The role of the Clinical Supervisor (CS) in interprofessional pre-registration student clinical education – the unmet educational need in university wide health studies clinical practice – stage two.

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3. Abbreviations

Abbreviation	Detail
CALD	Culturally and linguistically diverse
CCLHD	Central Coast Local Health District
CS	Clinical Supervision
CP	Clinical Placement
HNELHD	Hunter New England Local Health District
MRS	Medical Radiation Science
N&D	Nutrition and Dietetics
OT	Occupational Therapy
UON	University of Newcastle
UNDRH	University of Newcastle Department of Rural Health

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5. Introduction

This interprofessional study was funded by the Hunter & Coast Interdisciplinary Clinical Training Network (H&C ICTN) to research the role of the interprofessional Clinical Supervisor (CS) in pre-registration student clinical education. Students from Medicine, Physiotherapy, Nutrition & Dietetics, Radiation Science and Occupational Therapy in the final year of their degree were interviewed either in focus groups, or individually about their experience of clinical supervision during their compulsory clinical practice events.

Allied health and medicine clinical supervisors of final year students were surveyed using a previously validated and reliable opinion tool (Clinical Preceptor Experience Evaluation Tool - CPEET) across two NSW health districts. The survey was to ascertain supervisor opinion about the value of clinical supervision in the context of the roles they play as clinical supervisors, the challenges they face, educational and professional preparation for the role of clinical supervisor, and their overall satisfaction having final year students to supervise in clinical practice.

6. Aims

The study intended to:

- Explore and compare the role perception of Clinical Supervisors (CS) across health disciplines in precepting health students in clinical practice;
- Describe final year health students' perspectives and experiences of clinical supervision; and
- Drawing on data from focus groups and interviews develop an interprofessional model of clinical supervision based on multisource feedback from Clinical Supervisors and students from the different health professions.

The study is part two of a previous funded study using the CPEET which surveyed Registered Nurses, Midwives and Enrolled Nurses across the Hunter New England Health District regarding their experience of providing preceptorship to students on clinical practice (O'Brien et al., 2014). The slightly modified version of the CPEET used in stage two of the

research, utilised the term ‘clinical supervisor/preceptor’ instead of ‘preceptor’, and made some minor changes to terminology to cater for the interprofessional audience. O'Brien et al. (2014) identified that the major themes involved in preceptorship correlate closely with the Health Workforce Australia (HWA) (2011) definition for clinical supervision.

Preceptorship is both supportive and educational (Queensland Health, 2001). Some key features of clinical supervision include:

- Bridging the theory-clinical gap;
- Learning occurs in the everyday workplace, tailored to the discipline and learner needs (Cope, Cuthbertson, & Stoddart, 2000; Williams, 2010);
- Socialisation into nursing and health professions is facilitated by preceptor stewardship of the student (Cope et al., 2000; Myrick, Yonge, & Billay, 2010; Queensland Health, 2001; Roberts, 2009); and
- Preceptors foster the growth of practical wisdom (Cope et al., 2000; Myrick et al., 2010).

The Health Workforce Australia (HWA) (2011b) definition of ‘Clinical Supervisor’ subsumes the role of mentor, preceptor, buddy and facilitator of clinical practice. Despite the definition of the term clinical supervisor lacking consensus in the literature (Siggins Miller Consultants, 2012), the Health Workforce Australia definition has been used as the guiding force in this study.

Health Workforce Australia (HWA) (2011b) defines clinical supervision as involving the:

> “oversight – either direct or indirect – by a clinical supervisor(s) of professional procedures and/or processes performed by a learner or group of learners within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each learner’s experience of providing safe, appropriate and high quality patient-client care” (p.4).

The clinical supervisor is described as:

> “An appropriately qualified and recognised professional who guides learners’ education and training during clinical placements. The clinical supervisor’s role may encompass educational, support and organisational functions. The clinical supervisor is responsible for ensuring safe, appropriate and high quality patient-client care.” (Health Workforce Australia (HWA), 2011b, p. 4).

7. Background

In a broad sense, health professional students develop discipline specific knowledge by being able to practice (perform) the skills learned in their university program in the relevant clinical environment and practice context. Without clinical practice and client contact in the health care setting, they would have little, or no chance of developing into safe, competent, first-level practitioners. The practice environment is where the final year student puts 'two and two' together, and toward the end of their university program this experience has accumulated into a set of skills, applied knowledge and attitudinal attributes that enable the student to become a registered practitioner (Nolan, 1998; Perli & Brugnolli, 2009; Zilembo & Monterosso, 2008).

A clinical supervisor facilitates opportunities during a student's clinical practice event that enable the student to achieve their learning objectives; that is, to meet the competencies required by the regulatory authority for their particular discipline. When experiencing clinical practice, a number of variables can influence a positive clinical practice event and outcome, for the student and clinical supervisor.

Students report that the single most influential variable in the diverse mix of clinical opportunities for them when on practicum is the supervisory relationship (Henzi, Davis, Jasinevicius, & Hendricson, 2006; Papastavrou, Lambrinou, Tsangari, Saarikoski, & Leino-Kilpi, 2010; Saarikoski, Isoaho, Warne, & Leino-Kilpi, 2008; Saarikoski & Leino-Kilpi, 2002; Saarikoski, Leino-Kilpi, & Warne, 2002; Warne et al., 2010). It is also described as a significant factor influencing the students' satisfaction with the clinical learning environment (Fenton, 2005; Henning, Shulruf, Hawken, & Pinnock, 2011; Koontz, Mallory, Burns, & Chapman, 2010; McCall, Wray, & Lord, 2009; Rodger, Fitzgerald, Davila, Millar, & Allison, 2011; Rolfe & Sanson-Fisher, 2002; Sheehan, Wilkinson, & Billett, 2005; Siggins Miller Consultants, 2012).

There has been considerable work done in the Work Integrated Learning space (WIL), a catch all term used to describe a range of approaches and strategies to integrate theory and practice, where practice is the vehicle for consolidation of skills, knowledge and attitudes. There is a critical need to improve the correlation between clinical placement teaching and learning and the theoretical principles inherent in any health discipline curricula (Patrick et

al., 2008). Billett (2009) and Eraut (2007) highlight that WIL learning experiences must open up opportunities for learning to occur and be facilitated by organised CS's who provide structured and coherent tasks for the student to undertake. They further remind us that the on campus (University) preparation is critical to the value students' gain from the WIL experience. Curricula design, laboratory experiences, learning how to ask the right questions of their CS, finding resources in the clinical setting, being orientated to the WIL environment beforehand, being critically reflective in their thinking and moderating their behaviour based on constructive CS feedback are all processes that help enhance the clinical practice experience. d'Avray and Forrest (2010) also stress that using WIL educators from outside of the students discipline can highlight the importance of working in interprofessional teams.

Learning in an interprofessional context must also focus upon what the other health professions contribute to patient care in a holistic sense. For example, the health practitioner, who only focuses on his/her discipline and what it provides the patient, lives and works in a myopic clinical scope. The student supervisor relationship and how this develops is an essential component for their being a positive outcome from the clinical experience. The characteristics of a good relationship have been described as involving constructive dialogue (O'Donovan, Halford, & Walters, 2011; Vågstøl & Skøien, 2011); and open and honest communication (Bonello, 2001; Rodger et al., 2011), which includes frequent and constructive feedback (Bonello, 2001; Cole & Wessel, 2008; Löfmark & Wikblad, 2001; Rodger et al., 2011).

Students consistently report that they require a significant time investment from their clinical supervisor (Fenton, 2005; Happell, 2008; Henzi et al., 2006; Sheehan et al., 2005). Quality of time is important and access to uninterrupted one-on-one supervision is a highly valued interaction (Fenton, 2005; Young, Orlandi, Galichet, & Heussler, 2009). This is particularly the case if the relationship is developed over time. The time however on clinical placements a CS can spend with a student varies between health disciplines. This is also affected by the conflicting demands on any given day between service provision (patient load and care priorities) and other time-tabled teaching experiences. The CS relationship with the student is an educational and professional relationship; it is intended to be supportive, encouraging and responsive. When the CS is aware the student is coming to placement and they have set learning goals to accomplish, a more positive outcome and relationship can develop.

Fundamentally the CS relationship is a teaching and learning opportunity for the student to develop but also for the CS to look forward to passing on their skills, knowledge and professional aptitude. Students at times however can be challenging and this combined with clinical responsibilities can be problematic for CS's further complicating a coupling intended to generate positive learning outcomes. Preceptors are less satisfied when challenged with difficult students and those who are unmotivated, and where precepting becomes time consuming (O'Brien & Bremmer, 2008; O'Brien et al., 2014).

