The Learning Guide
a handbook for allied health professionals
facilitating learning in the workplace

This is a user-friendly handbook designed to support teaching and learning of allied health professionals locally within their workplaces. It provides information about:

• Practical strategies to facilitate adult learning
• Optimising opportunities for learning and teaching within day-to-day work

This handbook is not a policy document. It gives tips and suggestions based on published evidence that supports effective methods of promoting education, learning needs and professional development of allied health professionals working in clinical settings, to contribute to the safety and quality care of patients/clients of NSW Health.

ISBN 978-0-9871936-7-4

May 2012
FIRST EDITION
HETI | RESOURCE

Teach  Motivate  Empower
Engage  Facilitate
Learn
The Learning Guide

a handbook for allied health professionals
facilitating learning in the workplace

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www.heti.nsw.gov.au
Foreword

The Health Education and Training Institute (HETI) is delighted to present *The Learning Guide: A handbook for allied health professionals facilitating learning in the workplace*. This document is an exciting complement to *The Superguide: A handbook for supervising allied health professionals*.

Along with supervision, facilitating the learning of others is considered an integral part of a health professional’s role. With some of the most valuable learning and teaching experiences occurring as part of everyday duties, there is an opportunity to advance the skills and knowledge of the allied health workforce through workplace learning as the driver of education. This resource provides clinically relevant and practical information that focuses on the needs of clinicians at the point of health care delivery who wish to further develop their skills as facilitators of learning in the workplace.

Allied health professionals are recognised as essential members of the multidisciplinary team playing a critical role in prevention, treatment and management of complex co-morbidities across the continuum of care, reducing the impact of chronic disease and increasing patients’ quality of life.

It is hoped this document will be welcomed by the many dedicated allied health professionals working in the NSW Health system as a user friendly guide to facilitate learning through their everyday interactions with patients/clients, staff, colleagues and managers.

HETI Chief Executive

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About this guide

The Health Education and Training Institute (HETI) provides state-wide leadership and coordination in education and training of clinical and non-clinical health professionals working in NSW Health to ensure that the workforce has the necessary skills and knowledge to deliver high quality patient care to the people of NSW.

HETI has produced this guide in response to requests from many allied health professionals for practical guidelines to facilitate clinical education and learning in the workplace. Along with their roles in supervision, operational management and leadership, many allied health professionals are involved in facilitating clinical education and learning on a day-to-day basis, particularly in skill development and practice.

This guide is not a policy document. It provides information and guidelines based upon published evidence that supports effective methods of promoting education, learning needs and professional development of allied health professionals working in clinical settings, to contribute to the safety and quality care of patients.

It is acknowledged that education terminology and continuing professional development (CPD) requirements vary across the individual allied health professions. It is also important to recognise that each discipline has different qualification and training requirements and approaches to formally assessing competencies. However, common to all allied health professional roles is the opportunity to facilitate learning within everyday clinical activity. To do this, allied health professionals need to have the confidence and skills to effectively facilitate learning in others. This guide aims to provide user-friendly information to equip allied health professionals with practical strategies to become effective facilitators of learning in the clinical setting. It is hoped that the principles of this guide can be applied to all allied health professionals throughout their careers.

This document should be used in conjunction with existing discipline-specific requirements and Local Health District* policies. It also complements The Superguide: A handbook for supervising allied health professionals, and cross-references can be found throughout this guide. It will be reviewed regularly to ensure that information is current and useful.

Updates and other useful resources are available on the website of the Health Education and Training Institute: www.heti.nsw.gov.au

This guide has been written for allied health professionals of all levels of experience who could potentially facilitate learning within their workplaces.

* The term Local Health District used in the context of this document refers inclusively to Speciality Health and Hospital Networks such as St Vincent's Health Network, Forensic Hospital Speciality Network and Sydney Children's Hospitals Speciality Network.
Allied health in NSW Health

Allied health professionals:

- hold tertiary qualifications.
- hold relevant registration, license or accreditation to practise, eligibility for membership of professional associations.
- provide a range of therapeutic and diagnostic services in either the public, primary health or private health care sector.
- apply their skills and knowledge to restore and maintain optimal physical, sensory, psychological, cognitive and social function in their clients/patients.
- use a range of complex skills including specific professional clinical skills in addition to communication, clinical reasoning, reflection and evidence-based practice skills.
- work as sole practitioners and/or in teams, including multidisciplinary, interdisciplinary, and transdisciplinary.
- are allied or align with each other and other members of the health professional workforce, their patient/clients, their families, carers and community working across the health system.

NSW Health categorises the following 23 professions as allied health professionals*:

| Art Therapy | Nutrition & Dietetics | Podiatry |
| Audiology   | Occupational Therapy  | Psychology |
| Counselling | Orthoptics            | Radiation Therapy |
| Diversional Therapy | Orthotics & Prosthetics | Radiography |
| Exercise Physiology | Pharmacy           | Sexual Assault Workers |
| Genetic Counselling | Physiotherapy      | Social Work |
| Music Therapy | Play Therapy/Child Life Therapy | Speech Pathology |
| Nuclear Medicine Technology | Welfare Officer |

* Information provided by Brenda McLeod, Chief Allied Health Officer, Workforce Development and Innovation Branch, NSW Ministry of Health as per NSW Treasury Codes Classification System.
Roles and responsibilities

Within NSW Health, depending on job roles and responsibilities, all staff can contribute to facilitating their own and others’ learning in the workplace.

Allied Health Clinicians
All health professionals have a responsibility to engage in lifelong learning, to keep up to date with the changing work environment and current evidence-based practice, and to ensure they invest time in their own professional development (NSW Health, 2005). Clinicians can facilitate not only their own learning, but the learning of others through the sharing of knowledge, resources and information, and harnessing opportunities to engage in professional networks and communities of practice.

Student Educators
Student educators are responsible for discipline-specific clinical supervision, teaching and coordination of educational activities for students on clinical placements within one or more health facilities (NSW Health, 2011).

Allied Health Professional Educators
Some NSW Health Local Health Districts and Speciality Networks may employ allied health professionals who are responsible for the design, development, delivery and evaluation of education programs including continuing professional education, new graduate orientation and general staff development courses (NSW Health, 2011).

Managers/Team Leaders/Department and/or Unit Heads
Allied Health Managers, Team Leaders, Department or Unit Heads have a responsibility to provide a supportive environment for professional development and to foster the development of learning organisations. Managers, Team Leaders, Department or Unit Heads are encouraged to promote an environment where the sharing of information and resources between staff, across other discipline groups and Local Health District boundaries can occur.

Allied Health Directors
Allied Health Directors are responsible for the professional management of allied health services in Local Health Districts and Specialty Networks. Allied Health Directors have a responsibility to engage, facilitate, support and provide strategic oversight of allied health education and training and to provide advice to improve overall systems of governance for allied health.

NSW Health
NSW Health has a responsibility to set policy direction and provide physical and human resources to ensure that the organisation is responsive to the education needs of staff and that all employees receive appropriate learning and development opportunities to facilitate the delivery of safe, high quality health care.

Health Education and Training Institute (HETI)
HETI has leadership responsibility for the education and training of clinical and non-clinical health professionals working in NSW Health. HETI works closely with Local Health Districts, Learning and Development Units and other public health organisations and clinical training providers to develop and support the delivery of education and training across the NSW public health system.
The Learning Journey

Part 1: What is workplace learning? (page 8)
‘Within allied health many opportunities exist for learning with, from and about each other’

Part 5: Evaluation of workplace learning (page 64)
‘Evaluation is an essential part of any workplace learning activity and should be seen as a continuous cycle of reflection and improvement’
(Morrison, 2003)
**Part 2: Understanding the adult learner (page 16)**

‘Facilitating learning among colleagues can be done formally or informally’

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**Part 3: What skills are needed to facilitate learning? (page 22)**

‘Facilitating learning requires a range of skills and approaches that build on learners’ experiences and expertise’

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**Part 4: The where and how of facilitating learning in the workplace (page 44)**

‘Facilitating learning is as much about setting up the learning environment as it is about extending knowledge or sharing expertise’

(Hutchinson, 2003, p. 810)
Part 1

What is workplace learning?
Introduction: Understanding workplace learning

The workplace is one of the richest environments to facilitate the development of skills and knowledge required to deliver high quality patient care. While access to formally arranged and organised education is highly valued by allied health professionals, there is also a large range of enriching experiences and learning opportunities which form part of our day-to-day work. By seizing opportunities to learn within our workplaces we can maximise opportunities to learn from, with and about each other as we engage in workplace activity.

Before we can start to engage in facilitating learning within the workplace, it is important to understand the concept and benefits of workplace learning (often referred to as work-based learning within the literature) as a model for professional development of allied health professionals.

Work-based learning is defined as an approach that can “enable workplace transformation to be achieved and sustained by ensuring that workplace activity is the driver of learning and development” (Manley, et al., 2009, p. 88)

Work-based learning in a clinical setting has a number of benefits including:

• Being driven by the needs of patients/clients and health services to directly improve quality of care
• Supporting the implementation of evidence at the local level
• Using the potential to improve productivity
• Being cost-effective
• Increasing work satisfaction
  (Manley, et al., 2009)

Some key concepts explored in this section are:

• What is workplace learning in a clinical setting?
• What does facilitating learning mean?
• Who is a facilitator of learning?
• What are the attributes of an effective facilitator of learning?
• Informal and formal learning
• Facilitating learning in a regional, rural and remote locations

By seizing opportunities to learn within our workplaces we can learn from, with and about each other as we engage in workplace activity.
What is workplace learning in a clinical setting?

Effective workplace learning relies on allied health professionals who are able to recognise learning opportunities, and who are willing and able to communicate and share their professional knowledge (Spouse, 2001). This can occur as part of everyday duties, such as when talking to a colleague about a clinical dilemma (facilitating your own learning) or helping a recent graduate gain confidence with a procedure or task (facilitating learning in others).

Terms such as continuing professional development (CPD) and lifelong learning (LLL) are closely associated with workplace learning: they rely on the allied health professional and organisation to create an environment where expertise is shared, learning needs are identified and plans are made to meet these needs (Spouse 2001).

There are many opportunities available to facilitate learning within the workplace. Some examples include:

- Journal club
- Supervision
- Case conferences
- In-service presentations
- Joint consultations
- Interprofessional learning
- Tea room conversations
- On the ward
- On home visits
- In the clinic
- Peer learning
- Journal clubs

Some of these opportunities are explored further in Part 4 – The Where and How of Facilitating Learning in the Workplace.

So there are opportunities in virtually any clinical activity that I can use to facilitate learning.
What does facilitating learning mean?

When thinking about facilitating learning, it is helpful to distinguish among the terms ‘education’, ‘training’ and ‘facilitation’, although they are often used interchangeably (McKimm & Jollie, 2007).

‘Education’ is a ‘process by which one develops abilities, attitudes and other forms of behaviour considered to have value in the society in which one lives’ (UNESCO, 2011).

‘Training’ has traditionally been viewed as discrete planned events used to instruct people how to perform specific defined skills or procedures (Marsick & Volpe, 1999). In many aspects of our work as allied health professionals, training is commonplace, such as ‘on the job’ skills training or formalised training which is generally recognised with a qualification or certificate (Halliday-Wynes & Beddie, 2009).

‘Facilitation’ can be described as ‘a process of teaching in which the teacher endeavours to create a learning environment which is conducive to learning and aims to enable or empower the learner’ (McAllister, 2004, p.219).

Facilitation places emphasis on the learning process and outcome, to achieve purposeful, self-directed learning that is meaningful to the clinical setting and the delivery of quality patient/client care.

Who is the learner?

Professionals should be continually engaged in learning. LLL enables us to keep up-to-date with the latest evidence-based practice, adapt practice to meet patient needs, and ultimately provide the best possible care to our patients and clients. CPD and LLL are promoted by professional associations as best practice and CPD is now a mandatory requirement in an increasing number of allied health professions to maintain registration to practise or eligibility for professional association membership/professional certification.

We are all learners. Regardless of age, expertise and years of experience, all allied health professionals should be continually engaged in learning.
Who is a facilitator of learning?

Everyone is considered to be a learner and everyone has the potential to be a facilitator of learning. This guide considers a facilitator to be an allied health professional working alongside others to help transform themselves as individuals, team members and organisational employees. A facilitator of learning can be a peer, supervisor, mentor or manager. Learning facilitation can develop through a pre-established arrangement, such as via a line management or supervisor, or sourced through other relationships such as a team member, peers, social networking or communities of practice.

What are the attributes of an effective facilitator of learning?

- Encourages ‘hands on’ and interactive approaches to learning activities.
- Adapts the education and facilitation to the context in which the leaning occurs.
- Establishes learning goals and objectives that are clear, achievable and relevant.
- Seeks out opportunities to collaborate and negotiate learning processes with others.
- Acknowledges learners as ‘co-producers’ of new knowledge and skills.
- Recognises prior knowledge and life experience as valuable foundations for learning.
- Uses flexible teaching approaches that address’ different learning orientations.
- Values the social interactions involved with learning in groups.
- Directs the learner towards resources required to learn.

(Adapted from Smith & Dalton, 2005)

Which of these attributes have I seen in my workplace or found beneficial in my own learning experience?
Informal and formal learning

Informal learning
Contemporary understanding of informal learning is that individuals acquire attitudes, values, skills and knowledge from daily experience which happens outside of formal training situations (Halliday-Wynes & Beddie, 2009).

Informal learning ‘accounts for as much as 80–90% of all of our learning, in particular through the exposure to the opinions and practices of others also working in the same context’ (Matthews & Candy, 1999, p. 49).

There are a variety of ways in which informal learning can occur in a clinical setting:

- Work/practice experience
- Quality improvement activities
- Reflective practice
- Participating in meetings
- Pilot programs
- Reading
- Surfing the net
- Professional groups
- Supervision
- Mentoring
- Everyday communication
- Networking
- Critical incidents
- Root cause analysis

Formal learning
Formal learning refers to learning that occurs in structured programs. This may include anything from running an in-service in your workplace to doing postgraduate study.

Combining different forms of learning, and choosing an approach that ‘best fits’ a particular context or skill, it provides a coherent approach to workforce skill development as learners can be integrally involved with determining what is needed to achieve their learning goals (Misko, 2008).

So informal learning would include discussions with other allied health colleagues about how they managed a challenging situation or listening to a colleague explaining something to another colleague/student.
Facilitating learning in regional, rural or remote locations

Working in a regional, rural or remote context requires a unique skill set. The professional knowledge required by remotely located health professionals is similar to that required for metropolitan practice, but the challenge is the divide between specialist and generalist knowledge (Stagnitti, 2008).

An allied health professional working in a regional, rural or remote setting needs to be able to:

- work in geographically dispersed interprofessional teams
- take on greater responsibility, often with access to fewer formal co-located professional support structures
- provide services within broad clinical practice areas
- work with culturally diverse populations

(Lin, et al., 2009)

The rural and remote allied health professional also faces challenges associated with high client–therapist caseloads and covering large geographical regions (Stagnitti, 2008). But these challenges can also be turned into opportunities for learning. Of course, it is acknowledged that these challenges are not necessarily unique to rural and remote settings. Tips have been inserted throughout this guide to highlight useful information for allied health professionals to consider when working in a regional, rural or remote context.

Look out for this tip box which appears throughout the guide.

Rural practitioners may not have the opportunity to participate in things like in-service programmes or journal clubs, especially if they are working on their own in a geographically isolated region. The rural tips are present in this guide to draw attention to ways of learning that can be applied in more remote workplaces, whether or not there are other allied health professionals in the vicinity to learn from. Geographical isolation should not prevent facilitated learning at work.

For example: The relatively high turnover of the workforce in regional areas is a challenge for managers and health services to manage. It is also a challenge for the allied health professionals who continue to work in the region. But it can also be an opportunity to access a wider variety of health professionals with a wide range of skills and experiences as replacement staff join the team. Learning from peers is achievable when existing staff take an interest in facilitating the sharing of knowledge with newer staff in the workplace and when management supports such initiatives.
Reflective questions
Here are some reflective questions to get you thinking about how you might apply some of this information in your workplace.

- What opportunities are there in your workplace to facilitate learning?
- What interests you in becoming a facilitator of learning?
- What are some steps you can take to become a facilitator of learning?
- List some attributes you have that will make you an effective facilitator of learning.
Part 2

Understanding the adult learner

How do adults learn?
Introduction: Understanding the adult learner

To facilitate learning within a health care setting, it is important to understand the specific needs and attributes of adult learners. Adult learning principles stress the value of experience in the learning process, the adult learner’s self-concept and motivation to learn and the importance of self-directed learning (Boud, 1987).

Adult learners:
- Need to be respected, valued and acknowledge for their past experience and to have the opportunity to apply this experience to their current learning
- Learn best in environments that reduce possible threats to self-concept and self-esteem and provide support for change and development
- Are highly motivated to learn in areas relevant to their current needs, often generated by real life tasks and problems
- Need feedback to develop
- Value self-directed learning and learn best when they can set their own pace
- Learn more effectively through experiential techniques (e.g. discussion and problem solving) (Brookfield, 1998; Brundage & Mackeracher, 1980)

Within the workplace there are opportunities for adults to engage in learning situations where activities have meaning and directly influence their ability to perform their work better. This can include informal learning activities and self-directed learning.

This section explores:
- Strategies to optimise learning
- Considering individual differences and attitudes towards learning
- The importance of self-directed learning

Life demands teaching and learning for its own permanence, the very process of living together educates. It enlarges and enlightens experience; it stimulates and enriches imagination; it creates responsibility for accuracy and vividness of statement and thought… (Dewey, 1916, p. 11)
Learning styles, preferences and strategies

For facilitators of learning it is useful to have an understanding of terminology common in the educational literature, which explains different approaches to organising adult learning experiences.

