DWECH Clinical Placement Partnership

Clinical Supervision Handbook

For Supervisors of Students on Clinical Placement

Dhauwurd Wurrung Elderly & Community

Health Services Inc.

Heywood Rural Health,

Winda Mara Aboriginal Co-operative,

Portland District Health,

Guardian Pharmacy

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Acknoweldgement is also given to the authors of documents used throughout this Handbook, please refer to footnotes.

Best Practice Clinical Placement Learning Framework[[1]](#footnote-1)

This framework, developed by the Victorian Department of Health, underpins the DWECH Clinical Placement Partnership.

The Best Practice Clinical Learning Environment (BPCLE) Framework provides a guide for health services and training providers to coordinate and deliver high-quality clinical placements for health students.

There are six key elements of high-performing clinical learning environments identified in the BPCLE Framework:

* 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.

**Principles that underpin the framework and the DWECH Clinical Placement** **Partnership:**

Principle 1:

Patient (or client) care is an integral component of quality clinical education.

Patients/clients are central to the process of clinical education and are the most valuable

resource in a clinical learning environment.

Principle 2:

Learning in clinical environments is an essential component of training all health

professionals.

Principle 3:

Registration, accreditation or competency standards set down by professional

bodies (where these exist) are the appropriate mechanism for ensuring that clinical education arrangements meet minimum standards for educational or training outcomes.

Principle 4:

Many different models of clinical education and training exist and successfully

produce health professionals of required competency and standard.

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Section 1: ROLE AND RESPONSIBILITES

**Clinical Placement Partnership Student Co-ordinator**

The role of the Clinical Placement Partnership Student Co-ordinator Student Co-ordinator (CPPSC) is to complete all necessary pre-placement requirements with education providers and clinical placement settings including:

* Relationship agreements with education providers
* Student placement scheduling across settings
* Informing each setting about the placement schedule
* Ensuring student safety checks have been sighted[[2]](#footnote-2) eg police checks, immunisation
* Direct students to accommodation[[3]](#footnote-3)
* Confirming that clinical supervision arrangements meet education provider requirements
* Confirming assessment expectations, arrangements and timelines with Clinical Placement Setting Student Liason Officer/sfor each placement
* Completing student and placement statistical reporting to the Department of Health.

The CPPSC will make contact with the student liaison officer in each setting prior to the commencement, during and on completion of placements and is a person who may be contacted if there are concerns, queries or problems about a student during placement.

The Clinical Placement Partnership Student Co-ordinator is Elizabeth Munro and she may be contacted by phone on 5521 0627 or emailed at [EMunro.pdh@swarh.vic.gov.au](mailto:EMunro.pdh@swarh.vic.gov.au)

**Student Liaison Officer in each setting**

Each setting needs a contact person to liaise with the student on a daily basis as well as the Clinical Placement Partnership Student Co-ordinator.

The role and responsibilities of the Student Liaison Officer required in each setting includes:

* Welcoming students to the work environment
* Confirming expectations
* Explaining procedures and time frames eg breaks
* Orienting students to
  + staff and facilities
  + emergency procedures
  + manual handling and infection control
  + Make organisation values and expectations of the students’ behaviours clear
  + Confirming learning goals with the CPPSC
  + Confirming learning goals with the student

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**Supervising Clinician in each setting**

All students are aligned with a Clinical Supervisor at their placement setting.

Video conferencing facilities may be used to connect students back to their education providers for continuing education or special meetings. If video conferencing is used for supervision, this is only by agreement between the education provider and the Clinical Placement Partnership Student Co-ordinator.

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| The role and responsibilities of the Supervising Clinician in each setting includes:     * Confirming expectations * Equipment relevant to placement * Documentation expectations * Confirming learning goals with the student * Allowing time for learning goals and assessment * Student assessment such as when, where, how. |

In some settings, the Supervising Clinician may also perform the role of the Student Liaison Officer.

**Education Providers**

All communication to the Education Provider is undertaken by the Clinical Placement Partnership Student Co-ordinator.

Section 2: SUPERVISION- Definition, Function and Purpose

**What is supervision?**

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| **Supervision has been defined as** The oversight, direction, guidance and/or support provided to an employee by the health professional responsible for ensuring such an employee is not placed in situations where he/she is required to function beyond his/her level of educational preparation or competence.Direct Supervision - Is provided when the registered health professional is actually present, observes, works with and directs the person being supervised.Indirect Supervision - Is provided when the registered health professional works in the same facility as the supervised person but does not constantly observe his/her activities. The supervising health professional must be readily accessible.The supervising health professional remains accountable for the actions of the person under indirect and direct supervision. Nurses Board of Victoria (2007) |

**The purpose of clinical supervision[[4]](#footnote-4)**

Supervision is a ‘relationship based activity which enables practitioners to reflect upon the connection between task and process within their work.’

