

**HealthWorkforce**  
AUSTRALIA

# CLINICAL SUPERVISOR SUPPORT PROGRAM

DISCUSSION PAPER

JULY 2010



An Australian Government Initiative

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# 1 Introduction

## Purpose of the paper

In recent years, Australian governments have recognised the significant challenges that workforce shortages present to the quality and sustainability of Australian health care. Since 2006, governments have made significant investments to address these issues and ensure that there will be a health workforce to deliver essential health care into the future. A key strategy has been to train more health practitioners to increase workforce numbers. There have been substantial increases in professional entry university places, and an accompanying growth in demand for the associated clinical placements, requiring more clinical supervisors.

The growth in clinical placements occurs in a clinical environment which is increasingly complex and changing. Workforce shortages, greater demand for clinical services, an increased acuity and complexity of patients (both in the hospital setting and the community), and resource constraints all (Rodger et al 2008, pp. 56 - 57) impact on the ability and willingness of clinicians to take on additional student supervision. The challenge is how to expand student supervision capacity in this environment, where clinicians are already stretched to cope with service delivery pressures and their current student supervision load.

## The national health workforce agency: Health Workforce Australia

Health Workforce Australia (HWA) is an initiative of the Council of Australian Governments (COAG), and has been established to address the challenges of proving a skilled, flexible and innovative health workforce that meets the needs of the Australian community, now and into the future.

HWA was established following the development of a \$1.6Bn National Partnership Agreement (NPA) on Hospital and Health Workforce Reform by the Commonwealth and State and Territory Governments in November 2008.

HWA reports to Health Ministers and will operate across health and education sectors to devise solutions that integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training.

HWA's functions include:

- The provision of comprehensive, authoritative national workforce planning, policy and research advice to Ministers, Governments and key decision makers in the health and education sectors.
- Improving and expanding access to quality clinical education placements for health professionals in training across the public, private and non-government sectors. This will be achieved through programs that expand capacity, improve quality and other diversity in learning opportunities. This also includes a national network of simulated learning environments (SLE's) to enhance the quality, safety and efficiency of clinical training.
- Developing and implementing a national program of health workforce innovation and reform. This will encourage the development of new models of healthcare delivery, facilitate inter-professional practice and equip health professionals for current and emerging demands on the health care sector.
- Facilitating a nationally consistent approach to international recruitment of health professionals to Australia.

## Clinical Supervision Support Program

The Clinical Support Program (CSSP) of HWA aims to expand clinical supervision capacity and competence across each professional area; including allied health, dental, medical, nursing and midwifery. The CSSP consists of four phases. Phase 1 and 2 of this project, now complete, included:

- consultation with Health Departments, public sector, private sector and not for profit health services, and other stakeholders including accreditation bodies, specialist medical colleges, professional associations and regulatory bodies (see [Appendix A](#));

- a literature review researching recent (2007 onwards) Australian and international current and best practice approaches to clinical supervision of students being trained in health professions;
- a review of requirements for student supervision in accreditation criteria for health professional courses (see [Appendix B](#)); and
- analysis of data from a survey the National Health Workforce Taskforce (NHWT) conducted of all universities in relation to clinical placement issues for health courses, including placement supervision.

This Discussion Paper (Phase 3) brings together this information to provide a basis for gap analysis and identification of policy options to increase student supervision capacity. The policy options aim to build on the work of states and territories and stimulate discussion of the key issues raised by stakeholders.

HWA recognises that ongoing stakeholder consultation and engagement is critical to the development of any strategies in this area and would like to acknowledge the support stakeholders have provided for this project to date.

Phase 4, the development of a National Clinical Supervision Support Strategy and Framework, will commence following analysis of stakeholder submissions.

The following projects of HWA significantly overlap with the strategies outlined in this discussion paper and will be considered in the development of the National Clinical Supervision Support Strategy and Framework.

### **Clinical Training Funding Initiative**

Health Ministers recently endorsed a system of regional governance / co-ordination of clinical training. The proposed system, which is the subject of a further round of consultation and subsequent consideration by Health Ministers, includes a national network of Integrated Regional Clinical Training Networks.

HWA has recently called for proposals from government agencies, (including government health and aged care providers), universities and non government health and aged care providers to support the increase in clinical training for professional entry health disciplines for the 2011 academic year.

Funding is available through the Clinical Training Funding Initiative to deliver additional clinical training in public, non government, health, aged care and university sectors across Australia. Recurrent funding will also be made available to support growth in clinical training, and will build up to approximately \$145m annually.

In addition, there is one off incentive funding to support establishment of start up costs associated with new clinical training activity. Priority will be given to develop capacity in under-serviced areas and new settings, for example, rural and remote areas, primary care, mental health, aged care, dental and private sector settings.

### **Simulated Learning Environments (SLE)**

The November 2008 COAG health workforce reform package also included capital and recurrent funding to build and operate new Simulated Learning Environments (SLEs) or enhance current SLEs.

The Simulated Learning Environments project focuses on accessibility to regional and rural centres and encompasses both high and low technical training needs. Mobile SLEs will also be developed as a means of providing these training opportunities in the more remote locations. The distribution and configuration of the SLEs will be finalised following a national planning process.

Additional information about HWA and its work program can be obtained from the HWA website: [www.hwa.gov.au](http://www.hwa.gov.au).

## 2 Current Environment

### Introduction

#### Scope

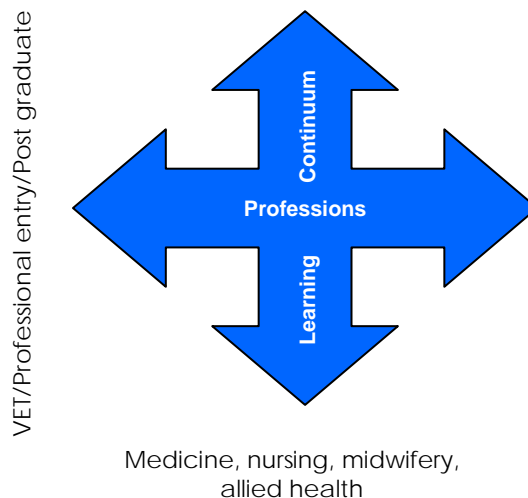
The National Partnership Agreement focuses on improving capacity for clinical supervision of professional entry students, however, following consultation with stakeholders it is recognised that in many cases clinical supervisors of these students also supervise others in the learning continuum.

This Discussion Paper considers supports for supervisors across the educational continuum from undergraduate and postgraduate students to vocational trainees.<sup>1</sup> It covers health professions including: dentistry, dietetics, medicine, midwifery, nursing, occupational therapy, oral health (dental hygiene and dental therapy), orthotics and prosthetics, pharmacy, podiatry, psychology, radiation science (radiation therapy, nuclear medicine technology and radiography), social work, speech pathology, audiology, sonography, paramedicine, orthoptics, optometry, exercise physiology, chiropractic, osteopathy and medical (laboratory) science.

#### Clinical supervisors - vertical and horizontal integration

Strategies to increase professional entry clinical supervisor capacity and competency need to ensure that they not only do not have any unintended consequences on the current practices on other areas, (e.g. VET, postgraduate, specialist and vocational education) but rather enhance and support those. Opportunities arise for all elements of the education continuum, both vertically and horizontally (i.e. across professions) to benefit from national approaches developed.

#### Clinical Supervision Support Strategy



"Vertical integration of general practice education is the coordinated, purposeful, planned system of linkages and activities in the delivery of education and training throughout the continuum of the learners states of medical education" (Thomson 2003). The provision of professional entry health education and training in Australia is multidimensional. For example in medicine the traditional model involves the continuum from intern to consultant. Consultants supervise registrars, junior doctors and undergraduate medical students; registrars supervise junior doctors under the overarching supervision of consultants; and registrars and junior doctors are involved in the supervision of undergraduate medical students. Similar approaches occur in a number of health professions.

In addition to vertical integration, there are opportunities to consider commonality and integration in clinical supervisor supports, programs and strategies horizontally across the professions. there is

<sup>1</sup> The Discussion Paper also covers clinical supervision in the continuing professional development context where relevant, although little information was identified about this issue.

commonality across professions of the issues faced by clinical supervisors as identified in this paper. Whilst the clinical skills required by supervisors may and do differ across professions, there are significant opportunities to develop a more consistent framework to improve quality and numbers of clinical supervisors through both training supervisors to common competencies and structuring supervision arrangements and support to embed them better in service delivery.

The CSSP provides an opportunity to work together to develop a National Clinical Supervision Support Strategy and Framework that incorporates, supports and enhances the overall continuum of clinical education and training of health professionals. Whilst the HWA can provide leadership and support, stakeholders involved in accreditation, education, clinical training and the provision of supervision will need to participate in the development of the strategy to ensure agreed national approaches are incorporated into more specific clinical training structures across the continuum. enable its successful implementation.

## Terminology

### Clinical supervision

The term “clinical supervision” is used in two major ways in the health sector:

- to describe a process of overseeing trainees or students on clinical placements; and
- to describe a broad approach to quality and professional skills development, which applies to the entire workforce within a profession.

There is no universally accepted definition of clinical supervision in the second context (Victorian Healthcare Association 2010). However, common features of clinical supervision of professionals have been identified as:

- “a dedicated interaction between two or more practitioners;
- A focus on reflective practice;
- A means to generate learning;
- Practice enhancement through self evaluation and development”; and
- (Victorian Healthcare Association 2010).

Clinical supervision in this professional context “addresses three categories of functions: normative (organisational responsibility, quality control), formative (development of skills and knowledge) and restorative (supporting personal well-being” (Lennox et al 2008, p. 10). For example, in the alcohol and drug field, clinical supervision has been defined as “directed at developing a less experienced worker’s clinical practice skills through the provision of support and guidance from a more experienced supervisor.” (NCETA 2005, p. 2).

This broader approach to clinical supervision is applied in a number of health professions, e.g. social work, midwifery, mental health, occupational therapy and is emerging in others (Driscoll & O’Sullivan 2006, pp. 9- 10) however it has not yet been consistently adopted by all health professions. There are also service-based approaches to clinical supervision e.g. clinical supervision of students may be part of a broader approach to clinical supervision across a profession or service, although this is not the specific focus of this Discussion Paper. However, as far as possible, strategies are intended to be relevant and useful across the continuum of clinical supervision.

Unless otherwise specified, whenever this report refers to clinical supervision or clinical supervisors, it is referring to the educational context of student and trainee learners and not clinical supervision in the broader sense.

### Names for clinical supervisors

One of the challenges in discussing clinical supervision across health professions is that there is no agreed generic or cross-profession name for this function nor agreed title for a person who supervises a student or trainee on a clinical placement. Different terms are used by different professions, and sometimes within a profession. Terms also vary across educational institutions and the terms used in Australia are sometimes different from those used in other countries.

The word “supervision” itself has a number of meanings. It is used in a general sense in the workplace, to describe an administrative or managerial function. Some consider that the

connotations of this type of supervision are not useful in the student context, and that a different term would be preferable to describe the role of overseeing trainees or students on clinical placement. In addition, as discussed above, the term “clinical supervision” has a specific meaning in some professions, which is much broader than supervision of students on clinical placements.

Whilst these issues relate to the term “clinical supervisor”, other possible generic or cross-profession terms such as “clinical educator”, “practice educator”, “student supervisor” etc are also already in use with particular meanings.

### **Different terms used to describe clinical supervisors**

In medicine, the term “clinical supervisor” is commonly used but the literature also refers to clinical teachers. In nursing, depending on the model, the specific role and the country, terms used include preceptor, facilitator, educator, mentor and buddy to describe various supervision roles. Nursing generally does not use the term “clinical supervisor”. In allied health, terms used include fieldwork supervisor, practice educator and clinical educator, although the term “clinical supervisor” may also be used.

The proposed strategies in this Discussion Paper are cross-profession, so it is important to find agreed terminology to describe clinical supervision functions and roles, to ensure common understanding. Previous documents discussing clinical supervision across professions have adopted different approaches. Victoria’s Best Practice Framework for Clinical Learning Environments (2009) refers to “educators” primarily, although there are passing references to supervisors, preceptors and facilitators. NSW Health’s Student Placement Agreement for Entry into a Health Occupation (2009), refers to student supervisors engaged by the educational institution and student workplace supervisors, who are nominated and employed by the public sector organisation to provide work based supervision to students on student placement (p. 8).

The literature acknowledges the range and variation of terminology/language used to describe clinical supervision (Henderson et al in press). However, some make the point that names may vary but the intent of the roles is essentially similar (Henderson et al, in press). Some commentators have suggested the term “clinical educator” as it emphasises the educative rather than the controlling aspect of the role (McAllister et al 1997, cited in Nash 2007, p. 32).

In preparatory discussions, stakeholders often commented about the specific terms used in their profession and the potential for confusion about language. They highlighted the need for clarity in the terms used when discussing clinical supervision across professions.

This Discussion Paper uses the terms “*clinical supervision*” and “*clinical supervisor*”, as this language is used in the National Partnership Agreement and associated documentation. However, the strategies section asks for comments about the terms to be used in future work.

In this Discussion Paper, clinical supervisor refers to a role responsible for the day to day supervision of a student on a clinical placement or a trainee, including feedback and often assessment, commonly on top of a clinical role, such as a preceptor or fieldwork supervisor.

Clinical educator refers to a role which includes providing support to clinical supervisors and may also involve day to day supervision of learners. For example, this would cover clinical facilitators in the nursing profession and the ACT Dedicated Clinical Educators responsible for supporting staff supervising students and students in clinical supervision who generally do not have their own non-student related clinical load and roles such as a Clinical Educator Coordinator whose role is also to provide education and support for student supervisors.

[Appendix C](#) contains a glossary of other terms used in relation to clinical supervision, including some used internationally.

### **Overview of current issues**

As context for the discussion of clinical supervision issues, the Discussion Paper provides a brief overview of issues identified during preparatory discussions with health services (public sector, not for profit and private), accreditation bodies, specialist medical colleges, professional associations, and regulatory bodies. A more detailed summary is at [Appendix D](#).

## Models

Different student supervision models operate in Australia (Dickson et al 2006). [Appendix E](#) summarises common models of student supervision.