**Learning styles** is a concept that describes the different modes of instruction or methods of study most effective for particular individuals (Pashler, et al., 2009). There are many tools available for assessing and understanding learning styles, some of which are more complex than others. Several have been reported as helpful in the process of education delivery. Although these tools are used widely by facilitators, questions have been raised about the validity of learning styles assessment tools and the evidence as to whether direct matching of learning styles to instructional methods produces the most advantageous outcome for the individual (Pashler, et al., 2009). For more information on learning styles refer to *The Superguide: A handbook for supervising allied health professionals*.

**Learning preferences** refers to how individuals may favour one mode of teaching over another. Preferences can differ depending on task and context (Smith & Dalton, 2005). For example, a person might express a preference to receive information in a visual or pictorial format rather than in written or verbal format.

**Learning strategies** refers to the way individuals decide to learn or teach something. Learning strategies are selected based on a combination of who the target learner is, the purpose, and the intended outcome. Strategies include reading, taking notes, highlighting, demonstration and practice. For example, if you wanted someone to learn a skill, the learning strategy would likely be demonstration followed by practice experience and feedback to improve performance.

To optimise learning experiences for adults, it is preferable to use a variety of methods that will appeal to different individuals and keep the learning experience interesting and engaging.

If I run an in-service and just talk, I find that half my audience looks bored and disengaged. But if I have handouts and ask questions to facilitate discussion, I manage to keep them interested, interactive and awake, even when it's after lunch!

Strategies to optimise learning experiences are explored further in Part 4 – *The Where and How of Facilitating Learning in the Workplace*. 
Considering individual differences when facilitating learning

Understanding difference is important for facilitators wanting to gain insight into how different learners approach tasks, what motivates them and how to minimise generational bias when facilitating a learning activity. Adults’ learning styles often reflect their previous learning experiences, their cultural background and generation.

Possible characteristics of different learners across the generations

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<tbody>
<tr>
<td>Strong work ethic; come prepared to the learning opportunity.</td>
<td>Want to learn usable skills.</td>
<td>Value knowledge access over knowledge memorisation. Experts in searching and accessing information, but not necessarily in analysing or synthesising the information.</td>
</tr>
<tr>
<td>May prefer more traditional methods of learning rather than a self-taught module.</td>
<td>Want things presented in a straightforward manner.</td>
<td>Want to take on challenging tasks in their learning environment (thus may appear arrogant if the instruction is vague).</td>
</tr>
<tr>
<td>May be less comfortable with technology but are conscientious and accept help.</td>
<td>Enjoy flexibility in their learning (e.g. self-directed modules).</td>
<td>Are computer savvy and use technology whenever possible.</td>
</tr>
<tr>
<td>Learn best when experience can be integrated with subject matter.</td>
<td>Want learning to be directly relevant to their work tasks. Don’t want to learn something just for the sake of learning.</td>
<td>Expect immediate feedback on their work as they are accustomed to information access 24/7.</td>
</tr>
<tr>
<td>Anticipate a slower paced and more formal introduction of the training and rationale for it – like to have a hard copy.</td>
<td>Want to learn in the easiest and quickest way possible.</td>
<td>Need to feel a sense of achievement. Want goals and rules to be transparent. Prefer experiential activities.</td>
</tr>
</tbody>
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(Adapted from Johnson & Romanello, 2005; Venne & Coleman, 2010)

Not everyone learns the same way as I do. We are all individuals and diversity is a strength.
Some tips for taking account of individual differences when facilitating workplace learning:

• Before you start, pause to think about the learner and their background. If you have little knowledge of their background, take time to discover their needs and experiences and how this links to the learning you are about to engage in.

• Allow some time after you have provided the instruction for the learner to talk about it in general conversation until you recognise that they have grasped the key points and their importance to their job role.

Self-directed learning

Self-directed learning is defined as ‘a process whereby you take the initiative and responsibility for the learning process. It requires no formal teaching input and can be facilitated by a range of methods and resources’ (NES Scotland, 2010, p. 40).

All allied health professionals should be engaged in self-directed learning on a regular basis. Self-directed learning generally occurs when the learners have interest and motivation in the subject matter. Self-directed learners have a particular attitude toward learning – they value learning as part of everyday life and experience.

Attributes of effective self-directed learners

• Self-motivated
• Organised
• Have a positive attitude
• Take responsibility for own learning
• Have an internal drive to learn

The diverse caseloads in rural allied health practice can be perceived as a positive element and an opportunity to engage in self-directed learning (McAuliffe & Barnett, 2009). For example, clients with unique and rare diagnoses often require rural allied health professionals to be well versed in skills to investigate the condition and potential impact on clients. Use these challenges as unique learning opportunities.
Tips to foster self-directed learning

- Recognise when learners are motivated to pursue their own interests or topic areas.
- Incorporate discussion of topics of interest into activities such as supervision or team meetings.
- Document learning objectives where learners identify their own learning goals and resources to support the achievement of these goals.
- Encourage engagement in ongoing reflection and self-evaluation.
- Be aware of life stages, maturity levels, personal and professional goals that can motivate people to engage in self-directed learning.
- Match the learner's interest, competency level and stage of development.
- Model self-directed learning through pursuit of education opportunities.
- Use workplace opportunities to increase motivation to engage in self-directed learning (e.g. clinically relevant research or quality improvement projects).

(Adapted from Smith & Dalton, 2005)

For facilitators of learning, the goal of workplace learning is to produce self-directed, lifelong learners who are skilled and competent clinicians and who provide quality care for patients/clients.

One of my level one staff members was concerned about rotating into a new position. She hadn’t worked in this area since she was on university placement and was concerned her knowledge was not up to date. She was motivated to learn so we collaboratively developed a self-directed learning plan to enable her to build her knowledge and skill base. Within a short period of time she was able to source the information independently and only required occasional chats to check her ideas as she progressed with her learning.
Part 3

What skills are needed to facilitate learning?

What skills do I need?
Introduction: Skills to facilitate learning

Allied health professionals need a number of core skills to facilitate learning in the workplace. Critical to the process of establishing an optimal learning environment is the ability of facilitators to build positive relationships and communicate effectively. Several important specific skills are required to facilitate learning in others and to encourage a deep approach to learning.

These skills are explored further in this section:

- Building relationships that support learning
- Communicating effectively
- Facilitating discussion
- Developing professionals along the continuum of learning
- Facilitating a deep approach to learning
- Setting learning objectives
- Using advanced questioning techniques
- Facilitating reflective practice
- Facilitating clinical reasoning
- Facilitating an evidence-based practice approach
- Giving effective feedback to learners
- Managing challenges in the learning process

In essence, effective facilitation of learning aims to achieve a ripple effect which influences people’s knowledge, skills and attitudes toward clinical professionalism and competence (Jeffs & Smith, 2005).
Building relationships that support learning

A facilitator should take time to establish a supportive, collaborative, non-judgemental and respectful relationship where effective and constructive feedback can be provided that contributes toward skill acquisition, growth and development.

Building a collaborative relationship
Collaboration is a process of learning through interaction with others (Way, et al., 2000). It relies on a relationship where facilitator and learner can jointly determine learning needs, and where both have responsibilities related to the outcomes of the learning relationship.

Establishing and maintaining a respectful relationship
Respect is a fundamental concept in any relationship and needs to be translated into action. There are several ways respect can be demonstrated in the learning relationship:

- Showing commitment to the relationship by being available, being open to feedback and following through with agreed-upon actions.
- Fostering open communication style through use of positive verbal and non-verbal body language.

Being an effective role model
Effective facilitators model attitudes and behaviour that help learner's to challenge and change their own attitudes and behaviours. How facilitators approach their own learning, professional development and opportunities to enhance skill acquisition has a direct influence on the attitudes toward learning in others.

Maintaining flexibility
Learners have varying needs, and the ability to meet these needs through the establishment of different types of learning relationships is essential. For example, one learner might require and request only intermittent support to achieve their learning goals. Others might need intensive input and instruction, especially if patient safety is at risk. A facilitator’s flexibility and ability to moderate between these differences has a direct impact on the success of the learning relationship.

Setting expectations in the learning relationship
When dealing with the interpersonal development of another person, it is important to set expectations of the relationship from the beginning. As in a supervision contract, a conversation about roles and expectations is an important step in managing issues that might arise in the future. For more information on supervision contracts see The Superguide: A handbook for supervising allied health professionals.

Strategies for establishing expectations in the learning relationship
- Brainstorm key expectations, such as frequency and availability to support the learner.
- Discuss the best way to provide feedback to the learner.
- Agree to confidentiality in the relationship.
- Cultivate a relationship where concerns and experiences can be raised and discussed.
- Agree about the level of support required (e.g. one-to-one, intermittent, or consultative).
Communicating effectively

Effective communication skills, especially listening and questioning skills, are essential to effective facilitation of learning. Facilitating learning requires communicating across a spectrum of situations and settings and in a variety of ways.

Tips to optimise effective communication:
- Ensure that the content of what is said matches the way it’s said and is reinforced by appropriate body language
- Be clear about the meaning that is being conveyed
- Minimise the possibility of distractions or interruptions

Active listening

Listening skills are required in many situations, including listening to colleagues, in meetings and when treating patients/clients (Trevithick, 2000). Active listening is another level of listening which ‘demands alertness on the part of the listener’ (Trevithick, 2000). The aim of active listening is to listen closely to the details that are being conveyed in order to ensure that not just the content is understood but also the intended message. The skill of active listening is important in the supervisory and learning relationships where feedback, reflective practice and facilitation of clinical reasoning are required.

Qualities of an active listener:
- Is non-judgemental
- Has open body language
- Asks questions to facilitate learning
- Seeks clarification to enhance understanding
- Is genuinely interested
- Summarises frequently to ensure understanding
- Is aware of tone and pays attention to nonverbal forms of communication in self and learner
- Seeks and gives feedback whenever possible
- Remains calm, in control and relaxed
- Allows time to articulate thoughts
- Paraphrases before disagreeing to demonstrate active listening and understanding
- Avoids making vague, unclear or ambiguous comments

(Adapted from Egle, 2009)

Sometimes I need to remind myself of the importance of active listening when engaged in discussion with colleagues. If I am preoccupied, it is easy to respond with vague, unclear or ambiguous comments often resulting in misunderstandings. By actively listening I can turn incidental encounters into learning opportunities.
Giving effective explanations

Whether it is during an incidental conversation, a workshop, in-service or lecture, it is important to communicate information, opinions and concepts in a way that promotes understanding for the listener so that learning can occur.

10 tips for providing effective explanations

1. Use verbal cues to indicate the structure and direction of an explanation
2. Indicate the beginning and end of a subtopic (particularly with complex topics)
3. Use statements that emphasise and highlight the key points. e.g. ‘So the main point is…’ or ‘Now this is very important’
   Note: varying your voice quality (volume or tone) also helps
4. Use words or phrases that link one part of an explanation to another, and the explanation to the learner’s experience
5. Use examples that are relevant and match the level of thinking and the experience of the learner
6. Pace it appropriately – use pauses and don’t talk too fast
7. Define new terms
8. Use straightforward sentence structure
9. Choose words or terms that are clear and precise
10. Monitor for understanding of your explanation by observing learner response (nonverbal and verbal cues)

(Adapted from Brown & Mangoue, 2001; Hatton, 1979)

‘To explain is to attempt to give understanding to another; and understanding is the creation of new connections in the mind of the learner’ (Brown & Mangoue, 2001, p. 237).
Facilitating discussion

The ability to generate and facilitate discussion is vital for optimising opportunities for learning. While discussion is occurring, knowledge and different perspectives can be analysed and evaluated in a deep and collaborative way, providing new opportunities for reflection and learning.

Example settings for facilitating discussion

- One-to-one with a colleague
- Giving a presentation
- Running a workshop
- Clinical discussions in your team/department/unit
- Engaging in mentoring sessions

Practical ways to facilitate discussion

<table>
<thead>
<tr>
<th>Ask questions that promote deep and continuous discussion</th>
<th>Maximise participation</th>
<th>Create a positive learning environment by acknowledging/rewarding responses</th>
<th>Use your starting and finishing well</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Open questions (e.g. what happened?).</td>
<td>• Use an experience or common area of interest as the basis of discussion, which will help provoke the urge to comment.</td>
<td>• Say ‘thank you’ or ‘well said’.</td>
<td>Starting usually includes:</td>
</tr>
<tr>
<td>• Key or focus questions.</td>
<td>• Use well-structured questions.</td>
<td>• Nod, smile, lean forward.</td>
<td>• Giving a brief discussion context to connect people to the topic.</td>
</tr>
<tr>
<td>• High order and probing questions.</td>
<td>• Use eye contact to scan the group.</td>
<td>• Build on what is said by using discussion points as a springboard for further discussion or refer back to a relevant comment made by an individual.</td>
<td>• Outlining the aims of the discussion (without pre-empting the learning).</td>
</tr>
<tr>
<td>• Be clear about what you want to achieve from the discussion.</td>
<td>• Use non-verbal encouragement such as leaning forward, head nods and looking expectant (i.e. curious, interested).</td>
<td></td>
<td>• Using a key discussion question.</td>
</tr>
<tr>
<td></td>
<td>• Redirect responses or questions aimed at the group leader back to the group by using nonverbal cues such as eye and hand gestures, or a question like... ‘What do other people think about that?’</td>
<td></td>
<td>Starting usually includes:</td>
</tr>
<tr>
<td></td>
<td>• Manage challenging group dynamics to maximise participation and contribution to the discussion.</td>
<td></td>
<td>• Indicating the discussion is coming to a close and giving last opportunity to comment.</td>
</tr>
</tbody>
</table>

(Adapted from Muller & Irby, 2005)
Developing the professional along the continuum of learning

Developing the learner along the learning continuum from non-expert to expert can be a formidable task. This section explores ways in which facilitators can think about how they want to target the learning material and activities to match the level and needs of the learner.

The diagram below demonstrates the acquisition and exercise of nephrology nursing expertise and may be helpful in understanding the stages of skill and knowledge acquisition and how a facilitator can best support the learner at each stage of development.

### Stages of skill and knowledge acquisition

- **Non-expert**: sometimes also referred to as a novice clinician performs best when provided with boundaries, detailed instructions and support. The facilitator should provide regular support to develop skills and knowledge and to ensure patient safety.

- **The experienced non-expert**: also known as a competent clinician decides on learning priorities based upon previous experiences. The facilitator can act as a role model, helping the learner to discuss matters and reflect on practice.

- **Expert**: Learner has a deep understanding of the situation and performance is fluid, flexible and highly proficient. The expert learner can autonomously seek out learning opportunities and is often engaged in facilitating the learning of others.

(Adapted from Benner 2004, p. 188, Dreyfus & Dreyfus 2005, Dreyfus 2004 and Smith & Blake 2005)
Promoting skill acquisition along the continuum of learning

Many approaches can be used to support a learner’s skill acquisition and movement along the continuum of learning. One method is ‘scaffolding’, which matches the approach with the learner by progressively withdrawing or changing assistance as expertise is developed (Smith & Blake, 2005).

Scaffolding

- Offers a means of motivation for the learner (as the task does not seem unattainable), reduces the task complexity and provides structure while reducing learner frustration (McLoughlin & Luca, 2002).
- Offers an opportunity to learn within a safe and supported environment.
- Promotes engagement in experiential learning.
- Does not need to be direct supervision, but should be planned to help the learner to understand how to apply their knowledge.

The trick to scaffolding is knowing what stage the learner is at and adjusting your instruction, teaching or facilitation accordingly.

Strategies for skilful scaffolding

- Identify the current knowledge and skill base of the learner and adjust your facilitator role accordingly.
- Carefully design and plan to ensure activities are meaningful.
- Make sure the learner can understand your terminology. The way experienced clinicians speak and behave can be overwhelming for new clinicians.
- Review the amount of facilitation or direction that is required throughout the activity (you may need to withdraw or increase the amount of assistance you provide).
- If the learner is not at the anticipated level necessary to complete the task (especially if patient safety is at risk), provide more support (e.g. demonstrate the skill and then verbally guide the learner through it).

Learning remotely often requires the support and guidance of another more experienced health professional, by means such as mentoring. See The Superguide: a handbook for supervising allied health professionals for information about mentoring. Rural and remote allied health professionals may become ‘accidental mentors’ (Mills, et al., 2007). An accidental mentor is an experienced clinician who does not plan to be a mentor, yet assumes the role with new or novice clinicians as a result of their need for support in difficult or stressful situations (Mills, et al., 2007). This might be a short-term relationship until the novice gains confidence and competence in practice.
Facilitating a deep approach to learning

Participants use different approaches to engage with a learning experience. Facilitators need to recognise this and to try and foster an approach that will help generate meaningful and life-long learning. Two typical approaches are referred to as a ‘deep’ and ‘surface’ approaches. When facilitating learning in the workplace the goal is to achieve deep learning by promoting a deep approach from the learner.

A deep approach refers to learning where learners are intrinsically motivated and have interest in the subject. They seek to understand the topic, read widely, discuss and reflect on the topic matter (Biggs, 1991).

A surface approach refers to the type of learning where learners tend to skim the surface; they are often extrinsically motivated, focussing on what they need to do to get by or to reproduce details accurately (Biggs, 1991).

Although learners may have a predisposition for either a deep or surface approach, the learning environment can shift learners from one to the other (Macaulay, 2000). It is the role of facilitators to maximise factors that lead to deep learning and minimise those that lead to surface learning (Biggs, 1991). This can be done through the conscious planning of learning tasks and implementation of several strategies:

PROMOTE
• Teaching and assessment methods that foster active engagement with learning tasks (see Part 3 & 4 for strategies).
• Using concepts that are related to everyday experiences.
• Relating and distinguishing new ideas in relation to previous knowledge.
• Demonstrating a personal commitment to the subject matter and communicating its meaning and relevance.
• Communicating learning expectations clearly.
• Interacting with peers and facilitators.
• Establishing a well-structured knowledge base.

