

Clinical supervision:
The use of DVD simulations to teach effective communication to clinical supervisors

A workshop toolkit for clinical supervisors

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HealthWorkforce AUSTRALIA

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FOREWORD

Most people have been taught frameworks for feedback and having the so-called “difficult” conversations. The obstacle that stops the conversations happening isn’t a lack of method; it’s often a fear-driven mindset. Adding more frameworks to the toolkit doesn’t generally lead to people engaging in the conversations they need to have.

This workshop was designed to help clinical supervisors come to terms with their fear and the consequences of letting that fear drive their behaviour when it comes to engaging in conversations with people they supervise (and anyone else for that matter!) What if the consequences of avoidance are more serious than the consequences of engagement? Understanding this is the heart of the shift in mindset which can lead to behaviour change.

Facilitators of this program need to understand this point. As I facilitated each workshop, I became acutely aware that often I was engaging in what might be considered to be a “difficult conversation” – whether this was with an individual, or with the group at large. Being confident to model these conversations is essential for anyone facilitating these workshops.

The other thing built into the design of the workshop is the idea that participants will draw their own conclusions about the necessity and benefits of engaging in any conversation that’s necessary if the arguments are made. This is designed with a facilitation approach (rather than a training approach) in mind.

I stocked my facilitator’s toolkit with curiosity and a desire to question rather than answer. I made it clear that there is no “perfect” conversation and that conversations are necessary to functioning relationships, whether personal or professional. At the end of every workshop I reflected on what went well and what I needed to change or be aware of. I also sought feedback from colleagues who observed the workshops. This approach was essential to support my work in the facilitation of a challenging workshop.

I hope this toolkit enables you to experience the joy of seeing the learning and growth that I did when this ‘inclusive’ and ‘questioning’ approach is taken.

Tanya Edlington

BACKGROUND

This Toolkit was developed as part of a collaborative project between Department of Health and Monash University: *Clinical Supervision: the use of DVD simulations to teach effective communication to clinical supervisors*. This project focused on delivering a series of workshops to clinical supervisors across Victoria, Australia, with emphasis on the importance of engaging in challenging and 'difficult' conversations, providing participants with strategies to plan and carry out these conversations, as well as opportunities to practise these conversations in a safe, supportive environment.

Although the workshops concentrated on the supervisor-student relationship, it was quickly evident that participants could see the value of the skills they had developed relative to having difficult conversations with all work colleagues. The impact of avoiding difficult conversations in the clinical environment is well documented and has been linked to reduced patient safety and increased clinical errors (Browning et al., 2007; VitalSmart, 2005, 2010).

Although the impact of avoiding difficult conversations is well documented, much of the research undertaken to explore ways to overcome these difficult conversations relates to those conversations between a clinician and a patient or patient's family. Given the importance of enabling difficult conversations in the clinical environment in general, there is a need to develop strategies, processes and tools that can be used by clinicians to have these conversations not only with their students, but also with their seniors, peers and other colleagues.

The aim of this project was to develop an educational toolkit, including DVD simulations and activity-based workshops, for clinical supervisors that focused on improving communication with students in a variety of circumstances. The purpose of the workshops was to create a positive mindset about the value of "difficult" conversations, refresh knowledge, build skill and translate the experience into clinical education practice.

A key focus of the workshops was to challenge the mindset of clinical supervisors about 'difficult conversations', the consequences of avoiding difficult conversations, and to offer activities that would enable supervisors to practice having difficult conversations. The project was also designed to add to the body of knowledge surrounding clinical supervision and communication with students. It is envisaged that this toolkit can be disseminated and facilitated as a stand-alone workshop in any healthcare program in Australia.

The original workshops were designed to run for 3.5 hours including 15 minutes for evaluation activities. While this toolkit outlines the session plan and timings used in the original workshops, these timeframes can be adjusted to suit course and learner requirements.

Participation was through recruitment of volunteers and numbers varied between 11 and 17 per workshop. Our experience suggests that a maximum of 12 participants provides the optimal conditions for productive and interactive conversation and practice opportunities. While audiences for these workshops can be uni-professional or multi-professional all our workshops were multi-professional. Feedback from participants suggests a multi-professional approach and perspectives is highly beneficial for participants and contributes to the richness and sharing within the workshops.

A professional facilitator with wide experience in all aspects of communication facilitated the workshops. References to relevant peer reviewed literature, theory and cases about difficult conversations and missed opportunities in the health sector were incorporated to make the case for having difficult conversations. Useful references are included in a reading list in this toolkit. The project's academic lead was also present at each workshop and provided input relating to clinical supervision where relevant. While this combination of skills and knowledge is ideal for facilitating the workshops, it is recognised that this will not always be feasible. Successful workshops should focus on facilitation skills rather than purely clinical skills. A complete list of resources needed for a workshop and time allocation for each activity is also included.

This toolkit is intended to provide all the tools needed to facilitate a similar workshop using either uni-professional or multi-professional health care groups.

We hope you find this toolkit useful for promoting capacity to have the "difficult" conversations whenever needed.

PROJECT VALUE AND NEED

This project directly addressed Health Workforce Australia's (HWA) Clinical Supervision Support Program (CSSP) which focusses on the development of clinical supervision capacity and competence across the educational and training sector by: i) preparing and educating clinical supervisors, and ii) producing a competent clinical supervision workforce that provides quality teaching and learning experiences (Health Workforce Australia, 2013a).

The literature highlights a number of challenges and difficulties clinical supervisors face when the need for "difficult" conversations arises, including the need to manage conflict and relationships (Browning et al., 2007). The supervisory role is responsible for managing many facets of clinical learning and culture within organisations. Some of these include: managing conflict, professionalism, self-awareness, feedback, active listening, empathy, performance management, professional development, and management of psychological risk. Many of these facets are outlined in two key documents produced by Health Workforce Australia (Health Workforce Australia, 2013b) and Department of Health, Victoria (Department of Health, Victoria, 2013). Research also suggests that educational interventions to address such challenges and difficulties are often underrepresented (Meyer et al., 2009).

The literature also highlights the challenges faced by students during clinical supervision, but much of this literature is in the nursing field. Beck and Srivastava (1991) conducted a study with undergraduate nursing students to investigate their perception of level and source of stress by identifying their level of physiological and psychological health. They found that one of the main causes of stress was the atmosphere created by the clinical facilitator. Given that this study did not focus on the clinical environment, but on the students' entire undergraduate experience, this finding is of great concern. Beck (1993) later focused on researching nursing students' initial experiences in the clinical area and showed that nurses often experienced pervading anxiety, feeling abandoned, reality shock, feeling incompetent, and questioned their career choice. The literature identified a range of other sources of stress and anxiety that nurse's experience during clinical placements (Elliot, 2002).

Cummins (2009) suggests that it is important to identify whether clinical supervision is simply a system to ensure an effective workforce or a system that will empower nurses to realise their vision of nursing. She advocates for the latter, and calls for the improvement of existing support structures such as preceptorship and mentorship. Given that both clinical supervisors and students face extensive challenges it makes sense to be focussing on clinical supervision education for clinical supervisors and students.

Clinical supervision needs to be seen not only as an educational activity but also as a relationship. Aston and Molassiotis (2003) evaluated the clinical supervision environment and suggest that both supervisors and students require preparation for successful implementation of clinical supervision. Elliot (2002) suggests that although nursing education has been university-based for many years in Australia, the use of the clinical environment as a learning or teaching experience is yet to be fully maximised.

Other literature focuses on the impact or consequences that occur when these conversations are avoided. For example, the Silence Kills Study (VitalSmarts, 2005) that used focus groups, interviews, workplace observations and survey data from more than 1700 nurses, physicians, clinical staff and administrators, identified a range of categories of conversations that are especially difficult and especially essential for people in healthcare. These conversations correlated strongly with medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover.