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| The purpose of clinical supervision is to ensure:   * delivery of high quality patient care and treatment through accountable decision making and clinical practice * facilitation of learning and professional development * promotion of staff wellbeing by provision of support. |

Supervision facilitates:

* acquisition of skills and knowledge
* reflective practice
* development of professionalism
* confidence and competence in clinical practice
* professional growth and development.

Supervision of clinicians has been identified as a national priority by Health Workforce Australia (HWA) as evidenced through the development of a National Clinical Supervision Support Framework and the Clinical Supervision Support Program[[5]](#footnote-5) (HWA 2011a; HWA 2011b). Contributing to the professional development of health professionals can be one of the most rewarding parts of a senior clinician’s job.

**Functions of supervision[[6]](#footnote-6)[[7]](#footnote-7)**

Supervision comprises a number of different functions. Kadushin’s model of supervision outlined three functions: educational, supportive and administrative[[8]](#footnote-8).

**Educational -** development of each worker in a manner that enhances hir or her full potential.

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* Providing knowledge and skills
* Developing self-awareness
* Reflecting on practice
* Integrating theory into practice
* Facilitating professional reasoning.

**Supportive** - maintaining harmonious working relationships with a focus on morale and job satisfaction.

* Dealing with job-related stress
* Sustaining worker morale
* Developing of a sense of professional self-worth.

**Administrative** - promoting and maintaining good standards of work, including ethical practice, accountability measures and adhering to policies of administration.

* Clarification of roles and responsibilities
* Work load management
* Review and assessment of work
* Addressing organisation and practice issues.

SECTION 3: BEING AN EFFECTIVE SUPERVISOR

**What makes an effective clinical supervisor?[[9]](#footnote-9)**

Many supervisors report that they simply do not have the time to actively supervise staff in the way that they would like. This is a real problem with no easy solutions. However even small changes in how supervisors organise their clinical duties can make big differences to the effectiveness of supervision.

Time spent actively supervising students is rewarded in two ways. The first is that active supervision improves staff performance, which saves time and enhances patient care. The second is that supervisors who increase their involvement with staff tend to report higher levels of job satisfaction, as playing a leading role in the development of health professionals is personally rewarding. It builds better team interactions and contributes to self-esteem for all involved.

In order to provide high quality supervision, there are a number of skills which supervisors should ensure they actively focus on developing:

**Supervisory skills**

Being available: This is the big one! Students appreciate receiving advice from their

supervisor when they encounter clinical situations beyond their current ability.

Being aware: Supervisors should know what level of supervision is necessary for safe

practice. They anticipate red flags and should be ready to respond if necessary.

Being organised: To make the most of the limited time available, it is important for a

supervisor to be organised. This includes prioritising time for structured supervision

sessions.

**Personal skills**

Empathy: Do you remember what it was like to be a student ? A good

supervisor uses insight and understanding to support students.

Respect: Showing respect for students and others promotes positive working

relationships. This should occur regardless of individual differences and levels of

experience.

Clarity of expectations: A common problem for students is uncertainty about what their

supervisor thinks or wants. Clear expectations and honest feedback from supervisors is

highly valued.

Confidentiality: Students are more open and honest about errors or lack of capability if they

can discuss these matters in confidence with their supervisor.

A motivating and positive attitude: Most people respond best to encouragement, and

feedback is more effective if framed in constructive terms.

Ability to reflect on practice: A supervisor who is able to reflect on their own practice

provides a valuable role model for supervisees.

Teaching skills: In order to be an effective teacher it is important to invest in your own

professional development to enhance teaching skills.

**Barriers to effective supervision**

It is important to identify the components which do not contribute to high quality supervision and

address these where possible:

Being absent or unavailable: Limited or no supervision and/or a lack of access to a supervisor

is ineffective and creates anxiety amongst students. It also has a direct impact on the delivery of high quality and safe patient care.

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Being rigid: Setting rules without giving reasons or giving instructions without an explanation does

not contribute toward a positive supervisory relationship. This is not to say that supervisors

have to explain everything all the time, but there has to be time for explanations.

Intolerance and irritability: This leads students to avoidance (eg, hiding errors and gaps in their capability).

Telling instead of coaching: This can lead to students feeling unsupported and unable to develop their skills within the context of their learning styles and education needs.