(Avoided from Ramsden, 1992)

Avoid
• Learning methods that require only simple recall of information (e.g. calculations or formulas).
• Giving poor feedback.
• Focusing the learning on detached elements of the task.
• Working through an excessive amount of material or information.

When facilitating learning in the workplace the goal is to achieve a deep approach to learning.

I recently ran a continuing education session at my monthly team meeting. Because my colleagues all had varying levels of experience and knowledge, to help prepare them I sent out a review article via email one week prior to the meeting and provided a clinically relevant focus question to direct their reading. During the session I used various methods to achieve deep learning. For example, I asked advanced questions using Blooms Taxonomy, I facilitated small group learning activities and provided examples of how theory can be applied to practice. I loved trying out new skills and working with my colleagues to explore how new learning can enhance practice and patient care.
Setting learning objectives

It is not always necessary to set formal learning objectives for every learning situation. However, when creating a learning situation a useful first step can be to set learning objectives. This can facilitate more effective evaluation of the learning process and outcomes.

Learning objectives:
- Provide focus, consistency and direction for the session
- Guide the selection of teaching content
- Offer a means for evaluating what participants have learned (Smith & Ragan, 1999).

<table>
<thead>
<tr>
<th>Learning objectives or goals</th>
<th>Describe what the learner should be able to have learned as a result of participating in a learning program (McMillan, 2001).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aims</td>
<td>Are what facilitators intend to ‘promote’ or ‘provide’ during the learning opportunity they are creating. For example; ‘To promote participation in group discussion’.</td>
</tr>
<tr>
<td>Specific Learning Objectives</td>
<td>Tend to be written for each individual learning session, and provides a means to determine evidence of learning achievement. These specific objectives should include four components: <strong>ACTION, CONTENT, CONDITION</strong> and <strong>CRITERIA</strong>.</td>
</tr>
</tbody>
</table>

How to write specific learning objectives

These should begin with a statement such as:

**At the conclusion of the session, it is anticipated that you will be better able to…**

**Step 1:** Determine what observable **ACTION** learners will need to display to indicate that they understand and have achieved the intended learning. For example, begin with using the verbs from Blooms Taxonomy (see Advanced questioning techniques on page 33 and Appendix A on page 73).

**Step 2:** Decide on the focus of the learning in terms of **CONTENT**. This can be facts, skills, attitudes, procedures or professional tasks. For example, ‘The components of a safe and effective immunisation program in my community pharmacy’.

**Step 3:** Determine under what **CONDITION** or circumstances it will be expected that the learner will perform the activity. This is essentially asking, ‘Using what?’ For example, ‘with a simulated patient’, ‘in discussion’, ‘in the ward setting’, ‘using a mobile x-ray’.

**Step 4:** Decide on the **CRITERIA** that will be used to determine the acceptable level of performance of the learning behaviour. These may be in terms of accuracy, speed, or proficiency, for example, ‘within 3 minutes’, ‘correctly on at least 3 attempts’, ‘at least 95% correct’, ‘as judged by clinical supervisor’.

(Adapted from Mandernach, 2003)

For more information on setting SMART goals see *The Superguide: A handbook for supervising allied health professionals.*
### Examples of specific learning objectives:

<table>
<thead>
<tr>
<th>DISCIPLINE</th>
<th>ACTION</th>
<th>CONTENT</th>
<th>CONDITION</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietetics</td>
<td>Demonstrate</td>
<td>Understanding of the role the SGA can play in nutritional assessment</td>
<td>During the session review</td>
<td>By identifying 3 advantages</td>
</tr>
<tr>
<td>Radiography</td>
<td>Complete</td>
<td>Radiographic technique adaption</td>
<td>During the ICU morning chest x-ray round</td>
<td>With optimal radiographic technique as judged by a senior</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Conduct</td>
<td>A test for vertebro-basilar arterial insufficiency</td>
<td>In a cervical spine muscul-skeletal outpatient</td>
<td>With 100% accuracy</td>
</tr>
<tr>
<td>Social Work</td>
<td>Demonstrate</td>
<td>Understanding of ways to support a family member who is in acute psychological distress</td>
<td>During a clinical supervision session</td>
<td>By explaining 3 key elements of crisis intervention</td>
</tr>
<tr>
<td>Speech Pathology</td>
<td>Demonstrate</td>
<td>Skills in assessment and analysis of a patient's ability to safely swallow orally</td>
<td>During a bedside examination</td>
<td>With appropriate techniques as judged by a senior speech pathologist</td>
</tr>
<tr>
<td>Psychology</td>
<td>Complete</td>
<td>Suicide risk assessment</td>
<td>During a mental health assessment</td>
<td>Able to determine appropriate risk and response as judged by the supervisor</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>List</td>
<td>The range of alternative medications of a patient with nasogastric tube unable to be administered a slow release dose form medication</td>
<td>In discussion with clinical supervisor</td>
<td>By identification of suitable dosage forms or alternative drugs in some drug classes as judged by clinical supervisor</td>
</tr>
<tr>
<td>Genetic Counselling</td>
<td>Demonstrate</td>
<td>Skills used in giving bad news result</td>
<td>In a role-play setting</td>
<td>With appropriate skills through discussion with senior</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Complete</td>
<td>Functional assessment of a stroke-affected upper limb</td>
<td>With a patient on the ward</td>
<td>As per department guidelines for upper limb assessment as judged by supervisor</td>
</tr>
<tr>
<td>Managers</td>
<td>Understand</td>
<td>Lean principles</td>
<td>At completion of lean principles workshop</td>
<td>By illustrating a worked example with manager</td>
</tr>
<tr>
<td>Generic</td>
<td>Apply</td>
<td>Key processes</td>
<td>To develop collaborative goals with clients in the community</td>
<td>With 100% accuracy</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Demonstrate</td>
<td>Skills in assessment and analysis of a neurovascular assessment</td>
<td>During patient review - bedside examination</td>
<td>Appropriate techniques as judged by senior podiatrist based on department guidelines</td>
</tr>
<tr>
<td>Exercise Physiology</td>
<td>Demonstrate</td>
<td>An exercise to assist in balance for falls prevention</td>
<td>During a clinical case review session for all new patients to the clinic</td>
<td>By identifying 3 key exercises</td>
</tr>
</tbody>
</table>
Advanced questioning techniques

Advanced questioning involves the skill of asking high order questions to provide opportunities for learners to respond in increasingly thoughtful ways, stimulating different levels of cognitive demand. You need to ask: What type of thinking do you want the question to generate? Whatever the learning setting is, the questions used should help develop the cognitive skills of reasoning and critique.

Bloom’s Taxonomy

Bloom’s Taxonomy is a classification of thinking (Bloom, et al., 1956) and in its revised state (Anderson & Sosniak, 1994) describes six levels of cognitive tasks from the most basic to higher order of thinking skills. These are shown in the diagram below:

- **Creating**
  - e.g. what would happen if...?
- **Evaluating**
  - e.g. is there a better solution to...?
- **Analysing**
  - e.g. how was this similar to...?
- **Applying**
  - e.g. could this have happened in...?
- **Understanding**
  - e.g. what do you think...?
- **Remembering**
  - e.g. what happened after...?

All learning needs to include the cognitive tasks of remembering, understanding and applying. To promote deep learning and enhance clinical reasoning, however, the aim should also be to use questions that promote analysing, evaluating and creating. This is particularly important when setting learning objectives (page 31) to ensure that learners achieve the level of thinking and reasoning required.

A colleague recently described to me a challenging patient/client scenario. After I heard the story, instead of either offering a solution or being silent, I asked “What do you think a possible solution is to [the issue]?” This is an example of helping someone do the task of ‘evaluating’.

A comprehensive table of questions to develop each category of thinking and verbs to set learning objectives (Bloom’s Taxonomy) can be found in Appendix A on page 73.
Probing questions

Probing questions are used to help learners think through their responses more thoroughly. You might use probing questions to gain clarification or encourage an expanded explanation.

Examples of probing questions

- Can you be more specific?
- What makes you think that?
- How might other people see this?
- In what ways is that relevant?
- What is an example of that?
- How reliable is the evidence?
- What is the underlying principle?

(Adapted from Van Ments, 1990, p. 80):

Using questions to model thinking skills

The ability to ‘think about your thinking’ is called metacognition (Barrows, 1992). Metacognition is an essential part of clinical reasoning which the facilitator can model (demonstrate or promote) by asking the learner to think or reason through a problem or situation.

Example questions to model thinking

- What is going on in this problem or situation? Do you have the entire picture?
- Have you experienced this situation in the past?
- Do you know enough about this problem or situation to handle it?
- Have you thought about the possibilities?
- What information do you need to consider these possibilities?
- What does this finding mean?
- What is the best way to manage this?
- What is the supporting evidence for this idea?

(Adapted from Barrows, 1992)

A colleague came to me with a clinical problem and asked me what they should do. Instead of following my initial reaction to provide advice straight away, I stopped myself and asked them some probing questions. Through this process they could solve the problem and come up with the solution themselves, which increased their confidence.
Facilitating reflective practice

Reflective practice is the ability to ‘reflect on action in order to engage in a process of continuous learning’ (Schön, 1983). The ability to reflect on professional practice, workplace experiences and interactions with others in the workplace environment is an essential skill of a 21st century allied health professional and is ‘regarded by many as an essential characteristic for professional competence’ (Mann, et al., 2009). Through both self-directed and facilitated reflective practice, individuals can increase their level of self-awareness and insight into practice, which in turn leads to improved standards of patient care (Health Education and Training Institute, 2012).

Reflective practice is a metacognitive process that enables individuals to make meaning of their experiences (Sandars, 2009). Either through self-reflection or discussion between two or more people, the focus is on ‘how’ and ‘why’ things have happened, rather than just ‘what’ has happened (Watson, et al., 2002). Some individuals are reflective by nature and will find the process of reflection comes naturally, but for those who are not, it is a skill which must be learned. The presence of a facilitator to promote reflective practice is a useful way to build capacity in this important skill and create a supportive workplace environment where learning from experience is valued (Boud, et al., 1993).

Tips to facilitate reflective practice in the workplace:

- Encourage use of reflective journals/templates and collation of information for CPD portfolios.
- Use guided and advanced questioning techniques.
- Encourage a reflective approach to discussion and actively seek feedback.
- Model reflecting openly on your own practice and past learning experiences.
- Embed a culture of reflecting on practice within a team/department by collectively reviewing projects/initiatives and identifying future system improvements.
- Create a non-threatening environment for people to discuss situations in depth.
- Promote regular discussions of complex or challenging patient/client scenarios.

For more information on reflective practice see The Superguide: A handbook for supervising allied health professionals

Remote allied health professionals need to be resilient, confident, and skilled in seeking out additional knowledge, obtaining feedback and furthering expertise. This can include seeking feedback from clients and the community. As well, listen and reflect with colleagues (e.g. the visiting GP or the community nurse) to determine the skill mix needed to practise in your community setting.
Facilitating clinical reasoning

The role of an allied health professional requires an ability to think and act independently when dealing with clinical problems, to determine the most appropriate way to treat or manage these scenarios. Effective clinical reasoning is an essential component of this role and needs to be fostered in workplace learning.

What is clinical reasoning?
Clinical reasoning is described as a context-dependent way of thinking and decision making, which incorporates discipline-specific knowledge (practical and theoretical), cognition (analysis, synthesis and evaluation) and reflective self-awareness (thinking about your thinking) during either individual or collaborative decision making (Higgs, cited in Higgs & Jones, 2008). Examples of clinical reasoning include mutual decision making through collaborative discussion, justifying a decision and integrating ethical judgements by using available knowledge and evidence (Higgs & Jones, 2008).

How to facilitate clinical reasoning?
Many learning opportunities to enhance clinical reasoning are unplanned and opportunistic. This is because our reasoning is often embedded in actions and interactions forming the community of practice (Ajawí & Higgs, 2008). It is important, however, to pay deliberate attention to how clinical reasoning is communicated and facilitated in individual professions and contexts. The following are some strategies to consider.

| Experiential strategies       | The learner is involved in a situation or experience that includes active experimentation, memorisation, reasoning, reflecting and evaluation resulting in a transformative learning experience (Boud, 1993). This can involve methods such as explicit guidance, observation, thinking aloud, modelling, discussion and feedback (Ladyshewsky & Jones, 2008; Narayan & Corcoran-Perry, 2008). Examples include:  
|                             | • Treating a patient together and thinking out loud while you are conducting an assessment or providing an intervention  
|                             | • The learner observing a more experienced clinician during client interaction then debriefing through discussion afterwards |
| Problem-based learning       | Case reports or case studies, clinical discussion forums  
| (Onyan, 2012; Rivett & Jones, 2008) |
| Promoting reflection        | Reflection prior to, during and after an action requiring reasoning enables professionals to self-evaluate and self-monitor their reasoning (Christensen, et al., 2008). Reflective journaling for example, can encourage the development of clinical reasoning  
| Other strategies             | • Concept/mind mapping (Cahill & Fonteyn, 2008)  
|                             | • Reflective writing (Ryan & Higgs, 2008)  
|                             | • Simulation (Edwards & Rose, 2008)  
|                             | • Discussing your own stories and experiences (Ryan & Higgs, 2008)  
|                             | • Using provocative readings followed by discussion (Ryan & Higgs, 2008)  

Facilitating an evidence-based practice approach

Implementing a broad evidence-based approach to practice is perceived as essential in the current healthcare environment (Grimmer-Somers, 2009; Taylor, 2007).

What is Evidence-Based Practice?
An evidence-based practice (EBP) approach requires allied health professionals to gather information from multiple sources of evidence, appraise the evidence and apply the best available contemporary and meaningful evidence to individual clients/situations (Grimmer-Somers, 2009; Taylor, 2007). EBP requires practitioners to use sound professional judgement, clinical reasoning and reflection (Higgs, Jones & Titchen, 2008; Taylor, 2007). Evidence is used to inform practice and to enable clinicians to provide optimal services for individual clients/patients (Grimmer, 2009). Although the focus of this section is on using and facilitating an evidence-based approach to clinical practice, it is also essential for others including allied health managers, supervisors/mentors and educators to use a broad evidence-based approach to their work.

Key Sources of Evidence
Individual allied health professions tend to have profession specific definitions of EBP. However, the key sources of clinical evidence are considered to be: the patient/client and their family, research/literature and the allied health professional's clinical experience (Taylor, 2007). Clinical guidelines and standards which have been rigorously developed and have a research/expert professional consensus basis are also core sources of evidence in some allied health professions (MacDermid, 2008; Taylor, 2004).

Evidence from the Patient/Client
Evidence from the patient/client and their family includes information gathered during assessments and ongoing interactions with clients and family members. This incorporates client/patient perspectives, preferences, values and goals (Byron & Pineda, 2009). The manner in which information is gathered from patients/clients and family members, and other aspects of interactions with clients/families will be guided by evidence from the research/literature and clinical experience (Pack, 2009). The person-centred approach to patients/clients service provision is retained within EBP (Higgs et al., 2008).

Evidence from Research/Literature
Evidence from research/literature incorporates developing a clinical search question, systematically and efficiently searching the literature notably using research databases, finding the most relevant rigorous research and interpreting the research findings including their clinical utility (Grimmer, 2009; Heath, 2009a&b). The traditional evidence-based pyramid can be found in Appendix C. (Glover et al., 2006). Although authors differ in their perspectives on the value of this approach (McDermid & Law, 2008; Stiwne & Abrandt Dahlgren, 2004), the contemporary tendency is to promote the use of the best available evidence from a range of sources relevant to a particular individual client/patient or situation (Grimmer, 2009; Taylor, 2007). To be able to implement effective clinical services, it is also important for clinicians to be knowledgeable about broader relevant research including effective models of care, assessments, teamwork and communication, cultural safety and consumer/service user perspectives (Pack, 2009).

Evidence from Clinical Experience
Although allied health professional’s experiential evidence has been identified as essential for the implementation of EBP (eg., Taylor, 2007), the literature tends not to provide a more detailed exploration of this key source of evidence.
Facilitating Evidence-Based Practice

Research findings (e.g. McCluskey, Home & Thompson, 2008; Taylor, 2004) suggest the following are essential for the implementation of EBP:

- A workplace which is supportive of EBP
- The availability of skilled supervisors/mentors
- Time available for clinicians to engage in EBP
- Adequate physical resources including access to information technology and computerized databases
- The provision of education and skills development, for example, skills to search for and critically appraise research evidence, communicate the evidence, and articulate clear rationales for practice decisions based on evidence
- Clinicians who have sound clinical reasoning, reflection and clinical judgement skills
- Team members who are committed to EBP
- Clinicians who are willing to change practice consistent with the best available evidence.

Supervisors, mentors, managers and colleagues can use information included in other sections of this guide and The Superguide to promote evidence-based approaches to practice and to facilitate an EBP workplace culture.

Within the context of current resources and models of service provision, allied health professionals make clinical decisions with and for individual patients/clients using the best available evidence from a range of sources including the patients/clients, contemporary, rigorous and relevant research/literature and the professional’s clinical expertise/experience (James, 2009; Taylor, 2007).

The workload demands and workforce shortages commonly faced by rural clinicians can make the decision to take on students a difficult one. Students can really help to contribute to evidence-based practice and workplace learning for time-poor clinicians.

For more information on tools to evaluate evidence see Appendix C on page 78.
Giving effective feedback to learners

Feedback is a mechanism that can help to determine how effective our communication has been with the learner. Feedback is critical to the learning cycle and leads to improvement (Rogers, 2001). The timing, type and amount of feedback given can influence how useful the information will be. As demonstrated in the diagram below, if feedback is given inappropriately it can have a negative impact on a learner's performance.