VitalSmarts conducted a further study in 2010 'The Silent Treatment' and showed that a culture of silence in organisations leads to communication breakdowns that harm patients. This study found that more than four out of five nurses have concerns about dangerous shortcuts, incompetence, or disrespect. More than half say shortcuts have led to near-misses or harm; more than a third say incompetence has led to near misses or harm; and more than half say disrespect has prevented them from getting others to listen to or respect their professional opinion. In addition, fewer than half of these nurses have spoken to their managers about the person who concerns them the most; and less than a third of these nurses have spoken up and shared their full concerns with the person who concerns them the most.

The human and financial cost of medical errors has also been well documented. A study by Waring (2005) showed that in the national health service of England and Wales, mistakes or 'adverse events' occur in 10% of inpatient admissions and the human cost of these mistakes has been 40 000 lives and a financial cost of over 2 billion pounds in additional care. A study by Kalra, et al. (2013) showed that 1.5 million preventable adverse events (AEs) occur each year in American hospitals. Between 44,000 to 98,000 deaths occur each year due to medical errors; 45 cents of every dollar spent in the US is related to medical mistakes; and 3.5 billion dollars per year are spent due to in hospital adverse drug events (26% of all preventable AEs). To put this in perspective, Kalra, et al. (2013) highlight that more Americans die each year from medical errors than from motor vehicle accidents, breast cancer, or HIV/AIDS.

The impact of medical errors in Australia is also a concern (Richardson and McKie, 2007). The 'Quality in Australian Health Care' (QAHC) study (1995) examined medical records for 14,000 admissions to 28 hospitals in New South Wales and South Australia and found that

there were 470,000 admissions/year (10-15% of hospital admissions) associated with an adverse event (AE) leading to approx. 18,000 deaths and 50,000 cases of permanent disability. In this QAHC study, it was shown that 50% of the AEs had a high preventability score and 60% of deaths could have been avoided. The direct hospital costs of AEs, both fatal and non-fatal, was estimated in the QAHC study at $900 million per/year. In another study examining the impact of medical errors in Victoria (Monash, 2007) it was found that 7% of routine admissions were associated with an adverse event (AE).

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PROJECT OUTCOMES

The outcomes of this project have direct application to both universities and the Australian healthcare industry. To our knowledge, no inter-professional clinical supervision education toolkit for clinical educators has been developed previously in an attempt to enhance clinical supervisors' skills in planning and having "difficult" conversations with their students. Therefore the project has significant value for the healthcare sector in general, not only by the development of a body of knowledge, but through the scholarly enhancement of a teaching resource that has the potential to have a direct impact on the supervisor-student relationship and the student experience during clinical placement. In addition, the majority of literature published in refereed journals relating to difficult conversations in healthcare is in the context of patient-clinician conversations and the majority of literature published in refereed journals about students is related to nurses' experiences when undertaking clinical training in hospitals (and not the experiences of clinical supervisors). No other clinical supervision research to date has included the interprofessional and multidisciplinary focus that this current project team has completed.

This project aimed to develop and evaluate an interprofessional workshop for building the capacity of clinical supervisors to engage in "difficult" conversations with students. Feedback during our workshops and from our evaluations showed that workshop participants saw that what they had learned had a much wider application; building their confidence to have "difficult" conversations with not only students, but also their peers, seniors and other colleagues. This suggests an even greater direct impact of our project; addressing the issue of healthcare practitioners avoiding "difficult" conversations which have then been linked to reduced patient safety and a large proportion of clinical errors leading to disability and even death. Our post-workshop in-depth interviews showed that 75% of participants had made specific practice changes as a result of our workshop and a further 10% of participants said that they had not had the chance to supervise any students since the workshop, but outlined specific strategies they were now going to use when they next had the opportunity to supervise.

Our workshops were specifically designed to integrate modelling behaviour. That is, our facilitator used processes and language that exemplified good communication and feedback, were inquiry-based, inclusive and positive, and allowed for diversity and the feedback from participants themselves. In our post-workshop in-depth evaluations, clinical supervisors stated that the majority of their "difficult" conversations were not about student clinical skills, but about student behaviour; and that it was these conversations about behaviour that they mostly avoided. This finding was apparent across all professions. This highlights the need to improve the skills set of clinical supervisors in not only engaging in "difficult" conversations, but also in modeling behaviour. Learning in clinical placements

is often opportunistic. That is, we cannot be certain that all students will learn about and make changes to their behaviour on placements. This toolkit will better prepare clinical supervisors to not only address behavioural issues during their supervision, but also model the behaviour they expect from students. In this way the toolkit is sustainable across different professions and institutions involved in the provision of clinical placement education.

This project provided an opportunity to assess clinical supervision in nursing, medicine and allied health. There are numerous studies which suggest ways to improve clinical supervision in nursing, but there are few studies that have involved improving clinical supervision in medicine and the allied health. In this project clinical supervision and interprofessional collaboration among paramedic, nursing, midwifery, occupational therapy, physiotherapy, nutrition and dietetics, radiography, medical, pharmacy, podiatry, and social work students was explored. In our post-workshop in-depth evaluation, 95% of participants said that the interprofessional nature of the workshops was beneficial and added value to their learning experience. This project has contributed to the limited body of knowledge about clinical supervision in the allied health fields and has been able to identify similarities and differences in clinical supervision among the healthcare disciplines.

The interprofessional “difficult” conversations toolkit and simulations provide important resources that are transferable particularly given the changes being proposed by national organisations such as Health Workforce Australia and the Health and Hospital Reform Commission. In addition, the project has significant value for the Australian healthcare system. The Productivity Commission and Health Workforce Australia have produced reports that have detailed Australian health workforce shortfalls (Productivity Commission, 2005). Both bodies have made recommendations for dealing with these issues that involve interprofessional practice, and improved education and training for students and staff. We propose that integrating interprofessional principles into the “difficult” conversation toolkit for clinical educators will not only provide clinical supervisors with an opportunity to learn with, from and about each other (CAIPE, 2006), but will also provide a richer perspective when examining strategies for success when engaging in “difficult” conversations.

HOW TO USE THIS TOOLKIT

This toolkit has been developed from the experience of facilitating the original workshops.

This toolkit provides a framework for facilitators leading these workshops. It is assumed that facilitators leading these workshops will have a basic understanding of facilitating groups. Experience from the first set of workshops highlights the need for the facilitator to model positive language and purposeful mindset when approaching "difficult" conversations. Drawing on relevant personal experience and stories, of participants and facilitators, can also help bring the subject to life.

Throughout this toolkit, the term "*difficult"* is used to describe conversations that people typically find challenging in some way. We use inverted commas when using the term "difficult" as we don't accept the premise that the conversations are inherently difficult. Perceptions about difficulty typically arise because of a lack of skill, practice and modelling and fear of unknown or perceived consequences.

Given the potential for a multidisciplinary audience, language should be considered for example, terminology used by different professions to describe the people in their care; for example, "patient", "client", "customer", "woman", "consumer" etc.

It is recommended that the "Background" section be read prior to facilitating a workshop as it provides useful context, which is likely to be relevant during various discussions. A complete list of resources needed for a workshop is also included.

We found other topics which assisted our preparation to facilitate the workshops included: Patient Safety; Reducing Medical Errors; Medical Malpractice; Difficult Conversations in Clinical Supervision; Health Care Teams; Interprofessional Collaboration; Overcoming Difficult Conversations; Channels of Face to Face Communication; Emotional Intelligence; Building Rapport; Active Listening, and Providing Feedback.

