

Educational resources and processes for health professionals who facilitate placements

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Executive summary

An increase in students exerts greater pressure on clinical placement venues, whose capacity and resources for the provision of clinical education are strained. Health students require quality clinical placement experiences so they can integrate and apply the knowledge learnt in the classroom and gain familiarity with the practice environment. Central to high-quality placements is the clinical supervisor who is adequately prepared and supported.

In the Hume Clinical Placement Network (CPN), workshops were held in November 2010 as a forum for identifying priority projects. The need for professional development for clinical supervisors of students was highlighted as a priority for the region and one outcome of the workshops was the Educational Resources and Processes for Health Professionals Who Facilitate Placements (Education for Supervisors) strategic project. The project, which was administered by a partnership of La Trobe University and Wodonga TAFE, ran from July 2011 until January 2012, and was complementary to other Hume CPN strategic projects running concurrently.

The overall goal of the project was to undertake a situational analysis of the current environment and support for health professionals in the Hume Region who undertake clinical supervision, preceptor, assessor, or other relevant roles in the clinical education for professional-entry health students.

The aim of the project was to inform future development of a coordinated and integrated plan to support and educate professionals who are responsible for supervising students.

This project set out to explore to what extent training is provided and to highlight where barriers and deficits exist, so that planning can be put into place for the allocation of funding in the most effective and sustainable manner. A review of outcomes of recent funding initiatives for supervisor education revealed that funded programs have not always demonstrated sustainability and that supervisor training does not always reach the practitioners most in need.

In this project all surveyed stakeholders agreed that preceptor workshops improved staff confidence and the quality of the placement. Some also reported an improvement in the organisation's capacity to take more students. There was no doubt that supervisor education, when provided, was well-received and beneficial but the teaching infrastructure at the Clinical Placement Providers (CPPs) was found to be variable.

Supervisors are more likely to be trained and supported in their clinical education role when there is a department or a coordinator responsible for training and when there is a clear organisational mission committed to clinical learning. Organisations without such a model, notably some small health services, community health centres, private practices and aged care, were those more likely to face difficulties in accessing supervisor training.

Isolation, both geographical and professional, was found to be a barrier to supervisor training. Time availability, cost implications, and personal attitudes were other inhibiting factors.

Expressed training needs varied considerably depending on the discipline and sector and included mentor training, preceptor training, practical workshops, refresher education and Certificate IV in Training and Evaluation (TAE). Pathways for those interested in ongoing education were also suggested. Education was considered vital to catch-up, and to keep up with staff turnover. The sort of education wanted by most respondents was that which provides a general clarification of their role as preceptor, some contextual practice, help with managing under-performing students and the use of assessment tools. Most supervisors wanted training delivered locally and recognised the value of using technology for education and support.

Because of the large area of the Hume Region, the diversity of sectors and disciplines, and the complexity of needs of CPPs within it, supervisor training and support provided by main education providers in the Hume Region was found to be irregular and fragmented. Currently, CPPs are grouped with their education partners for the purposes of supervision support, but it was demonstrated that this system is disjointed, and it is not possible for education providers to provide training to all supervisors in all locations. Some CPPs felt unsupported by their main partners. Furthermore, there was little evidence of coordination and collaboration between the main education providers, and at times a climate of competition was detected.

With expanded settings for clinical placements and increased numbers of students, with the development of a Best Practice Learning Environment Toolkit and the proposed Health Workforce Australia (HWA) Competency Framework, the time was considered right to put into place a consistent and coordinated supervisor education model in the Hume Region. It was hoped that a quality driven calendar of training will replace the often ad hoc request process that currently occurs.

Therefore a collaborative approach between the main players is recommended. The higher education and Vocational Education and Training (VET) sector have the capacity and the opportunity to join forces with fellow educators and CPPs to share resources, plan and deliver introductory and interdisciplinary preceptor training programs in a timely and coordinated manner. There are support networks and other training options which can be garnered to complement these programs.

A pathway is suggested which may then articulate into a career path for those wishing to become experts in the field of clinical education. Developing a pool of well-prepared clinical educators will ensure that supervision training remains high on the agenda, is ongoing and is sustainable in the Hume Region.

Background

Prior to conducting a situational analysis of the current supervisor environment, it was important to familiarise the project team with findings and recommendations which have emerged from previous research projects and resulting policy documents. Key documents which inform this project were identified and used to compare and measure the current environment against the recommended models and approaches.

The Victorian Department of Health's (2009) Scoping Report on clinical supervision for medicine, nursing and allied health, identified barriers and opportunities to expansion of clinical placement capacity and informed subsequent policies and programs, notably the development of the Victorian Clinical Placement Council and eleven CPNs, and funding in the form of Student Supervision Grants (SSG).

Darcy and Associates' report (2009) for the Department of Health, Best Practice Clinical Learning Environments (BPCLE) within Health Services, explored models of supervision for health students in Victoria, analysing the nature of successful placement models, and existing facilitators and barriers to BPCLE. The report revealed considerable variations in the organisation of clinical supervision, within and between health professions and health services.

Darcy described tiers or levels of the supervisor:

Tier one

A preceptor or buddy who works one-on-one with the student, modelling clinical skills and introducing the workplace culture.

Tier two

A clinical teacher, educator or facilitator, who oversees a group of preceptor-student dyads.

Tier three

A clinical placement coordinator who is a senior staff member with responsibility for supporting clinical education staff. Administrative functions are sometimes shared.

An outcome of this study was a BPCLE Framework (Department of Health, 2010). The Framework is the basis for a resource kit, currently being developed and promoted to health services.

The Framework comprises six elements. Elements one, three, four and five address the requirements for highly qualified supervisory staff:

- An organisational culture that values learning
- Best practice clinical practice
- A positive learning environment
- An effective health service – training provider relationship
- Effective communication processes
- Appropriate resources and facilities.