**Non-effective feedback cycle**

- Infrequent feedback
- Confusion
  - Defensiveness = worse performance
- Untimely feedback
- Unexpected
- Demotivating
  - Performance

**Effective feedback cycle**

- Frequent feedback
- Understanding
  - Openness = better performance
- Timely feedback
- No surprises
- Motivating
  - Performance

(Diagram adapted from: Freshtracks UK, 2011)

**Using a positive critique framework to give feedback**

A positive critique framework emphasises the positive aspects of the learning experience and promotes self-reflection (Vickery & Lake, 2006). A useful way to ‘start the conversation’ when giving feedback to individuals or groups is to begin by discussing what they think they did well, and then move on to what they think can be improved. This provides the opportunity to hear from the learner first and gauge how much self-reflection has occurred as part of the learning experience. The facilitator can then add other thoughts, and then the learner can reflect on areas of improvement.

‘Using regular feedback helps to encourage and correct learning, which improves outcomes and helps define goals’ (Vickery & Lake, 2006, p. 37)

For more information on giving feedback see The Superguide: A handbook for supervising allied health professionals.
Tips to giving effective feedback

• Feedback should be part of the overall communication approach with the learner.
• Give feedback as soon as possible and align feedback with the learning objectives.
• Focus on the here and now and comment on how success was achieved.
• Try to make objective rather than subjective comments, by removing the ‘I’ and replacing it with ‘there’ or ‘it’, e.g. ‘It was apparent that there was…’
• Comment on the performance or behaviour, not the person, and give examples.
• Find at least one positive comment to make in situations where performance was poor.
• Where possible, give feedback privately, unless there is adequate rapport established and it is agreed that it is suitable to do so in front of others.
• Collaboratively explore strategies to overcome the concerns raised in the feedback session.
• Use open-ended questions to ensure that the learner has understood the feedback and try to encourage the learner to explain what you have said.
• Provide feedback for every learning situation but not all at once – be selective.
• Be aware and address signs where feedback is rejected e.g. providing excuses, not paying attention, criticising and questioning the validity of the source, defensive body language.
• Give the learner time to reflect and respond to the feedback, demonstrating active listening.

(Adapted from Rogers, 2001)

Would you like to know how well you give and receive feedback? See Appendix D on page 80 for a quiz to test your feedback skills.
Managing challenging behaviours in learning activities

When you are facilitating learning, several challenges can dramatically impact on the learning process and outcomes. Common challenges occur around the learners’ behaviours and attitudes and/or the facilitator’s ability to manage or handle these challenges. Some examples and strategies for managing challenging behaviours and attitudes in an individual or group setting are given here.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Challenging behaviour or attitude</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td><strong>Side conversations</strong> – It is not uncommon for conversations to start between two people within a group. It is important to address this to minimise distraction.</td>
<td>• Ask them to share their idea with the group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Get up and casually walk around near those having the side conversation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Call them by name and ask if they want to add the topic of their discussion to the agenda.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Restate a recently made point and ask for opinion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Call on someone who is sitting next to one of them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remind people of the group rules – only one person talks at a time.</td>
</tr>
<tr>
<td>Group</td>
<td><strong>The quiet group</strong> – There are various reasons for a quiet group, such as:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• someone may be dominating the conversation (even the facilitator)</td>
<td>• If the group is familiar to you and they are always quiet then you might consider the possibility that you could be part of the problem. You might be talking too much or could have intimidated people when an idea was suggested that you disagreed with. To rectify this, try letting others lead the discussion and reducing the frequency of your comments. Ask more questions and make fewer judgements.</td>
</tr>
<tr>
<td></td>
<td>• the topic under discussion might be a sensitive issue that is dividing the group</td>
<td>• If the topic is sensitive in any way, consider getting opinions or ideas individually, then use them as general feedback to the group without acknowledging the source of the idea or statement.</td>
</tr>
<tr>
<td></td>
<td>• there is a general resistance to change.</td>
<td>• If you don’t know why your group is quiet, maybe you should just ask them. Perhaps the focus should be on evaluating the group format and considering another approach.</td>
</tr>
<tr>
<td>Group/Individual</td>
<td><strong>Overly disagreeable learner</strong> – This one is tricky, since he or she may have a legitimate point and you don’t want to shut down honest dialogue.</td>
<td>• Ask the learner to provide a rationale behind their thoughts. Remain curious and respectful to the learner, finding merit in the suggestions and by providing evidence and effective feedback.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Respond to the comments, not the attack.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Open the discussion to the group for comments.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Explain that, due to time constraints, the comments can be put on the agenda for the next time.</td>
</tr>
<tr>
<td>Setting</td>
<td>Challenging behaviour or attitude</td>
<td>Strategies</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Group/Individual       | The dominator – This person uses other group participants as an audience and manages to use any opportunity to dominate discussion. | • To change the pattern, especially in a group learning situation, send the question asked by the dominating learner to the group for a response.  
• During a pause for breath, thank the person for their comments, restate the agenda and time limits, and move on.  
• Ask for an explanation of how the comments add value to the topic being discussed. |
| Group/Individual       | The Sniper – This person may obstruct others with interrupting behaviour such as rude comments, sarcastic humour, biting tones of voice or rolling of the eyes. | • Stop what you are doing and look for the person who interrupted so all of the focus is on them.  
• In a neutral tone, ask for the true meaning or relevance of the communication, e.g. ‘When you said that, what did you really mean? or ‘what does that have to do with this?  
• If the behaviour continues, suggest discussing it one to one at an appropriate time and location. (Brinkman, 2002, p. 84) |
| Group/Individual       | The quiet or shy learner – You are aware that this person has something to contribute, but they seem too shy to share it within the group setting. | • Make eye contact with the learner and ask a simple question such as ‘Jill, I am wondering if you have had experience with this in your current clinical area? Do you have any thoughts on this topic?’ or ‘Jill, you were telling me about an idea you had last week. Why don’t you share it with all of us?’?  
• Involve them in a small subgroup discussion and ask for an oral summary of the discussion.  
• Recognise the contribution immediately, sincerely and encourage more.  
• Ask during a break or in private if there are any issues impeding their participation.  
• Suggest taking turns in sharing opinions. |
| Group/Individual       | The disengaged learner – Often quiet and reluctant to participate in activities. May be unprepared, bored, or from a CALD background. | • Need a motivating factor to engage them in discussion. Asking these learners particular questions (based on your understanding of what motivates them) will bring their focus to the topic and discussion.  
• Learners from a Culturally and Linguistically Diverse (CALD) background will require extra time, explanations and the same encouragement as shy or quiet learners. |
| Group/Individual       | The disruptive learner – These may be high achievers or can be overly sarcastic or a joker. | • The high achieving learner can be used to help facilitate group learning by encouraging a peer-mentoring role. However, do not let them answer all the questions and ask them to wait their turn to speak. If they continue to be a challenge give them a task, such as scribe or summariser.  
• Overly sarcastic learners or those who act the joker need to be engaged with questions and encouraged to be involved in the discussion. This will re-direct their focus and lessen their disruptive behaviour. |

(Adapted from Kitchen, 2012; Muller & Irby, 2005; Thompson, 2009; Brinkman, 2002).
Reflective questions

Here are some reflective questions to get you thinking about how you might apply some of this information in your workplace.

- What skills do you have that make you an effective facilitator of learning in your workplace? For example, what attributes do you show that make you effective at providing feedback, or facilitating reflective practice?

- What skills need development? What sort of situations do you find difficult to manage?

- List some strategies that you can try to help overcome these difficulties.

- Think of some cases where you have applied new evidence in your treatment programmes. What impact did this have on your practice, treatment and/or outcomes? Are there ways to ensure other treatment practices are kept up to date with the current evidence based practice?
Part 4

The where and how of facilitating learning in the workplace

Where can I use these skills?
Introduction: Where and how does learning occur in the workplace?

Within the clinical setting there are many opportunities to facilitate learning. To start it is important to create an ideal environment to optimise learning. Learning in the workplace can be facilitated in a number of contexts.

These include:
- Creating an optimal learning environment
- One-to-one
- Using clinical scenarios
- Within groups
- In lectures or presentations
- Workshops
- In-services
- Journal clubs
- Simulation
- Electronic media
- Interprofessional interactions
- Communities of practice

‘Facilitating learning is as much about setting up the learning environment as it is about extending knowledge or sharing expertise’ (Hutchinson, 2003, p. 810).
Creating an optimal learning environment

The Physical Environment
Managing external factors, such as minimising distractions and taking into account the learner’s needs (such as regular breaks or finding a quiet place to talk) contributes toward creating supportive learning environments.

<table>
<thead>
<tr>
<th>Check:</th>
<th>✓ Location</th>
<th>✓ Seating configuration</th>
<th>✓ Lighting</th>
<th>✓ The audio visual equipment</th>
<th>✓ Room temperature</th>
<th>✓ Room size</th>
<th>✓ Background noise</th>
</tr>
</thead>
</table>

Motivation
Motivation to learn may be intrinsic (from the learner) or extrinsic (e.g. via assessments or the need to comply with mandatory training requirements). The role of the facilitator to motivate the learner is paramount. Showing interest in the learner’s experiences, establishing a trusting relationship and having passion for the subject are all vital to creating an effective learning environment. Learners are motivated by inclusion and consultation (Hutchinson, 2003).

Safety
Creating a safe learning environment is not just about ensuring that there is a physically safe place to learn (Hutchinson, 2003). Learning can be emotionally and psychologically challenging, as individuals may be required to question their existing knowledge (at times in front of peers). Facilitators therefore should strive to create a safe learning environment that allows learning to happen.

Tips for setting up learning environments that facilitate learning
- Ensure regular breaks.
- Avoid busy times.
- Involve all learners in the development of ground rules.
- Provide constructive feedback on performance.
- Involve learners in developing learning content.
- Ensure that content is relevant to the learner’s needs; integrate it with practice examples wherever possible.

Special considerations for facilitating learning in clinical environments
- Ensure that patients/clients and families are comfortable and have given consent to having others present, such as students or other clinicians.
- Ensure that potential consequences for harm to the patient/client are discussed, managed and minimised.
- Ensure that the learner feels welcomed and is physically and psychologically safe.

For more information on teaching in the presence of patients/clients and/or families see The Superguide: A handbook for supervising allied health professionals.
Facilitating learning in one-to-one situations

One-to-one facilitation of learning provides a rich opportunity to engage with and learn from colleagues. It provides an excellent opportunity to customise teaching to the learner’s needs as well as to model personal and professional characteristics in authentic clinical settings. Facilitators can receive immediate feedback and adapt the teaching they provide (Gordon, 2003). Whether these opportunities are planned or impromptu, it is important for the skilled facilitator to use adult learning principles to optimise the potential for learning.

Opportunities to engage in one-to-one teaching can arise during supervision, coaching or mentoring sessions, clinical settings as well in more incidental settings such as walking to the car on the way to a home visit. The Superguide: A handbook for supervising allied health professionals highlights some important concepts in clinical teaching that can be applied during supervision sessions as well as other clinical teaching scenarios.

Opportunities for one-to-one learning

<table>
<thead>
<tr>
<th>Formal Non clinical Environments</th>
<th>Clinical Environments (with / without client/family)</th>
<th>Incidental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision</td>
<td>On ward</td>
<td>In corridor</td>
</tr>
<tr>
<td>Mentoring</td>
<td>In clinic</td>
<td>In cars</td>
</tr>
<tr>
<td>Coaching</td>
<td>On home visits</td>
<td>Walking to lunch</td>
</tr>
<tr>
<td>One-to-one</td>
<td>At handover</td>
<td>In tea/staff room/coffee shop</td>
</tr>
</tbody>
</table>

When facilitating learning in clinical environments or incidental settings it is imperative that patient/client confidentiality is maintained at all times.

Tips to making the most of one-to-one facilitation of learning

- **Set clear expectations and ground rules:** Novice or new clinicians may feel stressed in unfamiliar environments. With clear guidelines for expectations and availability, the learner is more likely to engage in the learning process.
- **Ask helpful questions:** Open-ended questions promote active learning.
- **Plan your teaching:** Even when learning opportunities occur without notice, take a moment to plan your teaching. This can also provide a structure and framework for evaluation.
- **Monitor progress and provide feedback:** One-to-one facilitation of learning can provide opportunities for the learner to gain practical skills in a safe and supportive environment. Be sure to provide timely feedback with sensitivity and in private.
- **Encourage reflection:** A facilitator in a one-to-one situation a facilitator can model reflective practice by reflecting on clinical reasoning processes and the ethical values that guide clinical care.

(Adapted from Gordon, 2003; Spencer, 2003).
Facilitating learning using case or clinical scenarios

Case-based or problem-based learning (or what is now also referred to as scenario based learning) is used extensively in health professional education. Scenario-based learning promotes the idea that learners should be ‘actively involved in the learning process in the context in which they apply knowledge’ (McLoda, 2003, p. 2). Scenario-based learning involves the use of authentic tasks, including analysing, evaluating and synthesising while responding to focus questions about a real life situation. Scenario-based learning has been shown to facilitate critical thinking, self-directed learning, and interpersonal communication (Amos & White, 1998; Bentley, 2001; Conyers & Ritchie, 2001).

Scenario-based learning has a role in many areas of the allied health workplace:
- Clinical scenario presentations
- Case conferences
- Team/department meetings
- Clinical discussions

Writing a clinical scenario
Development of clinical reasoning and transfer of learning can be influenced by the way the patient/client scenario is presented. It is imperative that the information in a clinical scenario resembles reality as closely as possible.
- Avoid presenting all the information about the whole patient/client scenario at the beginning.
- Provide original presenting symptoms and issues, and then follow up with focus questions.
- As you build the clinical scenario, gradually add further information.
- Facilitate re-evaluation of assessment and intervention approaches as changes to the presenting condition develop to simulate a real-life situation.

Facilitation strategies
For scenario-based learning in a group setting, consider the Encounter, Analyse, Reflect framework (Lockyer, et al., 2009) when presenting or planning a session. The Encounter, Analyse and Reflect design involves discussion about issues pertaining to a clinical problem presented by an incomplete patient/client scenario or clinical dilemma.

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th>TASKS</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario in problem format</td>
<td><strong>Encounter</strong> the scenario or problem</td>
<td><strong>Provide focus questions</strong> (progressive or all at once)</td>
</tr>
<tr>
<td></td>
<td><strong>Analyse</strong> scenario through question response in small group or individually</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reflect</strong> on answers to discussion (e.g. provide answers or review)</td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from Lockyer, et al., 2009)
RESOURCES
The provision of the scenario in a problem format can either be written or verbal. If it is a topical discussion rather than a specific patient/client scenario, present it as an overarching question that needs a solution (e.g., “When does total parenteral nutrition provision cause more harm than good?”). The question should be open-ended and broad. If the problem is presented in a patient/client written scenario, allow for relevant information to be introduced progressively during discussion.
For a worked example of a clinical/case scenario see Appendix E on page 82. While it is specific to dietetics, it demonstrates how a clinical scenario can be written to instruct learners to progressively analyse, evaluate and create responses to the information provided through higher order questioning.

TASKS

<table>
<thead>
<tr>
<th>Encounter</th>
<th>During this task, you will need to expose the learners to the clinical dilemma or patient scenario.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Prepare a scenario as close to reality as possible.</td>
</tr>
<tr>
<td></td>
<td>• Communicate all essential background information before the discussion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analyse</th>
<th>Learners analyse the problem or scenario by discussing and responding to a series of focus questions set by the facilitator.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Prepare focus questions before the session however impromptu probing questions may also need to be asked during discussion.</td>
</tr>
<tr>
<td></td>
<td>• Ask ‘high order’ questions that require someone to explain rather than respond with a simple answer.</td>
</tr>
<tr>
<td></td>
<td>• Focus questions should be clear, concise, and appropriate to the goals of the session, intended to guide individual analysis and promote discussion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reflect</th>
<th>The analysis task should smoothly transition to reflection time as the final phase in the session. You want to use this time not only to help learners consolidate their learning but also help you determine the learning that has occurred.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Discuss the conclusions or answers to the focus questions, and provide feedback to the learners on their responses.</td>
</tr>
<tr>
<td></td>
<td>• Reflect and assess the gaps in knowledge and alter reasoning processes.</td>
</tr>
<tr>
<td></td>
<td>• Disclose how the scenario should be managed.</td>
</tr>
</tbody>
</table>

SUPPORTS
The focus questions should assist in the development of reasoning and critique. They should be based on advanced questioning techniques and should encourage learners to analyse, synthesise, and evaluate, and should consequently facilitate reflection, clinical reasoning and deep learning.
Facilitating learning in groups

There are various contexts within the workplace where learning is facilitated within small or large groups. This section provides practical strategies that can be implemented to increase the quality and effectiveness of your facilitation in the most common of these contexts.

The strategies covered in this section should be considered in combination with the core skills required to facilitate learning (see Part 3 – What skills are needed to facilitate learning on page 22).