Preparatory work for this Discussion Paper involved discussions with a range of stakeholders, including Commonwealth, State and Territory Health Departments, health services (public sector, not for profit and private), accreditation bodies, specialist medical colleges, professional associations, and regulatory bodies. Key themes included:

- The need for clearer role definition, including better articulation of the role and function of supervisors and identification of generic core skills and competencies
- The need for better information about student knowledge and skills and learning outcomes
- The need for training in supervisor skills, and issues associated with access to training such as release and cost, and availability in some circumstances
- The tension between service delivery and supervision roles
- Constraints on supervision capacity imposed by infrastructure and physical resources
- The need for explicit expectations and leadership around teaching and learning culture to embed clinical supervision as a core activity
- The need to recognise, value and better support supervisors

Discussions identified a range of barriers to increasing the capacity of clinical supervision, including:

- The tension between service delivery and teaching
- The lack of support for underperforming students (increases load on supervisor)
- Lack of consistent assessment tools
- The lack of incentives for supervisors
- Issues with university scheduling of placements
- Lack of clearly articulated role, skills, expectations and associated training
- Access to training (release and cost)

Common gaps identified included the placement capacity in non-traditional areas and models of supervision that take into account the environmental pressures.

These issues are also reflected in the literature. For example, Hore, Lancashire & Fassett (2009) identified barriers to supervisors in medicine including work pressure, an expectation to supervise regardless of interest, little or no education on effective supervision and institutional disincentives.

An overview of issues raised by stakeholder groups is at [Appendix D](#).

## Functions of supervision and role clarity

### Functions of clinical supervision

Clinical education is a critical component of the process of educating and training new health professionals. It involves providing students with practical experience in clinical settings, often referred to as clinical placements, under the supervision of health practitioners. Clinical supervision incorporates a range of functions primarily aimed at assisting students in consolidating theory into practice (Erstzen et al 2009).

The function or purpose of supervision, the function or role of a clinical supervisor and the skills or competencies required for an individual to act as a supervisor are closely related issues. This section addresses the purpose of clinical supervision. The skills or competencies required by an individual to undertake the role of clinical supervisor and provide clinical supervision to students on placement are discussed later.

The ultimate aim of the supervision of a student's clinical education is to enable the student or trainee<sup>2</sup> to function as an appropriately skilled professional in the environment in which they will eventually practise. Clinical supervision allows the student to safely learn and practice the skills,

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<sup>2</sup> Supervisees are referred to as either students or trainees.

knowledge, and attitude they require<sup>3</sup>. While the main function of supervision is overseeing the provision of practical training and/or a learning experience for the learner, supervision also includes providing various forms of support.

Kilminster et al (2007) highlight the role of clinical supervision in ensuring the quality and safety of patient care during a clinical placement. There may be a tension between the learning needs of the student and the provision of quality care or need to prevent harm to the patient (e.g. Elkind et al 2007).

### **Functions of clinical supervisors**

Clinical supervisors oversee the development of both technical and associated skills required by trainees. Associated skills may include clinical reasoning, problem solving, time management, and interpersonal communication skills (Barnett et al 2008). In addition to meeting academic requirements through supervised practice, students and trainees learn to combine and integrate the knowledge, skills, attitudes, values and philosophies of their profession (Erstzen et al 2009). To that end, the supervisor often acts as a role model to enable students to develop an appropriate professional approach and attitude (e.g. Hanson and Stenvig 2008; Hore, Lancashire & Fassett 2009; Steves 2005).

The main functions of a supervisor may be categorised under three broad themes: educational, supportive, and managerial or administrative functions (Forsyth 2009, p. 196).

Under the educational theme the function of the supervisor is to “help bridge the gap between theory and practice by allowing students to apply what they have learned in the academic setting” (Gould 2007, p. 2). Supervisors guide and/or teach students by providing information and facilitating the development of clinical skills. They also provide informal feedback and more formal assessment of performance (Rodger et al 2008, Mannix et al 2006).

Supervisors direct the learning process by setting learning objectives and providing opportunities for practicing relevant skills. Learning takes place through both structured and informal learning opportunities (Barnett et al 2008, p. 56).

The supportive function of a supervisor may involve taking on the role of counsellor to address the “interpersonal or intrapersonal reality of the trainee (e.g. helping trainees explore their feelings toward clients)” (Johnson and Stewart 2008, p. 230). In this role the supervisor endeavors to assist the student or trainee in not only achieving academic aims but also to acclimatize to the professional environment and setting in which they will be working once they are fully trained. The role may also encompass other supportive features such as providing career advice (Forsyth 2009, p. 196).

The various functions of supervision and/or supervisors are influenced by the sometimes competing priorities of key stakeholders. For example, while the main aim of the health service<sup>4</sup> is to provide services, the private practitioner may instead be focused on client services and the education provider (university) would be mainly concerned with the training needs of the student (Rodger et al 2008, p. 58).

The main functions of supervision and/or supervisors discussed above are identified from the perspective of the education provider (university) and the health service, and follow from the role clinical education plays in training new health professionals. Secondary functions – such as potential future recruitment into the workforce of students on placement, opportunity for reflective practice for the supervisor, a sense of contributing to the future development of their profession - arise from the perspective of the individual supervisor and/or health service. These secondary functions are often referred to in the literature as ‘benefits’ to supervisors (e.g. Thomas et al 2007;

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<sup>3</sup> See the Australian Clinical Educator Preparation Program glossary ([www.clinicaleducation.info](http://www.clinicaleducation.info)).

<sup>4</sup> In this discussion we refer to the agencies or services that provide opportunities for clinical placement of students as ‘health services’. This terminology is used for ease of reference, and we acknowledge that, in practice, the actual location of student placements range widely – from large public hospitals to community settings, including private practices - and that the locations vary both within and across health professions.

Marriott 2006; Rodger et al 2008). Taken together they may be described as ‘positive side effects’ of supervision and show that supervision serves other purposes – beyond the primary function of educating new health professionals - to the practitioner(s) acting as supervisor, and/or to the health service providing the placement opportunity.

Initial discussions with public sector health agencies and services suggest a broad consensus across Australian states and territories about the function and purpose of clinical supervision (see Table 2: Functions of clinical supervision as identified by jurisdictions). However there seems to be less clarity and definition around the actual functions of a supervisor.

### Definition of clinical supervision

The value of a clear and consistent definition of clinical supervision was a regular theme of initial discussions with public sector health services. Work related to this issue is already underway in some states and territories.

The functions of clinical supervision that were raised in discussions with jurisdictions are generally consistent with the functions identified in the literature. Supervision functions identified by the jurisdictions<sup>5</sup> are shown in Table 2, categorised into two themes: ‘Educational functions’ and ‘Support and/or managerial functions’.

**Table 2: Functions of clinical supervision as identified by jurisdictions**

Educational functions	Support and/or managerial functions
appropriate and timely evaluation	nurturing and support
observe practise and provide feedback	socialise and orient students into the work environment (health sector and the organisation)
provide a high quality education experience to apply theory to practice	develop work readiness
identify learning needs	practice in organisation safely
teaching (impart knowledge)	ensuring a safe and supported space for the student to develop skills
bridge gap between theory and practice	managing risk
integrate learning and practice	balancing the needs of the student and the learning objectives of the organisation
develop reflective practice and technical skills	changing function and focus depending on rotation and/or level
interprofessional learning	role modelling (demonstrating what the student should be doing and high professional standards)
develop clinical confidence	ensure safe practise/patient safety

<sup>5</sup> Based on discussions with jurisdictional Health Department staff and public sector health service staff

Educational functions	Support and/or managerial functions
identify learning needs and expectations of student	recognise and remediate students who are underperforming
	stimulate critical reflection /demonstrate reflective learning

**Clarity of roles and other aspects of supervision**

Health service stakeholders identified the need for more clarity about clinical supervision expectations in relation to:

- Learning outcomes;
- Student levels, knowledge and competence;
- The supervisor’s role; and
- The roles and responsibilities of the respective stakeholders (i.e. university, health service, supervisor) e.g., identifying which stakeholder is responsible for student assessment.

**Learning outcomes**

Health services report that universities do not always provide clear learning objectives for the placement and that the standard of learning objectives varies. Some health service stakeholders perceive that a lack of clear learning objectives discourages some practitioners from taking on a clinical supervision role.

Health service stakeholders considered that the supervision task is easier when universities have clearly articulated expectations and the purpose of the clinical placement is clear. Good relationships between universities and health services help with understanding university expectations.

**Student information**

Feedback from clinical supervisors was that there are two types of information that would make supervision easier

- clear information from universities about each student’s level, competency and skills; and
- advice from universities about students who may have difficulties with clinical placement.

Varying curricula across universities means that not all students are at the same level at the same point in their program. Part time study is a further complicating factor. Clear information from universities about each student’s level, competency and skills facilitates the supervision function. Some supervisors commented that a standard curriculum across a profession would be useful, and would help supervisors understand what level a student could be expected to have reached.

**Supervisor role**

Jurisdictional meetings reported a lack of consistent expectations of supervisors across universities. Participants commented that there is often no clear statement from the university of what the clinical supervisor’s role involves for practitioners undertaking both a clinical and a supervisor role. Some role descriptions and functions exist but are variable. Some potential for contracts and clinical placement agreements to clarify expectations was identified. Agreements at the institutional, rather than the discipline level were seen as helpful.

Similarly, health services may not always articulate the role of clinical supervisors. Supervisors undertaking supervision in addition to clinical work reported that they often don’t have a detailed description of the supervision aspect of their role, although there may be brief general references in position descriptions or awards. There are usually more detailed role descriptions for dedicated clinical supervision positions, e.g. dedicated clinical educators. Medical Staff specialist and registrar positions in NSW Health include responsibility for supervision as a core function of the role. ANMC

competencies recognise that all registered nurses and registered midwives will be involved in teaching and learning activities.

### **Current approaches**

There are a range of approaches to clarifying university expectations and learning outcomes. Health services are reviewing and implementing clinical placement agreements with universities which usually require clear information on learning objectives for example, NSW Health's Student Placement Agreement specifies a range of information to be provided before the placement, including learning objectives, learning assessment tools to be used, area of clinical practice in which the student is to be placed, the skill level and past experiences of each student and the education prerequisites required prior to the placement.

The literature acknowledges the importance of clear information about student levels and expectations about learning outcomes. For example, the Australian Centre for Evidence Based Aged Care Best Practice Principles for Nurses in Undergraduate Aged Care Placements (2006) includes:

1. All stakeholders should agree and mutually understand definitions related to clinical placements.
2. Universities and industry organisations should have formal agreements/contracts that specify clearly the respective roles and responsibilities.
3. Reciprocal arrangements should be put in place to facilitate ongoing collaborative partnerships both during and between clinical placements.
4. All stakeholders should have a shared understanding of clinical placement requirements, student scope of practice and expected student learning outcomes."

The nursing profession course accreditation standards of the Australian Nursing and Midwifery Council incorporate some of these best practice principles (see Section 8). For example, Standard 8: Professional Experience, includes requirements for establishing shared formal agreements between the education provider and health services where students are placed for obtaining their professional experience.

Happell (2009) comments that there is little literature addressing the type of information and support preceptors seek from universities. She suggests that preceptors need "an overview of the student's theoretical component relating to the particular clinical placement; clear and realistic objectives for the placement; the opportunity for input into the clinical program (e.g. the type of learning objectives); and genuine input into students' progress" (p. 374).

Rodgers et al (2008) emphasise the need for coordination between the health and education sectors in relation to clinical education (p. 57). They identify the potential for tension between the focus on students of the educational institution and the focus on service delivery of the health sector. This reinforces the need for good communication between clinical educators and their managers and academic faculty. Rodgers identifies "clear guidance for supervision, evaluation and assessment of students" as one of the key supports for clinical educators (p. 59).

Henderson, Forrester & Heel (2006) explain that learning objectives "are broad educational objectives that do not clearly specify students' capacity or ability to undertake specific tasks in the area" (p. 278). There is no provision for the individual assessment of the competency of each student before the placement. Supervisors therefore rely on general indicators, such as the stage of the program that the student has reached. This makes it critical for the supervisor to accurately assess the student's ability (pp. 278-279).

Chur-Hansen & McLean (2007) considered the role of supervisor and interviewed 21 psychiatry supervisors. They found that when asked about the role of supervisor, not all interviewees were able to define exactly what it is they do or are expected to do. Chur-Hansen & McLean argue that to be competent in a role, an individual must be aware of the basics of the role and that supervisors should be provided with clear role requirements, including what they are expected to do and what can be considered optional.

The wide variation in students' theoretical knowledge on placement makes the clinical supervisor's role more difficult (Henderson, Forrester & Heel 2006).

The literature contains many articles which comment on the role of clinical supervisors within particular professions. For example, Steves comments on the importance of role modelling (Steves 2005). Lack of clarity of job descriptions has been identified as an impediment to clinical supervision in the medical profession (Hore, Lancashire & Fassett 2009).

Kirke et al (2007) identify features of a good placement, including provision of clear expectations for each placement; and clear guidelines about the expectations for student and educator.

Some commentators have identified the difficulties that some supervisors experience in failing students, which may be due to factors such as a lack of confidence, lack of evaluation skills, a conflict between the caring aspects of the nursing role and the evaluative aspects of the supervision role (Kevin 2006).

### **Future directions**

Initial stakeholder discussions suggest considerable consensus about the main functions of clinical supervision. Establishing a common and consistent definition of clinical supervision in Australia could achieve clarity and agreement about supervisors' roles and functions across professions, education providers, health services, practitioners and students. It could build on existing work to consolidate the perspectives and aims of these different stakeholders and ensure a common understanding to support other strategies.

## **Supervisor Development**

### **Core supervision skills and/or competencies**

In initial discussions, health service stakeholders broadly agreed that the features of a good supervisor are generally the same, regardless of the discipline. They identified some core skills such as:

- clinical skills and knowledge;
- adult teaching and learning skills;
- ability to give and receive feedback;
- communication;
- appraisal and assessment;
- remediation of poorly performing students; and
- interpersonal skills.

Understanding of the core competencies required to undertake the clinical supervisor role is influenced by the perspective of the stakeholder. Health service stakeholders generally considered it would be useful to identify the core skills of supervisors across disciplines, and to link them to different levels of supervisory ability and to appropriate training. This would provide role clarity and clear pathways to achieve the necessary skills.