THE SPOTLIGHT ON "DIFFICULT" CONVERSATIONS WORKSHOP

Section	Activity	Time allocation
Introduction	Icebreaker 0-10 Scale	15 minutes
Why do Conversations matter? Making the Case	Story Discussion	15 minutes
Types of and Successful Conversations: Building on Strengths	Brainstorming Drawing Parallels	10 minutes
Poor Feedback and negative language	Film Part A Debrief	30 minutes
Conversation planning and practice	Action Learning in Trios	50 minutes
Good Feedback and positive language	Film Part B Debrief	30 minutes
"Difficult" Conversation challenges	"What if you do?" "What if you don't?"	10 minutes
Modelling good "difficult" conversations	Real play demonstration and coaching	40 minutes
Commitment to Action	Writing a Postcard	5 minutes
Evaluation	Participatory Evaluation Formal Evaluation Survey	5 minutes

Introductions

(15 minutes**)**

The purpose of this section is to:

- provide an opportunity for participants to meet each other
- orient participants to the subject of the workshop
- provide information to the facilitator and each other about how confident participants feel about having "difficult" conversations

Overview: To achieve this purpose participants take part in producing a physical scale in response to a series of questions. Some of the questions are related to confidence and photographs are taken of participants' placement on the scale. At the end of the workshop the same questions are asked of participants and placement compared to these photos to demonstrate the impact of the workshop on their confidence levels. Participants also briefly introduce themselves while standing.

Activity: Physical Confidence Scales Icebreaker

1. Welcome participants and present the Workshop Overview (Slide 2)
2. Briefly explain to participants the purpose of the introductory activity
3. Ask participants to place themselves in a line to form a physical scale, standing in a line according to the date of the month of their birthday
4. As participants are arranging themselves, explain that a physical scale may have gaps in it, for example if no-one has a birthday date between the 8th and the 12th, then there will be a gap
5. Show participants the scale you have placed on the wall from 0 – 10 and explain that you will give them a series of statements to which they will need to place themselves on the scale
6. Start with easy, comfortable topics and then move to more challenging and directly relevant statements:

    a) Please stand according to experience level as a clinical supervisor *(0 being no experience and 10 being very experienced)*
    b) Please stand according to how you feel about giving feedback *(0 is I hate giving feedback and 10 is I love giving feedback)*
    c) How confident are you having a "difficult" conversation with someone you're supervising? *(0 No Confidence and 10 Very Confident: for this and following questions)*
    d) How confident are you having a "difficult" conversation with a peer?
    e) How confident are you having a "difficult" conversation with someone from another profession?

f) How confident are you having a “difficult” conversation with a superior?
g) How confident are you having a “difficult” conversation with a patient?

7. Take a photo of the scale for statements c) to g) to use at the end of the workshop

8. Ask participants to stay standing and introduce themselves to the group providing their name, where they work, their profession, and one thing they would like to get out of today’s workshop. Give a 45 second time limit for each participant.

A photograph taken at the beginning of a workshop in response to the Question: How confident are you having a “difficult” conversation with someone you are supervising?

A photograph taken at the beginning of a workshop in response to the Question: How confident are you having a “difficult” conversation with a peer?

Making the Case for Why Conversations Matter

(15 minutes)

The purpose of this section is to:

- introduce why it's important for healthcare professionals to have "difficult" conversations
- discuss what happens when these conversations do not occur

Overview: To achieve this purpose, the facilitator introduced a story to participants illustrating the systemic impact when "difficult" conversations were avoided in the healthcare sector. Participants were also asked to add detail to the story to draw on participant knowledge. Participants were then presented with previous research and statistics highlighting why conversations matter from a national and global perspective.

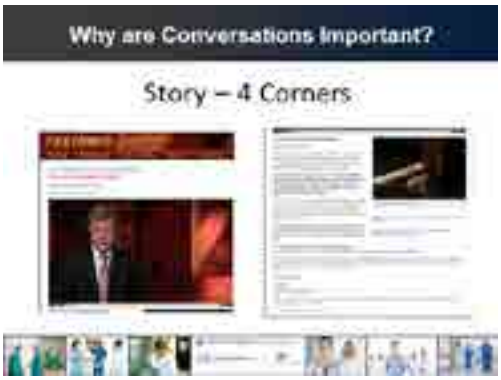
Activity: Storytelling and Research Findings

1. Introduce a story to the participants that illustrates a real life example of when avoiding "difficult" conversations has led to severe consequences

2. Ask participants if they have heard of the story first to draw on participants' knowledge. If they have, ask some of the participants to explain the basics of the story

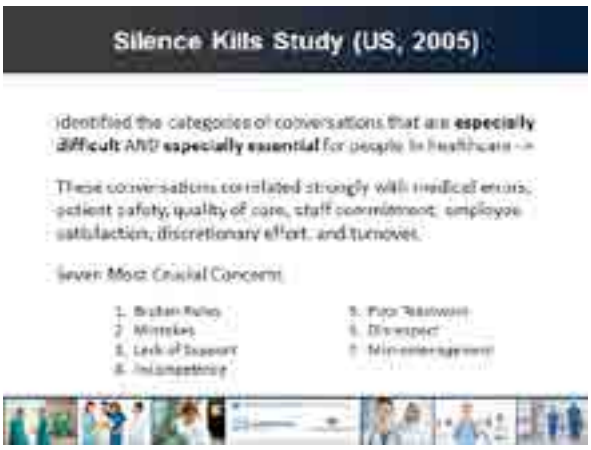
3. Elaborate on the story to illustrate what happened and lead a group discussion to highlight points relevant to making the case for why conversations matter and include what might not have happened if someone had spoken up about the behaviour they saw

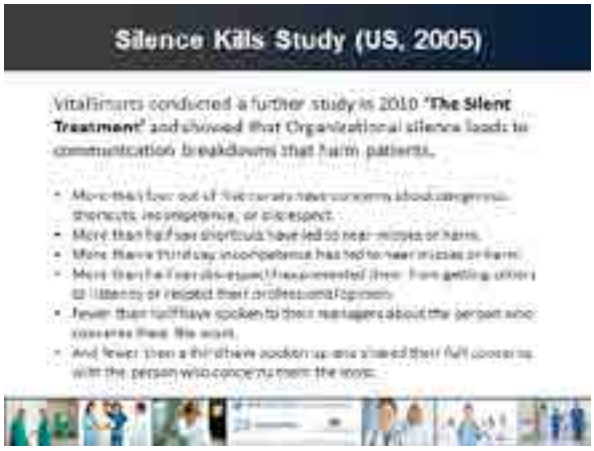
   We used a story which had aired on ABC TV's "4 Corners", The Hand that Holds the Scalpel (http://www.abc.net.au/4corners/stories/2014/08/25/4071837.htm) but any real life examples can be used (e.g. Italian 'serial killer' nurse Daniela Poggiali who is suspected to have caused the deaths of 96 patients, 'Doctor Death' Harold Frederick Shipman who killed 250 patients in the UK)

