



**HEALTH
EDUCATION
& TRAINING**

LEARNING AND SUPERVISING...

**A GUIDE FOR PARTICIPANTS AND SUPERVISORS IN THE
PROFESSIONAL DEVELOPMENT PROCESS PILOT**

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About this handbook

HETI has produced this handbook to support those involved in supervising the non-specialist medical workforce, culminating in a simple and practical guide to clinical supervision. Along with the supportive functions of supervision, it is also acknowledged that many supervisors are also involved in teaching and training of staff to facilitate professional development and competence in clinical practice. This guide therefore also provides information to equip supervisors with practical strategies to facilitate adult learning and the acquisition of skills and knowledge.

This handbook is not a policy document. It gives tips and suggestions based on the published evidence of what makes good supervision and the knowledge of many experienced supervisors in New South Wales.

It provides information about supervising non-specialist medical workforce in ways that contribute to the safety and better care of patients, effective methods of contributing to the education, welfare and professional development of the non-specialist medical workforce.

NSW Health supervision policies can be found at www.health.nsw.gov.au

The supersummary

Key messages

- The quality of supervision makes a difference to the quality of safe patient care.
- Supervision provides an ideal forum to promote a culture of life-long learning.
- Supervisees must be active participants in the supervision process.
- Supervisors should be aware of adult learning principles and learning styles.
- Contributing to the professional development of a medical colleague can be one of the most rewarding parts of a senior clinician's job.

Supervision facilitates

- acquisition of skills and knowledge
- reflective practice
- development of professionalism
- confidence and competence in clinical practice
- professional growth and development.

Purpose of supervision

- High quality and safe patient care and treatment
- Accountable decision making in clinical practice
- Facilitation of learning and professional development
- Promotion of staff well being

Learning plan and SMART goals

Every clinician should have an individual learning plan with specific learning objectives detailing what it is they are working towards.

Reflective practice

“A continuous process that involves thoughtfully considering one’s own experiences and applying knowledge to practice” (Schön 1983).

Setting expectations

When establishing a relationship between a supervisee and a supervisor, it is important to ensure from the very beginning that both parties have clear expectations of the process.

The A-rated clinical supervisor

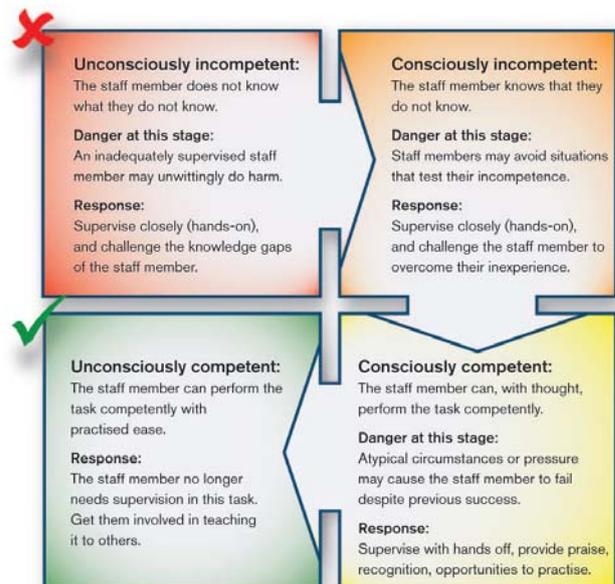
- Available
- Approachable
- Able (as both clinician and teacher)
- Active (finds the gaps)

What makes an effective clinical supervisor?

Patient safety comes first

Patient safety is a core responsibility of all clinical staff that cannot be delegated.

Knowing your supervisee's competence level



Active supervision

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support staff when they need help, whether or not a request for help is made. Active supervision acknowledges that some staff, or all staff in some situations, are “unconsciously incompetent” – that is, they do not know what they do not know, and will not always recognise situations that are beyond their current abilities where patient safety may be at risk.

Feedback

Feedback is one of the most important things that supervisees receive from their supervisors.

Clinical teaching aims to:

- improve knowledge and skills
- integrate theory into practice
- develop self awareness
- facilitate reflection on practice.

Promoting a culture of life-long learning

- Life-long learning encompasses not only structured learning through education but also learning through personal experience.
- Supervisors should encourage supervisees to undertake self-directed learning activities.

Facilitating learning

When facilitating adult learning, it is important to consider principles of adult learning and different learning styles. Adult learners need to be respected, valued and acknowledged for their past experience and have an opportunity to apply this experience to their current learning.

Ten top tips for the teaching supervisor

Importance of handover

- Failures in handover have been identified as a major preventable cause of patient harm.
- Medical staff need to be encouraged to value the task of handover and to see it as an essential and integral part of their daily work.

Developing skills in teaching and education

- Skills in clinical education must be learned like everything else in clinical practice.
- Years of experience in clinical practice does not in itself make a great clinical teacher.

Fostering interprofessional collaborative practice

As a supervisor, consider fostering interprofessional collaborative practice by:

- facilitating interdisciplinary group supervision
- inviting relevant disciplines to participate in seminars, workshops, ward rounds, and clinical reviews
- supporting interdisciplinary placement programs
- encouraging supervisees to enquire about the roles and responsibilities of other professional disciplines.

Managing a clinician in difficulty

Seek advice without delay: prevention is better than cure.

Part one: What is supervision?

Introduction: the purpose of clinical supervision

The purpose of clinical supervision is to ensure:

- delivery of high quality patient care and treatment through accountable decision making and clinical practice
- facilitation of learning and professional development
- promotion of staff wellbeing by provision of support.

Supervision facilitates:

- acquisition of skills and knowledge
- reflective practice
- development of professionalism
- confidence and competence in clinical practice
- professional growth and development.

The *Special Commission of Inquiry into the NSW Acute Public Health System* highlighted the link between patient safety and the availability of supervision for junior clinical staff (Garling 2008). While good supervision reduces errors and improves the quality of patient care, inadequate supervision is a contributing factor in critical incidents with poor patient outcomes (Kirk, Eaton & Auty 2000).

Supervision of clinicians has been identified as a national priority by Health Workforce Australia (HWA) as evidenced through the development of a National Clinical Supervision Support Framework and the Clinical Supervision Support Program (HWA 2011a; HWA 2011b).

The importance of active clinical supervision cannot be underestimated, yet many supervisors feel that they do not always have the time or the skills to provide it. This guide is focused on providing advice to improve the effectiveness and educational value of clinical supervision.

Facilitating clinical supervision

The components that contribute to effective clinical supervision include:

- understanding the roles and responsibilities of key individuals and organisations
- setting the expectations of the supervisory relationship
- using supervision contracts
- maintaining supervision documentation
- evaluating the effectiveness of supervision
- setting learning goals
- facilitating reflective practice
- providing a culturally safe and respectful environment.

Who provides clinical supervision?

Clinical supervision can be provided by senior clinicians, line managers, service managers, team leaders and external supervisors. Deciding who provides clinical supervision depends on the context, including the clinical setting, award requirements and the availability and skill mix of staff. It is acknowledged senior clinical specialists may find it difficult to access suitably experienced clinical supervisors.

In some cases, supervision may be sought from external professionals or organisations, often on a fee-for-service basis, as well as or instead of supervision provided from within the organisation. The availability of external clinical supervision will depend on local policy and the context in which the clinician is working (eg, rural or in isolation).

Methods of supervision

Supervision may occur in the following ways:

- On a day-to-day basis
- Structured one-to-one sessions
- In a group environment
- Peer-to-peer

Day-to-day supervision

Is conducted where the clinician has access to their supervisor in “real time” to facilitate the delivery of patient care. Also known as “informal” supervision, it can occur face to face, over the phone or even remotely via email. In addition, the supervisor may provide physical or “hands on” assistance if required to build clinician confidence and to support the delivery of safe patient care.

One-to-one structured supervision

Is conducted regularly, as determined by local supervision policies or professional practice requirements. The supervision session time should be protected and prioritised by both the supervisee and the supervisor. Supervision should be conducted in an appropriate environment that facilitates patient care/case discussion, reflective practice, and the setting and monitoring of learning goals and objectives. In the case of rural or sole/isolated clinicians, one-to-one supervision may be done by telephone, videoconference or online.

Group supervision

The purpose of group supervision is to provide a forum for facilitated open discussion and learning from each other's experiences. This may include clinical case discussions, topics of interest, interprofessional collaboration and team work. Group supervision is lead by a clinical supervisor and can be conducted face to face or via the use of telehealth and online technology, particularly for rural, remote or sole practising clinicians.