Having a negative attitude or “blaming”: Publicly criticising the student’s performance or seeking to humiliate the student leads to adverse relationships.

Not managing students in difficulty: There are many reasons for suboptimal performance,including poor orientation or poor supervision. Not supporting students in difficulty has a direct impact on the quality of clinical placement outcomes.

**Useful Tips – Being an Effective Supervisor** [[10]](#footnote-10)

* Allow the learner to observe your practices and explain your actions in order to learn the ‘how to’ of being a health professional
* Validate the learner’s skills – provide feedback and enable behaviour reinforcement and behaviour change
* Guide and direct the learner – high levels initially that decrease as the learner’s skill level increases
* As the learner progresses, allow them to take on more independent responsibilities
* Facilitate learning opportunities
* Support and promote the learner’s problem-solving and decision making skills
* Assist with orientation
* Facilitate a positive learning environment
* Be a clinical role model
* Be a professional role model
* Support the learner’s decision to become a health professional.

A useful statement to conclude with in a seperate box. 'It is not your responsibility to demonstrate someone else's competence' (Kaye Knight p. 21)

Section 4: STUDENT ASSESSMENT

Student assessment needs to:

* Be part of the complete learning plan
* Be undertaken with someone who has a relationship with the learner and understands the clinical context
* Involve the learner
* Promote self assessment
* Be completed in an appropriate physical setting
* Be fair and based upon evidence.

**Collecting Evidence for Student Assessment[[11]](#footnote-11)**

# Direct Evidence

### Observation of actual performance

Including general practice and set tasks requiring assessment in real work conditions e,g, drug round

### Demonstration of set tasks/skills

* Actual performance but not under real work conditions e.g. practice IV set up
* Questioning can occur during the demonstration

### Simulations

e.g. practice cardiac arrest response & CPR

### Products

Things people make/create e.g. wound dressing, bandaging

### Data Response

Involves interpreting, responding or manipulating gauges, data & technical equipment e.g. performing and ECG and interpreting the tracing, setting up/changing an IVAC/syringe pump, preforming a BSL and interpreting result.

**Indirect Evidence**

### Work Records

Audit care plans/care maps, documentation and progress notes

### Training Records

Credentials, certificates, licences e.g. ECG/Epidural course

### Testimonials

Interview/ask colleagues and clients to collect data regarding outcomes of interventions

### Questioning

Identifying knowledge through oral quizzing, or paper testing e.g. drug calculation, multiple choice, short answer questions, case studies

### Interviewing

Interview the learner to reveal their intentions and attitudes

### Performance Appraisals

Self appraisal and past performance reviews

### Reflective journal/ Journal of practice

Personal documentation by the learner of experiences during the shift and the significance of the same. Key competencies can be reflected within the learner’s descriptions and reflections

**Useful tips – Developing Learning Goals[[12]](#footnote-12)**

Every clinician should have an individual learning plan with specific learning objectives detailing what it is they are working towards. This provides a framework for learning and a reference to reflect upon in subsequent supervision sessions and (if appropriate) during assessment.

When developing learning goals, the supervisor needs to ensure that appropriate educational objectives reflect the activities and clinical context of the supervisee.

Learning goals should be documented and retained in the supervision record. They should be regularly reviewed and updated in line with the acquisition of skills and knowledge as the clinician develops.

Learning goals should be SMART: ie they should be Specific, Measurable, Achievable, Realistic and Timely

SMART

Goal must be well defined, clear and unambiguous.

What do you want to accomplish?

Why?

Who will be involved?

Where will it occur?

MEASURABLE

Define a criterion for measuring progress toward the goal.

How much?

How many?

How will you know when you have reached your goal?

ACHIEVABLE

Goal must be achievable.

How will your goal be achieved?

What are some of the constraints you may face when achieving this goal?

RELEVANT

Goal needs to be relevant.

How does the goal fit with your immediate and long term plan?

How is it consistent with other goals you have?

TIMELY

Goal should be grounded within a timeframe.

What can you do in 6 months from now?

What can you do in 6 weeks from now?

What can you do today?

**Useful tips –Questioning for Student Assessment [[13]](#footnote-13)**

What is effective questioning?

Questioning is an important tool for feedback and assessment. It is important to be aware of the effect that our questioning can have on the learner.