With reference to these reports and to stakeholder consultations and submissions, HWA (2011) developed a National Clinical Supervision Support Framework, whose focus is on clinical education and on the promotion of a learning environment in health service organisations.

A competency framework was proposed, consistent across professions, suggesting seven core competencies and twenty-two requisite skills. Training programs, it was suggested, should be aligned to the national competency framework, with flexibility, allowing for training to be delivered in a variety of modalities, inclusive of all sectors including VET and to be delivered locally.

In October 2010 it was announced that HWA would deliver nearly two million additional student training days throughout Australia (HWA 2011). Thirty-eight percent of these additional training days were allocated to five identified priority settings. Twenty-three percent were allocated to rural and remote areas and in the Hume Region, there is a projected thirty percent increase in students requiring placement in 2012 (Gleeson, 2011). The resulting increase strains existing resources.

In Victoria, the Victorian Clinical Placements Council (VCPC) was established to provide statewide leadership, coordination and oversight of professional-entry student clinical placements and eleven geographically-based stakeholder networks, the CPNs, were formed to support the development of coordinated approaches to clinical placement at a local operational level and to distribute funding.

In the Hume CPN, four strategic projects were setup, including Education for Supervisors, which will each contribute to greater coordination in the region. In addition, Multilateral Negotiations (MLN) were conducted to facilitate and streamline clinical placements, and a statewide profiling audit provided quantitative data on current supervision capacity.

Terminology

For the purpose of this project, a supervisor is defined as an appropriately qualified and recognised professional who guides students' education and training during clinical placements. The clinical supervisor's role may encompass educational, supportive and management functions and is inclusive of the terms clinical educator, clinical facilitator, teacher, mentor, buddy and preceptor. It refers to the educational context of trainee learners, and not to clinical supervision in its broader sociological context.

Allied health is a definition by exclusion, being health professionals or support staff working for a health service and/or community health service who are not medical, nursing or administration staff. This includes both university and VET sector prepared practitioners.

Objectives

- Review funding initiatives that have been implemented in the Hume Region over the last five years to improve core attributes, skills and knowledge expected of clinical staff and educators along the continuum of support. Evaluate the outcomes of these initiatives.
- Assess the current professional development needs of CPPs, which will in turn inform future.
- Development of a coordinated and integrated plan to support and educate professionals who are responsible for facilitating student placements across the region in the full range of placement settings.
- Survey existing and potential CPPs regarding the number of suitable available supervisors including compliant qualified VET assessors and their projected needs in regard to planned and potential capacity.
- Map professional development options available to clinical staff and educators along the continuum of support.
- Identify opportunities for CPPs to share human, environmental, equipment and education resources.

Methodology

Purposive sampling of stakeholder representatives was employed. A minimum achievable goal of representatives of each health sector and of main education partners was agreed upon for sampling. The key stakeholders were identified as existing and potential CPPs, which were further divided into sectors and education providers (EP), being those with significant numbers of health students in the Hume Region. Hume CPN documents, the Department of Health website and Yellow Pages directory were used to identify CPP and EP partners. Department of Health documentation was used to identify SSG recipients.

Data collection method

The data required for the project was established and three short questionnaires were devised, for identified funding recipients, CPPs and EPs respectively.

Recipients of government SSG funding were approached and phone interviews were conducted.

An advisory group of stakeholder representatives was set up and two meetings were held with the purpose of gaining the perspective of each sector.

Other CPP and EP representatives were contacted and where possible, face-to-face or group interviews were arranged. Some telephone interviews were conducted and some questionnaires were sent and returned by

email or post. If responses were not obtained following two approaches by the project worker, no further attempts were made.

Two forums were attended, which were used as information-sharing opportunities.

Data analysis

Information on funding initiatives, when obtainable, was measured against the stated objectives and purposes of the program. The clinical placement environment data was summarised by sector, grouped according to similarities and recurring themes were identified. The professional development options were summarised and compared against key frameworks and CPP findings.

Survey of CPPs

With concurrent projects being undertaken, it was important that stakeholders did not feel that they were being over-surveyed, so a sampling across the continuum was used to create an overview of the current situation.

Fifty-three CPPs and three regional general practice (GP) divisions were contacted and one or more representatives from forty-seven CPPs responded. The majority of respondents at health services were those in a managerial, educative or coordinating role. It was found to be more difficult to speak to the practitioners who actually work with students.

Being the largest workforce, nursing data was easiest to obtain. Allied health data was more difficult to collate due to the large number of separate disciplines and variations in service provision. The Allied Health Workforce Project (2010) identified thirty-seven allied health disciplines and four different service provision arrangements.

Similar themes and issues recurred in CPPs of certain sizes and types, so the data was grouped into eleven sectors: large regional and subregional hospitals; small rural and bush nursing hospitals; community health services; private hospitals; non-government organisations (NGO's) and private practices; Victorian Aboriginal Community Controlled Health Organisations (ACCHOs); aged care; mental health; psychiatric, disability, rehabilitation and support services (PDRSS); medicine; government departments.

Some of the sectors overlapped. For example, all public aged care facilities were part of a public or bush nursing hospital, a community health centre, or an ACCHO, so data in those sectors was inclusive of aged care.

Medical students are placed across all sectors, and were summarised as a discipline, divided into four cohorts. Two health services have psychiatric units, which are supported by the education departments at their hospital in addition to other specialist supports. They were categorised separately under the mental health sector. Nursing and allied health, when present in the same facility, were examined separately if possible.

