health

CPN Strategic Projects

Final report

Promoting education as core business in the GCPN

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Contents

Executive summary

Aims and objectives of the project

The key aims of this project were to expand clinical placement capacity and quality by identifying the potential to provide placements in expanded settings such as small rural public and private healthcare organisations. An action research approach was adopted to explore the extent to which education manifests in organisations' operational planning and activities and gain insight into the barriers that occur within health sectors/facilities that impact on education being valued as part of the core business of the organisation. This project sought to engage stakeholders in a reflection on the educational profile of their organisation to promote their realisation of the need for education to be seen as core business, and subsequently to facilitate opportunities for them to strengthen their clinical learning environments (CLEs) by planning for and aligning their operations with the Best Practice Clinical Learning Environments (BPCLE) (Darcy Associates, 2009).

Project activities and methodology

The Gippsland Clinical Placement Network (GCPN) Committee established a steering group to provide stakeholder input and oversee the project. An action research framework was adopted to empower key staff in partner organisations and maintain the momentum achieved following completion of the project. To map the status and profile of education of small health service organisations within Gippsland, twenty-two delegated contacts were interviewed using a semi-structured interview guide framed around the principles of the BPCLE Framework. The vision and mission statements of Gippsland health service organisations were also examined for evidence that education constituted core business.

Having established the profile of education in stakeholder organisations, the key contacts in these organisations were invited to participate in one of three geographically strategic workshops across Gippsland. Workshop programs and activities were developed on the basis of the interview findings and refined in accordance with stakeholder feedback. The goals of these workshops were to raise stakeholders' awareness of the BPCLE Framework, support their utilisation of the resources available to assist them to strengthen the quality of their particular CLE and to encourage them to network with each other. Findings and project activities were reported regularly to the steering group, CPN Committee and disseminated via the GCPN newsletter to keep stakeholders apprised of developments throughout the term of the project and prior to the final report.

Key outcomes

Opportunities were provided for key staff in thirty-eight health services within Gippsland to reflect on the role and status of education in their particular organisation, the quality of the CLE and the capability of the organisation to provide health professional students with quality clinical learning experiences. The health services that participated in this study all valued education as core business to some extent, though there was considerable variation in how this manifested. For most organisations education was perceived to be additional to their normal work. However, participants indicated willingness to increase their service's capacity and capability to provide quality clinical placements and eagerness to develop their educational profile, policies and resources consistent with promoting a positive CLE.

The findings provide a focused strategy and clear direction to strengthen the status of education in more than thirty of the thirty-eight organisations that engaged in the project. Apart from empowering key staff in partner organisations with knowledge skills, attitudes and resources to strengthen the CLE and align their operations with the BPCLE Framework, the project facilitated inter-agency and inter-sectoral networking and promoted awareness of the potential gains to be achieved through such networking.

Conclusion

Health services in Gippsland value education as core business, albeit to varying extents. The considerable variation in how education manifested as core business revealed a need and also opportunities to promote education as core business. As an outcome of this project some thirty-eight health service organisations in Gippsland are more aware of the characteristics of a BPCLE and many have already taken steps to progress the quality of their CLE. The findings also offer insight into how other organisations can strengthen the quality of their CLE in alignment with the BPCLE Framework.

In some organisations 'education champions' have been identified to increase the potential role health services in Gippsland can play in building clinical placement capacity. These champions, already committed to professional, evidence-based practice and supporting student learning, have been guided to network with external colleagues and, where possible, equipped with the requisite knowledge, skills, attitudes and access to resources to progress development of a BPCLE within their facility.

This project illuminates how the role and status of education can be promoted in health services within the GCPN. The quality of the CLE can be strengthened by: providing basic dedicated learning resources and space, considering educational needs in strategic planning, capital works, annual budgets, operational policies, procedures and activities, and supporting continuing professional development. Developing sophisticated communication channels and establishing information connectivity between education and placement providers emerged as priorities to reducing the barriers that constrain the ability of small rural organisations in Gippsland to service clinical placements.

This study highlighted the need for the appointment of an expanded settings development officer to facilitate the building of supportive infrastructure, bridge some of the differences found, optimise the potential achieved and maintain the momentum gained through this project. There is also a continuing need, as others have found, to invest in building and maintaining a critical mass of trained clinical supervisors in the region to mitigate burnout, address turnover and promote job satisfaction (Barnett et al., 2010; McKenna and Wellard, 2004). Furthermore, there is a need within organisations to build a learning culture, promote professional development, respect and value educative roles, and wherever possible to disentangle these from dual, often conflicting clinical and managerial roles that constrain their effectiveness and limit their ability to promote a quality CLE.

Background and context

Failure of health service organisations to value education and professional development as core business has the potential to impact adversely on staff and students by creating a clinical environment that is not conducive to Best Practice or optimal learning (Happell and Kelly, 2007). The CLE and how it is experienced by students may jeopardise clinical and academic outcomes. Edgecombe and Bowden (2009) use the analogy of the CLE as a 'swamp':

"… a rich environment which, initially, may seem wet, messy, boggy, opaque, threatening and confusing, but which, in reality, provides the nutrients, networks, and constant ebb and flow of new experiences and relationships novice practitioners need to enable them to understand, adapt to, learn how to survive in, thrive on and use its elements to mature from tadpoles … into frogs…, able to leap from swamp… to high ground… and vice versa, and to feel equally confident, competent and safe in each" (p.92).

The quality of the CLE not only affects students' ability to develop requisite professional knowledge, skills and values in the 'real-world' context (Happell and Kelly, 2007; Levett-Jones and Lathlean, 2008; Saito et al., 2010), but also their motivation to learn, self-confidence and morale (Cardell et al., 2008; Curtis et al., 2006; Saito et al., 2010). Factors known to influence students' experiences of placements include: familiarity, having a sense of belonging, feeling welcome, accepted, trusted, and respected, feeling valued as a practitioner, being given opportunities to practice with some degree of autonomy, having access to emotional as well as clinical learning support and being recognised for their contribution to patient care (Brammer, 2006; Chan, 2004; Clare et al., 2003; Edgecombe and Bowden, 2009; Lofmark and Wikblad, 2001). Awareness of the significance of these qualitative aspects of the CLE informed the interview content and project activities. Adopting an action research approach to raise awareness of the educational profile within organisations and involve stakeholders in this project as active change agents has enabled targeted strategies to be developed, the CLEs in partner organisations to be modified, and/or transformed, and subsequently has developed their potential to increase student placement capacity and/or the quality of students' learning experience.

Objectives

This project sought to:

- Explore and engage with stakeholder organisations within the GCPN, particularly smaller and more marginal health services, issues related to education provision;
- Identify barriers to integrating education into the core business of organisations;
- Map current education and supervision training provision and explore current policies related to education;
- Review organisation vision and mission statements;
- Develop strategies to improve the internal and external education services (including clinical placement) within organisations through promotion of the BPCLE Framework;
- Support organisations to develop mission statements that contain learning as an integral part, in alignment with the statewide implementation of the BPCLE;
- Support organisations to develop policies that include education programs, with orientation as an integral component, for staff and students;
- Provide a network and communication platform to support healthcare providers to integrate and promote education to internal and external stakeholders;
- Provide workshops to assist in the development of skills and attributes to promote learning as core business; and
- To expand capacity for clinical placements.

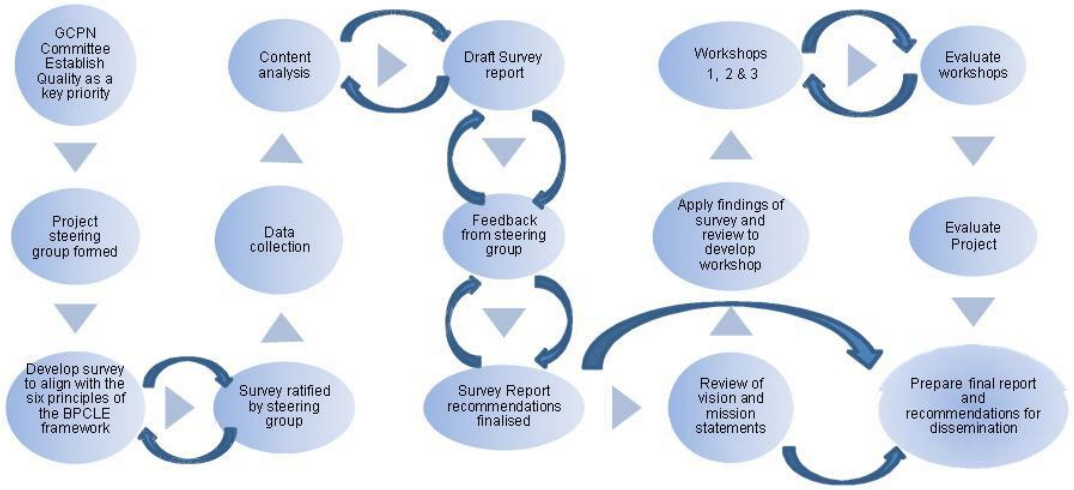
Project activities and methodology

Activities

In establishing the priorities for the GCPN, the Committee identified quality as one of its key concerns. The GCPN Committee formed a project steering group to progress the issue of building and sustaining quality clinical placements in expanded settings. The first priority involved establishing a baseline education profile of such organisations, i.e. the extent to which education was reflected as core business and thus, their preparedness for providing quality clinical learning experiences. Establishing the existing education profile of organisations provided a basis for understanding the barriers to them being considered quality clinical placement providers. It also identified the potential to elevate the role of education as core business and shed light on the types of resources that could support them to transform and/or elevate their education profile and the quality of their CLE in preparation for taking (more) health professional students for clinical placement.

