Tasmanian
CLINICAL SUPERVISION PROGRAM

LEARNING PACKAGE

Table of Contents

WHAT WILL BE COVERED (Introduction)

Welcome to the Tasmanian Clinical Supervision Learning Package for Health Professionals. This package has been developed to help guide and support clinical education and supervisor training activities in Tasmania. The Health Workforce Australia (HWA) National Clinical Supervision Support Framework provides the overarching principles that inform the content of this package. It aims to promote high standards of clinical supervision to all health professionals, across all disciplines and healthcare sectors. This package was first developed in 2012, as part of the Tasmanian Clinical Placement Partnership Project (TCPPP) and has been further enhanced to reflect inter-professional practice and the scope of the then Tasmanian Clinical Education Network (TCEN). In Feb 2018, additional supporting resources and references have been included.

HWA was an initiative of the Council of Australian Governments (COAG) which was established to address the challenges of providing a skilled, flexible and innovative health workforce to meet the needs of the Australian community, into the future (Health Workforce, 2011). The TCEN was Tasmania's response to HWA directive and played a pivotal role in facilitating, identifying and aligning clinical training placements across the higher education and training sectors, with public and non-government health providers.

One of the projects supported by the TCEN, was the Tasmanian Clinical Supervision Support Project (TCSSP). The TCSSP aimed to promote high standards of clinical supervision, expand capacity and capability of clinical supervisors, and cultivate public trust in the education and training of health professionals. This learning package has been produced in consultation with key stakeholders across Tasmania to provide the foundational knowledge required by health professionals when supervising students in healthcare environments.

Purpose

The purpose of this learning package is to provide foundational knowledge to all health professionals involved in supervising and supporting students during clinical practice. It is not intended to replace existing resources but rather provide supporting information that aligns with contemporary teaching and learning strategies and facilitates a common understanding of the terminology used by HWA for clinical education and training within the health setting.

Scope

This learning package is appropriately situated to inform staff working in the healthcare setting who are responsible for the supervision and support of health students inclusive of: undergraduate; postgraduate; vocational entry students as well as any new staff member to an organisation. It encompasses all disciplines including nursing and midwifery, medicine, dental and allied health and covers the full spectrum of organisations, sites and settings including public and private sectors; government and non-government; as well as not-for-profit organisations.

HOW TO USE THIS LEARNING MODULE

The learning module covers the following key areas:

- Communication (*Module 1*)
- Learning styles (*Module 2*)
- Assessment (*Module 3*)
- Feedback (*Module 4*)
- Learning Environments (*Module 5*)

Each module has information and activities that require the learner to perform an action and then provide self-reflection on how this relates to the individual workplace and work practice.

Activities are labelled with an icon that looks like this  . Within most activities are short video clips or quizzes that help consolidate learning. These activities are flagged by a link icon that looks like this  . These are hyperlinks or direct pathways through to the website containing the relevant information. To access these hyperlinks, hover your mouse arrow over the link icon  or the link address, and follow the instructions that ask the user to press the "Ctrl" key whilst left clicking the mouse key. This will transport the learner directly to that website. Please note that you will need to have computer access to YouTube to activate some of the activities. Learners are able to claim Continuing Professional Development (CPD) points by completing the learning module as the reflective work confirms the application to the practice setting. Your completed reflections will be able to be printed and kept in your professional portfolio as evidence of completion of individual Modules and/or the whole learning package.

This package will take approximately 3 - 4 hours to complete.

Principles

The principles underpinning this supervision package are:

(1) Application of contemporary learning principles is fundamental to the delivery of a supervision program
(2) An effective supervision education program provides opportunities for participants to:

- Develop an understanding of the concept of competence
- Apply contemporary learning principles to the learner's development and assessment
- Apply the principles of clinical supervision / preceptorship to practice
- Identify ongoing support through timely education, resources and communication networks
- Promote a learning and teaching organisational culture through a commitment to continuous quality improvement and lifelong learning

Objectives:

At the conclusion of this module it is expected you will be able to:

- Demonstrate an understanding of the role of a clinical supervisor / preceptor
- Demonstrate the ability to assess learning needs of students
- Identify strategies to address identified learning needs of students
- Understand adult learning principles and how they can be effectively applied in the practice environment
- Develop skills and behaviours related to the effective delivery of constructive feedback
- Utilise effective communication skills in the promotion of positive learning environments
- Understand the importance of performing objective assessments related to student learning

COMMUNICATION (Module 1)

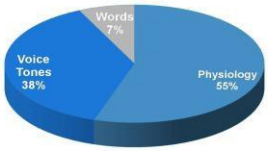
OBJECTIVES:

- To understand different methods of communication
- To develop an understanding of how information is interpreted
- To explore ways of improving your own communication skills

Impact of messages:

The impact of a message depends more on what is said non-verbally than on what is said in words. The ratio of total impact of a message is: (maximumadvantage.com, 2013)

- 7% verbal
- 38% vocal (tone, pace and pitch)
- 55% Facial expression



Perception:

Perception versus reality!
(www.theodysseyonline.com, 2018)

A learner's response to your message is based on what they perceive you said. Due to prior learning, you are likely to see or hear what you expect to see or hear.

Read through this list of colors, instead of reading the word; say the color of each word.
(CEMB-Forum, October 11, 2011)

If you found this difficult, then you have demonstrated the effect of prior learning on your perception. In the same way it is sometimes hard to really listen to the learner's explanation of their performance because it differs from our established expectations. There is never just one way of seeing things…

What do you see below? (Stankovich, April 15 2011)

In black you can read the word GOOD; but the word EVIL also appears in white letters inside each black letter.

ACTIVITY: Watch these short video clips below from "YOUTUBE" and reflect upon your learning. To activate, 'right mouse clip' on the YouTube hyperlink below and 'click' open.

ACTIVITY: YOUTUBE CLIP: EFFECTIVE COMMUNICATION BY INTEGRATION TRAINING
DURATION: 7.21 MINUTES

A short video by Mark Walsh giving 10 tips for effective communication.
(Walsh, Feb 28, 2011)

http://www.youtube.com/watch?v=K15ca0n0ois

REFLECTIVE EXERCISE: Based on the tips discussed in this video, describe a practice situation in which communication breakdown with a colleague occurred and why. How could this situation have been prevented?

ACTIVITY: YOUTUBE CLIP: VERBAL AND NON-VERBAL COMMUNICATION
DURATION: 4.38 MINUTES

A short video describing verbal and non-verbal communication with some cultural sensitivities.
(Roberts, October 17, 2008)

http://www.youtube.com/watch?v=vpPX70V_zIY&feature=related

REFLECTIVE EXERCISE: Observe some conversations at your workplace. What body language did you observe and was it consistent with the verbal content? Reflect upon your observations

Communicating effectively

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

Tips to optimise effective communications:

- Ensure that the content of what is said matches the way it's said and is reinforced by appropriate body language
- Be clear about the meaning that is being conveyed
- Minimise the possibility of distractions or interruptions.

Active Listening

The aim of active listening is to listen closely to the details that are being conveyed in order to ensure that not just the content is understood but also the intended message. The skill of active listening is important in the supervisory and learning relationships where feedback reflective practice and facilitation of clinical reasoning are required.

Qualities of an active listener:

- Is non-judgemental
- Has open body language
- Asks questions to facilitate learning
- Seeks clarification to enhance understanding
- Is genuinely interested
- Summarises frequently to endure understanding
- Is aware of tone and pays attention to nonverbal forms of communication in self and learner
- Seeks and gives feedback whenever possible
- Remains calm, in control and relaxed
- Allows time to articulate thoughts
- Paraphrases before disagreeing to demonstrate active listening and understanding
- Avoids making vague, unclear and ambiguous comments (HETI, May 2012).

LEARNING STYLES (Module 2)

OBJECTIVES:

- To understand adult learning principles
- Knowledge of how to appropriately situate learning for the adult learner using the Clinical Reasoning Cycle
- Identify your own learning style and understand how this may influence comprehension
- Understand emotional intelligence and how this impacts on interactions

The Adult Learner:

Adult learning theory is based on the understanding that adults are:

- autonomous and self-directed;
- have accumulated a foundation of life experiences and knowledge;
- goal and relevancy-orientated;
- practical;
- need to be shown respect.