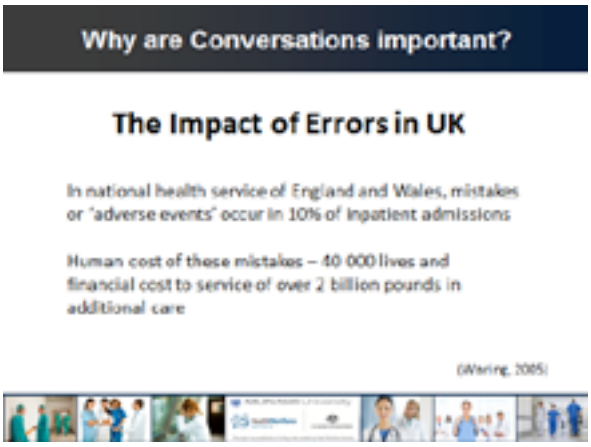


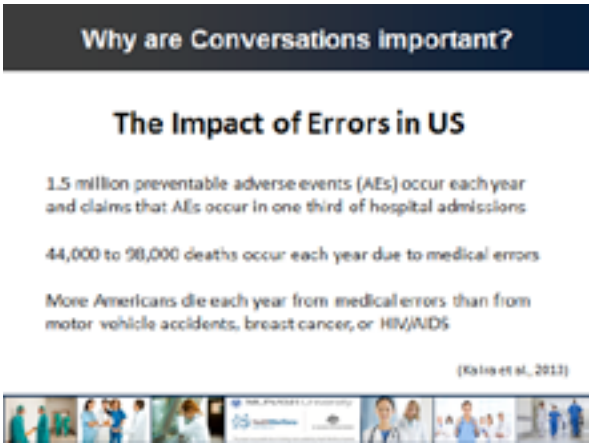
4. Present relevant statistics to base the need for having “difficult” conversations on empirical evidence (choose from Slides 7-18), emphasising themes of patient safety, consequences and responsibility, and leadership legacy

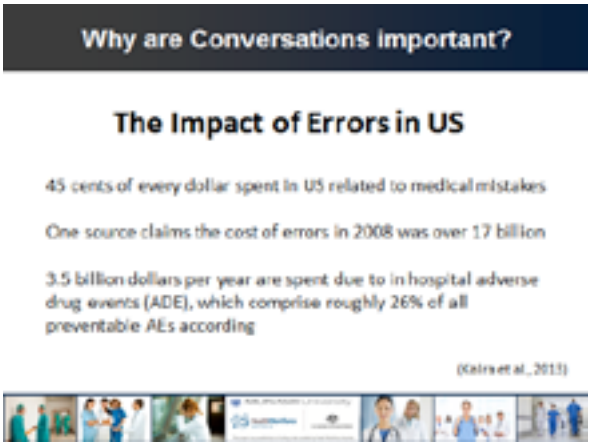
5. Allow participants to comment on or ask questions about what has been presented.

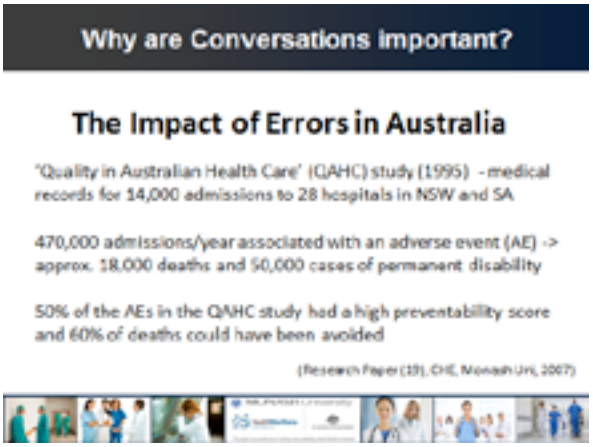












Some slides of empirical evidence we found important to include in our workshops

Types of and Successful Conversations: Building on Strengths

(10 minutes)

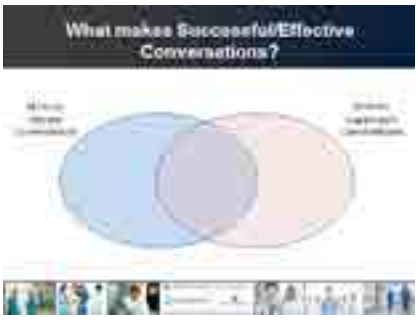
The purpose of this section is to:

- enable participants to discover for themselves that they already engage in "difficult" conversations as clinicians
- draw parallels between participants' expertise in "difficult" conversations as clinicians and the expertise needed in "difficult" conversations as clinical supervisors

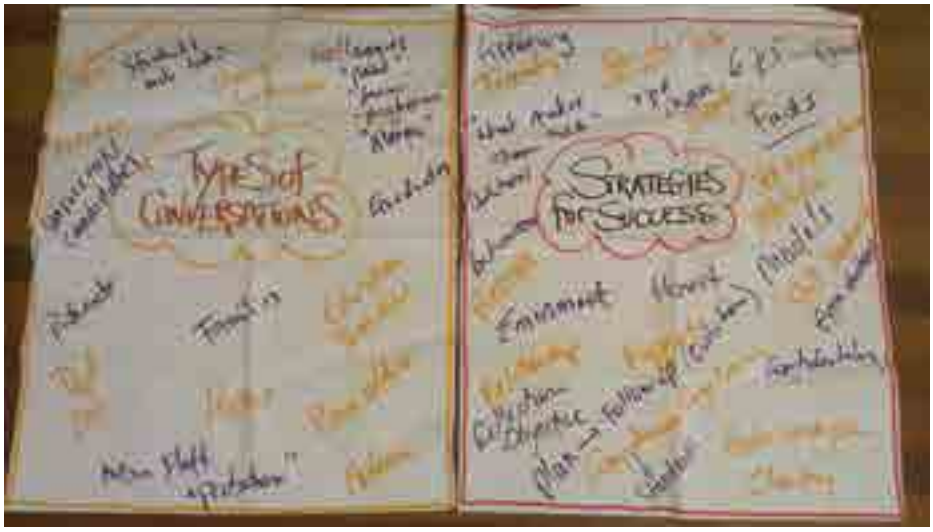
Overview: Participants brainstorm the different types of challenging conversations they have in their workplace and are then asked to brainstorm what makes these conversations a success. Parallels are then drawn between these and the types of conversations and skills that are required for "difficult" conversations with someone they are supervising, to highlight that they do have skills in "difficult" conversations that can be drawn from other relationships in their workplace and lives.

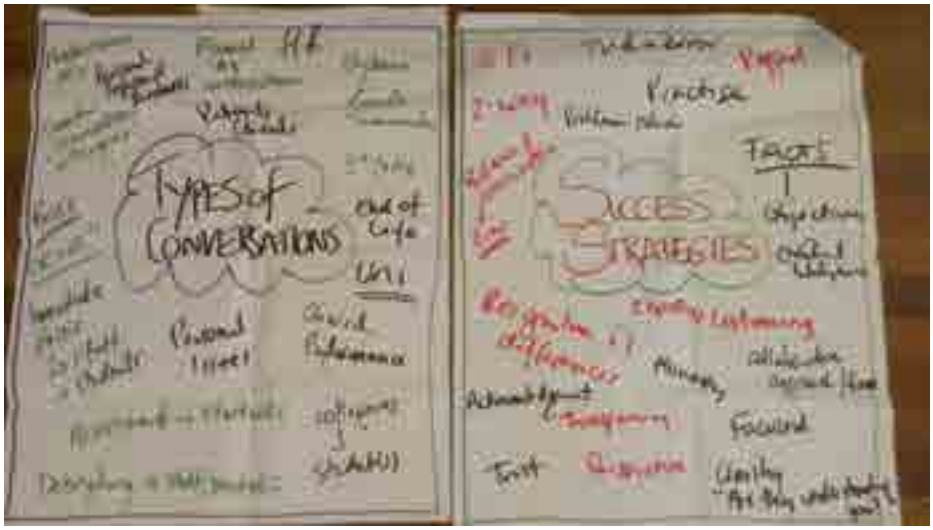
Activity: Brainstorming and Drawing Parallels

