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The Gippsland Regional Advancing Clinical Education (GRACE) Program

Submitted by:

Latrobe Regional Hospital

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Executive summary

Aims and objectives of the project

The aim of this project was to increase the capacity and quality of clinical supervision throughout the Gippsland Clinical Placement Network (GiCPN) for health professional students undertaking clinical placement. The project represented an integrated and staged approach to supervision training across the region and increased the number of clinicians trained to provide quality supervision to students undertaking clinical placements throughout Gippsland. This included clinicians working in large and small public, private and not-for-profit organisations, aged care, community-based services, mental health and private practice settings.

The objectives were:

* Developing a supervisor training and education program for GiCPN stakeholders.
* Increasing and sustaining supervision capacity in rural and remote clinical settings by increasing the number of trained supervisors across all sectors.
* Providing clinicians with ready access to affordable supervision training.
* Reducing the long-term financial cost of supervision training in the region.
* Increasing the quality and capacity of more organisations to accommodate students for clinical placement by developing their supervisory capabilities.
* Developing a peer support and mentorship platform and resources for clinical supervisors.
* Providing supervisors with additional methods for contact with education facilities to review student progress.
* Providing Aboriginal health care workers, mental health, aged care and community-based health professionals with the necessary skills and tools to train and support students within their scope of practice.
* Promoting collaborative interprofessional relationships and networking between partner organisations, and training and education providers.
* Developing interprofessional training materials, online resources and repository of materials for clinical supervisors.

Promoting sustainability of supervision training by developing a pool of ‘expert’ supervisors in Gippsland able to deliver training programs within and across the sectors and to network and develop learning tools for supporting staff and students.

Project activities and methodology

Region-wide surveys informed both the way the project was undertaken as well as the project activities. Student supervision workshops aimed at acute and non-acute clinical settings were delivered in all parts of the region and each workshop was evaluated. Evaluations were collated and analysed and helped inform each future workshop. The opportunity for supervisors to attain a Certificate IV in Training and Assessment (TAE) was offered across the region.

Key outcomes and findings

Across all settings in Gippsland 308 health professionals from 52 facilities undertook supervision training, representing 39 organisations. The project activities enabled 220 health professionals to attend basic and advanced train-the-trainer workshops, with a further 88 participants undertaking the Certificate IV in TAE.

Of the 51 participants who began the Certificate IV in TAE there were 39 full certificate completions. The remaining 12 participants completed between two and six competencies. Another 37 participants undertook the opportunity to upgrade to the current TAE, so in total 76 clinicians now hold a current Certificate IV in TAE as a result of this project. Because of the various modules and length of the program this qualification is considered an advanced supervision qualification and for the VET sector mandatory for supervision of enrolled nurses.

The Gippsland Regional Advancing Clinical Education (GRACE) program was developed and successfully piloted. Participant booklets, facilitator guides, PowerPoints, certificates and evaluation forms have been supplied across the region to enable to roll out of the GRACE program. There have been 28 facilitators trained to facilitate the program who will now continue to train supervisors and new facilitators.

Online supervision resources and a training DVD were also developed to enable ongoing up-skilling of supervisors across Gippsland.

Conclusions

By engaging clinical placement providers, providing supervisor training, developing the GRACE program and quality online student supervision resources for the GiCPN this project has resulted in many positive outcomes.

These include:

* Increasing supervisor capacity and capability,
* Engaging and training new clinicians and prospective placement providers,
* Increasing inter-sectoral and interdisciplinary opportunities to network and collaborate,
* Developing a regional basic student supervision program with high quality resources and trained facilitators,

Providing Gippsland clinical settings access to specific online resources.

Based on the outcomes of the project, supervision training is keenly sought by health professions who will attend if the opportunity is presented to them in an appropriate geographical location. The initial evaluations from participants indicate an improved understanding of the role and a willingness to implement these learnings in the clinical setting. Longitudinal evaluation is required to gauge the long-term impact of the initial and subsequent training outcomes in creating a quality clinical learning environment. There is the potential for this activity to occur as part of the implementation of the Best Practice Clinical Learning Environment (BPCLE).

Background and context

There were a number of drivers for this project that emerged from the GiCPN Strategic Projects 2011–12, including a limited number of trained supervisors creating replacement difficulties that limit clinical capacity, particularly in geographical remote locations. The geographical size of Gippsland has also meant that clinicians have had relatively few opportunities to access supervision training because of distance and cost. Information from placement activities (MLN 2011 and viCProfile, 2011) indicated a need to access mental health and community-based placements which could not be achieved without building supervisory capacity and infrastructure.

The uptake of Advancing Clinical Education (ACE) clinical supervision workshops provided in Gippsland in 2011 as part of two projects funded by the Department of Health (the department), together with evidence generated from profiling interviews and surveys reflected the ongoing demand for clinical supervision training. With payment of Melbourne-based consultants not sustainable, delivering a local supervision workshop based on local needs and facilitated by local clinicians was essential to provide ongoing training in a cost effective manner. The access and availability of supervisory resources in some organisations to promote and sustain a learning culture and quality supervision differed markedly across the region (GiCPN Strategic Projects, 2011–12) so it was important to get consistency of training through the development and delivery of the GRACE program and supervisory resources to all placement providers.

Aims

The aim of this project was to increase the capacity and quality of clinical supervision throughout the GiCPN for health professional students undertaking clinical placement. The project represented an integrated and staged approach to supervision training across the region and increased the number of clinicians trained to provide quality supervision to students undertaking clinical placements throughout Gippsland. This group includes clinicians working in large and small public, private and not-for-profit organisations, aged care, community-based services, mental health and private practice settings.

Project activities and methodology

An advisory group was formed, with membership from educators across the GiCPN. Region-wide surveys informed both the way the project was undertaken as well as the project activities. Workshops were delivered in all parts of the region and each workshop was evaluated. Evaluations were collated and analysed and helped inform each future workshop.

There were four parts to this project:

* Part 1: Basic clinical supervision training
* Part 1a: GRACE program
* Part 2: Advanced clinical supervision training – Certificate IV in TAE
* Part 3: Train-the-trainer

Part 4: Gippsland supervisor resource kit

Part 1: Basic clinical supervision training

There were two approaches to the provision of basic clinical supervision education in this project. Building on local Gippsland training capability, Latrobe Community Health Service’s (LCHS’s) Placement, Education and Research Unit (PERU) was engaged to develop and deliver a non-acute focussed clinical supervision training program. PERU was formed through a formal collaboration between Monash University Department of Rural and Indigenous Health (MUDRIH) and LCHS in 2009. It has since broadened its relationship with other education and research providers and the scope of its role. GiCPN engaged the clinical expertise and educational prowess of PERU to customise and deliver their non-acute focus supervision training to suit regional demands. Mental health, aged care, culturally appropriate and interprofessional case studies, scenarios and resources were developed to address the specific needs of the basic supervision training. Staff from PERU delivered six specifically focussed workshops – two non-acute community-based, one mental health / aged care and three interprofessional collaboration. Whilst participants working in acute settings were not excluded from the training, targeted marketing and the clear non-acute focus was easier to promote within the community sector. Workshop delivery at Bairnsdale, Sale, Leongatha and the Latrobe Valley ensured that participants were able to access a workshop within their subregion.

ACE level one was the second and very important aspect of the basic supervision training. ACE was developed by a university consortium with an interprofessional focus and was therefore suitable for all student supervisors, regardless of profession. There were 127 participants across 15 health organisations who had previously undertaken ACE training as part of two Department of Health Victoria funded projects in Gippsland in 2011, with the aim to train a further 90 at a basic level, although the final number was slightly less. More importantly for the future capability and capacity of organisations in Gippsland, ACE was also to be a starting point for the development of the GRACE program. Whilst the anticipated numbers proved a little ambitious, a total of 73 supervisors undertook ACE one and a pilot of the GRACE program. Equally important was the direct and critical input their feedback had into the GRACE program.