The experiential learning cycle helps inform this theory. An adult will have an experience; think about it; identify the learning needs for the future; plan what needs to be undertaken; and apply new learning in practice. Good feedback will help the learner to establish the links between these steps. As a clinical supervisor / preceptor, it will be helpful to understand how and why adults learn.

Think of how, what and why you learn.

Traits of Adult Learners

1. Self-direction
2. Practice and results orientated
3. Less open minded
4. Slower learning but more integrative knowledge
5. Use personal experience as a resource
6. Motivation
7. Multi-level responsibilities
8. High Expectations

(Knowles, 2011)

17 Tips for Motivating Adult Learners

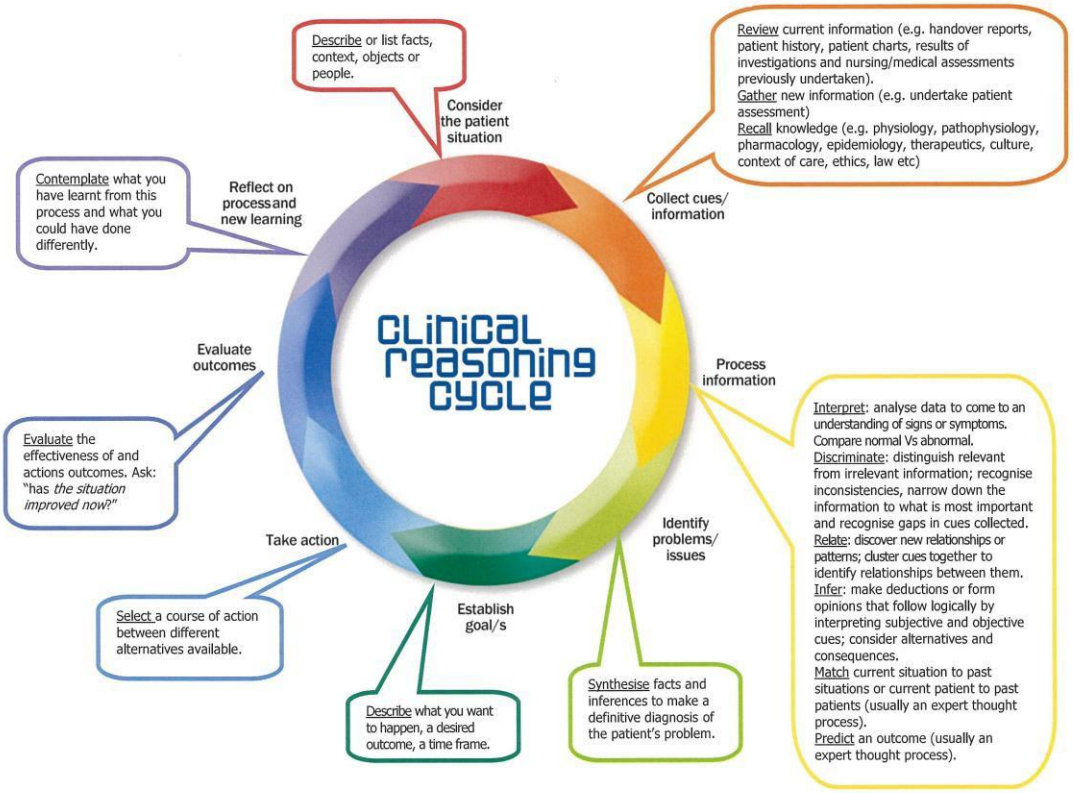
1. Create useful and relevant learning experiences based on the age group and interests of your learners
2. Facilitate exploration
3. Build community and integrate social media
4. A voice behind the video is not enough
5. Challenge through games
6. Use humor
7. Chunk information
8. Add suspense
9. Accommodate individual interests and career goals
10. Stimulate your learners
11. Let learning occur through mistakes
12. Make it visually-compelling
13. Get Emotional
14. Get examples of their workplace
15. Be respectful to them
16. Ask for feedback
17. Present the benefits of undertaking the course