A key theme in the literature across professions is that while clinical supervisors may be excellent clinicians, they do not necessarily have the skills required to act as supervisors and impart their knowledge to students or trainees. Teaching skills, in particular, are often identified as being critical for supervision but in many cases clinicians have not received any direct education in teaching and therefore are not necessarily knowledgeable about or experienced in this area.

As the core skills required by supervisors are often not clearly articulated, the basis used for selecting a clinical supervisor is frequently not related to the actual skill set and/or competencies of the potential supervisor, but, rather, is based on seniority and/or availability of the practitioner to act as a supervisor. Consequently, a practitioner may act as a clinical supervisor even though they may lack the required skills to undertake the role. While some of this skills gap can be mitigated by providing training for supervisors it may also be useful where possible to consider selecting clinical supervisors based on specific criteria related to core supervisory skills (Rodger et al 2008, pp. 57-58).

Identification of core supervisory skills would:

- Clarify the expectations of student supervisors in relation to the skills and attributes they require
- Be linked to appropriate training which could improve the skill base of supervisors
- Contribute to interprofessional learning, teamwork, and interprofessional understanding, through the identification of competencies across disciplines

### Current approaches

There are relatively few examples of current Australian supervision models and approaches which have defined the core competencies and skills of clinical supervisors. To some extent, core skills may be indirectly described in supervision training programs but are generally not explicitly articulated as foundation competencies and tend to be profession-specific (although examples of cross profession training seem to be growing). As noted above, although core skills of supervisors, as identified during stakeholder discussions, tended to be relatively consistent across professions, the research undertaken for this project did not identify any examples which explicitly identified core student supervision skills or competencies across health professions.

ClinEdQ has been working on developing a sustainable, scalable, multi-professional approach to clinical supervisor training based on a generic knowledge and skills set. Generic domains include:

- Learning environment;
- Planning learning;
- Teaching in a clinical area;
- Assessment and feedback;
- Dealing with difficult learners;
- Understanding legal and ethical requirements of supervision; and
- Work supervision – ‘supervising to ensure delivery of safe patient care’.

Victoria has developed a Best Practice Framework for Clinical Learning Environments (Victorian Department of Health 2009). The Framework identifies six elements which are required for a quality clinical learning environment. The Framework includes reference to “defined skill/competency levels for educators with a clear pathway from one level to the next.” (p. 5). Part of element three, a positive learning environment, involves high quality clinical education staff who display appropriate interpersonal attributes. According to the Framework, clinical education staff should “have experience and confidence, be reflective, flexible and good at handling problems... they should have the capacity to work interprofessionally and be a good role-model for learners” (p. 6). Element 5 emphasises effective communication which underpins most elements of the framework, and highlights the importance of feedback.

The Bridging Project (Integrating Medical Education and Training in Australasia 2008), has identified competencies for the role of Doctor as Educator. The Bridging Project developed a framework of seven educational subroles, including teacher and clinical supervisor. The competency statement for clinical supervisor – vocational trainee states:

- Organize and provide time for supervision.
- Provide a clear orientation for your junior colleagues.
- Identify the incoming confidence and competence, and learning needs of junior colleagues.
- Serve as a role model for the attributes of a vocational trainee.
- Identify learning opportunities for junior colleagues.
- Provide constructive feedback.
- Provide personal and professional guidance and support.
- Challenge your junior colleagues' clinical reasoning and decision-making.
- Analyse and pre-empt errors.
- Ensure effective clinical team functioning.

- Reliably assess your junior colleagues' performance.
- Analyse and address performance problems.

The Framework also identifies competencies for clinical supervisors who are students, prevocational trainees and independent practitioners.

Professional organisations may specify competencies for student supervisors. For example, the Nursing and Midwifery Council UK (2008) sets competencies for mentors (supervisors), including establishing effective working relationships, facilitation of learning, assessment and accountability of learning, creating an environment for learning and leadership. These competencies are linked to training.

The literature identifies a range of characteristics of effective supervisors both across and within professions. The literature tends to discuss the qualities of effective supervisors in terms of skills and attributes, rather than competencies. There is significant commonality across disciplines.

For example, in 2000, Kilminster and Jolly undertook a literature review which included identifying the skills and qualities of effective supervisors. They found effective supervisors give their supervisees: "responsibilities for patient care, opportunities to carry out procedures, opportunities to review patients, involvement in patient care, direction and constructive feedback." (p. 833) They found that supervisors of pre-registration doctors needed basic teaching skills, facilitation skills, negotiation and assertiveness skills, counselling and appraisal skills, mentoring skills and relevant knowledge of the environment, e.g. learning resources.

In medicine, Kilminster et al (2007) reviewed the literature in relation to effective education and clinical supervision and identified the following attributes that make an excellent clinical teacher:

- share a passion for teaching
- are clear, organized, accessible, supportive and compassionate
- are able to establish rapport
- provide direction and feedback
- exhibit integrity and respect for others
- demonstrate clinical competence
- utilise planning and orienting strategies
- possess a broad repertoire of teaching methods and scripts
- engage in self-evaluation and reflection
- draw upon multiple forms of knowledge, they target their teaching to the learners' level of knowledge

Sutkin et al (2008) reviewed the literature and noted that the most commonly cited themes on attributes of good clinical teachers were medical/clinical knowledge, clinical and technical skills/competence, clinical reasoning, the ability to form positive relationships with students and provide a supportive learning environment, communication skills and enthusiasm (pp. 456 – 7). Approximately two thirds of themes and attributes were personal abilities such as relationship skills, personality types and emotional states which are more difficult to teach and develop (p. 457).

In nursing, Wilson et al (2009) refer to a number of articles identifying characteristics of successful preceptors and mentors, including experience, attitude, commitment, responsibility and competence as a teacher, clinician and mentor. Other attributes include knowledge of theory and clinical practice, knowledge of the facility, positive professional and supportive attitude, organisational skills, teaching strategies, flexibility, commitment, negotiation and leadership skills and communication skills (e.g. Nash 2007, p. 30).

In dentistry, desirable attributes include professional competence, approachable personality, consistency and practicality (Elkind et al 2007). Skills include feedback, demonstration and integration of theory and practice (Elkind et al 2007, p. 128). In allied health, the literature cites appropriate and timely feedback, specific and constructive advice about performance, and facilitation skills.

Other skills, attributes and competencies identified in the literature are integration of theory and practice, rapport and encouragement. Bower (2008) identifies a range of features including leadership, feedback, role-modelling and self reflection (p. 296).

### **Future directions**

Identifying the core competencies of clinical supervisors would have the benefits of clarifying the skills, attributes and expectations of the role. It would also enable training to be linked to the core competencies, ensuring a basic level of supervisory skills and potentially enhancing supervisor confidence and the placement experience for both supervisors and students. Work could build on existing initiatives by stakeholders such as ClinEdQ (see below).

### **Training**

Good clinicians are not necessarily good educators (Rodgers et al 2008). Clinicians are generally not trained as educators in their professional entry programs of study (Dalton et al 2007). Access to training has been identified as a key issue impacting on the recruitment and retention of clinical supervisors, as well as the quality of their supervisor role. Training can also increase the number of students that a supervisor takes (Keane 2009). Adequate preparation for the student supervisor role can give clinicians confidence to take on the supervisory role and assist them to balance the dual demands of student supervision and service delivery.

Initial stakeholder discussions noted the assumption that teaching is embedded in professional roles, but recognised the need for training to develop the necessary skills. There was general agreement that entry to practice courses do not develop these skills and that specific training is required. Stakeholders recognised the potential to articulate basic training on core supervisory skills/competencies into higher qualifications.

### **Current approaches**

Initial stakeholder discussions expressed a range of views about student supervisor training. Most acknowledged that there are examples of good clinical supervisor training available. However, discussions often mentioned difficulties in accessing training due to the cost and/or the need to be released from service delivery responsibilities to attend. There was broad support for flexible delivery, particularly to improve access in rural and remote areas, although also a view that online courses alone are not the solution.

ClinEdQ has developed a comprehensive approach to supervision training, targeting general skills and profession specific issues. The Victorian Department of Health's *Best Practice Framework for Clinical Learning Environments* (2009) refers to high quality clinical education staff as a key component of a positive learning environment. These staff "display appropriate interpersonal attributes, are suitably trained for the task, are resourced to enable fulfilment of the educator role and are adequately prepared" (p. 6).

There are at least two examples of national evaluated training courses on clinical supervision of learners that have been developed or trialled for multiple professions and/or for an interdisciplinary audience.

### **Teaching on the Run**

Teaching on the Run is a well-respected program developed by Dr Fiona Lake at the University of Western Australia to help doctors increase their skills and confidence teaching and supervising in the clinical setting. It targets doctors who have had little or no teaching instruction. The program has six modules (see below) and each is designed to be delivered as a 2 – 3 hour workshop. The modules can be run alone, or together as part of a longer session. There is also a range of practical resources such as Teaching Tips on 14 issues such as teaching a skill, determining competence, assessment and appraisal and giving feedback.

The program is available to deliver locally if the health service has clinicians or educators who have attended Teaching on the Run workshops or been trained as facilitators. The University of Western Australia Faculty of Medicine and Dentistry also organises training for facilitators. Support for delivering the program locally includes running a workshop, supporting prospective facilitators and provision of all support material. Each half-day program contributes to CME points from various medical colleges (RACP, RACS, RANZCR, RACGP, ACEM, RANZCP, RANZCO).

Dr Lake has adapted and expanded the program to a broader group of health professionals, including nurses, allied health practitioners and veterinarians through a Fellowship from the Australian Learning and Teaching Council. The project was based on the premise that there are significant similarities in the way health practitioners teach and supervise in the clinical setting (Lake et al 2009, p. 3). The project also developed two modules relating to inter-professional teaching and supervision: 'Clinical learning with an inter-professional group of learners' and 'Skills and giving feedback'.

Modules have been successfully delivered to non-medical staff including groups of physiotherapists at Sir Charles Gairdner and Royal Perth Hospitals and staff from the Orthopaedic Physiotherapy Screening Clinic and Multidisciplinary Service at The Royal Brisbane and Women's Hospital. The program has also been delivered to nurses in collaboration with staff development at Fremantle Hospital and multidisciplinary groups from Curtin University of Technology and the University of British Columbia.

### The Australian Clinical Educator Preparation Program

The Australian National Strategy for Pharmacy Preceptor Education and Support developed an innovative national core pharmacist preceptor education and support model that could be customised for specific undergraduate programs (Dalton et al 2007). Electronic delivery options were deliberately chosen to improve accessibility to pharmacists regardless of geographical location. It has five modules: Introduction; Focus on the Student; Focus on the Preceptor; Challenges in Precepting; and, Putting the Theory into Practice. The program was delivered online and incorporates support mechanisms (Dalton et al 2007 p. 160).

The program was trialled and received a positive evaluation (Dalton et al 2007). It was redeveloped in 2007 by the Rural Health Support Education and Training to make it appropriate for clinical educators from a range of health professions. The resulting Australian Clinical Educator Preparation Program ([www.clinicaleducation.info](http://www.clinicaleducation.info)) is a nationally unified, interprofessional approach to providing training to clinical supervisors in Australia auspiced by the Australian Consortium for the Education of Preceptors.

The program is available to those taking on the role of clinical supervisor for health science professional entry and post graduate health professionals. Flexible, on-line, delivery of the training program facilitates access by rural and remote practitioners. It involves six self-paced stand-alone but related modules, a discussion forum and a journal. There is also a survival toolkit, which is a checklist for a supervisor preparing for a clinical placement. The entire program is expected to take about 20 hours over around three months.

### Modules from Teaching on the Run and the Australian Clinical Educator Preparation Program

Teaching on the Run	Australian Clinical Educator Preparation Program
Clinical (bedside) teaching	Clinical education theory and practice
Skills teaching	Focus on learning (how students learn and educational theories)
Feedback and assessment	Focus on being a clinical educator
Supporting trainees	The learner –clinical educator relationship
Planning term learning	Learning in the workplace
Effective group teaching	Mentoring

Examples of other national supervision courses include:

### **Professional Development of Registrars Program**

The Confederation of Postgraduate Medical Education Councils has developed a Professional Development Program for Registrars (PDPR). The PDPR “aims to improve the leadership and management performance of individual registrars” and to assist the career transition from junior doctor to registrar and front-line medical managers (CPMEC 2008). It “seeks to improve the quality of educational supervision provided to doctors in their prevocational years by developing the teaching and supervision skills of registrars” (CPMEC 2008).

The preferred format is a two-day, off-site program covering a range of issues including communication and learning styles, the registrar as teacher and giving and receiving feedback. Whilst the content and focus of this program is clearly broader than teaching and supervision, other components such as self-awareness and time-management are likely to assist these roles.

### **Other online resources**

There are examples of profession-specific online resources such as the information developed by the Queensland Occupational Therapy Fieldwork Collaborative (QOTFC 2007)<sup>6</sup>. The Clinical Educator’s Resource Kit is an on-line program developed to assist and support occupational therapists considering taking on the role of clinical supervisor. It covers various aspects of the supervision role including: pre-placement considerations for student clinical education; setting up and sustaining positive student clinical placements; approaches to clinical education; the feedback process and evaluation; and working with students who are experiencing difficulty.

### **Other courses**

The specialist medical colleges have developed a range of specialist specific resources and training courses for supervisors of specialist trainees. For example, the Royal Australasian College of Surgeons has developed an intensive, five-day course for educators held every three to four years. It also runs a two and a half day intensive surgical teachers’ course which attract CPD points and a Supervisors and Trainers course ([www.surgeons.org](http://www.surgeons.org)).

There are a range of other supervisor training courses (e.g. see Victorian Health Care Association).

### **Research and examples of good practice**

The literature notes that clinical supervisors may have little or no preparation for their educative and assessment role (e.g. Rodger et al 2008, Bower 2008). It strongly advocates for adequate preparation of clinical supervisors, to help their transition to the supervisory role and to support them in that role.

There are examples in the literature and from jurisdictions of how training can improve supervisory skills. For example, ACT Health provides a program of scholarships for allied health, nursing and midwifery educators to undertake a Graduate Certificate in Higher Education and the more recent Graduate Certificate in Tertiary Education at the University of Canberra. An evaluation survey indicated that the majority of staff undertaking these qualifications report improved education knowledge and skills.