Peer supervision

For supervision to be effective, it is recommended as a minimum that day-to-day supervision is provided in conjunction with one-to-one structured supervision sessions at a frequency relative to the supervised professional's experience in the clinical area and years of practice.

Supervision in rural and remote settings

It is recognised that clinicians working in rural and remote settings experience unique challenges in both obtaining and providing supervision. Some of the common issues experienced by rural clinicians include but are not limited to:

- The line manager is often also the supervisor hence it is challenging moving between both roles
- Line management of clinicians is often outside of the specific discipline
- Working in small department/teams and/or hospitals means there are fewer staff available to provide supervision and or/supervisors can experience burnout
- Working in isolation/as a sole clinician means there is reliance on the individual to be proactive in seeking support remotely
- Rural clinicians often work across a range of inpatient, outpatient and community settings which adds an additional level of complexity to the delivery of services and educational needs of the clinician.

Obtaining the required level of support may require “thinking outside the box” to harness resources and to obtain support from networks of peers or even staff located within other Local Health Districts.

Tips for rural and remote clinicians

- Encourage staff members to seek support and help from other clinicians:
 - within the local area
 - outside the local area (including metropolitan centres)
 - from professional bodies
- Network with other clinicians both within and outside of the Local Health
- District both in rural and metropolitan areas via email, phone and social media
- Join or create a peer support network to share experiences and learn from each

Confidentiality

Confidentiality is vital to supervision. Agreeing on the parameters of confidentiality protects personal and sensitive information and upholds professional integrity (Country SA 2009).

Confidentiality should be discussed as part of establishing the supervision contract.

This includes:

- mutually agreed reporting procedures if duty of care issues are raised by the supervisee
- mutually agreed reporting procedures if the supervisor has duty of care concerns pertaining to the supervisee
- agreement in relation to what feedback can be given to the line manager
- ensuring discussions are held in private and documentation is kept in a secure place.

It is important for staff to be aware that there are limits to a confidentiality agreement in the case of misconduct or following adverse patient care events.

Documenting supervision sessions

The agreed actions and outcomes of the discussions which occur during one-to-one supervision sessions should be documented on a supervision record form. This provides additional guidance to the supervised clinician regarding areas on which they need to focus, and records the agreement of both parties regarding actions they are committed to taking.

Notes can be taken by either the supervisor or supervisee during the session. The documented record should ideally be signed by both parties, who should each keep a copy.

Supervision records are legal documents and in the context of misconduct or legal proceedings arising out of adverse events may be used as evidence. Supervision notes must be objective and accurately maintained according to NSW Health standards and stored for a period of time in line with NSW Government State Record Requirements www.records.nsw.gov.au.



It is important to have systems in place to evaluate the quality and effectiveness of supervision. Evaluation of the supervisory relationship is a joint responsibility of the supervisor and the supervisee. Perspectives of both the supervisee and the supervisor should be included.

There are several ways to evaluate supervision, such as:

- review of the supervision contract
- regular review or reflective discussion throughout the supervisory relationship
- through a debriefing after a critical incident, misunderstanding or breakdown in communication
- using an evaluation form or other formal evaluation process
- through informal discussion.

Clinical supervision activities

Developing learning goals

Good supervision underpins individual professional development and can positively influence the career path of non-specialist doctors.

Every clinician should have an individual learning plan with specific learning objectives detailing what it is they are working towards. This provides a framework for learning and a reference to reflect upon in subsequent supervision sessions and (if appropriate) during formal reviews.

When developing learning goals, the supervisor needs to ensure that appropriate educational objectives reflect the activities and clinical context of the supervisee.

Learning goals should be documented, discussed with the supervision (where applicable) and retained in the supervision record. They should be regularly reviewed and updated in line with the acquisition of skills and knowledge as the clinician develops.

Learning goals should be SMART: ie, they should be Specific, Measurable, Achievable, Realistic and Timely (Doran 1981).

Specific Goal must be well defined, clear and unambiguous.

- What do you want to accomplish?
 - Why?
 - Who will be involved?
 - Where will it occur?
-

Measurable Define a criterion for measuring progress toward the goal.

- How much?
 - How many?
 - How will you know when you have reached your goal?
-

Achievable Goal must be achievable.

- How will your goal be achieved?
 - What are some of the constraints you may face when achieving this goal?
-

Realistic Goal needs to be relevant.

- How does the goal fit with your immediate and long term plan?
 - How is it consistent with other goals you have?
-

Timely Goal should be grounded within a timeframe.

- What can you do in 6 months from now?
- What can you do in 6 weeks from now?
- What can you do today?

Group supervision

- Many of the principles of one-to-one supervision are just as applicable in the group supervision context.
- Group supervision is led by an appointed supervisor. However, individuals can gain from the reflection, feedback, sharing and input from colleagues as well as the supervisor.
- Like all supervisors, group supervisors require specific knowledge and skills, in particular about managing group processes.
- Do some planning prior to establishing a supervision group, to ensure it is the most appropriate/feasible form of supervision and will meet the needs of the allied health clinicians requiring supervision.
- Carefully consider the composition of the group and selection of staff to be supervised. Important considerations include how many supervisees are in the group, as well as the skills, experience and individual attributes of the supervisees.
- Developing a clear supervision contract that is agreed to and signed by all is essential. This includes the frequency of meetings, participants, model of supervision, role of the supervisor, expectations of the supervisee, review and evaluation processes and confidentiality.
- It is important that there is clarity about how feedback will be given to individuals in the group and that a culture of learning and self-reflection is fostered amongst participants.
- Group dynamics do occur in group supervision and need to be managed.
- Managing time equitably and ensuring that the needs of each participant are met should be constantly monitored.

Peer supervision

- Peer supervision is much more a self-directed activity and involves two or more doctors meeting to supervise each other's work.
- It requires a strong motivation and commitment from all participants to drive the process. The responsibility for the group, its wellbeing and ensuring it meets its purpose is shared by all participants.
- Whilst peer supervision is often considered a less "formal" process, it still requires a clear purpose and structure. Contracts and/or agreements are important and should address goals, expectations of participants, how the process will work and any "ground rules".
- Groups may include staff that have had supervision training, but members share the responsibility for convening and facilitating sessions with members often taking turns in being the supervisor and supervisee.
- It often works well with staff of similar training and experience that share values but hold a range of experiences.
- It can be a valuable adjunct to formal supervision. It is also a consideration when addressing the needs of experienced clinicians or clinicians in rural settings
- It can involve a mix of case discussions, theoretical discussions, role plays or case based learning.
- It is important that there is clarity about how feedback will be given to individuals in the group and that a culture of learning and self-reflection is fostered among participants.
- Like all supervision, peer supervision requires regular review to ensure it is meeting participants' needs.

Checklist for effective supervision:

- Keep the clinician safe and well by actively monitoring his/her level of stress and ability to cope
- Acknowledge the current skills and experience of the clinician
- Address the individual needs of the clinician, including learning style
- Acknowledge the clinician as a person
- Provide positive reinforcement when new skills and knowledge are acquired to reinforce learning
- Develop a supervision contract which clearly defines the roles and responsibilities of the supervisory relationship
- Maintain confidentiality within the limits of supervision contract
- Ensure feedback is provided in a positive way and addresses areas of further development clearly and unambiguously
- Acknowledge and manage factors that may influence the relationship (e.g. seniority, gender, culture)
- Provide a supportive, professional but friendly environment, free from any intimidation
- Conduct supervision in the context of building a clinical team in which all members are accorded professional respect.

Part two: How to be an effective clinical supervisor

What makes an effective clinical supervisor?

Supervisory skills

Being available: This is the big one! Clinicians appreciate receiving advice from their supervisor when they encounter clinical situations beyond their current ability.

Being aware: Supervisors should know what level of supervision is necessary for safe practice. They anticipate red flags and should be ready to respond if necessary.

Being organised: To make the most of the limited time available, it is important for a supervisor to be organised. This includes prioritising time for structured supervision sessions.

Personal skills

Empathy: Do you remember what it was like to be a more junior clinician? A good supervisor uses insight and understanding to support supervisees.

Respect: Showing respect for clinicians and others promotes positive working relationships. This should occur regardless of individual differences and levels of experience.

Clarity of expectations: A common problem for clinicians is uncertainty about what their supervisor thinks or wants. Clear expectations and honest feedback from supervisors is highly valued.

Confidentiality: Staff are more open and honest about errors or lack of capability if they can discuss these matters in confidence with their supervisor.

