meetings, ward rounds and discharge planning were all important activities that facilitated development of students' communication skills and ability to work collaboratively with others. Another evaluation study considered the impact of an inter-professional training ward on occupational therapy students' clinical experiences (Mackenzie *et al* 2007). The evaluation identified the value of this learning experience in giving students an opportunity to appreciate the importance of interpersonal skills and to learn about other team members' roles and responsibilities.

Dubouloz *et al* (2010) believe that collaboration among health care professionals is the key to quality care for patients, and they therefore developed an Inter-professional Rehabilitation University Clinic in Primary Health Care in Canada. This facility offers inter-professional learning experiences for students of audiology, occupational therapy, physical therapy, speech-language pathology, and nursing. This is quite an achievement given clinical placements have been traditionally offered and studied on a discipline specific basis (Reeves 2008). Despite the complexity involved, Dubouloz *et al* (2010) believe inter-professional collaboration is the key to quality patient care, and there is therefore a need to invest in opportunities for inter-professional learning.

In the Australian context, the North Coast Medical Education Collaboration program provides interdisciplinary education in teams of health care students and practitioners and offers year-long rural placements. The goal is a medical education that emphasises multidisciplinary health care and research in rural placements (Page *et al* 2008). A pilot innovation in inter-professional clinical placements is under way for undergraduates in the health disciplines at Monash University. Its aim is to trial student led inter-professional clinical placements to develop collaborative practice-ready health workers and increase clinical training capacity. Pre-registration medical, nursing and allied health students attend the two week placement program in a practice-based learning environment. The student teams collaboratively assess and manage patients and deliver comprehensive care plans under supervision. The program is facilitated by an inter-professional teaching team including educators and multidisciplinary clinicians (Monash Online 2012).

Technology

Technological innovations relevant to quality in clinical placements include web-based clinical learning programs and simulations.

Web-based clinical learning programs

Web-based clinical learning programs targeted at students and supervisors have been facilitated by recent advances in information technology. Students have evaluated positively the integration of web-based virtual patient cases in clinical placements, which they perceive to be more effective than traditional learning methods. They felt the program allowed them to develop their medical knowledge and skills while alleviating pressures of accessibility to both patients and supervisors (Berman *et al* 2009). The use of online Digital Microscopy (DMs) in the education of pathology students has been shown to be an effective teaching method, particularly in more remote clinical

placement settings. Students using DMs reported faster learning, greater accessibility, increased opportunities for self-paced learning, and better collaborative learning (Sivamalai *et al* 2011).

Web-based e-learning programs have also been targeted at clinical supervisors. For example, a five-month based e-learning program enhanced supervisors' teaching capacity, facilitated their professional development, and improved the quality of clinical placements (Myrick *et al* 2011). Web-portals documenting placement contacts, aims and objectives, possible learning experiences for students, and available services in the placement area have been developed to increase information and access to clinical placements (Clark & Stevens 2006; Cooke *et al* 2009; Lasserre *et al* 2010).

Defined as activities which mimic the reality of clinical environments, the use of simulations in health care education is becoming increasingly common (Baillie & Curzio 2009). In simulation, students learn in a realistic clinical environment where they can practise their skills without risk to patients, and then apply these skills in a clinical placement (Baillie & Curzio 2009; Harder 2010). Studies of the effect of simulations on students' and supervisors' experience of clinical placements have found that they are regarded as educationally, professionally and clinically relevant (Williams *et al* 2009). Simulations have been found to increase student engagement, their psychomotor and clinical reasoning skills, self-confidence, self-efficacy, ability to manage unfamiliar situations, and satisfaction with learning (Baillie & Curzio 2009; Williams *et al* 2009; Harder 2010; Williams *et al* 2010).

Teaching and learning resources

Development of resources designed to enhance capacity and quality in clinical placements is a flourishing field. While it is beyond the scope of this project to produce an exhaustive list of resources and tools, the following are provided to illustrate different types of resources and tools and identify those that have been evaluated. For example, a number of studies have explored the value of learning contracts in clinical placements. A learning contract is defined as a written agreement between the student and clinical supervisor that makes explicit what the student will do to achieve specified learning outcomes (Chan & Wai-tong 2000; Chien *et al* 2002). Learning contracts place emphasis on the students' learning activities, student-supervisor interaction, subject matter, and implicitly promote self-directed learning. Evaluations of the effectiveness of learning contracts have shown they have a positive influence on learning by increasing students' autonomy, motivation and confidence to meet their own learning needs and bridge the gap between theory and practice (Chan & Wai-tong 2000; Chien *et al* 2002).

Cleary and Walters (2010) recommend use of ready-to-use toolkits in busy clinical settings. These typically include quizzes, crossword puzzles, vignettes, role-plays, storytelling or reflective activities; all of which have been found to increase student engagement. Additional benefits of these toolkits are that they are: simple and easy to compile, cost-effective, increase critical self-reflection, and allow health care professionals to remain up-to-date with the latest evidence (Cleary & Walters 2010).

The School of Nursing at Central Queensland University has developed a clinical learning guide which includes an organised sequence of events of the clinical practicum experience, accompanied by relevant resources that can be used at each phase of the placement. The guide informs supervisor workshops, and is supplemented by student and supervisor guides complete with checklists, clinical skills lists; CD-ROMS for supervisors, a pre-clinical resource package with information about the student's potential clinical experience, and specific information about clinical organisation and specific clinical areas within it (Reid-Searl & Dwyer 2005).

Bloomfield *et al* (2007) developed a Reporter, Interpreter, Manager, Educator (RIME) feedback tool to alleviate the challenge of providing frequent, specific and supportive feedback to medical students. It requires all health professionals working with a student to observe the student's performance under normal ward conditions for the entire term of the placement, rather than in single examination conditions. At the end of the term, the health professionals engage in a round-

table discussion about the student's progress on the RIME developmental ladder, and they create a consensus statement describing the student's performance which is then discussed with the student by a single member of the group. The Peshkin Approach also assists the feedback process.

The Peshkin Approach is a reflective tool designed to enhance students' self-reflection capabilities on clinical placements. It requires students to record their subjective thoughts and feelings, in order to identify aspects of their subjectivity that influence their clinical practice (Bradbury-Jones *et al* 2007; Murphy *et al* 2009). Evaluations of both these tools found them effective in enhancing supervisors' and students' capacity to give and receive feedback, and in increasing students' self-awareness and overall learning (Bloomfield *et al* 2007; Bradbury-Jones *et al* 2007).

Examples of clinical supervisor training resources include a 1-day sail training program to increase graduate nurse preceptor skills (Nicol & Young 2007) and the Five Minute Preceptor (5MP) teaching technique (Bott, Mohide & Lawlor 2011). The sail training program was designed to promote active experiential learning in supervisors to promote empathy, demonstrate clinical teaching skills and practice, and practise giving feedback. In the program, supervisors were exposed to an unfamiliar situation which induces anxiety, and asked to learn new skills in a team environment. The program was believed to be effective in developing clinical supervisors by increasing their awareness of students' needs, and by developing their teaching skills (Nicol & Young 2007). The 5MP is a teaching method with five steps: (1) get the student to take a stand; (2) probe for supporting evidence; (3) teach general rules; (4) reinforce the positives; and (5) correct errors or misinterpretations (Bott *et al* 2011).

Rural and remote considerations

Current projections to 2025 for the health care sector workforce in Australia indicate a potential shortage of nurses (109,000 or 27%), and doctors (2,700 or 3%), particularly in rural and remote locations (HWA 2012). There is a need to expand the workforce supply and the distribution of the health workforce to better meet community needs. *Health Workforce 2025* (HWA 2012) suggests that Australia's Health Workforce (particularly doctors) is not evenly distributed across the country, and some redistribution of the workforce is required. A challenge in providing healthcare services to rural and remote communities is recruitment and retention of staff (Mills *et al* 2005). Evidence suggests that providing high quality, positive clinical placement experiences for students in rural and remote areas may provide one way to address workforce shortage in these regions.

Positive rural and remote placement experiences have been found to be critical to attracting prospective health professionals to rural and remote areas (Killam & Carter 2010; Neill & Taylor 2002; Page & Birden 2008; van Diepen *et al* 2007). The likelihood of seeking employment in these areas may be influenced by the attitudes students form during a placement (Webster *et al* 2010). Rural and remote placements influence the future career decisions of medical (Page & Birden 2008) nursing (Armitage & McMaster 2000; Webster *et al* 2010), and allied health professionals (Richards *et al* 2002). Students who have a positive placement experience are more likely to return to work in a rural or remote location (Neill & Taylor 2002; van Diepen *et al* 2007; Page & Birden 2008; Killam & Carter 2010).

As well as addressing workforce shortages, opportunities for placements in rural and remote areas can enhance placement capacity. The increase in the number of students enrolling in health profession courses has also increased demand for clinical placements. The demand has put pressure on metropolitan areas, and rural and remote placements are seen as a way to expand capacity.

Enhanced student outcomes

In addition to bolstering the health workforce in rural and remote areas, rural and regional clinical placements are argued to provide unique benefits for the student engaging in the placement. Rural placements have been an important part of learning in Australia for many years, and students experience great benefits from them (Armitage & McMaster 2000; Denz-Penhey & Murdoch 2009; Couper *et al* 2011). They offer a diverse range of hands on and holistic experiences (Armitage &

McMaster 2000; Talbot & Ward 2000; Yonge 2007; Eley & Baker 2009; Sedgwick *et al* 2009; Webster *et al* 2010), and promote growth in clinical competence as well as practical skills (Couper *et al* 2011). There are opportunities for students to gain cultural understanding and awareness, for example about Aboriginal health issues (Webster *et al* 2010). These placements often take place in smaller settings, and students can learn and gain experience in team work, participatory learning, and mentoring along the patient journey as well as in the acute phases of illness (Couper *et al* 2011).

Another benefit provided by rural and remote placements is the opportunity for multidisciplinary experience and inter-professional practice that may encourage attraction and recruitment for students to these areas (Armitage & McMaster 2000; McNair *et al* 2005; Cragg *et al* 2010). As well as the skills and experiences these placements can provide, rural and remote placements also offer particular benefits in terms of the relationship with supervisors and preceptors. Couper *et al* (2011) describe how preceptors in these areas can become role models for students, and are able to provide teaching benefits beyond clinical components, such as professionalism and building patient relationships. In these locations, supervisors also provide social and pastoral support (Denz-Penhey & Murdoch 2009). Positive benefits may accrue to the preceptors themselves, by being professionally stimulated and rejuvenated in their practice.

Given these positive outcomes for bolstering Australia's health workforce in rural and remote regions, the enhanced skill set of students participating in these placements, and the potential benefits for the supervisors themselves, it is important that attention to be paid to ensuring rural and remote placement experiences are of high quality. There are several inherent barriers to quality clinical placements, which Eley and Baker (2009) say can be logistically complex in these areas.

Barriers in the rural and remote setting

Even though rural and remote placements may give students a broad range of experiences, it can still be difficult to expose students to the range of specialist disciplines (Couper *et al* 2011). Staff shortages in remote areas limit the number of students a site can accommodate, and may limit the teaching they receive, reducing their learning experience (Webster *et al* 2010). Students may face financial barriers in undertaking rural placements. For example, loss of income during placement is important for many students (Neill & Taylor 2002; van Diepen *et al* 2007; Page & Birden 2008; Killam & Carter 2010; Webster *et al* 2010). A practical issue is the difficulty of finding accommodation for students on placement (Jones *et al* 2003; Lang *et al* 2005; van Diepen *et al* 2007; Yonge 2007; Page & Birden 2008; Killam & Carter 2010).

In rural and remote placements, students may feel lonely and isolated away from family, friends and University support networks (Killam & Carter 2010; Webster *et al* 2010; Couper *et al* 2011). In addition to social isolation, students may feel unsupported by their faculty staff (Gum 2007; Yonge 2007). There may be difficulties inherent in the social support supervisors and educators can provide as well due to the ethical boundaries of supervision (Yonge 2007). Rural supervisors, especially GP and nurse educators, have often lacked peer support or guidance from source educational institutions in responding to students' needs (Baker & Walker 2004; Dalton 2004; Killam & Carter 2010).

Characteristics of these locations are barriers to placements such as limited access to technology, difficulty in contacting home, social supports and educational resources (Webster *et al* 2010; Couper *et al* 2011), environmental conditions (Killam & Carter 2010) and travel distances (Yonge, Ferguson & Myrick 2006; Killam & Carter 2010).

Enablers for rural and remote placements

In the face of these problems, what conditions and elements are needed to ensure the greatest benefits from rural and remote placements? Page and Birden (2008) suggest attention must be paid to the structure and support for these placements, particularly for longer placements which may be more beneficial than shorter placements. Eley and Baker (2009) say rural medicine needs to incorporate inter-professional and holistic features, which are enhanced when medical placements

collaborate with allied health and nursing. In developing rural placements, Page and Birden (2008) suggest that students and rural clinicians are involved in the development phase to ensure their relevance for both the student and the location. Different sites can provide for different needs, and should be carefully matched to students (Page & Birden 2008), taking students' needs and learning styles into account, and ensuring the allocation process is transparent and fair (Couper *et al* 2011).

Preparation and orientation of students are of particular importance for rural and remote placements. They include briefings on cultural awareness and work in cross cultural environments (NRHSN 2012; Lyle *et al* 2006), adequate preparation for the isolation that may be experienced (Couper *et al* 2011), and remote area specific skills such as driving on unsealed roads (Lyle *et al* 2006). Student preparation before arriving at the placement may also mean that students are already trained in the caring skills most in demand at the placement (Page & Birden 2008).

To reduce students' sense of isolation or loneliness in rural and remote placements, it is important for students to feel part of the community they are placed in (Webster *et al* 2010). Involvement and engagement in the community should be encouraged (Page & Birden 2008; Webster *et al* 2010; Couper *et al* 2011). Students should be supported in this engagement (NRHSN 2012). Face-to-face contact with other students is one way to reduce the sense of isolation (Couper *et al* 2011).

Practical support for students can alleviate accommodation and financial barriers. Webster *et al* (2010) and the NRHSN (2012) recommend assisting students financially in these settings. Hays *et al* (1993) and Armitage and McMaster (2000) described the University of Sydney's Rural Careers Project, which supported students financially to undertake rural and remote clinical placements. The University's current Rural Experience program contains advice on accessing the Rural Australia Medical Undergraduate Scholarships (RAMUS) scheme for financial support. Assistance with accommodation is also suggested (Page & Birden 2008; NRHSN 2012).

Students need adequate access to technology facilities and educational resources (NRHSN 2012). Eley and Baker (2009) describe providing students with personal digital assistants loaded with textbooks and resources as an example of how technology and resources may be provided in rural and remote areas.

Armitage and McMaster (2000) suggest that the relationship that develops between student and supervisor, mentor or preceptor contributes to the rural experience. Such a positive relationship has a strong impact on students' experience (Yonge 2007). The NRHSN Guidelines (2012) suggest that supervisors should actively engage students about their learning experience: it may mean allocating time for formal teaching, encouraging the student, creating learning opportunities, and providing regular feedback.

In addition to ensuring a positive relationship between students and supervisor, support for clinical teachers and supervisors is also necessary. Giving supervisors access to online journals, contact with other supervisors, and information on curriculum and assessment requirements are examples of the supports that should be provided (Page & Birden 2008).

This body of literature demonstrates that particular consideration should be taken to ensure quality rural and remote clinical placements, and the issues described above should form part of the development of any national plan to promote quality in clinical placements.

Diversity in clinical supervision

Cultural diversity and clinical supervision

Many jurisdictions, including Australia and New Zealand, have experienced a recent increase in the proportion of culturally diverse groups in the population (Tummala-Narra 2004; National Health Workforce Taskforce 2009). As a result, growing numbers of clinical supervisors and students from diverse cultural backgrounds and experiences now form part of the medical, nursing and allied

health workforce. (Jeon & Chenoweth 2007; Young 2009; Guerrero 2012; O'Donoghue&Tsui 2012). Research examining issues encountered and benefits accrued during cross- or multicultural supervision is relatively scarce (Nicholas *et al* 1997; Young 2009). Similarly, current supervision frameworks provide little guidance on how to address and integrate racial and cultural aspects in the supervisory relationship (Jernigan *et al* 2010), even though addressing cultural issues in clinical supervision has long been identified as an essential component of a student's personal and professional development (Duan & Roehlke 2001).