(Knowles, 2011)

Clinical reasoning cycle:

Clinical reasoning is a cognitive and metacognitive process that involves elements of critical thinking (thinking like a health professional). It is a cognitive process that manifests into an action. There are five **categories** of critical thinking: prioritization and delegation, problem recognition, clinical decision making, clinical implementation, and reflection (Bittner, Gravlin, MacDonald, & Bourgeois, 2017).
Clinical reasoning is a way clinicians can think about the issues they encounter in clinical practice (Levett-Jones et al., 2010). These skills can be taught to health professions and have been shown to improve once students are made aware of their own understanding of the way that they interpret and conceptualize the decision making process and apply this to a clinical setting (Grubbs, 2017).

Figure 2: The clinical reasoning process with descriptors



Clinical reasoning (CR) is based on what expert/experienced practitioners do automatically or instinctively (tacit knowledge). They engage in CR multiple times for each patient in their care. CR offers learners a model and explanation of what may seem tacit and implicit. Poor CR skills result in failure to collect cues and therefore failure to take action. CR is an educational model that has the potential to enhance your learner's skills. It also provides a language that supervisors / preceptors can use to facilitate discussion and reflection on case based learning and simulation. It is a language to assist the novice to learn from experiences in practice.

Five **rights** of clinical reasoning

The effective use of the clinical reasoning cycle is directly linked to the ability to:

- Collect the **right** clues
- Take the **right** action
- For the **right** patient
- At the **right** time
- For the **right** reason (Levett-Jones et al., 2009)

Ten Top Tips for the Teaching Supervisor

1. **Every little bit helps:** Seize the teaching moment. Even if you don't have the whole package worked out, it's still worthwhile sharing what you can, as best you can. Don't have time to run through a process or procedure in full? Draw the learner's attention to one key aspect of the task. No time for a complete debrief immediately after a difficult case? Ask a few key questions to check the learner's understanding of what occurred and give quick feedback. Follow up later when there is time.

2. **Teach by guided questioning:** Ask questions to discover the state of the clinician's knowledge and understanding. Encourage independent thinking and problem-solving. Effective questioning uncovers misunderstandings and reinforces and extends existing knowledge. Questions keep the learner engaged, "on their toes", listening and thinking.

3. **Invite the learner to set the agenda:** Adult learners should be involved in decisions about the direction and content of learning. Your ultimate objective as a supervisor is to foster the learner's ability to be a self-directed life-long learner.

4. **Encourage questions:** Questions from the learner should always be treated with respect. You may be shocked at what you did not know, but on closer inspection, may discover that others are just keeping quiet. The three most important words in teaching and learning are "I don't know'.

5. **Focus the learner:** Start any teaching session by setting up the importance of the session. Teaching is more effective if it is tailored to the learner's interests, ambitions, and current level of knowledge and ability. Answer the question: why should they pay attention to what you are about to teach them?

6. **Focus the learning:** Don't try to teach too much at once. Try not to repeat what is already known. Clinical situations are complex but limit the learning to the key aspects that form the learning edge of your audience's knowledge base. Procedures and processes can be broken down into steps, not all of which have to be covered at once.

7. **Encourage independent learning:** Don't try to teach everything – give enough information to start the learner on track, then ask them to complete the task themselves. Set tasks that require the learner to act on the information you have provided. Keep learning open ended. Encourage the learner to seek other educational opportunities and report back on their learning.

8. **Teach evidence-based practice:** Build a life-long learning attitude in the learner. Even more important than knowing the current best answer to a clinical problem is having the skills to identify a clinical question, search the clinical literature, appraise the evidence and form an evidence-based plan.

9. **Check the understanding of the learner:** Have the learner actually understood what has been taught? Can they demonstrate clinical reasoning and put knowledge and skills into practice? It not, perhaps revisit specific topics or skill areas until the learner feels confident and can show that they have learned.

10. **Evaluate your own practice as a teacher:** How well did the student learn from the information you provided? Every time you teach you have a chance to learn how to do it better (and more easily) next time. Try different methods and compare learner outcomes. Seek feedback from the learner. Compare notes with your peers.