A motivating and positive attitude: Most people respond best to encouragement, and feedback is more effective if framed in constructive terms.

Ability to reflect on practice: A supervisor who is able to reflect on their own practice provides a valuable role model for supervisees.

Willingness to allow staff members to grow, be independent and make some mistakes without fear of blame: While the aim of supervision is to minimise risk to patients and build confident and competent professionals, everyone makes mistakes. All supervisors were junior clinicians once and should acknowledge that some of the most important lessons learned were from making mistakes and putting plans into action to prevent them from happening again.

Clinical skills: The modelling of good clinical skills is one of the most effective ways that supervisors help their staff. The clinical skills of supervisors should be up-to-date and evidence-based.

Teaching skills: In order to be an effective teacher it is important to invest in your own professional development to enhance teaching skills.

The A-rated clinical supervisor

- Available
- Approachable
- Able (as both clinician and teacher)
- Active (finds the gaps)

Barriers to effective supervision

It is important to identify the components which do not contribute to high quality supervision and address these where possible.

Being absent or unavailable: Limited or no supervision and/or a lack of access to a supervisor is ineffective and creates anxiety amongst staff. It also has a direct impact on the delivery of high quality and safe patient care.

Being rigid: Setting rules without giving reasons or giving instructions without an explanation does not contribute toward a positive supervisory relationship. This is not to say that supervisors have to explain everything all the time but there has to be time for explanations.

Intolerance and irritability: This leads staff to avoidance (eg, hiding errors and gaps in their capability).

Telling instead of coaching: This can lead to staff feeling unsupported and unable to develop their skills within the context of their learning styles and education needs.

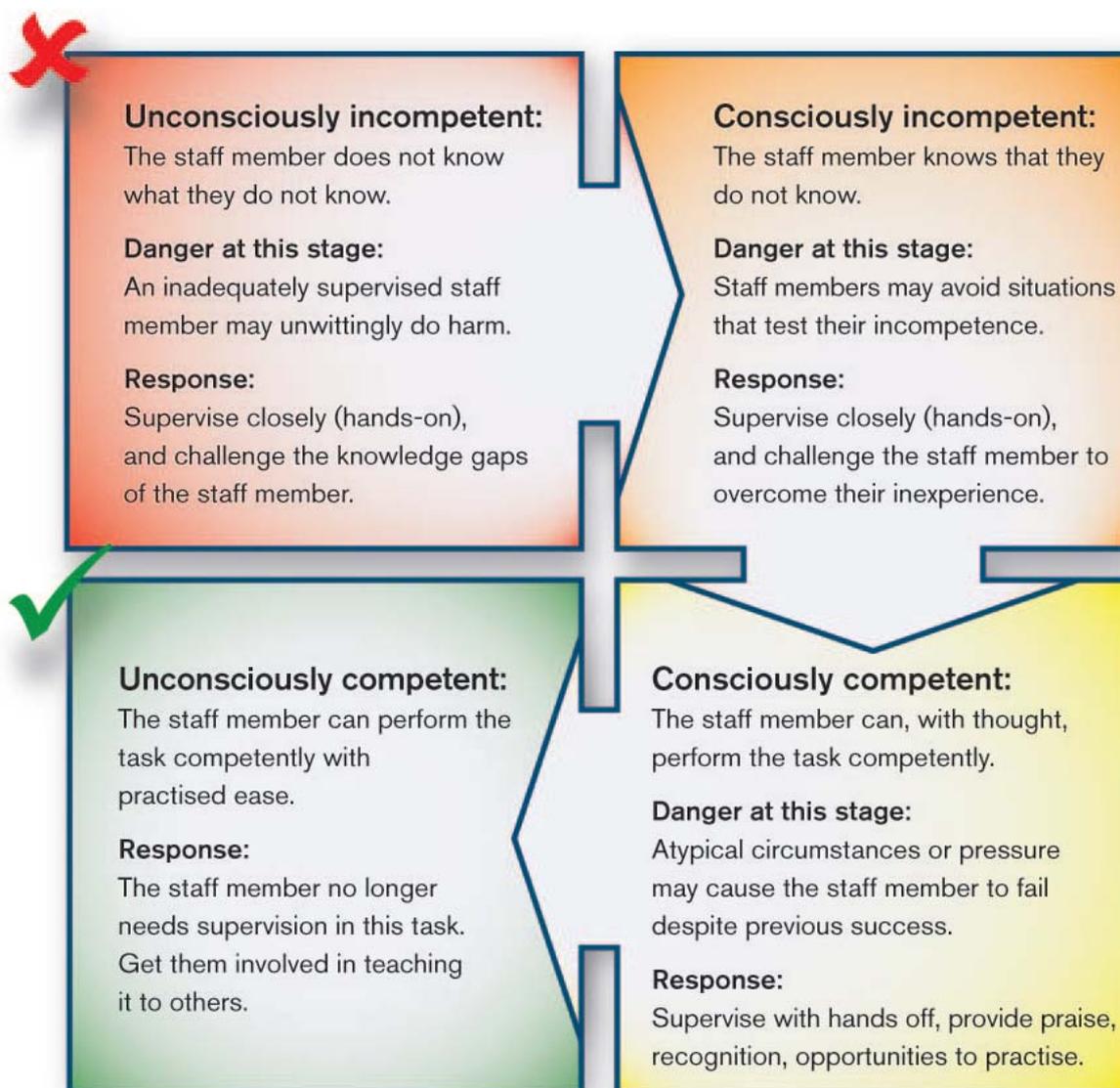
Having a negative attitude or “blaming”: Publicly criticising the staff member’s performance or seeking to humiliate the staff member leads to adverse relationships.

Not managing staff in difficulty: There are many reasons for suboptimal performance, including poor orientation or poor supervision. Not supporting staff in difficulty has a direct impact on the quality of patient care delivery.



Knowing your supervisee's competence level

In the learning cycle described by Peyton (1998), staff move through four stages in the acquisition of particular competencies, from unconsciously incompetent to unconsciously competent.



Active supervision

Active supervision occurs when the supervisor is sufficiently engaged and vigilant to support staff when they need help, whether or not a request for help is made. Active supervision acknowledges that some staff, or all staff in some situations, are “unconsciously incompetent” — that is, they do not know what they do not know, and will not always recognise situations that are beyond their current abilities where patient safety may be at risk. Active supervision requires the supervisor to continually seek clues or evidence that direct patient care or more support from the supervisor is required.

Giving feedback

Feedback is an essential component of supervision and is critical to the learning cycle and leads to improvement (Rogers, 2001). The timing, type and amount of feedback given can influence how useful the information will be.

To give effective feedback:

- **Be timely:** Give feedback as close as possible to the event. However, pick a good moment for feedback (not when you or the staff member is exhausted, distracted or upset). Feedback on performance should be a frequent feature of your relationship with your supervisee.
- **Be specific:** Vague or generalised praise or criticism is difficult to act upon. Be specific and the staff member will know what to do. Adopt a straightforward manner, be clear and give examples where possible.
- **Be constructive:** Focus on the positive. Avoid dampening positive feedback by qualifying it with a negative statement (“You did well in choosing the correct intervention for Mrs Smith, but ...”). For constructive criticism, talk in terms of what can be improved, rather than what is wrong. Ask the supervisee for a self assessment of their performance. Try to provide feedback in the form of solutions and advice. At the same time, if the staff member makes an error, feedback needs to clear.
- **Be in an appropriate setting:** Positive feedback can be effective when given in the presence of peers or patients. Negative feedback (constructive criticism) should be given in a private and undisturbed setting.
- **Use attentive listening:** Supervisees should be given the chance to comment on the fairness of feedback and to provide explanations for their performance. A feedback session should be a dialogue between two people.

(Cohen 2005; Lake & Ryan 2006)

Using a positive critique framework to give feedback

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

Consequences of a lack of clear feedback to underperforming staff

- Clinical care is not as good as it could be
- Anxieties and inadequacies are not addressed
- When weaknesses are exposed later in their career, the staff member has difficulty accepting criticism because of previous “good reports”
- Others are blamed when the staff member is unsuccessful
- Learning is inhibited, career progression is delayed
- Staff are not given the opportunity to develop to their full potential.

(Cohen 2005)

Supervisee engagement in supervision

While it is the responsibility of the supervisor to remain active in overseeing clinical care, as per the supervision contract, supervisees must be encouraged to engage and commit to the supervisory process. Supervision is one of the most important relationships of a clinician's career. This can be facilitated by actively encouraging the clinician to seek assistance when required and identify appropriate learning opportunities.