Culturally sensitive supervision

A supervisor in a culturally responsive relationship is described as someone “that acknowledges the existence of, shows interest in, demonstrates knowledge of, and expresses appreciation for the client's ethnicity and culture and that places the client's problem in a cultural context” (Burkard *et al* 2006, 288). Supervision that responds to and promotes cultural awareness positively influences student and supervisor outcomes (Constantine 2001; Burkard *et al* 2006; Young 2009). Some studies have observed higher levels of cultural competence among supervisors from culturally diverse backgrounds compared with those who were not (Constantine 2001; Hird *et al* 2004). A supervisory relationship that addresses these issues is associated with enhanced personal awareness of cultural issues and development of cultural competence in students. Student efficacy in working with culturally diverse clients has also been found to increase as a result of addressing multicultural issues in supervision (Constantine 2001; Burkard *et al* 2006). A culturally competent supervisor who can discuss and provide guidance on multicultural issues is greatly valued by students on clinical placement, and evokes greater student satisfaction with the supervision (Inman 2006).

Difficulties in providing effective cross-cultural supervision

Barriers to effective cross-cultural supervision include communication issues, differences in values and beliefs, cultural insensitivity towards the student, and difficulties in establishing trust (Young 2009). The primary barrier is the difficulty some students feel in initiating discussion with their supervisor about cultural issues. In a review of the literature, Yabusaki (2010) found students were often reluctant to discuss colour and race with their supervisor for fear of being perceived as using ethnicity as an excuse for poor performance. Some students who broached the topic reported unsupportive responses from their supervisors, resulting in feelings of discomfort, anger or frustration (Jernigan *et al* 2010). Students in this study described how they dealt with these responses, including withdrawing from the placement, going through the motions to pass the placement, and trying to educate the supervisor (Jernigan *et al* 2010).

Initiating and encouraging discussion of cultural or racial issues

Clinical supervisors rarely raise or discuss cultural and racial issues in supervision (Gatmon *et al* 2001; Burkard *et al* 2006). Students and supervisors have different perceptions of how regularly such discussion takes place. Many supervisors are inexperienced in supervising students who are racially or culturally different from themselves (Duan & Roehlke 2001). Discrepancies between supervisor and student training in cultural awareness and sensitivity may be potential sources of conflict during supervision (Burkard *et al* 2006). Initiating conversation about cultural issues may enhance the supervisory experience and reduce the likelihood of conflict (Gatmon *et al* 2001). Some studies have found that supervisors from culturally diverse backgrounds introduce the topic more often and more readily than those who are not from such backgrounds; but other studies say that supervisors are more likely to discuss such topics if a cultural difference exists within the relationship (Gatmon *et al* 2001; Hird *et al* 2004; Jernigan *et al* 2010). If supervisors overlook the importance of addressing multicultural issues, it is probably owing to inadequate supervisor training (Young 2009; Yabusaki 2010). Cultural or racial matching of supervisors to students has not been found to affect satisfaction with supervision (Gatmon *et al* 2001; Burkard *et al* 2006), and is not an adequate substitute for understanding cultural and racial issues (Jernigan *et al* 2010).

Experiences of Aboriginal and Torres Strait Islander students

Studies documenting the clinical placement of Aboriginal and Torres Strait Islander students are limited. Helpful strategies for addressing challenges faced by Aboriginal and Torres Strait Islander students during placement include Indigenous support units, mentors or tutors who understand the student's cultural background, and membership of networks with non-Indigenous students (Lindsay *et al* 2005). Indigenous support units and liaison officers who set up tutoring and mentoring have helped retain Indigenous medical students at university (Lawson *et al* 2007). In a study of challenges faced by Indigenous students in undergraduate nursing degrees, Lindsay *et al* (2005) found discrimination, staff insensitivity to cultural issues, and a lack of Indigenous mentors (along with financial hardship) were key concerns. Some students felt they were treated differently from non-Indigenous students, and others reported episodes of racism both at university and on clinical placement (Lindsay *et al* 2005). Similar occurrences of cultural insensitivity and racism have been reported among Māori student nurses on placement in New Zealand (McLeland & Williams 2002).

Gender

Although the literature is somewhat dated, gender has been found to play subtle but complex roles in clinical supervision (Munson 1987; Putney *et al* 1992; Osterberg 1996). Differential treatment of students as a result of gender was reported to occur in clinical placements (Nelson & Holloway 1990). Putney *et al* (1992) said that a supervisor partnered with a student of the opposite gender often allowed more autonomy in the way the student carried out the placement, as a way of decreasing any potential conflict that may arise, and women were perceived to be more effective supervisors than men (Putney *et al* 1992). After reviewing the literature, however, Osterberg (1996) concluded that gender differences within supervision were minimal, and that differences might be due to reporting of perceived rather than actual differences. Such issues could be readily addressed through regular discussion between the supervisor and student (Gatmon *et al* 2001)

Disability

Little attention has been paid to clinical supervision of students with a disability. A student's impairment could potentially become the focus of clinical supervision in a placement. Students with disabilities may face additional barriers in the quest for a successful and effective clinical placement. Securing a placement may be difficult owing to a shortage of organisations willing to accept a student with a disability (Olkin 2009). Taube and Olkin (2011) list additional barriers of kinds: structural needs (access to books on tape, Braille, and wheelchair accessible facilities), policy and procedural issues (such as extra time for assignments and completion of training); and treatment by instructors and peers (whether the student is accepted as a valid participant in clinical placement). Hantula and Reilly (1996) define effective supervision of a student with an impairment as "supervisory and management practices or systems which maximise individual performance and protect the dignity of the individual" (Hantula & Reilly 1996, 114). When supervision is carried out effectively, a student with a disability has been found to offer many benefits to the hosting organisation. Students with disabilities can offer a unique perspective of the placement experience, provide useful information to the organisation about working with people with disabilities, and assist in raising awareness and reducing barriers (Cooley & Salvaggio 2002). Initial discussion between the supervisor and student to discuss potential issues in an effective supervision experience remains the key message (Cooley & Salvaggio 2002; Morris & Turnbull 2007).

Summary

To manage placement quality and capacity issues, researchers are becoming innovative. Current innovations involve the mode of supervision used, the structure and length of placements, inter-professional placement designs, technologically based learning programs, and new resources to support the teaching and learning process. Indeed, many of these innovations were identified as enablers of rural and remote placements. The value of rural and remote placements to student learning and the health workforce at large, warrants a significant investment in overcoming the

barriers to quality rural and remote experiences. Finally, the diversity literature clearly articulates a need for all placement stakeholders to consider the implications of culture, gender, and disability as applicable to students, staff, and patients in the placement experience.

National stakeholder consultation

Concerns about the development and implementation of a national framework

Terminology

Participants in the consultation stressed the importance of avoiding confusion in the terms 'framework', 'supervision' or 'quality'. What a 'framework' meant, and the role and expectations of 'supervision' varied with both discipline and setting. 'Quality' was a complex term that could mean a range of things in a framework or in supervision. Most informants were aware of existing frameworks for clinical placement or supervision, but the few who were not aware of frameworks were familiar with "resources to guide good practice clinical supervision" such as the HETI Superguide and ClinEdQ resources.

Disciplinary differences in supervision

Disparity among the disciplines was considered a potential barrier to successful development and implementation of a national framework. On supervision, about half the respondents said there were differences among the disciplines in (1) commitment, (2) the role and workload of supervisors (is the supervisor a "designated" supervisor, a supervisor with multiple roles, or a clinical educator?), (3) the preferred form in which supervision takes place (one-on-one, peer, group), and (4) the technical knowledge or specific competencies required for adequate supervision of various healthcare roles. It was said that "one size does not fit all" - a national framework would need to make allowances for all these variations.

Differences in setting or context

Contextual differences both within and between disciplines were regarded as potential barriers to successful implementation of a national framework. In health, clinical placements and supervision take place in a range of clinical settings across vastly different geographical contexts, including hospital and community placements in metropolitan, regional, rural and remote areas.

About half of the participants said a blanket framework for placements that did not consider contextual differences or the availability of and access to resources would not be accepted widely, or be practical to apply. One said a framework would "...need to look at rural and remote placements in a holistic setting, not just clinical goals. Need to look at the whole experience, from leaving where they are based, to finding a placement, through to social outcomes in the rural setting."

Acknowledgment of existing frameworks

In light of the existing frameworks at both State and local levels (for example, in hospitals and universities), it was important to avoid duplication and make sure that developing a national framework did not "reinvent the wheel". A national, overarching framework could acknowledge what now exists by incorporating aspects of what has already been developed, rather than competing with them. One respondent commended the current implementation process of a quality framework in their home State: *"It has been respectful of the fact that work is being done, and supporting what is going on there, and making sure they don't do anything that is in competition with them, but rather working with and using the information they have learned and enabling it to be reflected in the framework."*

Other concerns

Respondents asked these questions about developing and implementing a national framework:

- How is it possible to determine what is best in clinical placements, or what works, in the absence of any significant evaluation of implementation or outcome?
- Could implementation of a national framework be hindered by resistance to change?
- Who will have the capacity to enforce a framework within organisations?
- If compliance and achievement were to be linked to funding, what difficulties should be anticipated in establishing uniform criteria and standards among the disciplines?

Participants proposed principles of flexibility, consultation, and collaboration to guide implementation of a framework.

Flexibility: Given the number of differences between and within the health disciplines, more than half the respondents strongly urged that a framework remain flexible and adaptable, particularly in its implementation. Those with some prior experience said that rigid frameworks with strict implementation guidelines had not worked well. Instead, a more beneficial and sustainable framework would provide tools, mechanisms and resources to support implementation, and practical advice about models suitable for certain settings and how to evaluate them in varied organisations. The framework should be aspirational and supportive, and contain quality principles for best practice.

Consultation: An important step in reaching consensus on a national framework was to consult with organisations that presently have frameworks in place, to gain adequate understanding of what frameworks operate in each State and Territory, and how a national framework would fit with existing frameworks and structures. Gaining support from key players involved in implementing the framework would increase its uptake. Since the framework concerns quality clinical placements with effective supervision, many participants said it was essential to take the students' perspectives into account, not only those of organisations, management or supervisors. Consultation was also a way to promote shared understanding of concepts, objectives and terminology across disciplines, an important determinant of uptake across the wide range of clinical placements.

Collaboration: Over a third of respondents said collaboration among key players such as universities, health services offering placement sites, and training organisations was important to ensure uptake of the framework. One commented: "There is certainly room for networking nationally" and described how their jurisdiction had sought collaboration with another State that used the same model and held an annual conference and regular teleconferences to discuss its implementation.

Stakeholders with experience or knowledge about developing such frameworks stressed the importance of collaborating with universities during the development phase - in particular, ensuring that the universities were on board and would support what the framework was proposing for their students. Collaboration with outside training organisations that provided education and training for supervisors and students would also be beneficial. One stakeholder suggested creating national supervisor networks: connect with others in a similar role, guided by a similar framework would be helpful. Such collaborations had the potential to assist in the expansion of clinical placement capacity, and increasing the opportunity for professional development.

Effective supervision

Stakeholders discussed aspects of supervision they believed would ensure quality clinical placements.

Learning culture: A third of respondents thought that, for quality clinical placement and supervision to occur, the workplace must support a "culture that values learning". Education and training of supervisors must be supported and valued by the workplace. A few commented that little attention was given to education and training within health, particularly ongoing training. This might result from a lack of designated funding and resources, and even when education and training was offered, it was not taken up by staff, perhaps because such training courses were often held outside normal working hours or duties. Conducting education and training courses within the normal working day would increase attendance, enhance the skills of supervisors, and convince employees that the organisation valued education and training. Addressing work culture and promoting a learning environment would reduce resistance that might arise in implementing a framework.

Supervisor roles: More than half of the participants in the consultation were concerned about differences among and within health disciplines about the role of a supervisor. Supervision was often not the person's only role. The supervisor's workload and the ratio of students to supervisors were two key factors in the quality of supervision. Where practical, dedicated supervisors or (perhaps more realistically) designated supervision time built into the supervisor's role were ways to address

these issues. If so, quality supervision which included taking time to meet, discuss and give good and honest feedback to the student would be more likely to happen.

Conclusion

The majority of participants in the national consultation were familiar with a range of existing frameworks for clinical supervision and placement. A framework flexible enough to be able to accommodate differences among and within health disciplines about concepts and expectations of supervision and settings for clinical placements would be helpful in increasing quality at a national level. In developing and implementing a national framework, respondents felt it was important to acknowledge and apply the existing work done within this area, by consulting with organisations and jurisdictions that may already have a framework in place, and by collaborating with key players in the field such as universities, supervisors, students, and organisations. Encouraging a learning culture and understanding the workload and multiple commitments of supervisors were identified as ways to address the effectiveness of supervision during clinical placements. These suggestions are consistent with the empirical research.

Frameworks for quality clinical placements

Description

Frameworks have been defined to include documents that provided guidance to placement sites, educational institutions, clinical supervisors and students about quality clinical placements and effective supervision. The search gathered frameworks, guidelines, and handbooks, but only a minority were specifically for quality clinical placements. Clinical supervision is a key component of placements, and therefore clinical supervision frameworks have been included in the search. A summary of the 23 frameworks reviewed and their contents appears in Appendix A. The number of frameworks in each category is as follows:

- Clinical supervision frameworks for students (1)
 - Australian (1)
- Clinical supervision frameworks for registered health practitioners (14)
 - International (6)
 - Australian (8)
- Clinical placement frameworks (5)
 - International (2)
 - Australian (3)
- Other relevant frameworks or resources (3)
 - International (2)
 - Australian (1)

Ten International and 13 Australian frameworks representing nursing, allied health and medicine were sourced.

Analysis

Concerns were raised in the consultations about development and implementation of a national plan for quality clinical placements – in particular, that a national plan must be applicable across health disciplines; be flexible (acknowledging that there are differences among and within disciplines); use consistent terminology; and integrate existing work in this area. These concerns and the literature reviewed guided an analysis of identified frameworks. Specifically, the interviews and literature review led to developing a set of evidence-based elements of quality, and each framework has been analysed by it. Table 4 illustrates this analysis. The table mirrors the literature review findings and includes the issues raised by the stakeholders. In summary, the analysis found that no single framework addresses all the elements of quality, and existing frameworks differ in elements they cover. The Best Practice Clinical Learning Environments (BPCLE) framework developed, piloted and evaluated by the Department of Health, Victoria, offered the best coverage of content, and was also the most progressed in implementation and evaluation. Several other frameworks provide useful information that could complement the BPCLE, providing a foundation for consultation about a national plan to promote quality in clinical placements. This analysis is discussed following the table, in the context of development, implementation, monitoring and evaluation of a national plan.

