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| Final project reportClinical Supervision Support Program |

South Coast Interprofessional
Clinical Supervision (SCICS) Program

Submitted by:

Gippsland Southern Health Service

In partnership with:

Bass Coast Regional Health

South Gippsland Hospital

**June 2013**

Executive summary

Aims and objectives of the project

The funding provided under the Clinical Supervision Support Program (CSSP) was intended to extend and augment the South Coast Interprofessional Clinical Supervision (SCICS) Project (originally funded under the Commonwealth Government’s Increasing Clinical Training Capacity Initiative). The aim of the SCICS Project was to establish a central clinical supervision program to support the three health services and five medical clinics in the South Coast area to work collaboratively to:

* Increase capacity to provide high quality undergraduate clinical placements across the subregion,
* Develop a learning culture and further strengthen collaboration amongst member agencies,
* Provide opportunities for student interprofessional learning and practice; and

Reduce duplication of effort and improve the synergistic relations across the member agencies.

With the funding granted under the CSSP the SCICS project was able to fund the role of a project manager and a health service facilitator. The funding also enabled the recruitment of two health service facilitators which allowed a part-time health service facilitator to be at each of the three sites. These roles were valuable to achieve the objectives, and also more effectively engaging the broader staff groups at each site. This project also provided funding to recruit a project officer/manager to oversee the project and meet accountability requirements.

Project activities and methodology

The SCICS Program used action research principles to engage managers, clinicians and educators in the partner health services, medical clinics and Monash University to:

* Identify opportunities and strategies for increasing clinical placements and interprofessional learning and practice; and

Develop, implement and review action plans to achieve these objectives.

The objectives of the Project were achieved through a combination of strategies including clinical supervision staff training; testing and refining alternative models of clinical supervision; establishing systems and cultures that foster positive learning experiences for both staff and students; staff engagement strategies and forums; development of organisational policies, supervision manuals and student orientation manuals, and other resources required for best practice clinical supervision.

Key outcomes and findings

This Project produced a range of positive outcomes, many of which have fundamentally changed the way clinical supervision is provided and managed within the health services and the broader subregion. This project created a level of collaboration between the health services and medical clinics that did not exist before. As a result of the project, health service managers and clinical supervisors regularly communicate and share resources. There is less likely to be duplication of effort now and more willingness to work together. Other significant outcomes attributed to this project are:

Increased the overall actual capacity to provide nursing clinical placements from 2193 days in 2011 to 3998 in 2013 (82% increase) across this subregion. Potential nursing placement capacity was increased in this period from 2193 days to 9954 days (354%)[[1]](#footnote-1).[[2]](#footnote-2). Medical placements have remained the same as placements were at capacity in 2011. There has been a significant decrease in allied health placement capacity from 515 in 2011 to 396 in 2013 (23% decrease) due to budget cuts and reduced staffing levels across all areas of allied health in the subregion.

* The interprofessional learning opportunities increased from 570 hours in 2011 to 599 in 2013 (5%),
* Expanded the settings where students can gain clinical experience, including more specialist acute areas (A&E, theatre) and in primary and community care settings,
* Increased the number of staff skilled in providing clinical supervision by 64. Improved ability to measure and report on clinical placement capacity,
* Improved quality of the placement experience as demonstrated by the extremely positive student feedback/survey results and improved compliance with the BPCLE tool; and

Raised the standard of clinical practice of staff generally because they were under greater scrutiny from students than ever before. The culture and platform for providing effective clinical learning has also supported an increase in graduate nursing positions and staff development.

Conclusions

The increase in the clinical supervision capacity required to meet the demand for placements in a rural setting is best achieved by a collaboration between health services (particularly the staff on the ground), medical clinics and higher education providers. To increase clinical supervision capacity and enhance its interprofessional focus, strategies need to fundamentally change the traditional approaches to clinical supervision that rely on a select few preceptors, where staff do not accept clinical supervision of students as their core responsibility. The strategies employed in this project to achieve this transformation focused on raising the expectation that clinical supervision was everyone’s responsibility, giving staff the skills to do this well, defining the behaviour norms and developing processes, structures and resources to foster a best practice clinical learning environment. It is critically important to actively engage staff in this venture as early and as often as possible. In this Project, this was made possible by creating part-time health service facilitators in each health service to engage staff and support them to make the changes needed.

The attention and priority given to the student placement experience has been substantially raised as a result of this Project both in the eyes of management and staff. Resources and time need to be devoted to maintaining this level of focus. This Project demonstrated that hospitals are able and keenly interested in making the changes needed to provide high quality student places. It is now up to the Universities to demonstrate their willingness to review their curriculums and how they place students to match the new capacity created.