Findings

Review of funding initiatives

The purpose of the SSGs is to support supervision skills training for staff who currently or potentially will participate in clinical supervision. The SSG funding is administered by the Victorian Healthcare Association (VHA). In 2009 there were seven SSGs awarded in the Hume Region, with five proceeding to completion. In 2010 there were three SSGs, with two proceeding to completion. Small rural health, aged care, mental health and community health were the areas of need which were targeted.

It was found that sustainability of the funded training programs is more likely where a staff member has the responsibility for professional development, such as an education coordinator. To be sustainable, programs need to influence the organisation as a whole, and not just the individuals undertaking the training, otherwise staff attrition and mobility, combined with a lack of structure and support from above, will render the benefits to the health service short-lived.

Reviewing and evaluating funding initiatives was made difficult by a lack of knowledge of said initiatives by the health services concerned and a lack of availability of rigorous evaluations of the programs. The aggregation of all programs in the state into one report, which is not yet available to the public, rendered it impossible to establish which type of training was most successful and which geographical area, size or type of health service were disadvantaged, or displayed the greatest benefit.

Findings by sector

Large regional and subregional hospitals

There are two large regional hospitals and two subregional hospitals. The subregional hospitals share their education department and resources.

Similarly to Darcy's report on large health services, the nursing education department at each hospital was found to be well-organised and structured, with a three-tier system, while allied health education ranged from highly organised at the sites where they shared the training structure and resources with nursing, to disjointed at the site where they did not.

Nursing

The nursing educators at the top tier had PhD or master's level qualifications, and provided regular in-house training for their preceptors. Other qualifications variously included the Certificate IV in TAE, preceptor and mentorship training. Second-tier nurses all had some training or qualifications in the preceptor role and provided some education. All nursing staff were encouraged or expected to act as preceptors, which was included in job descriptions and most had had training. Partner universities and the VET sector offered training but no regular schedule was adhered to. Other supports provided to nurses included study leave to attend outside training opportunities, informal debriefing and formal networking and coffee and cake vouchers.

Although well-provided for in terms of in-house preceptor training, the personal cost to staff choosing to progress to higher qualifications was seen as a barrier to career paths. Cost to the health service for TAE certification, release from the workplace for training, negative attitudes of staff to the preceptor role, ad hoc training by education partners and insufficient support for marginal students were also commonly cited issues.

Allied health

Allied health education coordination was included in the nursing education department at three of the hospitals, using the same structure and sharing a supervisor at one of the tiers. In-house preceptor training was also offered, with discipline specific training and support provided by some education partners in an ad hoc manner. The other site used senior practitioners as supervisors, and relied on its education partners to provide preceptor training.

Other supports varied, with some disciplines paid regular university educator visits, while others received only a phone call, described as irregular and unpredictable. One site had a mentor program for novice practitioners.

Allied health practitioners were more likely than their nursing counterparts to consider student supervision to be stressful and burdensome. They also cited the disjointed nature of being part of a multidisciplinary team, exacerbated by being partnered with many different universities, often from outside of the Hume Region, and several different institutes of Technical and Further Education (TAFEs), each having only a few students undergoing their placement at a hospital at any one time and most using different assessment tools.

At all sites, the education coordinators wanted more training, more often, by their education partners and timely, for example twice per year with at least six weeks' notice. The highest level educators wanted training to be more academic and less competency-based. Further support from universities in the form of scholarships for further supervisor education, was also suggested.

More help and support was wanted from education partners with managing the issues of marginal students. One allied health team felt that they needed a discrete allied health education department and coordinator, and a local coordinator for interstate and distant universities.

Small rural hospitals and bush nursing hospitals

A broad range of health practitioners from fifteen small rural and two bush nursing health services were surveyed. In small towns the local hospital usually provides all facets of health care and in many cases it is also the largest employer. Local factors contribute to the character of small hospitals, so each one is different and no one model or formula will meet the needs of them all. Some small towns are remote and difficult to reach, requiring them to be self-sufficient and innovative, while others are part of a collaborative subregional network. Small numbers of students are taken, and often from several different education partners.

Nursing

All surveyed small hospitals operated on a two or three-tier supervision model. Most had a part-time staff member with set hours allocated to the education portfolio. Some of these staff members were also required to coordinate all placements, while at other facilities this role was shared with, or carried out by, an administration officer.

Two small hospitals had strong links with a partner university. At hospitals without supervision capabilities, a registered training organisation (RTO) sent their own supervisors with their VET students.

Training and qualifications in student supervision varied widely across the sector and ranged from no preceptor training, to master's level. Because most small rural hospitals have a majority of aged care beds, the Certificate IV in TAE is more common in this sector than in others. Several respondents did not know that preceptor training was available.

The responsibility for training provision also varied greatly, with seven hospitals providing in-house training on a regular basis, and one facility setting itself up as an RTO and developing its own online competency package. Education partners had provided onsite training at twelve sites, some having been funded by SSGs and staff of several hospitals travelled to training organised by the regional Nurse Educators Group.

Ways that hospitals supported their supervisory staff included time to conduct assessments, debriefing opportunities in meetings, networks, catch-up time and negotiable hours.

When surveyed regarding barriers and issues, the recurring themes were time, isolation, smallness, staff attitudes or culture and the conducting of assessments.

At most hospitals, clinical educator time was a fraction of a full-time equivalent, which was considered insufficient time for carrying out the role adequately.

Training was not always delivered locally, with distance and isolation having staffing, travel and cost implications. Small hospitals also felt isolated from the education providers and some stated they received no site visits or supporting telephone calls during placements.

A negative attitude of staff towards taking students was an issue most commonly cited by staff in this sector. In small hospitals where aged care predominates, a very small number of registered nurses, often part-time or casual, have the majority of the responsibility placed on them for supervising students, leading to some reluctance.

Assessment tools were described by some respondents as arduous and time consuming, with terminology being too academic.