Adapted from ((HETI), April 2012)

It is important for clinical supervisors / preceptors to use language that leads the learner through the journey of exploration. Here are some examples that may act as cues when questioning learners.

Responses from supervisors / preceptors that can be used to encourage, facilitate and promote effective clinical reasoning:

- Let's explore this.
- Let's think this through.
- Now let's consider all the possible options/solutions/outcomes. Show me how you came to that decision
- Walk me through your thinking about this. That is one option; let's explore some others.
- What are some possible outcomes of this approach?
- That is a good thought/answer/response/idea … let's expand on it.
- Let's consider some alternatives Let's figure this out.
- Tell me about what you've learnt so far. Great question!
- Where would we find the answer to that? Let's try that one again.
- Why don't you lead us through that process?
- It's not just about the right answer it's about learning the process
- Good try … have another go.
- Now that you've worked that out let's try ….
- OK. You are on the right track. Let's try something a little more challenging now.
- Have you considered what could happen if …
- That is correct in this situation and for this person but what if … What do you think about ….
- How do you know that to be true … on what do you base your answer?

(Scheffer & Rubenfeld, 2006)

Creating an optimum learning environment

Physical Environment
Minimising distractions and taking into account the learner's needs, such as regular breaks or finding a quiet place to talk, contributes to creating a supportive learning environment.

Motivation
The role of the facilitator is to motivate the learner both intrinsically and extrinsically. As learners are motivated by inclusion and consultation, the role of the facilitator is to establish a trusted relationship and communicating a passion for the subject in order to create an effective learning environment.

Safety
Learning requires a safe environment ensuring a physically safe place to work. Learning can be emotionally and psychologically challenging and individuals need a place where they can be encouraged to question their own knowledge. Facilitators have to create a safe learning environment that allows learning to take place.

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

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

(HETI, May 2012)

With any new concept there are certain pitfalls that can occur. The following table outlines some of the more common Clinical Reasoning errors that may occur.

CLINICAL REASONING ERRORS	
Error	**Definition**
Anchoring	The tendency to lock onto salient features in the patient's presentation too early in the clinical reasoning process and failing to adjust this initial impression in the light of later information. Compounded by confirmation bias.
Ascertainment bias	When a practitioner's thinking is shaped by prior assumptions and preconceptions, for example ageism, stigmatism and stereotyping.
Confirmation bias	The tendency to look for confirming evidence to support a clinical diagnosis rather than look for disconfirming evidence to refute it, despite the later often being more persuasive and definitive.
Diagnostic momentum	Once labels are attached to patients they tend to become stickier and stickier. What started as a possibility gathers increasing momentum until it become definite and other possibilities are excluded.
Fundamental attribution error	The tendency to be judgemental and blame patients for their illnesses (dispositional causes) rather than examine the circumstances (situational factors) that may have been responsible. Psychiatric patients, those from minority groups and other marginalised groups tend to be at risk of this error.
Overconfidence bias	A tendency to believe we know more than we do. Overconfidence reflects a tendency to act on incomplete information, intuition or hunches. Too much faith is placed on opinion instead of carefully collected cues. This error may be augmented by anchoring
Premature closure	The tendency to apply premature closure to the decision-making process, accepting a diagnosis before it has been fully verified. This error accounts for a high proportion of missed diagnosis.
Psych-out error	Psychiatric patients are particularly vulnerable to clinical reasoning errors, especially fundamental attribution errors. Co-morbid conditions may be overlooked or minimalised. A variant of this error occurs when medical conditions (such as hypoxia, delirium, electrolyte imbalance, head injuries etc.) as misdiagnosed as psychiatric
Unpacking principle	Failure to collect all the relevant cues in establishing a differential diagnosis may result in significant possibilities being missed. The more specific a description of an illness that is received, the more likely the event is judged to exist. If an inadequate patient history is taken unspecified possibilities may be discounted.