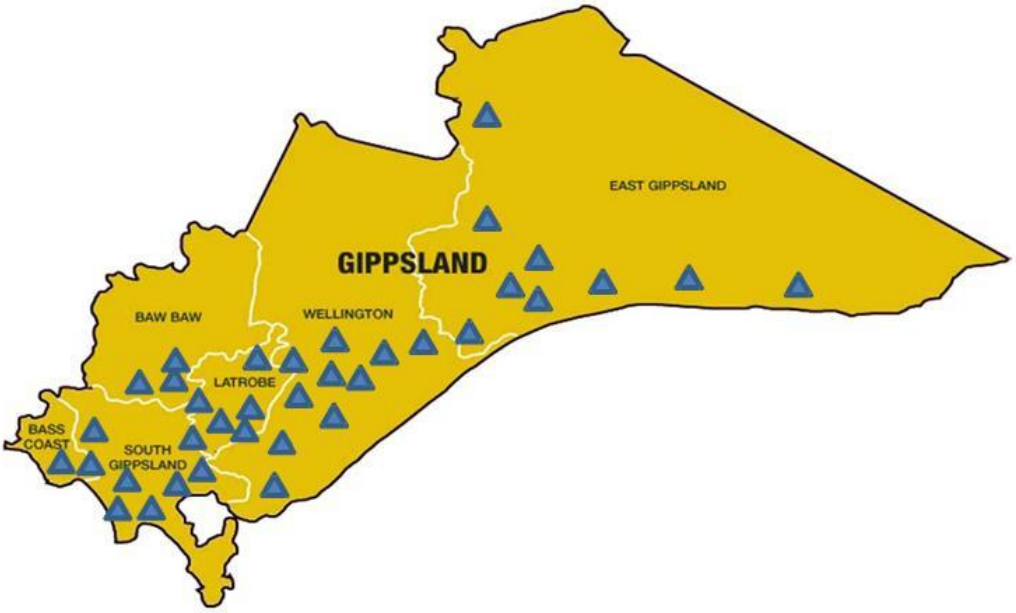
The steering group was established to oversee the project, identify target organisations, ensuring they included geographic and sectoral representation and to finalise the operational plan, project activities and evaluation criteria (see Figure 1). The steering group provided ongoing input and feedback and received progress reports from the project team, the key content of which they were expected to disseminate to their respective sectors and professional groups. Overall, eleven steering group meetings were held to drive decision making and provide feedback. The project officer furnished a report to each of these meetings and provided a monthly summary report to the GCPN Committee.

Figure 1: Evolution of the project



To maximise the reach of the study and elicit regional, organisational and sectoral insights the organisations studied were drawn from East, South and West Gippsland, Central Gippsland and the Latrobe Valley. This distribution covered the six local government jurisdictions: East Gippsland, Wellington, Latrobe, Baw Baw, South Gippsland and Bass Coast (Figure 2). The organisations included small public and private health services, small community and mental health settings, aged care, not-for-profit organisations, Aboriginal Community Controlled Health Organisations (ACCHOs), local government, private practices and government departments.

Figure 2: Map showing the breadth of project engagement across Gippsland



Prior to the CPN profiling information becoming available early in 2012, organisational contacts were identified by existing CPN stakeholder lists, partner organisations or members of the steering group applying local knowledge.

The project team, in consultation with the steering group, developed a semi-structured interview guide to focus conversations with the delegated key contacts in participating health services and stimulate reflection on the profile and status of education in these organisations. The BPCLE Framework indicators formed the basis of the content for this interview guide and provided an established measure for reflection and evaluation. Participants from twenty-two health service organisations in Gippsland were interviewed between October 2011 and February 2012. The data generated was subjected to content analysis and checked for congruence with the six key attributes of a BPCLE:

- An organisational culture that values learning
- Implementing or developing Best Practice
- A positive learning environment
- An effective service/education provider relationship
- Effective communication processes
- Resources and facilities that support education.

A draft report was disseminated to the steering group to enable further analytic discussion and generate recommendations. The interview findings and recommendations included in the final report have informed (a) the content of the resource development workshops, (b) strategic planning, (c) provision of specific assistance to stakeholders to develop educational resources and (d) subsequent grant applications.

The Mission and Vision statements of target organisations were also analysed to identify the extent to which education was evident in their strategic documents and reflected core business. This analysis of web-based documents, together with interview data, guided the invitations extended to the key contacts of participating organisations to participate in a resource development workshop and the structure and content of these workshops.

To provide stakeholders with practical support to strengthen their education profile and policies a series of three workshops were delivered in East Gippsland, the Latrobe Valley and South Gippsland. These workshops included an introduction to the BPCLE Framework, the resource toolkit and an overview of CPN placement tools, such as viCProfile. A total of twenty-five attendees, representing eighteen organisations across the GCPN participated in these workshops. Networking opportunities were facilitated by selecting subregional locations for the resource development workshops and allocating time for self-directed reflection, discovery, discussion and collaborative engagement. Although ACCHOs were unable to participate in these workshops, a sample of BPCLE

resource materials to provide support and motivate future engagement was adapted for use in consultation with one ACCHO delegate.

Methodology

Action research was utilised as the preferred methodological approach because of its congruence with the practical nature of the project and its goals to empower stakeholders and optimise the success and sustainability of outcomes (Kelly, Simpson and Brown, 2002). This approach involved a flexible, spiral iterative process which allowed action (change, improvement) and research (understanding and knowledge) to be achieved simultaneously (Figure 3). The process alternated between planning, action, evaluation and critical reflection as it moved forward, beginning with a critical review of the situation, followed by informed planning for the next action. Enabling those affected by the change to be involved in the action and the critical reflection increased their understanding and commitment to planned changes (Dick, 2002).

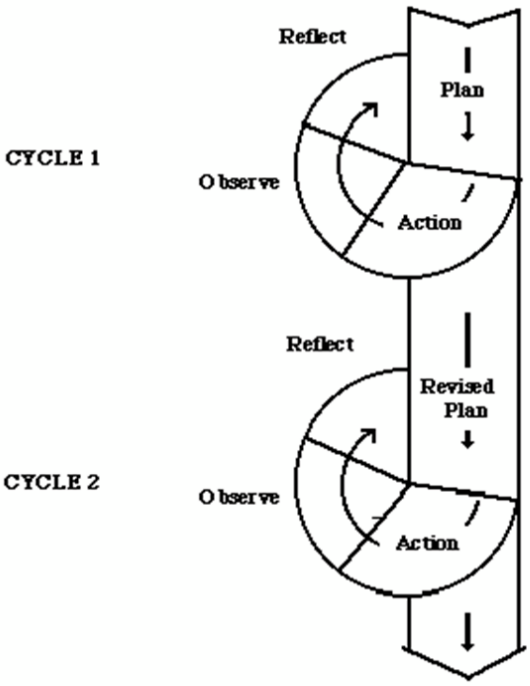
Action research was selected as the most appropriate methodology because it strives to:

"… contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously. Thus, there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is together regarded as a desirable direction. Accomplishing this twin goal requires the active collaboration of researcher and client and thus it stresses the importance of co-learning as a primary aspect of the research process (Gilmore, Krantz and Ramirez. 1986, p.161).

The primary focus in action research is on engaging participants as active researchers and change agents because "people learn best, and more willingly apply what they have learned, when they do it themselves". Action research takes place in real-world situations and strives to resolve real-world problems; therefore it also has a social dimension (O'Brien, 2001, p.5).

Evaluation was an ongoing iterative process that encompassed all aspects of the project. For example the semi-structured interview guide was critiqued by members of the steering group and their suggestions incorporated. Likewise the workshops were formally evaluated by participants and the content, supporting materials and format adapted on the basis of the feedback provided.

Figure 3: Action research process



Source: Kemmis (1990)

Details of this project have been disseminated to stakeholders via engagement with participants, interaction with stakeholder organisations and the CPN newsletter. Final results and report will be distributed to the CPN Committee and project steering group, Department of Health (DH) and members of other Victorian CPNs. It is anticipated that results will also be disseminated by means of stakeholder events, at least one colloquium, conference paper and publication.

Project management

Governance

The project was governed by a steering group comprising five members of the GCPN Committee at any one time and the CPN project manager. The project team included two part-time project officers and administrative support. Detailed progress reports were presented to the steering group at project meetings and a brief summary provided monthly to GCPN Committee members.

Engagement

Stakeholder engagement and consultation incorporated thirty-eight organisations across Gippsland representing each Local Government Authority (LGA) and health sector. Delegated representatives of twenty-two organisations were interviewed and twenty-five individuals from eighteen health services participated in the resource development workshops.

Budget

Latrobe Regional Hospital was the project fund-holder. The project funding was utilised in accordance with the grant application: project officers were appointed, office, accommodation and travelling costs were expended and funding was allocated for workshops and the development and provision of resource materials.

Time

Overall the projected timelines were achieved; however, the evolving nature of the action research approach required flexibility within the timeframe allocated. In effect program development and implementation occurred over the projected twelve-month period.

Outcomes and impacts

Extent education was reflected in strategic organisational documents

Understanding an organisation's mission, vision and core values are key to strategic planning and keeping the organisation on track (Adams, ND). Vision and mission statements provide a yardstick for use to measure present performance and plans against the strategic aspirations of the organisation: they are the cement that holds an organisation together and drive it forward. Ebben (2005) makes the analogy that the vision and mission provide direction, like the successful coach who has a vision for putting a team together and game plans for successful execution, without which it is difficult to develop a cohesive plan. In turn, this allows the organisation to pursue activities that lead it forward and avoid devoting resources to activities that do not.

Effectively, the mission statement describes the overall purpose of the organisation (the raison d'etre); while the vision statement includes vivid description of what the organisation wants to be as it carries out its operations. Values represent the core priorities in the organisation's culture, and often drive the intent and direction in terms of growth, values, culture, contributions to society and provide a framework in which decisions are made (McNamara, 2007; Renger and Titcomb, 2002). As identified under activities and methodology, the extent to which education was reflected in strategic organisational documents involved reviewing the web-based documentation of thirty-eight organisations (Table 1).

Table 1: Service sectors included in web-based document review

Service sector	Participants
Community health	5
Public health	9
Local government	2
Bush nursing	2
General practice	8
Education department	1
Aged care	5
ACCHO	2
Community mental health	3
Private health	2
Total	38

As noted earlier the CLE is where students learn the real-world context, however, there is evidence that stress and negativity within the CLE have the potential to detract from clinical and academic outcomes. Additionally, some organisations do not recognise continuing professional education as essential to the workplace and do not provide staff with learning opportunities. Failure of organisations to invest in the ongoing professional development of staff has implications for internal (staff) and external (students) stakeholders because it indicates education is not valued as core business. Ultimately, failure to support and promote staff development can lead to a clinical environment that is not conducive to learning which potentially compromises staff and student outcomes.

Education did not feature in the mission and vision statements of any of the organisations examined. Examination of the third level of this search – values statements – revealed references to learning and training in only two smaller health services, one public and one private.

Although reference to education and training were missing from mission and vision statements, a plethora of other descriptors were highlighted within the documentation. Quality, found in over half of the statements (twenty-one), predominantly in mission statements, was the descriptor most frequently noted. Other terms frequently espoused within these documents included: innovative, effective, outstanding, excellence and responsible (Table 2).