Effective orientation to the supervisor role is also important, including “curriculum requirements, the use of the assessment tool, strategies for supervision and alternative approaches to assessment” (Kevin 2006, p. 41).

Kilminster et al (2007) found that supervisor training needs to include understanding teaching, assessment, appraisal, feedback and interpersonal skills. Rodger et al (2008 p. 59) consider that supervisor training in allied health needs to ensure that educators can:

- Describe the role and identify the attributes of an effective clinical educator
- Apply learning theories appropriate for adult and professional learners
- Plan, implement and facilitate learning in a clinical setting

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<sup>6</sup> The Queensland Occupational Therapy Fieldwork Collaborative formed in 2004 and comprises representatives from the three Queensland universities providing occupational therapy training, occupational professional bodies, and major employers. (source: <http://www.qotfc.edu.au/> - accessed March 2010)

- Apply sound principles and judgement in the assessment of clinical performance
- Evaluate the learning experience
- Reflect on the experience and formulate action plans to improve future practice

Rodger et al (2008) also advocate for interprofessional training, where possible, to increase peer support amongst clinical educators, and argue that it should be recognised as part of continuing professional development (p. 59).

Nash (2007) notes that nursing preceptors may not have the required skills, especially in assessment/evaluation (Infante 1985, cited in Nash 2007, p. 30). The importance of supervisor training has also been highlighted for dental supervisors (Sweet et al 2008).

Dewey et al (2008) found that residents' teaching programs should cover general teaching concepts such as leadership, evaluation and feedback, bedside teaching and small group teaching skills (p. 82). There are studies which support the use of online education of supervisors (Parsons 2007).

Training needs to cover interpersonal skills, as the literature suggests that the quality of the relationship between the student and supervisor is important in achieving optimal learning outcomes (e.g. Mannix et al 2006). The literature also notes the importance of clinical placement supervisors engaging in supervision related professional development (e.g. Kirke et al 2007).

There are examples in the United Kingdom (UK) and the United States of America of training linked to accreditation for clinical educators. For example, the Chartered Society of Physiotherapists in the UK has an accredited clinical educator program, with experience and academic based pathways (Chartered Society of Physiotherapists 2010). The Nursing and Midwifery Council UK has established standards for nursing and midwifery supervisors linked to a core curriculum and training (2008).

The London NHS (London Deanery 2008) has developed a minimum training specification for clinical and educational supervisors in medicine, and advocates that a clinical supervisor should have undertaken some training or developmental activity in areas such as concepts and skills for one-to-one developmental conversations.

The *Professional Development Framework for Supervisors in the London Deanery* (2009) London Deanery, [www.londondeanery.ac.uk](http://www.londondeanery.ac.uk) outlines mandatory training for educational supervisors which covers all areas of the framework. For clinical supervisors mandatory training covers areas 1 – 4 of the following 7 areas of the Framework:

- ensuring safe and effective patient care;
- establishing and maintaining an environment for learning;
- teaching and facilitating learning;
- enhancing learning through assessment;
- supporting and monitoring educational progress;
- guiding personal and professional development;
- continuing professional development as an educator;

### **Future directions**

Most project discussions with health services were supportive of the concept of readily accessible, flexibly delivered basic training in the core skills/competencies of student supervision. For example, a basic package could be available online, supplemented where practicable by face to face sessions. This basic training could be generic, and should link to different supervisor levels. Discipline specific training could build on the basic training. The development of the generic basic training should draw on the examples of good practice identified above. For example, *Teaching on the Run* and the *Australian Clinical Educator Preparation Program* could be promoted and/or used as the basis for further work.

### **Career development**

A number of participants in project discussions commented that career opportunities in education and training would encourage practitioners to take up a supervision role. They perceived that opportunities for career development for supervisors would demonstrate that education and

training was valued within the organisation. It would also provide an incentive for practitioners to acquire and develop supervisory skills. Some stakeholders commented that organisational structures need to support clinical supervision roles.

### **Current approaches**

A number of jurisdictions commented that position or level descriptions included a reference to supervision being part of a clinical role (e.g. Victoria, Queensland), reflecting the philosophy that education is part of all health practitioner roles.

However, whilst there are increasing numbers of dedicated educator or supervisor positions these still seem to be relatively few compared to supervisors who also have a clinical load. Within health services, there are limited development opportunities for practitioners to specialise in education and training. Currently, the main opportunity for practitioners who wish to pursue a career in education and training is within an academic, rather than a practice, setting.

According to Victoria's *Best Practice Framework for Clinical Learning Environments* (2009), an organisational culture that values learning establishes dedicated teaching positions to provide alternate career pathways and a career structure for educators (p. 5).

The research identified in the project generally focused on academic teaching or research career pathways, rather than clinical supervision. For example, Pollard et al (2007) identify the need for a clinical education career pathway for nurses in the UK. However, Buchan et al (2008) report that there are few examples of integrated career structures that can accommodate clinical educator roles effectively, and that in general staff occupying these roles in different countries do not usually have a clear career path and at some point may have to decide to choose between education or service delivery as their career (p. 32).

### **Future directions**

Establishment of career opportunities is an issue for health services. However, career opportunities in education and training could support, complement and reinforce other directions identified here.

### **Functional supports**

Stakeholder discussions raised issues related to the following functional supports for clinical supervisors:

- Assistance with service delivery or supervision role ,i.e. reducing the double load of service delivery and clinical supervision;
- Assistance with poor performing students; and
- Assessment tools.

The reviewed literature recognises that supervisors benefit from support in addition to training (e.g. Williams & Irvine 2009).

Stakeholders identified service delivery pressures as the biggest barrier to increasing student supervision capacity. Most project stakeholders commented that student supervision was added onto a full clinical load. Discussions with health services almost all expressed concern about how student supervision capacity could be increased given growing service delivery pressures. This issue is linked to organisational teaching and learning culture and the value and priority given to student supervision. A number of stakeholders commented that service delivery issues such as waiting times take priority over student supervision.

Stakeholders identified two possible solutions to this issue:

- Reduce service delivery pressures, through protected time, backfilling of clinical positions or additional clinical staff; or
- Reduce the burden of the student supervisor role, through dedicated supervisors or other forms of additional support, e.g. clinical educators, who would assist student supervisors with the supervision task to help them to balance their supervisory and service delivery roles.

## **Current approaches**

In medicine, traditionally there has been a percentage of time quarantined for non-service delivery activities, such as teaching, research and administration. In practice, some stakeholders reported in project discussions that this quarantined time has been eroded.

Health services provided examples of how dedicated student supervisors or student supervisor support positions had increased capacity. For example, in Queensland, the establishment of Dedicated Clinical Educators has increased the number of student placements that are possible in some allied health professions. In South Australia, the establishment of a dedicated clinical supervisor position in dentistry enabled a greater number of dental students to be supervised simultaneously.

The literature has examples of how dedicated clinical educators have improved student supervisor support and increased capacity. For example, Henderson et al (in press) proposes that a clinical supervisor be used to support practising clinicians working alongside students. In Henderson's model, a practising clinician would not need to have a comprehensive understanding of learning styles or assessment procedures, because these issues would be the responsibility of the dedicated supervisor of clinical education rather than the clinician.

## **Future directions**

The Clinical Training Subsidy will provide additional funds which health services may choose to use to address the issue of balancing responsibilities for service delivery and clinical supervision. The use of dedicated supervisors or supervisor support and innovative models also has potential to address this issue (eg Roberts et al 2009).

## **Dealing with poorly performing students**

A number of health services raised the issue of the additional workload and pressure from supervising a poorly performing student. Supervisors in these services indicated that they usually have no warning that a student is likely to struggle with their clinical placement. In addition, some supervisors experienced difficulty in accessing assistance to remediate a struggling student.

This issue links to clarity of expectations and assessment tools. If the learning outcomes and supervisory role for the placement are clear, and the assessment tool is familiar and explicit about the assessment criteria, then it assists early identification of a student who is struggling.

## **Current approaches**

Anecdotally, assistance to deal with struggling students varies between universities and professions. In some cases there may be help available from a clinical coordinator, facilitator or dedicated clinical educator. However, in other cases, supervisors reported needing to address the issue without additional support.

The literature recognises the additional pressure on student supervisors from poorly performing students. These students take additional time, increasing the tension between service delivery and student supervision requirements. In addition, the student supervisor may feel a sense of failure and responsibility for the student's difficulty, which can discourage them from continuing in a supervisory role (Sharples & Kelly 2007). The literature emphasises the need for training to prepare supervisors to work with students who have personal, academic or clinical difficulties (Wilson et al (2009), Duffy (2003) cited in Sharples & Kelly 2007).

## **Future directions**

Giving supervisors the skills to address learners with difficulties and providing them with support to work with these learners could contribute to encouraging clinicians to take on a supervision role.

## **Assessment tools**

Students' performance on clinical placement needs to be assessed, to ensure that only students who are able to satisfy the clinical experience requirements progress in their studies. Among stakeholder discussions, assessment of student performance seemed to be accepted as a key component of a student supervisor's role in many health services (see 6.3.1 Functions of supervision) although NSW Health considers it to be the education provider's responsibility and Henderson et al

(in press) suggests that separating assessment from the day to day supervision role could encourage more clinicians to accept a basic supervisor role.

Education providers generally provide assessment documentation for student supervisors to complete. However, within a profession, these assessment tools may vary considerably across universities (Kevin 2006). This variation clearly adds to the amount and complexity of a clinical supervisor's work in assessing students, as they must become familiar with the different requirements and assessment approaches of different universities. For example, one health service spoke about the additional work and complexity that was involved in hosting nursing placements from many universities, each with a different assessment tool.

Health services generally considered that there would be benefits if universities used the same assessment tool for students within each profession. Those with experience of placements involving common assessment tools were universally positive about this approach.

### **Current approaches**

In Australia, common assessment tools have been developed for at least three professions: speech pathology, occupational therapy and physiotherapy. Work relating to a common assessment tool for the nursing profession is underway and is expected to be completed early in 2010. The Australian Learning and Teaching Council ([www.altc.edu.au](http://www.altc.edu.au)) has funded the development of some of these tools.

The development of common assessment tools is relatively recent and is continuing to gain momentum. Where the issue has been considered in recent literature, there is support and recognition of the potential of common tools to clarify and streamline the assessment process and reduce the burden on placement supervisors.

There is strong support for common assessment tools from health services hosting placements from multiple universities within a profession.

### **Recognition**

Stakeholder discussions often raised the issue of lack of recognition for clinical supervisors and their contribution to the future workforce. They reported a perception that health services generally do not recognise student supervision as a distinct role or function. There is generally no distinct career pathway within health services for clinical supervisors, and some perceive that the supervisory role is taken for granted and not valued by health service management.

There is a range of incentives for clinicians to take on a supervisory role which vary between health services and institutions. Health services mentioned many of the incentives raised in the literature, such as access to continuing professional development, letters of appreciation, certificates, attendance at celebratory events and adjunct or conjoint appointments to the educational institution.

### **Current approaches**

Where Australian best practice frameworks for clinical learning environments have been developed, they explicitly recognise the essential role of student supervisors. Victoria's *Best Practice Framework for Clinical Learning Environments* (2009) emphasises the need to value educators and the educational components of their jobs. The Framework also provides for educational activities to be counted and considered as part of career progression and for dedicated teaching positions to be established to provide alternate career pathways (p. 5).

ClinEdQ's *Framework for best-practice clinical learning environments in Queensland Health: Final draft* (2010) recognises the importance of "high-quality and consistent supervision by well-trained clinical educators" to best practice clinical learning environments (p. 2).

Universities offer clinical supervisor support, which varies by university (see section 7). For example, the University of Queensland has a Clinical Educator Support and Recognition Program, which highlights the potential benefits for clinical educators including the opportunity to obtain an honorary Associate Lecturer title. The appointment enables clinical educators to access a range of other benefits, including library access, professional development opportunities, email and internet access, IT support and training etc (University of Queensland 2010).

The literature reflects the importance of recognition to clinical supervisors, e.g. Paltridge (2006). Rodger et al (2008) identify a range of opportunities for formal recognition through academic titles, certificates of appreciation, additional payment, credit toward higher degrees, access to resources such as university libraries, e-mail and internet, reduced fees and leave for continuing professional development activities (p. 59). Kirke et al (2007) found that universities need to assist in creating opportunities for occupational therapy fieldwork educators to continue their own professional development and thus maintain their practitioner competence.

The Canadian Physiotherapy Association national clinical education awards program (Canadian Physiotherapy Association 2010) is an example of a program specifically designed to recognise and value a high standard of clinical supervision of students in the physical therapy profession. The award was introduced in 1999 and between one and three individual physical therapists working in the clinical environment are given the award each year (depending on the quality of applicants). Those recognised must have made outstanding contributions to the clinical education of entry-level students.

### **Future directions**

The need for recognition interrelates with the importance of a strong teaching and learning culture which reinforces the value and contribution of a clinical supervision role.

## **Supervision Environment**

### **Physical Environment and resources**

The infrastructure and resources available in the clinical placement environment are key determinants of clinical placement and supervision capacity. Jurisdictions and health service stakeholders frequently raised issues relating to infrastructure and resources as constraining an increase in the number of clinical supervisors, the number of students that existing clinical supervisors agree to supervise and, at the most fundamental level, the number of students that can be accommodated in the physical environment. The physical environment in which supervisors work, and the resources available to them, clearly impact on clinicians' decision to initially take on a clinical supervision role, and then to continue, expand or cease that role.

Whilst infrastructure and resourcing issues affect supervisors, these issues are being specifically considered by other HWA clinical education projects where solutions to these issues are more likely to be generated. These projects are discussed under 'Current Approaches' and 'Future Directions', found below in this section. Accordingly, the issues raised in this section have been shared with those projects and the Clinical Supervision Support Program will have input into that work in relation to how potential solutions would impact on clinical supervisors.

Issues about infrastructure and resources fall into 4 main categories:

- Resources to assist supervisors with their workload, e.g. to assist with supervision and/or service delivery work;
- The physical environment, i.e. the physical space where the placement occurs, IT resources, desks etc;
- Equipment or specific infrastructure required for the placement, e.g. dental chairs, ambulances, cost of materials for orthotic and prosthetic placements etc; and
- Issues associated with rural and remote placements, such as accommodation, transport, and other costs incurred by students undertaking a placement away from their home.