Some common teaching methods for large groups

<table>
<thead>
<tr>
<th>Teaching Method</th>
<th>Commentary</th>
<th>Primary Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop</td>
<td>The facilitator explains a topic or performs a skill while learners watch. Opportunities are given for practice.</td>
<td>Observation skills Knowledge of principles Knowledge of physical skills Manual skills</td>
</tr>
<tr>
<td>Group tutorial</td>
<td>A period of teaching devoted to a single topic</td>
<td>Individual development of higher level thought Asking questions Giving reasons</td>
</tr>
<tr>
<td>Lecture/ Presentation</td>
<td>A period of more or less uninterrupted talk by a facilitator/instructor/teacher (not necessarily a complete lesson)</td>
<td>Knowledge of information Obtaining general background to a topic</td>
</tr>
<tr>
<td>Seminar</td>
<td>Group discussion introduced by the presentation of a report, research or other piece of academic work</td>
<td>Critical thinking Ability to present an argument Development of thought at all levels</td>
</tr>
<tr>
<td>Step-by-step lecture</td>
<td>A lecture organised around 3-10 topics, each of which is presented for a few minutes followed by discussion or other activity</td>
<td>Knowledge of information Routine problem solving</td>
</tr>
</tbody>
</table>

(Adapted from Bligh, 2000)

For more information on the skills needed to facilitate learning in large groups see Appendix F on page 84.
Preparing to facilitate learning in groups

Different people prefer to prepare in different ways, and different subject areas might require different approaches. However, some basic decisions need to be made before presenting to a group. This checklist can help you prepare (Bligh, 2000).

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions about the organisation/audience</td>
<td>Who is your intended audience? What is your role as a facilitator of learning with this group?</td>
</tr>
<tr>
<td>Decide on or modify your learning objectives</td>
<td>Decide on what the audience should be able to do by the end of the learning activity.</td>
</tr>
</tbody>
</table>
| Decide and select suitable teaching methods                          | **FACILITATORS**: should choose methods that they feel comfortable using.  
**LEARNERS/PARTICIPANTS**: How does the session fit into the bigger picture of the learner’s development and experience?  
**ENVIRONMENT**: The physical environment can help determine selection of suitable methods (e.g. room size, location, available resources, seating arrangements, lighting, where you will be standing). |
| Decide on key points and organisation of subject matter              | Whatever format you choose, document the proposed arrangement into a session plan. |
| Decide how the teaching time is to be organised                      | You should have a clear idea of the structure and timing of the group session, including activities, breaks, change of topics, and use of visual aids. |
| Decide on participant pre-session preparation                       | Consider what previous knowledge is required or what instructions should be given to participants prior to the session. |
| Decide on detailed teaching techniques                               | Techniques refer to those specific actions you will instigate to promote learning within the session such as small group activities, explanations, key questions, use of video clips, brainstorming etc. They also refer to strategies to promote clinical reasoning, reflection and deep learning. |

A session plan template is provided in Appendix G on page 85 and a completed workshop example of a can be found in the Appendix H on page 86.
Facilitating learning in a lecture or presentation

If you are facilitating learning during a lecture or presentation, the strategies suggested below can help with increasing participant memory, attention and motivation as well as helping encourage deep approaches to learning. Your lecture or presentation should also aim to accommodate cultural and linguistic diversity.

Preparing the lecture or presentation

- Choose a topic if it has not been provided.
- Brainstorm content about the topic; facts, ideas, questions and link them.
- Produce a working title based on the ideas you have linked. Specify the objectives of the lecture/presentation.
- Set out a rough structure of the lecture/presentation.
- Read for specific ideas and facts.
- Set out the lecture/presentation and decide on use of audio-visual aids, activities etc. Check that the order of subtopics makes sense. Prepare a summary sheet.
- Think of a good way to open the lecture/presentation that will gain interest and provide a framework.
- Rehearse - about 35 mins in private is equivalent to 55 in the lecture/presentation.

(Adapted from Brown & Mangoue, 2001)

Using learning activities

It should not be assumed that giving a lecture or presentation for a set period of time requires you to talk for the whole time. Instigating activities during the lecture can help renew attention, generate interest, provide opportunities for learners/participants to think and allow you to gain some feedback about their understanding (Brown & Mangoue, 2001). Below are some practical ways to make your lecture or presentation more interactive. The methods chosen should be guided by the purpose of the presentation.

Tips to making lectures or presentations interactive

- Set a question or problem to be discussed in small groups.
- Show a video clip or demonstrate a task with instructions on what to look for.
- Frame questions in relation to data (or to make estimates).
- Solve a problem collectively.
- Arrange groups of two or three to briefly discuss a scenario, a research design or a set of findings.
- Come up with examples and compare with others.
- Consider advantages and disadvantages of a procedure or theory and compare them.
- To aid recall and understanding, review the key points that have been learned from the lecture/presentation.

(Adapted from Brown & Mangoue, 2001)
Delivering the lecture or presentation

Get the audiences attention

- Be ready before the session starts.
- Indicate you are ready by standing where you can be seen.
- Make eye contact as you scan the room. This helps with assessing the mood of the room.
- Use your voice to indicate you are ready to start. The volume should be the same as or slightly higher than your volume throughout the session.
- Show your interest by expressing your enthusiasm.

Vary the stimuli

- Consider opening with a question or problem to arouse the intellectual curiosity of the audience.
- Communicate the agenda for the session at the start to create a sense of direction and structure.
- A little bit of humour can do a world of good.
- Vary the pitch, volume and speed of your voice
  - Use silence to listen, to give ‘think’ time and give emphasis after a point is made.
  - Move around the room while presenting, but avoid constant movement as that can be distracting.
  - Use a short break – this will allow the level of attention to recover.
  (Adapted from Brown & Mangoue, 2001)

Make the most of media and materials

- Your participants will have different preferences for sensory modes so it is important to provide a combination of visual and auditory material to increase the likelihood of maintaining attention.

Remember

Attention levels within a lecture or presentation:
- Are at their highest within the first few minutes
- Drop off after 10-15 minutes
- Can peak again if learners’ interest is regained, but will drop off even more quickly after that
- Rise again at the end of a lecture.
(Bligh, 2000)

For more information about optimising the use of learning resources see Appendix I on page 87.

Giving a presentation at a conference

The same skills that are needed for giving a lecture or presentation are useful for presenting at a conference. However, given the difference in objectives and environment, there are some additional strategies that can maximise the effectiveness of the presentation. Submitting an abstract for a conference can also be a daunting task. For information about facilitating learning through conference presentations and writing a conference abstract see Appendix J on page 88.
Facilitating learning in workshops

A workshop can be a series or a one-off set of educational and work sessions. The key principle to delivering a workshop (as opposed to a lecture or presentation) is that it involves interaction and active participation, such as structured small-group activities. Skills required to deliver an effective workshop include facilitating discussion, advanced questioning, clinical reasoning, reflection strategies and using clinical scenarios to facilitate learning.

Before the workshop

Preparing for a workshop is similar to preparing for a lecture, and the session plan template in Appendix G (page 85) can also be used to help organise a workshop.

1. **Define the goals**: specify the learning objectives of the workshop. What knowledge and skills do you want people to leave with, and how will you measure this?
2. **Know your potential target audience**: know their learning needs, their current skills and background knowledge and experience. Find out what new knowledge and skills are needed.
3. **Choose the right location**: if you can choose your location, be mindful of size, layout and furniture available. Consider what your workshop design ideally needs. What is available will likely affect the group activities you will be able to use.
4. **Create the agenda or session plan.**
   (Adapted from Jacques, 2003)

Facilitating the workshop

- Begin with an ice-breaker to get people comfortable.
- Provide an ‘advance organiser’ at the beginning of the session, prior to presenting any material. An advanced organiser is something that enables learners to link existing ideas and concepts to what is about to be presented or discussed. An example is a concept map.
- Mix the presentation of information with opportunities to apply knowledge and skills.
- Use small group activities to help participants to think more deeply about the topic.

Small group activities

To carry out any of the group activity structures below, a clear task and topic are required, as well as movable furniture. Possible small group activity structures include:

- Rounds
- Circular interviewing
- Buzz groups, pairs, triads
- Pyramids
- Syndicates
- Fishbowls
- Brainstorms
- Crossover groups
- Horseshoe groups
- Syndicates

Descriptions and examples of small group activities can be found in Appendix K on page 90.

When conducting an educational session on clinical reasoning scenarios, I often break the larger group into small teams to work through the scenario. At the end of the session I bring the group back together to get them to discuss their outcomes. My role as a facilitator is to circulate among the groups and ensure that they are on track with their discussions, to address any problems or misunderstandings, and then facilitate large group discussion at the end. This seems to keep all participants concentrating and involved from start to finish.
Facilitating learning in an in-service

An in-service is another type of group education activity that provides an opportunity for ongoing professional development. It should:

- be determined by identified needs
- be workplace-orientated
- be of immediate use to the individual
- improve or extend job-related skills
- be focused on a specific group of individuals
- be resourced by the organisation

Purpose of an in-service

Within NSW Health, an in-service can be used to facilitate the learning of a process, a skill, the nature of someone’s role, a change in the workplace or to provide feedback from a meeting or conference. This may involve both interprofessional and interdisciplinary learning.

For example:

- A Dietitian provides an in-service on practical implications of enteral feeding in the acute setting to a specific group of Nurses and Dietitians from a specific clinical area.
- A Physiotherapist attends a conference and provides feedback to the department on what was experienced and learned by attending.

An in-service is an opportunity for someone to share expertise and knowledge in a specific clinical area or skill with others. In-services require minimal resources and can be organised in a relatively short period of time.

Giving an effective in-service

In-services mainly involve an oral presentation and small group activities. Refer to the Facilitating learning in groups (page 50) and Facilitating learning in a lecture or presentation (page 52) for strategies for facilitating learning in groups.

Tips to facilitating learning in an in-service

- Tailor the material to your target audience.
- Recognise your participants’ contribution to the unit, team, department.
- Plan in advance and keep to the time limit.
- Consider the motivation levels of your audience. Perhaps begin the session with a question to generate interest.
- The in-service should be about the learners’ needs, not the facilitator’s perceived need to deliver certain content.
- Summarise your main points or message at the end.
- Ensure that seating arrangements are adequate.
- Provide handouts for participants to share with colleagues.
Facilitating learning through a journal club

Journal clubs have been identified in the allied health professional literature as an effective method to promote engagement in evidence-based practice (International Centre for Allied Health Evidence, 2011). Information literacy skills are vital for all allied health professionals and are generally developed at undergraduate level. Information literacy skills enable participants to locate and critically appraise journal articles and other professional literature (Thompson, et al., 2009). These skills can be cultivated and maintained through participation in a journal club.

Develop information literacy skills by ensuring that participants can:

• Recognise professional literature
• Locate professional literature on the internet, or via library-based journal subscriptions or professional membership
• Recognise the type of journal articles contained within the journal
• Properly evaluate the quality and credibility of the information and evidence within the journal article.

The aims of setting up a journal club include:

• Keeping abreast of the latest technology, developments and findings to ensure that optimal practice is maintained
• Facilitating development of critical analysis skills
• Motivating participation in research and quality improvement projects.

The format of a journal club is not fixed. It can be conducted as a face-to-face discussion, through email or via online networks. Consider all options. For example, shift workers might find email or online discussion more flexible whereas non-shift workers might prefer face-to-face discussion group meetings.

Tips for setting up a Journal Club and creating learning opportunities

• As few as two participants can make a worthwhile journal club.
• Involve enthusiastic colleagues who enjoy reading and learning.
• Focus on a specific topic and look at a collection of literature from various journals and evaluate the literature on that topic.
• Choose a journal and evaluate the literature within it.
• Encourage colleagues to critically review the literature, enhancing information literacy skills.
• Identify a professional problem and locate literature to find solutions.
• Professional literature can be accessed via university and/or hospital library subscriptions, building a close relationship with your librarian can be very helpful.
Types of journal articles within the professional literature

- Original research (qualitative and quantitative)
- Review articles
- Short communications
- Research notes

Selecting articles for a Journal Club

Provide a variety of topics and types of literature to enhance participant learning. Encourage participants to contribute and suggest articles or focus topics for the group. Consider journals:

- with a high impact factor (but keep in mind that impact factor is not the only method for evaluating the quality, reliability or clinical utility of a journal)
- which are peer-reviewed
- from other disciplines such as medicine, nursing and other allied health professions.

Questions to facilitate critical evaluation of a journal article

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the main conclusions of the paper?</td>
<td>The answer generally lies within the abstract. If uncertain, start with the abstract and then read the conclusion to solidify your thoughts.</td>
</tr>
<tr>
<td>What evidence supports these conclusions?</td>
<td>The results section will have a description of the findings. It is important to make note of the results, check that they truly say what the researchers claim they do. Analyse the methodology to ensure vigour and consistency.</td>
</tr>
<tr>
<td>Does the data actually support the conclusions?</td>
<td>Understand the link between the data and the conclusions. It is a relationship that is sometimes not explained explicitly in a paper.</td>
</tr>
<tr>
<td>What is the quality of that evidence?</td>
<td>The best way to begin to understand the quality of the evidence is to initially understand how that evidence was derived. Pay attention to the method. Limitations of the methodology need to be examined: that information should be found in the discussion.</td>
</tr>
<tr>
<td>Why are the conclusions important?</td>
<td>The authors need to state clearly in several sections the impact the conclusions will have on the body of knowledge. Ensure that you agree with them, otherwise the conclusions may not be so important.</td>
</tr>
<tr>
<td>Are the conclusions clinically relevant to your profession? Are there implications for practice?</td>
<td>The answer to this question can inspire quality improvement initiatives and research projects. This question must be answered when evaluating evidence-based practice prior to implementation.</td>
</tr>
</tbody>
</table>

(Adapted from International Centre for Allied Health Evidence, 2011).

Keeping a record of journal club discussions can be useful evidence for a CPD portfolio. An example of a critical appraisal journal club review template is provided in Appendix L on page 92.
Facilitating learning using simulation

Health care clinicians commonly think about ‘simulation’ as the manikins and task trainers used to teach clinical skills. Gaba (2004, p. i2) defines simulation ‘as a technique — not a technology — to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner’. This ability to target key aspects of clinical practice and strategically recreate them in a simulated environment is what makes simulation such a powerful learning and teaching tool. Much of the experience in healthcare simulation lies within the medical, nursing, defence force and dental communities of practice. Allied health is well positioned to leverage these resources.

The benefits of simulation include:
- Repetitive practice until mastery
- Facilitation of feedback
- A controlled and safe environment for making, detecting and correcting errors
- The ability to alter task difficulty and complexity
- The ability to reproduce standardised experiences
- Active participation from the learner in their learning.

(Adapted from Hofmann, 2009; McGaghie, et al., 2010)

Planning a simulation session

Learning objectives should help determine the following:
- Simulator (manikin, part task trainer, simulated patient/actor, virtual reality)
- Environment (in situ in the clinical area, lab-based, computer)
- Teaching resources (props, medical records, scenario script, teaching and technical faculty).

Prepare your learners:
- Briefing: rules of engagement, equipment familiarity, learning objectives
- Simulation: length, expectations, use of video recording
- Debriefing: when, where and how this will occur.

Debriefing and feedback

Debriefing is the ‘purposeful, structured period of reflection, discussion and feedback’ following a simulation exercise and is an essential element of simulation-based learning (Flanagan, 2008, p. 155). Ideally debriefing should occur immediately or as close as possible to the completion of the simulation. Debriefing theory draws from experiential learning and reflective practice, with the goal being to explore the learning objectives, reflect upon actions taken or not taken, and their consequences and translate this to clinical practice in the real world.

Phases of debriefing:
1. Decompress: Release feelings and tension – ‘How did that feel?’
2. Describe: Get the facts of the case so everyone is on the same page – ‘Can you just run through the case please?’
4. Generalise: Summarise learning and how it can be extrapolated to clinical practice.

Visit the simulation facility in your Local Health District and talk to the experts, view the resources at the HWA website (www.hwa.gov.au), keep up to date with simulation at HETI (www.heti.nsw.gov.au), or join an online simulation community.
Facilitating learning through electronic media

Utilising electronic resources is an effective way to provide education and learning opportunities to a large number of participants. A number of electronic resources support the facilitation of learning.

**Tele/Video-conferencing**

Teleconferencing is a useful resource to connect people across large distances. There are many ways to connect via tele- (using telephones) or video- (using web-cams) conference; some Local Health Districts can provide access to tele/video-conferencing facilities.

**Webinar**

A webinar or web conference is another useful way to utilise the internet and connect with large or small groups that are geographically dispersed. Essentially a webinar is a seminar over the internet. Through the use of a webcam and specialised software (either downloaded or web-based), participants can be involved in the webinar and ask questions of the facilitator, be interactive with each other and have a very purposeful learning experience.

**The internet and websites**

When facilitating web-based learning it is important that learners evaluate the reliability of information that is found on the internet. Information literacy is an essential skill required to ensure that only accurate and reputable sources found online are relied upon for information (Thompson, et al., 2009). For example, caution is to be exercised when locating information on a ‘Wiki’ site, as this information is constantly changing, can be modified and therefore reliability of content varies.

**E-learning resources**

Numerous web-based e-learning resources are available; examples include Moodle and WebCT. E-learning software can provide an environment where deep learning can occur (O’Neill & Luck, 2006). This type of software allows participants to access the resource via intranet or internet. An example of the use of an e-learning tool is the ability to have threaded discussions, which are searchable and linked to a homepage. The facilitator can manage these discussions like a database of comments and interactions, to foster collaborative learning (Merryfield, 2000).

**Challenges associated with facilitating learning electronically**

Facilitating learning electronically requires additional skills to those used when facilitating learning in face-to-face environments. When utilising electronic media the facilitator acts as moderator and must ensure that each learner feels listened to, connected, and has equal opportunity to participate in collaborative discussion (Johnson & Brescia, 2006). The facilitator must also ensure that discussions remain on topic, are clear, and are not misinterpreted. The facilitator should have an understanding of the technological skill level of each participant. Furthermore, access to computer infrastructure and awareness of firewall restrictions are crucial to the success of facilitating learning electronically.