The following tips on questioning can be used to determine a student’s knowledge and understanding and can be used to gather evidence of this knowledge and during the feedback process:

Effective questioning can be used to:

* Arouse interest & motivate students
* Check comprehension & knowledge base
* Diagnose a students strengths & weaknesses
* Encourage discussion
* Direct students to alternative possibilities with problem solving
* Build a students self concept
* Assist in relating theory to practice
* Encourage the student to think more deeply or laterally
* Evaluate both the student’s and your performance
* Encourage the student to evaluate their own performance

Questioning Techniques

* **Pausing**

Allow 3-5 seconds for a student to respond (this allows for thinking time) before you use one or more of the following techniques (in no particular order).

## Prompting

If a student does not respond or only partially answers an initial question, a visual or verbal cue or an encouraging remark may prompt further response.

## Rephrasing

If a student does not understand a question, rephrase the question in a form they will understand - clarify the meaning of the question.

* **Asking supplementary questions**

If students give answers that are inadequate, expressed ambiguously or too restricted in focus, further questions may help them to clarify their thoughts and prompt them to explore other perspectives.

* **Providing additional information**

The student may be lacking a key item of information to answer correctly. Provide extra information to help lead them to the answer rather than providing the answer yourself.

* **Encouraging students to hypothesise**

Encourage students to make intelligent guesses if they are not sure of the answer. This encourages students to apply their knowledge to new situations.

## Repeating

Occasionally you may need to repeat a question and emphasise key words

**Useful tips – Student Assessment[[14]](#footnote-14)**

* Ascertain the student’s knowledge base early, identify areas of concern and work with the student to develop a learning contract
* Keep a diary of your observations to support your assessments
* Spend time with each student in the clinical area to observe his or her practice. Plan to assess a particular task with each student every day
* Get the student to regularly hand over their patients to you to explore their understanding and knowledge
* Develop a learning contract in line with the individual learner, workplace and education provider requirements. This will require setting learning objectives with the student and discussing how to meet them over the placement
* Consider the experience level of the student, prior learning experiences, goals, purpose of the placement and personal attributes
* Ensure assessment is fair, reliable and following education provider expectations
* Strategic questioning can help clarify overall impression of student performance
* Go through the clinical assessment tool and verify the student understands
* Feedback should be succinct and prompt, including praise and constructive criticism
* Feedback needs to be given with examples of practice from the learner to help them understand
* Organise small group assessments so students can learn and support each other
* Conduct formative assessment halfway through to focus on skills or behaviours that need to be developed
* Students can assess themselves. This will give a good idea of the student’s insight into his or her learning needs
* Make sure the students plan to involve you in their learning, such as planning a time to assess observations or planning a dressing around physio or meal times. This helps to develop organisational skills.

Section 5: GIVING EFFECTIVE FEEDBACK

Feedback is an essential component of supervision and must be clear so that the student is aware of his or her strengths and weaknesses and how they can improve.

The Easy-To-Read Guide to Giving Feedback[[15]](#footnote-15)

|  |  |
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| **Sequence** | **Explanation** |
| **1. "When you..."** | Start with a "When you..." statement that describes the behaviour without judgment, exaggeration, labelling, attribution, or motives. Just state the facts as specifically as possible. |
| **2. "I feel..."** | Tell how their behaviour affects you. If you need more than a word or two to describe the feeling, it's probably just some variation of joy, sorrow, anger, or fear. |
| **3. "Because I..."** | Now say the way you are affected that way. Describe the connection between the facts you observed and the feelings they provoke in you. |
| **4. Pause for discussion** | Let the other person respond. |
| **5. "I would like..."** | Describe the change you want the other person to consider. |
| **6. "Because..."** | ...and why you think the change will alleviate the problem. |
| **7. "What do you think?"** | Listen to the other person's response. Be prepared to discuss options and compromise on a solution. |

**Example**

"*When you* are late for meetings, *I get* angry *because* I think it wastes the time of all other team members and we are never able to get through our agenda items. *I would like* you to find some way of planning your schedule that lets you get to these meetings on time. *That way* we can be more productive at the meetings and we can all keep to our tight schedules."

**Useful Tips – Giving Feedback**

Acknowledge the need for feedback

* Feedback is vital to any student and clinician committed to improving
* Feedback skills will help you communicate effectively, improve meetings, and improve interactions between members.

Give both positive and negative feedback

* People will more likely pay attention to your complaints if they have also received your compliments

Know when to give feedback

* Consider more than your own need to give feedback
* Constructive feedback happens only within a context of listening to and caring about the person
* Do not give feedback when:
  + You do not know much about the circumstances of the behaviour
  + The feedback is about something the person has no power to change
  + The other person seems low in self-esteem
  + The time, place, or circumstances are inappropriate.