> Providing students with understanding of the preceptor role before and as part of an orientation process prior to a clinical placement experience may facilitate the development of a closer more rewarding educational relationship, and perhaps pre-empt some of the less satisfying aspects of taking on a student (O'Brien et al., 2014, p. 23)

Supervisors, who are unreasonable, abuse their power and violate ethical codes of practice have been described as ineffective and insensitive. There have also been comments that some supervisors fail to listen and can be insensitive and humiliate students on practice. Furthermore, students have reported condescending and insensitive interaction, negative and humiliating comments, and failure to listen, as having an adverse impact on their learning in clinical practice (Anderson, Rich, & Seymour, 2011; Bonello, 2001; Lew, Cara, & Richardson, 2007; Morris, 2007).

Poor supervisory relationships have included abuse of the supervisor's power, unreasonable work demands and criticism, and violation of ethical codes prescribed by professional bodies (O'Donovan et al., 2011). Ineffective communication also characterises poor clinical supervisor and student relationships. It is clear from the literature that a CS relationship requires a high quality level of interpersonal engagement where the CS employs higher order interpersonal skills involving feedback, active listening, remedial discussion and positive reinforcement, such skills are the hallmark of an experienced and qualified health care professional.

Health Workforce Australia (HWA) (2010) highlights the need for supervisor development and suggest that a good clinician is not automatically a good supervisor. There is a need for supervisor training so that supervision is standardised in some elements, even if it is discernibly different for some health disciplines. There are core elements associated with time commitment, expertise, availability, adequate educational preparation, positive attitude, feedback, and high quality interpersonal skills (Kilminster, Cottrell, Grant, & Jolly, 2007;

Tebes et al., 2011). In addition, the increasing importance of training CSs on how to adapt CP experiences, and provide the necessary support for the growing number of undergraduate health students from CALD background, has been recently highlighted (O'Reilly & Milner, 2015).

Health Workforce Australia (HWA) (2011a) emphasise that for CS there are continuing issues surrounding the procurement of placements for students and in the context of facilities experiencing real workforce issues related to staff shortages, lack of available supervisors and that supervisors can also feel they are educators not clinical supervisors, however the role is clearly both. Organisational culture can also be a barrier to providing an ideal placement especially where a student enters into an environment which might be counterproductive because of internal conflicts. CS is multi-complex and involves health care and education providers getting together to understand each other's role in the context of student orientation, placement complexities and logistics, curricula and clinical needs to ensure the health professional obtains the scope of practice skill-set in the often short time frame available for practice.

8. Methodology

8.1. Research Design

The first stage of this project involved surveying Clinical Supervisors/Preceptors of Nursing and Midwifery students within the HNELHD has already been completed (HNE HREC Approval number 12/02/15/5.08) and has been reported in O'Brien et al. (2014).

This second stage of the project involved:

- Surveying Clinical Supervisors of other health disciplines (Medicine, Physiotherapy, Nutrition & Dietetics, Radiation Science and Occupational Therapy) located within the Hunter New England Local Health District (HNELHD) and the Central Coast Local Health District (CCLHD).
- Conducting several small focus groups of health students from Medicine, Physiotherapy, Nutrition & Dietetics (N&D), Medical Radiation Science (MRS), Occupational Therapy (OT) and Nursing and Midwifery students located within the Faculty of Health and Medicine, University of Newcastle.

Drawing on the experiences and perceptions of both clinical supervisors and final year health students is intended to provide clarification of the issues surrounding teaching and learning in the clinical environment, orientation and final year student transition from the university to the clinical sector. Comparison of the results of the survey and focus group across a range of disciplines assists to identify common barriers and enablers in clinical supervision and clinical placement processes, as well as potential learning support and interprofessional capacity building needs.

8.2. Ethical Considerations

Approval to undertake this study was granted by the Hunter New England Human Ethics Committee (HNEHREC Reference No: 15/08/19/5.03) on 20 August 2015, with authorisation granted for the study to be conducted within HNELHD on 24 September 2015 (SSA Reference No: LNRSSA/15/HNE/355), and within CCLHD on 28 September 2015 (AURED SSA: LNRSSA/15/CCLHD/113). A variation was submitted to both ethics committees to add another research team member from the CCLHD. These were approved on 3 September 2015 by the HNELHD ethics committee and on 1 October 2015 by CCLHD.

The study was also registered and approved by the University of Newcastle's (UON) Human Research Ethics Committee (HREC Reference No:H-2015-0336) on 16 September 2015, as the research involved students of the UON. Potential survey respondents and focus group participants were provided with a detailed information sheet explaining the purpose of the research, how anonymity and confidentiality would be maintained, that participation in the research was entirely voluntary, and that they could withdraw from the research at any time without giving a reason.

Undergraduate students, who agreed to participate in a focus group, were asked to sign a consent form and to anonymously complete a form providing brief biographical data. Although they had the option of withdrawing from the research at any time, if they participated in the focus group discussion, they were not able to withdraw their individual comments as the data informed part of a larger conversation. Privacy was protected by ensuring that the researcher who moderated the focus group was not employed by the students' School as a Lecturer, Course Coordinator, or Course Convenor. Furthermore, the transcription of the focus group was undertaken by a confidential transcriptionist, and code numbers were used to replace names throughout the research process.

Data has been stored in a secure filing cabinet in the Principal Researchers' office. All computer information has been stored on a hard drive protected by a password access. Only the Project Manager and Principal Investigator have access to computer files and hard copy consent and transcript data.

For survey respondents, it was explained that neither responses nor individuals could be identified. Names of respondents could not be tracked to completed surveys in the password protected data base, and so their identity would be protected. Respondents' names or any other identifying information such as an email address, or phone number was not required on the survey. However, there was a negligible risk that a researcher may be able to identify an individual participant from the limited demographic data that respondents provided. As a result, participants had the option of selecting '*Do not wish to answer*' for the demographic questions relating to age and years of post-registration experience, to minimise this risk of identification.

8.3. Sampling and Recruitment

8.3.1. Clinical Supervisors' Survey

The UON health discipline departments involved in this study were contacted to obtain the email addresses of Clinical Supervisors in HNELHD and CCLHD, so that the relevant CSs could be invited to participate. However, identifying all the clinical staff involved in both formal and informal supervision of undergraduate students was not possible.

In the disciplines of MRS, OT, Physiotherapy and N&D, UON staff were able identify those CSs responsible for organising CPs, yet they noted that "…*there will be hundreds of staff that students will work with on a daily basis as qualified staff …these are staff that watch students work and know them best – but I suspect that they will be a hard source to get to reply*" (confidential email, 29 September, 2015). This was reinforced by student focus group members, who noted that they may be assigned to a CS, but work with a range of other staff on a day-to-day basis. We were also able to source the email addresses of a number of senior MRS, OT, Physiotherapy and N&D in the HNELHD to supplement the numbers obtained from the UON health departments, however, again it is unlikely that those involved informally in clinical supervision were included in our final distribution list.

In Medicine, the UON department did not have access to the email address of all Medical officers involved in clinical supervision, but were able to provide a limited list of HNELHD

Medical staff involved in supervising 4th year Medical students in one clinical school covering four hospital sites. Given the challenges of obtaining email address for CSs in Medicine CCLHD, we utilised broadcast email lists that included all Medical and Surgical officers. Broadcast email address lists were not available for HNELHD Medical staff. The challenge of identifying CSs was reinforced by Medical student focus group participants, who noted that in many cases they are assigned to a department, rather than to an individual Medical officer.

The invitation email to the survey included the Participant Information Statement and directed staff to a Survey Monkey site where the survey was available. The invitation to participate was distributed within CCLHD on 15 October. Reminders were sent on 22 and 27 October, with the survey closing on 28 October. The invitation was sent to HNELHD CSs on 5 November, and reminders sent 12 and 17 November. The survey closed for HNELHD staff on 18 November.

It was implied that participants gave their consent to participate once they completed the questionnaire. As the survey was anonymous, respondents could not withdraw from the research project once they submitted their survey.

8.3.2. Student Focus Groups and Interviews

Students were invited to participate in the focus groups via a number of methods:

- Program Convenors in MRS, OT, Physiotherapy and N&D disseminated the Participant Information Statement to all of their final year undergraduate students via email. Due to very limited responses from Physiotherapy students, a second email was distributed. As we received no responses from N&D students to the email invitation, the invitation was again disseminated at an on-campus compulsory workshop conducted on 17 November. To date, we have received no responses from this cohort of students, although it must be borne in mind that N&D students typically undertake a year-long CP off campus in their final year.
- The Bachelor of Nursing Program Convenor posted the invitation and the Participant Information Statement on the Blackboard site for the final year Bachelor of Nursing and Bachelor of Midwifery students. As no responses were received to this initial invitation, information about the study was posted on the 3rd Year Clinical and the Clinical Support

Unit Blackboard sites, with a mass email invitation distributed. An information flyer was also posted on a number of noticeboards within the School of Nursing and Midwifery.

- The Joint Medical Program Manager disseminated two email invitations to final year Medical students to participate in focus groups.

All publicity material advised that students should contact the Project Manager directly if they wished to participate. For OT, MRS and Nursing students, focus groups were arranged once sufficient numbers of students responded to the invitation. Those students not able to attend the focus group, but were interested in participating, were given the option of providing brief responses to the questions via email. Organising a suitable time for the Physiotherapy students to attend a focus group became problematic, and so students were given the option of participating in an individual telephone interview.