### **Resources to assist supervisors**

Workload and service delivery pressures were most frequently cited by health service stakeholders as a barrier to increasing student supervision capacity. As discussed above, there is often an inherent tension between education providers' student-focused priority on learning and health services' patient focused priority on service delivery.

Health services often perceived that the service delivery environment is so stretched that it is difficult to expand supervision capacity without providing some additional resources to assist either with the service delivery and/or the supervision workload.

Clinical placement management systems (generally IT based) assist with student placements. These systems do not currently necessarily directly assist supervisors, but assist in the coordination and administrative work associated with clinical supervision process overall. For example, Rodger et al (2008) note that “coordination between service sectors and the universities has been hampered by the lack of systematic data collection for practice placements” (p. 58). Rodger et al (2008) also notes that the lack of systematic data collection is a barrier to coordination between health services and universities (p. 58).

A number of jurisdictions and health services are already working on student placement coordination. For example, as part of the 2007 Community Health Student Placement Coordination Project, the Victorian Department of Human Services funded the Upper Hume Community Health Service and the Doutta Galla Community Health Service to “develop a sub-regional placement coordination model that could be replicated in other similar regions”.

### **Physical environment**

Many health service stakeholders emphasised that the physical environment limits the number of students that can be accommodated on placement. The workforce already experiences pressure for space and access to IT resources in many workplaces. More students in these workplaces adds to the competition for space and resources, and makes the working environment more crowded and pressured, increasing competition for access to electronic learning resources for students and supervisors, and difficulties finding appropriate places to teach, debrief and have private discussions with students about their performance.

### **Equipment or specific infrastructure**

Some disciplines require access to particular equipment for students on placement and these inherently limit the possible numbers of students and supervisors. Examples include dental chairs for dental students and ambulance places for paramedicine students. This is also an issue for students in medical radiation science disciplines and prosthetics and orthotics.

Simulated learning environments may have the potential to reduce pressure on the clinical placement environment (e.g. Barnett et al 2008), and this potential is being explored through HWA's Simulated Learning Environment project. There are positive evaluations of use of a simulated environment in different professions, including dental, which has particular infrastructure constraints associated with the need for a dental chair (e.g., Davies et al 2009).

### **Rural and remote placements**

The above infrastructure issues are often even more acute in rural and remote settings. In addition, the availability of student accommodation and assistance with costs such as transport were often reported as barriers to expanding student and supervision numbers in rural and remote locations. These issues were emphasised in the Northern Territory as was the importance of training in cultural issues. Travel and accommodation costs associated with clinical placements are also an issue for students who undertake a placement away from their place of study, e.g. orthotics and prosthetics students, as there is only one course in Australia, or where additional placement capacity exists in other States or Territories.

### **Current approaches**

Supervisor support, rather than physical infrastructure issues are the focus of this report. However, infrastructure and resources determine the environment in which supervision occurs and are clearly a concern to existing and potential supervisors. As indicated above, the issues will be referred to the Clinical Training Funding (CTF) Project which is developing a Clinical Training Funding approach to subsidise professional entry clinical training. For the first time, the new funding will flow through to the service setting in which students train thus ensuring the training outcome and enabling an expansion into non traditional training settings including primary, community and mental health, aged care and the private sector. The increased funding could potentially assist to address some of the physical infrastructure and other issues raised by health service stakeholders.

Jurisdictional work on best practice learning environments acknowledges the importance of physical infrastructure and resources. The Victorian *Best Practice Clinical Learning Environments within Health Services for Undergraduate and Early-Graduate Learners Final Report* (Darcy 2009)

comments that most of the literature on best practice clinical learning environments have focused on students and teachers, and not on the physical aspects of the environment and resources. Based on their research, Darcy Associates include physical infrastructure in their key elements of a best practice clinical learning environment.

*Queensland Health: Framework for best practice clinical learning environments in Queensland Health Final draft* (2010) identifies a number of key attributes of best-practice clinical learning environments, and comments that “[a] commitment to providing resources to the learning environment is an important part of this process, including provision of IT access, teaching spaces, social areas and equipment which is relevant to disciplines (such as dental chairs, audiology testing equipment etc)” (p.2).

The literature tends to comment on physical infrastructure in terms of barriers to expanding supervision capacity (e.g. Wilson et al 2009 regarding physical space limitations), however, proposed solutions focus more on different models of clinical education than directly addressing infrastructure issues. The difficulties in relation to accommodation and transport for rural and remote placements are acknowledged in the literature (e.g. Ralph et al 2008).

### **Future directions**

The Clinical Training Funding Subsidy will provide additional resources in the clinical training environment. Whilst the application of the funding has not yet been decided, the impact of infrastructure issues on supervisors and placement capacity will be taken into account in this work.

### **Organisational culture**

Organisational culture was a strong theme of preliminary project discussions and also appears in the literature on supervisor support. Many project stakeholders see teaching and learning as a core part of health service business, which was not sufficiently valued or recognised by the organisation or its leaders. Many consulted considered that the professionals in their health service had a strong teaching and learning philosophy, but that this was sometimes obscured, overwhelmed or impaired by service delivery pressures.

Stakeholder discussions confirmed the view that teaching and learning is part of a professional role. Whilst there was a general acceptance that involvement in education and training is part of a professional role, discussion participants felt that organisational culture did not value this aspect of a health practitioner’s work. Despite this, there is a recognition that not all professionals should teach.

Organisations often lack explicit leadership and performance indicators about a teaching and learning culture. Project discussions generally considered that there was a need for explicit articulation of this philosophy and specific performance indicators relating to a teaching and learning culture.

The Australian Medical Association junior doctors’ survey (AMA 2009) found that many public hospitals do not have a culture or environment that encourages high quality medical education (p. 4).

### **Current approaches**

ClinEdQ’s proposed *Framework for best-practice clinical learning environments in Queensland Health: Final draft* (2010) identifies the importance of a culture of learning and teaching at all levels (p. 2). It proposes the evaluation of clinical learning environments across Queensland against a consistent minimum data set, which includes a systemic commitment to education and value on lifelong learning (p. 5).

Victoria’s *Best Practice Framework for Clinical Learning Environments* (2009) is an organisational culture that values learning. This includes a section on valuing educators, including respecting their skills and encouraging them to continually improve those skills (for example, by pay loadings for educational qualifications). The section also advocates that “education activities should be counted and considered as part of career progression” (p. 5).

Clinical supervision is often seen as an inherent part of a health practitioner’s professional role (e.g. Thomas et al 2007). Nursing involvement in clinical teaching and learning has traditionally been assumed (Mannix et al 2006).

## Future directions

Based on the discussion above, the need for recognition (of supervisors' contributions) seems intrinsically related to the importance of a teaching and learning culture. A strong teaching and learning culture will recognise and reinforce the value and contributions of the clinical supervisor's role. For example, developing such a culture may include embedding statements reflecting the value of the role of clinical supervision in health service corporate documentation such as vision statement(s) and/or key performance indicators.

## Accreditation standards/criteria

### Overview

This section presents an overview of accreditation criteria<sup>7</sup> relating to clinical supervision aspects of education and training programs and courses for health professionals in Australia. It highlights common elements and/or themes of the criteria across professions and notes differences in terms of the coverage and type of criteria.

### Information sources

The main sources of information used for this discussion were:

- documents found at or linked to the websites of the relevant national accrediting bodies (where such a body exists<sup>8</sup>) for the health profession (see Appendix F for details of original source documents and references);
- information provided by accrediting bodies in response to a survey of accreditation bodies undertaken by the NHWT in March 2010; and,
- documents or other information supplied directly to this project by the profession's accrediting body<sup>9</sup>.

### Scope

The focus of this overview is primarily considering the Accreditation bodies' requirements of supervisors (e.g. qualifications, experience, roles and responsibilities); support(s) and/or resources available or provided to supervisors; and supervision arrangements. Other aspects of students' clinical experiences, including content (e.g. length and breadth of the actual clinical experience, such as minimum hours/weeks and types of clinical experiences/procedures required for the student to achieve competency), are noted where relevant to supervision aspects of the program but they are not detailed.

Criteria relating to professional entry level program(s) and/or courses are the main focus. For professions with postgraduate education programs that include detailed and/or specific criteria relevant to clinical supervision aspects of the program, these are included and identified.

As the main information sources used were the websites of each profession's national accrediting body, additional and/or supplemental criteria that may be published by state/territory boards or other bodies are not included.

In most cases the criteria discussed are relevant to Australia only; in those cases where the criteria apply to education programs for health professionals outside of Australia (New Zealand, for example), this is noted.

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<sup>7</sup> The term 'criteria' is used in Section 8.1, although in many cases specific professions may use other terms such as 'standards', 'requirements', or 'guidelines'. Section 8.2, Summary by profession, uses the term indicated within each profession's relevant documentation.

<sup>8</sup> Some health professions do not have a recognised accrediting body.

<sup>9</sup> As part of this project the accrediting body of each health profession (see Appendix E) was contacted and invited to provide references to documents and/or other information related to clinical supervision aspects of accreditation criteria of education programs or courses for their health profession.

## Analysis

Although most health professions do have course accreditation criteria, and many of them reference clinical supervision aspects of the course(s), the type, range and specificity of the supervision criteria vary considerably.

In some cases the criteria are provided as guidelines only, and in other cases they are mandatory requirements that must be met to achieve accreditation. The language used in the accreditation documents often allows a distinction between those criteria that are mandatory and those that are merely desirable. For example, the dentistry education program accreditation criteria<sup>10</sup> state that some criteria included in their course accreditation guidelines document are mandatory – indicated by the guideline worded as a “must” statement – and others are highly desirable – indicated by the guideline worded as a “should” statement.

Criteria for many of the health professions focus on the content of the clinical experience and/or placement(s) and are fairly non-specific with regards to the supervision aspects of the clinical experience. The criteria may include minimum requirements that detail the number of hours/weeks or days to be spent performing particular types of clinical work relevant to the profession and but will only include a broad statement indicating that the clinical experience must be appropriately and/or adequately supervised. The Australian and New Zealand Podiatry Accreditation Council states that supervision must be appropriate but does not define what is deemed appropriate. Such an approach allows the education institutions to develop individual programs to meet the established criteria.

Conversely, some professions have course accreditation criteria that impose a detailed set of requirements for various aspects of clinical supervision. For example, the Australian Psychology Accreditation Council provides detailed, prescriptive criteria relating to clinical supervisor qualifications, experience, roles and responsibilities.

Below is a brief summary of each of the main aspects of clinical supervision included in the criteria and a discussion of the similarities and differences among the professions. The following summaries are based on an analysis of the criteria for 22 professions<sup>11</sup>.

### Supervisor qualifications and/or experience

A total of ten of the professions have criteria that specifically detail requirements for supervisors' qualifications and/or experience. Many of these professions require the supervisor to be qualified and/or accredited in the profession in which they are supervising students, and to have a certain number of years of professional experience prior to undertaking a supervisory role. Most professions (12 of the 22 professions) have either no criteria or fairly general criteria that do not prescribe the specific qualifications or experience required of supervisors. Of those with more general criteria, some state that the clinical experience must be appropriately or adequately supervised (see, for example, Pharmacy and Dentistry) while others note that supervision is required but do not provide further details (see, for example, Paramedicine).

### Supervisor supports and resources

Only three of the professions – exercise physiology, occupational therapy and social work - have criteria that specifically and directly address the issue of supervisor supports. For three other professions – speech pathology, physiotherapy and dietetics – supervisor supports were identified as being important for the accreditation of courses, although they are not embedded in the criteria documentation.

Exercise physiology criteria include a general statement that supervisors must be provided with necessary support. Occupational therapy standards refer to supervisors being “adequately

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<sup>10</sup> Source: ADC/Dental Council of New Zealand (DCNZ) Accreditation Assessment Guidelines for University Programs in Dentistry, p 7.

<sup>11</sup> Two of the 24 health professions reviewed – orthoptics, and orthotics and prosthetics - do not appear to have course accreditation criteria.

supported". The criteria for social work programs go further and state that supervisors must be offered adequate support, including payment in some cases<sup>12</sup>.

The social work criteria list the supports that should be provided, including access to university resources such as the library, consultation with university staff if required, training and support in student supervision and other professional development activities.

Criteria of some other professions indirectly reference supervisor support by including standards that state supervisors must be adequately prepared for their role in supervision. Occupational therapy standards also require supervisors to be adequately prepared to fulfil their role and responsibilities.

For speech pathology programs, the accreditation panel requires evidence that the university offer training and support to external clinical educators. Similarly, in dietetics programs it is assumed that university clinical educators support placement supervisors, and, those universities without adequate support of placement supervisors will not pass accreditation. The accreditation process for physiotherapy programs requires that the university provide suitable programs to support clinical educators in their roles.

### **Supervisor roles and responsibilities**

10 of the accreditation bodies have criteria that include specific reference to the supervisors' roles and/or responsibilities.

Within the group of professions with criteria that include reference to supervisors' roles and responsibilities, at one end of the spectrum are those with non-specific statements about roles and responsibilities; they may simply state that the educational institution must define the supervisors' roles and responsibilities. At the other end of the spectrum are criteria that embed detailed descriptions of roles and responsibilities of supervisors.

### **Supervisor support roles**

A total of four professions – psychology, social work, dietetics, and nuclear medicine - have criteria that include identification of other supervisor types to support the main supervisor role. In practice, most other professions likely also have other supervisor types to support the main supervisor role, even though only four of the professions reviewed have these supporting roles documented in their education program accreditation criteria. For example, university based pharmacy programs are required to employ a 'clinical placements officer' to facilitate and support clinical placements.

Criteria for the psychology profession refer to the appointment of a placement coordinator who is responsible for liaising with all supervisors and ensures appropriate placements for students.

The criteria for the social work profession require assignment of a field education coordinator and a field education liaison staff for each placement and detail the roles and responsibilities<sup>13</sup> of these positions.

Criteria for the dietetics profession require the appointment of both a primary and a secondary supervisor. The role of the secondary supervisor is to provide expertise and supervision in their particular work setting<sup>14</sup>, and the qualification required of a secondary supervisor are less stringent than for a primary supervisor. The dietetics criteria also include reference to university appointed subject coordinators who are responsible for reporting assessments to the university.