1. Prepare a flip chart writing the words 'Types of Conversations' in the centre of the chart
2. Ask participants to brainstorm "What kinds of challenging conversations do clinical supervisors have?" and record these on the flip chart
3. Alongside this flip chart, prepare a second flip chart writing the words 'Strategies for Success' in the centre of the chart
4. Ask participants to brainstorm "What makes these conversations successful?" and record these on the second flip chart
5. Once the brainstorming process is over, ask participants to reflect on what the various kinds of conversations have in common
6. Ask participants about the parallels (Slide 22) between the skill set and preparation needed to have a "difficult" conversation with someone they supervise and other challenging conversations they have in their workplace (e.g. a challenging patient conversation)
7. Highlight and explore this expertise (elements of communication: visual, verbal, vocal, listening, empathy, purpose/outcome, questioning)



8. Display both flipcharts side by side for the duration of the workshop





Photos of Types of Conversations and Success Strategies representing typical responses from our workshops

Poor Feedback and Negative Language

(30 minutes)

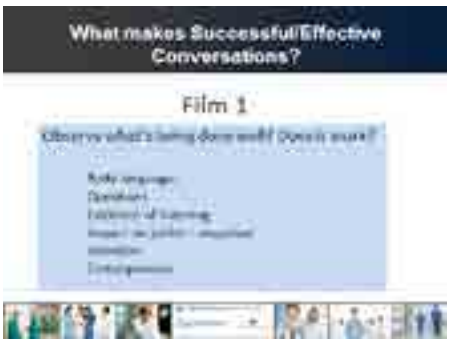
The purpose of this section is to:

- show participants an example of a poor approach to a "difficult" conversation during a clinical encounter and follow-up supervisory conversation
- enable participants to discuss different reasons for and different aspects of the poor approach to the conversation

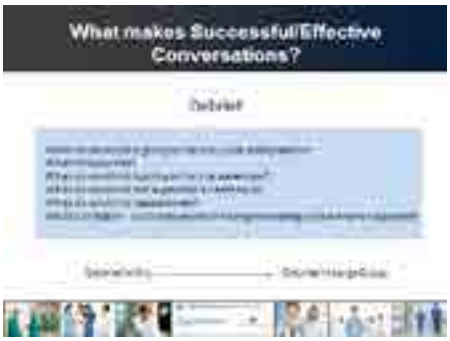
Overview: To achieve this purpose, participants watched one of the supplied films of a clinical encounter and follow up supervisory conversation. Prior to the film we provided participants with a range of questions to think about during the film. After the film, participants broke into groups of three to discuss these questions.

Activity: Film Part A

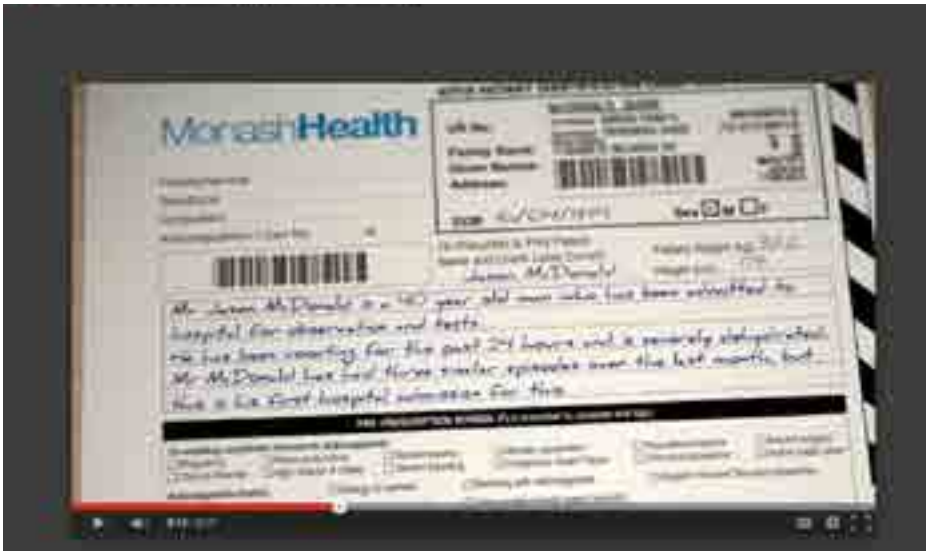
1. Introduce the section and provide participants with topics to think about as they are watching the film (Slide 23)



2. Play the film for participants and be sure to stop the film at the end of the first follow-up supervisory conversation (i.e. before the example of a good conversation – check time in film prior to workshop)
3. Break the large group into groups of three and ask the trios to discuss the film referring to the questions on (Slide 24)



4. Debrief with the complete group using the same questions on Slide 25 (We used this question to start the conversation: “What did you observe?” and then referred to the questions on slide 24 as relevant to the group’s needs.)



Patient Form and student-patient interaction from Film Part A

Conversation Planning and Practice

(50 minutes)

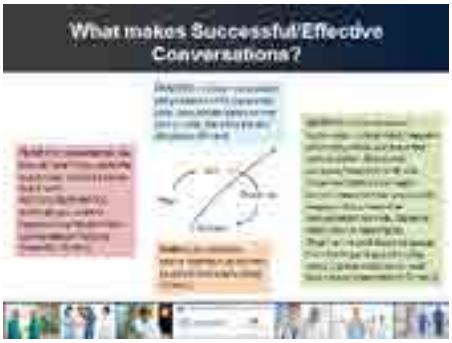
The purpose of this section is to:

- enable participants to plan and a "difficult" conversation
- use an action learning process so that participants can plan and practise a series of conversations and build on each trio's knowledge and experience over time

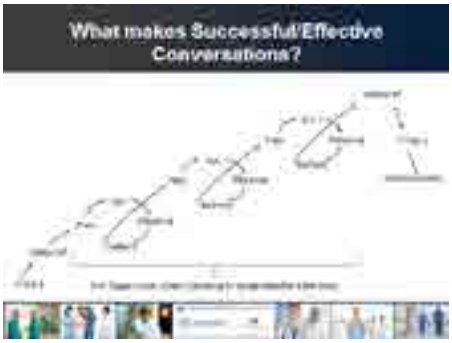
Overview: To achieve this purpose, we used small groups of three participants or 'trios' and watched one of the supplied films of a clinical encounter and follow up supervisory conversation. Prior to the film we provided participants with a range of questions to think about while watching the film. After the film, participants broke into groups of three to discuss these questions.

Activity: Conversation Practise using Action learning

1. Introduce the activity and explain the action learning process that will be used when practising a supervisor-junior conversation (Slide 26)



2. Ask each trio to decide who will play each role and explain that they will change/rotate roles so that they will all get a turn at each role (building knowledge over time)
3. Use slide 23 to describe the entire process with a series of action learning cycles



4. As the facilitator, make sure you keep time and tell the trios when to rotate. We used the following: 5 minutes per conversation and 3 minutes to reflect at the end of each conversation, share intention and check to see if the intention was fulfilled.

5. Debrief the activity with the whole group, highlighting what worked well, what didn't work so well, and what were the consequences, etc.

Photos of Trios planning, practising and reflecting on their "difficult" conversations

Good Feedback and Positive Language

(30 minutes)

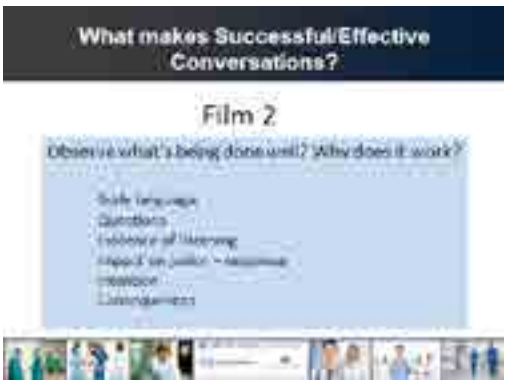
The purpose of this section is to:

- show participants a good example of a "difficult" conversation as an alternative approach to that seen in the earlier film during the follow-up supervisory conversation
- enable participants to discuss different reasons for and different aspects of a well conducted "difficult" conversation.