As Medical students were undertaking their CP at the time of recruitment, the date, time and location (a HNE hospital meeting room) was included in the invitation. A further invitation to participate in an additional Medical student focus group at another hospital was disseminated towards the end of the students' CP, although we received no responses to this second invitation. Given the limited number of participants in the Medical student focus group, those expressing an interest in participating, but unable to attend were given the option of participating in an individual telephone interview. No responses were received to this invitation.

Those students who contacted the Project Manager expressing interest in participating in the research, were emailed a copy of the Participant Consent Form and an Anonymous Biographical Questionnaire, and were asked to complete and return these documents prior to the focus group or interview being conducted.

8.4. Data Collection

8.4.1. Clinical Supervisors' Survey

The Clinical Preceptor Experience Evaluation Tool (CPEET) was administered to participants to gain insight into their opinions as to the preceptor experience in the workplace The CPEET has been utilised in a number of evaluative studies and has established cross cultural validity and reliability (Lee, 2011; O'Brien & Bremmer, 2008). The four subscales of CPEET measure opinion in relation to the preceptor/clinical supervisor:

Role — relationship between the student and the preceptor/clinical supervisor, role modelling, participating together in patient care, facilitation of critical reflection and being available to teach the student about case studies and care plans. The subscale includes items about the function and impact of the preceptor role.

Satisfaction — finding the time to teach and support the student in clinical practice, being motivated to do so and managing ones time to take on the challenge.

Experience and Education — enacting the role through others in their work environment and linking the student to clinical practice opportunities. Being with a student encourages the preceptor/clinical supervisor to stay up to date with the current evidence and to reflect on their own practice.

Challenges — being focused on the challenges faced when implementing the role into everyday practice, the rewards related to professional development, changing practice and the preceptor/clinical supervisor role having meaning, including an incentive to teach and engage the student.

A seven point Likert scale asked respondents to rate their level of agreement with the 39 items related to the four subscales. The Likert scale ranged from 1 — strongly disagree to 7 — strongly agree (O'Brien et al., 2014).

The terms used in the adapted version of CPEET were modified slightly to cater the different disciplines surveyed. In this version, the term 'preceptor' was changed to clinical supervisor in a number of questions. Other minor modifications included:

- Question 28 - 'as a nurse' has been deleted
- Question 30 -'nursing' has been replaced by 'professional'
- Question 37- 'nurses' has been changed to 'clinicians'
- Question 38 -'nursing' has been changed to 'professional'
- Question 39 -'nursing' has been changed to 'health'.

Participants

The participants were 129 clinicians from two regions: Central Coast (n = 41, 39.0%) and Hunter New England (n = 64, 61.0%).

The email invitation was distributed to 699 staff across both health districts, resulting in an overall return rate of 18.5 per cent for the total sample (refer Table 1 below).

Table 1: *Numbers of staff invited to participate in the survey*

Discipline	HNELHD	CCLHD	Total
Allied Health Total (incl. OT, MRS, N&D, Physiotherapy)	173	118	**291**
Medicine	57	351	**408**
Total	**230**	**469**	**699**

Of the 129 participants, 105 completed the Clinical Preceptor Experience Evaluation Tool, and 24 discontinued the survey before answering any of the items within the tool. The incomplete surveys were excluded from further analysis

The participants worked across a range of hospitals and facilities (See Table 2 below).

Table 2: *Hospitals and facilities*

Site	Frequency	Per cent	Valid Per cent	Cumulative Per cent
Armidale	4	3.8	3.8	3.8
Belmont	1	1.0	1.0	4.8
Calvary Mater Hospital	8	7.6	7.6	12.4
Gosford Hospital	23	21.9	21.9	34.3
JHH/RNC	13	12.4	12.4	46.7
Maitland	3	2.9	2.9	49.5
Manning Base Hospital	1	1.0	1.0	50.5
Moree	1	1.0	1.0	51.4
Tamworth	3	2.9	2.9	54.3
Wyong	12	11.4	11.4	65.7
Other	36	34.3	34.3	100.0
Total	**105**	**100.0**	**100.0**	

Their demographic profiles and professional information are provided in Tables 3 and 4, respectively. The majority of participants were female (n=76, 72.4%), aged between 31 and

60 (the median age was between 41and 50), with Bachelor degrees or higher qualifications, and had permanent positions. The participants worked in a range of disciplines and typically had over 10 years of experience.

Measure

In the present study, the internal consistency reliability (Cronbach's alpha) values for the four subscales were: roles domain (α = .81), challenges domain (α = .69), experience and education domain (α = .63), and satisfaction (α = .86).

Analysis

Data analysis was performed using IBM SPSS Statistics (Version 22). Descriptive statistics (*M*, *SD*) were calculated for each subscale. Each of the four Clinical Preceptor Experience Evaluation Tool subscales were approximately normal (all skewness values were below 1.0 and all kurtosis values were below 2.0), which meant this data could be analysed using parametric statistics. Inferential statistics (independent *t* tests, analyses of variance) were used to investigate differences in subscale scores on several participant characteristics (geographic location, profession).

When appropriate, post hoc comparisons were conducted using Tukey's HSD. Consistent with sound statistical practices (see, for example, Gaskin & Happell, 2013; Gaskin & Happell, 2014), effect sizes are reported. Using Cohen's (1988) broad conventions for the social sciences, small, medium, and large effects for η^2 are .01, .06, and.14, respectively, and for *d* are 0.2, 0.5, and 0.8, respectively.

8.4.2. Student Focus Groups and Interviews

Four focus groups were convened with the Project Manager and one focus group was conducted by a co-investigator at CCLHD. Although we aimed to bring together a minimum of 4 students for a focus group, this was not always possible due to last minute cancellations by participants. Focus group participants were asked to complete the consent form and anonymous biographical questionnaire prior to the commencement of discussion. The convenor briefly reiterated the key points from the Participant Information Statement and asked the participants whether they had any questions before proceeding. Audio recording then commenced, and the convenor then asked the following broad questions.

1. Tell me about your experience as a student during clinical placement (particularly those factors that affect the quality of learning)?

2. In an ideal world, how could the faculty/university improve the experience of students during their clinical placement (particularly those factors that affect the quality of learning)?
3. Is there anything that we haven't covered that you would like to mention?

Focus group discussions lasted between approximately 45 and 74 minutes. Individual interviews were conducted with three Physiotherapy students, as they were unable to attend a focus group at the same time. Interviewees were asked the same questions as the focus group participants, with individual interviews lasting between approximately 17 to 30 minutes. Interviews were also recorded. All audio recordings were transcribed by an external confidential transcription service.

Participants

The population of final year students at UON, and the characteristics of focus group and interview participants are detailed in the following Tables 3 and 4 respectively.

Table 3: *Final year student population (UON)*

Discipline	Callaghan	Ourimbah	Port Macquarie	Total
Midwifery	32	-	Not included as located at Mid North Coast Local Health District	
Nursing	253	117	49	419
Medicine	112			112
Physiotherapy	76			76
N&D	68			68
MRS	148			148
OT	80			80
Total	**769**	**117**	**49**	**935**

Table 4: *Numbers and characteristics of focus group participants.*

Discipline	MRS	OT*	Medicine	Nursing	Physiotherapy	N&D	TOTAL
No. of Focus Group Participants	3	6	2	5	-	-	**16**
Other Participants		1 with brief email comments	-	-	3 interviewed by phone	-	**4**
Age							
20-25	3	4	1	1	2	-	
26-30	-	1	1	1		-	
31-40	-	-	-	2	1	-	
41-50	-	-	-	1	-	-	
Gender							
Male	1	1	-	-	1		**3**
Female	2	6	2	5	2		**17**

* 2 students did not supply biographical information

Analysis

The transcripts from the focus groups, interviews and email comments were read to gain a preliminary impression of the data. Key themes were identified as a representation of student participant views regarding their experience of clinical supervision. The qualitative data was managed and coded using NVivo 11 (QSR International). The themes were populated with exemplars to ensure grounding in the data.