Nuclear medicine has a mentor program whereby each new graduate is assigned a mentor – an experienced nuclear medicine technologist – to provide guidance and support during the postgraduate development year. Although mentors are not supervisors they do represent an additional supporting role for nuclear medicine students during their professional development year of training.

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<sup>12</sup> In cases where student supervision is not included in the supervisors usual paid employment, it is expected that the university will negotiate payment of the supervisor (page 16, *Australian Social Work Education and Accreditation Standards*).

<sup>13</sup> For details of responsibilities of these positions, see section 4.3.3 (vi) and (vii) of the *Australian Social Work Education and Accreditation Standards*.

<sup>14</sup> See Section 2.3 of the DAA Manual for Accreditation of Dietetic Education Programs.

## **Supervision arrangements and models**

A total of three of the professions – dietetics, psychology, and social work – have criteria that include details regarding supervision arrangements and/or models. In each case these professions' education program accreditation criteria incorporate the specifics of supervisory roles and responsibilities, identify supervisor supporting roles, and detail other aspects relating to the supervision arrangements.

Criteria for other professions often include a requirement for collaboration and/or consultation between the education provider and the organisation where clinical placement is to occur, but the focus is generally on ensuring outcomes and/or desired competencies are achieved rather than on imposing specific supervision arrangements. For example, while criteria for the nursing and midwifery professions do not prescribe exactly what the supervision model should look like, they do state that supervision models must be focussed on achieving learning outcomes.

Education program accreditation processes for other professions are clearly concerned with supervision models but do not document any specific standards within their criteria. For example, within the accreditation documentation for the osteopathy and the optometry professions there is reference to providing, as part of the evidence submitted for accreditation, information about the ratio of clinical supervisor(s) to students, but no particular minimum ratio is stated within the criteria.

## **Terminology**

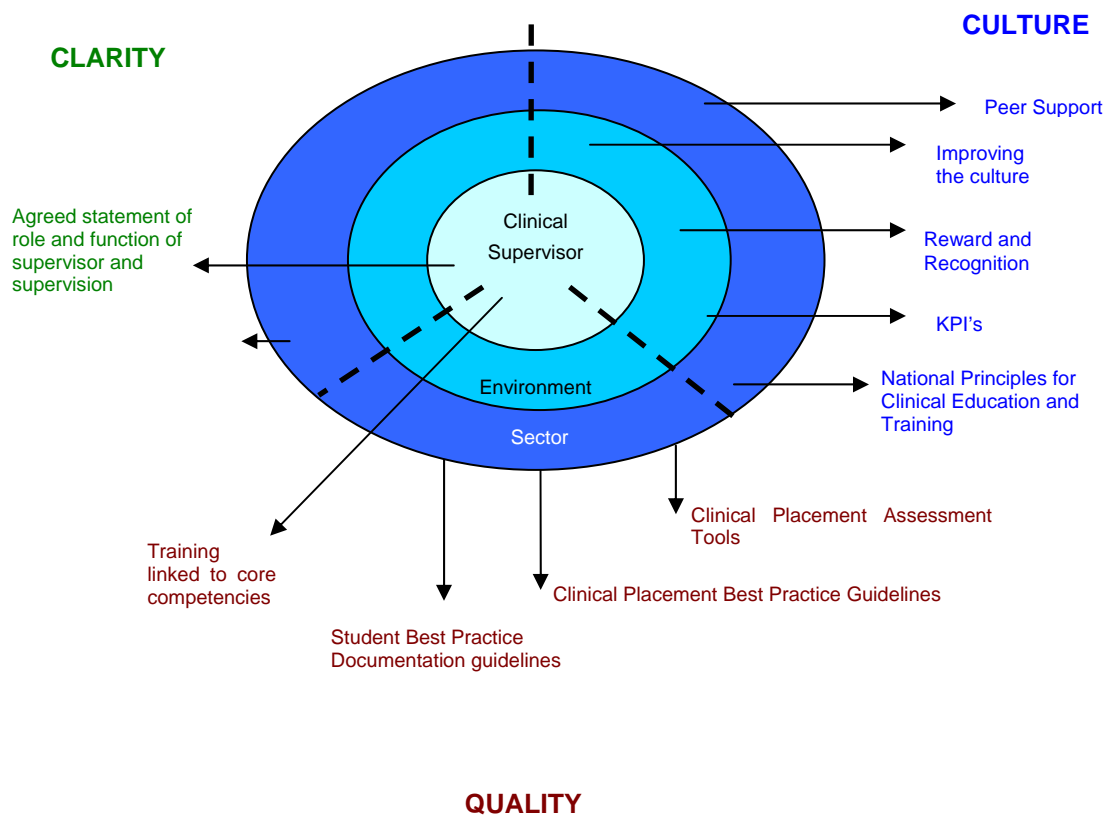
The course accreditation criteria for many of the professions reviewed use specific and different terms to describe a clinical supervisor. These include, for example, clinical instructor (Optometry), clinical educator (Physiotherapy), field supervisor (Psychology), and field educator (Social work). Even in cases where the terminology is not embedded in the accreditation criteria, profession specific terms for the clinical supervisor role may be used in practice.

### 3 Clinical Supervision Support Framework

The issues raised in development of the Discussion Paper identified three main themes relating to clinical supervision in Australia, as follows:

- Functions of supervision and role clarity
- Supervisor development (core skills required by supervisors, training, career development, functional supports, and recognition); and
- The supervision environment (physical environment and resources, and organisational culture).

In developing the strategies to address these issues and to increase the competency and capacity in clinical supervision three key areas were considered, the clinical supervisor, the environment and the sector. In addition the activities were targeted at three areas of action; clarity, quality and culture.



Firstly it is important to acknowledge the extensive work implemented or underway in states and territories to address the issue of increasing competency and capacity in clinical supervision. The strategies outlined below endeavor to build on this work and stimulate discussion of the key issues raised by stakeholders in the development of this paper.

The CSSP provides an opportunity to work together to develop a National Clinical Supervision Support Strategy and Framework that incorporates, supports and enhances the overall continuum of clinical education and training of health professionals. Whilst the HWA can lead this body of work stakeholders involved in clinical training and the provision of supervision will need to incorporate the Framework into their general clinical training requirements to enable its successful implementation.

#### Clarity

The objective of the strategies outlined in this section aim to achieve clarity, agreement and accountability across professions, jurisdictions and educational institutions in relation to the role and function of a clinical supervisor.

Develop national principles for education and training in the health Sector.

Similar to the National Health Workforce Strategic Framework (NHWSF) developed to guide health workforce strategic action, it is proposed that a set of nationally agreed principles be developed by HWA to guide clinical education and training action into the future. The clinical education and training principles would build on Principle 4 of the NHWSF which “is about common cohesive action among stakeholders to ensure the health workforce is sufficient and always skilled and competent. This may involve both existing and new training providers identifying the needs of the workforce and providing training in a variety of locations, using a range of modalities and diverse and extended curricula. Consideration of accelerated entry to the workforce may also be necessary”.

The nationally agreed principles would provide a simple set of statements, guidelines and aims which would allow all stakeholders to apply them to their own circumstances with a minimum level of prescription.

The national principles could focus on the following key action areas:

- Clarity
- Quality
- Culture

**Question for consideration:**

**Q1: Does your organisation have clinical education and training principles that could be applied to health services nationally? If yes, please include in your submission, if no, what are the key action areas that you would like included in national principles developed for clinical education and training in Australia?**

Develop a nationally agreed statement of role and function supervisor/supervision.

It is proposed that common and consistent terminology and definitions be established for the role and function of “clinical supervisor” and “clinical supervision” in Australia. This would be useful in facilitating communication across disciplines, organisations and sectors about clinical supervision issues and in achieving greater clarity and agreement, across professions and among jurisdictions and educational institutions, about supervisors’ roles and functions. It would contribute to sharing the different perspectives and aims of the major stakeholders (education providers, health services, practitioners, and students), provide context to the nationally agreed principles outlined in the first proposal and would support other strategies outlined in this paper.

Some stakeholders have suggested that the term “clinical educator” be used as it emphasises the educative rather than controlling aspects of the role. There are however, a range of terms use to describe this function which are set out in [Appendix C](#).

For the purpose of this discussion paper the terms “supervisor” and “supervision” have been used to provide some consistency and align to the language used in the National Partnership Agreement and other associated documentation. However, the terminology to be used in the National Clinical Supervision Support Strategies and Framework is an issue for further consultation.

**Question for consideration:**

**Q2: Does your organisation have agreed terminology and definitions for the role and function of “clinical supervisor” or “clinical supervision”? If yes, please include the definitions in your submission, if no, what terminology does your organisation use to describe these functions? What cross-profession terminology do you think should be used in the National Clinical Supervision Support Strategy and Framework?**

Develop an agreed national competency framework that defines the knowledge, skills and attributes necessary for quality supervision.

It is proposed to research, identify and agree on generic core competencies for clinical supervisors.

Identifying the core competencies of clinical supervisors would have the benefits of clarifying the skills, attributes and expectations of the role. It would also enable training to be linked to the core

competencies, ensuring a basic level of supervisory skills and potentially enhancing supervisor confidence and the placement experience for both supervisors and students.

The agreed competencies could focus on the core skills outlined in stakeholder consultation and within literature. These include:

- Clinical skills and knowledge
- Adult teaching and learning skills
- Ability to give feedback and receive feedback
- Communication
- Appraisal and assessment
- Remediation of poorly performing students, and
- Interpersonal skills.

It is also proposed that further investigation be undertaken to assess the extent to which the agreed competencies could be incorporated into professional entry training and guide development of Continued Professional Development (CPD) where ever possible.

**Questions for consideration:**

**Q3: Are there core generic competencies you would like added/deleted?**

**Q4: For organisations delivering professional entry training or other curricula: to what extent are the skills already included in current curricula? Do you support greater coverage of these skills in professional entry courses? To what extent could this replace post-entry to practice supervision skills development?**

**Q5: For professional associations and registration boards: does education and training form part of the current CPD program?**

Develop best practice guidelines and templates for clinical placement agreements between health services and universities.

It is proposed that best practice guidelines be developed for clinical placement agreements across health services and universities. The best practice guidelines would outline the expected level of support to be provided by health services and universities.

It is also proposed that best practice guidelines be developed for individual student placement documentation, which would include articulated learning outcomes, the context of the clinical placement within broader curriculum and student information include student history, skill level, past experience and prerequisites.

The best practice guidelines for clinical placement agreements and student placement documentation would be developed to allow all stakeholders to apply them to their own circumstances with a minimum level of prescription and to assist those jurisdictions that do not currently have agreements in place.

**Questions for consideration:**

**Q6: Do you currently have clinical placement agreements in place? If yes, please include a copy with your submission, if no please indicate what should be included in the best practice guidelines.**

**Q7: Do you currently have agreements in place in relation to student documentation? If yes, please include a copy with your submission, if no please indicate what should be included in the best practice guidelines.**

## Performance Development Framework (Quality)

Access to training has been identified as a key issue impacting on the recruitment and retention of clinical supervisors as well as the quality of the role. The objective of the following strategies are to build local capacity, reduce the tension between service delivery and teaching and to make the most effective use of supervisors' time.

### **Develop a generic training program aligned to agreed core competencies.**

Stakeholders have expressed a range of views about student supervisory training. Most acknowledged that there are examples of good clinical supervisor training available for example Teaching on the Run, The Australian Clinical Educator Preparation Program and the Professional Development of Registrars program etc.

It is proposed, that following agreement on the national core competencies for clinical supervisors, work be undertaken to establish a national approach to recognize, develop or enhance a generic training program to support these core competencies.

The training program would need to be readily accessible and flexibly delivered, recognising that online training alone is not the solution. For example a basic package could be made available online, supplemented where practicable by face to face sessions.

The training could be generic and link to different supervisor levels. Discipline specific training could build on the basic training program. The development of the generic basic training should draw on the examples of good practice identified above.

Additionally the project could encourage regulatory and professional bodies to recognise the course as contributing towards CPD.

#### **Questions for consideration:**

**Q8: Do you provide, or are you aware of, courses that are currently available that address some or all of the generic skills outline above?**

**Q9: Are you aware of a course that could be adapted to align to agreed core competencies that should be considered as part of this project?**

### **Support health services to deliver training locally that builds capacity.**

To support health service to deliver training locally that builds capacity a number of options may need to be considered. Two options put forward for discussion are:

HWA could provide a funding package to health services to support the delivery of training at the local level. The funding package could be used for a number of purposes i.e. backfilling of supervisors, payment of course fees, or to assist supervisors to attend courses (travel, accommodation) etc.

HWA could provide funding to the clinical training integrated regional networks (outlined in the introduction section) to establish "clinical placement support" positions to support clinical supervisors. These positions may be responsible for the coordination of clinical placements, provision/monitoring of training to clinical educators, monitoring student progress/performance, providing assistance with underperforming students and quality assurance etc.

#### **Questions for consideration:**

**Q10: Does your organisation have "dedicated clinical educator" positions? If yes, how is this position funded?**

**Q11: Are there other strategies that build local capacity that you would you like HWA to consider?**

### **Develop consistent clinical placement assessment tools within disciplines.**

The development of common discipline specific assessment tools is relatively recent and continuing to gain momentum in Australia. Common assessment tools have been developed for at least three professions and work has commenced for a fourth profession.

This strategy proposes to provide support for the development of nationally consistent discipline specific assessment tools where these do not currently exist.

**Questions for consideration:**

**Q12: Are there consistent clinical placement assessment tools in place for your discipline?**

**Develop a teaching and learning organisational culture.**

To recognise and reinforce the importance of the training and learning culture it is proposed that a project be established to develop nationally consistent Key Performance Indicators (KPIs) to measure education and training, student outcomes and supervision in health services.

The KPIs would be linked to the national principles for clinical education and training and would be incorporated into health service funding agreements.

**Questions for consideration:**

**Q13: What education and training activity would you like to see measured in health services?**

### Supervision Environment and Culture

The strategies outlined below aim to recognise and reinforce the value and contribution of clinical supervisors and to enable collaboration within and across professions.

**Implement a reward and recognition program**

**National Awards**

To raise the profile and encourage recognition of the important role clinical supervisors play in training our future workforce it is proposed that discipline specific National Awards be introduced for clinical supervisors where these do not currently exist. The introduction of national recognition awards may occur through organisations already undertaking this function or alternatively by HWA providing funding grants to peak bodies.