Part 1a: Gippsland Regional Advancing Clinical Education (GRACE) program

The GRACE program is the core element of sustainable, cost effective, accessible and consistent basic supervision training across Gippsland. The financial impact of continuing to rely on Melbourne-based facilitators to deliver ACE, and the identified need for a sustainable locally available education program that can be readily delivered within the GiCPN (GiCPN Strategic Projects, 2011–12) was the driving rationale behind the development of the GRACE program. Although loosely based on elements of the ACE program, the GRACE program includes key features identified by the local stakeholder advisory group as important concepts for supervision. In addition, each workshop participant was asked specifically about the importance and relevance of the proposed content to their workplace, other aspects/topics they would like to see included in a basic training program and if they felt a training program should be mandatory. Of these, 80% of ACE level one participants strongly agreed that there should be mandatory training. Whilst not mandatory, the GRACE program with its resources and trained facilitators will allow more staff in organisations which currently have little or no supervision training, to access well planned and structured training. It will also provide consistency of training across the region which will significantly contribute to organisations improving their status as quality clinical learning environments.

Part 2: Advanced clinical supervision training

During the life of the project 23 participants attended a three-day ACE level two workshop. A distinctive feature of ACE two is the syndicate groups which work on a project of their choice to be presented on day three several months later. A range of tools / programs / resources had previously been developed by ACE two syndicates and are being used within organisations across Gippsland to improve their clinical placement experience for students. ACE two participants were targeted as key practitioners who were approached to become the GRACE program facilitators and their evaluation of the ACE two course provided critical input into the GRACE program’s development.

The second element of advanced clinical supervision training was funding for individuals to undertake the Certificate IV in TAE 40110. Certificate IV in TAE is the minimum industry requirement for staff supervising TAFE students and there are increasing numbers of TAFE Diploma and Certificate students undertaking clinical placements in health care. In 2011 Certificate IV in TAE40110 replaced Certificate IV in TAA40104 as the industry standard. The project was to enable 50 supervisors attain the current Certificate IV and explore the possibility of Recognition of Prior Learning (RPL) and/or Credit Transfer for experienced clinical supervisors and educators. ACE two offers RPL from some universities toward a graduate certificate/diploma in clinical education and it was hoped that there c/would be an articulated pathway from ACE one and/or two to Certificate IV in TAE.

The third element of advanced clinical supervision training was to offer advanced training specifically for the community, mental health, aged care sectors where there has been identified potential capacity but requires building supervisory capacity and infrastructure (MLN, 2011, viCProfile, 2011). The advanced training was conducted at six sites across Gippsland to ensure ease of access. As with the basic supervision training, PERU was able to customise their advanced training program to meet the needs of GiCPN.

Part 3: Train-the-trainer

As a means of continuing the ongoing training of supervisors across Gippsland, the Train-the-trainer component of the project was of significant importance. In conjunction with PERUs advanced training, participants could attend an optional half-day Train the Trainer course. This activity targeted supervisors with more than five years’ experience, or with Certificate IV in TAE or with an education unit in a graduate diploma or higher education. The program provided supervisors with the skills and resources which could be customised and used to deliver training in their own organisations. This critical aspect of the training was offered in six sites across the region and will help encourage more supervision training in non-acute settings where currently very little training is offered.

The GRACE program also has a train the trainer component which is critical to ensure that well trained facilitators conduct the program throughout Gippsland. By ensuring that the GRACE program and resources are available to all trained facilitators and organisations across the region, the potential for consistent and effective training is promoted.

Part 4: Gippsland supervisor resource kit

It was noted in previous Strategic Projects 2011–12 that supervisory resources available in some organisations to promote and sustain a learning culture and quality supervision differed markedly across the region. In response to the identified inconsistency, an online resource kit has been made available to clinical supervisors and supervisor trainers for support and to better facilitate development of a BPCLE. The GRACE supervision resources were developed and initially produced as hard copies for the GRACE program delivery. There were also a number of short, focused topic-specific online resources which could be accessed as required. These resources were also provided on CD format and distributed throughout the region for easy access in areas where band width is still a limiting factor.

Governance arrangements

The project was governed by a stakeholder advisory group, including members of the GiCPN Committee, appointed for the purpose. A specific GRACE advisory group of key educators from across the region oversaw the development of the GRACE program. Latrobe Regional Hospital (LRH) was the project lead and ensured the milestones and deliverables were met.

Stakeholder engagement and consultation

Two advisory groups were formed from key stakeholders, one for the wider project and another specifically for the development of the GRACE program. Key educators from across the region were invaluable on the GRACE advisory groups and a broader section of stakeholders contributed to the project-wide advisor group. There was broad engagement and consultation from the east to west and north to south of the region. Table 1 highlights the level of engagement and consultation for each targeted training activity.

Table 1: Level of stakeholder engagement and consultation

|  |  |  |
| --- | --- | --- |
| Stakeholder activity | No of participants | Number of organisations |
| ACE Level One | 45 | 15 |
| ACE Level Two | 23 | 9 |
| GRACE pilot Supervision Training | 28 | 15 |
| Basic and Advanced Community Training | 123  | 29 |
| Certificate IV in TAE including upgrades | 88 | 21 |
| Advisory group | 14 | 14 |
| GRACE advisory group | 12 | 9 |
| Certificate IV in TAE | GippsTAFE and Advance TAFE | 4 sites |

Budget

LRH was the project fund-holder. The project funding was utilised in accordance with the grant application to appoint a full-time project officer who worked with the project lead (LRH). Other funding was expended on-costs associated with supervision training, workshops and on related project expenses. There were two revisions to the budget to enable activities to be progressed. These included an increased number of participants to undertake Certificate IV in TAE and to extend the duration of the role of the project officer to allow completion of activities and resources. The initial budget of $1500 for printing cost proved insufficient as the cost of the GRACE program’s ongoing materials and resources had not been included in the original budget. Another miscalculation to the original budget saw three ACE one and one ACE workshops budgeted for but not accurately costed. To overcome these shortfalls, $3000 from the Cultural Awareness workshop which did not take place, was utilised. The LRH acquitted the funds according to the project plan.

Timelines

The projected timelines were initially delayed due to administrative processes which contributed to the project officer being appointed in July rather than April as planned. Once employment commenced, timelines were rescheduled and most have been achieved as anticipated. The main delays have been in getting the specific training planned for ACCHOs and eventually some were cancelled due to lack of time and inability to engage the organisations. The piloting of the GRACE program and facilitator training had not been scheduled into the initial timelines, and the project activities were extended from 31 May to mid-October to ensure that this important aspect of the project was able to be undertaken and evaluated. Key activities and deliverables are summarised in table 2 below.