9. Quantitative Results

9.1. Demographic Characteristics

The participants were 105 clinicians from two regions: HNELHD (n = 64, 61.0%) and CCLHD (n = 41, 39.0%). Twenty four participants failed to complete the survey. Seventy six (72.4%) of the respondents were female, 27.6% male; over 60 per cent of the participants were aged between 31 and 60 years (31-40, 33%; 41-50, 27.6%; 51-60, 17%). The median age was between 41and 50. There were five respondents over the age of 60 years, two participants declined to answer the question. The majority of respondents were degree qualified (60-57.1%) with over 36 per cent of participants having achieved a Graduate Diploma or Master's Degree and PhD. The majority of participants worked full time (57%)

and permanent part time (32%). Detailed demographic statistics are reported in Table 5, below:

Table 5: *Demographic profile of the participants.*

Characteristic	*n*	%
Gender		
Female	76	72.4
Male	29	27.6
Age		
20-25 years	2	1.9
26-30 years	14	13.3
31-40 years	35	33.3
41-50 years	29	27.6
51-60 years	18	17.1
> 60 years	5	4.8
Did not wish to answer	2	1.9
Highest level of education		
Graduate Certificate	3	2.9
Diploma	3	2.9
Bachelor Degree	60	57.1
Graduate Diploma	11	10.5
Masters/PhD	16	15.2
PhD	2	1.9
Other	10	9.5
Employment status		
Permanent full-time (>35 hours weekly)	60	57.1
Permanent part-time (<= 35 hours weekly)	34	32.4
Temporary full-time	5	4.8
Temporary part-time	3	2.9
Other	3	2.9

9.2. Professional Backgrounds of the participants

The majority of the interprofessional disciplines completing the questionnaire were Occupational Therapists with the next largest group Medical staff (Doctors) and then Physiotherapy, Nutrition and Dietetics and Radiation Science respectively. The majority of the sample had been working in their discipline for over 10 years (71.4%), with 20 participants with between 5-10 years' experience and 10 participants with between 1-5 years of experience.

Table 6: *Professional backgrounds of the participants*.

Characteristic	*n*	%
Discipline		
Medicine	22	21.0
Physiotherapy	15	14.3
Nutrition & Dietetics	12	11.4
Radiation Science	13	12.4
Occupational Therapy	42	40.0
Other	1	1.0
Years of post-registration experience		
1-2 years	2	1.9
2-5 years	8	7.6
5-10 years	20	19.0
>10 years	75	71.4

9.3. Educational preparation for precepting, supervising, or teaching

Almost three quarters (*n* = 78, 74.3%) of participants reported having educational preparation for precepting, supervising, or teaching undergraduate health students. These participants were mainly trained through continuing education workshops that typically lasted 1 day or less (see Table 7). For most participants, 2 years or more had elapsed since their course.

Table 7: *Details of courses of the participants with educational preparation for precepting, supervising, or teaching (n = 78).*

	n	%
Type of course		
Continuing education workshop	61	78.2
Tertiary education	9	11.5
Other	6	7.7
Duration of course		
< 1 day	9	11.5
1 day	38	48.7
2 days - 1 week	14	17.9
> 1 week - 1 month	4	5.1
> 1 month	6	7.7
Time elapsed since course		
< 1 year	14	17.9
1 year - < 2 years	6	7.7
2 years - < 5 years	26	33.3
5 years - < 10 years	10	12.8
10 years +	8	10.3

Note. Frequencies do not sum to 78 and percentages do not sum to 100% due to missing data.

9.4. Participant involvement in student education.

In their current positions, participants reported spending (on average) between 1 and 5 hours in a student education role (either formally or informally) on any one shift (see Table 8). Most participants indicated that they were responsible for 1 or 2 students in clinical areas at any one time. Almost half the participants indicated that there were designated university facilitators available to support students in clinical areas.

At least 18 per cent of the sample conducted no supervision at all. The type of shift worked is a variable factor in this question as it is likely some facilities work eight, ten and in some cases twelve hour shifts. The length of shift worked however was not asked. In terms of the availability of clinical supervisors on the wards to supervise students in interprofessional disciplines more than half said they either did not know, or definitely there were no supervisors available.

Table 8: *Participant involvement in student education***.**

	n	%
Typical time spent on student education on any one shift		
0 hours	19	18.1
1-2 hours	46	43.8
2-5 hours	17	16.2
5-10 hours	21	20.0
>10 hours	2	1.9
Number of students responsible for in clinical area at any one time		
0	3	2.9
1	57	54.3
2	26	24.8
3	5	4.8
4	7	6.7
>4	7	6.7
Availability of designated university facilitator to support students in clinical areas		
Yes	52	49.5
No	36	34.3
Don't know	17	16.2

9.5. Clinical Supervision Experiences

Descriptive statistics (means, standard deviations) for each item of the Clinical Preceptor Experience Evaluation Tool are provided in Table 5. The means and standard deviations for the four subscales were: roles domain (M = 6.24, SD = 0.42), challenges domain (M = 4.89, SD = 0.75), experience and education domain (M = 5.80, SD = 0.64), and satisfaction (M =

5.90, *SD* = 0.67). On each subscale, the scores ranged from 7 (the highest possible average) to 0 (the lowest possible average).

9.5.1. Differences between Geographic Locations

There were no differences in the scores from participants in the Central Coast and Hunter New England regions on any of the subscales: roles domain (d = -0.14, p = .480), challenges domain (d = 0.01, p = .974), experience and education domain (d = -0.06, p = .787), and satisfaction (d = 0.11, p = .584).

9.5.2. Differences between Professions

A statistically significant difference between the five professions (medicine, physiotherapy, nutrition and dietetics, radiation science, occupational therapy) on the roles domain (η^2 = .13, p = .008) was found. Post hoc analyses revealed that the scores for medical professionals on the roles domain were lower than those of physiotherapists (M_{diff} = -0.45, p = .011) and occupational therapists (M_{diff} = -0.33, p = .021). No differences were found for the challenges domain (η^2 = .05, p = .336), experience and education domain (η^2 = .08, p = .097), or satisfaction domain (η^2 = .01, p = .912).

When the professions were divided into two categories (medicine and allied heath), differences were found between the professions for the roles domain (d = -0.76, p = .002) and experience and education domain (d = -0.68, p = .029), but not for the challenges domain (d = -0.13, p = .645) and satisfaction domain (d = -0.06, p = .805). Specifically, participants in allied health had higher scores for the roles domain (M_{diff} = -0.30) and the experience and education domain (M_{diff} = -0.42).

9.5.3. Descriptive statistics for the CPEET items

Descriptive statistics (means, standard deviations) for each item of the Clinical Preceptor Experience Evaluation Tool are provided in Table 9. The means and standard deviations for the four subscales were: roles domain (M = 6.24, SD = 0.42), challenges domain (M = 4.89, SD = 0.75), experience and education domain (M = 5.80, SD = 0.64), and satisfaction (M = 5.90, SD = 0.67).

Table 9: *Descriptive statistics for the Clinical Preceptor Experience Evaluation Tool items*

Item	*M*	*SD*
Roles domain		
1. Clinical supervisors/preceptors are a professional confidante to students.	5.50	1.23
2. Clinical supervisors/preceptors are a support person for students during their clinical placement.	6.27	0.81
3. Clinical supervisors/preceptors are a professional friend to students.	4.37	1.62
4. Clinical supervisors/preceptors are a positive role model.	6.53	0.65
5. Clinical supervisors/preceptors facilitate active learning experiences for the student.	6.57	0.81
6. Clinical supervisors/preceptors promote students' active participation in patient care.	6.46	0.81
7. Clinical supervisors/preceptors provide clinical practice supervision for the students.	6.52	0.62
8. Clinical supervisors/preceptors provide constructive feedback to the student.	6.60	0.69
9. Clinical supervisors/preceptors encourage students to apply theory to the clinical situation.	6.45	0.66
10. Clinical supervisors/preceptors facilitate students to make the links between theory and clinical practice.	6.45	0.71
11. Clinical supervisors/preceptors facilitate students to analyse clinical problems.	6.51	0.67
12. Clinical supervisors/preceptors facilitate students to critically reflect upon clinical problems.	6.44	0.80
13. Clinical supervisors/preceptors model multidisciplinary teamwork for the students.	6.37	0.75
14. Clinical supervisors/preceptors support students by being available to answer questions.	6.24	0.83
15. Clinical supervisors/preceptors facilitate students' learning by using case studies and care plans.	5.82	0.85
16. Clinical supervisors/preceptors treat students with respect.	6.56	0.59
17. Clinical supervisors/preceptors treat students fairly.	6.49	0.69
Challenges domain		
18. It is acceptable for students to clarify with the supervisor/preceptor when there is a difference in practice.	6.38	0.58
19. Personality clashes will not negatively affect my attitude towards a student.	5.45	1.48
20. Though I am very busy, I am willing to be a supervisor/preceptor.	6.22	0.69
21. I am motivated to supervise/precept students.	6.18	0.73
22. Being a supervisor/preceptor will not take my time away from providing direct patient care.	3.67	1.92
23. Being a supervisor/preceptor is not time consuming.	2.11	1.14
24. I am willing to make time to support unmotivated students.	4.24	1.63
Experience and education domain		

Item	*M*	*SD*
25. Clinical supervisors/preceptors clarify the role of preceptor with colleagues on a regular basis to ensure the needs of the students are met.	5.18	1.28
26. Being a supervisor/preceptor, I need to know what the expected level of skill competence should be for a student's scope of practice.	6.41	0.68
27. I read updated texts and journals regularly.	5.58	1.24
28. Being a supervisor/preceptor facilitates professional reflection on my own role.	6.26	0.83
29. Being a supervisor/preceptor challenges my work attitudes.	5.55	1.26
30. Being a supervisor/preceptor helps to expand my professional knowledge.	5.84	1.09
Satisfaction		
31. Being a supervisor/preceptor is meaningful.	6.22	0.73
32. Being a supervisor/preceptor is satisfying.	5.93	0.89
33. The role of supervisor/preceptor is professionally rewarding.	5.89	0.94
34. The supervisor/preceptor role is an incentive to teach.	5.65	1.10
35. I enjoy the student/supervisor/preceptor interaction.	6.08	0.73
36. Being a clinical supervisor/preceptor is an incentive for my own professional development.	5.67	1.25
37. I enjoy facilitating novice clinicians to develop as professionals.	6.25	0.74
38. The clinical supervisor/preceptor experience breaks the monotony of daily professional practice.	4.90	1.50
39. It is stimulating to work with enthusiastic health students.	6.52	0.64