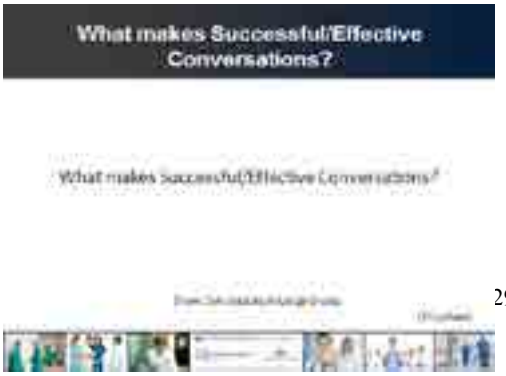
Overview: To achieve this purpose, participants watch the second part of the supplied film showing a good supervisory conversation. Prior to the film we reminded participants of the range of questions to think about during the film. After the film, participants broke into their groups of three to discuss these questions.

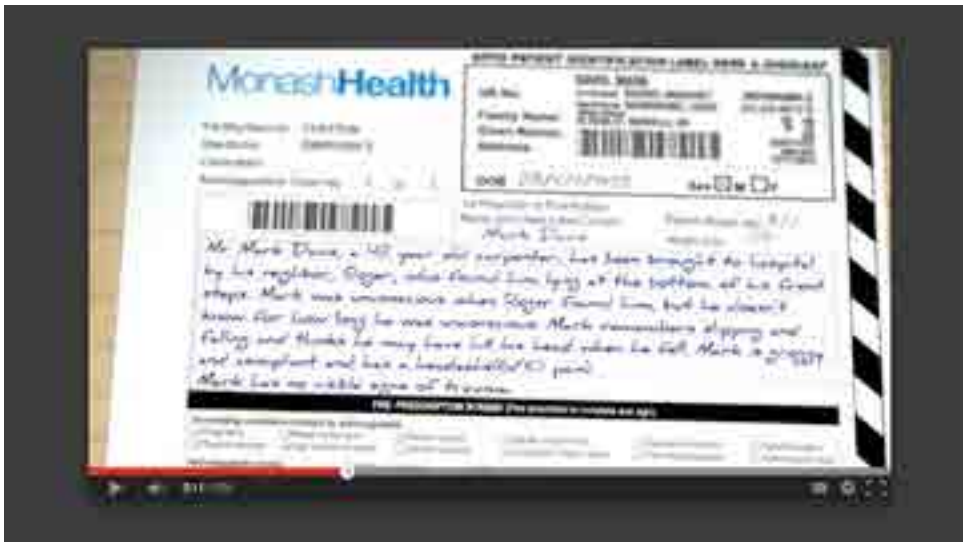
Activity: Film Part B

1. Provide participants with questions to think about as they are watching the second part of the film (Slide 28 – which is a repeat of Slide 24)



2. Play the second part of the film for participants (Film Part B)
3. Ask the group to break back into their groups of three and ask the trios to discuss the second part of the film. (NB. It is recommended to explain to participants that the example is an example of a well conducted "difficult" conversation, but may not be the *perfect* approach)
4. Debrief with the whole group using the questions "What was done well?" and "Why does this approach work?"





Patient Form and student-patient interaction from Film Part B

"Difficult" Conversation Challenges

(10 minutes)

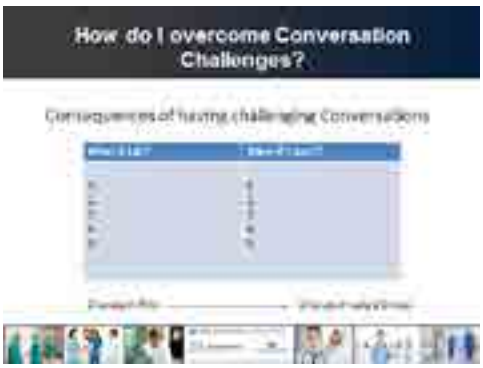
The purpose of this section is to:

- enable participants to examine what stops them from having "difficult" conversations
- have participants highlight the consequences of avoiding these conversations
- change participants' attitudes to engaging in "difficult" conversations

Overview: To achieve this purpose, participants are asked to think of a conversation scenario of which they are most afraid and worst things that could happen if they had the conversation and the worst things that could happen if they avoided the conversation. From the participant lists, a group list is made and a process is used to compare and draw conclusions about the group list.

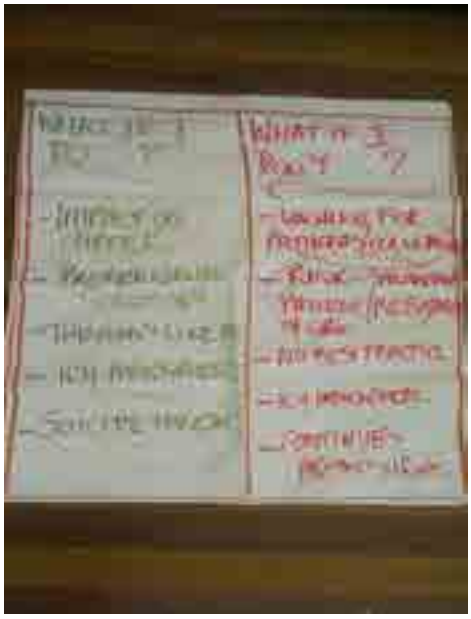
Activity: What if you do? What if you don't?

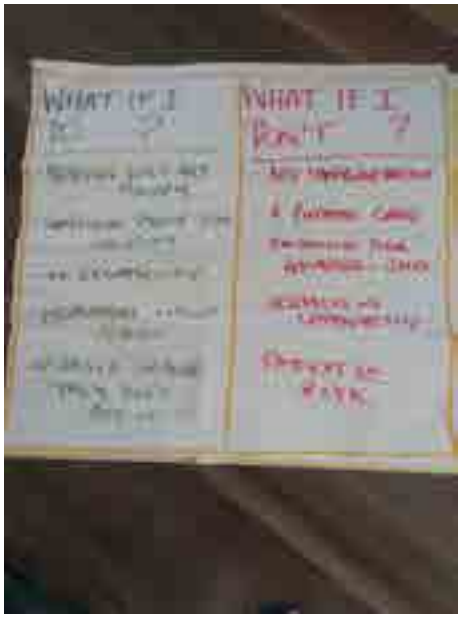
1. Ask participants to think of the conversation scenario of which they are most afraid
2. Referring to Slide 32, ask participants to work on their own for *3 minutes* and list the top five WORST things that could happen if they were to <u>have</u> the conversation and the top five WORST things that could happen if they continue to <u>avoid</u> having the conversation