Background and context

The original SCICS Project received funding in 2010 under the Commonwealth Governments Increasing Clinical Training Capacity Initiative. This previous project established a subregional approach to increasing rural health service and medical clinic capacity to provide clinical supervision and foster inter-professional learning and practice.

Context

The increasing gap between demand and supply of health professionals in rural and remote areas is already well documented (1, 2). In Bass Coast and South Gippsland however, this gap is exacerbated by a growing population, a substantial proportion of which are retirees looking for a ‘sea-change’. Over the past several years, there has been a dramatic increase in the number of undergraduate students from nursing, medicine and allied health requiring clinical placements in the Gippsland area. One of the key drivers of this increase has been the opening of the Medical School at the Churchill Campus of Monash University (2008). This increase represents an important strategy in responding to the health professional workforce shortages experienced in rural Victoria, particularly in the South Coast area. For example, almost all of the hospital medical officers (HMOs) recruited to Bass Coast Regional Health in the past two years have been overseas trained graduates. However, the opportunity to develop health professionals more locally is limited by the current capacity of local public health and private medical services to provide the clinical supervision needed by this growing population of undergraduate students.

The strategic basis for this project

There have been numerous reviews focusing on improving the capacity of the health workforce to respond to the growing health care demand associated with an aging population. Strategies recommended promote:

* Workforce responsiveness, flexibility, sustainability and innovation, such as introducing the new national system for registering health professionals and the accreditation, interprofessional learning and practice, advanced clinical training, collaborative practice models (3,4),
* Overhauling and broadening the clinical training base for health professionals (5),
* Exposure to rural health services in the curriculum (6),
* Encouraging students from rural backgrounds (7); and

Providing rural education and training experiences and rural scholarships/cadetships (8).

References

(1) Department of Health and Aged Care (Aust) 2001, Population Ageing and the economy - Research by Access Economics P/L. Department of Health and Aged Care, Canberra.

(2) Australian Health Ministers' Conference 2004, National Health Workforce Strategic Framework (Australian Health Ministers' Conference, ed), Australian Government, Canberra.

(3) Council of Australian Governments (COAG) communiqué 13 April 2007.

(4) Productivity Commission 2005, Australia's health workforce, Australian Government, Canberra.

(5) Ibid.

(6) Australian Medical Workforce Advisory Committee. The Medical Workforce in Rural and Regional Australia. Canberra: Australian Institute of Health and Welfare. 1996.

(7) Australian Medical Workforce Advisory Committee. Career Decision Making BY Postgraduate Doctors, Key Findings. AMWAC Sydney. 2005.

(8) Ibid.

Aims

To build on the SCICS Project aims of establishing a central clinical supervision program to support the three health services and five medical clinics in the South Coast area to continue to work collaboratively to:

* Increase capacity to provide high quality undergraduate clinical placements across the subregion,
* Develop a learning culture and further strengthen collaboration amongst member agencies,
* Provide opportunities for student inter-professional learning and practice; and

Reduce duplication of effort and improve the synergistic relations across the member agencies.

Project activities and methodology

Project methodology

The Project methodology was based on a previously funded projected designed to increase clinical supervision capacity and interprofessional learning opportunities. The following provides an overview of this methodology.

The SCICS Project used action research principles to engage managers, clinicians and educators in the partner health services, medical clinics and Monash University to:

* Identify opportunities and strategies for increasing clinical placements and interprofessional learning and practice; and

Develop, implement and review action plans to achieve these objectives.

A strategic planning workshop was held at the commencement of the original Project in September 2010 that engaged all the key stakeholders from the partner organisations. The resulting report formed the basis for the Action plan, which has guided this project.

The overarching outcomes of the Project were to:

* Increase placements,
* Increase IP learning/practice opportunities,
* Subregional program – infrastructure, coordination and collaboration; and

Sustainability – culture and skills (also includes funding sustainability)

Monthly Working Party meetings provided the forum for reviewing the progress of the action plan, the impact of the actions, discuss and resolve issues that emerged in relation to the Project and to agree on new strategies and models to implement.

To support the Project a small team was recruited comprising a part-time project manager, full-time health service facilitator and a GP (responsible for medical student placements in the area). As the Project evolved, and with the additional funding provided by the Department of Health and HWA, the full-time health facilitator role was converted into three part-time health service facilitators, one at each health service. These roles were valuable in providing the additional support to make the changes needed to achieve the objectives, and also more effectively engaging the broader staff groups at each site.