(Croskerry, 2003)

Learning styles:

Many people recognise that each person prefers different learning styles and techniques. Learning styles group common ways that people learn. Some people may find that they have a dominant style of learning, with far less use of the other styles. Others may find that they use different styles in different circumstances. There is no right mix. Nor are your styles fixed. You can develop ability in less dominant styles, as well as further develop styles that you already use well. (www.learning-styles-online.com, 2018)

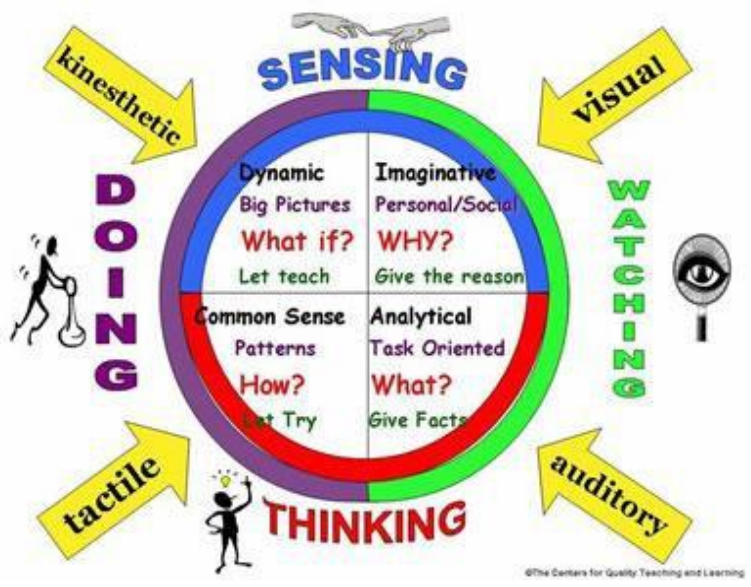
Using multiple learning styles and multiple intelligences for learning is a relatively new approach. This approach is one that educators have only recently started to recognise. Traditional schooling used mainly linguistic and logical teaching methods. It also used a limited range of learning and teaching techniques (www.learning-styles-online.com, 2018).

By recognising and understanding your own learning styles, you can use techniques better suited to you. This improves the speed and quality of your learning.

THE SEVEN LEARNING STYLES

1. **Visual (spatial):** You prefer using pictures, images, and spatial understanding.
2. **Aural (auditory-musical):** You prefer using sound and music.
3. **Verbal (linguistic):** You prefer using words, both in speech and writing.
4. **Physical (kinesthetic):** You prefer using your body, hands and sense of touch.
5. **Logical (mathematical):** You prefer using logic, reasoning and systems.
6. **Social (interpersonal):** You prefer to learn in groups or with other people.
7. **Solitary (intrapersonal):** You prefer to work alone and use self-study

(www.learning-styles-online.com, 2018)



http://www.proprofs.com/games/puzzle/sliding/t/learning/

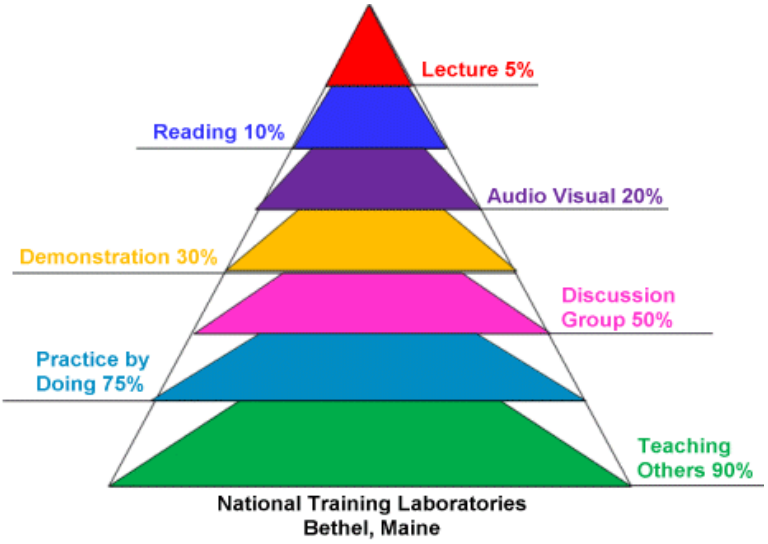
ACTIVITY: Go to the link below to identify your learning style.