Table 2: Summary of key activities and deliverables

|  |  |  |  |
| --- | --- | --- | --- |
| Project objective  | Project deliverable/target | Activities undertaken to achieve target/objective | Date completed |
| CPN Coordinator and Committee will advertise for and recruit Project Coordinator/Education Developer  | Begin February 2012, appoint by April 2012 | Commenced employment 9July 2012  | July 2012 |
| Organise and oversee ACE programs to ensure ACCHOs, mental health, community, public and private and aged care sectors are included. | ACE training delivered March – September 2012 | * Two ACE level I workshops delivered in July at Morwell and October 2012 at Sale.
* ACE level II delivered in February and May 2013 at Morwell.
* Third ACE level I (conducted as pilot for GRACE) in May 2013 at Traralgon
 | May 2013 |
| Organise meeting with ACE consultants to identify GRACE program objectives and content | Meeting undertaken and project objectives determined | Advisory group and consultants agreed on the objectives and content of GRACE. May pilot evaluated and GRACE objectives and content confirmed | July 2013 |
| Consultants will develop GRACE program | Development of GRACE program | GRACE piloted May 2013. Facilitator training delivered in July at Bairnsdale, Traralgon and Wonthaggi | July 2013 |
| Develop and make available three-step program ‘Training to facilitate interprofessional collaboration’ to regional public and private providers | Three repeat workshops – aged care, community health, community services, mental health and others will access the ‘Training to facilitate interprofessional collaboration’ program | Workshops delivered in March at Bairnsdale, Leongatha and Morwell | March 2013  |
| Develop a support program for participants from the ‘Training to facilitate interprofessional collaboration’ program | Three repeat workshops - Workshop conducted (10–15 participants representing varied sectors) ‘Training to facilitate interprofessional collaboration’ | Workshops delivered in March at Bairnsdale, Leongatha and Morwell | March 2013  |
| Develop and organise two mental health preceptor training workshops for staff in primary health settings | Two mental health supervisor workshops conducted (estimated 20–40 participants will be trained to supervise students undertaking mental health placements) | * Workshops postponed in February due to unacceptably low numbers
* Workshops delivered in June at Moe
 | July 2013 |
| Organise two I day ‘Student supervision for community service training’ for LCHS staff and stakeholders (1) and regional public and private stakeholders (2) | Public and private placement/ health service providers will have access to the community training program | Workshops delivered in December | December 2012 |
| Organise two I half-day Train the Trainer programs ‘Student supervision for community service’ | Supervisor support materials and activities provided by LCHS and PERU team | Workshops delivered in February | February 2013 |
| Develop a support program for participants from the ‘Student supervision for community service’ program | Supervisor support materials and activities provided by LCHS and PERU team due September 2012 | Workshops delivered in February | July 2013 |
| Organise I day ‘Student supervision for community service training’ for ACCHOs  | Student community service supervisor training programs conducted | Workshop unable to be delivered despite initial planning and advertising due to changing ACCHO personnel | July 2013 |
| Organise one half-day Train-the-trainer programs ‘Student supervision for community service’ | Advanced Train the Trainer community service supervisor training programs conducted including representation from ACCHOs | Workshop unable to be delivered despite initial planning and advertising due to changing ACCHO personnel | July 2013 |
| Organise cultural safety workshop | Cultural safety workshop conducted | Workshop unable to be delivered despite initial planning and advertising due to changing ACCHO personnel | July 2013 |
| Review and refine local and Department of Health resources to support clinical supervisors | Online and print-based supervisor resources including orientation kit and supervisor resource manual | Print-based and online supervisor resources developed | July 2013 |
| Liaise with TAFE regarding Certificate IV in training and assessment for credit and organise training | MOU with TAFE regarding Certificate IV in TAE | * Course delivered at four sites between November and April
* Upgrade to current TAE also offered
 | July 2013 |
| Develop a peer support platform and conduct clinical support meetings/activities | Engagement of supervisors from partner organisations in online, face-to-face, teleconference or videoconference linked discussions or meetings to facilitate local support for clinical supervisors | Gippsland clinical educators consulted to assist facilitation of this platform | July 2013 |
| Develop a database capable of tracking supervision uptake of ACE and Certificate IV training by organisations across the CPN | Database in place to track Supervisor training uptake | Template developed and distributed to organisations across region for their future tracking | July 2013 |
| Conduct training workshops on making and uploading video clips into an online format and developing proficiency in videoconferencing. | Delivery of four workshops for video and web-based activities number of participants can produce and upload videoconferencing clips | GRACE facilitators workshops delivered video and web-based resources and training | July 2013 |
| Set up CPN supervision website | Active CPN supervision website | Consultation occurred with CPN and GHA. Site developed as part of larger Gippsland education and training website which is awaiting launch.  | July 2013 |
| Evaluate workshops and resources, peer support platform, CPN supervision website and engagement with videoconferencing. | Preparation of evaluation reports  | All workshops evaluated after completion. Evaluation report written. | July 2013 |
| Record changes to existing CPN profile | Changes to the GiCPN profile will be identified with particular attention given to ACCHOs, community-based, mental health and aged care health services | Recorded changes as training activities were undertaken  | July 2013 |

Outputs

Throughout the project 308 supervisors were trained from 52 facilities representing 39 organisations. Ongoing outputs were developed to enable sustainability in the future. These include a GRACE participant booklet, facilitator guide including DVD training resources, certificate of attendance and evaluation form. There were also a series of supervisory subject/topic specific online training resources and a department/HWA data collecting tool.

During the course of the project a range of resources were developed for training purposes only but will not be used for future activities. They include manager and supervisor surveys, ACE level one and two evaluation forms, non-acute community basic and advanced evaluation forms, interprofessional collaboration basic and advanced evaluation forms and the GRACE program pilot evaluation forms.

Outcomes and impacts

This project trained 308 clinicians to provide quality supervision to students undertaking clinical placements across Gippsland through supervision training and the development of an education resource platform. In light of ongoing demand for clinical supervision training (GiCPN Strategic Projects, 2011–12), the GRACE program was developed, piloted and 28 facilitators were trained. To ensure access and consistency of training to all current and future supervisors, the GRACE program will be the basic supervision training to be delivered across Gippsland going forward.

Basic clinical supervision training

ACE level one and the GRACE program pilot

During the project two ACE level one workshops and a GRACE pilot were delivered at Morwell, Sale and Traralgon resulting in 72 staff from 29 facilities and 21 organisations undertaking this basic clinical supervision training. The following graph demonstrates the range of health professionals who undertook ACE level one and the GRACE pilot.

Graph 1: ACE level one and the GRACE program pilot professions

ACE was developed by a university consortium with an interprofessional focus and was therefore suitable for all student supervisors, regardless of profession.

Table 3 below shows the health sectors from which the ACE one and the GRACE program pilot participants represent. Table 4 over the page highlights the years of supervisory experience and the supervision training credentials of the participants.

Table 3: Sector represented by ACE level one and the GRACE program pilot participants

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Workshop | Public | Private | Community health | Aged care | Mental health | Aboriginal care provider |
| ACE level I | 33 | 1 | 1 | 5 | 4 | 1 |
| GRACE pilot | 12 | 3 | 8 | 3 | 1 | 1 |

Table 4: Supervisory profile: ACE level one and the GRACE program pilot

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Number of participants | < 2 years supervisory experience | 2 – 5 years supervisory experience | > 5 years supervisory experience | No prior supervisory training | Informal training only | VET qualification | Higher education qualification |
| 73 | 26 (35%) | 23 (32%) | 24 (33%) | 42 (56%) | 19 (25%) | 12 (16%) | 2 (3%) |

Although all participants were currently supervising students and 65% had supervised students for more than two years, 56% of all participants had no prior supervision training and another 25% had only informal training. Of those who had undertaken previous supervision training, 33% had undertaken it over five years ago and an additional 20% was undertaken over ten years ago. Anecdotally it had been reported that most hospitals previously offered refresher supervision training, but this has now ceased due to an unwillingness of supervisory staff to attend. As older supervisors remain in the system, the generation gap to the current students, their needs and preferred learning styles and tools, continues to widen.

Within the larger clinical settings preceptorship training and/or internal training was delivered to supervisors, however the course content and length varied widely ranging from a four-hour clinical task-orientated session to a one-day preceptorship workshop. In smaller settings there appeared to be little or no training for supervisors. In one group, 74% had no training at all even though they were all currently supervising students in larger settings were supervision training was delivered to staff. This evidence together with responses from our GiCPN supervisory surveys, indicate there is no systematic linking of students with preceptor or supervision training even when it exists.

Following the supervision training, ACE level one and the GRACE pilot participants identified practical strategies to improve their supervision practice such as better planning, more regular feedback, greater reflection and an improved learning environment through more structured programs. Clearer assessment goals and outcomes could be achieved because of a greater understanding of how learning and teaching styles impact on student understanding and clinical improvement.

Organisational aspects of supervision were able to be improved by more formal processes being put in place to facilitate the placement. Participants felt more confident in providing internal leadership and offering collegial support because of their understanding of the importance of learning as a core business, the assessment processes and procedures and greater appreciation of the complex physical, social and psychological aspects required for positive student placements.

Very importantly for the level of support given to supervisors within organisations, 84% of participants believed they were better able to assist colleagues who may be experiencing difficulty supervising their students. They identified a better understanding on learning styles, resources availability, ideas for problem solving, better understanding or how and why students may or may not learn, providing a more structured program, giving advice and encouragement and the need for patience as ways in which they were better able to assist colleagues by attending the workshops.

Of the participants 80% strongly believed that ACE level one or similar program should be mandatory for all clinical supervisors. They identified the value of a consistent training program such as ACE level one for its content and delivery, greater understand of teaching and learning principles and strategies, increased confidence for the new supervisor and a better understanding of self. Such responses further emphasized the importance of the GRACE program to the region.

Basic community (non-acute), mental health, ACCHO and Interprofessional collaboration training

The PERU based at LCHS delivered six basic supervision training for non-acute settings. As an introduction to interprofessional collaboration Gippsland was fortunate to gain the services of Professor Jillian Thistlethwaite. Jill presented a forum in Traralgon where she talked about the current impetus of interprofessional collaboration and its capacity to impact positively on clinical outcomes. There was also an interprofessional clinic demonstrated at the forum where eight students from different disciplines developed a care plan for a simulated patient who was clinically assessed by two of the students. Feedback from that forum highlighted the fact that whilst most workplaces were interested and keen to implement interprofessional training, there was a perception that not all disciplines equally embraced it. It was therefore interesting to note that the more experienced staff who attended the supervision training were primarily from nursing, whereas the younger participants included a broad range of disciplines including allied health, dentistry, radiology and mental health.