Effective supervision requires commitment, support and governance from management and organisations.

What makes the non-specialist workforce feel valued?

- Being supported, especially when confronted with clinically challenging situations or while working out of hours, in isolation or outside the acute hospital environment including home and community visits
- Being given responsibility for patient care
- Good teamwork
- Receiving feedback
- Having a supportive learning environment
- Being stimulated to learn
- Having a supervisor take a personal interest in their work and professional development. (Peyton 1998)

Tips to foster engagement of the supervisee

- Do the groundwork when establishing a new supervisory relationship. Developing mutually agreed expectations of supervision builds a solid foundation and helps address any future issues.
- Ensure you demonstrate to the supervisee that you view supervision as priority — make sure that supervision time is not hijacked by other competing demands.
- Regularly seek feedback from the supervisee about the quality of the relationship and the content of supervision.
- Be prepared to tailor supervision to meet the specific and changing needs of the supervisee.
- Address disengagement as a matter of priority.
- Develop an understanding of the supervisee's (and your own) learning styles and use this information to strengthen the learning and make supervision more meaningful.
- Review the logistics around supervision such as timing, venue and frequency, and ensure they continue to be suitable and are not impacting on attendance.
- Think of supervision as building on strengths rather than working on deficits.
- Be mindful that supervision can be anxiety-provoking for some staff, and ensure expectations are realistic and achievable.
- Regularly find opportunities to give positive feedback when the supervisee successfully uses the learning from supervision in their practice. This not only reinforces the value of supervision and increases the supervisee's clinical confidence it also ensures that patients receive quality care.

Responsibilities of the supervisee

Whilst the supervisor has important responsibilities to engage, facilitate learning and provide support, equally the supervisee has an important role to play in getting the most out of supervision.

Supervisees should:

- take responsibility for self-directed, lifelong learning including a commitment to ongoing professional development
- actively participate in the supervision process
- openly express needs and expectations related to supervision. Ensure these form the basis of the supervision contract
- make the best use of supervision by coming prepared. This includes having an agenda of points to be discussed so time can be used effectively
- make an effort to create and protect time for supervision. Try to keep scheduled supervision appointments, be on time and try and avoid interruptions
- be prepared to openly identify and discuss practice issues which are challenging and the skills that need developing
- work at developing trust in the supervisory relationship so that issues can be discussed honestly and freely. This makes supervision more meaningful and relevant
- contribute to reflective discussion about practice experiences and learnings
- be open to learning and improving clinical practice skills and incorporating this learning into ones work practice. Be prepared to be challenged in a supportive way
- be open to receiving support and feedback during supervision and take time to reflect and respond to this feedback
- take responsibility for seeking help when required, even if outside the regular supervision time. This ensures patient safety and wellbeing are always put first
- commit to regularly reviewing the supervision process and give honest feedback if it needs to be adapted to meet changing needs.

Part three: Clinical teaching and learning

The supervisor's role in clinical teaching

As per the functions of supervision outlined in section one, supervision also encompasses education. The purpose of the educational component of supervision is to develop each individual in a manner that enhances their full potential, ensure patient safety, effective and ethical practice. This may be complemented by the provision of education in other teaching forums such as in-service education, grand rounds and case discussion.

Clinical teaching aims to:

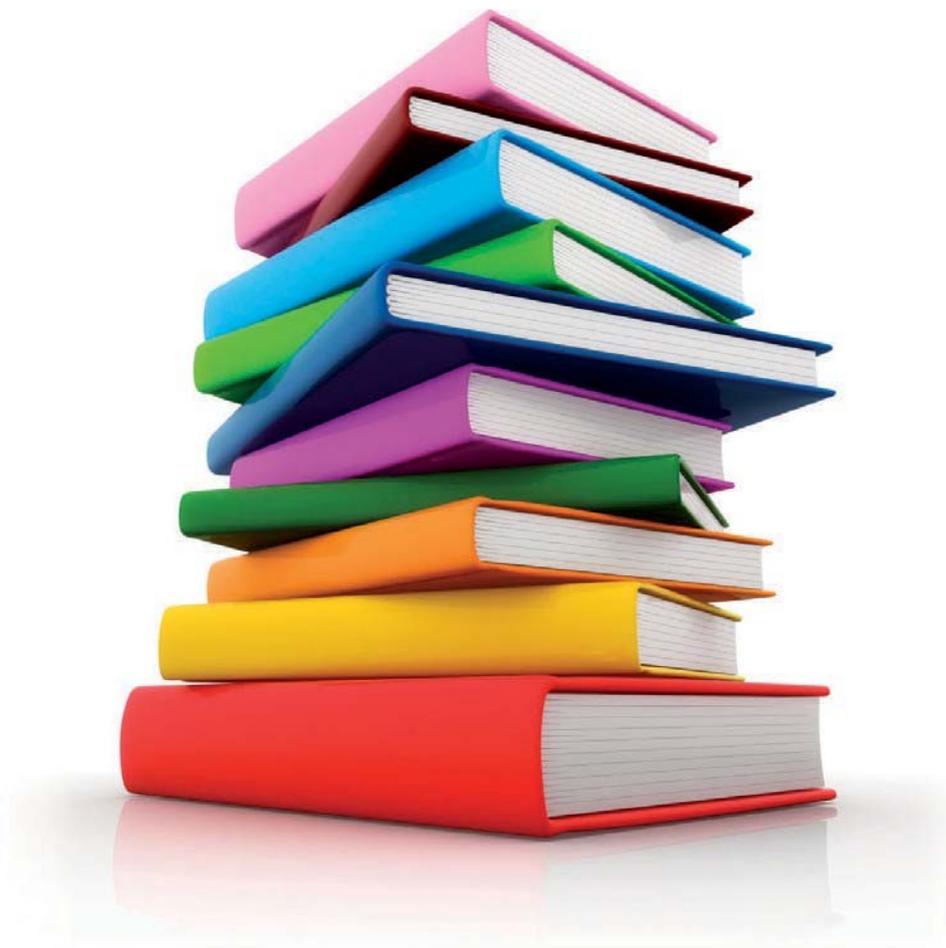
- improve knowledge and skills
- integrate theory into practice
- develop self awareness
- facilitate reflection on practice
- enhance clinical reasoning.

In addition to clinical skills, the supervisor should also teach the non-clinical skills needed to manage workload, interprofessional practice, team dynamics and the demands of the rapidly changing health care environment.

Promoting a culture of life-long learning

Supervision provides an ideal forum to promote a culture of lifelong learning. Lifelong learning refers to the continuous building of skills and knowledge through experiences encountered over the course of a lifetime. It encompasses not only structured learning through education but also learning through personal experience. Lifelong learning is linked to the pursuit of personal or professional knowledge and is voluntary and self-directed.

Linked to the concept of life-long professional learning, discipline specific professional associations and professional registration boards have guidelines regarding specific education requirements for their profession. This includes meeting continuing professional development (CPD) requirements and maintaining CPD portfolios. However, self-directed and lifelong learning is an attitudinal approach which should be modelled by all non-specialist medical officers over the course of their careers.



Facilitating the learning process

There are several approaches to learning that can occur within the context of supervision. Most people learn by a combination of deductive (learning through structure) and inductive (learning by experience) approaches. When facilitating learning, it is important to consider principles of adult learning, different learning styles and a mix of modalities.

Understanding the adult learner

Reference: (Allied Health HETI, The Learning Guide)

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

Adult learners:

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

(Brookfield, 1998; Brundage & Mackeracher, 1980)

Learning styles, preferences and strategies

As a facilitator of learning it is useful to have an understanding of terminology commonly referred to in the educational literature, which explain different approaches to organising adult learning experiences.

“Learning styles” is a concept which describes the different modes of instruction or methods of study most effective to a particular individual (Pashler, et al., 2009). There are many tools available for assessing and understanding learning styles, some of which are more complex than others. Whilst these tools are used widely by facilitators, there have been questions raised surrounding the validity of learning styles assessment tools and the evidence which supports whether direct matching of learning styles to instructional methods produces the most advantageous outcome for the individual (Pashler, et al., 2009).

“Learning preferences” refers to how an individual may favour one mode of teaching over another but can differ depending on task and context (Smith & Dalton, 2005). For example, an individual may say in general they prefer to receive information in a visual or pictorial format rather than in written or verbal format.