Know how to give feedback

* Be descriptive
  + Be objective and give specific, recent examples.
* Don't use labels
  + Be clear, specific, and unambiguous
  + Describe the behaviour and drop the labels.
* Don't exaggerate
  + Be exact
  + The receiver will argue with the exaggeration rather than the real issue.
* Don't be judgmental
  + Don't use words like "good," "better," "worse."
  + This invites the receiver to respond as a child since you are using the words of a controlling parent.
* Speak for yourself
  + Don't refer to absent, anonymous people
* Encourage others to speak for themselves
* Talk first about yourself, not about the other person
  + Say, "I appreciate your coming to meetings on time," not "You are very prompt for meetings."
  + This creates a peer relationship, not a ranked relationship.
* Phrase the issue as a statement, not as a question
  + Questioning can be controlling and manipulative.
* Restrict your feedback to things you know for certain
  + Don't present opinions as facts.
* Help people hear and accept your compliments when giving positive feedback.

Know how to receive feedback

* Listen carefully
* Ask questions for clarity
* Acknowledge the feedback
* Acknowledge valid points
* Take time to sort out what you heard.

# SECTION 6: Working with Aboriginal and Torres Strait Islander people

The impact of colonisation is vivid in the minds and lives of many Aboriginal people. Therefore, it is always important to remember that to some Aboriginal people, professionals working for the government are viewed with caution, no matter how friendly they appear. Extablishing rapport and establishing credibility is extremely important

# Cultural Respect - 3 important things to know about Aboriginal people and culture

* A one size fits all approach will not work when working with Aboriginal people.
* Family is very important to Aboriginal people and play an important role in obligations and decisions.
* It may take time to establish trust and rapport based on previous experiences of self/family with agencies

A lack of cultural respect can act as an overwhelming barrier, as without cultural respect it is impossible to overcome any other barriers. Cultural respect can determine the way services present and conduct themselves and as a result can determine the effectiveness of a service.

When working with Aboriginal communities, it is important to display a certain level of respect and understanding of Aboriginal culture. This does not mean you have to know everything about Aboriginal languages, belief systems, and cultural practices.

Cultural respect is being aware that Aboriginal culture differs from non- Aboriginal culture and that this culture may impact on the way that health and illness is experienced.

**Language**

Don’t assume that your meaning will be clear to everyone you talk to. People may not understand you because:

* Of the numbers and words you say or give in written information, try using visuals
* Jargon, accronyms and technical words may be confusing

Medical terminology can act as a real challenge and as for many lay people information needs to be stated simply and clearly. It is important not to assume that somebody has understood what has been said simply because they have said “OK, that’s fine” or something similar. People are often too embarrassed to admit that they don’t understand something ie “shame”.

It is often helpful to ask “Tell me what you understand by what we have discussed or what I have said so far”

Using too much medical terminology also creates more of a power imbalance and helps to make people feel inadequate. Many Aboriginal people who walk into a service are very aware of the power imbalances. Due to Aboriginal history and the continued discrimination, Aboriginal people often feel unequal to service providers. This is particularly true if the service provider is non-Aboriginal

**Listening**

Listen without interruption or stereotyping .

Often, Aboriginal and Torres Strait Islander people will want to fully explain their position to you and this can take time. Being attentive and patient during your conversations will help to establish a good relationship and build trust.

In situations where communication is sensitive or tense, it can help to paraphrase and show empathy, summarise and repeat what they have told you. By doing this you signal that you are serious about their views and that you are trying hard to understand their situation.

When introducing a new idea, watch for the response this may be conveyed with silence. Allow people time to think about the idea and for them to discuss it informally with others.

Remember, Yes is Not Always 'Yes' Aboriginal people may attempt to placate an angry or pushy person by either ignoring or agreeing with everything they want even they though they feel no obligation to fulfill any of the commitments made. In this situation - yes doesn't always mean yes, but simply a method for getting rid of you without offending

**Promises**

Never make any promises you can not deliver.

If necessary, explain carefully the constraints within you work. Be aware of what these constaints are in your role as a student in the organisation.

**Understanding Family**

Understanding structures and concepts that exist in Aboriginal families and communities is important in building relationships. Aboriginal people have strong family values. The family system has an extended family structure, as opposed to the nuclear or immediate family structure which is common in Western society.

The concepts of extended family and ‘community as family’ in Aboriginal communities encompass the idea that children are not just the concern of the biological parents, but of the entire community.

‘Sorry times’, funeral and personally paying respect to the family of the deceased person are taken seriously

Family is very important to Aboriginal people and in many instances will be most important thing at certain times eg times of mourning.