Table 4: Framework analysis for elements relevant to quality clinical placements

Framework	Does the framework include factors known to <i>enable</i> the clinical placement experience?							Does the framework address known <i>barriers</i> to clinical placement experience?	Are other <i>key issues</i> that impact on quality clinical placements addressed?				Framework supported with resources for implementation?	Published evaluation data available?	
	Culture for Quality			Effective Supervision	Learning Opportunities	Communication & Collaboration	Resources & Facilities	Occupational Stress	Workplace Aggression	Innovation	Rural & Remote	Diversity	IPE		
	Relationships	Learning	Best Practice												

Clinical Supervision Frameworks for Students

Australian

National Clinical Supervision Support Framework (HWA 2011)	✓		✓	✓		✓	✓	✓		✓					
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Clinical Supervision Frameworks for Registered Health Practitioners

International

The Foundation Programme: Reference Guide (UK Foundation Programme Office 2012)			✓	✓		✓									
Policy and Framework for Clinical Supervision for all Professional and Support Staff (Outer NE London Community Services 2011)		✓	✓		✓					✓			✓		
Clinical Supervision Framework (Ronis & Hubbert 2008)			✓	✓	✓	✓		✓		✓					
Clinical supervision handbook: a guide for clinical supervisors for addition and mental health (Bindseil <i>et al</i> 2008)		✓	✓	✓	✓	✓		✓		✓			✓	✓	
Clinical Supervision: A framework for action (Causey 2003-2004)	✓			✓		✓						✓			
Clinical supervision in the workplace: guidance for occupation health nurses (UK Royal College of Nursing 2002)				✓		✓	✓			✓					

Australian

The Superguide: A handbook for Supervising Allied Health Professionals HETI (2012)				✓	✓	✓								✓	
Preceptor Program: Implementation Guide (Old Health 2006)	✓		✓	✓		✓	✓								

Framework	Does the framework include factors known to <i>enable</i> the clinical placement experience?							Does the framework address known <i>barriers</i> to clinical placement experience?		Are other <i>key issues</i> that impact on quality clinical placements addressed?				Framework supported with resources for implementation?	Published evaluation data available?
	Culture for Quality			Effective Supervision	Learning Opportunities	Communication & Collaboration	Resources & Facilities	Occupational Stress	Workplace Aggression	Innovation	Rural & Remote	Diversity	IPE		
	Relationships	Learning	Best Practice												
Clinical Supervision Guidelines for Mental Health Services (Old Health 2009)				✓	✓	✓								✓	
Foundations to Supervision (WA Country Health 2009)	✓			✓	✓							✓		✓	
Clinical Supervision in Community Health: Introduction and Practice Guidelines (VHA.2007)	✓		✓	✓		✓		✓		✓					
NSW Drug and Alcohol Clinical Supervision Guidelines (NSW Health 2010)	✓			✓		✓				✓				✓	
Clinical Supervision- Psychologists (NSW Health 2006)	✓		✓	✓	✓	✓		✓		✓				✓	
Clinical Supervision: Framework for WA mental health services and clinicians WA Health (2004-2007)	✓	✓		✓						✓				✓	

Clinical Placement Frameworks

International

Indicators of Practice Education Quality in Health Care Organisations: A literature review (Newberry 2007)		✓		✓	✓	✓	✓	✓		✓			✓		
Placements in Focus: Guidance for education in practice for health care professions (UK Dept of Health 2001)		✓	✓			✓	✓			✓				✓	

Framework	Does the framework include factors known to <i>enable</i> the clinical placement experience?							Does the framework address known <i>barriers</i> to clinical placement experience?		Are other <i>key issues</i> that impact on quality clinical placements addressed?				Framework supported with resources for implementation?	Published evaluation data available?
	Culture for Quality			Effective Supervision	Learning Opportunities	Communication & Collaboration	Resources & Facilities	Occupational Stress	Workplace Aggression	Innovation	Rural & Remote	Diversity	IPE		
	Relationships	Learning	Best Practice												

Australian

Optimising Rural Placements Guidelines (DRAFT) (2012)						✓	✓				✓		✓	
Best Practice Clinical Learning Environments Frameworks (2010)	✓	✓			✓	✓	✓						✓	✓
Framework for best-practice clinical learning environments in Queensland Health (2010)	✓	✓	✓	✓	✓	✓						✓		

Other Relevant Frameworks

International

Education Commissioning for Quality: Guidance for Education Providers (UK NHS West Midlands(2010-11)						✓							✓	✓
Inter-professional Capability Framework (Inter-professional Education Team 2010)	✓		✓		✓						✓	✓		✓

Australian

The team leader model: an alternative to preceptorship (Russell <i>et al</i> 2011)	✓	✓		✓	✓	✓				✓				
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Development

Analysis suggests that the best available framework that could be adapted for national use is the BPCLE developed by the Victorian Department of Health. The BPCLE seeks to enhance the capacity and quality of clinical placements in medicine, nursing and allied health in Victoria. This analysis has chosen the BPCLE as a framework amenable to development at the national level because it is specifically designed to apply to all health professions in the Australian health system, it was developed through broad stakeholder consultation, and it was designed to be relevant to all health and social care settings that participate in clinical education and training (Darcy Associates 2012).

The BPCLE appears to be the only framework that has been piloted for implementation and evaluated in Australia or elsewhere, and is supported by an extensive resource toolkit. The BPCLE demonstrates some evidence for four of the five elements of quality: (1) a culture of quality focusing on relationships, learning, and best practice, (2) learning opportunities, (3) communication and collaboration, and (4) resources and facilities. While a cursory mention of supervision is made, it is not sufficiently detailed to support this aspect of the clinical learning environment. Further, like most other frameworks, the BPCLE does not address known barriers in the clinical placement environment - occupational stress, and workplace incivility and aggression. Limited reference is made to other key issues of innovation, rural and remote issues, and diversity. However, given the material available in existing frameworks and the literature, it offers a valuable opportunity to expand the core elements of the BPCLE to capture the full spectrum of factors influencing quality clinical placements.

First, frameworks such as *The Superguide: A handbook for supervising allied health professionals* developed by Health Education and Training Institute in New South Wales would be useful to consider. The handbook is a comprehensive guide to supervision, and includes specific information on "How to be an effective clinical supervisor" and a range of resources such as supervision contract templates. It was developed for use by allied health professions, but could be adapted to suit the broader range of health disciplines.

Secondly, the National Rural Health Students' Network (NRHSN) *Optimising Rural Placements Guidelines* (2012), currently in draft form, are an ideal resource for rural and remote considerations. This document is unique in offering the student perspective, and it makes a number of practical recommendations to enhance quality in rural and remote placements, relating to universities, faculties, schools, supervisors and students. It is not specific to any one health discipline.

Thirdly, there are several frameworks that address various aspects of innovation, and the research literature is prolific in this area. Fourthly, despite the strong argument in the literature for considering diversity in the context of quality placements, very few frameworks acknowledge this topic.

A document of note is the *Diversity- Clinical supervision handbook: a guide for clinical supervisors for Addiction and mental health* (Centre for Addiction and Mental Health 2008) which addresses cultural competence in supervisors.

Finally, the literature suggests we can improve student learning opportunities and expand placement capacity through inter-professional placements. *The Inter-Professional Capability Framework* (Walsh & Gordon *et al* 2005) is a specific framework that could inform the inter-professional aspects of a national plan. It defines capabilities that underpin inter-professional working and are relevant to all health and social care professions.

Implementation

The framework review provided a rich collection of resources useful for supporting implementation, with the BPCLE offering the most extensive suite of materials. These resources support implementation across key elements of (1) organisational culture, (2) best-practice clinical practice, (3) a positive learning environment, (4) an effective health service-training provider relationship, (5)

effective communication, and (6) appropriate resources and facilities. Other useful resources include the previously mentioned *Super guide: A handbook for supervising allied health professionals*, which includes templates such as a supervision contract, supervision log form and supervision feedback forms. In addition, the *Foundation Programme: Reference Guide* (UK Foundation Programme Office 2012) includes templates for clinical supervision and a competency framework for supervisors. To enhance learning opportunities, the *Foundations to Supervision* (WA Department of Health 2008) has resources on strategies to promote adult based learning and learning styles. In addition, it addresses the needs of educator and student by including resources such as 'tips for providing constructive feedback' and 'receiving feedback'.

Monitoring and evaluation

Very few frameworks have published evaluation data. Monitoring and evaluation should be a critical part of a national plan, and there are a number of frameworks which can guide this process. The BPCLE has a detailed performance monitoring framework which could be adapted to include other metrics. It could also be informed by the *Indicators of Practice Education Quality in Health Care Organisations* (Newberry 2007) which identifies the structures and processes organisations need to support quality practice education. Most applicable is the indicator checklist for results as a way to evaluate practice education: goals are set and performance is measured, stakeholder feedback is sought and is used to enhance the student learning experience.

Framed as a quality assurance framework, the *Education Commissioning for Quality: Guidance for Education Providers* (NHS West Midlands 2010) would also be useful since it details a process linking quality to funding, to standardise expectations of quality across education and placement providers. The supporting resources include education and practice partnership agreements, learning and development agreements, and education provider self assessment checklists.

Finally, *Placements in Focus: Guidance for education in practice for health care professions* (Department of Health and English National Board of Nursing, Midwifery and Health Visiting 2001) outlines the principles of providing quality practice placements, including student support and assessment of practice. They provide detailed checklists to monitor and evaluate the practice learning environment and the assessment of practice.

Conclusions

This report presents a thorough review of the literature relevant to quality clinical placements. While the literature is largely from the discipline of nursing, medicine and allied health are represented, as are all continents. The combination of qualitative and quantitative research method in the field provides reasonable comparison of research findings. A limitation of the research is that most of it is conducted in hospital settings. Future research needs to explore quality clinical placements in non-hospital environments.

The literature review revealed factors known to enable the clinical learning environment. They included: (1) a *culture for quality*, comprising relationships, learning, and best-practice, (2) *effective supervision* founded on a good supervisory relationship, (3) *learning opportunities* largely characterised by supported participation in direct patient care, (4) *effective communication and collaboration* between students, academic institutions, and placement sites to ensure adequate placement preparation, and (5) *resources and facilities* to conduct placement activities. Whether quality is defined in terms of student satisfaction or objective learning outcomes, it is largely determined by psychosocial characteristics that have an affective element. Resources and facilities are necessary requirements, but they cannot be the focus of placement administrators at the expense of those factors which have the greater influence.

The review also recorded factors known to impede quality placements. Barriers included *occupational stress* and *workplace incivility and aggression*. This review addressed the case where other staff were the perpetrators of aggression, but placement providers need to be alert to the threats posed by patients as well. These issues are prevalent in the literature, but absent the reviewed frameworks, indicating a significant gap between research and practice that should be addressed to ensure safe working environments for future health professionals.

The review has also highlighted considerations for placement quality including innovations in how placements are structured, how students are supervised, and how students learn, issues critical to address tightened placement capacity and larger health workforce issues. Enhancement of rural and remote placements could help address these issues, but significant investment in addressing the barriers to relocation to rural and remote areas would be needed. The National Rural Students Health Network's draft guidelines (2012) are an excellent starting point for this endeavour.

The literature also identifies diversity as relevant to quality, yet it is hardly mentioned by the reviewed frameworks. Inter-professional placements as a means to improve placement quality and increase placement capacity are noted as a recurring theme throughout the literature. They are reported as complex to arrange and confronted with traditional disciplinary divides, but if the key to quality patient care is inter-professional collaboration, inter-professional placements necessary to improve both the quality of care and the quality of placements.

The national stakeholder consultation evoked concerns about how a national framework would address disciplinary differences in supervision, settings or context. Respondents insisted that any national plan needed to be flexible, consultative and collaborative. Their statements about effective supervision were consistent with the empirical research literature, identifying the importance of a learning culture and clear supervisor roles.

The framework review found few frameworks that focussed specifically on quality in clinical placements. However, the BPCLE is an evidence-based, piloted, and evaluated framework suitable for the Australian context. Its' major limitation is the lack of detail about supervision as a factor influencing quality. However, if informed by this review, and supported by other relevant frameworks, it is realistic to consider it as the basis of a national plan.

Recommendations

Elements of a quality clinical placement experience

The elements of quality for clinical placements can be understood as enablers, barriers, and other key issues.

Factors enabling quality in clinical placements include:

- A culture for quality develops positive relationships, actively supports learning, and rewards best-practice.
- Effective supervision characterised by a good supervisory relationship and facilitated through supervisor characteristics, supervisor development, and appropriate recognition and reward of desirable supervisor behaviours.
- Learning opportunities that are diverse and appropriate for student competence, and comprise at least in part of supported participation in direct patient care.
- Effective communication and collaboration between students, academic institutions, and placement sites, in an effort to adequately prepare for the placement experience.
- Sufficient resources and facilities to conduct placement activities.

Barriers to placement quality include:

- Occupational stress which induces states of anxiety that inhibit learning, impair performance, and compromise health and wellbeing.
- Workplace incivility and aggression which threatens the socio-emotional and physical safety of students in the placement environment.

Other issues influencing quality include:

- Innovation to increase placement quality and capacity.
- Consideration of rural and remote issues as relevant to increasing quality, capacity, and addressing larger health workforce shortages.
- Issues of diversity, including culturally and linguistically diverse groups, the experience of Aboriginal and Torres Strait Islander students, and the impact of gender and disability.

These enablers, barriers and key issues should inform a national plan for promoting quality in clinical placements. It would be sensible to base such a plan on an existing Australian evidence-based framework such as the BPCLE which has extensive resource support, and evaluation data. As discussed in the framework analysis section, there are several existing frameworks that could be used to complement and supplement the BPCLE, so that it is suitable for consideration at the national level.

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Appendix A: Quality in clinical placements – table of frameworks

1. Clinical Supervision Frameworks for Students

Australian

- a. National Clinical Supervision Support Framework (2011), Health Workforce Australia

2. Clinical Supervision Frameworks for Registered Health Practitioners

International

- a. The Foundation Programme: Reference Guide (2012), United Kingdom Foundation Programme Office
- b. Policy and Framework for Clinical Supervision for all Professional and Support Staff (2011), London Outer North East London Community Services
- c. Clinical Supervision Framework (2008), Lincolnshire Community Health United Kingdom
- d. Clinical supervision handbook: a guide for clinical supervisors for addition and mental health (2008), Centre for Addiction and Mental Health
- e. Clinical Supervision: A framework for action (date unknown- but uses sources from 2003-2004), United States of America
- f. Clinical Supervision in the Workplace: Guidance for Occupation Health Nurses (2002), Royal College of Nursing United Kingdom

Australian

- a. The Super Guide: A handbook for Supervising Allied Health Professionals (2012), Health Education and Training Institute
- b. Preceptor Program: Implementation Guide (2011), Clinical Education and Training Queensland
- c. Clinical Supervision Guidelines for Mental Health Services (2009), Queensland Health
- d. Foundations to Supervision (2008), Western Australia Department of Health
- e. Clinical Supervision in Community Health: Introduction and Practice Guidelines (c.2007), Victorian Healthcare Association
- f. New South Wales Drug and Alcohol Clinical Supervision Guidelines (2006), New South Wales Department of Health
- g. Clinical Supervision- Psychologists (2006), South Eastern Sydney Illawarra NSW Health
- h. Clinical Supervision: Framework for WA mental health services and clinicians (2004-2007), Western Australia Department of Health

3. Clinical Placement Frameworks

International

- a. Indicators of Practice Education Quality in Health Care Organisations: A literature review (2007), Newberry for the BC Practice Education Initiative: A Practice Education Innovation Fund Project
- b. Placements in Focus: Guidance for education in practice for health care professions (2001), Department of Health and English National Board for Nursing, Midwifery and Health Visiting

Australian

- a. Optimising Rural Placements Guidelines (DRAFT) (2012), National Rural Health Students' Network (NRHSN)
- b. Best Practice Clinical Learning Environments Frameworks (2010), Victorian Department of Health
- c. Framework for best-practice clinical learning environments in Queensland Health (2010), Clinical Education and Training Queensland

4. Other Relevant Frameworks

International

- a. Education Commissioning for Quality: Guidance for Education Providers (2010-11) NHS West Midlands
- b. Inter-professional Capability Framework (2005), Walsh and Gordon.

Australian

- a. The team leader model: an alternative to preceptorship (2011), Russell, Hobson and Watts.