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

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

Skills to facilitate learning

Critical to the process of establishing an optimal learning environment is the ability for facilitators to build positive relationships and communicate effectively. In addition there are a number of important specific skills required to facilitate learning of others and to encourage a deep approach to learning.

The skills listed below will be explored further in this section:

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

Communicating effectively

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

Tips to optimise effective communication:

- Ensure verbal (content), meta verbal (the way it's said) and non-verbal (body language) communication is congruent (e.g. the content of what is said matches the way it's said and is reinforced by appropriate body language)
- Be clear about the meaning that is being conveyed
- Minimise the possibility of distractions or interruptions

Active listening

Listening skills are required in a variety of situations. Active listening is another level of listening, with the aim being to listen closely to the details that are being conveyed in order to ensure not just the content is understood but also the intended message. The skill of active listening is important in the supervisory and learning relationship where feedback, reflective practice and facilitation of clinical reasoning are required.

Qualities of an active listener:

- Makes eye contact
- Has open body language
- Asks questions to facilitate learning
- Seeks clarification to enhance understanding
- Is genuinely interested
- Summarises frequently to ensure understanding
- Is aware of tone and pays attention to nonverbal forms of communication in themselves and the learner
- Seeks out and gives feedback wherever possible
- Remains calm, in control and relaxed
- Allows time to articulate thoughts
- Paraphrases before disagreeing to demonstrate active listening and understanding
- Avoids making vague, unclear or ambiguous comments

Adapted from (Egle, 2009)

Giving effective explanations

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

10 tips for providing effective explanations

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

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

Facilitating discussion

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

Example settings for facilitating discussion

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

Practical ways to facilitate discussion

<p>Ask questions that promote deep and continuous discussion</p>	<ul style="list-style-type: none"> • Open questions (e.g. what happened?). • Key or focus questions. • High order and probing questions
<p>Maximise participation</p>	<ul style="list-style-type: none"> • Use an experience or common area of interest as the basis of discussion, which will help provoke the urge to comment. • Use well-structured questions. • Use eye contact to scan the group. • The use of non-verbal encouragement such as leaning forward, head nods and looking expectant (i.e. curious, interested). • Active listening. • Redirect responses or questions aimed at the group leader back to the group by using non-verbal cues such as eye and hand gestures or a question like... "What do other people think about that?" • Manage challenging group dynamics to maximise participation and contribution to the discussion
<p>Create a positive learning environment by acknowledging/ rewarding responses</p>	<ul style="list-style-type: none"> • "Thank you" or "well said". • Nod, smile, lean forward. • Build on what is said by using discussion points as a springboard for further discussion or refer back to a relevant comment made by an individual.
<p>Use your starting and finishing well</p>	<ul style="list-style-type: none"> • Starting usually includes: <ul style="list-style-type: none"> • Giving brief discussion context to connect people to the topic. • Outlining the aims of the discussion (without pre-empting the learning). • Using a key discussion question. • Finishing usually includes: <ul style="list-style-type: none"> • Indicating the discussion is coming to a close and giving last opportunity to comment. • Summarising and reflecting on the main points made (or the group leader can ask a participant to summarise) • Thanking the group for their participation.

Promoting skill acquisition along the continuum of learning

There are many approaches that can be used to support a learner's skill acquisition and movement across the continuum of learning. One such method is called 'scaffolding', which matches the facilitation approach with the learner by progressively withdrawing or changing assistance as expertise is developed (Smith & Blake, 2005). The trick is to know what stage the learner is at and to adjust your instruction, teaching or facilitation accordingly.

Scaffolding

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

Strategies for skilful scaffolding

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

Facilitating a deep approach to learning

There are various approaches participants can have when engaging with a learning experience. As facilitators, it is important to recognise this and to try and foster an approach that will help generate meaningful and life-long learning. Two typical approaches that exist can be referred to as a 'deep' or 'surface' approach. When facilitating learning in the workplace the goal is to achieve deep learning by promoting a 'deep' approach from the learner.

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

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

Although learners may have a predisposition for either a "deep" or "surface" approach, the learning environment can shift learners from one to the other (Macaulay, 2000). It is the role of facilitators to maximise those factors that lead to deep learning and minimise those that lead to surface learning (Biggs, 1991).

This can be done through the conscious planning of learning tasks and implementation of the following strategies:

PROMOTE

- Teaching and assessment methods that foster active engagement with learning tasks.
- Using concepts that are related to everyday experiences.
- Relating and distinguishing new ideas with previous knowledge.
- Demonstrating a personal commitment to the subject matter and communicating its meaning and relevance.
- Communicating learning expectations clearly.
- Interaction with peers and facilitator
- Establishing a well-structured knowledge base.

AVOID

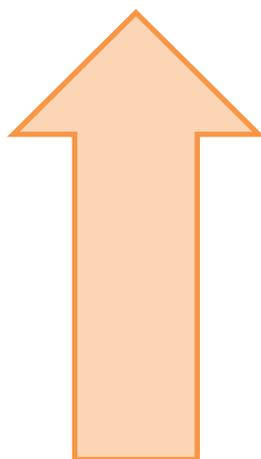
- Learning methods that only require simple recall of information (e.g. calculations or formulas).
- Giving poor feedback.
- Focussing the learning on detached elements of the task.
- Working through an excessive amount of material or information.

Advanced questioning techniques

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

Bloom's Taxonomy

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



Creating

e.g. what would happen if ...?

Evaluating

e.g. is there a better solution to ...?

Analysing

e.g. how was this similar to ...?

Applying

e.g. could this have happened in ...?

Understanding

e.g. what do you think ...?

Remembering

e.g. what happened after ...?

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

A comprehensive table of questions to develop each category of thinking and verbs to set learning objectives (Bloom's Taxonomy) is below.

Cognitive levels of thinking	Useful verbs to use when setting learning objectives	Sample questions that promote thinking at these levels
Remembering	Tell List Describe Relate Locate Write Find State Name	What happened after...? How many...? Who was it that...? Can you name the...? Describe what happened at ...? Who spoke to ...? Can you tell why ...? Find the meaning of...? What is...? Which is true or false...?
Understanding	Explain Interpret Outline Discuss Distinguish Restate Translate Compare Describe	Can you write in your own word...? Can you write a brief outline...? What do you think could have happened next...? Who do you think...? What was the main idea...? Who was the key person...? What differences exist between...? Can you provide an example of what you mean...? Can you provide a definition for...?
Applying	Solve Show Use Illustrate Construct Complete Examine Classify	Do you know another instance where...? Could this have happened in...? Can you group by characteristics such as...? What factors would you change if...? Can you apply the method used to some experience of your own...? What questions would you ask of...? From the information given, can you develop a set of instructions about...? Would this information be useful if you had a...?

Probing questions

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

Examples of probing questions

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

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

Using questions to model thinking skills

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

Example questions to model thinking

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

Reflective practice

Reflective practice is an effective process to develop self-awareness and facilitate changes in professional behaviour. Reflection can occur before, during or after an event (Sandars 2009). When reflection occurs in supervision, it can be in relation to reflecting on day to day clinical practice, triggered by a challenging clinical encounter or in anticipation of having to manage a complex situation. It is imperative that reflective practice is conducted in a supportive environment to allow individuals to freely share information that promotes learning. Examples of how reflective practice is conducted include:

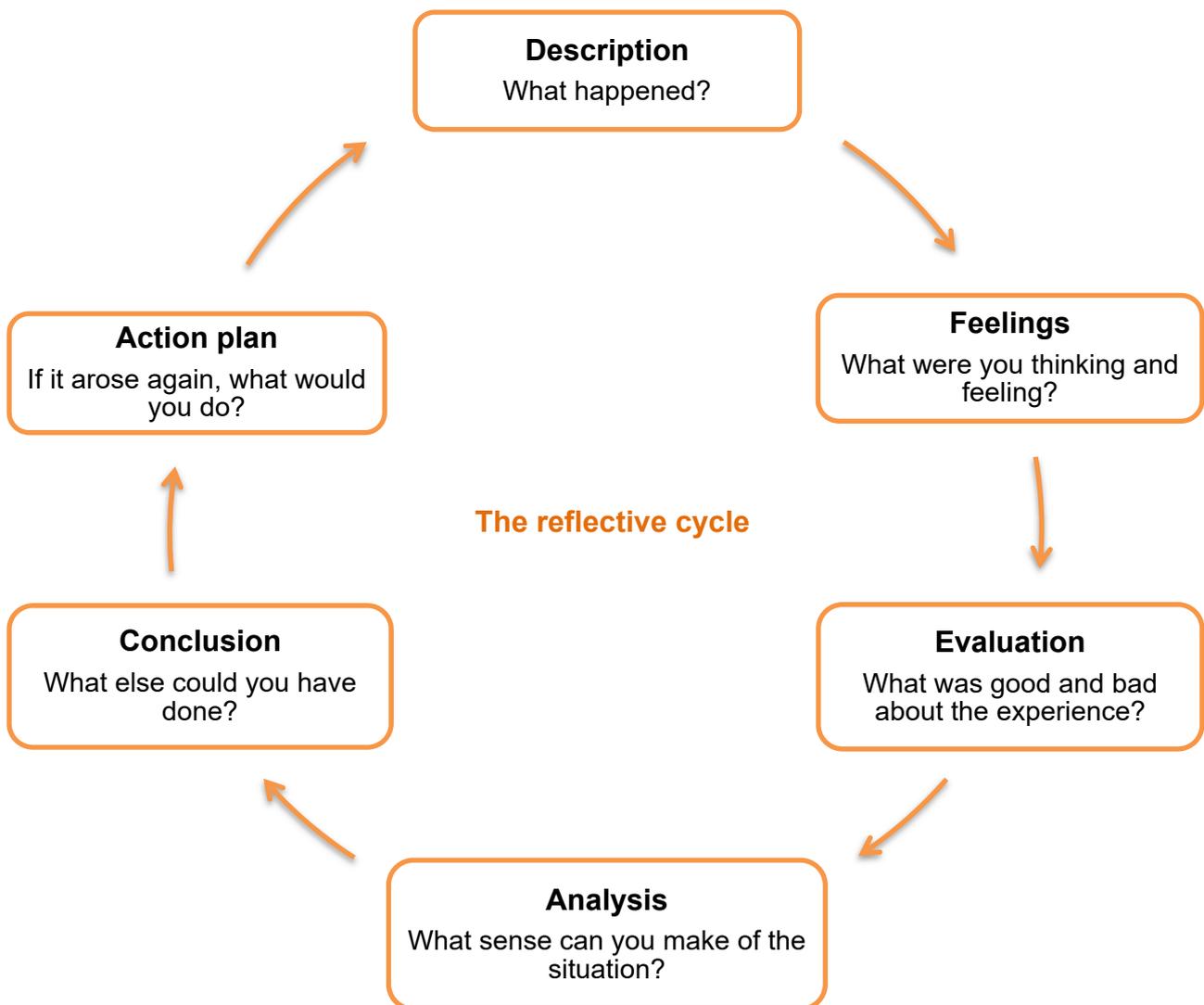
During structured supervision sessions the supervisee provides the supervisor with an overview of an issue or incident and the supervisor uses questioning to encourage reflection on its meaning (see example below).

Reflective journal/record keeping is a self-directed activity, where the clinician is guided by a template of key questions to record their experiences, work through the issues and reflect on their learning. They can then use this as a tool for discussion with their supervisor or to keep as a record of continuing professional development.

There are many models of reflective practice that can be used in supervision. One such model is Gibbs' model of reflection.

Model of reflective practice

Gibbs (1988).



Facilitating clinical reasoning

Effective clinical reasoning is an essential component of a doctor's practice and needs to be fostered in work place learning.

What is clinical reasoning?

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

How to facilitate clinical reasoning?

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

<p>Experiential strategies</p>	<p>The learner is involved in a situation or experience that includes active experimentation, memorisation, reasoning, reflecting and evaluation resulting in a transformative learning experience (Boud, 1993). This can involve methods such as explicit guidance, observation, thinking aloud, modelling, discussion and feedback (Ladyshewsky & Jones, 2008; Narayan & Corcoran-Perry, 2008):</p> <ul style="list-style-type: none"> • Treating a patient together and thinking out loud while you are conducting an assessment or providing an intervention • The learner observing a more experienced clinician during patient interaction then debriefing through discussion afterwards
<p>Problem based learning (Onyan, 2012; Rivett & Jones, 2008)</p>	<p>Case reports or case studies, clinical discussion forums</p>
<p>Promoting Reflection</p>	<p>Reflection prior to, during and after an action requiring reasoning enables the professional to self-evaluate and self-monitor their reasoning (Christensen, et al., 2008). Reflective journaling for example, can encourage development of clinical reasoning</p>
<p>Other Strategies</p>	<ul style="list-style-type: none"> • Concept/mind mapping (Cahill & Fonteyn, 2008) • Reflective writing (Ryan & Higgs, 2008) • Simulation (Edwards & Rose, 2008) • Discussing your own stories and experiences (Ryan & Higgs, 2008) • Using provocative readings followed by discussion (Ryan & Higgs, 2008)

Facilitating learning using case or clinical scenarios

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

Scenario based learning has a role in many areas of the workplace:

- Clinical scenario presentations
- Case conferences
- Team/department meetings
- Clinical discussions

Writing a clinical scenario

Development of clinical reasoning and transfer of learning can be influenced by the way the patient scenario is presented. It is imperative that the information in a clinical scenario resembles reality as closely as possible.

- Avoid presenting all the information about the whole patient scenario at the beginning.
- Provide original presenting symptoms and issues, and then follow up with focus questions.
- As you build the clinical scenario, gradually add further information.
- Facilitate re-evaluation of assessment and intervention approaches as changes to the medical condition develops to simulate a real-life situation.

TASKS

Encounter	During this task, you will need to expose the learners to the clinical dilemma or patient scenario.	<ul style="list-style-type: none"> • Prepare a scenario as close to reality as possible. • Communicate all essential background information before the discussion.
Analyse	Learners analyse the problem or scenario by discussing and responding to a series of focus questions set by the facilitator.	<ul style="list-style-type: none"> • Prepare focus questions before the session however impromptu probing questions may also need to be asked during discussion. • Ask ‘high order’ questions that require someone to explain rather than respond with a simple answer. • Focus questions should be clear, concise, and appropriate to the goals of the session, intended to guide individual analysis and promote discussion.
Reflect	The analysis task should smoothly transition to reflection time as the final phase in the session. You want to use this time not only to help learners consolidate their learning but also help you determine the learning that has occurred.	<ul style="list-style-type: none"> • Discuss the conclusions or answers to the focus questions, and provide feedback to the learners on their responses. • Reflect and assess the gaps in knowledge and alter reasoning processes. • Disclose how the scenario should be managed.

What makes effective clinical teaching?

Collaboration and active involvement. Adults like to have input into their learning.

Relevance to the clinical duties currently required of the staff member, or to their future career plans.

Ascertain what the staff member is interested in and then direct your teaching to this motivation. There may be opportunities to develop skills and confidence by encouraging the staff member to take on more complex cases as part of their clinical duties while the supervisor provides ongoing coaching and support.

Appropriateness to the level of the staff member.

Teaching by guided questioning. Asking and encouraging thinking.

Didactic teaching (lectures) is most effective when you know the knowledge base of your audience (ask first). A failure of some didactic teaching is that time is spent teaching staff members things they already know.

The advantage of guided questioning is that it reveals what staff members do know and invites them to extend their knowledge. But don't turn questioning into a grilling. Make sure staff members are provided with space to think about their responses and if they require more time to process what is being taught, offer to continue the discussion later once they have had a chance to reflect.

Setting clear learning goals with the staff member so expectations are clear. Document SMART learning goals: Specific; Measurable; Attainable; Realistic and Timely.

Giving feedback so that staff members know how they are going.

Seeking feedback so that you know how effective teaching has been.

Simply telling people what you expect them to learn will focus their attention in a clinical encounter. Feedback given and received lets everyone know whether the intended outcomes are being achieved. Adult learning is a collaborative process.

Teaching at handover

Well structured handover is an excellent learning experience that integrates communication, professionalism and clinical management. Staff members learn techniques of clinical description and case organisation when involved in the handover of a patient to others. Handover is also an important team-building exercise.

Clinical handover is important to effective clinical care. The practical operation of health services, including hospitals, means that patient care might be handed over from team to team in various situations including:

- following on-call and weekend shifts
- transfer of patients from one clinical setting to another
- discharge planning.

Supervisors should discuss principles of good clinical handover to build the skills of clinicians and facilitate the safe transfer of patients from team to team.

Clinical staff may experience challenges with handover, in particular if they are on the receiving end of information about patients they are required to look after on an after- hours or weekend shift. This creates a risk for the patient as it is not possible for the staff member to check information with the treating therapist or ask additional questions once the day shift has gone home.