All representatives of this sector wanted more education, more often, and local. Preferred types and modes of training depended on the site. A mix of in-house, videoconference or online options was preferred. Educators also wanted more financial support for education, backfill, greater recognition of the work of preceptors and more contact with partner education providers.

Allied health

Allied health staffing and contractual arrangements vary from one small hospital to the next, as identified by the Department of Health (2010):

- Allied health practitioners are employed by a hospital and are a part of the inter-disciplinary supervision model.
- Allied health practitioners share joint appointment arrangements with other hospitals. Their level of inclusion and support varies greatly across the sector and between disciplines.
- The hospital utilises contracted fee for service private allied health practitioners, who bring their own students with them, using an apprenticeship model.
- Private allied health practitioners have visiting service agreements with one or more public health services.
- The hospitals play no part in education or support for the supervisory practitioners in the private contract models. Visits or telephone calls from partner universities are their main resource.
- In addition to the issues faced by nurses, allied health practitioners can experience professional isolation, being the sole practitioner in their field.

Community Health Services (CHS)

A large sample of disciplines is represented in community health, including nursing, medicine, occupational therapy, physiotherapy, speech therapy, psychology, dental, and social work. Seven staff members across three CHS were interviewed.

A two-tier or apprenticeship supervision model exists at the surveyed services. None of the CHS had a designated educator position, and there was no supervisor education offered in-house or by partner organisations. Opportunities were taken for outsourced funded training, when offered and several staff members had completed preceptor training or Certificate IV in TAE some time ago. Recent SSG funding for a partnership of two CHS was provided mainly to managers without a clinical load. These managers were expected to use the skills to provide informal support and debriefing to clinicians. Supervising clinicians were not offered the training and were unable to report any impact on student supervision.

The main barriers to supervisor training were considered to be insufficient time to undertake training and a lack of appropriate training that was available, local and affordable. The absence of clinical placement coordinator or education portfolios meant that information about available training sometimes failed to reach the organisations and practitioners.

Those interviewed wanted training of any type and mode, including accredited modules, in-house, by videoconference and online. They also wanted a designated education role and the support of local networks.

Private hospitals

Nursing educators of three private hospitals were interviewed. They were all managed by the same large health care company, which is an RTO and reported a well-organised three-tier education model. All staff were expected to act as preceptors. Allied health practitioners used an apprenticeship model but were supported by the organisational education programs.

The RTO offered initial preceptor training to all staff, and annual refresher education was also available either in-house or online. In-house education was provided by the nurse educators. There was reported to be an inbuilt culture of learning and education, with education forming part of all job descriptions and good supports for preceptors in the form of debriefing by clinical facilitators and a preceptor network.

There were varying reports regarding support received from universities and TAFEs, such as poor communication and assistance with marginal students, and in one case a complete relationship break down. Despite this, all educators wanted some preceptor education to be provided by the partner universities.

Non-Government Organisations (NGO) and private practices

A physiotherapist and podiatrist in private practice and an occupational therapist at a NGO were interviewed. All take students in an apprenticeship model, with senior and junior therapists sharing the load.

In this sector, student placement was seen as the main strategy for future recruitment. However, private practitioners also considered it to be time consuming, meaning that the therapist can see fewer patients, therefore receiving less remuneration. This deterred one therapist from taking students, stating that it was not viable in the current model.

Two of the three therapists had been offered sporadic mentor or preceptor training by partner universities in the past but there was insufficient time to attend training and no funding allocated to professional development.

Support from universities consisted of emailed documents including assessment tools and one phone call during the placement.

Better incentives for taking students were suggested, including recompense for lost time, or in-kind benefits such as increased rights and relationships with a clinical school as an associate staff member, with the use of the library and other resources. The private therapists also wanted funded training, of any type and mode of delivery, to be provided locally.

ACCHOs

Aboriginal cooperatives are multi-functional service delivery centres, described as well-resourced organisations by those interviewed at one of the cooperatives. The cooperative has a three-tier model, with interdisciplinary supervision and the sharing of some resources with a large regional hospital.

All supervisory staff in aged community care had been provided with preceptor training, either in-house in a 'train-the-trainer' model, or by an educator from TAFE. Cultural training was also included and pathways for education and training included a graduate certificate in management, inclusive of preceptorship, proceeding to advanced diplomas in business management.

Other supports included staff debriefing, both internal and externally and roster flexibility as part of the cultural component. This roster flexibility resulted in frequent staff absences and was seen as one of the barriers to taking more students, as was the absence of an in-house dedicated education coordinator position. Staff interviewed wanted any sort of training on offer (preferably local) and in particular mentor training and support to undertake Certificate IV in TAE. External debriefing and supervision and site visits by education partners were also suggested.

Aged care

Most hospitals have aged care departments, with small rural hospitals in the Hume Region having more aged care than acute beds, so much of the data obtained from these small hospitals also pertains to aged care. In addition, two private aged care facilities were surveyed. A third aged care facility did not currently take students because there was no structure in place for placements.

Both facilities used a two-tier supervision model, with the top tier being a senior nurse or unit manager, or a supervisor sent from the partner RTO, depending on the discipline being supervised. Training and qualifications represented across the facilities were leadership, mentorship and preceptor training, and Certificate IV TAE, with the most recent training being three years ago, outsourced to a training provider. Leadership training was accessed by some staff from the Aged Care Channel.

One of the main barriers to staff being released for training was the paucity of registered nurses, particularly those with university qualifications. The attitudes of some staff were an issue, with aged care work traditionally being seen as undemanding in terms of professional development and career progression.

More training in mentoring was wanted by all respondents and also refresher programs. In particular, a higher proportion of Certificate IV TAE qualified staff was considered vital, due to the stringent requirements set out by RTOs regarding the mix of students and preceptors and the minimum qualifications.