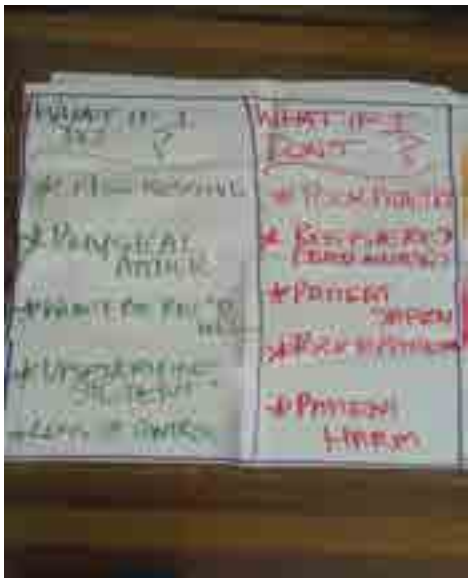


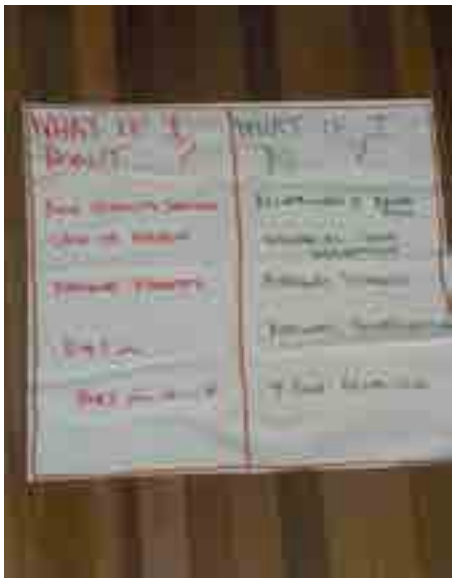
3. Ask participants to fill in the complete list, ensuring that they have five things in each column. (NB. We found this important to gain diversity and depth)
4. After 3 minutes, show a flipchart to the entire group and explain that you would like participants to offer some of their examples to create a communal list of consequences
5. Ask individuals to provide their WORST consequence from their "what if you do?" list until there is a list of five consequences on the flipchart
6. Asks individuals to provide their WORST consequence from their "what if you don't?" list until there is a list of five consequences on the flipchart

7. Referring to the list, ask the group to help interpret the flipchart. Ask the group to identify the WORST consequence in each list and circle these. Which list is worse? (We found that the flipchart should highlight why it matters to have “difficult” conversations, i.e. the consequences of not having the difficult conversation are worse than having the “difficult” conversation)









Photos that show a representation of the “What if I do?” and “What if I don’t?” responses by participants in our workshops

Real Play Demonstration and Coaching

(40 minutes)

The purpose of this section is to:

- have one participant practise a "difficult" conversation that they are avoiding in their workplace with the help of a mentor and other participants
- model good conversation strategies to all participants
- provide an opportunity for participants to give feedback on a real life scenario

Overview: To achieve this purpose, a fishbowl technique is used where one volunteer participant practises having a "difficult" conversation that they have been avoiding with an actor who takes on the role and persona of the person they have been avoiding having a difficult conversation with. The actor and volunteer swap roles so that the volunteer has a chance to 'feel' what it is like to be the person they are avoiding having the conversation with enabling them to highlight assumptions about that person. Other participants watch good conversations being modelled and also provide feedback.

Activity: Fishbowl

1. Ask the group to think about a conversation they are avoiding having
2. Explain to the group that one person will have the opportunity to practise this conversation and receive coaching and feedback
3. Set-up confidentiality with the group to ensure what's talked about stays in the group
4. Ask for a volunteer from the group to share their situation, and once a participant has volunteered, ask them to join you and an actor at the front of the room
5. Asks the participant to briefly describe the person they need to talk to, gaining enough information so that the actor is able to represent this person in the practice conversation
6. Ask the participant what their purpose/intention is for the conversation, asking a member of the group to note this down for later reference.
7. Ask the volunteer participant to set the scene and context for the conversation (e.g. is it in an office? over the phone?) and set up chairs and entry to the room as appropriate.
8. Play out the situation. This is REAL Play not Role Play, as the volunteer does not play a role, but they are themselves rehearsing the conversation. It is the 'actor' who takes on the role of the person being supervised.
9. Debrief first with the volunteer and then whole group

10. Reverse roles by asking the volunteer to be the person being supervised and the 'actor' to play the role of the supervisor. The actor needs to model an example of a difficult conversation which is aligned to fulfilling the participant's purpose.

11. Debrief first with the volunteer and then the whole group

Photo of the volunteer and the actor having a real "difficult" conversation

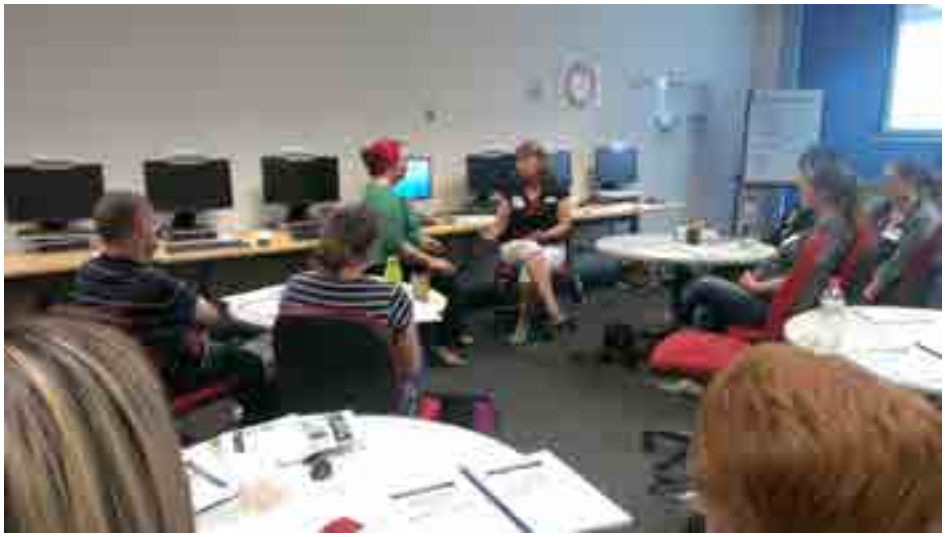


Photo of other participants observing the interaction between the clinical supervisor (real play) and the person being supervised (actor)

Photo of the volunteer and the actor when they swap roles NB. They change actual places

Commitment to Action

(5 minutes)

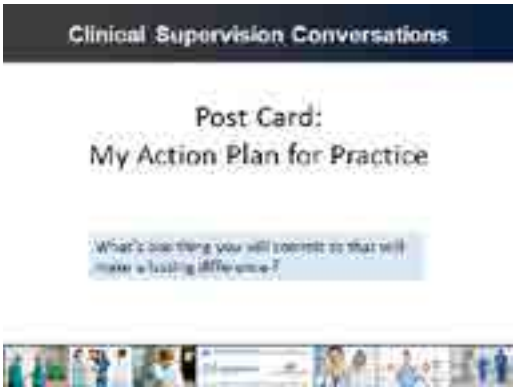
The purpose of this section is to:

- have participants reflect on what they have learned during the workshop
- enable participants to convert what they have learned into actions that they can apply in the workplace
- provide a process where participants will commit to applying one action in their workplace and check if they have followed through with this commitment at a later date