Table 2: Value descriptors in peak organisational documents

Descriptor	Mission	Vision	Values	Frequency
Quality	17	3	1	21
Innovation/innovative	4	1	4	9
Accountability/accountable		2	4	6
Effective	1	3		4
Efficient	1	3		4
Excellence	1	1	2	4
Ethical		1	2	3
Integrity			3	3
Responsible	1	1		2

Safe		1	1	2
Outstanding	1	1		2
Best patient outcomes	2			2
Continuous/quality improvement			2	2
Best meet needs		1		1
Comprehensive		1		1
Exceptional performance		1		1
High standard	1			1
Inspired		1		1
Research and development		1		1
Responsible	1			1
Responsive	1			1
Continuous learning			1	1
Well trained and committed staff			1	1
No statements/unable to access				8

Arguably, education is implicit in the mission, vision and values statements examined because organisations would be unlikely to achieve these goals without investing in education. However, there are subtle and important differences and the omission of explicitly addressing education at this level raises questions that education was indeed considered a core value by organisations, or that organisational leaders recognised the association between these aspirations and education. The profile an organisation gives to education is the visible manifestation of the status it holds in the agency and this has implications for the organisation's culture, operational decision making, staff morale and the climate of the CLE. Although it was beyond the jurisdiction of this project to suggest changes at this organisational level as initially proposed, participants acknowledged the need for education to be reflected in vision and mission statements.

Extent education was reflected in organisational operations

Evidence that education and training feature in the next level of organisational operation, strategic planning, was elicited by interviewing designated key contacts in twenty-two of the organisations whose web-based documents had been reviewed. The findings suggest it is likely that in many of the remaining sixteen organisations education may also be evident to a considerable extent in their strategic planning documents and operations. The inclusion of education at this level of an organisation's operations augers well for further developing smaller rural health services as suitable placement providers. Incorporating education into strategic planning paves the way for organisations to be receptive to external strategies and supports to assist them raise the profile of education within and throughout the organisation, a factor identified to promote the attractiveness of an organisation to prospective and existing employees (Curran, Fleet and Kirby, 2006; Struber, 2004). Developing and maintaining a high education profile is also likely to build a learning culture and make organisations characterising these traits more attractive to education providers and students.

Interview findings and discussion

Part 1: Extent small rural health services reflected an organisational culture that values learning

The potential to strengthen the status of education was identified in at least eighteen of the organisations studied though it is at least to some extent currently incorporated in the organisational practice of all twenty-two of the organisations examined (Table 3).

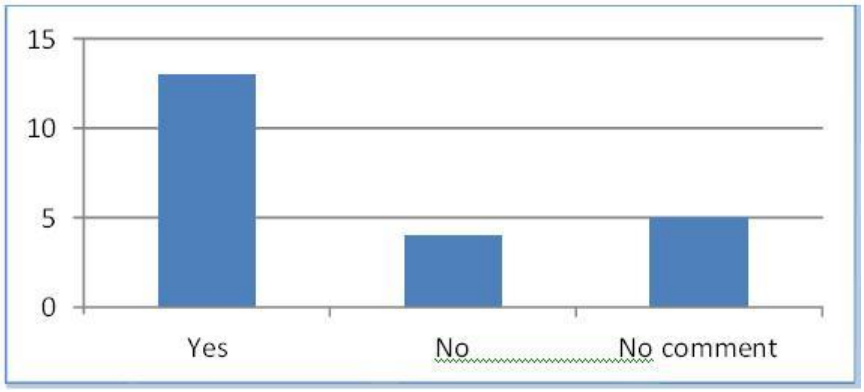
Table 3: Extent small rural health services reflected education as core business

Education is covered in depth in the organisation's mission, vision and strategic documents and is seen to be incorporated into regular work practices.	Education is only vaguely referred to in the mission, vision and strategic documents, but is seen to constitute part of the organisation's regular work practices.	The provision of education is perceived to be additional to regular work practices.
10	**3**	**9**

Attitudes of staff towards professional development were perceived to vary considerably within and between organisations and some participants were loath to take a stance. According to one participant, "some staff are very frightened about professional development." Another revealed that some staff value having access to paid study days but tend not to engage with unpaid study. Yet another participant reported, "some see it as a burden, many see it as something that is required and others seek it."

In twelve of the twenty-two organisations, time is regularly allocated for staff involvement with educational activities although in a further five, the time allocated varies or is unknown. The findings were similarly mixed regarding the allocation of funding for education (Figure 4).

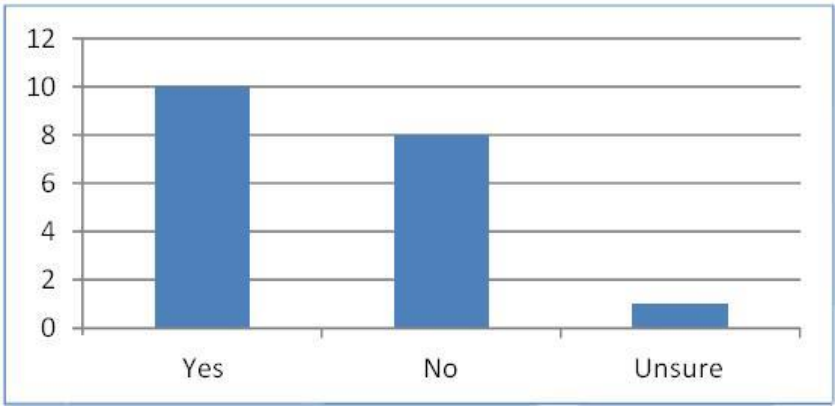
Figure 4: Number of organisations reported to allocate a budget for educational activities



According to one participant who indicated there is no annual budgetary allowance for education in their organisation, "such funding is embedded in the general budget". Another participant claimed funding for education forms "part of the EFT" (i.e. part of the staffing budget). It seems time and money for training is available for study, particularly mandatory training and even when none exists explicitly, that "funding can be found when individual staff express an interest." Highlighting the variable commitment of the organisations participating in the study to assign funding for educational purposes, one participant indicated the budget allocated is "growing, but not enough." Another claimed "it is limited and has recently decreased."

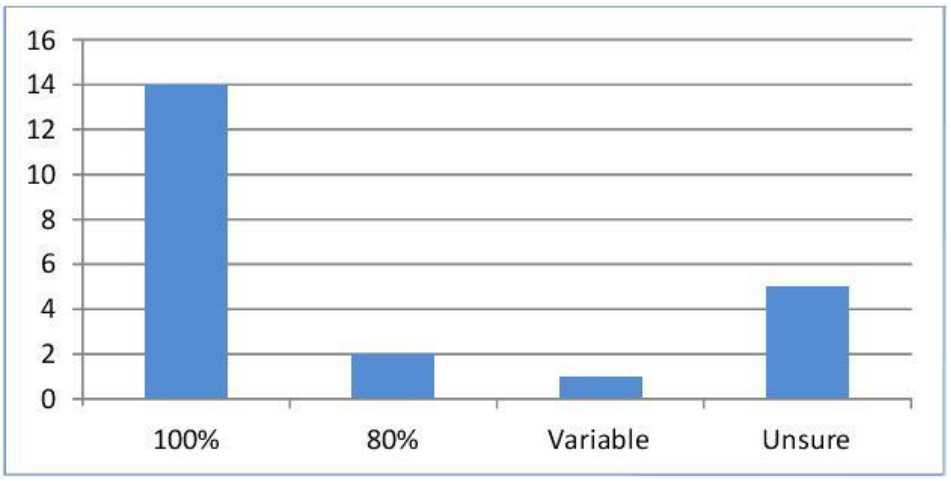
There is a designated person whose primary role is to provide education or facilitate clinical placement in less than half (ten) of the organisations studied (Figure 5). In some organisations an education/placement coordinator role is subsumed under other roles, for example, 'part of clinical manager's role'. One participant revealed that although there is no dedicated education position at the facility level there is at the organisational level; an important point given the size, staffing profile and multi-site nature of some small rural health services.

Figure 5: Number of organisations employing a person whose primary role is education/to facilitate clinical placement



Over two-thirds of participants (68%) stated education is incorporated into key performance indicators (KPIs) for all staff position descriptions (PDs). Nearly two-thirds of those interviewed (64%) indicated that all principal education staff in their organisation access professional development activities each year (Figure 6). Depending on the accuracy of this information, this means that for nearly one in three of the health services examined education is not currently a KPI of all staff PDs and similarly, that the staff whose primary role is education do not access professional development activities each year. Notably, five participants felt unqualified to answer this question.

Figure 6: Estimated proportion of principal education staff that access professional development activities annually



When asked how staff would probably rate the organisation's view of their educational role, responses were quite varied. More than two-thirds of those interviewed felt that staff would perceive their educative role being valued by the organisation. The remainder were uncertain about how staff would consider the organisation values their role. When asked to what extent it is important that students feel valued by the organisation, more than 80% of participants indicated it was important or essential and none felt it was of only minor or no importance.

Involvement in educational activities is a documented strategy for career advancement in fourteen of the organisations studied, however, for another seven, there is no such link between educational engagement and professional progression.

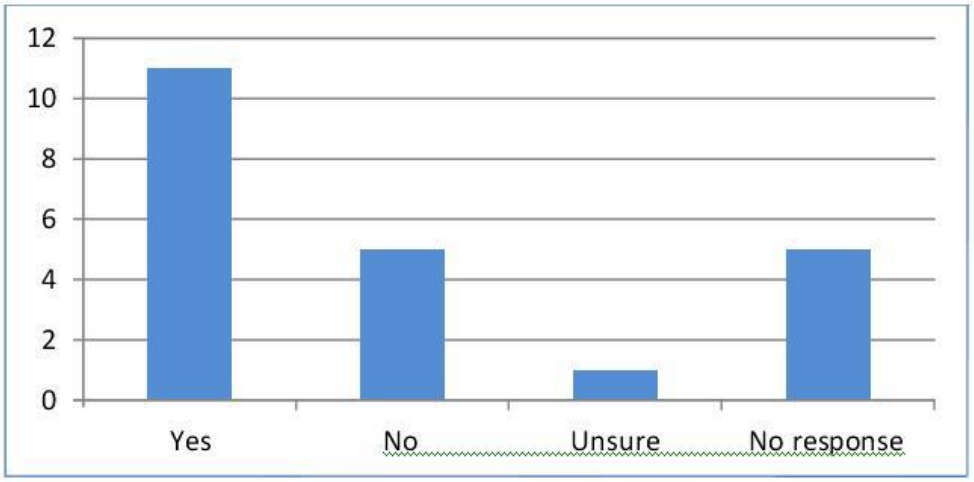
Of the eleven organisations examined that have building plans in place, six participants indicated these include educational requirements. One explained, "the recent upgrade … enabled the education area to be concurrently upgraded." Another stated, "in the new plans there are offices and training rooms." Two participants who indicated current plans do not address educational requirements reported space was already available.

Seven participants revealed education is included in organisational operational plans, four were unsure and two referred to education being included informally. Only one participant indicated education is not incorporated in the organisation's operational plan. Examples illustrating how education is included in the operational plans included:

- Having a specific education allocation in the organisational budget
- Education being included as an agenda item for discussion at staff meetings
- All areas having a training strategy
- Inclusion in the organisational structure of a strategic workforce capability role and infrastructure
- Education representation on the executive
- Having an organisational educational plan
- Inclusion of education in unit plans.