**Shame**

The loss of personal dignity eg being singled out in front of peers for criticism, praise of being laughed at will cause some individuals to suffer “ shame”. Barriers to effective health services for Aboriginal people are often intertwined. For instance, both *shame* and *communication* can be identified as barriers to accessing services for sexual health concerns.

*Shame* may act as a barrier in itself, in that shame may stop an Aboriginal person accessing a service altogether. However, an Aboriginal person may in fact access a service but due to shame that person may not clearly communicate the concern, or the service provider may not be skilled in a way that allows for culturally appropriate and respectful communication around shame issues. Therefore, *shame* and *communication* combined stop effective service delivery from taking place.

Shame is also linked with issues of confidentiality. For service providers, maintaining confidentiality is of utmost importance. If there is a breach of confidentiality, or even a perceived breach, gaining trust from the Aboriginal population and encouraging them to continue to utilise the service will be extremely difficult, if not near impossible.

# Medical Terminology

Using too much medical terminology also creates more of a power imbalance and helps to make people feel inadequate. Many Aboriginal people who walk into a service are very aware of the power imbalances. Due to Aboriginal history and the continued discrimination, Aboriginal people often feel unequal to service providers. This is particularly true if the service provider is non-Aboriginal. The use of medical terminology risks enhancing that feeling or perception

**Written Health Information ….. visuals can help for effective education**

Additional written material can often assist in communication, particularly if people are finding verbal communication difficult. Printed resources, flyers and visual aids can be of great assistance for encouraging understanding and awareness, or as an aid to explain something more thoroughly. For example, you could use a poster of a body and point to body parts.

Written material for clients to take home can be helpful, as taking in everything at once may prove too difficult.

When putting together written resources for Aboriginal people it is important firstly to make them culturally appropriate, and secondly, to take into account people’s varying reading and general literacy abilities. For example, a poster or diagrams may be more effective if it comprises more pictures than words.



For the full illustrated presenation of how kidneys function to kidney disease and vascular education refer to go to <http://www.kidney.org.au/LinkClick.aspx?fileticket=XCmf0Y1A9is=&tabid=770&mid=1848> and http://www.kidney.org.au/HealthProfessionals/IndigenousResources/tabid/770/Default.aspx

**Men’s and Women’s Business**

In some Aboriginal communities, some health issues are classified as either “men’s business” or “women’s business”. The Gunditjmara Nation people of south west Victoria are an example where “men’s and women’s business” is respected. For this reason, Aboriginal Community Controlled Health Services in this area have both male and female Aboriginal Health Workers and Hospital Liaison Officers.

Accommodating this cultural value can be one of the most difficult problems facing service providers. Obviously time and resource restrictions, play a big part in being able to meet this cultural need.

Suggestions to consider:

• Where possible, offer an Aboriginal person the opportunity to see either a male or female worker.

• If a choice of male or female worker is not possible, explain this to the client and ask them whether they would prefer to be referred elsewhere. A gender specific Aboriginal Health Worker or Hospital Liaison Officer may be able to assist the clinician.

# Aboriginal / non-Aboriginal Workers

In addition to seeing a health care worker of the same gender, some people believe that Aboriginal people only want to see an Aboriginal worker. This, however, is highly contested. Some service providers believe that Aboriginal people only want to see an Aboriginal worker as they feel that they, and their cultural values, are better understood in such a situation. Others, however, have said that Aboriginal people often don’t want to see an Aboriginal worker, as they have the fear of that person then knowing “their business”, and the fear that this information might then make its way back to their community.

Whether or not an Aboriginal patient would prefer to see an Aboriginal service provider is a personal preference and impossible to know without asking.

Suggestions to consider:

• Where possible, offer any Aboriginal people the option of either seeing an Aboriginal or non- Aboriginal service provider.

• If a choice of an Aboriginal or non-Aboriginal worker is not possible, explain this to the client and ask them if they would prefer to be referred elsewhere

• If for example you only have a non-Aboriginal worker at the service, is it possible to make links with another service that has an Aboriginal service provider who may be able to assist when needed?

. Contact the local Aboriginal Community Controlled Health Service or Aboriginal Hospital Liaison Officer

# Service Specific Innovation for Cultural Safety

## Accident & Emergency

* Ensure front of staff have respectful disposition toward Aboriginal people
* Provide staff with Aboriginal self identification training and when positive offer linkages with Aboriginal Hospital Liaison Officer as described in the hospital policy manual
* In life threatening emergency situations, some Aboriginal people may reject “western medicine” for the demands of “spiritual guides” .
* Experiences of Aboriginal people may include seeing spirits or hearing voices of deceased loved ones. When this occurs contact the Aboriginal Hospital Liaison Officer or next of kin to assist to assure cultural safety for the patient “Next of Kin” can be extended beyond the “immediate family” in an Aboriginal context.