Table 5 shows the health sectors the non-acute participants represent and Table 6 highlights their years of supervisory experience and their supervision training credentials.

Table 5: Sector representation of Basic non-acute supervision participants

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Workshop focus | Public | Private | Community health | Aged care | Mental health | Aboriginal care provider |
| Community non-acute |  |  | 26 | 6 | 11 | 2 |
| Interprofessional Collaboration | 16 | 4 | 2 |  | 7 | 1 |

Table 6: Supervisory profile of basic non-acute community supervision and Interprofessional collaboration participants

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Number of participants | < 2 years supervisory experience | 2 – 5 years supervisory experience | > 5 years supervisory experience | No prior supervisory training | Informal training only | VET qualification | Higher education qualification |
| Non-acute basic community supervision training  |
| 45 | 14 (31%) | 16 (36%) | 15 (33%) | 33 (73%) | 9 (20%) | 3 (7%) |  |
| Interprofessional collaboration basic supervision training |
| 30 | 8 (27%) | 1 (3%) | 21 (70%) | 8 (22%) | 6 (17%) | 14 (39%) | 8 (22%) |
| Total |
| 75 | 22 (29%) | 17 (23%) | 36 (48%) | 41 (51%) | 15 (19%) | 17 (21%) | 8 (10%) |

The participant profiles were indicative of the sophistication of the subject matter, with less experienced staff being more focused on their own disciplinary supervision, while more experienced staff were trying to better understand how to improve the interprofessional collaboration within their work teams and organisations. There were 37 participants who attended two workshops in Moe and Morwell. The basic non-acute community participants were primarily from community health organisations where 73% had no prior supervision training and of the remaining staff that did have some form of training, 20% had informal preceptorship or task orientated training only. These statistics highlight the accuracy of the findings from MLN, 2011, and viCProfile, 2011, where there had been identified potential capacity for the community, mental health, aged care sectors but required building supervisory capacity and infrastructure.

There were 30 participants who attended three workshops in Morwell, Bairnsdale and Leongatha. The majority of the interprofessional collaboration participants were very experienced supervisors with 70% supervising for over five years. Indeed many were in key education positions within their organisations and keen to give their current supervision training a more explicit interprofessional focus. It is interesting to note that 27% were very inexperienced and had been supervising for less than two years. Generally speaking this was a much younger cohort than any other workshop cohort with many having been graduated less than two years. The interest in interprofessional collaboration by this young cohort may be indicative of the changing emphasis on teams and interprofessional collaboration specifically during training and graduate years.

All participants from the non-acute community supervision training agreed (13%) and strongly agreed (87%) that the well planned workshop included examples relevant to their practice, assisted them to apply the concepts learned, allowed them to reflect about their current practice, helped them practice student supervision and provided a manual and toolkit which will be a useful resource for them.

All but one participant from the basic interprofessional collaboration supervision training workshops felt that following the workshops they could help students and health professionals from their own and other disciplines to learn together, develop students’ and health professionals’ capacity for interprofessional collaborations and could consider ways in which to implement interprofessional learning and collaboration within their own context to a high (75%) or very high (21%) standard.

Advanced and ‘Training the Trainer’ clinical supervision training

ACE level two

Table 7 shows the health sectors the advanced training participants represented and Table 8 highlights their years of supervisory experience and their supervision training credentials.

Table 7: Sector represented by ACE level two supervision participants

|  |  |  |
| --- | --- | --- |
| Public | Private | Aboriginal care provider |
| 16 | 6 | 1 |

Table 8: Supervisory profile of ACE level two participants

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Number of participants | < 2 years supervisory experience | 2 – 5 years supervisory experience | > 5 years supervisory experience | No prior supervisory training | Informal training only | VET qualification | Higher Education qualification |
| 23 | 9 (39%) | 8 (35%) | 6 (26%) | 12 (50%) | 6 (25%) | 4 (17%) | 2 (8%) |

Despite all participants currently supervising students, 50% had no previous supervision training. The informal training which 25% had attended included ACE one and a preceptor workshop, 17% had undertaken Certificate IV in TAE and 8% had undertaken education as part of a higher education qualification.

The immersion in experiential learning and the opportunity to learn from others within the group was positively commented on by 97% of participants, while 76% felt they had a much better understanding of the differences between clinical practice, clinical expertise and clinical reasoning and 74% could see ways to improve student supervision within their organisation. The course would be recommended to colleagues by 86% of participants who rated it good or very good. Only three (14%) participants rated it as average.

The best part of ACE two was the challenge and opportunity to undertake a project with a syndicate team. Where teams were from the same organisation, very specific, in-house projects were developed to address their individual needs. For example, one private hospital was in the process of changing the way the nursing staff worked on their shifts, and their project was a new model of team care management of their patients, agreed to by management and nursing staff after much consultation. Where team members were from different organisations a more systemic and transferable project was undertaken. One such team focused on communication between student and supervision by producing a formalised structured tool which helped alleviate the supervisors ‘lack of knowledge of students’ capabilities and needs within the workplace.

Advanced community (non-acute), mental health, ACCHO and Interprofessional collaboration training

The PERU based at LCHS delivered six advanced ‘Train the Trainer’ supervision training for non-acute settings and interprofessional collaboration advanced training for acute and non-acute settings.

Table 9 shows the health sector the advanced non-acute training participants represented.

Table 9: Sector represented by advanced non-acute supervision participants

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Workshop focus | Public | Private | Community health | Aged care | Mental health | Aboriginal care provider |
| Community non-acute |  |  | 14 | 7 | 8 | 1 |
| Interprofessional collaboration | 5 | 4 | 2 |  | 7 | 1 |

Table 10 highlights the years of supervisory experience of the participants and their supervision training credentials.

Table 10 Supervisory profile of advanced non-acute community supervision and interprofessional collaboration participants

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Workshop focus | < 2 years supervisory experience | 2 – 5 years supervisory experience | > 5 years supervisory experience | No prior supervisory training | Informal training only | VET qualification | Higher education qualification |
| Community non-acute 30 | 1 (3%) | 16 (53%) | 13 (43%) | 17 (49%) | 11 (31%) | 7 (20%) | 0 |
| Interprofessional Collaboration 19 | 5 (26%) | 1 (5%) | 13 (68%) | 4 (17%) | 5 (21%) | 8 (33%) | 7 (29%) |
| Total 49 | 6 (12%) | 17 (35%) | 26 (53%) | 21 (36%) | 16 (27%) | 15 (25%) | 7 (12%) |

The community non-acute participants were all from the community sector and 80% had either no prior training or informal training only. Indeed, the eight who had previous training cited the basic community non-acute training as the training undertaken. In total then, before the basic training the previous day 71% had no prior training. The fact that those with formal qualifications held VET Certificate IV in TAE and none held a higher education qualification may indicate that there are very few supervisors within the non-acute settings who have education as a vocational focus. These statistics again highlight the accuracy of the findings from MLN 2011 and viCProfile 2011 where there had been identified potential capacity for the community, mental health, aged care sectors but required building supervisory capacity and infrastructure. The keenness of these sectors to undertake training may be indicative of their understanding and possible desire to be seen as clinical settings that can offer students a valuable and more holistic clinical placement.

As with the basic interprofessional collaboration participants, those wishing to train others also demonstrated the interest in the very young supervisor and the much more experienced supervisor who, in several cases were educational managers, clinical educators and university lecturers. The five participants, who had been supervising for less than two years were very young and mostly had graduated within the last two years. Of these five, four had no previous supervisory training and one had informal training only. The interprofessional training participants were also the most experienced of all the workshops delivered within the project and most had VET and/or higher education qualifications in supervision or education. Tellingly, they represented acute settings that have been placing students for a long period of time and in many cases have structured infrastructure and roles in place to support clinical training.

The advanced and Train the Trainer workshops explored the educational theory behind the basic supervision workshops and discussed strategies to deliver the training to a variety of group sizes, some which may be homogenous work teams and others which may not be. All advanced participants were given the basic supervision training resources and following the workshops were able to customise them for delivery within their own facility/department/organisation. This was a critical aspect of increasing the ongoing capacity of the region to train supervisors and has great potential to continue to build capacity and capability well beyond the scope of current funding opportunities.

All community non-acute participants agree or strongly agreed that the well planned workshops were relevant, examples and rationale for using them assisted them to better understand how adult learning concepts could be applied, and that the workshops gave them the skills, resources and confidence to train other staff as basic level student supervisors.