Participants were less inclined to respond about the inclusion of education in their organisation's strategic plan than the operational plan. Only five of the twenty-two key contacts interviewed reported education is included in their organisation's strategic plan and one indicated that it is not. Five were unsure. Without knowing whether the sixteen organisations for which this information is not known, do or do not include education as an integral part of their strategic planning it is difficult to comprehend the extent to which education manifests as core business in these services. The inclusion of education as a standing agenda item for meetings at the senior managerial level also appears quite variable, though this may be an artefact of the awareness of the person interviewed (Figure 7).

Figure 7: Number of organisations that include education as a standing agenda item for senior management meetings



The findings raise some doubts about the extent to which education is a standing item on senior managerial meeting agendas and therefore valued by the organisation. One of the five participants who indicated education is not routinely included as an agenda item at the senior management level qualified this saying it is regularly added and another, that education is addressed informally. Yet another participant who stated education is included as a standard agenda item tempered this by explaining, "only in relation to staff." Another of the principal ways an organisation reflects an organisational culture that values learning is by providing dedicated education facilities. Of the twenty-two organisations studied, dedicated education facilities were frequently either non-existent or considered disproportionately small for the size of the organisation (Table 4).

Table 4: Number of organisations that provide dedicated education facilities

Dedicated education facilities are not available	Dedicated education facilities are available but the size limits the number of student places available	Dedicated education facilities are available and the size is proportionately appropriate to the size of the organisation
15	**2**	**5**

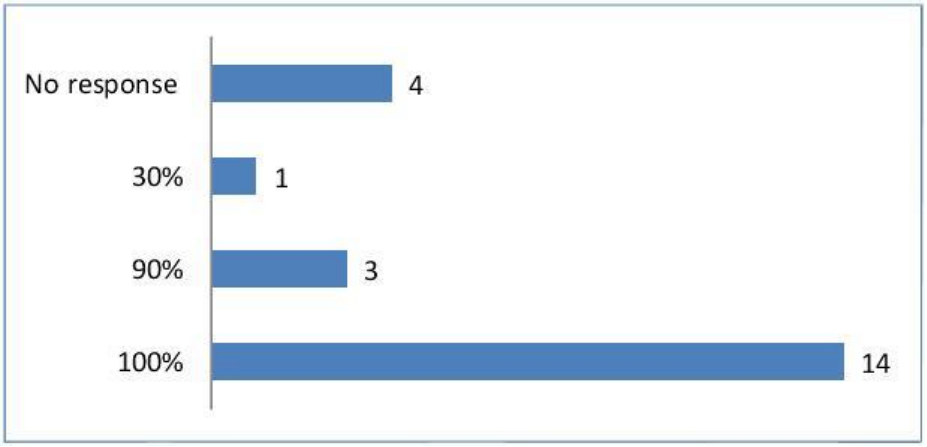
Part 2: Extent organisations reflected a BPCLE

Participants claimed policies and procedures were always or usually updated to support continuous quality improvement in all but one of the organisations studied. The frameworks, structures, mechanisms and tools reportedly used to support evidence-based practice and decision making included:

- Accreditation tools and standards
- Joanna Briggs Best Practice Guidelines
- Business excellence framework
- Accountability framework
- IT access
- Dedicated quality IT office, monthly QA audits, IT access to QA network, improvement plans and logs.

The estimated proportion of non-education specific staff reported to access professional development activities each year was generally very high (Figure 8).

Figure 8: Estimated proportions of non-education staff that access professional development activities each year



The proportion of staff from the small rural organisations studied that ostensibly engage regularly in professional development activities suggests the CLE of these health services should not be summarily dismissed as unsuitable for student learning. However, it is salient to note that apart from the currency and competency of staff, the quality of the CLE in terms of exposing students to Best Practice, also relates to organisations operating on the basis of new evidence.

In only four of the organisations were practice guidelines reported to always be reviewed against new evidence, though in a further fourteen they were usually. One participant estimated their organisation reviewed their practice guidelines against new evidence about half of the time. Of the remaining three organisations studied, there was no information provided about the frequency they factor new evidence into practice guidelines.

The ability of an organisation to offer a positive learning environment is reflected in a variety of ways, including students' ongoing interest in the organisation as a preferred clinical placement option or place of employment. However, it is important to note that the 'student return rate' is affected by multiple extraneous factors.

Part 3: Extent organisations reflected a positive learning environment

Only one participant indicated students always return to the organisation for work or further study. However, given the numerous options available to students, the limited employment opportunities available in some small rural organisations and multiple factors associated with further study, it is unlikely all students would ever be likely to choose to return to a particular organisation for work or further study regardless of how positive a student perceives the learning environment to be. It is important to note however, that nine participants reported students usually do return to the organisation for work or further study and an additional seven suggested students return about half of the time. These findings are significant because personal and geographic factors such as residential

location, distance, transport, accommodation and opportunity are likely to impede students' continuing engagement with a placement provider. For these reasons it is not surprising that two participants reported students seldom return to their organisation.

All participants reported that students always or usually participate in orientation programs. When asked if, in the evaluation of student placements, students report being satisfied with the welcome they receive, eight participants indicated they always report being satisfied and a further ten that they are usually satisfied. Though a welcoming environment for students was generally perceived to be provided this element was not always measured. This question drew to attention that some placement providers (four) did not evaluate students' placement experiences at all, even though they may have lamented the lack of feedback from education providers about students' satisfaction with placement.

Exemplars provided by participants of policy statements that ensure the learning environment of an organisation is safe included:

- The organisation has a suite of Human Resource policies and procedures that support the safety of the organisational environment for students.
- Students are treated just the same way as staff. The same Occupational Health and Safety (OH&S) policies and procedures apply (they are not specific for students); all employees and students sign off on OH&S policies.
- Safety issues are covered in orientation, e.g. secure staff car park policy, security checks, lighting, night-time lock-up, fire safety and processes for complaints.

Participants also identified a raft of protocols that exist to support learners who are struggling and require assistance. Only one participant referred to there being an official agreement with education providers related to managing struggling students although an additional four identified contacting the education provider and enlisting their support as strategies used to deal with what many perceive to be a perennial problem. Other protocols included:

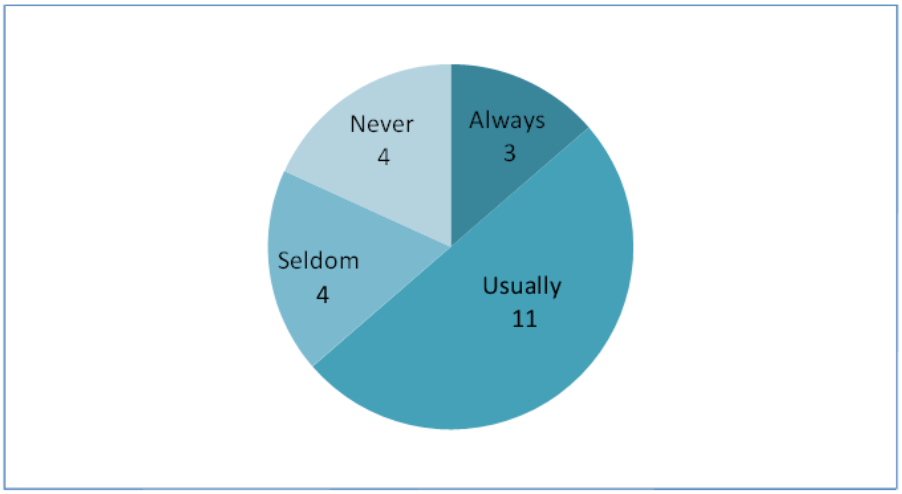
- Involvement of the clinical teacher
- Mid-point appraisal to detect early the students who are struggling
- Students being mentored 1:1 and being appraised and receiving feedback daily
- Mentoring staff being allocated a reduced clinical caseload to allow time to nurture students, and staff being allocated time (e.g. forty-five minutes/day) to review the work of their students.

In nearly half of the organisations studied (ten) there were no formal protocols to address the matter of struggling students. The approach taken reflects staff supporting students, managers supporting staff, and staff's (a mentor's) individual style and discretion. One participant explained, "staff have been trained to observe student progression and learning styles against expected. It depends on the profession… they are skilled and experienced people with access to education staff." Reflecting the diversity, size and level of engagement of some small organisations, another participant explained, "it depends on the site. The CEO works with the staff member (supervising the student) to attempt various strategies." Working with struggling students surfaced repeatedly as a key challenge for supervisors in the Advancing Clinical Education (ACE) Supervisor training workshops conducted in the region during the same period as this study. Workshop discussions indicate the response to this challenge often varies with the experience, skill and learning style of the supervisor.

When participants were asked how students would rate their feeling of safety and wellbeing in their organisation during clinical placement, nine indicated students would feel very safe and a further eleven that they would likely rate it as 'mostly safe'. Notably, rather than being indicative of a student-measured outcome these results reflect participants' confidence that students are never or rarely alone. Only one participant made explicit reference to student perceptions of safety and wellbeing not being measured. The extent to which students are included in team meetings and interprofessional activities also reflects an important dimension of the positivity of the CLE. Fifteen participants in this study reported students are always included in team meetings and the remaining seven, that they are usually included.

There was considerable variation in the frequency with which placement providers report they are provided with information about students' knowledge and level of proficiency (Figure 9).

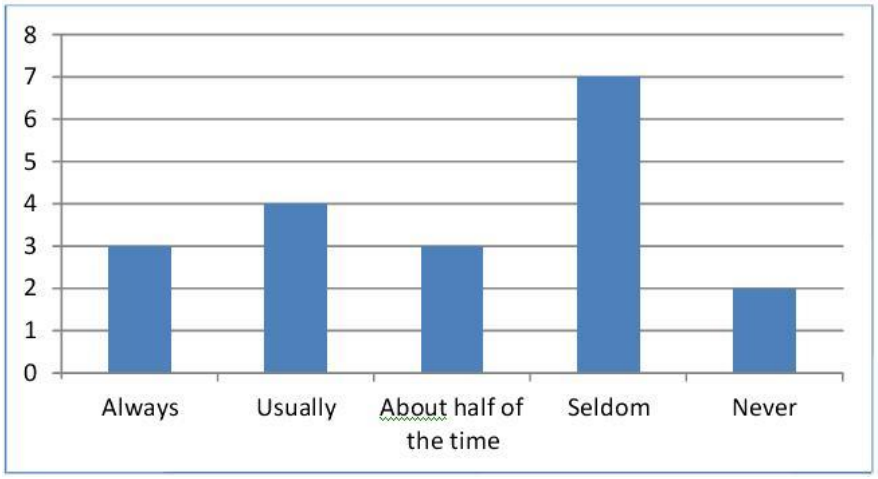
Figure 9: Frequency placement providers report being given information about students' knowledge and proficiency



Communication protocols to clarify educational objectives, student knowledge, proficiency level and assessment are principally driven by education providers, especially in the case of universities, and are documented in agreements. As stated by one participant, "common systems and relationships have been established between education providers and (key staff) in the organisation." There is also evidence of reliance at the clinical coalface on information provided in clinical workbooks (five organisations) and communication with students and clinical teachers (four organisations). In contrast, one participant claimed, "there's not much information – no cooperation or planning." Another stated there was no protocol for clarifying matters or exchanging information; "No, they just visit for the day." One participant reported clarification is hampered by not always knowing the appropriate contact person. The quality of communication with education providers may be dependent on the education provider and their proximity to the placement provider. Smaller private education providers were cited most often as expecting an unreasonable level of assessment.