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For workers in the rural and remote context, distance learning and the use of technology can reduce professional isolation (Curran, et al., 2010) and assist with the development of networks for similarly isolated clinicians (Newman, et al., 2009). These media also offer flexible, convenient and interactive forms of CPD for busy clinicians who might have difficulty attending formal education sessions (Curran, et al., 2010). To access and take advantage of these existing and emerging technological opportunities, allied health professionals need to be techno savvy.
Facilitating learning interprofessionally

Interprofessional Education (IPE) involves two or more professions learning with, from and about each other to improve collaboration and the quality of care (CAIPE, 2002). The aim of IPE is to foster the development of Interprofessional Collaborative Practice (ICP) which is a patient-centred process of communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence patient/client care (Way, et al., 2000).

IPE activities can involve students, clinicians or both, pooling disciplinary knowledge to address complex real world problems. IPE activities can:

- Enhance the learners understanding of other professionals roles and responsibilities
- Foster mutual respect
- Promote teamwork and collaboration.

Learning activities should be designed to capitalise on learners’ experiences and be directly relevant to the context in which they are practising (e.g. community or hospital setting), with the end result being to improve patient-centred care. An IPE learning example can be found on the following page (page 61).

According to Nisbet and Thistlethwaite (2007) effective IPE facilitators:

- Have knowledge and competence in working within an interprofessional team environment
- Role model teamwork and collaboration
- Are available to and value learners
- Provide feedback.

Some challenges of using IPE to facilitate learning include:

- Difficulty getting people together from different geographical areas
- Time/schedule clashes
- Overcoming the silo/tribe mindset
- Obtaining buy-in from management/supportive workplaces.

Interprofessional education underpins interprofessional learning, which supports quality interprofessional practice.

Working collaboratively with other professionals enables me to understand their professional point of view and communicate my professional point of view. With respectful inter-professional understanding we put the patient’s care in focus.
Example: IPE Scenario

This IPE clinical scenario example aims to enhance understanding of other professionals’ roles and responsibilities and to promote insights into the value of teamwork and collaboration.

Scenario Activity

Harry Smith, a 79 year old married man diagnosed with stage 3 mesothelioma is about to be discharged from hospital and admitted to a hospice for palliative care. Mr Smith was exposed to asbestos over 25 years ago while working in the construction business. Until his admission to the hospital, he has managed to live fairly independently at home with the assistance of his wife and a community nursing team. Mr Smith is concerned that the hospital won’t pass on the results of his latest diagnostic tests. He is also concerned that his doctor for the past 10 years may no longer have the time to provide him with follow-up treatment of his ongoing symptoms. Mr Smith is demanding to know who is in charge of his care and transfer to the hospice.

For multi-professional learners, ask them to do the following:

1. First, develop your preliminary care plan for Mr Smith that will aim to ease his transition to hospice care. Do this from an individual profession’s perspective.
2. In multi-professional small groups, share your care plans with each other.
3. Now develop another care plan based on your shared perspectives.

Reflective questions

1. In what ways do the individual care plans differ from the collaboratively produced ones?
2. While developing the collaborative care plan, what types of things have you learned about the roles and responsibilities of others involved in Mr Smith’s care?
3. What differences in care and communication might Mr Smith and his family notice between the individually produced care plans and the collaboratively developed one?
4. What have you learned from this activity?

Exchange opportunities between rural and urban clinicians are another way of actively learning from peers. Work shadowing allows the rural clinician to access specialist knowledge and resources, to observe practical applications of skills and also to extend professional networks. Work shadowing is an effective use of the rural clinician’s time because the learning is targeted and intensive. The practical nature of work shadowing secondments ensures that relevant work skills are applied rapidly to the workplace and consolidated by the clinician.
Facilitating learning through communities of practice

Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Lave & Wenger, 1991). Here, learning is a process of engagement with work colleagues, professional associations and networks by collectively managing knowledge, constructing meaning, sharing practices and interpreting this within work environments (Lave & Wenger, 1991; Davis, 2006).

‘There is a diverse range of people that we learn from at work, very few of whom are recognised by the employing organisation as people with a role in promoting learning, that is people designated as supervisors or trainers’ (Boud & Middleton, 2003). In communities of practice people can be engaged in a process of collective learning on a topic of shared concern.

Communities of practice are a useful model for development of the allied health workforce because they enable collective responsibility to be taken for managing knowledge sharing and attainment. Communities of practice can cross professional, organisational and geographic boundaries. They can exist in an online environment, remotely or face-to-face within local workplaces.

Communities of practice form naturally where people have a strong interest in improving particular areas of practice and where they can learn from one another about how to manage situations and issues cannot necessarily be learned in the training room or from a text book. This is often referred to as acquisition of tacit knowledge – the ‘how’ to do something rather than just the ‘what’ to do (Duguid, 2005). The result is that individuals are better equipped to thrive in organisational situations, deal with complex challenges, and manage and negotiate relationships within the workplace.

Communities of practice may be large or small and based at a local or broader community level. Opportunities to engage in communities of practice can be found in these examples:

**Local level**
- Sharing information with colleagues
- Workplace committees
- Working groups
- Book and journal clubs
- Ward/service-based projects
- Collaborative quality improvement activities

**Broader community level**
- List serves/mailing lists/online networks
- State/national committees
- International networks
- Secondment placements/work shadowing
- Sharing information across networks
- Interagency collaboration
- Special interest groups

Professional isolation is common in the rural and remote practice setting; it is up to the clinician to create networking opportunities. To maximise opportunities for creating professional learning networks and personal support networks, rural and remote allied health professionals should seek contact with others in the area, volunteer for working groups or join list serves.
Reflective questions

Here are some reflective questions to get you thinking about how you might apply some of this information in your workplace.

- Where in your workplace do you currently facilitate learning and with whom?
- What are some of the challenges in your workplace that hinder your ability to set up an optimal learning environment?
- How can you overcome these challenges?
- List the settings in which you would like to facilitate learning. What resources and/or support do you need to achieve this?
- Are there any opportunities in your department to start a journal club, provide an in-service or present at a conference?
Part 5

Evaluation of workplace learning

How do I evaluate what I have done?
Introduction: Why is evaluation of learning important?

Facilitators of learning need to determine if the methods and processes they use are achieving the objectives of the learner and optimising patient/client services. Evaluation can be conducted via various methods and usually involves gathering information and feedback from learners, analysing processes and outcomes and identifying opportunities for future improvement.

Evaluation is also a critical component of clinical supervision, as outlined in The Superguide: A handbook for supervising allied health professionals.

This section explores:
- The purpose of evaluation
- Evaluation of informal learning
- Evaluation of workshops, seminars or in-services
- Key points to remember when conducting an evaluation

‘Evaluation is an essential part of any workplace learning activity and should be seen as a continuous cycle of reflection and improvement’ (Morrison, 2003)
Purpose of evaluation

Evaluate the effectiveness of learning in the individual to...
- ensure learning needs/objectives are met
- identify further gaps in knowledge, skill or attitude
- direct allocation of resources, energy and focus of learning, education or CPD opportunities.

Evaluate the performance of the facilitator to...
- reflect on performance as a facilitator of learning
- provide feedback to facilitators.

Evaluate impact on the system to...
- monitor the impact of improvements in the health/wellbeing of patients/clients
- improve and inform the development of learning program design
- influence strategic direction and development of education and training in the organisation, unit or team (Morrison, 2003).

Evaluating informal learning

A common approach to evaluation of informal learning is dialogical evaluation (Jeffs & Smith, 2005). This approach places responsibility for the evaluation on the facilitator and the learner. It usually does not use formal tools. Instead, it develops through conversation. As such, this form of evaluation is incorporated directly into the learning process and its purpose is to enrich practice by encouraging people to discuss and describe experiences, explore meanings, confront issues, and reconstruct practice (Jeffs & Smith, 2005). By using guided questioning, the facilitators can develop learners’ skills to evaluate their own experiences and can also obtain feedback about how they are performing as a facilitator. Dialogical evaluation can also be incorporated as part of clinical supervision. For more information on supervision see The Superguide: A handbook for supervising allied health professionals.

Challenges to evaluating informal learning

In a healthcare climate with a focus on outcomes and evidence-based clinical intervention, evaluating informal or one-to-one learning can pose some problems for facilitators.
- The indirect impact of informal facilitation of learning can be difficult to breakdown into measurable steps. It often occurs opportunistically, either as a one-off interaction which has left a lasting impression on the learner or over a long period of time when progress has been gradual and almost invisible to the learner and facilitator. It is particularly hard to identify changes in values, and the way that people come to appreciate themselves and others — especially while it is happening (Jeffs & Smith, 2005).
- Change is difficult to monitor. Baseline and post-intervention evaluations are rarely undertaken, given the fluid and interpersonal nature of the relationship between learner and facilitator. Progress can best be monitored by self-reporting progress or facilitation of dialogical evaluation.
Process evaluation of informal learning

Process evaluation addresses factors that impact on learning. These include the physical environment, education and facilitation methods, and logistical arrangements (Morrison, 2003).

Tips for evaluating informal learning processes

<table>
<thead>
<tr>
<th>Physical environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Did the workplace environment facilitate or hinder your learning?</td>
</tr>
<tr>
<td>• What are the pros and cons of learning in this environment?</td>
</tr>
<tr>
<td>• Do you have any suggestions for improvement?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education methods and facilitator performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can you share your thoughts about the way I showed you how to…?</td>
</tr>
<tr>
<td>• Was I clear in my instruction/explanation/demonstration?</td>
</tr>
<tr>
<td>• Did I provide you with adequate time to reflect?</td>
</tr>
<tr>
<td>• Did I provide you with adequate opportunity to practice?</td>
</tr>
<tr>
<td>• Was the discussion we had about… useful? In what way?</td>
</tr>
<tr>
<td>• Was the feedback provided helpful?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the time/session length/frequency suitable?</td>
</tr>
<tr>
<td>• Would you like anything to change?</td>
</tr>
</tbody>
</table>

Outcome evaluation of informal learning

Outcome evaluation focuses on an individual's change in knowledge, skills, attitudes and behaviour (Morrison, 2003).

Tips for outcome evaluation

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Questions to facilitate discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: learners reaction</td>
<td>Outcomes relate to participants views and satisfaction with their learning experience.</td>
<td>It has been (X time) since we started working together on… Can you tell me what this experience has been like for you? (can also connect back to process questions above)</td>
</tr>
<tr>
<td>Level 2a: acquisition of knowledge/skill</td>
<td>Outcomes relate to attainment of concepts, procedures or mastery of a skill.</td>
<td>Has your practice and/or understanding changed? In what way? What do you do differently now compared to before?</td>
</tr>
<tr>
<td>Level 2b: acquisition of attitudes</td>
<td>Outcomes relate to change in attitude toward patients/clients and their condition, circumstances, care or treatment.</td>
<td></td>
</tr>
<tr>
<td>Level 3: changes in behaviour</td>
<td>Observed transference, application and integration of learning to the workplace.</td>
<td>Have you observed any changes or improvements yourself?</td>
</tr>
<tr>
<td>Level 4: changes in organisational practice</td>
<td>Wider changes in the organisation or observable improvements in the health/wellbeing of patients/clients.</td>
<td>What has been the impact on your treatment approach or practice with your patients/clients? Have you had any feedback from colleagues, patients/clients, etc.?</td>
</tr>
</tbody>
</table>

(Adapted from Barr, et al., 2000, p. 10).
Evaluating workshops, seminars, in-services

There are many different ways to evaluate workshops, seminars, in-services or online learning modules. Qualitative and quantitative approaches are commonly used and generally, the more resources (time, money, energy) that have been devoted to the education activity, the more this should be reflected in the evaluation approach. For example, a one-off in-service given to a group of clinicians may only need a simple evaluation survey or a quick feedback session, to determine if the content has been useful and has met the session learning objectives. On the other hand, a formally designed and funded online learning module would require a formal evaluation strategy.

Here is a sample of methods to evaluate education activities:

<table>
<thead>
<tr>
<th>Method</th>
<th>Purpose</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaires</td>
<td>Simple non-threatening way to gather information</td>
<td>Anonymous, inexpensive, can compare and contrast data</td>
<td>Impersonal, required to compare and contrast data, bias toward questions needs to be mitigated</td>
</tr>
<tr>
<td>and surveys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td>To fully understand the learners’ experience or further explore answers to a questionnaire</td>
<td>Flexible, can obtain a range and depth of information</td>
<td>Time consuming, can be hard to analyse and compare, bias toward responses needs to be mitigated</td>
</tr>
<tr>
<td>Focus groups</td>
<td>In-depth exploration of topics</td>
<td>Common impressions, range of perspectives</td>
<td>Hard to analyse and compare, reliant on a good facilitator, logistical challenges</td>
</tr>
<tr>
<td>Observations</td>
<td>To gather operational information, to find out more about a process</td>
<td>Can get an impression of a process as it is occurring</td>
<td>Difficult to interpret/categorise observations, logistic challenges</td>
</tr>
</tbody>
</table>

(Adapted from Authenticity Consulting LLC, n.d.)

Self-Evaluation

Self-evaluation and critical reflection are vital processes to engage in after providing a presentation, workshop or in-service (Exley & Dennick, 2009). As well as having learners and observers provide feedback, facilitators can keep a log book, diary or portfolio in which they record their reflections on what went right or wrong, what was learned from the situation, and ideas on what to do differently next time.
Observer evaluation

It can be helpful to ask a colleague to be an observer of your educational session to help evaluate your facilitator performance and content against a set of agreed standards.

The following could be used by an observer to assist with evaluation:

<table>
<thead>
<tr>
<th>Mood</th>
<th>Does the facilitator display a professional and appropriate attitude towards learners?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does the facilitator introduce him or herself?</td>
</tr>
<tr>
<td>Context</td>
<td>Is the topic introduced in a stimulating way?</td>
</tr>
<tr>
<td></td>
<td>Is prior learning activated?</td>
</tr>
<tr>
<td></td>
<td>Are connections made to previous sessions or knowledge?</td>
</tr>
<tr>
<td></td>
<td>Are the importance and relevance of the topic stressed?</td>
</tr>
<tr>
<td></td>
<td>Are the learners’ motivated to learn?</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Are learning outcomes stated?</td>
</tr>
<tr>
<td></td>
<td>Are they relevant and appropriate to the overall educational aims and expertise of the learners?</td>
</tr>
<tr>
<td></td>
<td>Are they achievable in the time available?</td>
</tr>
<tr>
<td></td>
<td>Do they show a cognitive range?</td>
</tr>
<tr>
<td>Content</td>
<td>Is there an appropriate amount of information presented in the time available?</td>
</tr>
<tr>
<td></td>
<td>Is the information structured effectively?</td>
</tr>
<tr>
<td></td>
<td>Does the facilitator help learners navigate through the content?</td>
</tr>
<tr>
<td></td>
<td>Are the explanations clear and do they use examples, images and analogies?</td>
</tr>
<tr>
<td>Presentation Skills</td>
<td>Is the facilitator articulate, enthusiastic?</td>
</tr>
<tr>
<td></td>
<td>Does the facilitator use a clear and well-modulated voice?</td>
</tr>
<tr>
<td></td>
<td>If a whiteboard, overhead projector or PowerPoint is used, are slides/pages well organised and is the writing or font size adequate?</td>
</tr>
<tr>
<td></td>
<td>Are other audio-visual aids incorporated into the presentation?</td>
</tr>
<tr>
<td></td>
<td>Are handouts clearly written and designed?</td>
</tr>
<tr>
<td></td>
<td>If interactivity is used, is it well managed and are learners adequately primed and encouraged to participate?</td>
</tr>
<tr>
<td>Closure</td>
<td>Does the facilitator emphasise the conclusions and summarise key points?</td>
</tr>
<tr>
<td></td>
<td>Does the facilitator give the learners a sense of accomplishment?</td>
</tr>
</tbody>
</table>

(Adapted from Exley & Dennick, 2009)
Key points to remember when conducting an evaluation

<table>
<thead>
<tr>
<th>Evaluation should...</th>
<th>• be a positive experience that adds value to the whole educational process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of an evaluation should...</td>
<td>• be clearly articulated and linked to learning objectives and outcomes</td>
</tr>
</tbody>
</table>
| When conducting an evaluation... | • aim to obtain information from more than one source  
• use results to inform improvement  
• make sure information is presented clearly and is easy to follow |
| Learners should... | • be involved in developing an evaluation  
• feel their time is valued and opinions acted on |
| Evaluators should... | • engage in a cycle of continuous improvement (see diagram below) |

**Evaluation cycle of continuous improvement**

Like quality improvement, evaluation of learning is a continuous cycle where ongoing review and reflection, followed by a change in practice, enhance learning processes and outcomes.

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Part 6

Appendices

Now I am on my way to becoming an effective facilitator in my workplace!
Appendices

These appendices are a selection of helpful resources and examples that can be adapted to the facilitator’s settings and needs. It is not a comprehensive selection but provides a basis for further exploration.