The facility without students wanted to put a structure in place, which would include training by their TAFE partner.

Mental health

Two area mental health services cover the whole Hume Region, providing inpatient, outpatient and community mental health services. A diverse range of disciplines undergo student placements in the mental health area.

A three-tier supervisory model is used. Supervising is voluntary and staff who choose to take a supervisory role are offered annual in-house and outsourced preceptor training and regular updates. One service was the recipient of SSG funding for preceptor training.

Good supports for supervisors were evident and included a multi-disciplinary education committee, monthly preceptor meetings and trouble-shooting sessions. Whilst able to access training through their partner large hospitals, most of it is considered unsuitable for the mental health specialty and targeted training is accessed through the North-East Victoria Innovative Learning (NEVIL) cluster. This is a consortium of seven public mental health services in the eastern and north-eastern region of Victoria, which provides education and training to this sector.

A heavy clinical workload is the main barrier to release for professional development, particularly in inpatient units. Reluctance of some community mental health nurses to supervise students was reported and it was suggested that more recognition for supervisors who take on the extra load might increase willingness of some practitioners to take students.

A perceived lack of guidelines for student assessments and giving negative feedback was exacerbated by the wide range of differing disciplines undergoing placement in the mental health area, from four main education providers.

Therefore, educators at the two services wanted, as a priority, training and support in appraisal tools and competency assessment and in giving feedback to students.

PDRSS

Four PDRSS organisations were surveyed, providing a snapshot of the sector. The services are each structured and function differently but share similar issues and requirements.

Two services had local organisational support and a structured education model. At these services, all staff act as supervisors, and all had been provided with training ranging from mentoring to Certificate IV in TAE. Training was provided by their parent organisations in Melbourne, or locally. For some there was a career path in place whereby student supervision training lead to staff supervision, which is on a higher level and pay rate within the organisation. As well as general organisational support, local social work networks and NEVIL provided support and training.

Clinical placements and training at the two other services were coordinated through their head office in Melbourne and student assessments were performed by visiting university staff. Those interviewed were unaware of supervisors having received any preceptor training, or of any local support networks such as NEVIL. Support was provided by regular team supervision meetings but supervisor training was not on top of the priority list.

The main barrier or issue referred to by all four services was that of the distance and time required to travel for training and the absence of backfill. Lack of awareness of the benefits of preceptor training and no career paths or local support networks were related to the structure being one of remote management.

Those interviewed wanted local training, funded by a partner university or government department and possibly coordinated by a local network such as NEVIL or other discipline-specific networks. The preferred content was to include assessment, a general exploration of the role and of the time commitment involved in taking students, and delivered in a mix of modes.

Other supports suggested were online forums or chat rooms and due recognition and recompense. A qualification allowance for preceptor qualifications, or higher status when taking students, was suggested, along with supervision being written into the job description.

Government departments

Two government departments which took allied health students on placement were surveyed.

At both agencies, allied health practitioners acted as preceptors in a multidisciplinary model and a clinical placement coordinator oversaw placements and provided in-house support and training for practitioners. Some supervision education had been provided by partner universities. The lack of available regional training was a barrier to adequate supervisor education, due to the need to travel, thus taking practitioners away from clients.

Those interviewed would welcome mentor or preceptor training, preferably accredited, including refresher training, in any mode and in partnership with universities, according to discipline.

Other suggested supports were online links and resources, remuneration to backfill positions, membership and access to libraries and resources and invitations to hear guest speakers at universities.

Medicine

General practitioners, practice nurses, practice managers and conjoint university lecturers were interviewed or completed an emailed survey.

Medical student training follows an apprenticeship, or single-tier model, in both the hospital and general practice setting, although a second-tier coordination level exists in most settings. Medical education is provided in the Hume Region principally by two universities, each using a different model and can be grouped into two settings and four cohorts.

General practice

In the Rural Health Module, all medical students are required to do two weeks in rural GP training.

GP placement students are required to spend five weeks in a general practice in any location, in addition to their compulsory two-week rural placement.

One university connects medical students with a primary supervisor, who may be a GP, practice nurse or allied health practitioner, or in some cases a shared role. The interdisciplinary model is encouraged and in some locations is a necessity due to a shortage of available supervisory doctors. This university offers an annual half-day preceptor workshop to all supervisors and an annual tutor training day in Melbourne, for GP supervisors.

The other university selects general practitioners who show an interest in teaching, and have many years' experience. No formal supervisor training is provided. The university provides a manual and an assessment tool.

Hospital and community health setting

In the Extended Rural Cohort, students spend three semesters at a rural hospital and two semesters in rural community settings, such as community health centres and allied health practices. Medical registrars provide apprenticeship-style supervision.

Supervisors receive a half-day orientation at the beginning of the intake.

In the Murray to the Mountains program, medical interns are supervised by interested GPs.

Quarterly GP supervisor workshops are provided by Bogong Regional Training Network. At least three workshops per year need to be attended to become an accredited supervisor and to continue accreditation.

Additional incentives for GP supervisors include a federal government stipend for taking students, and registration as a conjoint university lecturer. Conjoint university appointments, while not remunerated, bring with them a title and the use of library and other resources.

Despite the existence of highly coordinated supports offered to GP supervisors, it was reported that some GPs never attended the optional training, due to being badly timed and, being in Melbourne, too far away.

The main issue for GP supervisors was the pressure placed on doctors by the increased numbers of students through the extended rural cohort. Taking on a supervisory role was seen as a recruitment strategy but concerns were expressed that overloading with students may deter some doctors, particularly if the strategy to

recruit a partner or replacement does not work. Some doctors felt that the government stipend was not enough. Stretched resources also created more competition between the lead universities.