WEBSITE: free on-line learning style identification duration: 16 questions

A quick free on-line questionnaire that helps you to identify the way you learn the best (http://vark-learn.com, 2018).

www.vark-learn.com/english/page.asp?p=questionnaire

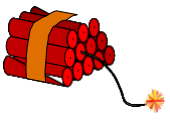
REFLECTIVE EXERCISE: What was identified as being your learning style preferences and how will this inform your practice as a preceptor into the future?



Common Problems in Student Learning Experiences*:*

1. Lack of learner focus:
- The learner attempts to do too many things at one time – the result can be a failure to make a useful amount of progress in any one area
- Focus may be reduced by lack of logical progress and limited grouping of related activities

2. Loss of learning opportunities:
- Many opportunities may be difficult to use effectively
- Sometimes productivity can conflict with learning needs
- Expectations may be unrealistic and sometimes do not reflect the amount of preparation, orientation and support provided
- Some important events occur unexpectedly



3. Mistakes:
- Reflect on how you feel when you make mistakes
- Mistakes can happen
- The pressure not to make mistakes is immense

4. Supervision practice:
- Supervised practice can change perceptions
- when someone is looking over our shoulder
- Find ways to help without interfering (unless the actions have the potential to cause harm)

***Tip:** To consolidate learning, have a student present a patient case study to the unit or another health professional to help reinforce knowledge*

Salovey & Mayer (1990, p. 189) define 'Emotional Intelligence' as "the subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions to discriminate among them and to use this information to guide one's thinking and actions".

'The emotionally intelligent workplace' developed the idea of a culture of an appropriate level of emotion intelligence to support the atmosphere within a business (Goleman & Cherniss, 2001).

Emotional Intelligence is the integration of thought and feeling; between cognition and emotion. Goleman discussed four domains: Self-awareness; self-management; social awareness; and relationship management (Goleman, 2001). Having a higher awareness of these principles assists people to be more effective in the work place. Cherniss and Goleman's book 'The Emotionally Intelligent Workplace' (2001) is available as a free download at the following site:

http://downloadmore.in/ebooks/Management/[downloadmore.in]Management_Ebook_The%20Emotionally%20Intelligent%20Workplace.pdf#page=28

ACTIVITY: Go to the link below to discover your emotional intelligence rating!

WEBSITE: Hay Group - emotional intelligence quiz: 13 questions

A quick free on-line questionnaire that helps you to identify your emotional intelligence

http://www.haygroup.com/leadershipandtalentondemand/Demos/EI_Quiz.aspx

REFLECTIVE EXERCISE: Do these results surprise you? Reflect upon a past situation and describe how an increased emotional intelligence may have changed the outcome.

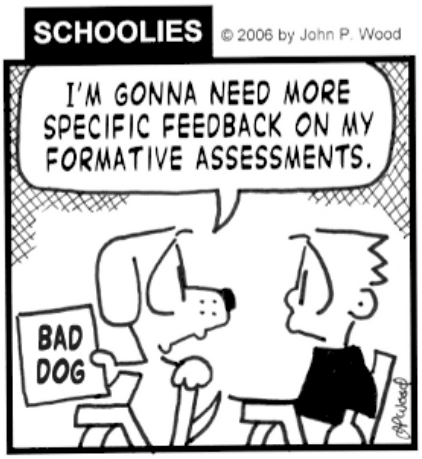
ASSESSMENT (Module 3)

OBJECTIVES:

- Understand the difference between formative and summative assessment and how this is conducted in the practice setting
- To understand how to apply learning objectives during clinical placement

ASSESSMENT:

The National Clinical Competency Resource (Health Workforce Australia, 2014) identifies activity into three separate domains which are Clinical Supervision Safety and Quality in clinical supervision; and organization. Assessment falls within the Clinical Supervision domain and most students require some form of assessment during their clinical placement. In a balanced assessment both summative and formative assessments are required to provide a broad understanding of student capability.



Formative assessment refers to the information that is received from multiple sources for example, by clinical supervisors /preceptors performing activities with students during clinical placement. This provides multiple sources of information that when discussed with the student, help direct student learning on a day to day basis.