Project management

Governance arrangements

The governance arrangements used in this project were the same as those established in the 2010 project mentioned above. They comprise the following:

* A Project Management Team (Steering Committee) was established at the commencement of the SCICS project, whose membership included executive representatives from all collaborating organisations. This committee met second monthly to provide direction, approve project activities and expenditure, and monitor progress.
* A Clinical Supervision Working Party was established with membership including managers and experienced educators from all collaborating organisations and the Gippsland Clinical Placement Network. This Group met monthly to agree and implement project activities, identify strategies to engage stakeholders within their organisations, discuss and resolve issues.
* Gippsland Southern Health Service was the lead agency and held the funds. This organisation discharged the following lead responsibilities:
* ensure that the terms and conditions of the Funding Agreement and Schedule were met,
* establish a project officer/manager to oversee the project and meet accountability requirements,
* engage and manage appropriately qualified and experienced subcontractors to undertake project activities, in accordance with the funding submission and subsequent Funding Agreement and Schedule,
* maintain contact with the Department of Health; and
* ensure output reporting in accordance with the Funding Agreement and Schedule.

Stakeholder engagement and consultation

* Key stakeholders: CEOs of all partner health services, CEO of GPA South Gippsland, practice managers of all partner general practices, representatives from medicine, nursing and allied health faculties (Monash University, Gippsland), SCICS clinical supervision facilitator, student educators at all partner sites, students attending clinical placements.
* Consultation activities: Members of the SCICS Steering Committee and Clinical Supervision Reference Group were charged with promoting the projects aims and activities, and engaging their staff and colleagues across their organisations.

Communication strategy: Project initiatives and outcomes were communicated via health service newsletters, publication in health service annual reports and quality of care reports, presentation of papers and progress reports at a variety of conferences and public forums (e.g., submission of abstracts to clinical placement/education conferences). A website was developed for the project (<http://www.scics.com.au/>) containing the various resources developed during the project or offered for sharing across the partner organisations.

Budget

Funding was granted under the CSSP to capitalise and build on the work initiated and undertaken by the SCICS project, which was originally funded by the Commonwealth Department of Health and Ageing between January 2010 and December 2011.

Timelines

This report relates to the key activities undertaken as a result of the CSSP.

Table 1: Summary of key activities and deliverables

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| Project objective  | Project deliverables/target | Activities undertaken to achieve target/objective | Date completed |
| To increase clinical supervision capacity across the subregion by a minimum of 50% during 2012. Student numbers are expected to increase by a further 15% (minimum) in 2013. | Create placement capacity to support 74 medical students, 320 nursing students and 48 allied health students who are planned for placements in 2012. | Implemented a variation of the Primary preceptor model (previously called the ‘Bairnsdale model’) in BCRH and SGH.Introduction of weekend rostering of students to support this model in BCRH.  | 30 June 2013 |
| To introduce and support new placements within expanded settings; aged care, private general practices. | Clinical placements available in non-traditional settings | Extended placements to specialised health service departments (i.e., Operating Theatre, Accident and Emergency) as a routine part of student placements so students benefit from exposure to more clinical areas and the clinical supervision load is spread more evenly across more clinicians. Increased number of specialty placements by 450 placement days for 2013 by incorporating Operating Suite, Emergency Department and Community Placements.190 new placement days in community settings including GP clinic and Community Health Centre. 15 OT joint placement days between hospital and community centre. | 30 June |
|  | Extend to include additional disciplines and partners (i.e., GippsTAFE, Holmesglen and Skills Training Australia) in order to expand clinical placements for vocational health students including enrolled nurses, paramedics and allied health assistants. | Eight new partnership agreements with vocational EP’s for 2013 across all sites. | March 2013 |
| To foster interprofessional clinical learning and practice. | Increase student interprofessional learning hours by a minimum of 50% during 2012 (a target of 840 IPL hours in 2012) and ensure this target is maintained during 2013 and beyond. | IP weekly tutorials promoted and held regularly throughout 2012-13 across the health services. At the end of June 2013, 599 IPL hours were recorded for 2013. A total of 1672 IPL hours were created during the SCICS Project 2011-2013.A shared calendar of interprofessional activities across the region is currently in use for 2013.IP student case conferences continue to be held across the health services.A list of existing learning packages which can be used to accompany training equipment has been established.  | 30 June |
| To ensure all project partners meet the Department of Health criteria for a best practice clinical learning environment by May 2013. | * Auditing clinical learning environments within each health service.
* Initiatives to be implemented by local working parties to address areas of non-compliance.
* Communication strategies to encourage more staff and managers from a variety of health services to engage in project activities.
 | Each health service was audited against the draft BPCLE tool. Areas for improvement included implementation of a learner survey, orientation documentation and clinical placement policies and procedures.Actions taken:* Discussions with executive staff regarding incorporation of learning culture into organisational strategic plans currently in progress.
* Department specific orientation manuals have been developed, in addition to orientation documentation (student welcome pack)
* Learner survey has been introduced into each health service.
* Local student supervision policies and procedures have been developed.