Clinical Supervision Frameworks for Students

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
Australia			
<p><i>National Clinical Supervision Support Framework (2011)</i></p>	<p>Australia students undertaking education and training within the health sector (medicine, nursing, midwifery, dental, and allied health)</p>	<p>Summary. Developed by Health Workforce Australia, this document asserts that quality clinical supervision is the central feature of a quality clinical placement, and in turn central to the competence of health practitioners.</p> <p>Definition. Supervision “involves the oversight – either direct or indirect – by a clinical supervisor of professional procedures and/or processes performed by a student or a group of students within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each student's experience of providing safe, appropriate and high quality patient care.” (p.4)</p> <p>Principles. Clinical education and training in the health sector need to consider:</p> <ol style="list-style-type: none"> 1. <i>Clarity</i> <ul style="list-style-type: none"> • Roles and responsibilities • Expectations of supervisors, students and placement sites 2. <i>Quality</i> <ul style="list-style-type: none"> • Patient care • Clinical supervisor knowledge and skills • Education program attributes • Preparation and support 3. <i>Culture</i> <ul style="list-style-type: none"> • Organisations • Resources • Relationships • Learning environment • Recognition <p>Web Address: https://www.hwa.gov.au/sites/uploads/hwa-national-clinical-supervision-support-framework-201110.pdf</p>	

Clinical Supervision Frameworks for Registered Practitioners

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
International			
<p><i>The Foundation Programme: Reference Guide (2012)</i></p>	<p>United Kingdom, London - medical doctors</p>	<p>Summary. Created by the UK Foundation programme office this is a guide for supervisors in the foundation programme. This programme is a two-year programme aimed at preparing junior doctors for specialist or general practice training. The foundation doctor (junior doctor) is supported by both a clinical and an educational supervisor. This programme is the only common component for medical students and doctors across the UK. The programme is designed for newly qualified doctors to help them develop their clinical and professional skills in the workplace. Through an appropriate management and supervision foundation doctors are able to learn whilst ensuring the safety of patients.</p> <p>Definitions.</p> <ul style="list-style-type: none"> • An education supervisor helps “foundation doctors with their professional and personal development.” (p.15). • A clinical supervisor oversees the clinical work and provides constructive feedback to the foundation doctor. <p>Superiors.</p> <p><i>Educational:</i> Responsibilities include:</p> <ul style="list-style-type: none"> • Sharing relevant information and areas for development with the clinical supervisor for the next placement • Supporting and identifying foundation doctors needing additional help <p><i>Clinical:</i> Responsibilities include:</p> <ul style="list-style-type: none"> • Making sure that foundation doctors are never put in a situation where they are asked to work beyond their competence without appropriate support and supervision. Patient safety must be paramount at all times • Seeking regular feedback from the placement supervision group on the foundation doctor’s performance • Providing regular feedback to the foundation doctor on their performance <p>Web address: http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs</p>	<ul style="list-style-type: none"> • Training, monitoring implementation and review of clinical supervision • Competency framework for supervisors of clinical supervision • Standards • Clinical supervision documentation (contract, record, attendance)
<p><i>Policy and framework for clinical supervision for all professional and support staff (2011)</i></p>	<p>United Kingdom: London Outer North East London Community Services (ONELCS) - nurses and allied health professionals</p>	<p>Summary. ONELCS is committed to the continuous professional development of nurses and allied health professionals in order to foster a positive learning environment. This framework was developed as a way to improve clinical practice through effective supervision.</p> <p>Definition. Clinical Supervision is “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical settings.” (p.4)</p> <p>Principles. The key principles of the framework include:</p> <ul style="list-style-type: none"> • All staff will be offered access to a trained supervisor with the relevant professional knowledge and expertise • Senior managers will support clinical supervision by ensuring time is made available for supervision • Clinical supervision, in certain circumstances may become mandatory for some groups of staff for a limited period of time, at the discretion of the organisation <p>Benefits</p> <ul style="list-style-type: none"> • For Individuals: Identify solutions to problems, further develop their skills and knowledge, enhance understanding 	

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
		<p>of their own practice</p> <ul style="list-style-type: none"> For Organisations: Helps support a performance management framework, ensures safer work practices and increases awareness of accountability <p>Model of Supervision. The framework includes an integrated model of clinical supervision (Proctor 1986) which incorporates three functions:</p> <ul style="list-style-type: none"> <i>Restorative</i> function: embraces work-related emotional stress. Staff members who feel supported are more aware and empowered to deliver safe patient care with good outcomes, and will be better prepared to meet the rigorous demands of practice. <i>Formative</i> function: is the educative process of identifying and developing professional skills and understanding through reflection and exploration of clinical practice. The focus is on client and team interaction, and integration of theory with practice. <i>Normative</i> function: focuses on evaluation of work and caseload management, and explores accountability and the delivery of high standards of quality within the organisations clinical governance framework (p.8) <p>Supervision should be:</p> <ul style="list-style-type: none"> Flexible, held in private, practitioners may seek supervision from another discipline Structured around a written contract Agreement to participate in clinical supervision be part of employment contracts for all registered clinical staff in the organisation <p>Method of Supervision. The framework suggests two models of supervision:</p> <ul style="list-style-type: none"> <i>Peer review</i> which aims to help practitioners assess their own strengths and areas for improvement. Enables practitioners to meet with peers to identify agreed criteria for quality of service and give and receive constructive feedback <i>Group</i> supervision which aims to provide support through the exchange of ideas and dialogue <p>Supervisor. Supervisors should be:</p> <ul style="list-style-type: none"> An experienced and qualified practitioner Promote patient care Credible, professional, trustworthy Empathetic, Encouraging and benevolent Experienced as being a supervisee <p>The role of supervisor should include:</p> <ul style="list-style-type: none"> Establishing a safe environment for the supervisee Being supportive and facilitative Sharing information, experience and skills <p>Supervisee. The role of supervisee should include setting up a supervisory contract - including extent of record keeping, venue, timekeeping, commitment and accountability, the limits of confidentiality and applicable codes of conduct.</p>	


Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
		<p>Web address: http://www.onelcommunityservices.nhs.uk/content_files/staff_files/Policies/NHSLA_policies/Clinical_Super_vision_Policy_and_Framework.pdf</p>	
<p><i>Lincolnshire Community Health Services: clinical supervision framework (2008)</i></p>	<p>United Kingdom, Lincolnshire - Nursing and allied health practitioners</p>	<p>Summary. Created by the Clinical Governance Committee this framework “outlines shared responsibilities for the planning, resourcing and embedding of clinical supervision in practice between the Workforce Development Team, Professional Development function, individual staff and their managers” (p.4).</p> <p>Definition. Clinical supervision is a “formal process of support and learning which enables individual practitioners to develop their knowledge and competence. It enables them to consider accountability for their own practice and supports the protection of consumers in receipt of care in complex clinical situations. Clinical supervision is central to the learning process and should be seen as a means of encouraging self assessment utilising analytical and reflective skills.” (p. 6).</p> <p>Model of Supervision. This framework acknowledges that a number of supervision models exist, but they suggest the Proctor (1986) model which has three functions:</p> <ul style="list-style-type: none"> • Normative • Formative • Restorative <p>Method of Supervision. This framework suggests the following methods of supervision :</p> <ul style="list-style-type: none"> • Individual supervision • One to one • Peer supervision • Group supervision <p>This framework notes that supervisees should be able to choose their supervisor.</p> <p>Supervisor. The framework outlines that responsibilities should include:</p> <ul style="list-style-type: none"> • Recognising issues of accountability. • Boundaries of supervision in relation to professional responsibilities and ethical practice. • Keep up to date with supervisory issues/responsibilities and undertake further training, where possible. • Setting time aside dedicated to reflection <p>Supervisee. The framework outlines that responsibilities should include:</p> <ul style="list-style-type: none"> • Organising their personal, professional and practice development and relevant supervision arrangements. • Being aware of their professional codes of conduct and competencies and keeping notes on the outcomes of their supervisory sessions. <p>Web Address: https://www.lincolnshirecommunityhealthservices.nhs.uk/Public/filebrowser/download/5011</p>	

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Clinical supervision handbook: a guide for clinical supervisors for addiction and mental health (2008)</i></p>	<p>Canada - Nursing and Social Work</p>	<p>Summary. This handbook was developed by a group of experienced social workers and nurses who are/have been clinical supervisors. They used their collective experiences to create a model of supervision to use in their organisation – Centre for Addiction and Mental Health (CAMH). The handbook provides principles to guide the process of clinical supervision through its various stages. The handbook is described as a “work-in progress”.</p> <p>Principles. The key principles guiding clinical supervision at CAMH are:</p> <ul style="list-style-type: none"> • Organization context and its crucial impact on the nature and quality of clinical supervision • Improved client outcomes • Accountability • Advancement of clinicians’ specialized knowledge, skill and use of evidence-based practice • Learning and professional development <p>Supervision Model. The components of clinical supervision are:</p> <ul style="list-style-type: none"> • Administrative/normative (managerial) • Educational/formative • Supportive/restorative <p>Supervision Methods. Methods of clinical supervision include:</p> <ul style="list-style-type: none"> • Demonstration/reflecting mirrors • Co-therapy • Role-playing • Reviewing audio and/or video tapes. <p>Supervisor. Supervisory skills include:</p> <ul style="list-style-type: none"> • Relationship skills (building a supervisory alliance) • Sensitivity to multiple roles with supervisee and able to balance multiple roles • Ability to assess supervisee’s learning needs and developmental level • Ability to encourage and use evaluative feedback from supervisees • Flexibility <p>The supervisor role includes:</p> <ul style="list-style-type: none"> • Incorporating evidence-based practice • Incorporating cultural competence into clinical supervision practices • Opportunities for observation and practice • Providing corrective feedback that is experienced by clinicians as constructive, relevant and credible • Discussing mutual obligations and expectations related to the clinical supervisor’s authority <p>Practice Environment. The practice environment must include multiple perspectives and interests as well as honest communication and active and ongoing dialogue among employees at all levels.</p> <p>Web Address: http://knowledgex.camh.net/amhspecialists/guidelines_materials/Documents/Clinical_Supervision_Handbook.pdf</p>	<ul style="list-style-type: none"> • Supervision contract • Supervisor register • Record of supervision

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Clinical Supervision: A framework for action</i> (Year unknown- but uses sources from 2003-2004)</p>	<p>United States of America, Hawaii - Social workers</p>	<p>Summary. This power point presentation suggests the combination of a supportive relationship and strong working alliance significantly contributes to the quality of the supervisory relationship. The presentation briefly describes the characteristics of a novice versus an experienced supervisor and then discusses what contributes to high quality supervision.</p> <p>Principles. The presentation suggests the following contribute to a framework for supervision:</p> <ul style="list-style-type: none"> • Develop a strong supervisory relationship and working alliance • Create a supervisory plan • Allocate time and preserve sanctity of that time • Facilitate learning • Provide ongoing evaluation and feedback • Document your supervisory work <p>Supervisory Relationship. Factors contributing to a strong supervisory relation and working alliance:</p> <ul style="list-style-type: none"> • Supervisor has knowledge and experience relevant to trainee • Supervisor shows empathy, affirmation, approachability and attentiveness • Supervisor encourages supervisee to disclose actions and attitudes • There is a pre-determined procedure for providing regular feedback structured around agreed-upon goals • Supervisor can identify problems and initiate discussion of them <p>The presentation notes that diversity should be addressed during supervision in relation to issues such as differing views of authority, power dynamics and nonverbal communication. It also notes that conflict resolution should be addressed by initiating discussions of conflict because it promotes trust, encourages trainees to self disclose clinical errors and conflicts. In addition, the presentation suggests a written supervisory contract be established which may include an explanation of the relationship, responsibilities and rights of each part, and parameters of confidentiality.</p> <p>Web address: http://www.nasmhpd.org/general_files/publications/Hospital%20CEO%20Toolkit/Updated%20PDF%20Toolkit/4.2%20U.%20Hawai%E2%80%99i%20Clinical%20Supervision%20A%20Framework%20for%20Action.pdf</p>	

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Clinical supervision in the workplace: Guidance for occupational health nurses (2002)</i></p>	<p>United Kingdom - Nursing</p>	<p>Summary. Developed by the Royal College of Nursing for occupational health nurses who want to develop and implement clinical supervision into their workplaces. These guidelines suggest how nurses can develop and implement clinical supervision plans.</p> <p>Definition. Clinical supervision is “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations”.(p.3)</p> <p>Benefits</p> <ul style="list-style-type: none"> • For individuals: reflect on practice, identify room for improvement, meet continual professional development requirements, develop expertise, gain professional support and find new ways of learning. • For organisations: improved service delivery, improved staff recruitment and retention, improved efficiency and effectiveness. <p>Starting clinical supervision. Nurses should:</p> <ul style="list-style-type: none"> • Gain the commitment and support of key members of staff early in the development phase • Find existing local RCN groups • Lead supervision, to prevent it becoming a management tool to assess performance <p>Model of Supervision. The guidelines suggest the supervision model, initially developed by Proctor (1986):</p> <ul style="list-style-type: none"> • Educative (formative)- e.g. how to develop an understanding of skills and ability • Supportive (restorative)- e.g. exploring the emotional reaction to pain, conflict and other feelings experienced during patient care • Managerial (normative)- e.g. how to address quality control issues <p>The guidelines note that nurses do not have to adhere to this academic model, instead these should be adopted to suit nurses own workplace needs.</p> <p>Method of Supervision. The guidelines suggest a structured forum for peer supervision by:</p> <ul style="list-style-type: none"> • Meeting with nurses from other organisations • Considering partnership in supervision with non-OH professionals • Using facilitated group supervision <p>Supervision Structure. The structure should include:</p> <ul style="list-style-type: none"> • Outline of the process Clearly defined aims and objectives • An evaluation system Outcomes to measure success <p>Supervision Agreement. Agreement should outline:</p> <ul style="list-style-type: none"> • Ground rules and responsibilities Commitment to confidentiality • Sharing best practice Relevance to clinical practice <p>Further information. The guidelines encourage nurses to read further in order to develop their own clinical supervision plan. They recommend accessing the guidelines bibliography for further information.</p> <p>Web address: http://www.rcn.org.uk/_data/assets/pdf_file/0007/78523/001549.pdf</p>	

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
Australian			
<p><i>The Superguide: a handbook for supervising allied health professionals (2012)</i></p>	<p>Australia - NSW Allied health professionals</p>	<p>Summary. This document was developed by the Health Education and Training Institute (HETI) in response to a request from those involved in supervising allied health professionals for a simple and practice guide to clinical supervision.</p> <p>Purpose of Supervision. Supervision facilitates:</p> <ul style="list-style-type: none"> • Acquisition of skills and knowledge • Reflective practice • Development of professionalism • Confidence and competence in clinical practice • Professional growth and development <p>Benefits</p> <ul style="list-style-type: none"> • Facilitate learning and professional development • Ensures high quality and safe patient care and treatment is provided. <p>Method of Supervision. They suggest a “hands-on, hands-off” approach to supervision. They define “Hands-on” supervision as “when the supervisor is directly involved in monitoring or helping the supervised clinician as he/she performs tasks”. They define “Hands-off” supervision as “when the supervisor trusts the supervised clinician to act independently, leaving space for the supervisee to deploy emerging skills and test growing clinical abilities”. They note, however, that “hands-off” supervision is not the absence of supervision.</p> <p>Supervisor. An “A-rated” clinical supervisor as someone who is <i>available, approachable, able</i> (both as clinician and teacher) and <i>active</i> (finds the gaps). Supervisory skills include::</p> <ul style="list-style-type: none"> • Empathy, Respect Clarity of expectations • Confidentiality A motivating and positive attitude Ability to reflect on practice <p>The supervisor should remain active in overseeing clinical care, and encourage supervisees to engage and commit to the supervisory process.</p> <p>Supervisee. An “A-rated” supervisee as someone who has the right <i>attitude</i> and <i>aptitude</i>, and is <i>attuned</i> and <i>aware</i>.</p> <p>Feedback. Feedback needs to be timely, specific, constructive, and in an appropriate setting.</p> <p>Clinical Teaching. The guidelines also look at clinical teaching and learning for supervisors who are in the role of clinical teaching. This section includes information on promoting a culture of life-long learning and identifying differing learning styles. The guidelines also have information regarding the management of clinical staff including managing performance and common challenges for supervisors.</p> <p>Web Address: www.heti.nsw.gov.au/secure/downloadfile.asp?fileid=1008205</p> <p>Reference for “hands-on, hands-off” approach to supervision: Iedema R, Brownhill S, Haines M, Lancashire B, Shaw T and Street J. (2010). 'Hands on, Hands off': a model of clinical supervision that recognises trainees' need for support and independence. Australian Health Review, 34(3):286-91.</p>	<ul style="list-style-type: none"> • Supervision contract example • Clinical supervision agreement example • Notes on supervision session example • Supervision log example • Supervision feedback form example • Smart goal template example • Reflective practice template example • Supervision session outline example