All but one participant attending the interprofessional collaboration advanced workshops believed they better understood how theories of adult learning support interprofessional collaboration and that they had the skills, resources and confidence to deliver interprofessional collaboration training in their own work context to a high or very high level. To the time of the project completion there was no follow-up of training provided by the train the trainer participants, therefore it was not identified how many of the participants had provided training to others.

Certificate IV in Training and Assessment (TAE40110)

In 2011, Certificate IV in Training and Assessment (TAE40110) replaced Certificate IV in Training and Assessment (TAA40104) as the industry standard. The project was to enable 50 supervisors attain the current Certificate IV in TAE and explore the possibility of RPL and/or Credit Transfer for experienced clinical supervisors and educators. ACE two offers RPL from some universities toward a graduate certificate/diploma in clinical education and it was hoped that there c/would be an articulated pathway from ACE one and/or two to Certificate IV in TAE. It was initially thought that the 50 supervisors could attain the Certificate IV primarily by RPL and some limited gap training.

Initial liaison between GippsTAFE and GiCPN occurred very early in the project before the project officer was appointed. Following that appointment, Advance TAFE (formerly known as East Gippsland TAFE) was approached to ensure that both Gippsland TAFEs had the opportunity to participate in the project. Initial discussion occurred around the opportunity for either ACE one or two to form the basis of possible RPL toward some or all of the Certificate IV in TAE. Given that ACE two is recognised via credit transfer by some Universities there was a genuine expectation that there could be a pathway between the ACE courses and the Certificate IV in TAE.

After three months of exploring this option in great detail with both TAFEs, it was decided that RPL was not possible. The main barriers were the interface between graded assessment and competency-based assessment. Nowhere in ACE one was there an assessment task and the only assessment task in ACE two was a syndicate group presentation. This was assessed by written and oral feedback by participants and signed off by the facilitators for the University. Whilst participants were able to demonstrate presentation skills, it was not enough to satisfy an entire unit of competency within the Certificate IV in TAE. For example, one unit ‘BSBCMM401A Make a Presentation’ requires the candidate to make two separate presentations on two different occasions to two different learner cohorts on two different subjects, thereby disallowing one presentation to adequately satisfy RPL for that unit, although that didn’t preclude the ACE two presentation from being one of the two presentations offered as evidence of competency. It did, however, preclude the completion of ACE two as a credit transfer or RPL in its own right.

Throughout this period it became clear that staff who held a designated educator role within an organisation were possible RPL candidates for some units. One of the required documents for RPL was a current position description which clearly articulated the planning and delivery of training within the currently held position. RPL must be applied for at the time of enrolment, so it was critical that the RPL options were explored before expressions of interest were called for. In mid-October, expressions of interest were called for together with an indication of when and where each candidate preferred the training to take place. An unexpected limiting factor by this time was the cost. From the initial project proposal to the project commencement the cost was significantly higher than expected. Initially it was thought that the numbers should be revised down to match the unexpected cost. Very quickly it became clear that many more than 35 wanted to undertake the study and that there was enough interest to deliver in Sale and Bairnsdale as well as a class in Warragul and Leongatha. In October 2012 an amendment to the project was submitted to the Department with a resultant reallocation of funds so that 50 candidates could undertake the training across the four TAFE campuses.

Certificate IV in TAE is an extensive course consisting of ten units – three relating to designing learning, three to workplace delivery and four workplace assessment units. Both TAFEs had quite different delivery models with Advance TAFE delivering the three blocks of units usually three days running, then a gap for assessment tasks to be completed, then the second block usually delivered over three days running with another gap for assessment tasks to be planned and then delivered in class, and finally the third block being delivered in three consecutive days with a gap before the final assessment day in class. GippsTAFE on the other hand usually delivered 20 days of training over a six-month period and offer it as four full weeks over six months with significant gaps between each full week for assessment tasks to be planned and delivered. Neither of these models were suitable for clinical staff with four-day rosters. Both TAFEs were therefore asked to deliver on only one weekday and because of the project timelines and the amount of time spent on possible RPL options, it was requested that only ten delivery days be held. The TAFE closure from late December to late January further restricted the delivery time options.

Advance TAFE agreed to undertake the three designing learning units one day a week for three weeks in November and December with assessment tasks for those units being due the first day back in February, then the three delivery units over three single days for the next three weeks with a one-day assessment day four weeks later, then the final four units being delivered over the next three weeks with the final assessment day for those units being three weeks later. GippsTAFE agreed to begin with only one day in December introducing students to three units which they were to complete over the January break (which made it difficult for many candidates as students are not common in the workplace during January), then seven single days for seven weeks beginning in early February then a three-week break and two final single days where assessment tasks were delivered and finalised. Both models had pros and cons. One significant con for both models was that tutors were not available to candidates over the January period, even though candidates were being expected to complete assessment tasks. Whilst this was an annoyance for some, it did not directly impact on any candidate’s ability to meet due dates. If this training was to be undertaken again, a six-month block within a calendar year would be beneficial to all candidates.

Initially 51 candidates representing 13 organisations began the training in November and December 2012. Of those 51, 11 were offered the opportunity to apply for as many as four units through RPL. Not all took up the opportunity, and eventually eight were granted RPL for between two and four units. The formatting of RPL documentation was very prescriptive and different between both TAFEs. The project officer was very experienced with TAE RPL and asked candidates to send all their evidence through to her, and then she formatted and catalogued the evidence in the manner that the relevant TAFE requested. This was a very time consuming process and highlights the complexity of background documentation needed for RPL. The project officer met face-to-face with all but one candidate and over a period of two to three months gained the level, type and presentation of documentation required.

Unfortunately there was a significant drop out of numbers throughout the course. Between the start of the course and February re-commencement the biggest drop out of numbers occurred. Nine candidates dropped out because their work roles had changed, family trauma, increased clinical workloads or the course wasn’t what they expected it to be. Over the next couple of months there were four more that dropped out through leaving the clinical setting and moving outside of Gippsland or family trauma. All but two candidates completed between three and six units which could be used for credit transfer at a later time. By the end of the course, 39 candidates had satisfactorily completed their Certificate IV in Training and Assessment.

As expressions of interest were being called for there was a significant number of clinical staff asking if they were able to be funded to upgrade their Certificate IV in Training and Assessment (TAA40104) to the current TAE. GippsTAFE offered a very good deal for upgrades which is undertaken through direct credit transfer as long as TAADEL402 Facilitate Group Based Learning was undertaken as an elective. Where this was not the case, an RPL process needed to be undertaken for TAADEL402. From December to March 37 clinicians representing 12 organisations upgraded from TAA to TAE. Table 11 shows the health sectors the Certificate IV in TAE candidates and those seeking to update their qualification represented. Table 12 highlights their years of supervisory experience and their supervision training credentials.

Table 11: Sector represented by Certificate IV in Training and Assessment candidates

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Qualification | Public | Private | Community health | Aged care | Mental health | Aboriginal care provider | Total |
| Certificate IV in TAE40110 | 37 | 3 | 2 | 5 | 3 | 1 | 51 |
| Upgrade TAA40104 to TAE40110 | 32 | 2 |  | 2 | 1 |  | 37 |

Table 12: Supervisory profile of Certificate IV in Training and Assessment candidates

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Qualification | < 2 years supervisory experience | 2 – 5 years supervisory experience | > 5 years supervisory experience | No prior supervisory training | Informal training only | VET qualification | Higher education qualification |
| Certificate IV in TAE40110 | 10 (10%) | 16 (16%) | 25 (24%) | 24 (24%) | 25 (26%) |  |  |
| Upgrade TAA40104 to TAE40110 |  |  | 37 |  |  | 37 | 6 |

In total, 76 Gippsland clinicians now have a current Certificate IV in Training and Assessment (TAE40110). With Certificate IV in TAE being the minimum industry requirement for staff supervising TAFE students and there are increasing numbers of TAFE Diploma and certificate students undertaking clinical placements in health care it is pleasing to see candidates from each sector represented. This has increased the capacity and capability of a wider range of organisations within Gippsland to have suitably trained staff to supervise clinical students particularly those in community health, mental health and aged care.