SCICS website updated regularly and articles published in health service newsletters and local media. | May 2013 |
| To further develop the clinical supervision capacity of general practitioner staff, nurses and allied health professionals and provide ongoing recognition, support and mentoring to student supervisors. | At least six local staff members to undertake Advancing Clinical Education (ACE) train-the-trainer education during 2012 (to be developed and delivered by the Gippsland CPN).In-house ACE training throughout the subregion will commence in 2013. It is anticipated that a minimum of 80 staff within the subregion will attend ACE training courses during 2013, facilitated by local trainers. | Opportunities for staff to attend regional clinical student supervision training during 2012-2013 were promoted within each health service.SCICS funded two local student supervision training courses in 2011 and 2013. All staff were invited to participate in the training. In the event, only 64 local staff attended these programs in total instead of the 80 anticipated. Some staff attended the same program that was funded by the Gippsland CPN and run around that same time.A further 11 staff attended advanced component of the ACE program funded by SCICS.In addition the Gippsland CPN have developed and will run a train-the-trainer modified ACE program (GRACE) in July 2013. Eight local staff will undertake training so that the modified ACE program can be run in local health service in late 2013 and beyond.An electronic subregional Clinical Supervisors Network has been established. The platform encompasses a blog, website links, documents and shared calendar.An award system was trialled but supervisors preferred a more private system of feedback and recognition. A supervision feedback form was developed which is provided back to the preceptor and the Department Head for use in the appraisal process. | March 2013 and ongoing |
| To ensure project initiatives continue beyond the funding period. | Objectives achieved to date are sustained. | * Subregion is considering a proposal to recurrently fund a central position to continue supporting the health services to maintain a collaborative approach to managing clinical placement capacity. However, budgetary cuts may impede this.
* A subregional executive group includes clinical placement capacity on their agenda. Plans are being developed to hold a clinical supervisors network meeting 1-2 times a year; possibly engage the CPN in holding an annual conference for clinical supervision.
* The culture of two health services has undergone a review, which has formed the basis for a cultural transformation action plan.
 | Ongoing |

Outputs

The partners of the SCICS collaborated in developing the following resources (outputs) to improve the capacity to deliver high quality clinical placements:

* Organisational Student Orientation Manuals for each health service and departments.
* Orientation booklet for students to familiarise themselves with health service
* Interprofessional Orientation Program
* Student Placement Evaluation Survey
* Student placement policy and procedures, including guidelines and support for clinical supervisors of underperforming students
* Student Supervision Support Manual 2012
* Interprofessional Student Forums Facilitator Manual
* Student placement objectives document
* Student welcome letter
* Student registration form
* Database of local accommodation posted on the website
* Interprofessional tutorial presentations and facilitator guides for:
* Women’s Health interprofessional tutorial
* An introduction to interprofessional learning and practice
* Menopause and HRT
* Menstruation and bleeding
* Disability tutorials
* PACES (Professional Attitudes & Cultural Education Studies) tutorials
* Interprofessional Friday Forums
* Advancing Clinical Education Supervision training surveys
* Primary Clinical Supervision Model

Online South Gippsland Clinical Supervision SharePoint Network

Outcomes and impacts

This Project produced a range of positive outcomes, many of which have fundamentally changed the way clinical supervision is provided and managed within the health services and the broader subregion.

This Project created a level of collaboration between the health services and medical clinics that simply did not exist before. Health service managers, and clinical supervisors regularly communicate and share resources. There is less likely to be duplication of effort now and more willingness to work together. The CEOs have indicated that they are keen to work collaboratively on issues of shared importance, such as clinical placements.

The overall actual capacity to provide nursing clinical placements increased from 2193 days in 2011 to 3998 in 2013 (82% increase) across this subregion. Potential nursing placement capacity was increased in this period from 2193 days to 9954 days (354%)[[3]](#footnote-3). Medical placements have remained the same as placements were at capacity in 2011. There has been a significant decrease in allied health placement capacity from 515 in 2011 to 396 in 2013 (23% decrease) due to budget cuts and reduced staffing levels across all areas of allied health in the subregion.