10. Qualitative Findings

Analysis of the data identified the following 6 key themes and codes:

Table 10: *Qualitative themes and codes*

Categories	Codes
1. Definition of Clinical Supervision/Mentoring	Role of Clinical Supervisor
	Role of day-to-day mentor/clinician
	Role of Clinical Facilitator (Nursing)
2. Preparation for Clinical Placement	Allocation to Site/Facility
	Orientation and contact by site/facility
	Preparation of CS, department or team
	Quality and number of clinical placement places available
3. Structure of Clinical Placement	Overall attitude to clinical supervision
	Delegation of supervision/teaching responsibilities
	Interaction with Clinical Supervisor/Mentor
	Team knowledge of student skills
4. Learning Processes &	Content learnt

Categories	Codes
Outcomes	Feedback & review process
	Shadowing/observation
	Independent working & learning
	'Testing' of students
5. Assessment	Assessment process
	Input from mentors and others
	Personality and relationships affecting assessment
	Variability in definition of grades/standards
6. Support During Clinical Placement	Support from University
	Support from other students on placement
	Support or debrief following adverse event on CP

10.1. Definition of Clinical Supervision and Mentoring Roles

Although there were common elements, there was also variation in the terms used, and the roles undertaken by health district clinicians engaged in supervising undergraduate students during CP. Among Medical MRS and OT students, the CS was seen as the more senior staff member who had been trained in clinical supervision, completed the final assessment, yet the day-to-day supervision or mentoring may have been delegated to others within the department. Physiotherapy students tended to use the term 'Clinical Educator' rather than CS. The final year nursing students used the term CS and mentor interchangeably "*Well, I think they're the same thing…It's who you're working with on that shift*". Moreover, nursing students may have a different CS on every shift:

But you are usually, if you're lucky, assigned to a mentor for a week or 2 or the entire time, if you're really lucky, but sometimes…just because of staffing, there's a different one each day…It's hard.

The main difference in Nursing is that the Clinical Facilitator (also known as the Clinical Liaison Nurse), who is employed by the University, conducts the assessment of the student. The Clinical Facilitator is also responsible for the supervision of students during their first and second year placements at health facilities, yet this responsibility devolves to the CS by the third year.

10.2. Preparation for Clinical Placement

Student and health facility preparation for CP were seen to be a vital step in determining the success of the placement, yet these processes did not always operate smoothly.

10.2.1. Allocation to Site or Facility

MRS students spoke positively about their professional placement system "*that we put in preferences and that allocates us to certain placements…that's a very good tool to use*". However, they highlighted, that delays in when they were notified of their placement site by UON, did make processing of the necessary documentation very rushed, particularly for interstate placements:

Yes, so I think if we knew where we were going earlier then we would be able to prepare better, but it's also that period where knowing what we need to prepare for. I think that information's not really well laid out either.

The Medical and OT students discussed the challenges associated with being allocated to a site or a department, with those involved in day-to-day supervision not being included in the decision to accept students.

I think part of that goes to the ClinConnect system where it's not actually allocating a supervisor, it's allocating a site, like a service, and sometimes, like the OTs don't even get called up, like they themselves don't have any decision really about whether they're taking a student or not; it's their manager who decides or not if they're going to take students. So it depends on the site. (OT Student)

So you weren't allocated, like, a specific Supervisor, you were just kind of allocated to the ICU area and we were ignored by the Consultants there, and then the Registrars said that they were too busy to look after us. So we literally stood there until like we'd done our hours and then left. (Medical Student)

We just rock up on the first day and it's a surprise to them that there's a new group of students (Medical Student)

Not being allocated to a specific CS, can also be problematic:

I just like rock up and then I look like a deer in the headlights, and then I look for someone who looks important, so someone who scrubs is always a good one, or who has gloves on, you're like, okay they're important, or who is wearing like a suit with a coffee, but they're too important. You don't want to go for the too important people because you don't to want to harass Consultants. So you have to find like a middle Registrar or JMO to initially approach and then you hope that someone can point you in the right direction. (Medical Student)

10.2.2. Orientation and contact by site/facility

Those students who were contacted by their site or facility prior to the CP, and were provided with an orientation package, spoke very positively about this preparation, for example:

I also got a package when I went to the ICU, they've got their own education unit at the ICU, and it was brilliant. Like, it was way above my expectations, working there, because they, because of the contact that happened before the placement which, you know, I had to instigate by just saying, "This is me, who I am" and, you know, just their welcoming, like welcoming me to their unit. And then they also had organised like a student introduction to the unit and gave a package, you know, which was a folder, a booklet of all the stuff that was important about that unit (Nursing Student).

The same student further noted: "*a lot of the units that I went on, there's no sort of induction into the unit or to where you're working*."

Lack of contact between the student and a rural mental health facility resulted in embarrassment for one student, who turned up to the CP wearing her uniform (mental health staff typically wear casual attire). Another nursing student found that she had been given the incorrect address of a facility.

10.2.3. Preparation of CS, department or team

Various students describe how their CSs felt inadequately prepared to teach and assess students.

…the rotation that I'm on at the moment is really good but the Supervisor there has absolutely no idea like what my role is. So, and they ask me what I'm meant to be getting out of the experience and I don't even know. (Medical Student).

One MRS student observed: "*Like we prepare for prac but it's like they don't, sort of thing."*

There was one instance where an international student recounted her CS's expressed need for training in how to manage students from culturally and linguistically diverse (CALD) backgrounds:

I would think that supervisor has a critical role in supporting us, and they could be better trained in supporting international students and being more culturally sensitive. And because some of my culturally embedded behaviours were misinterpreted by my supervisors,

like I tend to leave work late to show my initiative, and this is very common and expectation in the Asian countries, but my supervisor interpreted it as I was not coping with my workload…she also explicitly said she wants more supervision from the uni, that how to supervise international students which is, she never have that training before, and this was her first time to take an international student (OT Student).

10.2.4. Quality and number of clinical placements being available

A common concern expressed by the students was that the increasing demand on health providers to provide CPs had the potential to compromise the quality of placements being offered:

We've become increasingly aware of how few placement opportunities there are in relation to the number of students…I think it gives them less opportunity to be selective about where they're sending the students to, and it gives them less opportunity to kind of research to where they're sending students to. (OT Focus Group)

I kind of feel like, our uni, we're sort of pumped out like a production line. I feel like they take too many of us in and they struggle to find placements, so therefore the facilities in which we are doing placement on have got no opportunity but to take more students than what they should, because the uni's bringing too many students in. (Nursing Student)

I find they're worried about the clinical supervisors and losing that placement because they're hard to get for the people, so they take into consideration a lot that you know, they try and please the supervisor rather than helping the student. (MRS Student)

10.3. Structure of Clinical Placement

Structure was consistently highlighted as being a defining feature of a successful CP:

So every department I've been in they've sort of had like a structure for students to follow that's been good and then if you go into a department where it's been unorganised and non-structured and they don't have sort of like you know…student plans, it's just not a good placement. And you don't really get the outcomes that you're hoping for. (OT Student).

I had one clinical placement out of state …,they have an amazing kind of process up there where the hospital I went to had one clinical supervisor who was in charge. We had a meeting with that supervisor every week, he ran us through the different goals we wanted to

achieve each of those weeks. We actually had a roster as to which camera we were on, what scans we could do, he continually checked up on us…So there was that continued support that, he even though he wasn't able to be there every single day, he had the tools that could show my ability to work over the clinical placement in total so it was actually a true reflection of what I could do as a student rather than just a hearsay or this or maybe this or maybe this, kind of thing. So there was much more structure and I found that even though, you know the marks were similar from both places I think that I felt more comfortable with the results that I did get from the place that had, you know the structure. (MRS Student).

10.3.1. Overall attitude to clinical supervision

The overall attitude to clinical supervision expressed by the CS or other team members, often reflected the structure of the CP, and the learning outcomes for the student:

Really good placements that I had, the clinical educator made me feel really confident, made me feel welcome. The placements were well organised and they were well organised in a way that enabled me to progress and grow my confidence as the placement progressed and that really helped, so I started off with fairly simple cases and that helped build my confidence and by the end I was dealing with more complicated conditions. And so the two placements that I had that were absolutely fantastic, that I thoroughly enjoyed, that was a common theme in those two placements. (Physiotherapy Student).