**Total outcomes of basic and advanced supervision training across Gippsland**

The project has been successful in attracting 308 clinical professionals from 39 organisations to attend the supervision workshops. A key aim of the project was to improve the capability of continuing to expand the number of trained supervisors across all settings in Gippsland and this was achieved. The actual numbers for the Certificate IV in TAE need some explanation. Of the 88, 37 were clinicians who had an existing Certificate IV in TAA and upgraded it to the current TAE. Of the 51 who commenced undertaking the Certificate IV in TAE, although only 39 completed the full certificate, the remaining 12 completed between two and six competencies. So in total 76 clinicians now hold a current Certificate IV in TAE. This training is important not only for supervision of the increasing TAFE students within the health sector, but an organisation, department or unit which has a qualified Certificate IV in TAE holder, should be better supported and have a better understanding of how to plan and implement a robust learning program for a student than one who has no such qualified staff member.

The anticipated and actual numbers of participants for each of the training opportunities are summarised in Table 13.

Table 13: Participant numbers

|  |  |  |
| --- | --- | --- |
| Workshop | Anticipated numbers | Actual numbers |
| ACE I | 90 | 73 |
| Basic non-acute community focus | 96 | 75 |
| ACE II | 30 | 23 |
| Advanced Train the Trainer | 39 | 49 |
| Certificate IV in TAE | 50 | 88 |
| Totals | 305 | 308 |

Of the participants attending the ACE one and two and basic supervision training, 89% believed they were now better able to assist colleagues who may be experiencing difficulty with students, increasing the opportunity for mentorship and support of supervisors. From an organisational perspective 84% felt they were better able to promote shared attitudes and values following their attendance at the workshops.

Prior to the workshops 25% neither agreed nor disagreed and 63% agreed that they had the skills and confidence to support other supervisors within their organisation. Following the workshops and 90% of participants agreed or strongly agreed not only that their problem solving skills and confidence had improved significantly, but they felt confident enough to assist colleagues in the supervision of students.

The number of supervisors who undertook ‘Train the Trainer’ training in the non-acute settings was significant and represents a key group of trained supervisors who now have the skills, resources and confidence to train others within their organisations. With travel and time costs a limiting factor for Gippsland clinicians to access training in Melbourne, it is critical that there continues to be a bank of trained trainers who are able to continue to expand the numbers of trained supervisors within the region.

Table 14 highlights the health sectors represented by all project participants.

Table 14 Sector represented by all participants

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Public | Private | Community health | Aged care | Mental health | Aboriginal care provider | Total |
| 151 | 23 | 55 | 28 | 42 | 9 | 308 |

The increased engagement of mental health, aged care and community-based services in education has been a very important outcome for the region and has improved the capacity and capability of the non-acute sectors to become settings and organisations which can support and provide a worthwhile learning placement for a student. Whilst it is too early to see placement numbers increase in the non-acute sector, Gippsland providers are now in a much better position to become viable clinical placements.

### Another positive outcome for the non-acute community sector was the strengthened connections and collaboration with other providers across the region. A tangible benefit from using PERU and MUDRIH to undertake the basic and advanced student supervision and interprofessional collaboration training is the relationship that now exists between many of the non-acute providers. MUDRIH has received funding for the Gippsland Regional Interprofessional Partnership in Simulation (GRIPS) project and there have been mutual benefits to reach further out to organisations who currently aren’t beneficiaries of GRIPS training and give them an idea of the potential benefits their organisations could gain from future GRIPS involvement.

Table 15 highlights the years of supervisory experience and supervision training credentials of all project participants.

Table 15: Supervisory profile of all participants

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 2 years supervisory experience | 2 – 5 years supervisory experience | > 5 years supervisory experience | No prior supervisory training | Informal training only | VET qualification | Higher education qualification |
| 73 (24%) | 81 (26%) | 154 (50%) | 153 (46%) | 102 (30%) | 51 (15%)Upgrade 37 (100%) | 28 (8%) |

There was a wide range of experience in supervision within the project participants. The numbers who have been supervising for over five years is a little artificially inflated because of the experience of the 51 who undertook the Certificate IV in Training and Assessment (TAE) as well as the 37 clinicians who upgraded their Certificate IV in Training and Assessment (TAA) to (TAE). This cohort was a very experienced cohort who wanted to formalise their training after many years supervising students. If the 88 Certificate IV in TAE candidates were excluded from the 152 participants with more than five years’ experience, there would have been a fairly even spread of experience across the supervision workshops.

It was interesting to note the experience and training difference between acute and non-acute settings. As a group, the non-acute settings had a majority of clinicians who had been supervising for less than five years. They also had more supervisors with no supervisory training. In a number of cases participants undertaking the advanced ‘Train the Trainer’ sessions cited the basic training the day before as their only informal training. This highlights the importance of supervision training within the non-acute settings as a critical aspect of improving capacity and capability within the settings and justifies the projects aim to conduct specific non-acute training.

All but two participants attending all training were currently supervising students or had supervised students within the past year. It was therefore surprising that 49% of them had no prior supervisory training. It was also surprising that 33% of those with training had informal training only. The most common form of informal training was a one-day preceptorship workshop or a four-hour clinical skills/task-orientated training workshop. The other interesting aspect of those with informal training was that there was no systematic linking of students with preceptor or supervision training even when it exists. The project has therefore increased the skills and confidence of many existing supervisors improving the likelihood of current and future students having a better learning experience in their clinical placements.

From the information collected from workshop participants, clinicians with VET and higher education qualifications primarily worked in acute settings with over 60% having qualifications from both sectors. This may be indicative of the increasing numbers of TAFE students in clinical settings requiring supervision by VET qualified staff (Certificate IV in TAE). This not only emphasises the need for non-acute clinicians to get VET or higher education qualifications, but could also be a current barrier to non-acute sessions not being able to offer significant numbers of clinical placements.

GRACE – Gippsland Regional Advancing Clinical Education Program

The GRACE program was the centre piece for the project to provide sustainable, long-term, low-cost training by local expert trainers. Based loosely on the University developed ACE, it included the critical parts of ACE level one and two, as well as aspects identified by the local GRACE program advisory group. The two-day workshop is best delivered over a two or three-week period, although with pre reading, it could be delivered in two consecutive days. Although ACE one is delivered over two consecutive days, consistent feedback from staff educators rather than ACE participants was that it would be organisationally more appropriate to be delivered over two non-consecutive days. The GRACE program offers the flexibility to suit any clinical setting.

From June 2012 to May 2013, the GRACE program was developed and refined by consultants and agreed to by the advisory group. In mid-May 2013, rather than a third ACE level one being delivered a pilot of the GRACE program was delivered to 28 participants from across the region. The two-day workshop used the newly developed GRACE Participant Booklet. The pilot was video recorded and was edited and commentary added to create a resource which was used in the facilitators training session as well as becoming a resource for novice facilitators to refer back to in their own time.

The GRACE program activities were mapped to the HWA National Clinical Supervision Competency Resource validation framework. The program was developed to meet training requirements from Foundational (support) to Intermediate (conduct) across the three domains.

The project extension from 31 May to 31 July has enabled the GRACE program facilitator training to be delivered in three locations across the region. The training was undertaken by 28 very experienced supervisors and/or educators and was led by the Melbourne consultants who developed a Facilitator Guide and used video recorded at the pilot workshop and small group work to highlight to key educational models for delivering the GRACE program. Attending the facilitator training entitled the organisation and individual to have a hard and soft copy of the Participant Booklets, power point presentations and videos. Each organisation was given hard copies of the participant booklets and videos as well as a master copy of the Participant Booklet and Facilitator Guide.

Gippsland supervisor resource kit

In response to the identified inconsistency of access to supervisory resources, an online resource kit has been made available to clinical supervisors and supervisor trainers for support and to better facilitate development of a BPCLE. The Gippsland supervisor resource kit contains a GRACE Participant Booklet and Facilitators Guide. Each public facility has a master copy of these. A training DVD has also been developed from video from the GRACE pilot. Key experiential training opportunity and techniques have been highlighted and commentated on for future facilitators to gain deeper appreciation of the unique training features at a time to suit themselves. There were also ten online supervisory resources which sit on a CD and the CSSP website as well as a DVD which all public facilities and GRACE facilitators have been given. The online resources are short, sharp, stand-alone resources which could be accessed by an individual supervisor or be used as part of an education session within a clinical setting. Subjects include Tips for Being a Good Supervisor, Understanding the Role of Supervisor, Challenging Students, Education Practice, Education Theories, Education Practice and Theories (a combination of the previous two), Giving Feedback, One Minute Supervisor, SMARTIE – teaching and learning strategies and Assessment and Evaluation.

Table 16 summarises the capacity and quality outcomes of the project.