* The interprofessional learning opportunities increased from 570 hours in 2011 to 599 in 2013 (5%). The strategies used to generate these opportunities were:
* Nursing, midwifery and allied health students attending the Gippsland Medical School Interprofessional Wednesday Tutorials with the medical students,
* Women’s Health Conference for medical and nursing/midwifery students, which was held in September 2012,
* Mental Health Interprofessional Workshop held in May 2012,
* Friday Forums with medical and nursing students working together on patient cases; and
* Expanded the settings where students can gain clinical experience, including more specialist acute areas (A&E; Theatre) and in primary, community and aged care settings.

Improved ability to measure and report on clinical placement capacity owing to the:

* Consensus on the definition of placement,
* Development of a clinical placement database (placement calendar – which was overtaken by ViCPlace); and

Regular discussions and review of clinical placement capacity across health services.

Improved quality of the placement experience as demonstrated by the extremely positive student feedback and survey results. This is attributed to:

* Heighten awareness and improved skills of staff to deliver high quality placement experiences,
* A focus on transforming the culture in the health services to foster behaviour that contributes to a positive learning environment,
* The development of a range of resources to orientate students and prepare them for their placements and to guide staff in providing clinical supervision,
* Engaging student in innovative interprofessional learning opportunities,
* Creating learning spaces containing lockers and computers that students are encouraged to use to relax, study or meet each other,
* Actively seeking student feedback and acting on it; and

Prepared the health services to respond proactively to the introduction of the BPCLE, which will eventually be linked to funding.

Issues

While much of the changes made as a result of this project are sustainable, the reality is that with the significant increase in clinical supervision capacity, the increased precision and regularity of report, there is substantially more work in this area. The health services facilitators were an additional resource that has largely concealed the increased workload. Without these positions, health service will struggle to meet the increased demands of clinical supervision capacity management unless they increase the human resources devoted to this area.

Other factors that will continue to impede the goal of increasing clinical supervision capacity that emerged from this Project were:

* The limitations placed on endorsed nurses supervising endorsed nursing students; and

The inability or reluctance demonstrated by Universities in rethinking their curriculum and clinical placement arrangements to make better use of the placements coming on line.

Table 2: Capacity and quality outcomes

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| Objective | Capacity/quality target | Outcomes |
| To increase clinical supervision capacity across the subregion by a minimum of 50% during 2012. Student numbers are expected to increase by a further 15% (minimum) in 2013. | Create placement capacity to support 74 medical students, 320 nursing students and 48 allied health students who are planned for placements in 2012. | 74 medical students, 339 nursing students, 10 allied health students in 2013 (There has been a significant decrease in allied health placement capacity due to budget cuts and reduced staffing levels across all areas of allied health in the subregion. It is expected that this will improve in 2014).  |
| To introduce and support new placements within expanded settings; private general practices. | Clinical placements available in non-traditional settings Extend to include additional disciplines and partners | Increased number of specialty placements by 450 placement days for 2013.190 new placement days in community settings including GP clinic and Community Health Centre.15 OT joint placement days between hospital and community centre.Eight new partnership agreements with vocational EP’s for 2013 across all sites. |
| To foster interprofessional clinical learning and practice.  | Increase student interprofessional learning hours by a minimum of 50% during 2012 (a target of 840 IPL hours in 2012) and ensure this target is maintained during 2013 and beyond. | 599 IPL hours were recorded to June 2013. The target was not met owing to two key people leaving during this period – one being a medical specialist who provided the facilitation at BCRH and the other being a dietician who was key to arranging and delivering the IP Friday Forums across the sites. |
| To ensure all project partners meet the Department of Health criteria for a best practice clinical learning environment by May 2013. | * Auditing clinical learning environments within each health service.
* Initiatives to be implemented by local working parties to address areas of non-compliance.
* Communication strategies to encourage more staff and managers from a variety of health services to engage in project activities.
 | All three health services have been audited against the draft BPCLE. All areas requiring improvement have been addressed (e.g., implementation of a learner survey, orientation documentation and clinical placement policies and procedures.)SCICS health facilitators have been promoting the BPCLE and assisting health service staff to understand the implication of this framework. |
| To further develop the clinical supervision capacity of general practitioners staff, nurses and allied health professionals, and provide ongoing recognition, support and mentoring to student supervisors. | At least eight local staff members to undertake Advancing Clinical Education (ACE) train-the-trainer education during 2012 (to be developed and delivered by the Gippsland CPN).In-house ACE training throughout the subregion will commence in 2013. It is anticipated that a minimum of 80 staff within the subregion will attend ACE training courses during 2013, facilitated by local trainers. | SCICS funded two local student supervision training courses in 2011 and 2013. 64 local staff attended these programs in total.A further 11 staff attended advanced component of the ACE Program funded by SCICS.The number of staff who are now able to provide clinical supervision confidently has increased to 64 (While, 45 existing clinical supervisors had received basic training, they were not all confident and many were not actually providing clinical supervision). |
| To facilitate greater project engagement, collaboration and communication amongst health providers throughout the subregion. | Increase opportunities for sharing, communication and rotating students across sites. | The interprofessional tutorials rotating between the three health services.Feedback from health service staff and Working Party indicates that collaboration and communication between them occurs more frequently than since they become involved in the Project. |