Whereas other places you can tell they don't like working with students and so it really affects the learning outcome because, either whether it's through their body language or their lack of communication or their feedback, you can tell that some people don't want to work with students (MRS Student).

In my second year placement it was made very, very clear to me by my supervisor that taking on students was part of their contract, it was not her choice to have students, and that was why I was there, that I would just stand there and do as I was told and she was forced to have a student. It wasn't her choice. (OT Student)

10.3.2. Delegation of supervision/teaching responsibilities

The students recounted a number of examples where due to workload demands or roster arrangements, day-to-day supervision responsibilities were devolved to other members of the department. For the most part, students perceived this as a negative characteristic of their placement experience:

My last clinical placement I found that over the four weeks I was there I had three shifts with my clinical supervisor. So I think again it's a reflection of, there wasn't one person in charge of me there was five or six, and those five or six people didn't have much interest in allowing me to do things, allowing me to show my ability (MRS Student).

Unfortunately those involved in mentoring or informally supervising students are less likely to be prepared to undertake supervision responsibilities, and this impacted on learning:

If you have someone in the department that, you know is not prepared for your arrival, doesn't know you're coming, doesn't know they're going to be working with you, they're much less likely to want to help you, want to be involved because they're kind of like, well why are you here, I had my day planned doing this and this and now I have this student tailing along with me, kind of thing (MRS Student).

One nursing explained how her CS was often required to work in Triage, and was unable to supervise students while she was working in that area. As a result, the student had to find other mentors to work with:

Because I was having to find my own supervisor, they weren't necessarily briefed on what, you know, that they were going to be doing that or, so it's a bit stressful for them as well, I suppose. And, you know, it could be stressful. But the positive thing was I more proactive in finding out ways of fitting in to a system that wasn't really set up or organised.

Nevertheless, a small regional hospital managed to overcome resource limitations and implement an effective shared clinical supervision arrangement:

I was in a small regional hospital and so there was only ever two registered nurses on the entire ward for the entire shift, like each shift. So the chances of you getting the same mentor between one shift and another shift was slim to none. But something that they did that was really great was they do patient handover and they'd say about all of the different patients, but then they'd hand me over as well. So it still was like sharing information, "Well today [the student nurse has] taken three patients", you know, "She's been doing this and doing that. Tomorrow I think she's ready for this new learning." (Nursing Student)

10.3.3. Interaction with Clinical Supervisor/Mentor

Regular reviews and discussions between the CS and the student were considered crucial:

So my latest clinical experience was my 5 week experience and I was fortunate enough to be assigned to one mentor for the majority of the time, probably worked four out of five shifts with the same nurse. Which was really beneficial because she knew where I was at at every stage, every day, and so like she could say, "Okay, today you're going to take three of your own patients", or, "You've mastered three patients; you do all four." And so that was just really helpful because we could develop a professional relationship, and when she gave me feedback I could take that on-board and it was just really helpful to have that continuity that we haven't had on previous placements. (Nursing Student)

Lack of interaction proved very challenging to students:

And during the entire time I found a very large lack of support during my clinical placement. The supervisor that I was allocated was barely there to give me any kind of real support. Only really a couple of sessions out of four weeks (MRS Student).

One of the biggest challenges was that our supervisor was actually based in [one rural town] and we were based [another rural town, over 200 km away]. So our supervisor never actually saw us [at the sites] that we were working in; she came down once a week and saw us in an office on a Monday for a couple of hours, but she didn't actually get to see us interacting with the [clients] ...or doing most of our practice (OT student).

One Medical student had to manage not seeing her CS for most of her rotation:

I even got a rotation where the Registrar said, "you are not going to see your Clinical Supervisor at all for this next two weeks", and ... then, he suggested that, right, so since you're not going to see him I suggest that you do a log book and record every single thing that you do and submit that at the end of your form to him. So that's what I did.

10.3.4. Team knowledge of student skills

Lack of knowledge of student skills was cited as an impediment to learning. In one case supervision responsibilities had been ineffectively devolved to other team members, and so:

They definitively, as I said they kind of restricted my workload because they didn't want to take on the responsibility of potentially me doing something wrong or, you know being out of my scope of practice, and the supervisor, they're kind of worried as to what the supervisor would think. (MRS Student).

Some CSs had little knowledge about the skills that the students had acquired during their degree:

I think we want to do the things we want to do at uni and more and sometimes we get to those placements and they don't let us do the things we're even doing on a weekly basis at uni, so. Like our clinical labs with, you know drawing up injections and practicing scans and things like that so. I think, we expect to be able to do those things competently on placement and sometimes aren't allowed to (MRS Student).

Others overestimated the skill level of students:

She also had a misunderstanding about how much experience myself and the other student had in Paediatrics, and was kind of like, wanted us to go in guns blazing, get started, like do everything and we felt like we were unqualified to do that much in the initial weeks (OT Student).

Even when a scope of practice document is issued by the University to the facility, not all staff take the time to read the document:

I'm not saying that they all know it, but there is a document that is put in the tearoom or it's issued to the facility. And it's up to the nurses, the mentor, to take that responsibility and reading and understanding it…And yeah, that nurse I was with would have been aware that it was outside of my scope of practice to, you know [deal with], the patient with the tracheostomy (Nursing Student Focus Group discussion).

As one nursing student mentioned, however, each University has a different scope of practice document, and therefore it can be difficult for staff to keep abreast of the different standards.

10.4. Learning Processes & Outcomes

10.4.1. Content learnt

The nursing focus group participants identified how constant changing in mentors adversely affected their learning outcomes:

Because it's really hard as a student when you're in that situation where you start with one mentor and then the next shift you'll have a different mentor…I felt like I was treated as like slave labour... I was having to do all the showers, all the beds...but in your scope of practice

it gets bigger as you go through your degree, and I didn't feel like I was learning anything in that situation because I was still doing beds and showers, which was a 1st year kind of thing.

A well-structured CP supplemented by education sessions was particularly beneficial for one Physiotherapy student:

So it was structured in the sense that – so firstly, the number of patients that you were seeing a day. At the beginning you had longer booking times with your patients, so that was the first thing. And then the second thing was they were just fairly straight forward injuries where you're really just treating one thing and you just needed to treat that one thing well. But that was also backed up by having education sessions throughout that week that were related to the patients that you were seeing that week. And so that was really, really helpful because you had – I'm a practical learner and it was really helpful to have that context so close to those tutorials.

10.4.2. Feedback & review process

Effective regular feedback and review was viewed as an essential to CP:

The best mentors I've had just let you show what you know, show your knowledge. So then at the end of the week you would have a sit down with your mentor and they would run you through where you can do better next week. And then, so each week you would have a meeting with your mentor and then at the end of the five weeks you sit down with the clinical educator and they read all your reports and they talk to your mentors and they give you a final report. (MRS Student).

The better supervisors also give you, at the end of every week they give you some feedback, they sit you down, sometimes you even get it daily, like the best supervisor I had, she would sort of say to me, just quietly after a patient, just give me some encouragement, like "I noticed that you did that, next time can you try and do this?", and the next time when you did do that, she'd acknowledge it, so you got that constant feedback, it wasn't just the formal mid-unit and end of unit, which was really helpful. (Physiotherapy Student)

Conversely, lack of feedback from the supervisor can create unhealthy competition between students who are on CP together:

Probably some of the negatives would be when you're on a prac with a couple of other students, and I guess just the lack of communication with the supervisor in how you're going

and what they're expecting of you, which can lead to sort of, I think the students that are competing against one another, and everyone's just not really sure if they're going well, so it creates a bit of tension between people. (Physiotherapy Student).

Delayed or an emphasis on negative feedback also proved to be problematic:

But otherwise in a negative sort of way, if there was something that I was doing wrong or not in the best way, it was often the fact that she would try and let me find out for myself, like try and let me identify it independently. And so she would let it go on for like a week or more, and without me knowing that it was not the best course of action. (OT Student).

[The CS] sort of delivered feedback in a way that it felt very negative a lot of the time. So I'd sort of leave and go home and never be quite sure whether she was happy with what I was doing or not. So she would give not negative but not overly positive verbal feedback, but then her demeanour would not match what she was saying. (OT Student)

10.4.3. Shadowing/observation

Shadowing or observation of clinicians was typically viewed as the least effective process for learning:

The mentors I've found have been good in places where sort of they let you show what you know instead of like you shadowing them…the bad placements I've had have is just shadowing mentors and not being able to do much. (MRS Student).