**Supervisor Supports**

The NHWT undertook a survey of all universities that offer courses in the agreed 24 professions and part of this survey focused on additional types of support, other than education, universities offer their supervisors as incentives. Universities indicated that they provided between 1 and 7 other types of support to their supervisors which include:

- Honorary university appointments
- Access to university resources
- Access to general CPD
- Access to conferences/seminars/workshops
- Certificate of attainment/appreciation/recognition, awards, invitations
- Funding towards university courses, remuneration, car parking
- Research funding/students/advice/collaborations/support
- Professional development
- Social activities

It is proposed that a review of supervisor supports be undertaken to enable universities to introduce effective consistent supervisor supports across universities/professions to encourage supervisors to take up and maintain their involvement in supervision.

**Questions for consideration:**

**Q14: Does a national award program exist for your profession?**

**Q15: For universities: is there scope to standardise supervisor supports in your organisation?**

**Integrate and recognise supervision as a core component of the clinical role.**

Recognition, value and support for supervisors were common themes raised by stakeholders in the development of this discussion paper.

One way to promote supervision recognition, value and support at an organisational level would be for health services to explicitly recognise the philosophy that education is part of all health practitioner roles and the importance of the education of future practitioners to future health service delivery. Mechanisms could include reflection of these values in documents such as the organisation's vision or strategic plan, or recognition of the supervision role in position descriptions, where appropriate.

**Questions for consideration:**

**Q16: Does your organisation currently include education and training as a core function within position descriptions? Does your organisation explicitly recognise the philosophy that education is a part of health practitioner roles?**

**Develop national support mechanisms for clinical supervisors.**

It is proposed that online resources accessible to clinical supervisors across professions and the learning continuum be developed to enable collaboration across and within professions and jurisdictions and to encourage support networking. The online resource could provide a forum for discussion, resource documentation, training and development information etc

**Questions for consideration:**

**Q17: As a supervisor do you see benefit in developing an online resource to support supervisors? If yes, what information would you like made available online to assist with this role?**

## 4 Next Steps

### Submissions:

Submissions are invited on the issues raised in the discussion paper and the questions below.

The closing date for submissions is **3 September 2010**.

Stakeholders are asked to forward submissions to Health Workforce Australia at: [cssp@hwa.gov.au](mailto:cssp@hwa.gov.au)

It is requested that submissions are provided on the template provided on the HWA website: [www.hwa.gov.au](http://www.hwa.gov.au) or alternatively contact Sharyn Cody on (03) 6233 2756 to obtain a copy.

Following analysis of the submissions provided by stakeholders a National Clinical Supervision Support Strategy and Framework will be developed for Health Ministers' consideration.

### Discussion Questions:

- Q1: Does your organisation have clinical education and training principles that could be applied to health services nationally? If yes, please include in your submission, if no, what are the key action areas that you would like included in national principles developed for clinical education and training in Australia?
- Q2: Does your organisation have agreed terminology and definitions for the role and function of "clinical supervisor" or "clinical supervision"? If yes, please include the definitions in your submission, if no, what terminology does your organisation use to describe these functions? What cross-profession terminology do you think should be used in the National Clinical Supervision Support Strategy and Framework?
- Q3: Are there core generic competencies you would like added/deleted?
- Q4: For organisations delivering professional entry training or other curricula: to what extent are the skills already included in current curricula? Do you support greater coverage of these skills in professional entry courses? To what extent could this replace post-entry to practice supervision skills development?
- Q5: For professional associations and registration boards: does education and training form part of the current CPD program?
- Q6: Do you currently have clinical placement agreements in place? If yes, please include a copy with your submission, if no please indicate what should be included in the best practice guidelines.
- Q7: Do you currently have agreements in place in relation to student documentation? If yes, please include a copy with your submission, if no please indicate what should be included in the best practice guidelines.
- Q8: Do you provide, or are you aware of, courses that are currently available that address some or all of the generic skills outline above?
- Q9: Are you aware of a course that could be adapted to align to agreed core competencies that should be considered as part of this project?
- Q10: Does your organisation have "dedicated clinical educator" positions? If yes, how is this position funded?
- Q11: Are there other strategies that build local capacity that you would you like HWA to consider?
- Q12: Are there consistent clinical placement assessment tools in place for your discipline?
- Q13: What education and training activity would you like to see measured in health services?
- Q14: Does a national award program exist for supervisors in your profession?

- Q15: For universities: is there scope to standardise supervisor supports in your organisation?
- Q16: Does your organisation currently include education and training as a core function within position descriptions? Does your organisation explicitly recognise the philosophy that education is a part of health practitioner roles?
- Q17: As a supervisor do you see benefit in developing an online resource to support supervisors? If yes, what information would you like made available online to assist with this role?

## Appendix A: List of Stakeholders

### Health services

ACT	Jurisdiction level meeting Two health service meetings
Commonwealth	Department of Health and Ageing
NSW	Jurisdiction level meeting Health service meeting
NT	Jurisdiction level meeting Health service meeting
Qld	Jurisdiction level meeting Two health service meetings
SA	Jurisdiction level meeting Two health service meetings
Tas	Jurisdiction level meeting Health service meeting
VIC	Two health service meetings
WA	Jurisdiction level meeting Two health service meetings

## Organisations Contacted

NHWT requested that we initially contact stakeholders by telephone, except for the National Registration Boards, which received a letter. All the listed organisations were phoned and where initial contact was not made, a message was left and subsequent calls were made. Invariably the stakeholders contacted sought further information, so in most cases where there was a response to the contact, an explanatory email was forwarded. Detailed information was provided either by way of phone comment, email or a combination of both.

(Those marked \* provided information either by telephone and/or email)

Audiological Society of Australia \*

Australian Association for Exercise and Sports Medicine

Australian Association of Clinical Biochemists \*

Australian Association of Occupational Therapists \*

Australian and New Zealand College of Anaesthetists\*

Australian and New Zealand Podiatry Accreditation Council

Australian and New Zealand Society of Nuclear Medicine

Australian Association of Social Workers\*

Australian College of Ambulance Professionals

Australian College of Emergency Medicine

Australian College of Midwives \*

Australian College of Rural and Remote Medicine\*

Australian Dental and Oral Health Therapists Association \*

Australian Dental Association \*

Australian Dental Council \*

Australian Institute of Medical Sciences \*

Australian Institute of Radiology

Australian Medical Association \*

Australian Medical Council \*

Australian Nursing Federation\*

Australian Orthotic and Prosthetic Association

Australian Osteopathic Association \*

Australian Osteopathic Council

Australian Pharmacy Council \*

Australian Podiatry Association \*

Australian Podiatry Council\*

Australian Physiotherapy Council \*

Australian Private Hospitals Association \*

Australian Psychology Accreditation Council \*

Australian Psychological Society \*

Australian Sonographers Association

Catholic Health Australia \*

Chiropractors Association of Australia

Chiropractic Board of Australia

Confederation of Post Graduate Medical Education Councils \*

Council of Chiropractic Education Australasia

Dental Board of Australia  
Dieticians Association of Australia \*  
General Practice Education and Training Australia  
Medical Board of Australia  
National Aboriginal Community Controlled Health Organisation  
Nursing and Midwifery Board of Australia  
Occupational Therapy Australia \*  
Optometrists Association of Australia \*  
Optometry Board of Australia Optometry Council of Australia and New Zealand  
Orthoptic Association of Australia \*  
Osteopathy Board of Australia  
Pharmacy Board of Australia  
Physiotherapy Board of Australia  
Podiatry Board of Australia  
Psychology Board of Australia  
Pharmacy Guild of Australia  
Royal Australasian College of Physicians  
Royal Australasian College of Surgeons  
Royal Australian College of General Practitioners  
Royal Australian and New Zealand College of Obstetricians and Gynaecologists \*  
Royal Australian and New Zealand College of Psychiatrists  
Royal Australian and New Zealand College of Radiologists  
Royal Australian College of Nursing  
Royal College of Pathologists of Australasia \*  
Speech Pathology Australia

**Individuals Consulted as advised by the Expert Reference Group**

Kate Birrell - St John of God Hospital – Ballarat  
Lachlan Henderson - St John of God Hospital - Perth  
Lynette Saul - Sydney Adventist Hospital  
Jim Houston - Greenslopes Private Hospital - Brisbane  
Catholic Health Australia  
Ms Anne Fallon (Expert Reference Group)  
Dr Luis Prado (Expert Reference Group)

## Appendix B: Accrediting bodies and source documents, by profession

Profession	Organisation name and website <sup>1</sup>	Source document(s)	Date of document(s)	Is there accreditation of education program(s)?
Audiology	Audiological Society of Australia (ASA)	<i>Professional Standards of Practice for Audiologists</i> ; Section III. C. Professional Standards of Practice: Procedures, #24 Student Supervision	March 1997	yes (postgrad only)
	<a href="http://www.audiology.asn.au">www.audiology.asn.au</a>			
Chiropractry	Council on Chiropractic Education Australasia Inc (CCEA)	<i>Standards for First Professional Award Programs in Chiropractic</i> ; Section 3 Educational Resources, 3.1 Academic Staff, and 3.4 Clinical Training Resources	September 2003	yes
	<a href="http://www.ccea.com.au">www.ccea.com.au</a>			
Dentistry	Australian Dental Council (ADC)	ADC/Dental Council of New Zealand (DCNZ) Accreditation Assessment Guidelines for University Programs in Dentistry; Guideline 8 The curriculum	June 2005	yes
	<a href="http://www.dentalcouncil.net.au">www.dentalcouncil.net.au</a>	Accreditation of Postgraduate Programs (MDS, MDSc, MComDent and Clinical Doctorate) offered by Australian and New Zealand Dental Schools	2004	
Dietetics	Dietitians Association of Australia (DAA)	<i>Manual for Accreditation of Dietetic Education Programs</i> ; Section 2 DAA Policy on Education for Dietitians, 2.2 Professional Practice Program, and 2.3 Student supervision	Reviewed 2007	yes
	<a href="http://www.daa.asn.au">www.daa.asn.au</a>			

Profession	Organisation name and website <sup>1</sup>	Source document(s)	Date of document(s)	Is there accreditation of education program(s)?
Exercise Physiology	Australian Association for Exercise and Sports Science (AAESS) / Exercise and Sports Science Australia (ESSA) <sup>2</sup>	Guidelines and application form for academic units applying for full accreditation of a course with the Australian Association for Exercise and Sports Science (AAESS); Application Section 5: Work experience, A5.1 Information on work experience arrangements, A5.1.3 The supervisor	Updated September 2009	yes
	<a href="http://www.aaess.com.au">www.aaess.com.au</a>			
Medical Sciences	Australian Institute of Medical Scientists (AIMS)	While the AIMS website refers to AIMS accredited undergraduate medical science degree programs, there is no documentation of course accreditation criteria <sup>3</sup> .	n/a	yes <sup>3</sup>
	<a href="http://www.aims.org.au">www.aims.org.au</a>			
Medicine	Australian Medical Council (AMC)	Assessment and Accreditation of Medical Schools: Standards and Procedures, 2009	2009	
	<a href="http://www.amc.org.au">www.amc.org.au</a>	Replacement (2008) of Part B of the AMC guidelines, Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures, 2002	June 2008	yes
Nursing and Midwifery	Australian Nursing and Midwifery Council (ANMC)	National Framework for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia	Amended May 2009	yes
	<a href="http://www.anmc.org.au">www.anmc.org.au</a>	Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia - with Evidence Guide <sup>4</sup> ; Standard 8: Professional Experience	February 2009 <sup>4</sup>	yes

Profession	Organisation name and website <sup>1</sup>	Source document(s)	Date of document(s)	Is there accreditation of education program(s)?
Occupational Therapy	World Federation of Occupational Therapists (WFOT) www.wfot.org	Minimum standards for the education of occupational therapists 2002	2002	yes <sup>5</sup>
Optometry	Optometry Council of Australia and New Zealand www.ocanz.org	Accreditation Manual for Optometry Courses in Australia and New Zealand, Part 2 Guidelines; Guideline 6 Clinical training and settings	April 2006	yes
<b>Oral Health</b> (Dental Hygiene and Dental Therapy)	Australian Dental Council (ADC) www.dentalcouncil.net.au	ADC/Dental Council of New Zealand (DCNZ) Accreditation Assessment Guidelines for Programs Offered in Dental Therapy and Dental Hygiene; Guideline 8 The curriculum	November 2007	yes
Orthoptics	Australian Orthoptic Board (AOB) www.australianorthopticboard.org.au	The AOB website lists currently <u>recognised</u> degree programs in orthoptics offered at Australian universities, but does not provide details regarding standards for recognition of courses.	n/a	no
Orthotics and prosthetics	No accrediting body	Based on information on the Australian Orthotic and Prosthetic Association (AOPA) website, www.aopa.org.au, there appears to be no course accreditation process or accrediting body.	n/a	no
Osteopathy	Australian Osteopathic Council (AOC) www.aoc.org.au	Standards and Procedures for the Accreditation of Osteopathic Courses; Standard 11 Clinical training	September 2008	yes

Profession	Organisation name and website <sup>1</sup>	Source document(s)	Date of document(s)	Is there accreditation of education program(s)?
Paramedicine	Council of Ambulance Authorities <a href="http://www.convention.ambulance.net.au">www.convention.ambulance.net.au</a>	Guidelines for the Assessment and Accreditation of Entry-level Paramedic Education Programs; Guideline 4. Standards for Entry-level Paramedic Education Programs	May 2009	yes
Pharmacy	Australian Pharmacy Council (APC) <a href="http://www.pharmacycouncil.org.au">www.pharmacycouncil.org.au</a>	Accreditation Standards; Standard 5 The Curriculum	December 2009	
Physiotherapy <sup>6</sup>	Australian Physiotherapy Council (APC) <a href="http://www.physiocouncil.com.au">www.physiocouncil.com.au</a>	Accreditation of entry level physiotherapy programs - a manual for universities (pre-publication version of document)	May 2009	yes
		Australian Standards for Physiotherapy	July 2006	
Podiatry	Australian and New Zealand Podiatry Accreditation Council (ANZPAC) <a href="http://www.anzpac.org.au">www.anzpac.org.au</a>	Accreditation Standards and Procedures for Podiatry Programs for Australia and New Zealand; Part C, Curriculum and Assessment, C3 Clinical Experience.	August 2009	yes
Psychology	Australian Psychology Accreditation Council (APAC) <a href="http://www.apac.psychology.org.au">www.apac.psychology.org.au</a>	<i>Rules for Accreditation and Accreditation Standards for Psychology Courses;</i> Section 4, Undergraduate 4th year and four year courses, Section 5, Postgraduate professional 5th and 6th year courses	August 2009	yes
<b>Radiation Science</b> (Radiography and Radiation Therapy)	Australian Institute of Radiography (AIR) <a href="http://www.air.asn.au">www.air.asn.au</a>	<i>AIR Educational Policies;</i> Section 5.0 Guidelines for the Development of Courses in Medical Radiation Science, Section 8.0 Professional Development Year	Revised January 2004	yes