In most of the organisations staff with education training, experience or qualifications are not frequently mapped against their primary or secondary involvement in educational activities (Figure10). In contrast to the widespread disregard of staff members' educational capability, one placement provider revealed a flexible and well developed education staffing structure whereby 'all staff have a base in Certificate IV Training and Assessment and development ranges from a Diploma of Management to a Master's in Education.'

Figure 10: Frequency organisations map staff with education training, experience or qualifications to related educational activities



The variation in the frequency staff with education skills are delegated educational roles suggests many of the organisations examined devalue the advantages of new staff and students learning from staff who have educational interests and expertise. Apart from being better equipped to supervise students, staff that choose to

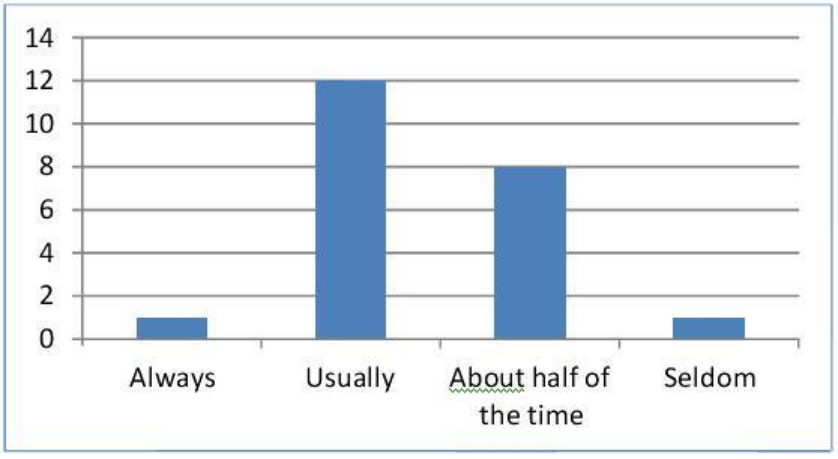
train as educators may be more interested and willing to supervise and support student learning and therefore better suited to supervising them than staff that have not shown this interest in clinical education.

One of the known barriers to clinical staff being willing to supervise students relates to a perception students are not always adequately prepared for clinical placements. When asked how frequently participants felt staff in their organisation consider students are well prepared for placement, only one participant suggested that this is always the case (Figure 11).

Whilst seventeen of the key contacts interviewed agreed with the statement 'students feel they have appropriate access to educators', only four strongly agreed; notably, three were undecided and two disagreed. Although the statement is subjective and likely to be viewed differently from a student perspective, for the purpose of this study the accuracy with which stakeholder perceptions would match a student viewpoint is reasonably unimportant. However its inclusion required participants to reflect on their local situation and the level of access students undertaking placement in their organisation have to educators.

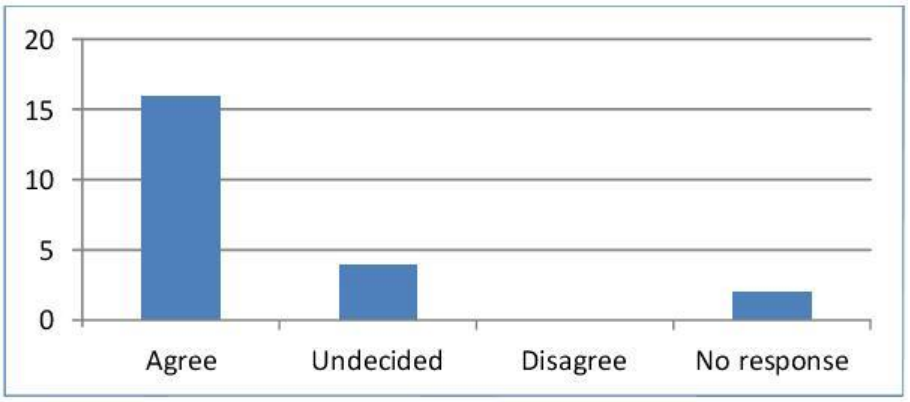
Asking participants to identify the approximate proportion of learners to educators may have been misinterpreted by those who were interviewed. The proportion of learners to educators could be interpreted in a number of ways and is not something that organisation's usually consider or quantify when considering their placement capacity. Participants invariably chose to respond to this item by identifying the clinical supervision model in place in their organisation, for example, a one to one supervision model or a one to six to eight clinical teacher to student ratio. The mentor/preceptor model was by far the most dominant model in place in the organisations studied with eighteen of twenty-two participants reporting their organisation utilises a one to one educator/supervisor to student ratio. The reasons underpinning the proportion of learners to educators in the organisations studied were not explored although additional comments shed light on variations between disciplines, education provider requirements and the presence of hybrid models.

Figure 11: Frequency participants report staff consider students well-prepared for placement



One aspect underpinning the quality of the learning environment is the level of engagement students have with clients. There is a potential for clients to feel over-burdened by their engagement with students. Participants were asked to what extent they agreed that clients feel their level of interaction with students is appropriate (Figure 12).

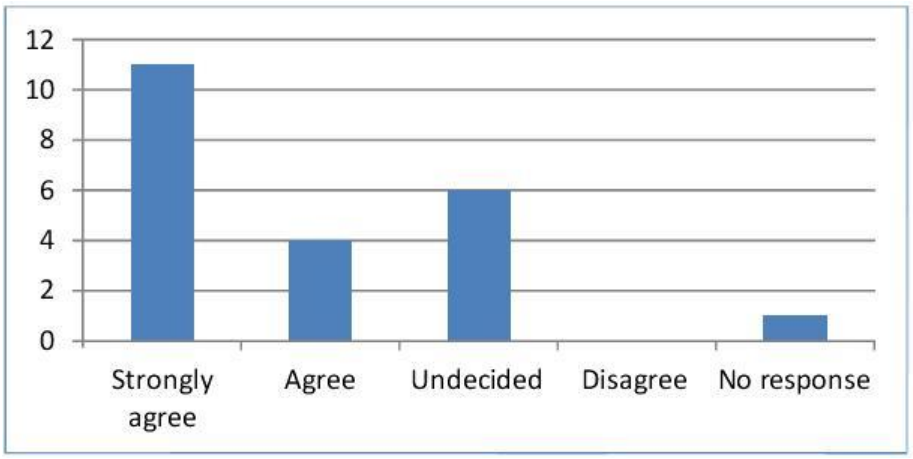
Figure 12: Level of agreement clients consider their interaction with students appropriate



Some of those who agreed clients in their organisation probably feel their level of interaction with students is appropriate, qualified their responses to the effect that clients are always introduced to students and given the opportunity to say 'no' to having students attend to them. The conclusion to be drawn from this result is that from the perspective of the key contacts, the clients in their organisation are reasonably likely to be satisfied with the level of interaction they have with students.

Participants were also asked to consider the student perspective and the likelihood they would feel that they have enough access to clients (Figure 13). Where participants were undecided about the adequacy of student access to clients, this was usually attributed to service fluctuations and periodic shortages of clients through the service.

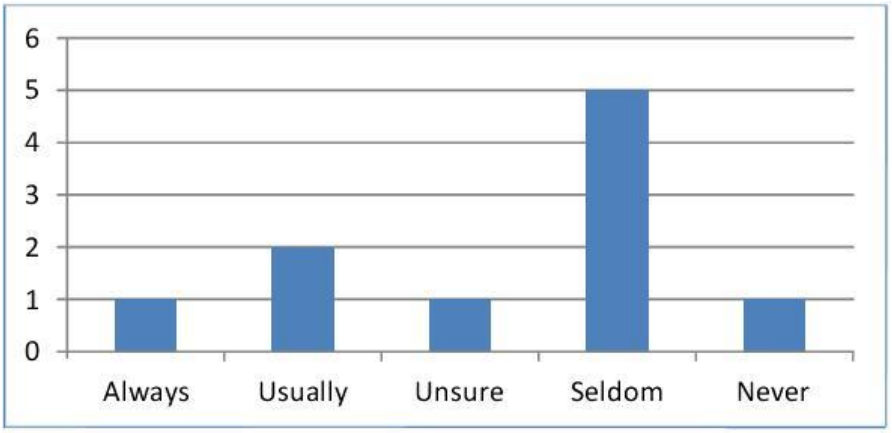
Figure 13: Level of agreement students perceive they have adequate access to clients



Students sometimes undertake more than one placement in an organisation. Participants were asked how frequently, if learners return to the organisation, protocols are in place to incorporate their previous experience. Because students do not return to their organisation this item did not apply for ten participants. For organisations where there is a potential that students return, only one reported that protocols are always in place to incorporate their previous experience (Figure 14).

In only two of the organisations studied were there always, and in three others, usually, relationship agreements that included protocols to optimise the continuity of learning experiences. Three participants indicated agreements never include protocols to optimise continuity of learning. Ten participants employed in the organisations that do not see students return deemed inapplicable the item about optimising learning continuity. It should be noted that if a student returns to an organisation for placement this will be at a different stage of their course so the learning objectives, experiences sought and desired outcomes are likely to differ. For this reason communication and information from a previous placement may not be perceived as useful.

Figure 14: Frequency protocols are in place to incorporate previous experience when students return (n=11)



Tools are always utilised to assess learner needs in ten of the organisations studied. Seven participants reported assessment tools are usually used and one that they are about half of the time. Two participants indicated that in their organisation assessment tools are seldom used and another two, that they are never used to assess student learning. When asked the frequency learners have learning contracts or portfolios, eleven participants reported they always do and nine that they usually do. Only two participants reported that students have learning contracts or portfolios less frequently. Agreements between education providers and health services usually specify the parameters of the learning contract. Where there is no formal agreement there is potential for assessment requirements to be overlooked.

Participants were also asked the frequency students not in a structured program are satisfied with their access to learning opportunities such as rooms, clients and clinicians' teaching time. Twelve participants indicated this was not applicable as all the students they have on placement are undertaking structured programs. Of the organisations that do provide places for students not in structured programs, five suggested students are always satisfied and another two, usually satisfied. Two participants reported that students not undertaking structured programs would likely seldom be satisfied with access to learning opportunities in their organisation.