Although training is available to supervisory practice nurses, those interviewed were not aware of any supervisor training offered to them and reported very little other support from partner universities and TAFEs. Supervisor education and support for nurses and allied health workers at hospitals where medical students train is in-line with that provided for supervision of all other disciplines and varied according to the location, as outlined in the previous sections.

Suggestions for improving the pressure on GP supervisors included taking steps to increase willingness to supervise, for example by requiring that new facilities and practices should establish a commitment to teaching as a pre-requisite. Linking training to accreditation, such as in the Murray to Mountains program, was seen as additional reward and incentive.

Practice nurses wanted site visits from partner universities before students arrive. To help with the medical student orientation, it was suggested that training for practice nurse supervisors could be coordinated through the GP divisions.

Review of professional development options

Many Victorian and interstate education providers place students in the Hume Region. The lead education partners were identified and surveyed and professional development options available to clinical staff were explored.

The training provided to supervisors in the Hume Region was reported by educators to be variable across and between education providers, campuses and disciplines. All nursing and allied health educators agreed that it was ad hoc and fragmented, while medical educators described their provision as well-coordinated.

Approaches to preceptor training, when undertaken, included occasional training to several smaller hospitals at once, or offering training only to major partners yearly or per semester. Larger health services sometimes had several different education partners providing training, with no sharing or cooperation between them.

All education providers reported the ability to offer courses and modules covering the breadth of skills and attributes suggested in HWA's Competency Framework. However, very few provided them on a regular basis, but in response to requests.

Universities

Progression towards a graduate certificate, diploma or master's degree was available through some universities, but there was little or no support for interested educators to do so. Training consisted of short workshops, which are not accredited but provided participants with a certificate of attendance.

For most universities, financial, distance and time constraints affected the amount of education and the levels of support offered. Education providers were able to provide some support by telephone.

Poor communication pathways were evident, with universities commenting that CPPs didn't seem to know when to ask for help, while the university didn't always know what the CPPs wanted. For example, whereas many of the CPPs wanted more support with marginal students, the universities despaired that they were not notified of such issues until it was too late to put effective strategies in place. Educators recognised that it is particularly important to reach the practitioners at the 'coal face' but suspected that manuals providing information about the course content and requirements of students while on placement were not disseminated to the supervisors.

With medical preceptor training, a highly coordinated system was reported by one university, which was co-located with a health service at two sites, thus immersing the health services in a philosophy of teaching and learning. Regular workshops were offered to medical supervisors, including an international preceptor training course, available to those with a funded academic appointment.

VET sector and other RTOs

RTOs offer preceptor training to their larger partners, and also provide in-house support and supervision to smaller facilities. The health services with their own built-in RTO have the advantage of a coordinated and well-supported educational program, resulting in self-sufficiency and the ability to match up their student and staff capacities.

In the VET sector, Commonwealth regulations governing health training and assessment clearly sets out the qualifications required by supervisors of students. The result is an approach which differs in some ways to that of universities and to some degree is more defined, whilst at the same time being more likely to limit capacity of organisations to take students. For example, enrolled nurse and allied health assistant students are required to be supervised by someone with a qualification at or above their course's level and to be assessed by someone with a higher qualification and who also holds a Certificate IV in TAE.

Cost constraints can affect the number of practitioners obtaining the Certificate IV in TAE, thus impacting on some facilities' capacity to take students.

The structure of the VET competency package allows for selection of relevant modules, which can then become the building blocks of an accredited qualification.

Online learning

Three online preceptor training courses were investigated. Online learning allows accessibility to education for supervisors, especially those in remote or rural areas, as well as being a low-cost option. The courses can be used as initial preceptor training, as part of a mixed mode of training, or for refresher education. Skype conferences and online resource kits are also available. Barriers to the uptake or success of this approach relate to personal learning styles, levels of motivation and dedicated time allowance for doing these courses.

An interstate program of interest to some CPNs runs facilitator workshops for groups of participants in their local area. It can be modified to suit the group's needs, and the training is supported by an online resource.

Conclusion

Supervisor preparation processes are in place in the Hume Region but there are many variables affecting its delivery. The findings of this report echoed many of those in Darcy's 2009 paper and in addition, highlighted issues affecting small rural settings and inequities in supports between disciplines.

Funding

Funding initiatives are required to be targeted at areas of need but there was evidence that front-line practitioners who could most benefit from supervision training, do not receive it. In an organisational culture of learning, all current and potential supervisors would be required to have at least a basic level of supervision training. Training programs should not be seen as a one-off stab but as the beginning of ongoing programs. Train-the-trainer models and a regular refresher schedule are some of the reported sustainable outcomes. Managers need to keep a register of staff training and documentation on the changes implemented and improvements noted, as part of quality improvement.

Models

Models consist of levels of responsibility. Where there is an educator at the highest tier of the model, there are more likely to be well-organised mechanisms and processes for preceptor training. This model occurs in larger, regional and subregional hospitals, private hospitals and medicine and sometimes, in smaller hospitals.

Sectors

Small health services across the region vary considerably in the way they organise education for supervisors, some using innovative models, and some struggling to provide any education or support to their staff. In some organisations education tends to be a low priority. Where CP coordination is managed remotely, and in the absence of connections to a local education network, training and support, if occurring, is likely to be missed.

Disciplines

Some disciplines and sub-specialities have grouped together to provide education and support, representation and advocacy, such as the NEVIL cluster, the Hume Region Nurse Educator Group, and GP divisions.

The nursing discipline is generally well-organised, and medicine is well-resourced, although some gaps and deficits have been identified.