The challenge of handover

- Being confident to speak up and be an active participant in the handover process. Staff must feel able to ask questions if they are unsure of details in someone's handover.
- Providing the most critical and relevant information in sufficient detail to ensure the issues are clear (just enough versus not too much). This is vital to continuity of care and safe clinical practice.
- Ensuring time is prioritised in the daily schedule for handover of patient information, with consideration of all the points where handover may occur, such as from shift to shift, ward to ward and inpatient to outpatient.
- Being punctual and consistently turning up on time to handover sessions.
- Being organised and planning for absences such as periods of leave.
- Ensuring effective and accurate documentation of patient issues occurs in handover notes, medical records and discharge summaries.
- Maintaining patient confidentiality and privacy while providing appropriate clinical handover, particularly if referring to agencies outside NSW Health. (Further information is available in the NSW Health Policy Directive PD2005_593: Privacy Manual (Version 2) 2005 - NSW Health).

The ISBAR framework for communicating at handover

ISBAR is the NSW Health accepted methodology for clinical handover. The process of handover should occur as per the framework outlined below.

Further information is available in the NSW Health Policy Directive 2009_060: “Clinical Handover – Standard Key Principles” (2009) and NSW Health Caring Together “Implementation Toolkit – Standard Principles for Clinical Handover” (2009).

I	<p>Introduction – Identify yourself, role, location and who you are talking to.</p>	<p>“I am (name and role), from (ward/facility) and I’m calling because (clear purpose)”</p>
S	<p>Situation – state the patient’s diagnosis/reason for admission and the current problem</p>	<p>“The situation is that I have a patient (age/gender), who is (diagnosis/deteriorating/stable). My concerns are (clear and succinct concerns). The current presenting symptoms are (clear, current and relevant symptoms and observations).”</p>
B	<p>Background – what is the clinical background or context?</p>	<p>By way of background (give pertinent information which may include: Date of admission / presenting symptoms / medication / previous recent vital signs / test results / status changes and any relevant medical and social history)</p>
A	<p>Assessment – What do you think the problem(s) is? (Don’t forget to have a key issues list ready!)</p>	<p>“My assessment on the basis of the above is that the patient is ... They are at risk of ... and in need of ...”</p>
R	<p>Recommendation – What are you asking the person to do?</p>	<p>“My recommendation is that this patient needs (what test action) by (who) within (timeframe).” Repeat to confirm what you have heard, eg, “I understand that I am to ... and you will ...”</p>

Tips for teaching at handover

- Supervisors can select particular patients as the subject of teaching.
- Handover is an excellent opportunity for clinicians to take the lead in a teaching session. Ask the clinician to select a case to present in more detail regarding the patient's background, who they are being handed over to, why, and what is the essential handover information that the receiving clinician/team needs to know to meet the patient's care needs.
- Aim for one teaching point at each handover. A brief (not exhaustive) exploration of a key issue is of lasting value for the staff involved.
- All staff members should be familiar with the ISBAR framework for communications at handover, which is recommended for all clinicians in the NSW Health system (NSW Department of Health 2009b).

Fostering interprofessional collaborative practice

This guide has provided some useful insights and guidance on issues relating to teaching and clinical supervision in the context of the public health system. Learning interprofessionally, when two or more professions learn with, from and about each other to improve collaboration and the quality of care (Freeth et al. 2005) can have many benefits to both patients and health professionals.

This marks a significant departure from the ways in which health care workers are traditionally educated and supervised: each discipline training or learning separately to work separately.

Interprofessional teaching and supervision can prepare health professionals to question taken-for-granted professional assumptions and explore different professional perspectives. It also prepares health professionals for team-based care or interprofessional collaborative practice (IPCP).

A growing amount of evidence has emerged outlining the benefits of IPCP which include:

- increased staff motivation, well-being and retention
- decrease in staff turnover
- increased patient and carer satisfaction
- increased patient safety
- increase in appropriate use of specialist clinical resources
- reductions in patient mortality and critical incidents, and
- increase in access to and coordination of health services.

(WHO 2010)

Supervision and clinical education that facilitates greater awareness of the roles and responsibilities of others (nurses, allied health staff and patients), and that motivates health professionals to engage and communicate with those from other professions, can better prepare doctors for work in today's public health system.

Supervisors can consider fostering interprofessional collaborative practice by:

- facilitating an interdisciplinary group supervision session
- inviting relevant disciplines to participate in seminars, workshops, ward rounds, clinical reviews etc
- supporting interdisciplinary placement programs
- encouraging supervisees to enquire about the roles and responsibilities of other professional disciplines.

For more information on team-based care or interprofessional collaborative practice, visit the HETI website:
www.heti.nsw.gov.au

Part four: Management of clinical staff

Managing clinical staff

As per the functions of clinical supervision outlined in section one, supervision also encompasses an administrative role. The purpose of administration is to promote and maintain good standards of work, including ethical practice, accountability measures and adhering to policies where they exist.

In NSW Health there is a diversity of organisational structures and lines of reporting which need to be considered in the context of supervision. In some situations the clinical supervisor may also be the line manager and hence performs dual roles.

This can include the following tasks in relation to the supervisee:

- clarifying roles and responsibilities
- workload management
- review and assessment of work
- addressing organisation and clinical practice issues.

Key Tasks

There are some administrative tasks required to support a clinician which have an important role in clinical education and training. These activities may be performed by the line manager, supervisor or collaboratively between the two depending on local service arrangements.

Four key tasks include but are not limited to:

- managing for performance (to promote and encourage progress)
- orientation
- being or sourcing mentors, coaches and buddies
- managing clinicians in difficulty

There are many skills required to operationally manage clinical staff in NSW Health which are beyond the scope of this document. The following section aims to provide tips for supervisors on how to effectively carry out some of these tasks as well as explore some of the “common challenges” experienced by supervisors when attempting to manage and support a clinician in difficulty.

Managing for performance

Management for performance is generally undertaken by the operational line manager, which may include a unit head, team leader, head of department or service manager. This may be the clinical supervisor if they are also the line manager. However, if the clinical supervisor is not also the line manager they may also be involved in this process. This provides an opportunity for collaboration to occur for the benefit of the supervisee.

“Managing for performance is a process that commences with the recruitment and orientation of an individual and involves an on-going cycle of planning, coaching and reviewing individual, work, team and organisational performance within the context of the organisation’s goals and strategies” (NSW Department of Health 2005a, p. 4).

It is important to note that managing for performance is not disciplinary action but is about ongoing two way feedback to promote development. It also involves a formal review often referred to as the annual performance review (NSW Health 2005a).

The process of clinical supervision links into the formal review as it is based on individual learning goals relating to clinical practice. These items can therefore be discussed in addition to the organisation/service requirements of the supervisee.

If supervision has been effective throughout the year, there should be no surprises at the formal review. The staff member should be well aware of the progress they have made and the opportunities for further improvement. This should be achieved through regular:

- feedback on performance
- review of learning goals
- one-to-one supervision sessions to discuss progress and opportunities for improvement
- use of reflective practice to develop increased self awareness.

Purposes of the formal review

- To provide staff members with feedback about their performance and facilitate their learning and development.
- To review evidence that staff members are progressing and achieving their learning objectives. A good review system should assure senior staff/management that allied health professionals are meeting certain standards of practice and competence before advancing to higher levels of responsibility.
- To set objectives for the following year and identify areas for professional development in line with service needs and the staff member's career aspirations.

For more information, please refer to the NSW Health Policy Directive, PD2005_180, Performance managing for a better practice approach for NSW Health 2005.

Mentors, coaches and buddies

There are many ways which clinicians can obtain additional support to facilitate learning in the workplace. This may include obtaining a mentor, coach or buddy.

Mentoring has been described as a “developmental, caring, sharing and helping relationship where one person invites time, know-how and effort in enhancing another person’s growth knowledge and skills” (Shea 1999, p. 3, cited in McCloughen, O’Brien & Jackson 2009).

Coaching is a solution-focussed approach used to assist people to retrieve and utilise their personal experiences, skills, intuition and expertise in order to find creative, individual solutions to work and personal life situations (Greene & Grant 2003).

Buddies are pairings of clinicians (usually one who is more experienced than the other) for similar purposes.

Informal mentoring, coaching and buddy relationships can naturally form in the clinical environment. They can also be formalised and deliberately fostered by supervisors as a support to clinical supervision. These relationships can also form the basis of a peer supervisory relationship. Some mentors and/or coaches have skills obtained through formal qualifications and training.