Part 4: Extent organisations enjoy effective health service-training provider relationships

When exploring the frequency resource exchange mechanisms are established between partners to assist with training only one participant reported this always occurs and another two that it occurs very frequently. Almost half (ten) of those interviewed indicated no resource exchange mechanisms have ever been established between training providers and their organisation to facilitate training. Two participants reported mechanisms to exchange resources to promote training are occasionally established, and a further six that such mechanisms are rarely established. Probing the extent to which organisations are satisfied with the relationships with training provider partners revealed less than half (seven) were satisfied. In conversation, participants explained that the level of satisfaction varied between training providers. For example, they may be very satisfied with one organisation but refuse to take students from another. This could also account for why two participants indicated they were neither satisfied nor dissatisfied and another two that they were satisfied on some grounds and not on others. Notably, eleven participants did not offer an opinion. As noted by one participant, 'the standards differ from organisation to organisation and are generally quite person-dependent.' Perceived differences between education providers including the structured formality and breadth of their contractual arrangements with placement providers and extent they service the relationship advantages some and disadvantages others. For example, "One uni visits students onsite whereas another has no contact. The contract with the uni is comprehensive with one but loose with another."

The findings reveal the frequency that health service staff teach into training provider courses is more likely to be occasional (ten) or rarely (six) than very frequently (four). However, only two participants reported that staff in their organisation never teach into training provider courses. Health service educators are also reasonably unlikely to receive training to develop their educational skills from training partners. Nine participants report never receiving training from education providers to develop their educational skills and a further eight that such training

is provided only rarely or occasionally. In contrast, two participants report training providers very frequently provide training to assist the development of educational skills.

Regarding mechanisms to deal with placement issues, fifteen participants report there is always access to a point of contact within the health service and within the training provider and an additional five report that there is very frequently. Two of those interviewed indicated only occasionally is there a point of access within the health service and education provider. Stakeholders report drawing on a number of formal and informal mechanisms to resolve placement issues as they arise (Figure 15).

More than half (thirteen) of those interviewed perceived the description best fitting the nature of the clinical agreement between their organisation and training partners as one that, 'covers resources, induction, and orientation, level of interaction and other aspects that support the relationship between the health service but does not include KPIs.' Eight participants considered 'a partnership agreement that includes KPIs covering resources, induction and orientation, level of interaction and other aspects that supports the relationship between the health service and partner organisations' to best fit their clinical agreements.

Figure 15: Mechanisms in place to resolve placement issues service agreement

Key contact/coordinator contacted by phone or email
Plan negotiated to follow up together
Formal channels/policies exist to resolve issues and concerns
Begin at the lowest level and work up following written policy
HR contacts education provider
Phone contact or email the coordinator
Informal between buddy and student
Relationship-based
Formal complaints/grievance system

Part 5: Extent organisations reflect effective communication processes

Communication was considered to be essential by almost three quarters of those interviewed and to be important by the remainder. When asked whether communication influences actions, behaviours and decision making for student placement, eleven participants reported definitely, a further eight, to a large extent and one identified it to be important.

In the context of clinical placement and student learning feedback, represents an important manifestation of communication effectiveness. Among the organisations there was considerable variation in how feedback was valued. In seven of the organisations examined, feedback mechanisms and measures are reportedly purely informal. In another five organisations feedback is more highly valued and structured. In these organisations feedback mechanisms are in place and staff view them as important. In eight of the organisations feedback can be considered to be valued even more highly. In these organisations feedback mechanisms are not only in place and seen by staff as important but, according to participants, there is evidence that learners are satisfied with the feedback received during the learning experience. Given this finding it is noteworthy that improving feedback featured as a key area for change by those attending ACE supervisor training seminars.

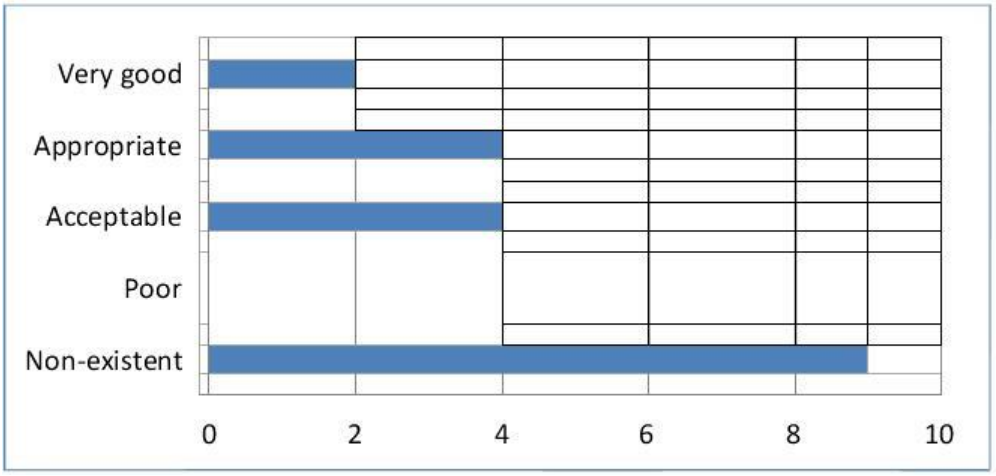
Examining the frequency the organisation provides opportunities for informal training in communication skills reveals another way that organisations value effective communication. In only five of the organisations examined, were learning opportunities to promote communication perceived to always or very frequently occur. For nine organisations informal communication learning opportunities were reported to occur sometimes and for another six, only rarely. The most common focus for in-service training was client communication, an approach not necessarily suited to the nuances and communications skills needed to communicate effectively with students.

Part 6: Adequacy of appropriate learning resources and facilities

Dedicated education facilities were frequently non-existent in the organisations studied, however when there was such a facility it was generally seen to be acceptable for the size of the organisation and its capacity to provide education. Notably, only two participants considered the education facility available in their organisation to be very good (Figure 16).

According to one participant it is not education facilities that limit the number of students that could be accommodated but the educator workforce: “We would be able to support more placements if we had the educator workforce to supervise them.”

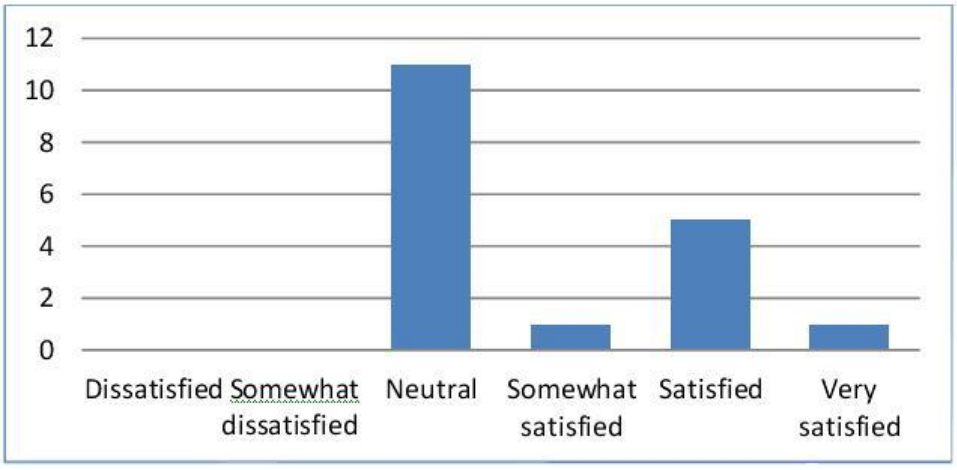
Figure 16: Perceived adequacy of a dedicated education facility



Ten of those interviewed perceived staff within their health service to be satisfied with IT and internet access. Seven others considered that learners as well as staff would be satisfied with IT and internet access within the health service. Three participants from the twenty-two small rural health services studied perceived IT and internet access in their organisation to be inadequate for staff let alone student usage. Students have access to IT equipment and internet access in a limited way but this is in competition with staff and in some services, clients. Depending on how representative the organisations examined are compared to others in the region, these findings suggest that though IT and internet access are likely to be available in the majority of Gippsland’s small rural health services, they are likely to be somewhat inadequate for student learning.

Overall, access to learning resources within the small rural health services studied was quite limited. From the placement provider perspective, participants were largely unsure about how satisfied learners might be with the learning resources available to them. Eleven key contacts sensed students would likely feel neutral about the availability of learning resources such as books, equipment and IT/internet access (Figure 17).

Figure 17: Perceived learner satisfaction with the availability of learning resources



Three participants indicated their organisation does not measure learner satisfaction with the resources available so chose not to comment. Regarding the fragmented location of resources, one participant stated, “we would like to pull resources together in a centralised library and would be keen to have clinical education books.” However others reflected that books rapidly become out-dated and that internet access is more valuable. One participant reported, “The Aged Care Channel forms the basis of our education program for staff.”

Accommodation and support for learners do not feature at all in the relationship agreements between education and placement providers in twelve of the twenty-two organisations studied and for one organisation, very little. In only two organisations staff reported that accommodation and support feature in relationship agreements to a great extent and in another five to some extent. Despite the absence of accommodation in relationship agreements, accommodation was considered by the majority of participants to be a significant issue for students on rural clinical placements. According to one participant, “a flat is available to assist with accommodation” however, student access to onsite accommodation is the exception rather than the norm. According to viCProfile (2012) eighteen placement providers in Gippsland provide onsite accommodation. Drilling down, this includes seven public and private health services, two medical centres and two radiology services. Only six of these facilities provide accommodation to students other than medical, pharmacy or radiology students. Two are in East Gippsland, one in West Gippsland and three in South Gippsland. Apart from emphasising the need for accommodation, those interviewed made suggestions about other ways to attract students and to strengthen the quality of the CLE (Figure 18).

The findings suggest the major barriers/limitations compromising the CLE in small rural health services are lack of staff to supervise students, lack of trained supervisors, limited learning resources and space, including basic resources such as student designated desks, computers and internet access and limited if any accommodation and even when it is available, variable disciplinary access.

Figure 18: Suggestions to improve the quality of the CLE

To provide a welcome email to students
To have a desk with a computer allocated to students
To provide students with an orientation/resource manual
To promote students’ welcome by including them in team social events and meetings
Allocating a training budget of $500/therapist
Providing access to a library with learning resources
To have specific agreements ready for training organisations for each field
Providing supervisors with guidelines for what to do with students for each profession
Having a clearly documented process for students to come to the service

There is also a need to find ways to increase the access staff have to professional development opportunities, leave entitlements and to create a flexible ‘fallow period’ to ‘relieve’ staff from their supervisory/ educative role to mitigate burnout.

The common priorities from an organisational perspective are to:

- have a dedicated learning space available for students;
- have more staff suitably trained to supervise students, for example, preceptor training; and
- address the lack of or limited student access to computers and support.