However, support for allied health supervisors is less organised and their needs are less likely to be expressed, when often not represented at a CPP coordinator level and not supported by a regional educational network. With allied health students being scattered far and wide, usually in small numbers, support for supervisors from their partner university or TAFE can be scarce. The Allied Health Workforce Mapping Project (2010) made recommendations for the development of an allied health leaders council and an education network. The leaders council was set up, but the development of an education network is still in progress. Approaching supervisor education by discipline, in the absence of a strong allied health educators' network, would not benefit the disciplines in greatest need.

Training and qualifications

Irrespective of the model in use, the planning and preparation of the supervisor is critical.

At most facilities, at least some of the staff had had preceptor training. Higher education qualifications were concentrated in the large health services. Certificate IV in TAE was more common in hospitals with predominantly aged care.

Those least likely to have had training were those practitioners working in small rural hospitals, community health services, private allied health practices, PDRSS, and medical practice nurses. Some small rural hospitals and community health services relied on funded opportunities, such as those provided by SSGs, or by their regional education networks, if they belonged to one.

What do supervisors want?

The outcomes of training were without exception, positive, where success was measured in terms of staff confidence and understanding levels. All who were interviewed wanted more training, more often and local. The type of education and mode of delivery wanted by health services varied according to sector and discipline.

Health services want to have enough supervisors to go around. In aged care this is an increasingly growing concern due to the changing qualifications of workers in aged care and to industry requirements surrounding VET trained disciplines.

It is also important to have good quality supervision. The difference in quality of supervision between novice and experienced practitioners was noted, particularly by medical and allied health practitioners. However, it is recognised that supervisor training aims, in part, to assist the practitioner in translating theory to practice and relating to students as adult learners. These attributes and skills are not necessarily dependent on years of clinical experience.

Barriers and issues

For rural locations, isolation is one of the main constraining factors against supervisor education, with much training on offer being delivered at larger centres, often a distance away. With some education providers and other train-the-trainers not feeling it worthwhile to travel long distances for a few participants, the small rural sites have tended to miss out on training opportunities. It is these sites which are also more likely to be taking single students of different disciplines and from different educational institutions, thus compounding their difficulties. Videoconferencing and online options were seen as acceptable alternative modes of delivery.

The reluctance of staff to take students was a commonly cited barrier and could be a reflection on the culture of the health service. In a learning culture, supervision is considered to be core business and is supported at the highest level within health services. Some respondents were unaware that preceptor training was available and therefore did not know that they needed it.

Time for supervision and training was less likely to be factored in where there was not a supportive education structure. Whilst time for training was funded in some health services, and several shared the load in a team approach, backfill in effect was not provided. Release for training impacts on service provision. The smaller the facility, the greater the impact – this particularly applies to the aged care sector, which generally operate with a minimum of registered nurses. For private practitioners, time equates to money and was given as a reason for not taking students.

Another recurring theme was the need for perceptible benefits and recognition of the supervisor role. Negative attitudes towards students may be related to the lack of supports and reward offered. For most health practitioners it is not always enough incentive just to know that they are training the next generation. At the bare minimum, supervisors want to be thanked for their efforts. Elevation to a higher pay scale whilst supervising students has been suggested. For doctors, an associate lecturer position with its attached benefits and subsidies for taking students are an incentive and private allied health practitioners saw potential for a similar arrangement.

Sharing of resources

The sharing of resources in groups of common interests is a cost-effective and inclusive approach to ensuring good supports and education for supervisors. Resource-sharing was encouraged and was evident in the SSG funding grants, which linked health services together for the purposes of the grants. Interdisciplinary training is a strategy for maximising student learning in small sites with a mix of disciplines.

Large regional and subregional hospitals are the referral point for their catchments, and already have relationships with many other providers across sectors and disciplines. They also have stronger relationships with universities and TAFEs. Therefore, grouping by geographical areas, or catchments, for the purposes of coordinating training, is recommended. Recognition and inclusion by large services of all the small service providers in their catchment would change the existing situation where some isolated practitioners miss out.

All education providers have the ability to provide high-quality supervisor training. By forming a collaborative relationship with other providers, they would be able to relinquish the obligation to educate supervisors in far-flung corners of the region, instead concentrating their efforts in a designated geographical area.

The co-location of a university with health services is an example of the sharing of resources and further benefits from the existing model might be broader provision of preceptor training and support to include practice nurses and others working with medical students and allied health students.

The CPNs are accumulating a body of information and educational resources through the projects being undertaken, and these resources can be shared within and between CPNs.

With expanded settings for clinical placements, increased numbers of students, the development of a BPCLE toolkit and the proposed HWA Competency Framework, the time is right to put into place a consistent and coordinated supervisor education model, which includes recognition of prior learning and the sharing of resources across health services and the higher education system, inclusive of the VET sector. It is hoped that a quality driven calendar of training will replace the often ad hoc process that currently occurs.

Recommendations

Regardless of discipline, the basic building blocks of most supervision training teach the fundamentals of supervision. At a minimum, it is recommended that all supervisors have an introductory preceptor workshop, covering these basic skills. A survey or assessment tool, conducted at each current and potential CPP, could ascertain who needs introductory training. It is important to gain access to those sectors which in the past have been overlooked.

For those who progress beyond the novice supervisor level and wish to take it further, opportunities need to be available for them to further their education, so that they will be trainers and champions of supervisors in their workplace. Discipline-specific content is additional and complementary and can be provided by the networks already existing for nurses, mental health workers, and social workers, to name a few. GP supervisors are already well supported by the Rural Clinical School but practice nurses acting in supervisory roles should be included in the medical school's training programs.

All training providers reported the ability to tailor their courses to suit the setting, some even renaming the modules in order to suit participants' expectations.

Support from universities and VET sector

For staff with a particular interest in clinical education who would like to proceed to a graduate certificate or higher, there is a personal cost. Darcy states that universities have a responsibility for funding some training, for example in the form of scholarships and this potential should be considered when planning a pathway for supervisor education.