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Preceptor Program: Implementation Guide (2011)</i></p>  <p>SIGGINS MILLER</p>	<p>Queensland- Nursing and midwifery staff</p>	<p>Summary. Developed by the Clinical education and Training Queensland the Queensland Health Preceptor Program adopted preceptorship as the model of transition support for nursing/midwifery staff. The guide provides the context of the preceptor program and guidelines for implementation, ongoing management and policy development to support the program.</p> <p>Aim. “To provide a supportive network of experienced staff that will facilitate the socialisation and assimilation of newly graduated or transferring nurses/midwives into Queensland health facilities” (p.9)</p> <p>Key features the programme was developed from:</p> <ul style="list-style-type: none"> • Spheres of learning including: clinical, organisational, professional areas of learning and career development activities • Staff development components: orientation and induction, transition and continuing professional development <p>Guiding principles include:</p> <ul style="list-style-type: none"> • Employer allocates sufficient resources • Review of transition support process (with all stakeholders involved) • Preceptors are guided by standards Preceptors are educationally prepared for their role • Acknowledgement and value placed on preceptors’ contribution • Individualised transition plan for nurse or midwife • Nurse or midwife receive constructive feedback • Transition process complete when they are confident and competent for practice in the unit • Risks are identified and managed <p>Preceptor training</p> <p>Modules include the concept or preceptorship, adult learning, assessment, communication and socialisation, leadership, teaching and strategies for effective preceptoring.</p> <p>Benefits</p> <ul style="list-style-type: none"> - Promoting the success of new nurses/midwives Enhancing clinical performance - Improving the quality of patient care <p>Developing successful program</p> <ul style="list-style-type: none"> - Assess needs Identify the philosophy Create the plan - Organise Implement Evaluate <p>Roles and responsibilities</p> <p><i>Preceptor :</i> Participation in continuing education activities</p> <ul style="list-style-type: none"> - Implementing the role as outlined in policies and protocols - Role modelling best practice in patient care, leadership, communication and problem solving - Supporting integration of new staff members into the culture and norms of the work unit <p><i>Preceptee:</i> Being actively involved in the process</p> <ul style="list-style-type: none"> • Being accountable and responsible for their own performance • Using reflective practice to identify learning needs <ul style="list-style-type: none"> • Openly communicating about successes and issues, skills levels, prior experience and learning needs 	<ul style="list-style-type: none"> • Queensland health preceptor model • Divisional/work unit orientation/induction activity booklet • Preceptor role checklist • Ongoing monitoring of performance development

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Clinical supervision guidelines for Mental Health Services</i> (2009)</p>	<p>Queensland - Medical, mental health and nursing staff, allied health, indigenous mental health, consumer and carer workforce, and other clinical staff</p>	<p>Summary. Created by Queensland Health the Clinical Supervision Guidelines for Mental Health Services provides draft guidelines for the standardised, generic and flexible statewide approach to clinical supervision for all mental health professionals involved in mental health service delivery.</p> <p>Definition. Clinical supervision is “a designated interaction between two or more practitioners, within a safe environment, which enables a process of reflective, critical analysis of care, to ensure quality consumer services.”</p> <p>Supervision Model.</p> <ul style="list-style-type: none"> • Formative • Restorative • Normative <p>Supervisor. The supervisor role includes:</p> <ul style="list-style-type: none"> • Working with clinicians to agree on goals for supervision session, and putting in place processes for regular reviews of progress • Facilitating a safe and trusting environment for supervision sessions • Validating good practice and providing constructive feedback • Ensuring regular attendance as agreed by the organization and in line with local policies and procedures • Taking action in relation to any developmental needs identified through clinical supervision <p>These guidelines note that as the focus of supervision should be on the role and clinical practice of the clinician a useful way of presenting issues is through a case presentation of review, which would allow discussion and identification of pertinent issues. It is also a requirement that supervisors attend training for supervisors before commencing a supervisory relationship.</p> <p>Supervision Agreement. Clinical supervision is supported by a supervision agreement including:</p> <ul style="list-style-type: none"> • Dates and location of supervision sessions • Record keeping and responsibilities for documentation • Outline any particular responsibilities of each party <p>Web Address: https://docs.google.com/viewer?a=v&q=cache:ltbqUMqbLnoJ:www.psychologyboard.gov.au/documents/default.aspx?record%3DWD12%252F7465%26dbid%3DAP%26chksun%3Dwn1dw%252F0JV9PLEAY7hO5kJw%253D%253D+Clinical+supervision+guidelines+for+Mental+Health+Services&hl=en&gl=au&pid=bl&srcid=ADGEEsJraVmi7aHn1EQ-d61w5sh9HVvTqWOu2JYfSIVayPFT-oVp-Lpl7kSPZoVorO81qvA98ub-XpBY_JidAqoT_0pcSG9K0ttMtS6uq3b7YHyqbiWIZrhQeNBhiodAQ_0Bdkbm8w1&sig=AHIEtbQJPMJEfi_s2vRMMMyJ5_cay84Vytw</p>	<ul style="list-style-type: none"> • Record of supervision meetings • Clinical supervision agreement

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Foundations to Supervision (2008)</i></p>	<p>Western Australia - WA Country Health Services</p>	<p>Summary. This learning package was designed by the Government of Western Australia Department of Health for supervisors and supervisees to assist them in gaining the necessary theoretical knowledge and skills to participate in supervision in a clinical context. Specifically it is designed for “all WACHS health professionals undertake some form of supervision within their role” (p.5).</p> <p>Definition. Supervision “Literally meaning “over see”, developed from industry, where technical skill and task completion was supervised, often by a person with recognized more experience or expertise” (p.5).</p> <p>Supervision Model.</p> <ul style="list-style-type: none"> • Formative Restorative Normative <p>Supervisor and Supervisee. Supervisors should be able to (1) apply adult learning principles, and (2) acknowledge that people have different learning styles and that this is important to consider in any supervisory relationship. The supervisory relationship is a critical part of supervision and should consider the following:</p> <ul style="list-style-type: none"> • Factors which may influence this relationship such as differences in gender, culture, power etc., • Management of such factors through an environment of open communication, and • Tailoring of the supervisory relationship to the supervisee’s individual needs. <p>The supervisor and the supervisee each have certain rights and responsibilities, which this package covers in detail. For example, a supervisee has the right to be treated with respect as an equal partner in the supervisory relationship and they have the responsibility to prepare for supervisory sessions. And for the supervisor, they have the right to break confidentiality in agreed circumstances and the responsibility to be accessible, and protect time for supervision.</p> <p>Stages of Supervision. There are four stages that underpin supervision:</p> <ul style="list-style-type: none"> • Planning and contracting Assessment and evaluation Monitoring and follow up Termination <p>They also note in this section that although the supervisory process should be flexible it is important, especially in the early stages, that the supervisor and supervisee have a shared understanding of the common steps in supervision. The last section of the package outlines how to evaluate supervision. They suggest that evaluating is good practice and should be done at the end of each session, and at periodic intervals as well as at the conclusion of the supervision relationship. The package suggests a range of questions which can be considered when evaluating supervision including questions around the sessions, the process, skills, the relationship and the outcomes.</p> <p>Web Address: http://www.curch.uwa.edu.au/cucrh/images/stories/Preceptor/Foundations_to_Supervision.pdf</p>	<ul style="list-style-type: none"> • Strategies to promote adult based learning in a clinical context • Learning styles • Tips for giving feedback • Tips for receiving feedback • Deciding the type of feedback • Providing constructive feedback • Supervision contract • Five principles of goal setting

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Clinical supervision in community health: Introduction and Practice guidelines (c. 2007)</i></p>	<p>Australia - Community health sector</p>	<p>Summary. Created by the Victoria Health Care Association to improve clinical supervision in the community health sector.</p> <p>Definition. Clinical supervision is a formal process, between two or more professional staff, creating a supportive environment, which encourages reflective practice and the improvement of therapeutic skills. The supervisory relationship provides an opportunity to address ethical, professional and best practice standards and to promote appropriate, respectful and effective client care.</p> <p>Supervision Model. The model includes three components:</p> <ul style="list-style-type: none"> • Educational • Supportive • Managerial <p>Benefits</p> <ul style="list-style-type: none"> • For individuals: ongoing education and professional development, decreased levels of stress and burnout, and reduced feelings of isolation. • For organisations: workforce retention, monitoring and improving clinical service delivery and workforce development. <p>Supervision Method. There are four common forms of clinical supervision:</p> <ul style="list-style-type: none"> • One to one • Group • Peer • Live/observational <p>Web Address: http://www.vha.org.au/uploads/Clinical%20Supervision_Background%20_Final_.pdf</p>	

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>NSW Drug and alcohol clinical supervision guidelines (2006)</i></p>	<p>Australia - NSW Medical and nursing staff, psychologists, social workers, D&A workers and D&A counsellors.</p>	<p>Summary. This document, by the New South Wales Department of Health, provides comprehensive guidance in relation to the implementation of clinical supervision programs within NSW Drug and Alcohol (D&A) services. It informs local policies and provides a framework for good practice that D&A services can refer to.</p> <p>Definition. Clinical supervision is defined as: “A formal and ongoing arrangement between one worker and a (generally) more experienced practitioner whereby the clinical practice of the worker is reviewed and discussed in confidence” (p. 3).</p> <p>Purpose. The purpose of clinical supervision is to:</p> <ul style="list-style-type: none"> • Further develop the supervisee’s professional identity and clinical practice skills and knowledge. • Ensuring supervisee’s are operating within relevant clinical, organisational, ethical and professional boundaries. • Monitoring and supporting the supervisee’s wellbeing and coping capacity in relation to their work. <p>Benefits. The benefits of clinical supervision include facilitating the acquisition of complex clinical skills and supporting staff retention.</p> <p>Supervisor. A supervisor role includes:</p> <ul style="list-style-type: none"> • Ensuring that supervisees are clear at the outset about the purpose of supervision, what is expected of them, the role of the supervisor, the parameters of confidentiality, and the appropriate mechanisms for addressing any difficulties or concerns about the clinical supervision process. • Working with supervisees to agree on goals for supervision sessions, and put in place processes for regular review of progress. <p>Supervisee. A supervisee role includes:</p> <ul style="list-style-type: none"> • Negotiation of arrangements for clinical supervision, in line with organisational policies or procedures, and with line management approval. • Ensuring regular attendance as agreed with the organisation, and in line with local policies • Working with the supervisor to agree the goals of clinical supervision, and ways of working together <p>These guidelines outline organisational considerations with clinical supervision which centres on developing a supportive environment, recruitment and selection of supervisors and the importance of policy, procedures and record keeping. As well as the importance of monitoring and evaluation of clinical supervision.</p> <p>Web Address: http://www.health.nsw.gov.au/resources/mhdao/pdf/ClinicalSupervisionGLines.pdf</p>	<ul style="list-style-type: none"> • Clinical supervision contract • Record of clinical supervision session • Annual evaluation form • Annual report from clinical supervisors

Title and Year Developed	Jurisdiction and Scope	Description of Framework	Resources
<p><i>Clinical Supervision- Psychologists (2006)</i></p>	<p>Australia - South Eastern Sydney Illawarra NSW Health- Clinical Psychologists</p>	<p>Summary: This procedures document applies to all psychologists employed by the SESIH. It establishes a formal link between the clinical and administrative lines of responsibilities of psychologists and is complementary to the Area performance management process.</p> <p>Definition. Clinical supervision “is an intervention, which is provided by an appropriately qualified psychologist (supervisor) to another psychologist (supervisee) or psychologists” (p.2). They further describe the supervision relationship as an evaluative and educative one. The relationship is based on a relationship of trust which helps in the development and enhancement of professional skills.</p> <p>These guidelines outline the importance of evaluation which they define as “the ongoing feedback to the supervisee with a simultaneous focus upon the supervisee’s future learning steps” (p.3). Further, the process for evaluation should be based on mutually determined and specific goals, with clear indicators of goal attainment. Any evaluation of supervision should take into account issues of process, progress and outcome. The evaluation should also have a clear structure and format. Web</p> <p>Address: http://www.seslhd.health.nsw.gov.au/Policies_Procedures_Guidelines/Clinical/Allied_Health/documents/PD-128-Psychologists-Supervision.pdf</p>	<ul style="list-style-type: none"> • Clinical supervision record • Clinical supervision contract
<p><i>Clinical Supervision: Framework for WA mental health services and clinicians (2004-2007)</i></p>	<p>Australia - Western Australia - Mental health workers working within a clinical area</p>	<p>Summary. Created by the Western Australia Department of Health this framework outlines that the objective of clinical supervision is to “provide staff with a confidential, safe and supportive environment, to critically reflect on professional practice” (p.1).</p> <p>Definition. Clinical supervision “is the process of two or more professionals formally meeting to reflect and review clinical situations with the aim of supporting the clinician in their professional environment” (p.1).</p> <p>Supervision Model. The framework notes that there are numerous models for clinical supervision but recommends the developmental model and the supervision specific model.</p> <ul style="list-style-type: none"> • The developmental model is supervision with a practitioner who is highly experienced and able to draw on their wisdom and expertise. • The supervision specific model focuses on three main functions- normative, formative and restorative (i.e. Proctor’s model, 1986). <p>Potential formats for supervision include:</p> <ul style="list-style-type: none"> • Group supervision, peer group supervision Individual supervision Cross discipline supervision <p>Supervisor. A supervisor should be open and honest, aware of strengths and weaknesses, and empathetic. The supervisor role includes personal availability, record-keeping,</p> <ul style="list-style-type: none"> • Awareness of limitations in knowledge and the responsibilities of the supervisee (which include, preparing issues to discuss, confidentiality and record-keeping). <p>Supervisee. A supervisee should be open and honest, able to accept responsibility for own practice, and able to give and receive constructive feedback.</p> <p>The framework also goes through some specifics in regards to the supervision process including entering into a supervisory agreement, arranging meetings and time frame and review. Web</p> <p>Address: http://www.health.wa.gov.au/docreg/Education/Population/Health_Problems/Mental_Illness/HP3095_Clinical_supervision_framework_for_WA_mental_health.pdf</p>	<ul style="list-style-type: none"> • Supervision agreement template • Supervision record notes • Clinical supervision schedule