# Sexual & Reproductive Health and Continence Services

The spread of blood borne and sexually transmitted diseases, including HIV and AIDS is largely preventable and is a key focus in improving the sexual health of Aboriginal and Torres Strait Islander people. The National Aboriginal Health Strategy, the 3rd National AIDS Strategy and, more recently, the Indigenous Australians' Sexual Health Strategy all provide a framework for the conduct of HIV/AIDS and sexual health services for Indigenous people[[16]](#footnote-16)

* Sexual health is an important issue for all communities
* For Aboriginal people, with consent, contact the Aboriginal Hospital Liaison Officer to assist in the provision of Aboriginal Health Workers for “mens” and “women’s” health needs. The gender specific AWH are able to work alongside mainstream clinicians. These cultural values can also affect Aboriginal people’s willingness to access services for sexual health information and testing.
* Sexual health is a private issue associated with embarrassment and shame. Shame, or the fear of shame, amongst Aboriginal peoples is a concept that has the potential to make sexual health education problematic and complex, as people do not like to be singled out or to be made to feel different in any way.
* Shame may not only be attached to talking about sexual health matters, but arise in relation to accessing health services and STI testing. This is further compounded by other barriers all young people face such as location of services, confidentiality concerns and willingness to access health services to discuss sexual health matters[[17]](#footnote-17)

# Maternity Services[[18]](#footnote-18)

The Koori Maternity Service is a program set up to provide additional and culturally appropriate care to Aboriginal women during pregnancy, birth and in the immediate period after birth. This program is provided through a partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Victorian Aboriginal community controlled organisations throughout Victoria.

Mothers are cared for by an Aboriginal maternity health worker and a midwife, while an Aboriginal health worker supports them during pregnancy and after birth and is responsible for linking them with other service providers as needed.

The key issues include:

* Ensure care givers are friendly and patient, take their time to explain,
* Do not be hurried as this can be taken as “ can’t be bothered “
* Listen very carefully to what is being said
* Be clear with explanations and don’t assume that everything is being understood
* Always ask for a support person
* Offer the organisations Aboriginal Hospital Liaison Officer especially if mother and baby are being transferred
* Keep mother and baby together
* For mothers and babies being transferred, don’t assume there are finances for accommodation or transport for the patients and families
* Don’t stereotype
* Self Identify both mother and baby
* Ask to use Aboriginal “cot cards” and baby wraps

# Mental Health[[19]](#footnote-19)

Begin by having a yarn with the person. Spend time with them and let them know that you are worried about them. Ask the person where they would be most comfortable to have a yarn, be aware that confined places may cause the person anxiety and outdoors might be more relaxing.

* Ask for the person’s permission before asking about sensitive topics, but suggest that they may feel better once they have spoken about their problems. Be careful not to falsely imply that by talking about mental illness the person’s problems will go away. Instead, just reassure the person that you care and want to help.
* When discussing your concerns, use simple and clear language. Avoid asking lots of questions and speaking to the person in a patronising manner. Allow for periods of silence while the person considers what you have said and allow them plenty of time to tell their story.
* If family members are present, expect that they might answer some questions on behalf of the person. Avoid asking questions that might embarrass the person in front of their family and friends and remember never to criticise members of the extended family in front of the person.
* If you think that it might make the person more comfortable, ask them if they would like to find another safe area to talk away from family and friends. Remember that it is more important to make the person feel comfortable, respected and cared for, than to do all the ‘right things’ and follow all the ‘rules’ when communicating with an Aboriginal person. Importantly, if the person finds it too hard to talk about their problems, you should respect that.

Being culturally competent when providing mental health first aid involves:

• Being aware that a person’s culture will shape how they understand health and ill-health

• Learning about the specific cultural beliefs that surround mental illness in the person’s community

• Learning how mental illness is described in the person’s community (knowing what words and

ideas are used to talk about the symptoms or behaviours)

• Being aware of what concepts, behaviours or language are taboo (knowing what might cause

shame)

**Grief and loss[[20]](#footnote-20)**

Grief and loss issues are prevalent in many Aboriginal families and communities and continue to

adversely impact the lives of many people. These grief and loss issues are a combination of colonisation resulting in the forced removal of children and other underlying socio-economic factors. The path of destruction is cyclical and inter-generational.