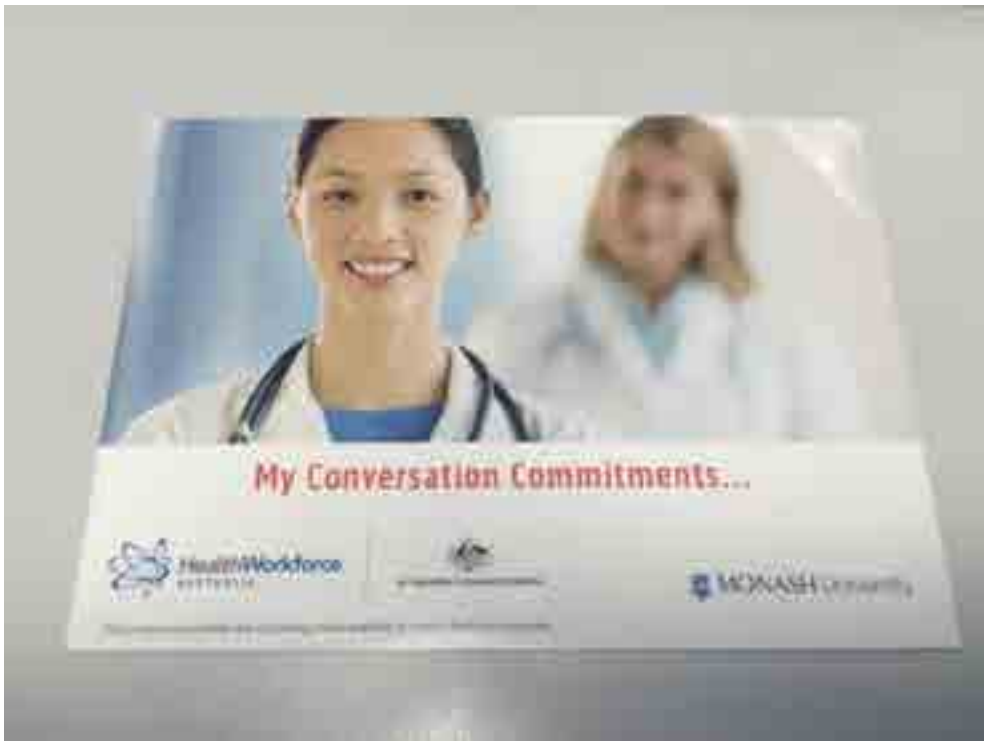
Overview: To achieve this purpose, participants are asked to reflect on what they have learned in the workshop and asked to think about what this means in terms of possible actions that they can apply in the workplace. A postcard activity is then used to have participants commit to one action, enabling them to check if they have fulfilled this later.

Activity: Writing a Postcard

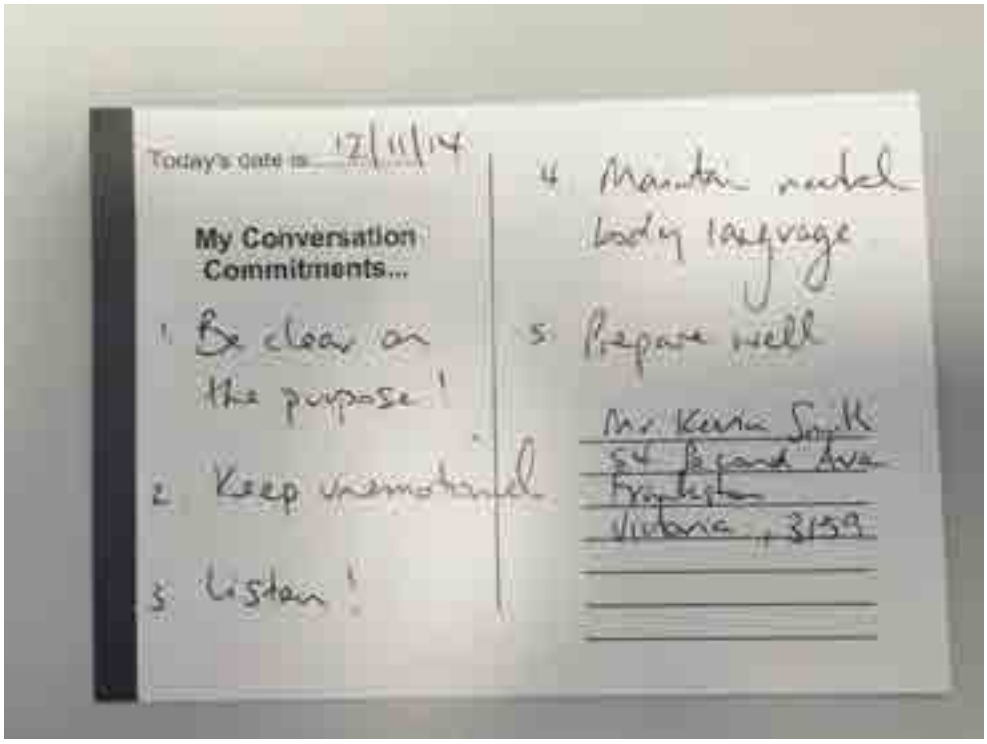
1. Ask participants to individually reflect on what they have learned during the workshop
2. Once participants have had a chance for reflection, ask participants to write down how they could apply this knowledge in the workplace
3. Ask participants to select one specific action that they would be willing to commit to applying in the workplace over the next four weeks using the question "What is one thing you will commit to that will make a lasting difference?"



4. Hand out postcards to participants and ask them to write themselves a postcard stating their commitment (including other details such as name and address, noting they may wish to have it sent to home
5. Collect the postcards from participants and let them know that you will post these back to them in four weeks' time, explain that this will act as a reminder for participants about their commitment.



Front of Postcard



Back of Postcard

Evaluation

(5 minutes)

The purpose of this section is to:

- Enable participants to participate together in their own evaluation of the workshop in term so of its impact on their confidence to have "difficult" conversations
- Collect additional evaluation data

Overview: To achieve this purpose, the original 'Icebreaker' process is repeated and the results are compared to the photos depicting participant confidence at the beginning of the workshop. A formal evaluation questionnaire is also filled out be participants to gain a greater depth of understanding about the impact of the workshop on participants' knowledge, attitudes and skills.

Activity: Revisiting the physical confidence scales (Participatory Evaluation).

1. Repeat the 'Icebreaker' process at the beginning of the workshop
2. As you go through the series of statements, show the corresponding slide from the beginning of the workshop illustrating changes in confidence levels
    a) How confident are you having a "difficult" conversation with someone you're supervising? *(0 No Confidence and 10 Very Confident: for this and following questions)*
    b) How confident are you having a "difficult" conversation with a peer?
    c) How confident are you having a "difficult" conversation with someone from another profession?
    d) How confident are you having a "difficult" conversation with a superior?
    e) How confident are you having a "difficult" conversation with a patient?
3. Ask participants as a whole group to comment on the changes in confidence that they observed
4. Hand out any further evaluation surveys that you require

    We recommend evaluating participants' experience of the workshop. We used a pre and post design using a self-report questionnaire. We have included this in the toolkit.
5. Thank participants for their participation and provide any further information and contact details

Photo of the scales taken at the beginning of the workshop to the question "How confident are you having a "difficult" conversation with a peer?"

Photo of the scales taken at the beginning of the workshop to the question "How confident are you having a "difficult" conversation with a person you are supervising?"

WHAT RESOURCES DO YOU NEED FOR FACILITATING THE WORKSHOP?

- Pen or pencil for each participant
- Workshop manual
- Name tags
- Attendance list
- PowerPoint slide deck
- Reusable adhesive (e.g. Blu tak)
- Flip chart paper
- Flip chart markers
- Scale markers “0” and “10”. (We laminated an A4 piece of paper)
- PC/DVD player (with sound and projection)
- Copy of film on DVD/memory stick or internet access to watch directly from Vic Portal: https://vicportal.net.au/vicportal/index.jsp
- Camera (with capacity to download photos to computer during workshop)
- Surveys
- An actor (The project team can be contacted for guidance on finding an actor(s))

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Conversations

1. Scott, S. (2002). Fierce Conversations—Achieving Success at Work and in Life, One Conversation at a Time**.** New York, N.Y.: Viking.
2. Patterson, K. (2002). Crucial conversations: tools for talking when stakes are high. New York: McGraw-Hill.

PARTICIPANT MANUAL

(there are an additional 43 pages [1 powerpoint slide per page])

These are attached in the email too.