Challenges and risk management strategies

The following table describes in brief the key challenges that we encountered in delivering the project and how we addressed them.

Table 3: Risk management

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| Risk | Management strategy | Outcomes |
| Lack of engagement within the health services. | Funded a part-time health service facilitator (project officer) in each health service | Increased the rate of change within the health services in reviewing their systems, revising/developing policies, resources and practices. Increased the amount of local innovation in terms of the models of clinical supervision implemented. |
| Key project personnel left | Because the SCICS team had expanded to include two more part-time health facilitators, these were able to expand their roles fill the gap left by their team member. | Work continued across the subregion however, the level of engagement at the local level in the health service where this facilitator was located diminished markedly. |
| Potential lack of engagement of staff in the cultural transformation project | Information and engagement sessions held in October included senior level nurse managers to demonstrate their support of this project.Project has been deferred until more people are available to attend the first workshop in February (and to ensure the ethics application has been approved).Working Party have discussed this possibility and health executives are directing their nursing managers to promote the project at every staff meeting.Promotional brochures are being distributed. | Excellent attendance at the workshop in February (18 staff at one health service and executive and a selection of staff at another health service).One health service was unable to find a date that suited most staff so have elected not to go forward with this strategy. |
| Potential that medical clinics are unable to offer clinical placements to nursing students. | Develop an MOU between the University, clinics and hospital that allows the hospitals to take on more of a role in coordinating placements for the medical clinics. | The MOU was developed between two of the health services and their local GP clinics. |

Evaluation

The methodology used to evaluate this project involved:

* Assessing the current situation with respect to the clinical supervision capacity and approach of the partner organisations. To this end an audit report was prepared and presented to the key stakeholders in a Strategic Planning Day in October 2010;
* Agreeing on the outcomes (aims) of the project, which occurred in the first Strategic Workshop;
* Identifying the qualitative and quantitative data needed to measure these outcomes, develop the data collection tools (i.e., placement database/calendar and student evaluation forms);
* Routinely collect and report on these to the Working Party and the Steering Committee;
* Final evaluation of the Project impacts by gathering feedback from key stakeholders via:
* Facilitating a focus group with the Working Party to ascertain their views on the difference the project made with respect to the outcomes, and other unexpected consequences (negative and positive)
* Interviewing self-nominated stakeholders (those who accepted an invitation to be interviewed), including the CEOs of the health services.

The following table sets out the objectives (aims) of the Project, the data collected to measure achieving of the objectives and the outcomes achieved.

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| Objective | Data collection | Outcomes |
| Increase in clinical supervision capacity | Placement hours available Number of students placed | Nursing 995 days hours, medicine stayed the same (as intended because it had already reached capacity), allied health decreased by 19 days due to staff shortages. |
|  | Number of staff trained to provide clinical supervision. | 64 basic training and 11 advanced training. |
|  | Increase staff supervising students. | Increase across the region of 30% (100% increase in one of the health services). |
|  | Number of nursing students attending primary health care placements within GP clinics. | 16 actual primary care placements in 2013. One prior to this. |
| Improve quality of clinical placements. | Cultural diagnostic (Human Synergistics OCI). | Improvement in the constructive cultural styles that contribute to a positive learning environment in the Health Service Unit under study. |
|  | Student feedback (student survey) | Overwhelmingly positive feedback provided by students surveyed. (Not base line collected because there was no student survey prior to the start of the Project). |
|  | Manager/executive feedback (interviews/focus group). | An improvement in the value and awareness staff has of their role in providing quality clinical supervision.An improvement in the willingness and ability of staff to provide high quality clinical supervision.More inclusive of students as part of the team.More considered and evidence-based approach to planning and delivering clinical placements.The value and level of importance given to clinical supervision has been raised as a result of this project – it is now everyone’s business.The resources, policies, tools and communication structures that resulted from this project have significantly improved the quality of the placements. |
|  | Compliance with draft BPCLE tool | Addressed areas for improvement identified by the audit |
| Increase IP learning/practice opportunities. | Hours attending IPL exercisesStudent feedback (session evaluations) | 1672 hours in total.Students reflected on the benefits of working as a team, reporting each team member contributed a different perspective to the management plan and focussed on different aspects of patient care. |
| Subregional program – infrastructure, coordination and collaboration. | Manager/executive feedback (interviews/focus groups). | Clinical supervision is on the agenda of the South Coast Subregional Planning Group (CEOs and DONs).Managers and executives generally agree that the quality and amount of collaboration has significantly improved as a result of the Project.Resources are freely shared (i.e., policies, manuals, training opportunities).Joint funding applications have been submitted to government initiatives (i.e., HWA Research Fellowship).A calendar of clinical training events is being maintained and shared across the subregion. |