In some organisations there is tension and competition between staff and students and even students and students to access an available computer. Even when IT access is available, software and organisational policy may not allow Skype and there may be no access to videoconferencing or telemedicine to support and augment student learning.

By exploring the factors that impact on learning and quality outcomes within organisations in the GCPN, this project has encouraged key stakeholders to view their organisation from an educational perspective. As part of the project stakeholders have been encouraged to identify the multi-dimensional factors within the CLE that challenge staff and students and impact on learning. Involving stakeholders in this project has enabled common and specific strategies to be identified that can modify, and in some cases potentially transform the CLEs of the organisations studied. Promoting a change in perspective to a focus on education has empowered key staff in these organisations to develop the potential of their facility to increase student placement capacity and strengthen the quality of their CLE.

In promoting education as core business and assisting and supporting key contacts in partner organisations to develop their educational profile, this project has motivated interest and commitment to expanding capacity for clinical placements in the GCPN in areas of demonstrated workforce shortage. Participants from a variety of health services indicated a willingness to increase their service's capacity and capability to provide quality clinical placements. The medium to long-term impacts of promoting education as core business in participating agencies should translate into these organisations being better prepared and committed to developing and maintaining their particular CLEs in accordance with the BPCLE indicators. However, these anticipated impacts will not be known unless they are monitored.

This project provided strategic direction, confidence, inspiration and practical resources for organisations to embed education (and clinical placement capacity) as core business. Three workshops and supportive resources were provided to assist stakeholders in eighteen organisations overcome identified barriers to clinical placement. Developmental work was undertaken to assist participants to refine pertinent documents, including orientation, to reflect education as core business. By engaging smaller and more marginal placement providers in GCPN activities, this project has situated them well to build their capacity and capability as quality placement providers and prepared them to be receptive and committed to the projected rollout of the BPCLE Framework.

Opportunities to network with other health care providers (residential, community, acute, public and private services) were embraced by participants who appreciated the potential to share and promote educational activities with others. In the medium-term, this opportunity to network may encourage stakeholders to develop cooperative, collaborative arrangements across traditional jurisdictional divisions that will build and sustain quality clinical placements in expanded settings.

Indicative of their stated commitment to education and the importance of supporting student learning in the practice setting, the majority of stakeholders embraced project activities. Furthermore, participants demonstrated preparedness to take responsibility for clinical education through their enthusiasm to develop and/or refine their organisation's educational profile, policies and resources consistent with promoting a positive CLE. In the medium to long-term, the ability of local resource personnel in small health services to take responsibility for clinical education will promote the overall quality of the CLE and the capability of staff in these settings to support and optimise students' clinical learning experiences.

In the medium to long-term, elevating the profile of education in expanded settings as this project has achieved, will help enhance their suitability and acceptability to education providers and students as valued clinical placement options and also their attractiveness to potential recruits.

Limitations and management strategies

This project targeted small rural health organisations that may not have valued education as core business. Engagement with stakeholders was sometimes constrained by conflicting workload priorities, dual roles, patient acuity and complexity, time and distance. Access to partner organisations was one of the key limitations of the project from two standpoints: a) for the project team to access stakeholders, and b) for stakeholders to be able to attend and engage with project activities. The issue of access was partially addressed by providing multiple opportunities for organisations to be engaged and participate in project activities. In addition, project staff adopted a flexible approach to the timing, mode and location of meetings, interviews and workshops. Access and engagement was further enhanced by delivering workshops in geographically strategic locations to reduce the time and costs associated with travel. Whilst these strategies did not fully resolve the issue of access they facilitated local subregional networking.

Another limitation of the project related to the difficulty engaging certain stakeholders. 'Gate keepers' (Brammer, 2006) in some organisations chose not to engage despite continued efforts by project staff. Furthermore, they obstructed engagement by other staff. The approach taken was to persevere and source alternative personnel within the organisation who recognised the value of participating in activities and being engaged. This process was time consuming and potentially limited the gains achieved. However, the composition of the steering group and their local knowledge and expertise provided valuable insight, guidance and direction to resolve such problems and promoted opportunities to engage target organisations.

Self-report data can be inaccurate, biased and represent a limited perspective (Grant-Vallone and Donaldson, 2001). There was a risk that those interviewed may not have been the most appropriate personnel to answer at least some of the questions asked or to act as change agents. To increase the likelihood participants were the most appropriate staff to be interviewed and involved in project activities, those targeted were limited to the key contacts nominated by the organisation as being the most appropriate staff to address education-related information.

Findings can be distorted by a halo effect, such as the failure of staff to acknowledge limitations within their organisation. The trustworthiness of the information gathered was checked by active listening, probing responses to clarify issues and asking participants to provide examples.

While it was anticipated that health service organisations would have their documents readily accessible on the web, the search proved otherwise. For several organisations, it was difficult to access any relevant information relating to strategic documents despite exhaustive searching. Accordingly, the findings reported here regarding web-based document review may understate the extent to which education is actually incorporated into the key documents of smaller rural health services. To address the deficits of web-based documentation, the project team adopted a
mixed-methods approach that sought to supplement the desktop review with self-report data.

Evaluation

Evaluation is a core element of all stages and processes of action research because this ensures the changes proposed are shaped and refined consistent with promoting positive outcomes (Stringer and Dwyer, 2005). Crinall and Laming (2012, p.11) claim that in action research:

"… evaluation constitutes a dynamic, embedded process, which directly integrates theory (or ideas) with practice. This design enables both formative and summative evaluation."

For example, the semi-structured interview guide was critiqued by members of the steering group and their suggestions incorporated. Interview findings were reported to the steering group for further analytic discussion and to generate recommendations. Likewise, the workshops were formally evaluated by participants and the content, supporting materials and format changed or adapted on the basis of the feedback provided. These continuous and cyclical processes provided opportunities for consistent and focused evaluation data to be realised and supported O'Brien's (2001) claim that people more willingly commit to applying new learning and implementing change when empowered to do it themselves.

Evaluation of resource development workshops

The workshop program, developed to meet the objectives outlined in the project brief, included an introduction to the BPCLE Framework, an overview of BPCLE indicators to measure an organisation's success against the Framework, the BPCLE resource toolkit and structured time to give participants an opportunity to work together utilising various BPCLE resources. The program also introduced participants to the use of viCPlace, the online data information and management tool developed to assist placement and education providers with placement planning. A booklet containing a collection of resources and instructions for using a sample of tools from the BPCLE resource kit was provided to participants to optimise the utility of the workshop, reinforce learning and encourage participants to continue working with the resources available online. Participants were also given a memory stick with a collection of resources including, among others, the BPCLE Framework and the BPCLE resource kit.

Expressions of Interest (EOI) to participate in a clinical placement resource development workshop were sought from targeted project partner organisations. The project partners targeted included a selection of expanded rural health service settings such as medical clinics, residential aged care facilities, community mental health and smaller rural health services. Responses to the EOI were received from eighteen organisations. In light of the broad geographic distribution of interested organisations, workshops were conducted in three strategic locations across Gippsland; Bairnsdale, Morwell and Leongatha. The twenty-five people who participated in the workshops included education providers and health service staff who held varying roles related to clinical education, supervision and/or coordination of student placements (Figure 19).

Figure 19: Profile of workshop participants

Interprofessional program facilitator
Assistant practice manager
Educators
Director of nursing and residential care
Education coordinators
Nurse manager
Office manager
Practice supervisor
Senior recovery support worker
Mental health program coordinator

Apart from evaluating workshops in terms of the breadth and depth of engagement geographically across the region, by health sector and professional profile of participants, the workshops were evaluated by mapping their contribution to the objectives of the project (Table 5).

The workshops were also evaluated by participants completing an evaluation survey distributed at the end of each workshop. Of the twenty-five who participated in the workshops, twenty-two completed the evaluation survey. Prior to the workshop eleven of the twenty-two participants who completed the evaluation were aware of the BPCLE Framework, seven were unaware of it and two were unsure. Having completed the workshop, all participants reported their knowledge of the BPCLE Framework had improved and five considered all of the information about the BPCLE Framework beneficial.

The workshop information cited most frequently by participants to be of greatest value was the BPCLE resource toolkit. While none of the participants were aware of the BPCLE resource toolkit prior to the workshop, following the workshop they could all see ways to improve clinical placements in their organisation by using resources from the toolkit. The resources participants reported they planned to utilise are listed in Figure 20.

Table 5: Relationship between project objectives and resource development workshops

Objective	Workshop contribution
To explore and engage with stakeholder organisations within the GCPN, particularly smaller and more marginal health services issues related to education provision.	Interview surveys completed and organisations invited to participate in workshop.
To identify barriers to integrating education into the core business of organisations.	Interview surveys completed and workshop program developed with a focus on areas of deficit identified in surveys.
To develop strategies to improve the internal and external education services (including clinical placement) within organisations through promotion of the BPCLE Framework.	The promotion of the BPCLE Framework constituted a major component of the workshop program. Workshop evaluation surveys reveal participants gained an increase in knowledge and understanding of the BPCLE from

	participating in the workshops.
Support organisations to develop mission statements that contain learning as an integral part, in alignment with the projected statewide implementation of the BPCLE.	Although the workshops were not designed to specifically address the development of education-focused mission statements, the BPCLE information and resources used in the workshops stimulated discussion and heightened awareness that these statements should reflect education being highly valued in health services.
Support organisations to develop policies that include education and orientation programs as an integral component, for staff and students.	Tools available to facilitate the development of placement-related policies and documents were incorporated in the workshop program and time allocated during workshops to develop orientation and other resource materials.
Provide network and communication platform to support healthcare providers to integrate and promote education to both internal and external stakeholders.	Workshops provided a networking opportunity and chance to build partnerships. Experiences with clinical placement were shared and discussed. Participants indicated their intention to use the BPCLE as a basis for progressing education development in their organisations.
Provide workshops to assist in the development of skills and attributes to promote learning as core business.	Workshops were provided.
Expand capacity for clinical placements.	The planning and provision of resources together with networking and discussion identified the potential to expand clinical placement capacity.

Figure 20: Online BPCLE resources participants planned to utilise

Resource
Orientation handbook template, program guide or checklist
Placement evaluation/learner survey
Welcome letter template
Relationship agreement guide
Student logs
Various/many of the resources
VCPC website resources generally

All participants indicated they would recommend the resource development workshop to colleagues. Reasons given for recommending the workshop included the practical application of useful resources, opportunity for shared learning and networking and increased awareness of the CPN. Other positive comments included elements such as the choice of workshop locations, quality of presenters, content, hand-outs, and catering. Suggestions were also made relating to the need to focus some attention on the needs of private clinics and to consider making the workshop a half-day program from 8:30–12:30 to facilitate access, particularly for smaller organisations.