In some cases, it was the result of not being prepared for the student:

Then the problem of shadowing comes in because if someone is not prepared for you really sometimes all you can do is shadow because they don't want to break their routine and they're not prepared to teach you. (MRS Student)

Because it turns out I got a job for next year in private practice, and that was my private practice prac. So during my interview they're saying "Okay, so tell us a little bit about this prac where you were working in a private practice, what did you get to do, what were your responsibilities?", and I would have loved to have said "Oh, I had my own case where I was treating patients and I was really hands on", but I had to be honest and say "Oh, look, their policy was that I was largely observational, I'd go and get T packs for them, put on some pressures, compression things, and watch" (Physiotherapy Student)

10.4.4. Independent working & learning

In contrast, independent working and learning can be particularly beneficial for final year students who are soon to embark on their first year of practice:

On one of my pracs…we ended up with a full caseload, it was in a hospital, we ended up with a full caseload by the end of the prac, we were working independently, but we also had to work, we were encouraged to have a role within the multidisciplinary team, which was really, I mean, just for me, because as a student I just kind of didn't expect that nurses or doctors or anyone would be interested in what I had to say, and that prac was the first prac where my supervisors really encouraged me to speak up and to seek out other people that work in the hospital, and work with them, so that was really good, what that supervisor did in showing me that (Physiotherapy Student).

However, in some instances students found themselves working independently with little backup:

Although in some situations, as far as support goes, often if there was a smaller amount of patients there would only be one registered nurse. And so it would just be me and the registered nurse looking after the entire ward and that was scary at times, you know, when you were put into situations where, "We're really short-staffed, I'm sorry, but you're going to have to take these four patients and come and get me if it's an emergency", you know what I mean? (Nursing Student).

[The CS] admitted to me straight up that she didn't have much experience in it, and I mean I, because of that I got a lot of independence but it wasn't, I thought I was going along fine, but then I realised that I probably wasn't getting enough supervision because I was thinking, "Fourth year," I wasn't sure what the expectations were, "Should I be doing this on my own? Like I'm supposed to be practicing next year, or should I be getting a lot of supervision for this?" And it actually came up but it was in Week 8 that both of the ward OTs were away for a week, just it was a mistake they shouldn't have been away; it was for a professional development. And I pretty much had to run the ward by myself. (OT Student).

10.4.5. 'Testing' of students

Unfortunately some CSs and mentors saw on-the-spot testing of students as a valid teaching tool; the students typically did not respond well to this process:

Instead of turning everything into a spot quiz, you know what I mean. (OT student)

There are some Supervisor that doesn't even acknowledge that you're there and if you don't know the answers to the question that they ask they would somehow, you know, "what have you been doing in med school?" (Medical Student)

[I] think it would be good for them to learn or to realise that people do learn differently. Just because somebody doesn't remember something instantly doesn't mean that – I just hope that just because I can't remember things instantly that doesn't mean that I'm going to be a crap physio, which sometimes that's what the sort of implication feels like. (Physiotherapy Student]

10.5. Assessment

10.5.1. Assessment process

Each discipline had its own assessment process and tools, and a full description of each is not provided in this report. However, there were a number of elements that were relevant across the disciplines.

10.5.2. Input from mentors and others

One CS in Medicine relied on input from other clinicians and patients in determining her assessment of the student; the student viewed this as a very positive approach:

One of my Supervisor, past Supervisor, is not always there, but what she did was, when I finished my rotation and…she went through every single patient and she went through her team members and asked about me, and then she grade based on that, not just based on when she sees me but based on what the staff nurse said about me, what the Registrar said about me, what the intern said about me, and then when she went and see her patient she ask, "oh did my student come and see you", and then she graded me based on that.

However, another student did not view this approach positively:

The only feedback that my clinical supervisor could give me was the ones that was given to him from the others. So all in all I think that was a very big disadvantage to me and it was a very negative outlook on…one of my clinical experiences and I think it could have been done a whole lot better. (MRS Student).

10.5.3. Personality or relationships affecting assessment

A consistent theme was that personality or relationships unfairly biased CSs' assessment of student performance:

My marks were based upon the opinions of others who I routinely you know, worked differently and sometimes if I had a personality clash with them it would greatly affect my marks whether it was true or not. (MRS Student)

Yeah, it's certainly not a great, and if you're, just say if you get a Supervisor who you get along well with but you not necessarily turn up when you should, then they're going to mark you well, like, no matter what you kind of do. I feel like, and there's a lot of room for kind of manipulating the system with how they were, how the Supervisors rate us, but I don't know how you can fix that. (Medical Student).

And I know a lot of people think that that's not fair because that's the mark that you get for the whole course, and if you get an educator that you don't get on with and they mark it really subjectively, well, that's your mark for that practical course. (Physiotherapy Student).

10.5.4. Variability in definition of grades/standards

There was variability in the standards applied by different CSs in assessing students. This was particularly noted in the OT focus group:

It's really variable. Sometimes people get a capped mark and there's no consistency between supervisors. I think they're told that they don't have to do that but they just decide it….In the prac I was just on in [a regional city], when we had our SPEF-R meeting at halfway, they're like, "We'll sit down and talk about how we grade, because we've had students upset with the way that we grade." So they grade five as you're an experienced therapist, four is you're a new grad, and three is a student…Which is not the idea….like the whole thing is meant to be a student evaluation, so it's really strange. (OT Student Focus Group Discussion).

For the students in the Medical focus group, the marks assigned did not always reflect the student's standard of work:

And when they are so responsible for you passing that rotation it can be quite an uncomfortable situation that you'll be in and there's, I know for a fact that there's students who have failed a rotation because their Supervisor has been a poor Supervisor and has given them a mark that didn't reflect the amount of work they put in…And I went around and

asked other students if we're coming to this focus group, so they wanted me to relay the message.

10.6. Support during Clinical Placement

10.6.1. Support from University

The student's CP experience can sometimes be a stressful one, and there were a number of students who felt that additional support needed to be provided by the University. One MRS student had to leave her CP due to personal and family issues, and felt inadequately supported by the University during that time. However, she noted:

And I've noticed this year I know a couple of people this year that have just spoken to the lecturer and said look this is the situation, I'm not getting the marks I wanted because of these issues personality wise with these people, and they said that's fine, we'll give you another placement. So I think, looking back, I'm happy for those people but looking back I think I was just like very hard done by considering the circumstances.

In the OT focus group, one student commented that she had no contact from the University during her CPs:

We never actually had any formal feedback, like no one ever actually sent an email. It was like, "Are you still alive on prac?" or call and said, "Is everything okay?" or like across the whole four years.

In contrast, an OT whose CP was arranged through the University of Newcastle's Department of Rural Health (UNDRH), felt very supported:

Two of my pracs, including my most recent prac, I had two of them that were supported by the UNDRH, so I actually had members of the UNDRH on both of those pracs come out and actually physically come to my site and sit down and just sort of sit with me and my supervisor and say, "How's it going? Do you need any extra support?" either the student or the supervisor, "We're here if you need any help. We're available at all times".

Other students indicated that they felt very constrained in raising issues with the University, as they were all too aware of scarcity of good quality CPs for students:

That's right, yeah, no one wants to complain very much, if at all, because obviously it's not fun hearing complaints, and we know how much effort they go to to get us out there in clinical placements. (Physiotherapy Student)

I guess we're very aware that there's repercussions if we make any sort of complaint…Negative comment…about a prac that we're on because it's made very clear to us, or I feel very clear that we're very, very lucky to have pracs at all, so you don't rock the boat. (OT Focus Group).

10.6.2. Support from other students on placement

For some students, have other students working with them on CP provided an added means of support:

So, and another positive was that I was with another student. I found that to be really good as an opportunity to kind of like bounce off one another and reflect ideas. (OT Student).

However, there are situations where this can add to the student's burden, as occurred with one nursing student who was working with five internationals students on the ward:

I just ended up being the person that all the other students kept turning to to ask everything. And I was trying my best, but at one point I just actually felt quite overwhelmed and thought, "Hang on, I'm a student here too just trying to do my placement and I am constantly answering questions", just basic stuff right through to, like a nurse came over to me in tears, [an international] student, saying, "My nurses wouldn't work with me" so I had to, I was like, "Okay, just take a moment. It's probably not that she doesn't want to work with you", whatever, then I had to go and find the actual nurse and say, "Look, there's a problem here."…And I just thought, this is not really cool because I'm probably missing, you know, I can't get into a stream where I'm just actually being here as a student, you know.

In Physiotherapy, having more than one student on site was viewed as an impediment, as the students tended to compete against each other:

I've had other experiences with students where the students basically put you down in front of the educator, you know, to make themselves look better. And they do it. And there's a couple of students that do it particularly well and it just seems to go in their favour and you don't ever feel like you can say anything to that student on the spot because you feel like that would look poorly on you.

10.6.3. Support or debrief following adverse event on CP.

Various students highlighted the need for additional support or debrief following a confronting event on CP. This could be provided by the University, or by an independent counsellor who has knowledge of the health context, and the profession of the student:

I think also maybe when something bad happens, like something traumatic happens 'cause like you see people die and that, kind of like a debriefing. They have debriefing in ED or like trauma cases, but sometimes, for the Consultant or the Supervisor, a patient dying in the ward is just like an everyday thing for them, whereas, for a student it might be the first time that you see it or it might be quite upsetting and there's no kind of real framework for addressing that. (Medical Student)

One nursing student located within a rural mental health facility had to manage a crisis situation alone:

We had 26 clients and then this one client was kind of flying off the radar, was playing up, and that escalated to nearly every client within this facility having to, I can't use proper terms because, they were just all, it was just like a ramification, if one flew off the handles; they all flew off the handles...Yeah, definitely distressed, it escalated the situation, so they all became the same. And that was very frightening. Yes, we had duress alarms and all of that, but I had no training in how to protect myself and protect others in a non-confrontational manner.