Table 16: Capacity and quality outcomes

|  |  |  |
| --- | --- | --- |
| Objective | Capacity/quality target | Outcomes |
| LRH will advertise for and recruit Project Coordinator/Education Developer. | Project Coordinator appointed. | Appointed 9 July 2012. |
| Organise and oversee ACE programs to ensure ACCHOs, mental health, community, public and private and aged care sectors are included. | Anticipated increase of 90 trained clinical supervisors at ACE I (6 ACCHO staff) and 30 at ACE II (2 ACCHO staff).Deliver three ACE I and 1 ACE II. | 73 trained supervisors at ACE I level and 23 at ACE II.In total, 96 trained supervisors including 61 from public, 10 from private, 9 from community, 8 from aged care, 5 from mental health sectors and three Aboriginal workers. (Although only three Aboriginal workers attended ACE I or II, over the course of the project, 9 undertook supervisory training offered.90% agreed or strongly agreed that the workshops had improved their supervisory skills and knowledge. |
| Organise meeting with ACE consultants to identify GRACE program objectives and content. | Access to supervision training within the GiCPN by local expert trainers. | GRACE materials developed and pilot took place. 100% agreed or strongly agreed that knowledge and skills required for supervision had improved and there were things they would do differently in the future because of the training.Participant Workbook and Facilitators Guide developed and distributed as hard and soft copies. A DVD of key experiential training features also developed and distributed. |
| Consultants will develop GRACE program. | Access to supervision training within the GiCPN by local expert trainers. | 28 experienced Gippsland facilitators now trained to deliver GRACE across the region. The first training workshop was delivered at LRH in August.  |
| Develop and make available three-step program ‘Training to facilitate interprofessional collaboration’ to regional public and private providers. (Basic). | Anticipated increase of 30 (part of 96 trained clinicians as advanced specialist supervisors as per initial proposal).Three repeat workshops – aged care, community health, community services, mental health and others will have access to the ‘Training to facilitate Interprofessional Collaboration’ program. | 30 trained supervisors including 17 from public, four from private, two from community health and seven from mental health sectors.93% of participants believed they had a high or very high understanding of interprofessional collaboration following the workshops. |
| Develop a support program for participants from the ‘Training to facilitate interprofessional collaboration’ program (advanced). | Anticipated increase of 19 (part of 39 trained clinical supervisors as trainer – short term – as per initial proposal).Three repeat workshops – Workshop conducted (10–15 participants representing varied sectors) ‘Training to facilitate interprofessional collaboration.’ | 19 trained supervisors including 11 from public, three from private, three from community health and two from mental health sectors.75% of participants believed they had a high or very high capacity to train colleagues about interprofessional collaboration following the workshops. |
| Develop and organise two mental health preceptor training workshops for staff in primary health settings. | Anticipated increase of 22 (part of 96 trained clinicians as advanced specialist supervisors as per initial proposal).Two mental health supervisor workshops conducted (estimated 20–40 participants will be trained to supervise students undertaking mental health placements in a broad range of mental health settings across the region).Anticipated increase of six (part of 39 trained clinical supervisors as trainer – short-term – as per initial proposal). | Eight trained supervisors including two from aged care and six from public or community mental health sectors.100% agreed or strongly agreed that the workshops had improved their supervisory skills and knowledge.Six trained supervisors including two from aged care and four from public or community mental health sectors.100% strongly agreed or agreed the workshop provided them with skills and knowledge to train other supervisors. |
| Organise two I day ‘Student supervision for community service training’ for LCHS staff and stakeholders (1) and regional public and private stakeholders (2). | Anticipated increase of 22 (part of 96 trained clinicians as advanced specialist supervisors as per initial proposal).Public and private placement health service providers will have access to the ‘Training to facilitate Interprofessional Collaboration’ program.Anticipated increase of 10 (part of 39 trained clinical supervisors as trainer – short term – as per initial proposal). | 18 trained supervisors including 15 from LCHS, two from aged care and two from mental health sectors attended the Basic supervision one-day workshop.100% strongly agreed or agreed the workshop provided them with relevant and practical strategies.12 trained supervisors attended the Advanced Train the Trainer workshop including seven from LCHS, two from aged care and two from mental health sectors.100% strongly agreed or agreed the workshop provided them with skills and knowledge to train other supervisors. |
| Organise two 1 half-day Train the Trainer programs ‘Student supervision for community service.’ | Anticipated increase of 10 (part of 39 trained clinical supervisors as trainer – short term – as per initial proposal).Supervisor support materials and activities provided by LCHS/PERU team. | 12 trained supervisors including seven from community health, three from aged care and two from mental health sectors attended the Advanced Train the Trainer workshop.100% strongly agreed or agreed the workshop provided them with skills and knowledge to train other supervisors. |
| Develop a support program for participants from the ‘Student supervision for community service’ program. | Anticipated increase of 22 (part of 96 trained clinicians as advanced specialist supervisors as per initial proposal).Supervisor support materials and activities provided by LCHS/PERU team due September 2012. | 19 trained supervisors including 14 from community health, two from aged care and three from mental health sectors.100% strongly agreed or agreed the workshop provided them with relevant and practical strategies. |
| Organise I day ‘Student supervision for community service training’ for ACCHOs. | Anticipated as part of 96 trained clinicians as advanced specialist supervisors as per initial proposal. | Unable to be achieved, planned to be delivered as part of Expanded Settings project. |
| Organise one half-day Train the Trainer programs ‘Student supervision for community service’ | Anticipated as part of 39 trained clinical supervisors as trainer – short-term – as per initial proposal | Unable to be achieved, planned to be delivered as part of Expanded Settings project |
| Organise cultural safety workshop. | Cultural safety workshop conducted. | Unable to be achieved, planned to be delivered as part of Expanded Settings project. |
| Review and refine local and Department of Health (BPCLE) resources to support clinical supervisors. | Online and print-based supervisor resources including orientation kit and Supervisor resource manual. | Supervision (GRACE) facilitator guide developed with training DVD. Participant handbook and facilitator guide can be downloaded and master hard and soft copies given the public hospitals. Ten online supervisor subject specific resources developed and accessed online as well as being distributed as local resources. |
| Liaise with TAFE regarding Certificate IV in Training and Assessment for credit and organise training. | Anticipated increase of 50 clinical supervisors undertaking Certificate IV in Training and Assessment. | In total, 76 clinicians now have current Certificate IV in TAE.51 commenced the Certificate IV in TAE, with 39 (77%) attaining the full qualification. Of the remaining 12, 10 completed between 2 and 7 of the required 10 units which will be recognised if they choose to complete the qualification. 10 clinicians were granted RPL for between two and four units of the TAE.37 clinical staff upgraded their Certificate IV TAA to the current TAE through Credit Transfer. |
| Develop a peer support platform and conduct clinical support meetings/activities. | Innovative professional development and networking opportunities. | Workshops provided opportunity for peer support and where appropriate email networks were established. |
| Develop a database capable of tracking supervision uptake of ACE and Certificate IV training by organisations across the CPN. | Database in place to track supervisor training uptake. | Database distributed for local settings to monitor and track training. |
| Conduct training workshops on making and uploading video clips into an online format and developing proficiency in videoconferencing. | Delivery of four workshops for video and web-based activities.Number of participants can produce and upload videoconferencing clips. | Three GRACE facilitator training sessions enable facilitators to access and utilise video and web-based resources. |
| Set up CPN supervision website. | A central repository of supervisor support materials and resources top assist with ongoing training and development of supervisory staff. | Set-up.Site developed, awaiting link-up to main Gippsland regional education and training webpage. Target audience supervisors in the Gippsland region. |
| Evaluate workshops and resources, peer support platform, CPN supervision website and engagement with videoconferencing. | Preparation of evaluation reports. | Each workshop evaluated and helped to inform future training workshops. |
| Record changes to existing CPN profile | Changes to the GiCPN profile will be identified with particular attention given to ACCHOs, community-based, mental health and aged care services. | Changes to GiCPN contacts list as new organisations and individuals presented at workshops. |

Challenges and risk management strategies

Table 17 summarises the challenges and risk management strategies employed throughout the life of the project.