Coaching and mentoring can be used to complement an existing supervisory relationship or when the supervisor feels he or she does not have specific knowledge, skill and expertise in a particular area of the supervisee’s interest (such as research) or a specific therapeutic modality. In this situation, the supervisor can source support from an appropriate colleague to act as a mentor or coach to the supervisee.

Providing a mentor, coach or buddy can be an effective way of:

- introducing a staff member to a new facility or a new clinical area
- supporting personal and professional growth and development
- helping a staff member in difficulty by giving an extra avenue of support
- building closer links within and between clinical teams.

It is important to note, mentors, coaches and buddies do not necessarily need to be from the same discipline as the staff member. Smith and Pilling (2007) demonstrated that the use of interdisciplinary peer support was valued by new graduate allied health professionals as part of an interprofessional education program.

Generally speaking, a formal mentor, coach or buddy to a staff member should not be the supervisor of that staff member, as the roles can conflict.

To be a good coach or mentor (Cohen 2005, Rose 1999)

As a supervisor or senior clinician, you may be approached to become a coach or mentor for another staff member. Here are some helpful tips to being a good coach or mentor.

Do	Don't
<ul style="list-style-type: none">• Create a safe and supportive environment• Establish a professional relationship built on mutual respect and trust• Establish the focus of your coaching/ mentoring relationship, including an agreement for working together• Collaboratively identify, agree upon and realise the mentoring or coaching goals• Empathise, show patience and allow the staff member to express feelings• Provide constructive feedback and clarify how the staff member would like feedback conveyed• Ask appropriate and relevant questions that facilitate communication and clarification• Identify and encourage strengths in the staff member• Encourage the staff member to think reflectively and critically explore options together.	<ul style="list-style-type: none">• Dominate or control the staff member (physically, verbally, psychologically)• Allow interruptions to your coaching/mentoring time or be distracted/interrupted by “more important” issues• Assume what you think the staff member wants to hear or learn• Assume that staff members are used to being given constructive feedback• Take over, show the staff member what to do, show off your knowledge or insist on the staff member doing things your way• Create dependency on you• Show irritation, impatience or annoyance• Talk more than you listen• Forget what you experienced when you were learning and developing• Breach confidentiality.

Common challenges for supervisors

The goal of supervision is to bring out the best in every staff member. There are often challenging moments on the way to this goal. The challenges are unique to the individual and require solutions tailored to the circumstances. Many problems can be avoided by carefully orienting the clinician to their role and to the organisation, setting clear expectations and establishing a supervision contract. This will go a long way towards preventing any misunderstandings and alert the supervisor to issues that may need management.

It is recognised that most clinicians receive little or no formal training in managing staff issues and often acquire these skills through experience and/or modelling other senior staff behaviour. It is important that supervisors and managers invest in their own professional development and supervision to improve confidence in managing complex issues.

Many factors may affect a clinician's performance. Some of the more common issues (and potential responses) are listed below. The first response to any problem should involve a face-to-face discussion with the clinician. If the issues involved are sensitive, this should be conducted in a private location, free from interruptions and at a time when neither is distracted or overstressed. If the issues are serious or if attempts to resolve the issues are failing, it is appropriate to seek additional assistance. In particular, if supervision is provided separate to line management responsibilities, the line manager should be consulted.

Challenges and solutions

The clinician with communication problems: Does the clinician recognise that communication is a problem? If yes, remediation can be relatively straightforward (eg, writing courses, conversational practice, providing scripts or templates to model effective communication practices, providing a mentor or buddy, use of audiovisual equipment). If no, then the issue is more complex, because the solution has to begin with the clinician gaining insight into the problem. For example, members of the clinical team may report that the clinician is impolite and uncommunicative while the clinician considers that he/she is efficient and focused. Readjusting the clinician's perceptions involves developing his or her empathic ability and, if identified as a problem, should become the focus of supervision.

The clinician who is uninterested in the area of clinical work: It is best to identify this early and plan accordingly. In some instances, the clinician's lack of interest will be based on a misconception of the content of the work or on a failure to appreciate its relevance to their area of interest. In many cases, the supervisor can highlight aspects of the work that will be of interest to the clinician. In others, an appeal to the clinician's sense of responsibility to the team may motivate them.

The reluctant supervisee: Where the clinician has no interest or cannot see the benefit of supervision. The supervisee needs to be encouraged to see the importance of supervision as part of professional development and delivery of safe patient care. Ensure the supervisory relationship and process appropriately meets the needs of the supervisee.

The overconfident clinician: Overconfidence is potentially dangerous and it is important to provide a reality check at an early stage. This may occur by asking the clinician to provide advice on a hypothetical case and then through guided questioning, give a constructive critique of their management plan. Consider highlighting the potential consequences of overconfident practice in relation to a real patient. This should never be done in a way that will belittle or embarrass the clinician.

The perfectionist clinician: Some clinicians are so determined to do everything perfectly that they cannot meet realistic deadlines and are in danger of burning themselves out. It is important with these staff to develop an appropriate priority list and work on realistic time management skills.

Managing a clinician in difficulty

Any of the challenging situations described on the previous page, and others, may become a “clinician in difficulty” — somebody who is not progressing as they should and potentially placing themselves and others at risk.

A clinician in difficulty may be supported by both the supervisor and operational line manager. Clear processes defining the role of each person are required in the case where the line manager is not the clinical supervisor. Where there are specific clinical practice issues, a suitably qualified senior clinician from that discipline should be involved in the process.

It is important to recognise that, in the case of less experienced staff, being a junior clinician with limited experience can be challenging. Most problems can be resolved if they are appropriately identified and managed. The general approach to dealing with clinicians in difficulty rests on three principles:

- 1 Clinicians in difficulty require ongoing supervision and support
- 2 Patient safety should always be the primary consideration
- 3 Prevention, early recognition and early intervention are always preferred over a punitive approach in dealing with identified issues.

The saying “prevention is better than a cure” applies here. Being astute and responding to issues early prevents a situation escalating to a major incident.

When a supervisor encounters a clinician in difficulty, he/she should seek advice without delay. Experience has shown that simple interventions can be very effective if made early enough. Seek advice early from your line manager, other senior colleagues or workforce services department. Other units such as the employee assistant program and professional practice unit may also be of assistance to both supervisors and supervisees.

Example: Having a “crucial conversation” with a supervisee

You have noticed that a supervisee is having difficulty with workload management. You know this because you have noticed that he/she is frequently staying back to get work done, is often working through lunch and looks exhausted and overwhelmed. You are also taking note of the issues the supervisee brings to supervision and you are finding that the supervisee is taking on too much extra work. You suspect that the supervisee is doing “above and beyond” the work that is required because he/she does not understand their role and is therefore anxious about performance and unsure about boundaries. You decide to address this in the next supervision session. This entails having a ‘crucial conversation’ with the supervisee.

Steps in a crucial conversation

Setting the scene	Be transparent. Discuss and mutually agree upon what will be on the agenda for discussion.	<p>“What would you like to discuss in supervision today?”</p> <p>“Because it has been such a busy time of the year, I would also like to take some time today to discuss workload management</p>
Discussing the evidence as a basis for your concerns	Focus on observable facts and behavioural evidence. Be constructive, timely and specific	<p>“I wanted to share with you some thoughts about what I have noticed over the last few months”</p>
Exploring the issues	Use active listening skills (empathy, questioning and open body language) and show genuine interest when trying to find out the cause of the issues	<p>“I am really concerned that you may be overdoing it at work. I have noticed that you are staying back late on a regular basis and often not taking lunch breaks. I am wondering what sort of an impact this is having on you?”</p>
Looking for solutions/ support	Discuss strategies and support options to help address the issue. In this case it could be scheduling more regular supervision sessions, teaching time management skills or role playing how to say ‘no’ to requests made that are outside of role or scope of practice	<p>“My job as your supervisor is to ensure you are supported in all areas of your work. This means looking at ways in which we can help you to manage your workload”</p>
Steps and timeline for improvement	<p>Responsibility should be shared when looking for solutions.</p> <p>Mutually agree on one or two steps, strategies, solutions or support options that are realistic and achievable within a timeframe.</p> <p>Develop a SMART goal</p>	<p>“So we have agreed that over the next month we will meet once per week instead of once per fortnight. Let’s make a time now for a session next week.</p> <p>For our next session, I will find some material for you to read in regard to workload management and you will keep a reflective practice log”</p>

Process for managing a staff member in difficulty

The algorithm below outlines a useful process to facilitate managing a staff member in difficulty.