Fortunately, a debriefing session was arranged for this student with the University via SKYPE.

Another nursing student who was asked to run an ECG on patient, but the student was not advised by the team that the patient had just identified her deceased husband:

It was right at the beginning of me setting up the whole ECG which is a very, you know, it's like quite a, you know, personal and takes a good 10 minutes, 15 minutes. So then I had to communicate, you know, therapeutic communication with the patient, who was then detailing me and I think I was the first person in the Emergency that had actually sort of brought it up, so then she poured it all out.

Luckily this student was able to secure her own support and assistance by discussing this episode with another nurse in the staffroom.

11. Discussion

This study systematically obtained data from final year interprofessional health students and their clinical supervisors across two NSW health districts regarding their opinions and expectations about clinical supervision. The project employed mixed methodology combining quantitative survey data and qualitative data derived from focus groups and semi-structured interviews. It is apparent from the statistical analysis that there are differences in the roles undertaken as clinical supervisors from a health discipline perspective, including their education and experience orientation to student clinical practice.

To more deeply understand the relationship between the student and the clinical supervisor and how they participate together in patient care is worthy of further investigation. It is also indicative that each discipline facilitates engagement with other health disciplines in the work environment and has its own approach to linking the student to clinical practice opportunities. What is evident from combining the results is that each health professional has an intrinsic responsibility to link their students to patient care.

The qualitative data provides a unique window into the values and beliefs of the students based on their personal experiences of clinical supervision across the duration of their degree program. Refining a model of clinical supervision from this data will be of value to future students and for faculty and clinical supervisory staff to have a deeper appreciation of what it means for the student to be paired with an experienced clinician. In most cases faculty development and engagement is crucial within the professional health sector, as the majority of teaching is performed on a volunteer basis. Barriers to effective teaching in the clinical environment can include balancing heavy clinical workloads, lack of time, isolation, keeping up to date, managing the assessment and reporting processes, legislative requirements (e.g. safe hours and manual handling) and heightened expectations (patients, students, community). A balanced appreciation of what the issues for students and staff are can only benefit the improvement of clinical supervisory relationships and models.

The study has revealed information to inform curricula and clinical experience planning (rostering and orientation) and to further guide the improvement of clinical supervision events. As one nursing student said "*a lot of the units that I went on, there's no sort of induction into the unit or to where you're working*." The age of the smallish survey sample is

indicative of an ageing health workforce with the majority of participants aged between 31-60 years (with a median age of 41-50). It does seem as if there is a need to focus on succession management and the development of recent graduates to begin providing clinical supervision early in their career and to not just rely on the older more experienced clinicians.

As the NSW Health Training and Education Institute (HETI) have been providing Master classes over the last two years in NSW, some of the sample may have been to these sessions. Although not everyone indicated they had received training and over 60 per cent of the sample have had no training for at least 2 years. One MRS student observed: "*Like we prepare for prac but it's like they don't, sort of thing*." Such a time lapse between educational events, points to a need to create courses and programs focusing on clinical supervision which are integrated in both health agencies and health discipline university curricula. In any event, some attempt to orientate students and health staff to the principles of clinical supervision has to be a good thing. A medical student makes the point: "…*the rotation that I'm on at the moment is really good but the Supervisor there has absolutely* no idea like what *my role is. So, and they ask me what I'm meant to be getting out of the experience and I don't even know*".

The student staff ratio varies across disciplines indicating that some supervisors may be carrying bigger loads than others which can affect the quality of the clinical supervision. As mentioned earlier the student supervisor relationship is an essential component for their being a positive outcome from the clinical experience (O'Donovan et al., 2011; Vågstøl & Skøien, 2011). Quality of time is important and access to uninterrupted one-on-one supervision is a highly valued interaction (Fenton, 2005; Young et al., 2009).

To drill down to the micro level in the pairing of a student and their clinical supervisor would provide a better understanding of the real issues involved in the workplace. An OT student suggested: … *if you go into a department where it's been unorganised and non- structured and they don't have sort of like you know...student plans, it's just not a good placement.* There is also some evidence that there is a need for clear policy and procedures around the management of challenging or unmotivated students. This aspect perhaps underscores the need for clear instructions and schedules shared across students and clinical supervisors, and students being better orientated to the challenges of the clinical practice environment.

This MRS student said:

During the entire time I found a very large lack of support during my clinical placement. The supervisor that I was allocated was barely there to give me any kind of real support. Only really a couple of sessions out of four weeks.

The workplace environment has its own set of challenges and there is evidence on a number of different levels that students can feel exploited and vulnerable when attending clinical placement events. The Expert Advisory Group (EAG) to the Royal Australasian College of Surgeons (RACS) (2015) for example, suggest that discrimination, bullying and sexual harassment exist in the practice of surgery. Such claims are not isolated, and there is an abundance of research regarding workplace violence (bullying) and its effect on retention and attrition, with much of this research focussing on nursing. For example, a recent analysis reinforces how such bullying, harassment or horizontal violence not only adversely affects the workplace satisfaction, retention and the health of nurses, but potentially impacts negatively on the quality of patient care (Vessey, DeMarco, & DiFazio, 2010).

It is clear from the data that a supervisor being a friend or confidante to the student is not always a favourable approach in the development of a professional relationship with the student. This perhaps highlights the need for the supervisor to be friendly, but professional and available to students because of the nature of the supervisory relationship; a relationship that facilitates and affirms the student competency within their scope of practice.

12. Limitations

There were a number of limitations in the design and completion of the study that should be considered before delving deeper into the important issues the project has revealed about clinical supervision of interprofessional health students. The team spent considerable time and effort obtaining ethical approvals, and trying to compile decent-size survey distribution lists. This is not generally an issue, but with a four month turn-around this did create tensions. Some students agreed to turn up for focus groups and then didn't show up, and we were unable to recruit Nutrition and Dietetic students to the focus groups as they were on long-term placement during the period of data collection.

Not being able to obtain a larger sample size from clinician's from the various health disciplines has been a limitation. Having access to a larger sample would increase the

distribution across the professional groups. Perhaps sampling each individual discipline separately and then combining samples would yield different results, as some disciplines are larger than others. There were staff who did not complete the survey, which speculatively provides an indication that the questions about clinical supervision were not necessarily applicable to them, they were too busy to take the time, or that the survey was not relevant to their practice situation.

13. Conclusion

Despite the study limitations, it has yielded important information about the interprofessional clinical supervisor's perceptions of the role, and the challenges that are associated with being a clinical supervisor. There is also clarity around their perception of preparedness for, and satisfaction with, the role of CS. It is fair to say that a group of clinical supervisors with years of experience are more likely to say they are better prepared to supervise a student, than a group with less experience, but perhaps not from the theoretical perspective of clinical supervision itself.

The thematic development of data from the student experience perspective provides important touchpoints to consider when developing curricula and clinical supervisors to support students. Students want to ensure that they receive effective and timely preparation for the placement event; equally, they want assurance that the facilities, CSs and day-to-day mentors are sufficiently prepared for their arrival.. Excellent placements and excellent supervisors are defined by a number of key characteristics, including preparedness, structure, and overall attitude to supervision; and each of these characteristics impact on one another.

The study provides useful information for fine tuning and further development of clinical supervisor roles, and highlights the need for continuing education for clinical supervisors. Such fine tuning can occur with the orientation and preparation of students and clinical supervisors prior to the eagerly anticipated workplace experience for the student. The qualitative findings provide useful direction to clarify clinical supervision roles and in the student, supervisor and facility preparation for the relationship. Focusing in on the structure and function of the placement and how this aligns with learning expectations and outcomes is also critical to a successful clinical supervisor student experience.

14. Recommendations

It is recommended that:

- Health services and university interprofessional departments work closely to clarify the expectations around a clinical supervisor relationship with a student;
- There be a standardised approach to the education and training of clinical supervisors and that this occur as mandatory continuing education for both health district and university interprofessional clinical staff. This should incorporate training in how to supervise students from CALD backgrounds;
- A handbook be created to share with the student and clinical supervisor outlining a blueprint for excellence in interprofessional clinical supervision;
- University curricula incorporate student perspectives and concerns about how they might derive the most from a CP and from the pairing with an experienced clinical supervisor;
- Students be orientated to all CPs so that they have an understanding about the placement, but particularly how to engage and get the most from their CS. It is likely that additional support is needed for those students from CALD backgrounds;
- Faculties develop guidelines for students and supervisors around what they want from the clinical supervisor-student relationship, which also include examples of how to manage difficult situations and challenges, including withdrawing a student from clinical practice;
- Universities and health services provide simple clear reporting guidelines for any identified discrimination, or harassment occurring during a student clinical supervision event; and
- Universities and health services review current processes for supporting students who experience adverse or confronting events whilst working on CP.

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