Key findings of SCICS project

The key findings of the evaluation are set out below and can be transferred to any project designed to achieve major system, practice and cultural change.

Strategies to increase clinical placement capacity and interprofessional learning

The Project aim of increasing clinical placement capacity and inter-professional learning was achieved by:

* Revealing the existing unused clinical placement capacity through a concerted focus on identifying placement opportunities. A comprehensive audit of capacity through consulting with the different areas of the organisation has been instrumental in this;
* Creating opportunities and support to continually review the traditional approaches to providing supervision;
* Adopting a primary preceptor approach so that students were not ‘passed-around’ to multiple staff members but became the responsibility of one or two primary preceptors who were buddied up to a student. The primary preceptor was responsible for planning the placements and ensuring the students’ assessment documents were completed. The students were supported by a secondary preceptor when the primary preceptor was not available. The roles of primary and secondary preceptors were shared across many more staff so that the workload was actually lessened, reducing the level of burnout previously experienced;
* Actively engaging staff in defining the culture that supports positive learning, fostering an inclusive approach to students and making clinical supervision everyone’s responsibility;
* Expanding clinical supervision opportunities to more shifts, specialist areas of the hospitals, GP Clinics, aged and community centres; and

Ensuring staff have the skills to provide effective clinical supervision by providing formal training and mentoring.

Collaboration and active engagement

Collaboration across every level of the organisations (between staff, educators and management) and across the health services and GP clinics was considered critical to the success of the Project and will be sustained. A Steering Committee and Working Party with stakeholder representation, as well as a central management role was helpful in generating this level of collaboration.

At the beginning of the Project, there was a concerted effort to implement it with the support of a central team working across the partner sites. When the primary health service facilitator role was extended, it was possible to divert a small amount of funding to a part-time position in each of the health services. Rather than diminishing the collaborative approach, this strategy actually enhanced it as the health service facilitators at the local level were better placed to engage staff in the project, and also worked very closely together as a team. The relationships forged by this team are sustainable and will ensure that the collaboration continues.

It cannot be done within existing resources

When the Project started there was an initial view that increasing the quantity and quality of clinical supervision was really a matter of working better and smarter – changing the way things were done and how people perceived student supervision. It was found that in fact, the significant changes were achieved as a result of dedicating resources to the project at the sub-regional and local health service levels. This had the affect of demonstrating the value and priority granted to clinical supervision by the organisations.

Funding a health service facilitator in each of the health services significantly improved the penetration of the Project into the culture and organisational systems. This demonstrated the impact that having resources dedicated to clinical placement has on increasing their capacity. In one health service, they were able to self-fund an additional clinical facilitator with the extra funding they attracted through increasing their students numbers.

Further, it was found that with the increase in clinical supervision capacity, there was an increase in the work needed to maintain it, including reporting requirements. The SCICS Health Service Facilitators enabled the health services to respond proactively to the introduction of the ViCPlace and BPCLE. However, there is now a concern expressed in the health services that without these facilitator positions that the additional workload required to comply with the ViCPlace and the new BPCLE will be overwhelming.

During 2013, one of the health services experienced severe budgetary difficulties and was forced to close beds and redeploy staff. This had the affect of reducing the number of students that could be placed at this health service.

Increasing health service capacity does not necessarily translate into realised capacity

While there was a significant increase in the health services capacity to provide clinical placements, this was not all taken up by the education providers. In fact, there continued to be a practice by HEs of booking placements and then cancelling them with little or no notice or explanation. This is concerning as creating and holding the clinical supervision placements has a resource implication for health services. It is hoped that the new ViCPlace system will overcome this issue.