One of the most common requests by supervisors was for more support from partner universities and TAFEs. Preparation in the form of manuals, information sessions and workshops, provided before the placement, were suggested to overcome these issues, and form part of the BPCLE Framework's resources.

The four main education providers in the Hume Region have been approached to offer an introductory preceptor workshop to a group, with whom they will be partnered. Therefore every practitioner will come under the auspices of an education provider. The group may not correspond exactly with major partners but for the purposes of supervisor education, the programs will be similar and therefore applicable to all. The workshops will then be held in four strategic locations that are geographically accessible to all in the group.

Coordination of training

It has been shown that having a person with responsibility for education impacts directly on the training provided to staff. For small organisations without such an arrangement, help needs to be provided to assist with access to training and organising it.

It is recommended that a coordinator be appointed to set up groups or consortia, giving small facilities links to a large regional or subregional hospital with expertise, resources and processes already in place.

Proposed education pathway

This project showed that supervisors consistently wanted training in:

- Mentoring skills
- Assistance with remedial students
- Assistance with assessment tasks
- Knowledge of students' course and scope of practice.

It is recommended that these competencies be included in beginner supervisor training.

HWA's (2011) recommended core competencies can be used as a guide to structuring programs.

Any training offered should be a module in its own right, or part thereof, from one of the training courses available. These can then lead on to an accredited qualification, thus allowing for the development of and providing more incentive for, a career structure in clinical education for those wishing to pursue one. Credit transfer would be expected to occur between sections of the proposed pathway. A suggested pathway consists of six blocks.

Block One
<ul style="list-style-type: none"> • A one-day non-accredited preceptor training workshop • Offered one to two times per year across the Hume Region • Targeted at novice level supervisors <p>Minimum inclusions:</p> <ul style="list-style-type: none"> • Mentoring skills • Assistance with remedial students • Assistance with assessment tasks • Knowledge of students' course and cope of practice

On its own, Block One would give the participant professional development points. With additional training, this could articulate into Block Two or Three and become an accredited competency.

Block Two
<ul style="list-style-type: none"> • A one or two-day accredited supervisor skill set/advanced workshop • Targeted at semi-novice level

Blocks three and four can be delivered by other providers and other modes, for example, online or blended modes and be funded for those wishing to specialise by scholarships.

Progression towards a graduate certificate, diploma or master's degree is available through the partner universities and the Certificate IV in TAE through partner TAFEs. The possibility of those providers structuring their training in this manner could be explored.

- Block Three: Certificate IV in TAE
- Block Four: Graduate certificate level
- Block Five: Graduate diploma level
- Block Six: Master's level

Evaluation

Rigorous and transparent evaluation of any programs is required in order to streamline and improve on the model as necessary, and to make it sustainable. The frequency of novice-level training would decrease as competency becomes more widespread and continuous monitoring and development of the pathway would be required. An ongoing coordinator position created by the Hume CPN would ensure the continuation and progression of the pathway model.

Other supports

In the future, the resources at other universities and RTOs can also be utilised and included in a regional plan. Smaller specialised organisations can contribute specific components, for example cultural training. More co-location of universities and health services, with associated academic appointments for all disciplines, could be investigated.

Professional education networks which already exist should continue to support their members and it is recommended that an allied health regional educators group also be established. Discipline-specific professional development could complement the more general supervisor training program. Online chat rooms and resources, which already exist, should be promoted and included in the supervisory domain.

When allocating funding for training, allowances for release of staff for training and for supervising students, need to be included. Recompense in the form of higher pay for supervisory time is also recommended, and the development of reward and recognition processes and scholarships could also be a part of the regional strategy.

References

Darcy and Associates (2009) Best Practice Clinical Learning Environments within Health Services for Undergraduate and Early-Graduate Learners Final Report, Feb; www.health.vic.gov.au/vcpc/resources.

Darcy and Associates (2010) Hume Region Clinical Placement Network Workshop Report; www.health.vic.gov.au/vcpc/resources

Department Of Health (2009) Clinical Placements Scoping Projects – Summary of Findings and Related Policy Initiatives; www.health.vic.au/workforce/placements/data-and-planning/scoping-projects

Department Of Health (2009) Student Supervision Grants Successful Agencies 2009; www.health.vic.gov.au/_data/assets/pdf_file/0004/408352/Website-CSG-Successful

Department of Health (2010) Allied Health Workforce Mapping Project, Hume Region; www.health.vic.gov.au/workforce/rahworks

Department Of Health (2010) Student Supervision Grants Successful Agencies 2010; www.health.vic.gov.au/_data/assets/pdf_file/0004/408352/Website-CSG-Successful

Gleeson, D (2011) Hume Clinical Placement Network Update, Power Point Presentation, Moira Health Service Forum, October 5.

Health Workforce Australia (2010) Clinical Supervision Support Program Discussion Paper, July; www.hwa.gov.au

Health Workforce Australia (2011): Clinical Supervision Support Program Directions Paper, April; www.hwa.gov.au.

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- Wodonga TAFE
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Abbreviations

BPCLE	Best Practice Clinical Learning Environments
CHS	Community Health Service
CPN	Clinical Placement Network
CPP	Clinical Placement Provider
GP	General Practitioner
HWA	Health Workforce Australia
NEVIL	North-East Victoria Innovative Learning
NGO	Non-Government Organisation
PCA	Personal Care Attendant
PDRSS	Psychiatric, Disability, Rehabilitation and Support Services
RTO	Registered Training Organisation
SSG	Student Supervision Grant
TAE	Training and assessment
TAFE	Technical and Further Education
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VET	Vocational Education and Training
VHA	Victorian Healthcare Association