Appendix B: Quality in clinical learning environments – primary research

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
1997	Dunn & Hansford 1997, Undergraduate nursing students' perceptions of their clinical learning environment	Australia	Nursing	Explore the factors characterising students' perceptions of the CLE.	Survey, Clinical Learning Environment Scale, administered to 229 undergraduate students.	Interpersonal relationships between the participants in the CLE were crucial to a positive learning environment. Collaboration between nurse educators, clinical venues, and all others participating in clinical education is needed in order to promote quality clinical placements.
2001	Bonello 2001 Perceptions of fieldwork education in Malta: Challenges and opportunities	Malta	Occupational Therapy	Explore the fieldwork experiences of recently qualified occupational therapists in Malta.	Interviews with 18 recently qualified occupational therapists.	Students identified the following themes as important in the fieldwork experience. 1. Administration influences - including how placements were organised (e.g. placements interspersed between lectures fragmented the experience, whereas block placements were considered to be more meaningful). The number of placements was perceived to be insufficient to develop competency, and the length of each placement too short. 2. Disempowerment through assessment - students reported inconsistency between supervisors' ways of grading them, and different standards expected at different placement sites. Students felt some supervisors did not have the necessary experience to be assessing student performance. Feedback that was infrequent or non-existent was reported. 3. Fieldwork educator as role model and effective supervisor - some students felt that some educators did not behave in ways that provided meaningful learning experiences. Effective educators were available, good communicators, friendly, clinically experienced, attended to student needs, provided opportunities for practical treatment techniques, support and guidance, encouraged active learning, explained reasons for clinical decisions, did not over or under supervise, allowed students responsibility for patient evaluation, treatment, and report writing, and provided constructive criticism and feedback.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2001	Lofmark & Wikblad 2001, Facilitating and obstructing factors for development of learning in clinical practice: a student perspective	Sweden	Nursing	To provide information on what student nurses found facilitating and obstructing for their learning during clinical practice.	47 student nurses completed weekly diaries during their final clinical placement.	Facilitating factors included 1. Responsibility and independence - being allowed to take responsibility or initiative, 2. Being allowed to work independently, 3. Practising tasks and receiving feedback, 4. Collaboration with staff and being able to supervise others, 5. Having a clear overview of the work environment and understanding what students have control over. Obstructing factors included 1. Poor student-supervisor relationship characterised by disrespect, insufficient or inappropriate supervision, lack of feedback, or opportunities to reflect. 2 Organisational factors in supervision including lack of continuity between supervisors, lack of guidelines for nursing care, stress or lack of time, lack of opportunities to practice or not permitted to take part. Students own shortcomings included experience of failure, difficulties in taking initiative or being self reliant and insufficient knowledge.
2002	Saarikoski & Leino-Kilpi 2002, The clinical learning environment and supervision by staff nurses: developing the instrument	Finland	Nursing	Aimed to describe students' perceptions of the CLE and clinical supervision, and to develop an evaluation scale by using the empirical results of this study.	Survey, CLES of 416 Finnish nursing students.	The method of supervision, the number of separate supervision session, the psychological content of the supervisory contact and a positive ward atmosphere, were the most important to students' clinical learning. Results also indicate that ward managers can create conditions of a positive ward culture and a positive attitude towards students and their learning needs. The most important factor in the students' clinical learning is the supervisory relationship.
2003	Papp <i>et al</i> 2003, Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experience	Finland	Nursing	To describe Finnish student nurses' experiences and perceptions of the clinical environment as a learning environment.	16 student nurses interviewed.	Four elements: appreciation, support, quality of mentoring and patient care, and self-directedness. A good clinical learning environment was established through good co-operation between the school and the clinical staff.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2004	Chan 2004 Nursing students' perceptions of hospital learning environments - an Australian perspective	Australia	Nursing	To investigate the relationship between student learning outcomes from their clinical placement and their perceptions of social climate of the clinical learning environment.	CLEI administered to 108 second year nursing students on clinical placement across 14 metro hospitals.	Students' perceptions of outcomes of their clinical placement are strongly associated with all five scales of the CLEI: Individualisation, Innovation, Involvement, Personalisation and Task Orientation.
2005	Andrews <i>et al</i> 2005, Place(ment) matters: students' clinical experiences and their preferences for first employers	United Kingdom	Nursing	To consider students' experiences of clinical placements, in the context of workforce recruitment and how they may act upon preferences for working for health care providers.	Place-sensitive geographical perspective and combined questionnaires (n=650), interview (n=30) and focus group (n=7) methods to collect data on the complex range of clinical experiences which together impact upon perceived attractiveness of different health care settings.	The factors which combined to create students overall experiences of places included: adequate or inadequate mentorship; effective or ineffective ward management; appropriate or inappropriate learning opportunities (that promoted or inhibited their professional development), and a lack of or existence of racism.
2005	Klang 2005, How do we care for our students? A three-year follow-up of medical, nursing, physiotherapy and occupational therapy students in Sweden	Sweden	Medicine, Nursing, Physiotherapy, and Occupational Therapy	What are students learning experiences like across disciplines in hospital settings?	Survey, N=447 medical, nursing, physiotherapy, and OT students.	Commonly discussed themes included: the learning environment, sense of belonging, preceptors interest, competence and attentiveness, clarity in goals, time and opportunities for learning, quality of care given, atmosphere in the staff team, and the attitudes to, and interest in students.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2005	Sheehan <i>et al</i> 2005, Interns' participation and learning in clinical environments in a New Zealand hospital	New Zealand	Medicine	Explore factors that encourage interns to participate actively with clinical rotations.	17 interns participated in interviews and focus groups while on clinical rotation.	Factors encouraging participation included: taking responsibility in the absence of more experienced staff where the student was competent to do so; the attributes of teams and the guidelines they operated under; the relationship of students with the supervisor, including needing to feel valued; interactions with more experienced staff, the capacity of staff to effectively use questioning and feedback. Barriers to participation and learning mainly focused on insufficient time and/or access to the supervisor.
2006	Henzi <i>et al</i> 2006, North American dental students' perspectives about their clinical education	United States	Dentistry	What are dental students' perceptions of their learning experiences in the clinical setting?	655 junior, senior, and graduate dental students at 21 North American dental schools completed the Clinical Education Instructional Quality Questionnaire (ClinEd IQ).	Students identified four areas of concern: 1. Inconsistent and sometimes insensitive feedback from faculty, 2. Excessive amounts of non-educational 'legwork' such as billing, patient scheduling, phone calling, completing paperwork, and performing other clinic operation tasks, 3. Limited access to faculty because of: insufficient numbers of instructors on the clinical floor, and difficulty locating faculty when they were needed for coaching, work evaluation, and chart signatures, 4. Concerns about the strategies employed to meet procedural requirements that some students thought were ethically questionable. The strongest aspect of clinical education was the relationship with the faculty, while the clinical learning environment the second most influential factor.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2006	Leners <i>et al</i> 2006, Perceptions of nursing students' clinical placement experiences	United States	Nursing	To examine the nursing education issues associated with student clinical placement, as experienced by hospital personnel who coordinate the placements with various schools of nursing.	Qualitative, semi-structured interviews of personnel directly associated with clinical site placements in acute care agencies throughout the central and northern section of Western U.S. state. Interviews were audio taped and transcribed verbatim. N=15 volunteers	Placement site personnel identified the following as impacting on the placement experience: lack of consistent terminology and definition of student and preceptor roles; quantity and quality of students (e.g. different preparation levels of students); quality of clinical scholars, clinical faculty and preceptors; onsite clinical supervision preferred (clinical scholar model) rather than faculty supervision. The rewards to personnel for supervision of students needed to include financial compensation and reduced workload. Negative factors identified included: too many students were hard to manage; additional workload; concerns about competence of students and patient safety; and poor communication, preparation and organisation in the placement process itself.
2006	Levett-Jones <i>et al</i> 2006, Enhancing nursing students' clinical placement experiences: A quality improvement project	Australia	Nursing	Describes a quality improvement project to improve the clinical e-learning experience of nursing students.	Qualitative and quantitative data collected through focus groups, brainstorming sessions, interviews and surveys of clinicians' perceptions about quality clinical placements.	Key areas identified by clinicians as impacting quality in clinical placements: 1. Communication breakdowns between the university and clinicians (i.e. limited information about what students had learned prior to placement, difficulty in contacting university staff, and lack of timely information regarding student placement details). 2. Mentorship (i.e. difficulties providing consistent and experienced mentors for large numbers of students) 3. Preparation for clinical placements (i.e. information about venues prior to student's placements, relevant and clear clinical objectives, orientation of students to clinical venues). 4. Clinical competence (i.e. clinicians critical of students' lack of clinical competence), 5. Graduates' readiness for practice - clinicians concerned about universities graduating students not ready for practice and felt at times their feedback about performance was ignored.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2007	Hartigan-Rogers <i>et al</i> 2007, Nursing graduates' perceptions of their undergraduate clinical placement	Australia	Nursing	To describe graduates' perceptions of clinical placements and provide recommendations for placements.	All 1999 - 2002 graduates from one School of Nursing, located at two sites, were interviewed (N=70)	Four themes emerged about graduates' perceptions of the relevancy of these clinical placements to their future practice: 1. Developing nursing skills and knowledge – students wanted placements that provided frequent opportunities to practice skills. 2. Experiencing the realities of work life was considered useful, including realistic client care situations and workloads, as well as shift work. 3. Preparing for future work through exposure to a wide range of nursing roles and opportunities to explore clinical interests. Active participation in patient care rather than observation only, was also noted in this theme. 4. Experiencing supportive relationships was considered most important. Environments were judged as non supportive where nursing staff were perceived as stressed, intimidating, and not prepared to accept learners. Positive clinical experiences are more likely related to how valued and supported students feel, rather than the physical aspects of placement.
2007	Kirke <i>et al</i> 2007, Informing fieldwork design: Key elements to quality in fieldwork education for undergraduate occupational therapy students	Australia	Occupational Therapy	Explore stakeholder inputs to design an OT fieldwork program.	5 focus groups involving 47 occupational therapists.	Quality fieldwork program would include: 1. Regular and clear communication regarding the curriculum and fieldwork program. 2. Clear expectations for students and personnel involved in fieldwork placement, 3. A collaborative design with input from fieldwork educators. 4. A culture of appreciation for work completed on the university's behalf. 5. Token of appreciation such as professional development vouchers or administrative support for student orientation and paperwork. Characteristics of good fieldwork educators include: well prepared; provides orientation and understands placement requirements; communicates well and gives effective feedback; clear expectations; spends adequate time with students; demonstrates clinical reasoning. Capable students are self-directed learners, display professional behaviours, interact well with staff, and learn from mistakes. Good collaboration between university and placement sites would include regular site visits by the university to students on placement and provide free professional development for fieldwork educators.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
						Occupational therapists identified 3 areas of focus to improve quality in clinical placements: ongoing professional development for fieldwork educators, the need to develop tangible strategies that recognise their contribution towards clinical education, and closer collaboration between universities and field work educators.
2007	Lew <i>et al</i> 2007, When fieldwork takes a detour	United States	Occupational Therapy	Explored the experience of occupational therapists who encountered counterproductive events during their fieldwork training.	13 interviews with students who had a negative fieldwork experience	Challenging events with supervisors were considered the major factor contributing to a negative fieldwork experience. Specifically, the role of the supervisor was discussed in terms of lack of supervision and commitment, failure to acknowledge or address students' needs regarding orientation and structure, and provisions for the student in the supervisor's absence. Poor supervision characteristics included insensitivity and negative attitude towards the students. This was magnified by other factors, such as lack of academic program support.
2007	Morris 2007, Factors influencing the quality of student learning on practice placements	United Kingdom	Physiotherapy	Explored which aspects of physiotherapy placement most facilitated and least facilitated learning.	17 final year physiotherapy students, interviews	Within placements, the following most facilitated learning: direct involvement with patients, positive educator-student interaction, positive interaction with peers, and the employment experience. Across placements, students identified placement variety and range of clinical educators as most useful. Within placements, the following least facilitated learning: expectations and responsibility above student status, negative educator-student interaction, limited contact with patients, and a negative employment experience. Across placements, students identified external pressures, such as travel and other university commitments, along with how and when placements were organised.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2008	Cole & Wessell 2008, How clinical instructors can enhance the learning experience of physical therapy students in an introductory clinical placement	Canada	Physical Therapy	Evaluate physical therapy student's perceptions of their learning experiences during a clinical placement.	Qualitative questionnaire completed by 51 PT students in a 2 year masters program, on each day of placement.	Clinical instructors could improve learning experiences by: 1. Preparing students by introducing, explaining, demonstrating, or allowing them to obtain information; 2. Confirming learning by providing feedback and recapping, 3. Providing 'hands on' experiences appropriate to students' knowledge, skills and comfort; 4. Challenging students by questioning, discussing possibilities, providing reflection time. 5. Respecting students, valuing their input and allow them an appropriate level of independence. 6. Demonstrating professional behaviour related to communication, evidence-based practice and continuing education.
2008	Happell 2008, Clinical experience in mental health nursing: determining satisfaction and the influential factors	Australia	Nursing	Determine the impact of several variables on student satisfaction with mental health clinical placement experiences.	Survey, 703 undergraduate nursing students who had completed mental health placements	Variables explored included: number of placement days, time spent with preceptor, number of clinical hours per day and type of service. Clinical placements were rated significantly more positively when there was: 1. More time spent with preceptor; and 2. The placement was longer in duration.
2008	Levett-Jones & Lathlean 2008, Belongingness: A prerequisite for nursing students' clinical learning	Australia	Nursing	As belongingness emerged from a broader study as a critical and recurring theme, this smaller study investigated how belongingness influences the placement experience?	Qualitative interviews with 18 nursing students.	Belongingness was positively associated with motivation to learn, self-directed learning and confidence to ask questions. Absence of belongingness was associated with anxiety and considered a barrier to learning.
2009	Grealish & Ranse 2009, An exploratory study of first year nursing students' learning in the clinical workplace	Australia	Nursing	Explored how first year undergraduate nursing students learn in clinical placements.	49 written narrative accounts of student learning experience were analysed.	Learning is greatest when: students are able to participate or observe tasks or procedures, when students are emotionally confronted by the work, and when exposure to different nurses provides different perspectives on what it is to be a nurse.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2009	James & Chapman 2009, Preceptors and patients - the power of two: Nursing student experiences on their first acute clinical placement	Australia	Nursing	Explored how placement experiences influenced student decision making about their future in nursing.	Interviewed 6 second year undergraduate nursing students undertaking their first placement.	Preceptor behaviours contributing to positive perception of placement experience included: acknowledging students for positive actions. This increased confidence and self-efficacy, and feeling of belonging to a team.
2009	Livsey 2009, Structural empowerment and professional nursing practice behaviours of baccalaureate nursing students in clinical learning environments	United States	Nursing	Examine associations between professional behaviours of baccalaureate nursing students and student perceptions of factors within the CLE.	Survey of 243 recent nursing school graduates.	Structural empowerment refers to the combination of organisational strategies that allow individuals within the environment to work in an empowered manner. This study found a direct relationship between student perceptions of structural empowerment in the clinical learning environment and self reported professional nursing practice behaviours such. Structurally empowering learning environments increase student motivation, confidence and promote self-directed learning. Students' sense of self efficacy had a significant impact on student professional nursing practice behaviours.
2009	Newton <i>et al</i> 2009, Journeying through clinical placements - An examination of six student cases	Australia	Nursing	To map novices' participation and learning through their clinical experiences from student to graduate, as part of a multi-method longitudinal study examining nurses' workplace learning.	Case studies based on interviews, N=6 student nurses representing broader group of 29, chosen for case study	Four themes identified 1. Creating learning opportunities for active participation in patient care. 2. Gaining independence as students have opportunity to acquire the knowledge, skills and confidence to practice independently. 3. Becoming part of a team. 4. Generational differences - interacting with older nurses that may not have studied at a tertiary level.
2009 a	Newton <i>et al</i> 2009a, Lost in translation: barriers to learning in health professional clinical education	Australia	Nursing	What factors within the university and clinical environments influence the transfer or translation of learning for undergraduate nursing students?	Longitudinal design including interviews, surveys, and field work observations. This article focuses on interview data, N=28 student nurses.5 interviews with each participant over 2 years.	4 themes identified. (i) curriculum, i.e. the timing and sequencing of clinical placements; (ii) pedagogy – potentials, i.e. the opportunities available for learning; (iii) personal epistemologies, i.e. individuals' beliefs and values; and (iv) impact of workplace. Being able to actively participate in clinical skills enhanced learning, while limited opportunities or staff indifference to students restricted it. Called this "degrees of affordance". Impact of preceptor also highlighted.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2009	Ralph <i>et al</i> 2009, Practicum and clinical experiences: Post practicum students' views	Canada	Nursing	To collect e-mail survey responses from 63 post-practicum nursing students who had just completed their culminating fourth-year clinical course, in order to identify the most positive and most negative aspects of their final practicum experience.	Survey, 63 post practicum nursing students after final placement experience	Most positive aspect of placement experience: 1. Reduced the theory-practice gap, 2. Received effective mentoring, 3. Worked with supportive staff members, 4. Were treated as a team member, 5. Developed self confidence. Most negative aspect of placement experience: 1. Received poor mentorship, 2. Were assigned unproductive tasks, 3. Encountered unrealistic time constraints, 4. Received poor placements (characterised by poor supervision), 5. Experienced unfair evaluations, 6. Experienced financial difficulties.
2009	Young <i>et al</i> 2009, Effective teaching and learning on the wards: easier said than done?	Australia	Medicine	To evaluate the teaching and learning during a clinical placement, and to draw lessons from the findings to inform medical educators about more efficient and effective ways of teaching and learning.	Surveys, focus groups, and observations carried out on 40 students in 2 successive rotations of a clinical discipline followed for 8 week periods. Plus 10 clinical teachers	Perceptions of what constitutes good clinical teaching did not differ between clinicians and students. Both groups highlighted the value of hands-on experience, a broad knowledge base and working in small groups with clinicians. Students valued learning opportunities with clinicians that involved quality time during which they could practise clinical skills in an environment in which they received focused feedback.
2010	Koontz <i>et al</i> 2010, Staff nurses and students: The good, the bad, and the ugly	Australia	Nursing	To explore student nurses' perceptions of their clinical learning environment experiences, with the hopes of discovering positive and negative factors influencing learning.	3 small focus groups (2, 5, 3) with nursing students	Elements of CLE identified as having a positive impact on learning: 1. Preceptorship, 2. Responsibility and trust between students and nursing staff/ patients, 3. Reflection on learning experiences, 4. Different perspectives provided by observing skills of different nurses.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2010	Newton <i>et al</i> 2010, Clinical Learning Environment Inventory: factor analysis	Australia	Nursing	To test the psychometric properties of the Clinical Learning Environment Inventory (CLEI) using factor analysis.	Survey, Clinical Learning Environment Inventory (CLEI), 659 nursing students, testing psychometric properties of CLEI	Six factors emerged: 1. Student centeredness - clinical teacher's time taken to engage with students on an individual level, 2. Affordances and engagement - student intrinsic motivation to engage and the opportunities afforded for students to actively engage in ward activities at work, 3. Individualisation - students being able to have some control over their clinical experience and facilitate the achievement of their individual learning needs, 4. Fostering workplace learning - infrastructure in place that fosters learning, assignments are clear, well planned and interesting, and they have opportunities to express opinions, 5. Valuing nurses' work - students recognise the value of nursing work, and 6. Innovative and adaptive workplace culture - workplace promotes creative, flexible, and adaptable work practices.
2010	Papastavrou <i>et al</i> 2010, Student nurses experience of learning in the clinical environment	Cyprus	Nursing	1. To explore how student nurses in Cyprus find their experiences of the learning environment and supervision in clinical placements. 2. To identify which factors of the clinical learning environment and supervision contribute to learning. 3. To create a database on clinical learning and supervision that will form a starting point for future studies in Cyprus.	Survey, Clinical Learning Environment and Supervision scale (CLES), N=645 nursing students	Five factors identified in order of importance: 1. Supervisory relationship, 2. Ward atmosphere, 3. Premises of nursing on the ward, 4. Premises of learning on the ward, and 5. Leadership style of the ward manager.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2010	Smedley & Morey 2010, Improving learning in the clinical nursing environment: perceptions of senior Australian bachelor of nursing students	Australia	Nursing	To assess senior Bachelor of Nursing students' perceptions of the characteristics of their clinical learning environment, and to consider the implication of the data for future education of work-based mentors and institution-based facilitators.	Survey, Clinical Learning Environment Inventory (CLEI), nursing students asked to complete for actual (n=55) and preferred (n=38) clinical experience	Student involvement and personalisation are the most important aspects of quality. Student involvement: extent to which students participate actively in hospital ward activities. Personalisation: opportunities for individual students to interact with clinical teacher and concern shown for student personal welfare. Development of a positive relationship with staff was critical and student satisfaction increased when the student was part of the 'community of practice' in the placement. Findings showed task orientation (extent to which placement activities are clear and organised) was perceived as a precursor to student involvement my students.
2010	Warne <i>et al</i> 2010, An exploration of the clinical learning experience of nursing students in nine European countries	Western Europe: Cyprus, Belgium, England, Finland, Ireland, Italy, Netherlands, Spain, and Sweden.	Nursing	A composite and comparative view across 9 western European countries of what factors enhance the learning experiences of student nurses whilst they are in clinical practice	Survey CLES+T (Clinical Learning Environment, Supervision and Nurse Teacher evaluation scale), N=1903 nursing students from Cyprus, Belgium, England, Finland, Ireland, Italy, Netherlands, Spain, and Sweden.	A successful supervisory relationship was identified as most important factor to student satisfaction with clinical placements. Most satisfied students completed at least a 7 week clinical placement supported by individualised mentorship.
2011	Anderson <i>et al</i> 2011 Undergraduate dental education in New Zealand: 2007-2009 final-year student feedback on clinical learning environments	New Zealand	Dentistry	To report on the findings of clinical learning environment questionnaires delivered to final-year Bachelor of Dental Surgery students at the University of Otago, from 2007 to 2009, relating student responses to the findings of previous literature, and to outline subsequent programmatic responses and research initiatives.	Survey, 156 final year dentistry students	Findings focus mostly on affective characteristics and to lesser extent the physical characteristics (e.g. equipment, buildings, and organisational matters) of the clinical learning environment. (Is our energy going to the wrong place – probably a bigger focus on fixing infrastructure, but affective issues are more relevant to students). Relationship with tutor very important. Student suggestions for improving clinical learning environments focused on teaching-related improvements rather than physical or organisational improvements (e.g. staff to student ratio, competence of clinical teaching staff, constructive feedback, consistent and meaningful assessment approaches). Physical and organisational aspects included updated facilities, more space and chairs, and access to more materials.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2011	Brown <i>et al</i> 2011, Practice education learning environments: The mismatch between perceived and preferred expectations of undergraduate health science students	Australia	Health Sciences including paramedics, midwifery, radiography, occupational therapy, pharmacy, nutrition and dietetics, physiotherapy, and social work	To investigate how undergraduate students enrolled in health-related education programs view their clinical learning environments, and to compare students' perceptions of their 'actual' clinical learning environment to that of their 'preferred/idea;' clinical learning environment.	Survey, CLEI, 548 undergraduate health science students, asked to rate their perceptions of the CLE at the completion of placements	1. Personalization reported as most important domain in actual placement, as students valued positive relationships with supervisors. Students reported needing to be treated with respect, feel appreciated and feel part of a team. On preferred form, task orientation found to be most important. Individualization scored the lowest on both forms. The fact that that subscale received the lowest rating on the 'actual' form indicated that students did not feel that they were currently able to make their own decisions or were treated according to their abilities. Aligned with other research that students felt unsupported and devalued by nursing staff. Individualisation also scored lowest on preferred form – students viewing it as a factor that does not influence learning as much as other scales.
2011	Courtney-Pratt <i>et al</i> 2011, Quality clinical placements for undergraduate nursing students: a cross-sectional survey of undergraduates and supervising nurses	Australia	Nursing	To describe the quality of clinical placements provided to second year undergraduate students in an acute care hospital	Survey, at 2 points within a year, 178 undergraduate nurses, 22 clinical facilitators, 163 supervising ward nurses	Relationships: supervisor-supervisee relationship important to whether placement is positive or negative. Organisational structure: support provided to students by supervisors and clinical facilitators, number of undergrads in placements on each ward, business of acute care. Most comments were made about knowledge and experience as related to opportunities provided in placement to develop.
2011	Rodger <i>et al</i> 2011, What makes a quality occupational therapy practice placement? Students' and practice educators' perspectives	Australia	Occupational Therapy	To address practice educators' and students' perspectives regarding quality practice placement experiences	In total, 29 students, 41 practice educators and 8 practice education staff members, across 3 QLD universities participated in focus groups and individual interviews (n=78), focusing on their views about quality learning experiences on placements.	Identified quality indicators across the phases of placement establishment, preparation, maintenance and review. University preparation processes. Welcoming learning environment. Detailed orientation and clear expectations. Graded program of learning experiences. Quality modelling and practice. Consistent approach and expectations. Quality feedback. Open and honest relationships. Supervisor experience and skills.