Appendix A: Blooms Taxonomy
Appendix B: Useful web links
Appendix C: Tools to Evaluate Evidence
Appendix D: Giving and receiving feedback quiz
Appendix E: Clinical scenario worked example
Appendix F: Skills for effective facilitation of learning in large groups
Appendix G: Session/workshop/lecture plan template
Appendix H: Workshop plan worked example
Appendix I: Optimising use of learning resources in lectures or presentations
Appendix J: Strategies for delivering an effective conference presentation
Appendix K: Small group activities
Appendix L: Critical appraisal journal review template
### Appendix A: Bloom’s Taxonomy

<table>
<thead>
<tr>
<th>Cognitive levels of thinking</th>
<th>Useful verbs to use when setting learning objectives</th>
<th>Sample questions that promote thinking at these levels</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remembering</strong></td>
<td>tell, list, describe, relate, locate, write, find, state, name</td>
<td>What happened after…? How many…? Who was it that…? Can you name the…? Describe what happened at…? Who spoke to…? Can you tell why…? Find the meaning of…? What is…? Which is true or false…?</td>
</tr>
<tr>
<td><strong>Understanding</strong></td>
<td>explain, interpret, outline, discuss, distinguish, restate, translate, compare, describe</td>
<td>Can you write in your own words…? Can you write a brief outline…? What do you think could have happened next…? Who do you think…? What was the main idea…? Who was the key person…? What differences exist between…? Can you provide an example of what you mean…? Can you provide a definition for…?</td>
</tr>
<tr>
<td><strong>Applying</strong></td>
<td>solve, show, use, illustrate, construct, complete, examine, classify</td>
<td>Do you know another instance where…? Could this have happened in…? Can you group by characteristics such as…? What factors would you change if…? Can you apply the method used to some experience of your own…? What questions would you ask of…? From the information given, can you develop a set of instructions about…? Would this information be useful if you had a …?</td>
</tr>
</tbody>
</table>
## Appendix A: Bloom’s Taxonomy (continued)

<table>
<thead>
<tr>
<th>Cognitive levels of thinking</th>
<th>Useful verbs to use when setting learning objectives</th>
<th>Sample questions that promote thinking at these levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysing</td>
<td>analyse, distinguish, examine, compare, contrast, investigate, categorise, identify, explain, separate, advertise</td>
<td>Which events could have happened…? If … happened, what might the outcome have been? How was this similar to…? What was the underlying theme of…? What do you see as other possible outcomes? Why did … changes occur? Can you compare your … with that presented in…? Can you explain what must have happened when…? How is … similar to…? What are some of the problems of…? Can you distinguish between…? What were some of the reasons behind…? What was the turning point in the case? What was the problem with…?</td>
</tr>
<tr>
<td>Evaluating</td>
<td>judge, select, choose, decide, justify, debate, verify, argue, recommend, assess, discuss, rate, prioritise, determine</td>
<td>Is there a better solution to…? Judge the value of… Can you defend your position about…? Do you think … is a good or a bad thing? How would you have handled…? What changes to … would you recommend? Do you believe? Are you a … person? How would you feel if…? How effective are…? What do you think about…?</td>
</tr>
<tr>
<td>Creating</td>
<td>create, invent, compose, predict, plan, construct, design, imagine, propose, devise, formulate</td>
<td>Can you design a …to…? Can you see a possible solution to…? If you had access to all resources how would you deal with…? Why don’t you devise your own way to deal with…? What would happen if…? How many ways can you…? Can you write a new plan for…? Can you develop a proposal which would…?</td>
</tr>
</tbody>
</table>

(Adapted from Dalton & Smith, 1986)
Appendix B: Useful web links

This selection of websites may be of interest to allied health professionals. It is collated from a diverse range of allied health stakeholders. The list is of course not comprehensive: new websites will continue to emerge.


AIPPEN: Australasian Interprofessional Practice and Education Network: A network of individuals, groups, institutions and organisations committed to researching, delivering, promoting and supporting interprofessional learning, through interprofessional education and practice, across Australia and New Zealand. [http://www.aippen.net/](http://www.aippen.net/)


ANZCTR: Australian and New Zealand Clinical Trials Register: Register of all clinical trials conducted in Australia and New Zealand. It is a requirement to register on this site if conducting a research project and most journals require the registration number to publish. Users can search for information regarding completed or ongoing clinical trials in any clinical field. [http://www.anzctr.org.au/](http://www.anzctr.org.au/)

Amedeo: Site for health care professionals seeking access to timely and relevant information within their fields. The site includes a multidisciplinary journal club. [http://www.amedeo.com/about.php](http://www.amedeo.com/about.php)

ARCHI: Australian Resource Centre for Health Care Innovations: A national site with resources such as clinical trials and quality improvement projects covering all aspects of quality health care. The site also includes discussion groups and newsletters. [http://www.archi.net.au/home](http://www.archi.net.au/home)

Austpar: Site for professionals working with amputees. Provides resources, guidelines, education and peer support for clinicians. [http://www.austpar.com/index.html](http://www.austpar.com/index.html)


CIAP: Clinical Information Access Programme: Free access to all employees of NSW health, both at work and at home. Has access to multiple search engines and full text articles on evidence-based practice in all health areas. Accessed through Health intranet.


Health Change Australia: An organisation working in the area of health behaviour change for chronic disease prevention and self-management support. Offers professional development training and consultancy in health coaching to improve and motivate patients’ ability to change behaviour in regard to self-management. http://www.healthchangeaustralia.com/


Noigroup: A research and therapy based group that specialise in pain and management of pain. Website contains resources and links to research along with courses. Users can sign up for monthly newsletters containing education and information regarding latest developments in pain theory. http://www.noigroup.com

NPS: Website with access to various publications relating to prescription of medicines along with educational and quality improvement activities, case studies and evidence-based information on drug and therapeutic topics. http://www.nps.org.au/

Neuroscience Research Australia: Not-for-profit research institute with a focus on brain and nervous system research. Its stated goal is to prevent, treat and cure brain and nervous system diseases, disorders and injuries through medical research. Website contains information on current projects along with background behind the numerous medical conditions which the research group is investigating. http://www.neura.edu.au/


Orthosports: NSW-based orthopaedic group. Website contains post-surgery protocols, information sheets, videos and animations of surgery. Users can register to receive question of the month where users can submit a question regarding a general orthopaedic issue / topic and one of the orthopaedic specialists answers as a monthly email post. http://www.orthosports.com.au

OT CATS: Data base of critically appraised topics (CAT) and critically appraised papers (CAP) specific to Occupational Therapy practice. A CAT is a short summary of evidence on a topic of interest, usually focused around a clinical question and involving several papers. A CAP is an appraisal of one article. http://www.otcats.com/intro.html

OT Seeker: Database containing abstracts of systematic reviews and randomised controlled trials relevant to Occupational Therapy. Trials have been critically appraised and rated to assist in the evaluation of validity and interpretability. http://www.otseeker.com/

PEDRO: Physiotherapy Evidence Database: Database of randomised trials, systematic reviews and clinical practice guidelines in Physiotherapy. Trials are independently assessed for quality to assist readers to determine the validity and clinical relevance of the paper. Also contains tutorials on how to determine if trials are clinically relevant or valid. http://www.pedro.org.au/
**Pennutrition:** A dynamic knowledge translation subscription service. Its search tools and ‘Knowledge Pathway’ format and deliver evidence-based guidance to nutrition practice questions. [www.pennutrition.com](http://www.pennutrition.com)

**PREZI:** Web-based presentation software available for developing highly interactive and animated presentations. Users can add text, images, videos and other presentation media into the presentation for ease of transition during presentations. [http://prezi.com/](http://prezi.com/)

**Psycbite:** Database of studies of cognitive, behavioural and other treatments for psychological problems and issues occurring as a consequence of acquired brain impairment (ABI). Studies are rated for their methodological quality and rigour. [http://www.psycbite.com/](http://www.psycbite.com/)

**Psychinfo:** Database with peer-reviewed literature in psychological, social, behavioural and health sciences with access to journal articles, books, chapters and dissertations. [http://www.apa.org/pubs/databases/psycinfo/index.aspx](http://www.apa.org/pubs/databases/psycinfo/index.aspx)

**Researchreview.co.nz:** New Zealand based site containing access to current literature and practice updates on various medical and health topics. Users can register for specific groups such as breast cancer to receive updates containing latest published articles. [http://www.researchreview.co.nz](http://www.researchreview.co.nz)

**SARRAH:** Services for Australian Rural and Remote Allied Health: Provides networking, resources, access to information along with journals and conferences specific to rural practice. [http://www.sarrah.org.au/site/index.cfm](http://www.sarrah.org.au/site/index.cfm)

**SpeechBITE:** Database that provides open access to a catalogue of best interventions and treatment efficacy across the scope of Speech Pathology practice. [http://www.speechbite.com/](http://www.speechbite.com/)

Appendix C: Tools to Evaluate Evidence

When evaluating evidence presented in professional literature and how it applies to practice, it can be helpful to keep the following pyramid in mind.

Evidence-based pyramid

**Encouraging evidence-based practice and research**

This task could be given to any colleague with intent to improve information literacy skills, encourage critical review of relevant professional literature, enhance independent problem solving, aid in the development of an in-service or promote evidence-based practice through an associated quality improvement projects.

<table>
<thead>
<tr>
<th>Step 1:</th>
<th>Develop a question to research related to your clinical practice; perhaps an area you think requires improvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2:</td>
<td>List two sources of information and try to answer your question from Step 1. Justify your choice of sources.</td>
</tr>
<tr>
<td>Step 3:</td>
<td>Discuss your question and sources of information with a colleague. What other sources of information could there be?</td>
</tr>
</tbody>
</table>
| Step 4: | Perform an evidence search using CIAP or other journal database. Review the current literature related to your question. Save the search and set up an alert to receive relevant journal articles regularly. Answer the following questions:  
  - Are the findings clinically relevant to your area of practice?  
  - Is the article of a high quality? (e.g. use of PEDRO score)  
  - How could you utilise these results in your clinical practice?  
  - Would others in your area of specialty have the same opinion?  
  - If you are the only person to identify this area requiring improvement, why is that so?  
  - Does the evidence found in your literature review suggest an improvement to the practice you are investigating?  
  - Could you implement the evidence found in your literature review in the context of your service and resources?  
  - If you implemented a new practice based on the evidence found in your literature review, could you measure it, would others support it? |
| Step 5: | Discuss with managers the feasibility of implementing the findings of the research in the form of a quality improvement project. |

(Adapted from: Penz & Bassendowski, 2006)
Appendix D: The giving and receiving feedback quiz

Giving Feedback Quiz
For each statement, check ‘rarely’, ‘sometimes’, or ‘often’ to indicate how consistently you use the described behaviour in the workplace.

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I pick an appropriate time and place to give feedback.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I keep my emotions in check remaining calm and keeping my voice even.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I provide specific, detailed information about a person's behaviour or performance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I explain the impact the actions are having on the team or organisation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I really listen to the response of those receiving my feedback.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I clarify my expectations if there is any confusion about the behaviour in question.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I remember to thank and encourage the receivers of my feedback.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I provide input as needed in developing an action plan for meeting behavioural or performance goals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I focus on the steps of the feedback process to keep the dialogue on track.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I try to understand feedback from the other person's point of view and preferred communication style.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I provide feedback that is fact-based.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Feedback I provide has a positive intent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I end a feedback session with an action plan to move forward.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from: Hockfield, 2003; Wemyss, 2011)
**Receiving feedback quiz**

For each statement, check ‘rarely’, ‘sometimes’, or ‘often’ to indicate how consistently you use the described behaviour in the workplace.

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I truly listen to what feedback givers are saying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I keep feedback in perspective and don’t overreact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I try to learn from all feedback, even if it is poorly given.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I am willing to admit to and learn from questions about my performance or behaviour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Rather than avoiding feedback I attempt to turn every feedback session into a useful encounter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I accept redirection and reinforcement rather than denying them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I accept responsibility for my role in achieving individual, team, and organisational goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I accept responsibility for searching for solutions to performance and behavioural problems that threaten goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I accept responsibility for keeping my emotions in check during feedback discussions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I am committed to listening and learning in all feedback situations.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Adapted from: Hockfield, 2003; Wemyss, 2011)

**Scoring chart**

<table>
<thead>
<tr>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is room for improvement. Gaining insight into your skills is the first step in improving.</td>
<td>You are on your way to demonstrating good feedback behaviours – keep practising!</td>
<td>Excellent work – but there is always room for improvement!</td>
</tr>
</tbody>
</table>
Appendix E: Clinical scenario Dietetics worked example

You have been referred to see Mr NC, a 77yo male who recently commenced peritoneal dialysis due to ESRF.

**Premorbid history:** CRF, HTN, Asthma, Depression, THR 2002

**Medications:** Irbesartan, Mirtazapine, Temazepam, Seretide, Lasix

**Anthropometry:**

- **Weight:** 76.5kg today, 75.3kg yesterday (dry weight)
- **Weight History:** 80kg 6 months ago
- **Height:** 178cm (reported)

**Physical Ax:** mild upper and lower body muscle and fat depletion evident.

**Biochemistry:** (most recent) Na 133, K 4.5, Ur 17, Cr 500, Alb 29, Mg 0.8, Phos 2.9, Hb 104, GFR 8

**Clinical:** Mr NC complains of ongoing poor appetite with occasional nausea and vomiting prior to admission. He also notes decreased energy levels and taste changes.

**Dietary** Mr NC reports taking less orally (reduced portion sizes) than usual in the past few months. Home diet is as follows:

- **B**) 3 x Weetbix or rolled oats (1 sachet) with 100ml milk
- MT) 1 x toast with Nutella/peanut butter
- L) 1 x eggs and 1 x sausage with 1-2 x bread + 1 fruit (apple or pear)
- AT) Cheese and Jatz
- D) Meat/chicken/fish (60g), steamed mixed vegetables + 2 small roasted potatoes + 1 cup tinned fruit salad and 2 scoops vanilla ice-cream
- SU) 2 x Chocolate biscuits and tea

Add salt to meals, drinks water and orange juice, reports an aversion to meat.

**Questions:**

1. What other information would you need to collect to complete your assessment?
2. Which weight would you use to calculate the patient's estimated nutritional requirements and why?
3. Calculate Mr NC's nutritional requirements.
4. Explain your overall assessment.
5. What other information would you request from the medical team, if any?
6. Explain what dietary advice you would give Mr NC (general topics).
7. Calculate the amount of high biological value (HBV) protein that Mr NC requires (assume 12 CHO portions).

8. What advice would you give regarding PO4 restriction?

9. Would you discuss potassium restriction (yes/no) and explain your reasoning?

Some months later Mr NC is readmitted with peritonitis (now resolving), but due to complications he must now have haemodialysis temporarily. Prior to his admission he reported improved appetite and oral intake and his weight has been stable at 75kg. A diet history reveals he has been adding more fat and sugar into his diet and his portion sizes (especially protein) have improved. His recent blood tests reveal a potassium level of 5.6

10. Would you revise his estimated nutritional requirements and explain your reasoning? If so, what are they?

11. Explain the education you would provide to Mr NC prior to discharge.

12. Identify the high potassium foods that Mr NC is consuming. What are some suitable alternatives?
# Appendix F: Skills for effective facilitation of learning in large groups

<table>
<thead>
<tr>
<th>Skill</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation</td>
<td>Takes into account current knowledge of learners.</td>
</tr>
<tr>
<td></td>
<td>Specifies purposes or outcomes and provides structure and sequence.</td>
</tr>
<tr>
<td>Openings</td>
<td>Gains attention, establishes rapport and provides framework of lecture or presentation.</td>
</tr>
<tr>
<td>Explaining</td>
<td>The key skill. Creates understanding, clarity, generates interest and persuasion. Embraces many skills of presenting such as preparation, openings, use of audio-visual aids/IT, summarising.</td>
</tr>
<tr>
<td>Presenting information</td>
<td>Is concerned with essential coverage of facts or theories.</td>
</tr>
<tr>
<td>Narrating</td>
<td>Tells the story of a patient/client, scenario, or experience that captures the imagination of the learners and deepens their understanding.</td>
</tr>
<tr>
<td>Comparing and contrasting</td>
<td>Requires a clear outline of what is to be compared and contrasted and careful framing of the comparisons. 2x2 matrices are useful for paired comparisons.</td>
</tr>
<tr>
<td>Design and use of audiovisual aids</td>
<td>Provides visual diversity to help maintain attention. If overdone, distracts learners from key messages.</td>
</tr>
<tr>
<td>Responsiveness to audience</td>
<td>Includes monitoring audience, reading reactions of audience and responding accordingly.</td>
</tr>
<tr>
<td>Varying participant activity</td>
<td>Aims to improve learning and heighten interest if the changes in activity are relevant.</td>
</tr>
<tr>
<td>Summarising</td>
<td>Used during presentation as well as at the end. Emphasise the key points, shows the links within the presentation topic and between the topic and cognate topics.</td>
</tr>
</tbody>
</table>

(Adapted from Brown & Mangoue, 2001)
Appendix G: Session/workshop/lecture plan – template

Administrative Details

<table>
<thead>
<tr>
<th>SESSION TITLE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME:</td>
</tr>
<tr>
<td>LEARNING HARDWARE:</td>
</tr>
<tr>
<td>ROOM CONFIGURATION:</td>
</tr>
<tr>
<td>EQUIPMENT REQUIRED:</td>
</tr>
<tr>
<td>TECHNICAL REQUIREMENTS:</td>
</tr>
<tr>
<td>PRE-SESSION PREPARATION:</td>
</tr>
</tbody>
</table>

Specific Learning Objectives

Session Plan

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Content</th>
<th>Teaching/ Learning Process</th>
<th>Learning Resources</th>
<th>Assessment of Learning Objectives</th>
</tr>
</thead>
</table>
## Appendix H: Workshop plan – worked example

### Administrative Details

<table>
<thead>
<tr>
<th>SESSION TITLE:</th>
<th>Improving skills in managing patients with asthma and COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME:</td>
<td>2-3 pm</td>
</tr>
<tr>
<td>LEARNING HARDWARE:</td>
<td>Placebo inhalers – metered dose inhaler (MDI), turbuhaler, spinhaler, accuhaler, spacer</td>
</tr>
<tr>
<td>ROOM CONFIGURATION:</td>
<td>NIL</td>
</tr>
<tr>
<td>EQUIPMENT REQUIRED:</td>
<td>Teleconferencing facilities</td>
</tr>
<tr>
<td>TECHNICAL REQUIREMENTS:</td>
<td>Teleconferencing booking</td>
</tr>
<tr>
<td>PRE-SESSION PREPARATION:</td>
<td>Pre-work references and quiz (available on Pharmacy intranet education webpage)</td>
</tr>
</tbody>
</table>

### Specific Learning Objectives

By the end of this session, it is anticipated that participants will better be able to:

1. Use clinical reasoning skills to identify the critical aspects of a given case scenario.
2. Use knowledge of medication to review the patient’s medications, identify pharmacokinetic and pharmacodynamic issues impacting on the use of these medications and suggest suitable alternatives to optimise this patient’s care.
3. Use appropriate communication skills to act on proposed interventions into a patient’s care in a manner that would be expected to affect positive change.
4. Understand the impact of health literacy on counselling methods.
5. Counsel simulated treatment-naïve patients on the correct use of specified common inhalation devices.