Profession	Organisation name and website <sup>1</sup>	Source document(s)	Date of document(s)	Is there accreditation of education program(s)?
Radiation Science (Nuclear Medicine Technology)	Australian and New Zealand Society of Nuclear Medicine (ANZSNM)	Competency Standards for Nuclear Medicine Science in Australia, Entry Level Practitioners, 3rd Edition 2006	2006	yes
	<a href="http://www.anzsnm.org.au">www.anzsnm.org.au</a>	Mentoring and the Professional Development Year: Accreditation Board Guidelines; Section 3 Syllabus.	2009	
Social Work	Australian Association of Social Workers (AASW) <a href="http://www.aasw.asn.au">www.aasw.asn.au</a>	<i>Australian Social Work Education and Accreditation Standards</i> ; 4.3 Learning for Practice in Field Education, 4.3.3 Roles and Responsibilities and 4.3.4 Location of placements	Updated June 2009	yes
Sonography	Australasian Sonographer Accreditation Registry <a href="http://www.asar.com.au">www.asar.com.au</a>	<i>Program Accreditation Guidelines Of Educational Programs/Qualifications in Medical Sonography</i> ; 7.2.2 General sonography-clinical supervision, 7.3.2 Vascular sonography- clinical supervision, 7.4.2 Cardiac sonography - clinical supervision, 7.5.2 Obstetric sonography - clinical supervision, 7.6.2 Breast sonography- clinical supervision, 7.7.2 Cerebral sonography- clinical supervision.	Updated June 2009	yes
Speech Pathology	Speech Pathology Australia (SPA), <a href="http://www.speechpathologyaustralia.org.au">www.speechpathologyaustralia.org.au</a>	Competency Based Occupational Standards (CBOS) for Speech Pathologists - Entry Level	Revised 2001	yes

Notes:

- All websites were accessed between 16 January and 27 January 2010.
- AAESS changed its name to Exercise and Sports Science Australia (ESSA) in January 2010.
- AIMS advised there no course accreditation criteria documents.
- There are different *Standards and Criteria* for each of the four nursing professions: Midwives, Registered Nurses, Enrolled Nurses, and Nurse Practitioners.  
All four sets of *Standards and Criteria* were published in February 2009 and the *Standards and Criteria* for Midwives was revised in September 2009.
- In the case of the Occupational Therapy profession, the process is termed 'approval' rather than 'accreditation'.
- The accreditation manual (*Accreditation of entry level physiotherapy programs - a manual for universities*) is primarily concerned with the accreditation process; the *Manual* references the *Australian Standards for Physiotherapy* as the source outlining the actual requirements for accreditation.

## Appendix C: Glossary of Terms

A **facilitator** (nursing) a supernumerary supervisor typically responsible for a group of nursing students, usually about 8, on clinical placement. According to Nash (2007) responsibilities typically include student briefing and debriefing, assessment of students' learning needs, clinical teaching/supervision of students' practice, liaison with health service and university staff, consultation with students about progress and evaluation of student performance.

A **link** lecturer is a university lecturer who maintains contact with the clinical placement setting when students are on placement. A link lecturer may be involved in the planning of the clinical placements, as well as being available to address any concerns or queries raised (Kevin 2006).

**Mentoring** refers to "a voluntary long term commitment relationship supporting the learner through a professional transition and maintained through mutual and negotiated consent" (Lennox et al 2008).

A **preceptor** (nursing) is generally a practising registered nurse providing individual clinical supervision/teaching on a 1:1 basis (Nash 2007). Responsibilities are similar to the facilitator but the preceptor maintains his/her normal clinical workload.

A **sessional facilitator** is a facilitator employed on a short-term basis while students are on placement (Nash 2007)

The *Bridging Project* defines the clinical supervisor role as a subset of the teacher role.

### UK terminology

From Nursing and Midwifery Council UK Standards to support learning and assessment in practice: NMC standards for mentors, practice teachers and teachers (2008)

There is a single developmental framework to support learning and assessment of nurses and midwives in the UK developed by the Nursing and Midwifery Council. The *Standards to support learning and assessment in practice: NMC standards for mentors, practice teachers and teachers* (2008) include role descriptions, criteria for supporting learning and assessing in practice and competence and outcomes for mentors, sign-off mentors, practice teachers and NMC teachers. The standards also set requirements for mentor preparation programmes, continuing professional development and allocated learning time for mentor activity (the percentage of a students time where the student must be supervised by a mentor/practice teacher while giving direct care).

**Mentor:** A registrant who has met the outcomes of stage 2 (of the standards) and who facilitates learning, and supervises and assesses students in a practice setting

**Practice Teacher:** A registrant who has gained knowledge, skills and competence in both their specialist area of practice and in their teaching role, meeting the outcomes of stage 3 (of the standards), and who facilitates learning, supervises and assesses students in a practice setting.

**Preceptorship:** The process through which existing nurses and midwives provide support to newly qualified nurses and midwives.

**Sign-off Mentor:** are required to meet specified criteria in order to be able to sign-off a student's practice proficiency at the end of an NMC approved programme. All midwife mentors and practice teachers will have met the requirements through their preparation programme.

**Teacher:** A registrant who has undertaken an NMC approved teacher preparation programme, or equivalent and successfully achieved the outcomes defined in stage 4 of the developmental framework.

### Canadian Nurses Association (2004).

**Preceptorship:** is a frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one-to-one relationship of pre-determined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting

to and performing a new role. Novice may be a student or an already practising nurse moving into a new role, domain or setting.

**Mentorship:** is a voluntary, mutually beneficial and long term relationship where an experienced and knowledgeable leader (mentor) supports the maturation of a less-experienced nurse with leadership potential.

**Buddy system:** an unprofessional term referring to a relationship between an experienced nurse and a novice, in which the senior buddy is a resource person the newcomer can go to for advice or information on an episodic basis. p. 53

## Appendix D: Overview of current issues raised in stakeholder discussions

### **Public sector health service issues**

A number of discussions with public sector health services raised the issue of greater clarity and accountability for clinical placement funding provided by universities, to ensure that it is directed to supervisor support.

### **Private and not for profit health service issues**

Private and not for profit health services were particularly concerned about funding to support placements and clinical supervisors in the private and not for profit sectors. Organisations consulted accepted that they had a responsibility to support education and training and that staff should be available to provide supervision.

A limiting factor was, however, funding availability and in some cases the development of supervisor 'fatigue', given the demands of supervision with little recompense and recognition. Availability of funding also included provision of physical infrastructure such as lecture theatres and other teaching and training rooms. Grants made to one private hospital to establish that infrastructure provided a significant incentive to participate in student training across medicine, nursing and allied health.

Private sector discussions also raised the issue of the lack of availability of MBS payments for student work.

### **Accreditation body issues**

The approach of accreditation bodies on supervision requirements is generally reflected in the standards and guidelines that are discussed in section 8.

The approaches range from the prescriptive (i.e. supervisor/student ratios, dedicated time and resources etc) to the simple requirement that clinical supervision must be available to secure accreditation.

However the service delivery pressures and the demands on time of professionals were acknowledged as significant issues.

### **Professional association and other stakeholder issues**

While acknowledging the range of issues associated with current approaches to clinical supervision, some professional associations advocated for systemic change in a number of areas.

One fundamental change proposed was for the public health sector to adopt education and training as a core responsibility, and for the performance of organisations and institutions to be measured in relation to the quality of education and training outcomes. It is argued that education and training should be accepted as part of the business and culture of the organisation or institution in the same way as the delivery of health care services. Governments are seen to have a critical role to play in providing leadership and direction to enable such a change to happen.

Structuring work responsibilities of public sector clinicians so that a percentage of work time was allocated and dedicated to education and training responsibilities was also advocated. This was seen to not only enable time for the effective education and training of students, but would also enable the health professionals the time to acquire necessary teaching skills and time to undertake student assessments.

There is an accepted recognition of the need for many health professionals to learn the skills of being an effective educator and for the development of courses to that end. However any course and resources prepared need to take account of the fact that these health professionals are time poor, so resources need to be readily and routinely accessible. Funding to support such developments is considered essential.

## Appendix E: Summary of common supervision models

Different student supervision models operate in Australia (Dickson et al 2006). This section briefly describes common models of student supervision based on initial project discussions to provide a context for the later sections of the report.

Despite the additional pressure of adding clinical supervision to a clinical role, typically supervisors have not been paid extra for this work. This flows from the traditional philosophy that education and training is part of a health professional's role. Although in some cases universities pay the health service for placements, it seems that these funds are rarely tracked and may not directly benefit those taking on the supervisory role (Rodger et al 2008, p. 58).

### Medical

Clinical supervision of students in the medical profession has traditionally been on an apprenticeship 1:1 model. The traditional model of clinical supervision of students and trainees in medicine involves the continuum from intern to consultant. Consultants provide supervision to registrars, junior doctors (PGY 1 and 2) and undergraduate medical students (Hore, Lancashire & Fassett 2009). Registrars undertake most day-to-day supervision of junior doctors (PGY1 and PGY2) under the overarching supervision of consultants. Registrars and junior doctors are involved in the supervision of undergraduate medical students. The level of supervision decreases as a doctor moves along the continuum from undergraduate medical student to consultant (AMA 2009b).

### Nursing

There are a number of models of clinical supervision in nursing and the following are common:

In the preceptor model, a student is assigned to a registered nurse (i.e. this is a 1:1 model). The student works alongside the registered nurse, generally known as a preceptor, who provides day to day supervision and undertakes assessment. Preceptors usually have completed preceptorship training.

In the facilitation/supervision model, a registered nurse supervises a group of students, usually with a ratio of 1:6 to 1:8. The facilitator or educator evaluates the clinical placement. Facilitators have generally undertaken training for their role. The facilitator may be drawn from the university or the health service staff. Where the facilitator is a health service employee, the university may reimburse the health service for their time in the facilitation role.

A combined facilitation preceptorship model involves a student being buddied with a designated clinical nurse and a facilitator who is responsible for the supervision or management of a number of students, under a 1:8 ratio or greater. This model has similar employment and funding arrangements to the facilitation model.

The Dedicated Education Unit model is a variation on the combined model which involves a partnership between the health service and the university. This model emphasises support and training for clinicians. A facilitator from the health service or university provides 1:8 supervision, whilst there is also a preceptor for each student (PhillipsKPA 2008). There may also be a Clinical Liaison Nurse, a registered nurse from the area who provides the link to the university.

The mentor model is similar to the preceptor model, but involves a longer term relationship between the student and the supervisor.

### Dental

Chairside teaching is traditionally carried out on a 1:1 model, involving one clinician supervising one student. However, other models exist including a model involving a dedicated clinical supervisor supervising a number of dental students.

## 5 List of Acronyms

AAESS	Australian Association for Exercise and Sports Science
AASW	Australian Association of Social Workers
ACT	Australian Capital Territory
ADC	Australian Dental Council
AIMS	Australian Institute of Medical Scientists
AIR	Australian Institute of Radiography
AMA	Australian Medical Association
AMC	Australian Medical Council
ANMC	Australian Nursing and Midwifery Council
ANZSNM	Australian and New Zealand Society of Nuclear Medicine
ANZPAC	Australian and New Zealand Podiatry Accreditation Council
AOB	Australian Orthoptics Board
AOC	Australian Osteopathic Council
AOPA	Australian Orthotic and Prosthetic Association
AOU	Academic Organisational Unit <sup>15</sup>
APAC	Australian Psychology Accreditation Council
APC	Australian Pharmacy Council <i>or</i> Australian Physiotherapy Council
ASA	Audiological Society of Australia
ASAR	Australasian Sonographer Accreditation Registry

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<sup>15</sup> An AOU is the term used by the Australian Psychology Accreditation Council (APAC) to refer to a School of Psychology in the context of describing standards for the accreditation of psychology courses.

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BPCLE	Best Practice Clinical Learning Environment
CBOS	Competency Based Occupational Standards
CCEA	Council on Chiropractic Education Australasia
CHPO	Clinical Health Professions Office (Western Australia)
ClinEdQ	Clinical Education and Training Queensland
CME	Continuing Medical Education
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CPMEC	Confederation of Postgraduate Medical Education Councils
CSSP	Clinical Supervision Support Program
CTF	Clinical Training Funding
CTFS	Clinical Training Funding Subsidy
DAA	Dietitians Association of Australia
DCNZ	Dental Council of New Zealand
HWA	Health Workforce Agency
IMET	Institute of Medical Education and Training
MBS	Medicare Benefits Schedule
NBT	Nursing Board of Tasmania
NCETA	National Centre for Education and Training on Addiction
NHS	National Health Service (UK)
NHWT	National Health Workforce Taskforce

NMC	Nursing and Midwifery Council (UK)
NSW	New South Wales
OCANZ	Optometry Council of Australia and New Zealand
OT	Occupational Therapy
PD	Professional Development
PDPR	Professional Development Program for Registrars
PDY	Professional Development Year <sup>16</sup>
PGY	Postgraduate Year
PIP	Practice Incentive Program
QOTFC	Queensland Occupational Therapy Fieldwork Collaborative
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RANZCR	Royal Australian and New Zealand College of Radiologists
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
SA	South Australia
SCPU	Student Clinical Placement Unit
SLE	Simulated Learning Environment
SPA	Speech Pathology Australia

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<sup>16</sup> The PDY is part of the education program for medical radiation science professions including radiography, radiation therapy and nuclear medicine.



UK	United Kingdom
VET	Vocational Education and Training
WA	Western Australia
WFOT	World Federation of Occupational Therapists

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