Year	Author/s, Date, Title	Country	Discipline/s	Purpose	Method	Elements of Quality CLE
2011	Skaalvik <i>et al</i> 2011, Clinical learning environment and supervision: experiences of Norwegian nursing students - a questionnaire survey.	Norway	Nursing	To measure nursing student's experiences and satisfaction with their clinical learning environment, by comparing the results between students in nursing homes and hospital wards.	Survey CLES+T (Clinical Learning Environment, Supervision and Nurse Teacher evaluation scale), N=511, of nursing students	Staff and student relationships critical to meaningful learning situations as they promote psychological and pedagogical support. Ward leadership critical to creating a positive learning environment. Effective supervision.
2011	Stupans <i>et al</i> 2011, Indicators of a quality clinical placement in pharmacy: Stakeholder perspectives	Australia	Pharmacy	To develop indicators that can be used to describe a quality clinical placement; and to determine stakeholder perspectives on the occurrence of the indicators in Australian pharmacy student workplace placements.	Survey of 370 students, 14 academics, and 27 preceptors	Indicators of quality clinical placement in pharmacy included appropriate resources, range of learning opportunities, welcoming staff and actively engaging in student development. Staff are positive role models, preceptors should involve student in practice activities and spend time with them, providing specific and constructive feedback. Universities provide suitable preparation for placements, where placements have clear aims and objectives, clear assessment requirements, students have sound knowledge base and can transfer learning from university to the placement. Students can also take responsibility for their own learning.
2012	Gallagher <i>et al</i> 2012, Simple truths from medical students: Perspectives on the quality of clinical learning environments	NZ	Medicine	To investigate the key conditions that students most value when placed in clinical settings	4 focus groups, study conducted on medical students by medical students, N=30	Structural factors: how well the placement was organised. Interpersonal factors: how students were supported by peers and staff. Intrapersonal factors: included student personality and how proactive and prepared individual students were. Vocational development opportunities: practical experience or clinical exposure and teaching opportunities.

Clinical Placement Frameworks

Title and Year Developed	Jurisdiction and scope	Description of Framework	Resources
International			
<p><i>Indicators of Practice Education Quality in Health Care Organisations: A literature review (2007)</i></p>	<p>British Columbia</p>	<p>Summary. The report developed by Jan Newberry for the British Columbia Practice Education Initiative,“ identified structures, processes and resources from the relevant literature, that health care organisations should have in place to support quality practice education” (p. 3).</p> <p>Definition. “Quality practice education means practice education that prepares students well for their future professional roles, that is a highly satisfying experience for stakeholders, and those uses resources as efficiently as possible”</p> <p>Indicators of Practice Education Quality</p> <p>The report has adapted the Baldrige National Quality Program (2007) indicators to provide a framework for categorising indicators of quality practice education in health authorities.</p> <ol style="list-style-type: none"> 1. <i>Leadership</i> <ul style="list-style-type: none"> • Senior leadership accountability and commitment Middle management commitment 2. <i>Strategic Planning</i> <ul style="list-style-type: none"> • Structure, planning and resources Formal affiliation agreements Collaborative approach • Capacity Inter-professional learning and practice Innovation 3. <i>Measurement, analysis and knowledge management</i> <ul style="list-style-type: none"> • Data gathering Data analysis and reporting 4. <i>Workforce focus</i> <ul style="list-style-type: none"> • Participating in student practice education Preceptor/mentor education programs • Time for student supervision Recognition and thanks • Link with recruitment needs 5. <i>Facilities and equipment support</i> <ul style="list-style-type: none"> • Adequate space, equipped with appropriate teaching equipment, is available for student tutorials, seminars and debriefing • Students can access the health authority’s intranet for patient clinical information on the unit • Students have access to a library and study areas and internet • Students have remote access to specialized learning opportunities, e.g. through e-learning, webcasting, videoconferencing, etc. • Students have access to lockers and change facilities • Office space is available for senior students doing clinical work • New models of practice education, e.g. those incorporating simulation or group supervision components, are considered when designing new space 6. <i>Process Management</i> <ul style="list-style-type: none"> • Standard operating processes: policies and guidelines, standards procedures are in place for negotiating numbers and types of student placements, receiving requests for placements and for confirming placements • Communications: health authority communicates to the education institutions/students its requirements for students and faculty • Orientation: access to on-line information, standard orientation, regular orientation program • Addressing problems: clear processes for working with students having difficulty, complaints reporting and processes for resolving broader conflicts 	<ul style="list-style-type: none"> • Checklist of indicators of practice education quality

		<p>7. <i>Results</i></p> <ul style="list-style-type: none"> • Goals are set and performance is measured for organizational performance related to practice education, e.g. related to capacity, utilization, satisfaction, recruitment • The health authority seeks and uses stakeholder feedback on the quality of practice education to promote good practice and enhance the student learning experience • The health authority works with its major education institution partners on evaluation and research projects intended to increase the quality of, or access to, student practice education <p>Web address: www.hspcanada.net/docs/quality_indicators/quality_indicators.pdf</p>	<ul style="list-style-type: none"> •
<p><i>Placements in focus: Guidance for education in practice for health care professions (2001)</i></p>	<p>United Kingdom- Nursing, Midwifery and health visiting</p>	<p>Summary. The guide developed by the Department of Health and the English Board for Nursing, Midwifery and Health Visiting is aimed to “help in commissioning, planning, providing and quality assuring practice placement experiences to ensure that students get the most out of their placements and that practice mentors/assessors place greater emphasis and value on the quality of that experience” (p. 6). The guidance is offered as a framework and is not intended to be prescriptive or exhaustive; instead, the guidance will constitute a model of good practice.</p> <p>Aims</p> <ul style="list-style-type: none"> • Enhance and build on existing guidance and standards • Improve quality assurance procedures • Focus on common expectations across the health professions • Support development of innovative ways of making best use of placements- reflecting the varied communities and situations in which health care professionals work • Share ideas about new opportunities for practice experience • Facilitate communication between health and social care professionals on placement issues <p>Providing practice placements</p> <p><i>Underlying principles</i></p> <ul style="list-style-type: none"> • Partnership: effective working partnership between education and service-based organisations • Shared outcomes: outcomes of the programme must be considered by both education and service staff • Commitment to practice placements: development and provision of placements must be valued and owned at the high level within education and service provider organisations <p><i>Guidance includes:</i></p> <ul style="list-style-type: none"> • Jointly developed strategy for the selection and monitoring of practice experience and placements • Practitioners should have appropriate experience • Plans for placements should demonstrate equity of opportunity to enable each student to have a rich variety of learning experiences • Programme leaders should take account of any special needs students may have • Placements areas should be audited • Outcomes of audit should lead to the dissemination of good practice and joint action planning to address any areas of concern or needing enhancement <p>Practice Learning Environment</p> <p><i>Underlying Principles</i></p> <ul style="list-style-type: none"> • Placement environment: carefully prepare and continuously develop practice learning environments to ensure quality care and treatment of patients and clients 	<ul style="list-style-type: none"> • Checklists- key questions which address: <ul style="list-style-type: none"> ➤ Providing practice placements ➤ Practice learning environment ➤ Student support ➤ Assessment of practice