A further issue that may limit the health services fully realising their capacity is that students tend to prefer placement closer to where they live and may also hold the view that rural placements may not give them the clinical experience and exposure that metropolitan and region placements will.

Overt executive support and devolved management

More positive outcomes and changes were achieved where there was overt executive support but devolved clinical supervision management. Where only higher-level managers were involved and the responsibility for the Project had not been delegated to lower levels, there was less positive change.

The involvement in the Project had the effect of raising the value, priority and resource given to the management of clinical placements.

Broader impact than students

It was noted by a number of the stakeholders that increasing the capacity of health services to provide clinical supervision had the effect of raising the standard of clinical practice and also strengthening the learning culture and platform for staff and postgraduate placements. At one health service they have been able to offer more graduate nursing places than was previously the case owing to the impact of the SCICS Project. Part of this was attributed to the change in attitude and assumptions of existing staff so that they were more open to having students.

Limitations

The systems for collecting qualitative and quantitative data on clinical placements were rudimentary or non-existent when the Project started. It was not possible to create an accurate base line of placement capacity. So the original base line may not have been correct. Nevertheless, once systematic data collection started, it became apparent that the number of hours of clinical supervision capacity was steadily increasing as a result of the interventions of this Project.

Other factors that will continue to impede the goal of increasing clinical supervision capacity that emerged from this Project were:

* The limitations placed on endorsed nurses supervising endorsed nursing students; and

The inability or reluctance demonstrated by universities in rethinking their curriculum and clinical placement arrangements to make better use of the placements coming on line.

Future directions and sustainability

Much of the work of the SCICS was designed to create a best practice learning environment in each of the health services that could be sustained beyond the project. In order to sustain the increased clinical supervision capacity created through this project, strategies focused on developing the organisational systems (i.e., data capture; policies and procedures, manuals and resources) and culture to foster positive clinical placements. Making it clear that all staff were expected to take responsibility for providing positive clinical supervision experiences to students, and giving them with the skills was also central in ensuring that positive outcomes of this Project are sustained. The collaborative working relations that were formed between the health services, the Medical Clinics and the Community Centre will be sustained, continuing to support the interprofessional learning opportunities, sharing of resources, joint system development and training, and rotating student placements across acute, aged care, primary and community care settings.

The increase in clinical supervision capacity achieved in this Project has resulted in an increase in clinical placement management and compliance requirements (i.e., ViCPlace and BPCLE). There is a realisation that more resources are needed recurrently to maintain the improved clinical supervision standard and capacity, which have not yet been identified. A proposal is being considered to fund one part-time position to work across two of the three health services to continue the health service facilitator role. However, the budgetary difficulties currently facing one of the health services may preclude this strategy.

The health services are now focusing on ensuring they comply with the BPCLE and ViCPlace requirements. There is also interest in establishing a network of clinical preceptors, supervisors and educators that might meet twice a year, possible as part of a regional conference. This type of event would be motivational and inspiring, and foster cross generation of ideas. This might be a strategy that could be facilitated by the Gippsland CPN.

Conclusion

The increase in the clinical supervision capacity required to meet the demand for placements in a rural setting is best achieved by a collaboration between health services (particularly the staff on the ground), medical clinics and higher education providers. To increase clinical supervision capacity, and enhance its interprofessional focus, strategies need to fundamentally change the traditional approaches to clinical supervision that rely on a select few preceptors, where staff do not accept clinical supervision of students as their core responsibility. The strategies employed in this project to achieve this transformation focused on raising the expectation that clinical supervision was everyone’s responsibility, giving staff the skills to do this well, defining the behaviour norms and developing processes, structures and resources to foster a best practice clinical learning environment. It is critically important to actively engage staff in this venture as early and as often as possible. In this Project this was made possible by creating part-time health service facilitators in each health service to engage staff and support them to make the changes needed.

1. Actual capacity equates to the students that were placed. Potential capacity equates to the placements available in total and was calculated in consultation with the different units across the three hospitals. These were not taken up by students for a range of reasons including some being cancelled by the Universities. [↑](#footnote-ref-1)
2. Estimates from June to December are extrapolated from the figures from January to June. [↑](#footnote-ref-2)
3. Actual capacity equates to the students that were placed. Potential capacity equates to the placements available in total and was calculated in consultation with the different units across the three hospitals. These were not taken up by students for a range of reasons including some being cancelled by the Universities. [↑](#footnote-ref-3)