Table 17: Risk management

|  |  |  |
| --- | --- | --- |
| Risk | Management strategy | Outcomes |
| LRH will advertise for and recruit Project Coordinator/Education Developer. Risk of delay in recruitment. | Recruitment commenced, anticipated start in June | To mitigate late recruitment, CPN initiated initial meetings with TAFE for Certificate IV delivery. |
| Develop and make available three-step program ‘Training to facilitate interprofessional collaboration’ to regional public and private providers | LCHS/PERU team to discuss development of materials. Further meeting to be held early June | CPN initiated two initial meetings with LCHS/PERU which took place prior to project officer commencement. |
| Organise and oversee ACE programs | Initial discussion with consultants regarding dates, meeting scheduled for 28 May | CPN initiated planned, advertised and organised the first ACE level one and it was delivered two days after project officer commenced work. All ACE level one and two dates were set prior to project officer commencing work. |
| Organise I day ‘Student supervision for community service training’ for ACCHOs.Organise 1 half-day Train the trainer programs ‘Student supervision for ACCHOs’. It has been difficult to engage participants from this sector in the past. | Broaden contact by identifying key colleagues who may be able to act as initial contact point | Given the history of engagement, the Department of Health supplied a name of contact in Melbourne to assist and the local ACCHO contacts and stakeholders were also approached. Successfully engaged in April 2013 and planning began for training. Despite initial progress, an appropriate time for training could not be found before the end of the project, however, it is planned to be delivered as part of Expanded Settings project. |
| Organise cultural safety workshop. Risk of lack of engagement by stakeholders. | Broaden contact by identifying key colleagues who may be able to act as initial contact point | Expressions of interest called for, flyers and reminders sent, and workshop scheduled for late June. Extremely low interest by key stakeholders, workshop was cancelled. |
| Low numbers for mental health supervision training | Originally scheduled for February but postponed due to low numbers.  | Used Expanded Settings mental health contact list to direct email key organisations and facilities. It was decided to run the workshop with a low number of attendees rather cancel. |

Evaluation

Evaluation has been embedded in each activity throughout the project (Table 16). The ACE one and two and basic and advanced community non-acute focus and interprofessional collaboration workshops were evaluated by post workshop survey. Satisfaction ratings of 80% or higher were indicative of positive outcomes. The tools developed as part of this project, namely the supervisor training workshop evaluation surveys have been based on previously tested and generated valuable learnings that could inform similar training workshops elsewhere.

The Certificate IV in Training and Assessment and upgrade was evaluated by units of competency satisfactorily completed as deemed by training staff at GippsTAFE and Advance TAFE.

The reach of the project, the previous supervision experience and training of attendees, the level of participation and geographical engagement, and the participation by individuals, professional groups and organisations were evaluated by pre workshop data collection, tracking attendance records, registration, withdrawal and non-participation.

The subject specific supervision online resources developed were trialled and written evaluation provided by management and staff of the Staff Development Unit at LRH.

The key project findings were:

* Increased capacity for quality student placements by increasing the skills and supervisory capabilities of 308 health professional staff in total in the GiCPN.
* Increased capability of 39 health professionals who now hold a Certificate IV in Training and Assessment (TAE) and a further 37 who have upgraded their out dated Certificate IV in TAA to the current TAE. A further 12 staff hold between two and eight units of competency within the Certificate IV in TAE.
* Increased capacity for quality student placement by increasing the skills and supervisory capabilities of 110 community-based, non-acute health professionals across the Gippsland region.
* Additional 86 health professionals across the region increased their skills and capabilities by undertaking either ACE one or two. This number is in addition to 127 who previously undertook ACE one or two training in the 2011–2012 projects.
* Increased capacity for Gippsland health professionals to train other staff within their organisations with 43 undertaking student supervision and facilitating interprofessional collaboration Train the Trainer training across public, private, community health, mental health, aged care and Aboriginal care providers.
* Development of the GRACE program which was been piloted and evaluated. A total of 28 facilitators have been trained to deliver the GRACE program across the region. The first workshops were delivered in August by LRH and there is planning underway for a regional timetable.
* Development and distribution of quality supervision training resources for Gippsland providers:
* The GRACE program training resources have been distributed to all providers who had staff attend the facilitators training. The GRACE program resources have been delivered to all public providers as hard and soft copies masters.
* A set of ten online topic specific resources will be able to be accessed from the Gippsland Region Education and training when it becomes live and have been provided on CD ROM to the GRACE programs facilitators and providers. The resources will be able to be accessed by anyone interested in supervision activities.

Limitations

Longitudinal follow up of all workshop attendees would add substance to the long-term impact of the supervision training. Anecdotal evidence suggests that supervision practices have changed in a number of organisations as a result of key staff attending training; however follow up evaluation would be beneficial in gauging organisation change in capacity and/or capability. There is the potential for this activity to occur as part of the implementation of the BPCLE.

Time has not allowed the GRACE program delivery as the base supervision training to be imbedded across the region. Whilst the pilot program has occurred and been evaluated, the long-term success of the GRACE program has not yet been established. The future success of the GRACE program may well be strengthened by a regional facilitator and/or bank of trained facilitators who can co-deliver the GRACE program in the interim while facilitator numbers and organisations delivering the GRACE program continue to grow.

Transferability

This project and the outcomes could be transferred to other regions and states. All project deliverables were non-discipline specific and based within the interprofessional collaboration principle.

Learnings from project to inform future work

* Longitudinal evaluation is required to fully identify the strengths and any short comings of supervision training being able to impact to strengthen the capability and capacity.
* There is particular concern for smaller organisations who find it difficult to send even one staff member, despite generous back fill being offered. Whilst the payment is welcome, the reality often is that there is no one locally who can provide back fill. For training to be accessible to many small and remote organisations, one on one or two may be the only way to up-skill staff and management with trainers going to individual workplaces rather than expected them to come to a more central location.
* Offering specific community non-acute training is successful in attracting non-acute staff. Many community-based staff acknowledged they often felt over-awed by the capacity, processes and infrastructure the larger acute setting have for supervision training. Being able to network with staff from organisations of similar focus and staff numbers, was beneficial in strengthening networks and being able to link staff between organisations.
* Candidates non-completion of Certificate IV in Training and Assessment sits nationally between 60 and 75% for a number of reasons including its intensity, large number of assessment tasks, course structure and length of delivery. This is particularly taxing for health care professionals whose work patterns, rosters and frequency of changing roles impacts directly on their ability to commit and complete the course. It may be beneficial to any future delivery to require candidates to pay a small fee, which could be refundable on completion. This may help to reduce the likelihood of drop out.

The engagement of ACCHOs was challenging and time consuming. Changing stakeholder staff, meeting delays, postponements and cultural sensitivities frequently led to disappointment that perceived progress had not been achieved. Whilst the project was able to attract a number of health professionals who work with Aboriginal clients, it was difficult to fully engage ACCHOs. Identifying and building rapport with key staff within ACCHOs is critical to success in engaging them more fully.

Future directions and sustainability

The development of the GRACE program is the key sustainable outcome of the project. There were 28 Gippsland supervisors/educators who attended training workshops who can now deliver the GRACE program to staff in their respective organisations and act as a resource and provide peer support across the CPN. Facilitator Guides, Participant Booklets and Evaluation forms have been developed and delivered to key training organisations for future delivery of the program in addition to a training DVD and online resources to support new trainers and supervisors. The facilitators across the region will deliver the program locally and it is anticipated there will be sharing of education days across organisations and a timetable of activities developed.

The programs will be funded by the individual organisations with a proposed fee for outside participants. There is an education consortium within the region and it is anticipated that the resources will be maintained by this group in conjunction with the facilitators.

To further promote the continued and sustainable delivery of the GRACE program there has been a Gippsland submission to HWA for inclusion as a provider of supervision education in the CSSP Multi Use List. A successful outcome would promote the sustainability of future delivery of the GRACE program across the region.

Conclusion

By engaging clinical placement providers, providing supervisor training, developing the GRACE program and developing quality online student supervision resources for the GiCPN this project has:

* Increased supervisor capacity and capability
* Engaged and trained new clinicians and prospective placement providers
* Increased inter-sectoral and interdisciplinary opportunities to network and collaborate
* Developed a regional base student supervision program with high quality resources and trained facilitators

Provided Gippsland clinical settings access to ten subject specific online resources

Based on the outcomes of the project, supervision training is keenly sought by health professions who will attend if the opportunity is presented to them in an appropriate geographical location. The initial evaluations from participants indicate an improved understanding of the role and a willingness to implement these learnings in the clinical setting. Longitudinal evaluation is required to gauge the long-term impact of the initial and subsequent training outcomes in creating a quality clinical learning environment. There is the potential for this activity to occur as part of the implementation of the BPCLE.