		<ul style="list-style-type: none"> • Clinical governance: students should experience the positive culture of clinical governance • Multiprofessional focus: students should experience working as part of a multiprofessional team <p><i>Guidance includes:</i></p> <ul style="list-style-type: none"> • practice area should have a stated philosophy of care • practice provision should reflect respect for the rights of health service users and their carers • interpersonal and practice skills should be fostered through a range of methods including the use of experiential and problem-based learning • practitioners to engaged in continuing professional development <p>Student Support</p> <p><i>Underlying Principles</i></p> <ul style="list-style-type: none"> • Student support: students need to supported in identifying their learning needs as well as well being active in their own learning • Information technology: students should have insight into the use of IT and some basic IT skills prior to their practice experience <p><i>Guidance includes:</i></p> <ul style="list-style-type: none"> • Students should be provided with comprehensive programme information including information on their particular placement • Students should have written learning outcomes for each of their placements • There should be consistent supervision in a supportive learning environment • Lecturers should contribute to the support of students' learning in practice areas <p>Assessment of Practice</p> <p><i>Underlying Principles</i></p> <ul style="list-style-type: none"> • Importance of assessment of practice: assessment must be developed by education and service colleagues working together, and must be valid and reliable • Common assessment documents: common assessment documents should be provided where students of one professional group from a number of institutions undertake practice in the same practice environment <p><i>Guidance includes:</i></p> <ul style="list-style-type: none"> • There should be a named mentor/assessor to assess students in practice placements • Students should demonstrate competence through the achievement of learning outcomes in both theory and practice • Students practice should be assessment within the context of the multiprofessional team • Assessment strategy should reflect progression, integration and coherence <p>Expanding capacity: Innovative approaches in practice</p> <p><i>Identifying, selection and increasing placement opportunities</i></p> <ul style="list-style-type: none"> • Effective communication and collaboration between key staff with those who manage health and social care services is needed to expand placement opportunities • Senior practitioners and staff can collaborate to develop standards for placements • Practice experience units can ensure informed and effective use of all available practice experience • Multiprofessional audit can facilitate multiprofessional learning and team work • Access to rural and outlying areas can be opened up through the use of pool cars, travel permits, or negotiating with service the possibility of temporary accommodation • E-learning can be used to enable students to develop their clinical skills 	
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Australia			
<p><i>Optimising Rural Placements Guidelines (DRAFT) (2012)</i></p>	Australia	<p>Summary. The guidelines developed by the National Rural Health Students' Network are currently in draft form and are not for public distribution. The guidelines are a summary of the important points that they have found, based on experiences of student members, to enable optimal rural placements for health students.</p> <p>Purpose. The purpose of the document is to provide generic information to both students and supervisors regardless of their discipline.</p> <p>Recommendations for those involved in rural placements:</p> <p><i>Universities/faculties/schools</i></p> <ul style="list-style-type: none"> • Orientation: appropriate introduction and orientation prior to commencement of placement • Types of placements: be exposed to two rural placements, one early one and a second longer term rural placement • Educational infrastructure: have access to adequate educational resources and infrastructure to support their learning experience • Support for clinical teachers: well-briefed clinical teachers and preceptors to have an optimal rural placement experience • Financial support • Accommodation: affordable and adequate accommodation while on placement • Collaboration: work collaboratively with their rural health club on initiatives to promote rural placements <p><i>Clinical teachers and preceptors</i></p> <ul style="list-style-type: none"> • Orientation: students are well-orientated to their environment at commencement of the placement • Education support and teaching • Educational facilities: provide adequate resources, secure space to store students belongings • Community integration <p><i>Health students</i></p> <ul style="list-style-type: none"> • Personal attributes such as attitude, punctuality, respect and professionalism • Behaviour such as seek out learning opportunities, understand administrative processes, Identify own learning objectives 	<ul style="list-style-type: none"> • NRHSN rural placement guide

<p><i>Best Practice Clinical Learning Environments Frameworks (2010)</i></p>	<p>Victoria</p>	<p>Summary. Created by the Victorian Department of Health this framework focuses on clinical education and training provided to learners in medicine, nursing and allied health disciplines. This framework provides guidance in relation to six key elements that are the underpinnings of a quality clinical learning environment.</p> <p>Definition. Clinical learning environment “used in the broadest sense of the word ‘environment’, to encapsulate the range of factors that impact on the learning experience.” (p. 30)</p> <p>Principles. Four principles underpin this framework:</p> <ul style="list-style-type: none"> • Patient (or client) care is an integral component of quality clinical education • Learning in clinical environments is an essential component of training all health professionals • Registration, accreditation or competency standards set down by professional bodies (where these exist) are the appropriate mechanism for ensuring that clinical education arrangements meet minimum standards for educational or training outcomes. • Many different models of clinical education and training exist and successfully produce health professionals of required competency and standard. <p>Practice Environment. The six key elements of best practice clinical learning environment are:</p> <ul style="list-style-type: none"> • An organisational culture that values learning • Best practice clinical practice • A positive learning environment • An effective health service-training provider relationship • Effective communication processes • Appropriate resources and facilities <p>Factors affecting learning environments.</p> <ul style="list-style-type: none"> • Internal factors: “factors controlled by the health service. These include: staffing levels and allocation of resources; educational skill level (and level of preparedness) of educators and/or supervisors; cultural attitudes towards education; enabling structures and policies; and communication practices” (p.32). • External factors: “factors not controlled by the health service that could influence the way clinical education is delivered. These include: levels of funding (from external sources, i.e. governments and training providers) provided for educational activities; key performance indicators; the availability of skilled staff in the community; the academic practices of education providers and the way learners are prepared for clinical rotations; the social, political and economic climate; accreditation requirements and the patient case load” (p.32). <p>Web address: http://docs.health.vic.gov.au/docs/doc/EC92EAE6B9180A08CA2578720018726C/\$FILE/best_practice_report.pdf</p> <p>Resources are from: http://docs.health.vic.gov.au/docs/doc/29CB7064E6083784CA25794800839898/\$FILE/BPCLE%20Resource%20Project%20report%20FINAL_%20Appendix%203.pdf</p>	<p>The resources are divided into six categories:</p> <ul style="list-style-type: none"> • An organisational culture that values learning e.g. clinical educator resource guide, orientation program template • Best practice clinical practice e.g. patient consent template • A positive learning environment e.g. learning contract template, student support document guide • An effective health service-education provider relationship e.g. health-service-education provider agreement guide • Effective communication processes e.g. health service staff survey questions • Appropriate resources and facilities e.g. learning contract template <p>Some resources apply to more than one category.</p>
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<p><i>Framework for best-practice clinical learning environments in Queensland Health (2010)</i></p>	<p>Queensland – the pre-entry, or undergraduate, learner and the established professional clinician.</p>	<p>Summary. Created by Clinical Education and Training Queensland, with the overall goal of achieving best practice in the learning environments across Queensland Health, this framework was developed to create equity and consistency within the learning environments.</p> <p>Practice Environment. These attributes contribute to environments which create a positive experience for learners:</p> <ul style="list-style-type: none"> • A culture of learning and teaching at all levels • Adequately prepared, motivated and orientated learners • High-quality and consistent supervision by well-trained clinical educators • Opportunity to practice and build knowledge and skills • Attention to adult learning principles • Identified triggers for the provision of individual training • Established systems for feedback and communication • Inter professional learning experiences. <p>Standards. The framework is based on the following standards. These standards will be used to evaluate the framework.</p> <ul style="list-style-type: none"> • A systemic commitment to education • Life-long learning is valued • Positive partnerships in learning • Quality learning environments • A commitment to resourcing. <p>Web Address: http://www.health.qld.gov.au/clinedg/documents/10CEO001.pdf</p>	
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Other Relevant Frameworks

Title and Year Developed	Jurisdiction and Scope	Description of Framework	
International			
<p><i>Education Commissioning for Quality: Guidance for Education Providers(2010-11)</i></p>	<p>UK</p>	<p>Summary. These guidelines, developed by the NHS West Midlands, were produced to “standardise the quality management and assurance expectations of education and placement providers (p. 5)”.</p> <p>Process. The quality monitoring process is an annual cyclical review process. The process involves identifying and planning for education and training needs, commission provision accordingly and subsequently quality assuring this.</p> <p>Educational Planning, Commissioning and Quality Assurance Cycle</p> <ul style="list-style-type: none"> • Workforce planning: national policy drivers, horizon scanning • Contracting and commissioning: new workforce educational needs requiring innovation and curriculum development, feeding into future commissions • Quality monitoring: quality assurance, management and coordination <p>Education commissioning for quality (ECQ) Process Overview (ECQ) is important because it:</p> <ul style="list-style-type: none"> • Informs commissioning decisions and financial payments and quality premium payments • Identifies areas of concern, allows interventions to be put in place to ensure that all educational and placement providers are working towards agreed standards • Identifies areas where educational provision can be enhanced beyond currently accepted standards • Acts as strategic educational development tool, representative of all key stakeholders to ensure that the future development of education is producing fit for the future graduates • Identifies areas of exemplary notable practice and acts as a mechanism to capture and share thus best practice <p>Process is conducted with:</p> <ul style="list-style-type: none"> • Education commissioner • Education provider • Placement provider <p>Quality Indicators:</p> <ul style="list-style-type: none"> • Recruitment and selection • Learning in the University: course content and course delivery • Learning in practice: placement indicator review and academic support for placement provider • Learning in placement: student fitness for placement, criminal records bureau/independent safeguarding authority and occupational health checks and student core knowledge, skills and behaviours • Commitment and Transparency: Third party review, student feedback and data performance returns <p>Web Address: http://www.westmidlands.nhs.uk/Portals/0/Content/Workforce/Education%20Development/ECQ/ECQ%20Guide%202010%20-%20HEI%20%28Final%29.pdf</p>	<ul style="list-style-type: none"> • Placement provider self assessment against quality indicators • Education provider annual ECQ self assessment • ECQ quality performance indicator descriptions • ECQ guidance for placement providers • Education and Practice Partnership Agreement (EPPA) • Learning and Development Agreements

<p><i>Inter-professional Capability Framework (2005)</i></p>	<p>UK</p>	<p>Summary. This framework, developed by, Walsh and Gordon (2005) was designed to provide students with the learning outcomes they need in order to become effective inter-professional workers. The capabilities that are defined within this framework are relevant to all social and health care professions.</p> <p>Definition: Defines multi-professional education as: "Occurrences when two or more professions learn from and about each other to improve collaboration and the quality of care." (Barr 1997as cited by Walsh & Gordon 2005, p. 231)</p> <p>The four domains of the inter-professional capability framework are:</p> <ul style="list-style-type: none"> • <i>Knowledge in Practice.</i> Having awareness of inter-professional team member's professional regulations. Awareness of the structure, functions and processes of the team. How anti-discriminatory, non-judgemental practice informs a patient/user centred participatory service. • <i>Ethical Practice.</i> Promoting the patient/user participation in the decision making processes;" the need for practitioners to be sensitive to both the demands made in law of the other professions, with regard to their duty of care, and the underpinning ethos of the different professional groups". (p. 235) • <i>Inter-professional Working.</i> Includes developing participation, assessment and communication strategies to identify and work towards mutual adaption between patient/user and the team. Identifies the importance of co-mentoring activities across professions in developing successful inter-professional team. • <i>Reflection (learning).</i> Harnessing and promoting reflective learning. Developing the reciprocal approach across professions, along with the utilisation of Evidence Based Practice and an integration of Continuous professional development. <p>Reference: Walsh, C. L., M. F. Gordon, <i>et al</i> (2005). Inter-professional capability: A developing framework for inter-professional education. <i>Nurse Education in Practice</i>, 5(4): 230-237.</p>	
<p>Australia</p>			
<p><i>The team leader model: an alternative to preceptorship (2011)</i></p>	<p>Western Australia Nurses</p>	<p>Summary. Russell, Hobson and Watts (2011) wrote a research article which looked at improving the clinical practice environment for student nurses through an increased understanding of the relationships and of the situations in which that practice occurs.</p> <p>Team Leader Model. Designed to share the workload of student supervision, the elements of the model include:</p> <ul style="list-style-type: none"> • moving the responsibility for the supervision of undergraduate students from one staff member, the preceptor, to the ward staff together managing their placement and experience; • teams of three: a registered nurse as 'Team Leader' and supervisor, an undergraduate student and the third being a staff member who would benefit from additional support e.g. graduate nurse; • reality of practice - allocation of a patient load to the undergraduate student for the shift; • inclusion of undergraduate students on continuous practice as ward 'staff' e.g. on roster; • the support role of ward 'Student Liaison Nurses'; • culture change - importance of ongoing staff education. <p>Results. The Team Leader Model demonstrated that it provided an improved allocation model of student supervisors, students felt a greater sense of reality of practice, and graduates appreciated the support of the Team Leader.</p> <p>Conclusion. The model has been perceived by staff and students as a practice that can provide for a better clinical practice placement for the student.</p> <p>Reference: Russell, K. Hobson, A., and Watts, R. (2011). The team leader model: An alternative to preceptorship. <i>Australian Journal of Advanced Nursing</i>, 28 (3), 5-13.</p>	

Appendix C: Interview protocols

Consultation Protocol 1: Stakeholders *with* existing frameworks in their State or Territory

Name _____

Position _____

Location: State or Territory _____

Employer _____

(eg health department, health service, private sector, non government)

(Interviewer to determine which of these questions are relevant after perusing documentation sent by the interviewee)

1. What was the process of developing this framework?	
2. Who was consulted?	
3. Did you do a literature review? What were the key findings? If yes, can we please have a copy?	
4. Are there any supporting tools, templates and protocols?	
5. Did you identify the aspects of quality included in the framework? If yes, what process was used to determine the aspects of quality included in the framework?	
6. Have you found the framework to be useful? If yes, please provide detail.	
7. What do you think the strengths of this framework are?	
8. Are there any limitations to the framework that have become apparent?	
9. What have you learnt about the framework since implementation in practice?	
10. Are you aware of any formal monitoring and evaluation?	
11. What advice would you give for the development of a national quality in clinical placements framework?	
12. Do you know of any other people who might be able to contribute to this project?	
13. Do you have any other comments?	

Consultation Protocol 2: Stakeholders *without* existing frameworks in their State or Territory

Name _____

Position _____

Location: State or Territory _____

Employer _____

(eg health department, health service, private sector, non government)

<p>1. Are you aware of any quality in clinical placement frameworks in other States or Territories or internationally?</p> <p>If yes, please name and provide details, and are you able to supply us with a copy?</p>	
<p>2. Are there any plans in your State or Territory to develop similar frameworks?</p> <p>If yes, how are you doing it?</p> <p>What is the timeframe?</p> <p>Have decisions been made about what the elements of the quality framework would be?</p>	
<p>3. Are you aware of any formal monitoring and evaluation?</p>	
<p>4. What advice would you give for the development of a national quality in clinical placements framework?</p>	
<p>5. Do you know of any other people who might be able to contribute to this project?</p>	
<p>6. Do you have any other comments?</p>	

Consultation Protocol 3: Consultants working on related projects

Name _____

Position _____

Location: State or Territory _____

Employer _____

(eg health department, health service, private sector, non government)

<p>1. Are you aware of quality clinical placement frameworks? If yes, can you please provide us with a copy of this, or a link and/or reference to this?</p>	
<p>2. How is what you are doing for HWA a potential source of information for this project – do you see any links?</p>	
<p>3. What other work do you suggest we should look at to inform this project?</p>	
<p>4. Are you aware of what the experience has been like in those places where these frameworks have been developed and implemented?</p>	
<p>5. Are you aware of any lessons learned?</p>	
<p>6. Are you aware of any formal monitoring and evaluation?</p>	
<p>7. Do you have any advice to give to the development of a quality in clinical placements framework?</p>	
<p>8. Do you know of any other people who might be able to contribute to this project?</p>	
<p>9. Do you have any other comments?</p>	

Consultation Protocol 4: Other stakeholders with relevant expertise

Name _____

Position _____

Location: State or Territory _____

Employer _____

(eg health department, health service, private sector, non government)

<p>1. Are you aware of quality clinical placement frameworks? If yes, please list them. If yes, can you please provide us with a copy of this, or a link and/or reference to these? If there are a number of them, would you prefer some rather than others, and if so, why?</p>	
<p>2. Have you experience implementing them or seeing them implemented? What was the effect?</p>	
<p>3. What other work do you suggest we should look at to inform this project?</p>	
<p>4. Are you aware of what the experience has been like in those places where these frameworks have been developed and implemented?</p>	
<p>5. Are you aware of any lessons learned?</p>	
<p>6. Are you aware of any formal monitoring and evaluation?</p>	
<p>7. Do you have any advice to give to the development of a quality in clinical placements framework?</p>	
<p>8. Do you know of any seminal theory/research about quality in clinical placements?</p>	
<p>9. Do you know of any other people who might be able to contribute to this project?</p>	
<p>10. Do you have any other comments?</p>	