The workshops augmented and complemented the project objectives. Practical opportunities to minimise some of the barriers that had been identified for including education as core business were discussed and applied in the workshop. Resources to improve education and promote the BPCLE Framework were utilised and all participants indicated their intention to use their new knowledge to promote quality placements by applying the procedures, checklists and guidelines engaged with during the workshop. The workshop also provided a networking opportunity and stimulated discussion and problem solving conversations within each group. The application of BPCLE resources specified by participants to better support clinical placements in their organisation has the potential to provide a strong a foundation for increasing the capacity and quality of clinical placements.

On the basis of the evaluation feedback, it is anticipated that further BPCLE promotional workshops will be welcomed by health services in expanded settings. Future workshops may be improved by providing examples of

BPCLE resources that could be better utilised by private clinics and other non-traditional sectors. For smaller organisations constrained by limited staffing and access issues, a half-day program may also be an option to facilitate attendance at the workshops. Locating workshops in regional areas was appreciated by participants who felt it promoted a welcome and inclusive environment for services where distance and time constraints may otherwise have precluded their engagement. Despite continued efforts, engagement with the ACCHOs in the region proved difficult, however, to promote their inclusion individualised support was offered, and subsequently accepted by one organisation.

Evaluation of project activities

Originally, this project sought to engage with fifteen partner organisations, however by completion, had involved thirty-eight smaller and more marginal health care services operating across each of the local Government jurisdictions in Gippsland and achieved nine out of ten stated objectives. The one objective that was unable to be achieved related to the organisational processes involved in developing vision and mission statements. However, as already noted, amendments to vision and mission statements were beyond the reach and jurisdiction of this project.

The action research framework of the project was designed to empower stakeholders, enable them to evaluate the education profile of their organisation and equip them to redevelop the CLE of their organisation in alignment with the BPCLE Framework. The interview process raised participants' awareness of the status of education in their organisation and opportunities to promote education as core business.

Workshops were evaluated and the resultant data analysed. Participants embraced the opportunity to work with and adapt the document templates provided within the BPCLE resource kit. As stated by participants, it was "Great to have templates to utilise" (c1), and "the range of resources available [means] I don't have to reinvent the wheel" (c2). Other comments made by participants regarding the benefits they derived from the BPCLE resource kit included the ability to "… review our current resources and improve what we have" (c3), and to… "using the templates and being able to use them in our practice" (c4). The document templates from the BPCLE resource kit considered most useful included: the student evaluation survey, student welcome letter, orientation information and checklist, and confidentiality statement. While some participants indicated they were likely to utilise one or two documents, a number felt all the resources demonstrated from the resource kit were valuable and would be beneficial in strengthening their CLE. Another benefit deriving from the workshop was the introduction to the viCProfile data (c5).

The key findings of the project were that education is already, though to varying degrees, reflected in the organisational operations and planning of all of the health services examined. Desktop analysis of Vision and Mission statements revealed that none of the health services examined made any specific and very little indirect reference to education. While organisational formalities and procedures precluded supporting health services to redevelop mission statements, participants revealed an interest in education being incorporated at this level.

For five organisations the first reference to education appeared at the strategic planning level and for eleven others as a standing agenda item for senior management meetings. The adequacy of resources and facilities available to support staff development and student learning varied considerably. Dedicated education facilities were frequently small or non-existent, though when provided they were highly valued.

While none of the organisations studied reflected all six elements that characterise a BPCLE, there was evidence that stakeholders were keen to strengthen their organisational culture to provide a positive learning environment. An important discovery was the notable variation in the effectiveness of health service-training provider relationships. Long-standing partnerships between universities and TAFE providers tended to be perceived as more satisfactory, mutually collaborative and to have clearer, more effective communication channels. The need was identified for improved communication processes within organisations to ensure all staff are cognisant of organisational values, priorities and plans. These findings have informed strategic decision making to promote the status of education as core business in most of the organisations that participated in the project and provide clear directions for future planning.

Participants' responses highlighted evidence of the limited and variable integration of education as core business. For example, in nine of the twenty-two organisations the provision of education was perceived to be additional to

regular work practices. There was an individual whose primary role was to provide education or facilitate clinical placement in less than half of the organisations studied. Staff in almost one-third of the organisations studied reported uncertainty about how the organisation valued their educative role. Staff attitudes towards professional development also varied considerably within and between organisations.

Barriers to integrating education into the core business of organisations were identified by delegated staff reflecting on their organisations' education profile and practices in light of the BPCLE Framework. These results are consistent with education not being core business as evidenced by the omission of education in mission and value statements.

Examining the extent to which education manifested as core business highlighted a number of potential barriers to placement similar to those reported elsewhere (Barnett et al., 2010), for example, the lack of opportunities for supervision training. Participants described current supervision and training provision and explored current policies related to clinical education which indicated similar constraints. Results from this analysis were collated in the survey report and informed the rationale underpinning the GCPN's drive to promote a career path in clinical supervision and improve access to clinical supervision education.

In nearly half of the organisations studied (ten) there were no formal protocols to address the matter of struggling students however, questioning participants about their protocols to manage this aspect of student placement generated strong support for developing policies and routines to address what has been a perennial issue.

Prior to attending the resource development workshop ten participants were unaware of the BPCLE Framework and all were oblivious to the BPCLE resource portfolio. The workshop strategy adopted to promote knowledge of the BPCLE Framework and utilisation of online resources was successful in improving knowledge and encouraging participants' engagement.

Future directions

This project has identified a range of barriers that limit clinical placement capacity and the quality of the CLE in expanded settings, and in the process, illuminated potential solutions.

Expanded settings

The settings (sectors) involved in this project included private practice, aged care, rural, ACCHOs and community mental health, areas targeted by the DH as expanded settings suitable for building placement activity. In recognition of the difficulties faced within these sectors to effectively service clinical placements, the DH has identified the need for additional support in these non-traditional settings. In anticipation of placement activity in expanded settings the GCPN has been funded to continue the gains achieved through this project by the appointment of a regional education champion. The role of the Gippsland expanded settings development officer (GESDO) will involve providing support to progress the development of smaller health services as quality placement providers.

To advance the profile and the quality of the CLE the GESDO will encourage and assist organisations to consider education as part of their core business and adopt a coordinated approach to reflecting this in organisational strategic documents, planning and operations. The role will also facilitate the forging of collaborative, inter-sectoral and interprofessional partnerships to enable clinical staff in expanded settings to access professional development opportunities in larger organisations.

Promoting a BPCLE

The opportunity to apply the BPCLE Framework and utilise resources from the toolkit was considered valuable by participants. They felt this engagement would assist them to improve their CLE and indicated they were likely to engage with other resources within the kit. The BPCLE Framework has recently been piloted in sites across Victoria by Darcy Associates for the DH. Following evaluation of the trial there is an anticipated rollout (to commence late 2012) of both the framework and resources to assist stakeholders.

By actively engaging stakeholders across the CPN in resource development workshops, the BPCLE rollout will assist to maintain the momentum achieved and continue the work that has been undertaken in this project.

Schemes to promote the quality of the CLE should be directed to the particular needs of an individual organisation and to aligning their policies and procedures regarding clinical placements to the BPCLE Framework.

Clinical supervision training and support

Clinical supervision training and support was identified as an area of need by many participants; however these problems are not limited to the local region (Barnett et al., 2012). In recognition of the widespread need and the varied levels of supervision support currently available in CLEs, Health Workforce Australia has targeted this as a funding priority. The GCPN was successful in receiving funding for a submission to advance clinical supervision activities, which include the development of a specific Gippsland program and various supportive workshops for areas such as interprofessional learning and mental health.

It is anticipated the appointment of a clinical supervision support officer for the CPN will further assist stakeholders to adopt a standardised approach to the training of clinical supervisors to promote their understanding and ability to differentiate alternative supervision models.

Other strategies that should be implemented to support clinical supervisors and assist them in managing challenging student situations are the establishment of a peer support network and a web-based repository of supervisory resources.

Recommendations to further strengthen the CLE

Additional strategies to strengthen the quality of the CLE in expanded settings and increase placement capacity in Gippsland include:

- Assist organisations to provide a designated basic student space/workstation comprising study desk, chair and computer with internet access.
- Provide an articulated connectivity platform in Gippsland to promote inter-sectoral and inter-agency communication, networking and support between placement providers and key education providers in the region.
- Develop a common Gippsland student survey that reflects the principles of a BPCLE to evaluate students' rural placement experiences in Gippsland in order to establish a benchmarking framework.
- Organisations track the students returning to the organisation and their reasons for doing so to furnish evidence of a relationship between providing a positive learning environment.

Conclusion

Rural health services in Gippsland value education as core business, albeit to varying extents. The considerable variation in how education manifested as core business revealed a need and also opportunities to promote education as core business, however, the marked variation in the level of readiness of organisations to effectively service clinical placements precludes a single approach. As an outcome of this project some thirty-eight health service organisations in Gippsland are more aware of the characteristics of a BPCLE and many have already taken steps to progress the quality of their CLE.

Adopting an action research approach to engage key organisational staff in target partner organisations and empower and enable them to redevelop the status and profile of education within their organisation as core business proved to be a valuable strategy in garnering interest and commitment, dealing with the learning, reflective and practical changes required and increasing the likelihood project partners will continue to refine their operations in-line with providing staff and students a BPCLE long after the completion of the project. The findings also offer insight into how other organisations can strengthen the quality of their CLE in alignment with the BPCLE Framework.

In some organisations 'education champions' have been identified to increase the potential role health services in Gippsland can play in building clinical placement capacity. These champions, already committed to professional, evidence-based practice and supporting student learning, have been guided to network with external colleagues

and where possible equipped with the requisite knowledge, skills, attitudes and access to resources to progress development of a BPCLE within their facility.

This study highlighted the need for the appointment of an expanded settings development officer to facilitate the building of supportive infrastructure, bridge some of the differences found, optimise the potential achieved and maintain the momentum gained through this project. There is also a continuing need to invest in building and maintaining a critical mass of trained clinical supervisors in the region to mitigate burnout, address turnover and promote job satisfaction. Furthermore, there is a need within organisations to build a learning culture, promote professional development, respect and value educative roles and wherever possible to disentangle these from dual, often conflicting clinical and managerial roles that constrain their effectiveness and limit their ability to support staff and student learning and promote a quality CLE.

The collective activities of this project have clarified how the role and status of education can be promoted in health services within the GCPN. The quality of the CLE can be strengthened by: providing basic dedicated learning resources and space, considering educational needs in strategic planning, capital works, annual budgets, operational policies, procedures and activities, and supporting continuing professional development. Developing sophisticated communication channels and establishing information connectivity between education and placement providers emerged as priorities to reducing the barriers that constrain the ability of small rural organisations in Gippsland to service clinical placements. Combining the various strategic activities planned for the region provides an opportunity to consolidate and integrate the gains achieved to date.

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