**Drug and Alcohol**

**Myth** - Most Aboriginal people have alcohol problems

**Fact** - Alcohol abuse is a problem for many people in Australia, black and white. There is no scientific evidence that genetics would predispose any racial or ethnic group to alcohol or make them less tolerant. In fact, humans are very genetically similar, sharing 99.9% of their genomes in common

**Myth** – Most Aboriginal people drink alcohol

Fact- Aboriginal and Torres Strait Islander people are less likely to use alcohol, but more likely to do so dangerously compared to the non-Indigenous population.

One of the major concerns regarding alcohol use is exposure in pregnancy leading to Foetal Alcohol Syndrome or effects causing major developmental issues for children. These babies are however rare in south west Victoria. Alcohol use has also been implicated in domestic violence and family dysfunction.   
  
Rates of smoking are higher among Aboriginal people, being roughly double the national average.

1. Best Practice Clinical Placement Framework resources http://www.health.vic.gov.au/placements/resources/index.htm [↑](#footnote-ref-1)
2. Students are requested to have the “original” safety check information with them on all settings; without this they can be denied access to the placement setting [↑](#footnote-ref-2)
3. Dhauwurd Wurrung Elderly & Community Health Service Inc (Portland) has five student apartments available for student accommodation [↑](#footnote-ref-3)
4. The Superguide – A Handbook for Supervising Allied Health Professionals Health Education and Training Institute (HETI), NSW Department of Health 2012 [↑](#footnote-ref-4)
5. HWA 2011a; HWA 2011b [↑](#footnote-ref-5)
6. The Superguide – A Handbook for Supervising Allied Health Professionals Health Education and Training Institute (HETI), NSW Department of Health 2012 [↑](#footnote-ref-6)
7. Adapted from Northern Sydney and Central Coast Area Health Service, Social Work Supervision and Consultation Guideline, November 2009, [↑](#footnote-ref-7)
8. Kaye Knight LearnPRN Pty Ltd Mobile: 0428340221 :kaye.knight@learnprn.com [↑](#footnote-ref-8)
9. The Superguide – A Handbook for Supervising Allied Health Professionals Health Education and Training Institute (HETI), NSW Department of Health 2012 [↑](#footnote-ref-9)
10. Kaye Knight LearnPRN Pty Ltd Mobile: 0428340221 :kaye.knight@learnprn.com [↑](#footnote-ref-10)
11. Kaye Knight LearnPRN Pty Ltd Mobile: 0428340221 :kaye.knight@learnprn.com [↑](#footnote-ref-11)
12. The Superguide – A Handbook for Supervising Allied Health Professionals Health Education and Training Institute (HETI), NSW Department of Health 2012 [↑](#footnote-ref-12)
13. Kaye Knight LearnPRN Pty Ltd Mobile: 0428340221 :kaye.knight@learnprn.com [↑](#footnote-ref-13)
14. The Superguide – A Handbook for Supervising Allied Health Professionals Health Education and Training Institute (HETI), NSW Department of Health 2012 [↑](#footnote-ref-14)
15. The Team Handbook, Peter R. Scholtes and others, Joiner Publishing, 1988, <http://www.foundationcoalition.org/resources/first-year/asu/course-materials/constructive-feedback.html> Accessed January 2013 [↑](#footnote-ref-15)
16. *Core Competency Standards for Aboriginal and Torres Strait Islander HIV/Sexual Health Workers in NSW 1999* [*http://www.health.nsw.gov.au/pubs/1999/pdf/core.pdf*](http://www.health.nsw.gov.au/pubs/1999/pdf/core.pdf) *Accessed July 2012* [↑](#footnote-ref-16)
17. Sexual Health Fact Sheets, <http://www.ncahs.nsw.gov.au/sexual-health/index.php?pageid=4057&siteid=154> NSW government, North Coast Area Heath. Accessed September 2012 [↑](#footnote-ref-17)
18. Kay Netherway Gunditjmara Koorie Maternity Nurse/ Midwife Personal Communication September 2012 [↑](#footnote-ref-18)
19. Guidelines for providing mental health first aid to an Aboriginal or Torres Strait Islander. Beyond Blue <http://www.mhfa.com.au/documents/guidelines/8307_AMHFA_Cultural_guidelinesemail.pdf> Accessed June 2012 [↑](#footnote-ref-19)
20. Working with Aboriginal Families and Communities, NSW Government 2009 http://www.community.nsw.gov.au/docswr/\_assets/main/documents/working\_with\_aboriginal.pdf [↑](#footnote-ref-20)