### Session Plan

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
<th>Teaching/ Learning Process</th>
<th>Learning Resources</th>
<th>Assessment of Learning Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>2pm – 2:10pm</td>
<td>Introduction and outline of session</td>
<td>Introduction of presenter and general housekeeping Introduction of topic and address questions arising from pre-work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:20pm – 2:40pm</td>
<td>Case study</td>
<td>Introduce case study Teaching Points: • Clinical reasoning • Medication and therapeutic knowledge • Communication</td>
<td>Australian Medicines Handbook Therapeutic Guidelines – Respiratory</td>
<td>Names at least 5 significant clinical issues that impact on patient safety</td>
</tr>
<tr>
<td>2:40pm – 2:55pm</td>
<td>Counselling on inhaler technique</td>
<td>Role play Each intern pharmacist to counsel another (at a different site) on the correct use of a different inhaler device and provide feedback.</td>
<td>Placebo inhalers</td>
<td>Correct technique explained using simple language</td>
</tr>
<tr>
<td>2:55pm – 3pm</td>
<td>Summary &amp; conclusion</td>
<td>Intern pharmacists to provide a summary of key learning points. Presenter to fill in any knowledge gaps and provide feedback on performance.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I: Optimising use of learning resources in lectures or presentations

<table>
<thead>
<tr>
<th>Learning Resource</th>
<th>Tips to optimise use</th>
</tr>
</thead>
</table>
| Whiteboard, flip charts           | • Write large enough for the back of the room to be able to see.  
• Plan the use of board space, always starting left to right.  
• Don’t try to write and talk at the same time.                                                        |
| Overhead projector (OHP) or visualiser | • Position the machine so you will not be in the way and it is easily viewed.  
• Use dark colours for writing, lighter colours to highlight or emphasise points  
• Use at least size 24 font equivalent.  
• Use images or graphics wherever possible.                                                        |
| Presentation software: Microsoft PowerPoint Prezi (also see weblinks in Appendix B) | • Don’t include too much material. As a rule of thumb for every 10 minutes of presentation use a maximum of 15 slides, 20 words per slide and 10 images.  
• Use size 24 font or larger, limit number of lines to about 6 per slide.  
• Do not use full sentences unless providing a quote.  
• Use contrasting colours and bold to vary emphasis of points.  
• If using animation to bring in slides, keep the same theme throughout.  
• The automatic tendency for the viewer’s eye is from top left-hand corner to bottom right-hand corner. Use images or icons to capture attention.  
• Label graphs, including title axes, parts of charts, tables and diagrams.  
• On a table, highlight key numbers and convert data into graphic form.  
• Minimise the amount of visual information the audience must process so they can focus on the most important material.  
• Graphs, tables and charts should be large enough for back row to see.  
• Try to maintain good eye contact, avoid reading your presentation. |
| Handouts                          | • Rather than provide the complete presentation to participants (copy of the PowerPoint presentation) choose a handout that provides information for later reference but also supports interaction and active learning.  
• Provide skeleton notes (e.g. key diagrams, lecture outline) so participants can add detail to them during the presentation. Where possible, provide this in advance to give an overarching view and connection to the topic.  
• Provide interactive notes containing tasks such as:  
  – Text additions. Leave spaces for missing facts, points, definitions etc.  
  – Image additions. You may give directions for participants to add detail to the notes themselves.  
  – Problems and questions. Include in the handout opportunities to apply knowledge to questions or problem scenarios.  
  – Print presentation as a handout using greyscale.                                                        |
| Video Clips                        | Provide a different and stimulating way of bringing material into the presentation.  
Gain consent as required and ensure material complies with copyright laws.                          |
| Demonstrations                    | This can include:  
• Modelling a skill or procedure  
• Displaying a sample or example  
• Using a model to explain a complex or abstract idea  
• Asking participants to demonstrate through personal experience  
• Presenting an actual or simulated situation or scenario.                        |
Appendix J: Strategies to delivering an effective conference presentation

Writing an abstract for a conference

If you want to present at a conference you must first submit an abstract, which will be reviewed by a conference committee. Each conference has set criteria for writing and submitting abstracts. The abstract should be a summary of what the paper will present with explanation/arguments to support the central idea.

Abstracts submitted for a conference paper should:

1. Describe to the audience what you are going to say.
   - Identify the topic/subject of your paper — the question/problem it raises.
   - Locate the topic/subject in terms of a field of scholarship — who/what provides the intellectual context for the problem/question the paper raises.
   - Emphasise your position/proposition — your central idea regarding the question/problem.

2. Interest the audience in coming to hear you say it.
   - Devise a title that is descriptive and inviting, and relevant to the conference theme/sub-themes.
   - Use terminology that is accessible to both people within your specific field and those who may be attending that are not from your direct area.

Tips to writing an abstract — (Adapted from Milech, 2004)

<table>
<thead>
<tr>
<th>Do your homework</th>
<th>Read in detail the guidelines for submitting abstracts provided by conference organisers and follow these exactly, when writing the abstract. Link it to the conference theme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be concise</td>
<td>Abstracts have a word limit. You must keep to this exactly.</td>
</tr>
</tbody>
</table>
| Content should include | • A clear statement of the topic of your paper and your research question. You need to say how your research was/is being undertaken (e.g. is it empirical or theoretical? Quantitative or qualitative?).  
|                  | • Briefly describe the work to be discussed in your presentation or paper.                                                                  
|                  | • Give a concise summary of the findings.                                                                                                   
|                  | • Abstract should not include diagrams.                                                                                                    
|                  | • In general references are not required in the abstract unless requested.                                                                 |
| Edit             | Carefully check for correct grammar, punctuation, typos, etc.                                                                              |

General principles when preparing a conference paper

Know your goal  
The aim is to generate curiosity and interest in your work so that audience members are prompted to reflect and learn from your work, and hopefully seek further information about the work you have undertaken.

Know your audience  
Your audience will have different perspectives from yours on your project. Think about how you can translate the ideas that you have become highly familiar with to a broader group.
Know your medium

Listeners have one chance to hear your talk and can't 're-read' when they are unclear. There are two well-known ways to communicate your point effectively:

- K.I.S.S. (keep it simple stupid)
- Repeat key insights: tell them what you're going to tell them (forecast), tell them (content), and tell them what you told them (summary).

Cut material ruthlessly

- Minimise words and maximise pictures.
- Simplicity is the best when it comes to PowerPoint slide presentations.
- Alert your audience to transitions and changes of subject by demarcating each new section of the talk.
- Organise your content.

Make one point

Each slide should make one point and each 'talklet' (3-5 slides) should make one key point. Ask yourself 'What am I trying to say' every step of the way.

Use transitions

Before you make a point, the audience needs to know the point you are aiming to make and why it is important. These become the verbal transitions between slides. Always direct the audience back to the relevance of the point to the bigger picture of the presentation.

Practise

Practise, practise and practise! This improves the confidence of the presenter and promotes a successful presentation.

Tips for delivering an effective conference presentation

| The countdown before | • Spend the 30 minutes beforehand thinking about the talk.  
| Poise and energy | • Introduce yourself to the session chair and advise where you are sitting.  
| Structure | • Spend 5 minutes thinking about the delivery of the first few slides.  
| • Vary the volume and rhythm of your voice.  
| • Deliver the talk from different positions (but don’t overdo it).  
| • Make eye contact with the audience.  
| • Related work is generally abbreviated in a short talk. However if there is someone in the audience who has done related work, credit them in your talk.  
| • Use fonts 18 point or larger (20pt if using an LCD projector)  
| • Sentences longer than one line are to be avoided.  
| • Debug your slides before presenting.  
| • Check: legible colours, spelling, grammar consistency.  
| Answering questions | • Let the questioner finish asking the question before you answer.  
| • Repeat audience questions before answering them:  
| • Makes sure everyone has heard the question.  
| • Gives you a moment to think about the question.  
| • Don’t read too much into a question. You are likely to know much more about the topic than the questioner.  
| • Perhaps think through a quick outline of your answer before you start talking. It’s OK to pause for 5 seconds before answering a complex question.  
| • If you don’t know, say so. Don’t bluff.

(Adapted from Shewchuck, 2008)
Appendix K: Small group activities

Small group activities can be facilitated in many ways. Here are short descriptions of some different types of small group activities.

**Rounds**
This involves each person within a group briefly speaking in turn. It often works best if participants are arranged in a circle. You might present a question to the group and each member has 15 seconds maximum to reply in turn with the option of ‘passing’. You can allow for longer time per person if you are trying to encourage extensive exploratory and reflective talk.

**Circular interviewing**
This form of group interaction involves each person interviewing or questioning the person directly opposite about an agreed topic. Then the interviewer and interviewee change roles by moving one place around the circle until everyone has played both roles.

**Buzz groups, pairs and triads**
Buzz groups are small groups of 2-3 people formed in an impromptu manner, who discuss issues or problems for a short period. This can be useful to generate active learning, renew attention by changing the stimuli, get the group going at the beginning of the session, or finalise a topic or section of a session.

‘To start off with, let’s buzz for 3 minutes on what your initial reactions or thoughts are when you encounter a patient who has…’

**Pyramids**
Using pyramids involves asking individuals to work alone on reading a passage, case study or problem before putting participants into pairs, then fours, then sixes and finally as a whole group. These stages might typically involve:

- 5 minutes Working individually
- 15 minutes Sharing and discussing in pairs
- 30 minutes Comparing and debating in fours
- 10 minutes Pooling and gaining an overview as a whole group

Your role as facilitator is to make sure participants have instructions for each stage.

**Syndicates**
Syndicates are teams of people working on the same task simultaneously. It could be a case study, solving a problem, brainstorming around an issue or designing something. Each group presents the outcomes in a plenary session. Sometimes the teams may be in competition with each other. Your role as facilitator is to make sure the task is suitable, the layout of the teams is practical, and to check on progress by moving from one team to another without disrupting them.
Fishbowls
This type of discussion arrangement can be useful when there is quite a large group and you feel that discussion within the whole group would be unproductive and perhaps dominated by a few people. With fishbowls, two circles of chairs are arranged. The inner circle includes those who are having the discussion, the outer circles are those that quietly listen. Anyone from the outer circles may join the discussion simply by ‘tapping out’ those in the fishbowl and swapping seats. Fishbowls can also be used to debrief group work instead of the group plenary seats.

Brainstorms
This is a technique used for creative problem-solving. The aim is to first launch ideas in groups of people up to 12, then work through the list of ideas to see which ones are worth keeping. This approach should reduce the reluctance people may have to contribute ideas if they first have to be analysed. Each group should have a scribe appointed and an apparatus on which to write. Participants need to call out simple words or short phrases, avoiding long sentences or elaborations that would hold up the scribe. There should be no comments, questions or criticisms of the ideas produced while brainstorming.

Crossover groups
Participants are divided into small groups, with each person identified by a different colour or number. After a set time of discussion, participants are re-assigned to a new group based on their original categorisation. This allows for maximising crossing over of information.

Horseshoe groups
This method is one of the more common structures used in workshops and facilitates alternating between presentation and discussion quite easily. Groups are arranged around tables in a horseshoe pattern with the open end facing the front of the room, where the facilitator or board is based.

Group-by-group reporting of activity or outcomes can become quite boring. You might therefore prefer using fishbowls, written reports that get circulated, or the crossover method to facilitate feedback from group tasks.

(Adapted from Jacques, 2003)

Learning Pods
This is a useful way of presenting a lot of theory in an active way. It involves small groups discussing aspects of a topic or reviewing parts of an article. Each group is assigned a part to research or think about. Each group then presents back to the larger group towards the end of the session. Because the work is divided into parts, each participant needs to listen to the others in order to gain an understanding of all the information related to that topic or article (Aronson, 2012).
Appendix L: Critical appraisal journal review – template

Date: ___________________________ Reviewer: ___________________________

<table>
<thead>
<tr>
<th>Article Title</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full reference</td>
<td></td>
</tr>
</tbody>
</table>

Critical Appraisal Summary:

<table>
<thead>
<tr>
<th>P: Patient/Problem/Population</th>
<th>Any characteristics that define your patient/client or population e.g. age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Intervention</td>
<td>e.g. form of treatment, education programme, type of service delivery, factors influencing prognosis</td>
</tr>
<tr>
<td>C: Comparison/Control (if applicable)</td>
<td>Alternatives to main intervention e.g. placebo</td>
</tr>
<tr>
<td>O: Outcomes</td>
<td>Any outcomes or effects relating to interventions e.g. prevention, quality of life, cost effectiveness.</td>
</tr>
</tbody>
</table>

Implications for practice:

Further acknowledgements

Contributions and reviews were provided by many people, in particular:

<table>
<thead>
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<td>NSW Department of Health</td>
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<td>John Merrick</td>
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</tbody>
</table>

Allied health professionals across NSW Health have generously provided information and feedback during the development of this document.

A special thanks to allied health staff and others who provided specific input into the following sections: considering individual differences when facilitating learning, setting learning objectives, managing challenging behaviours in learning activities and appendices.

The HETI Learning Guide Working Group and Allied Health Advisory Committee would also like to acknowledge the many allied health professionals and colleagues who provided constructive, useful and relevant feedback on the state-wide consultation draft.
Glossary of terms

ACTIVE LEARNING
Active learning is a broad term used to encompass learning strategies which focus on acquiring skills and knowledge through doing, performing and taking action. Such strategies can include the use of role plays, simulations, demonstrations, team activities, ‘hands on’ doing or games (Job Access, 2010).

ACTION LEARNING
Action learning is a continuous process of learning and reflection, supported by colleagues, with an intention of getting things done. Through action learning individuals learn with and from each other by working on real problems and reflecting on their own experiences (McGill & Beaty, 2002, p. 11).

CONTINUING PROFESSIONAL DEVELOPMENT
Continuing professional development (CPD) is the means by which members of a profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.

Under the National Law which governs the operations of the National Boards and AHPRA, all registered health practitioners must undertake CPD (AHPRA, 2011).

DEEP APPROACH TO LEARNING
A deep approach refers to learning where learners are intrinsically motivated and have interest in the subject. They seek to understand the topic, read widely, discuss and reflect on the topic matter (Biggs, 1991).

FORMAL LEARNING
Takes place in situations where there is a curriculum and a sequence of planned teaching and learning activities – what we associate with classrooms in their various forms (Smith & Blake, 2005, p. 8).

INFORMAL LEARNING
Informal learning is not normally associated with classrooms of structured learning, but is largely under the control of the learner setting out to learn something. It is achieved through observation, discussion with others, asking questions, and even making mistakes and learning from them (Smith & Blake, 2005, p. 8).

INCIDENTAL LEARNING
Learning that happens as the by-product of some other activity (Smith & Blake, 2005, p. 8).

INTERPROFESSIONAL COLLABORATIVE PRACTICE (ICP)
A patient-centred process of communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence client/patient care (Way, et al., 2000).
INTERPROFESSIONAL EDUCATION
Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care (CAIPE, 2002).

INTERPROFESSIONAL LEARNING
‘Interprofessional learning (IPL) is centrally concerned with improving the way people work together so that clinicians can grow professionally, learn from others, provide support to colleagues and improve the quality of care to patients’
(Braithwaite & Travaglia, 2006, p. 5).

LEARNING OUTCOMES
Learning outcomes relate to what the learner will be able to do at the end of a period of learning. Learning outcome statements relate therefore to educational ‘outputs’ of learning, rather than educational ‘inputs’, the teacher-directed taught content (Flanagan, et al., 2000, p. 361).

LIFELONG LEARNING
Is a continuous lifelong process that involves integration of formal and informal learning so as to create an ability for continuous development across a life span (OECD, 2010).

PRACTICE-BASED KNOWLEDGE
Practice refers to how people actually get work done. Practice includes the means and the ends of work, the practical wisdom people rely on, and the rich, socially embedded clinical know-how that encompasses perceptual skills, transitional understandings across time, and understanding of the particular in relation to the general (Benner, 2004, p. 5; Brown & Duguid, 1991; Dougherty, 2004).

PROBLEM BASED LEARNING
Problem-based learning occurs through the activities associated with solving a problem. It may take place in a formal setting where the set problem is designed to result in particular learning outcomes, or the learning may be achieved quite informally through working on a real-world problem in a context such as a workplace (Smith & Blake, 2005).

SITUATED LEARNING
Occurs when the knowledge being acquired is to be used in the same situation in which it was gained (Smith & Blake, 2005, p. 8).

SOCIAL LEARNING THEORY
Social learning theory focuses on the learning that occurs within a social context. It acknowledges that people learn from one another, and includes such concepts as observational learning, imitation and modelling (Ormond, 1999).

WORK-BASED LEARNING
Work-based learning is the bringing together of self-knowledge, expertise at work and formal knowledge. It takes a structured and learner-managed approach to maximising opportunities for learning and professional development in the workplace (Flanagan, et al., 2000, p. 360).
References


The Learning Guide

This is a user-friendly handbook designed to support teaching and learning of allied health professionals locally within their workplaces. It provides information about:

- Practical strategies to facilitate adult learning
- Optimising opportunities for learning and teaching within day-to-day work

This handbook is not a policy document. It gives tips and suggestions based on published evidence that supports effective methods of promoting education, learning needs and professional development of allied health professionals working in clinical settings, to contribute to the safety and quality care of patients/clients of NSW Health.