Summative assessment is the overall or final assessment of student capability, for example the final assessment completed at the end of student placement. This is a 'summary' of the student activity and should include the formative assessment collected during placement (Graduate Students, 2018).

(For more information, Ctrl and click here)

Formative assessment should be closely aligned with feedback so that students are provided with the opportunity to direct their own learning and development. Students should be given the opportunity to reflect upon assessment and construct a plan to enhance their practice accordingly. The supervisor / preceptor is pivotal to this process as they guide the student to self-correct and engage with their learning process. When managed well, this process motivates the student and augments lifelong positive learning experiences (Catherine Garrison, 2018).

A component of assessment is the setting of realistic and informed learning objectives. The clinical supervisor / preceptor and student must set these very early in the clinical placement so there are clear and transparent pathways to improve student learning. It involves making your expectations clear to students and setting appropriate outcomes for learning. Formative assessment can be used to determine how well student performance matches learning outcomes. The learning objectives should be student centered, break down the task and focus on specific cognitive processes (Carnegie Mellon University, 2016).

How to set learning objectives

Learning objectives need to be specific, measurable and realistic. They should outline where the student should be positioned at the completion of training. The following diagram outlines the steps that a supervisor / preceptor undertakes when interacting with a learner. It allows continuous improvement of learning processes.

Competency Standards and Standards for Practice

Most professions have national competency standards or standards for practice that are the benchmark against which performance is assessed. These exist to ensure a minimum professional standard that ultimately protects consumers of healthcare services. Student performance should be situated along the practice continuum with the objective of being positioned at the beginning level practitioner competency level on completion of training. Clinical placement assessments are instrumental in arriving at this point.

For individual competency standards, please refer to your professional body – here are some examples

http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

http://www.pharmacyboard.gov.au/Registration-Standards.aspx

http://www.physiotherapyboard.gov.au/Registration-Standards.aspx

ACTIVITY: YOUTUBE CLIP: FORMATIVE AND SUMMATIVE ASSESSMENT
Duration: 4.49 Minutes

Rick Wormeli who is an American educational consultant and author, speaks about how to use assessment to get the best out of student learning. This is constructed around education not health but the concepts are parallel.

http://www.youtube.com/watch?v=rJxFXjfB_B4

REFLECTIVE ASSESSMENT: *Can you relate this information to the clinical setting? Reflect upon the links between feedback and formative assessment and how this may further inform your practice.*

FEEDBACK (Module 4)

OBJECTIVES

- Develop an understanding of the ways to deliver effective feedback
- Determine what constitutes constructive versus destructive feedback

Feedback is the information given to a person about their performance which is used as the basis for improvement (2013, Oxford Dictionary). It is given in relation to the standard the job requires. It is an essential component of any learning environment. Constructive feedback is motivational and encourages continued learning and development. It provides information about behaviour and encourages the student to reflect upon practice. It identifies the strengths and areas for focus in the student and builds confidence in skill development. It provides direction and clarity of purpose.

Preparing for feedback*:*

When preparing to give feedback, all relevant information should be collected so that all the facts are available. The clinical supervisor / preceptor must be familiar with the standard that is required and the individual objectives to ensure that the learner is being assessed fairly. The clinical supervisor / preceptor should be properly prepared for the session including:

- Identifying and minimising any personal bias or pre-conceived impressions
- Predict the learners' likely response
- Contemplate possible solutions
- Allow time to give feedback
- Provide a private setting

Guidelines for giving feedback:

Feedback should be:

- Selective
- Specific
- Timely
- Descriptive
- Sensitive
- Creative.

Consider patient safety as a guideline in deciding when feedback is appropriate. For example, if a vital step has been missed during a procedure, ensure you intervene immediately by prompting the student to act:

"Andrew, when would be the time to perform your hand hygiene".

When giving feedback, always maintain positivity throughout. As adult learners, it is essential that the student is given the opportunity to reflect upon their own performance and identify strengths and weaknesses themselves (http://essentialcomm.com/tips/execcoachtips/05-10-06.pdf).

"So Andrew, how did you find that activity? .... What worked well for you? ... What would you do differently next time?"

With the appropriate insight, this allows the student to self-correct their practice with minimal intervention from the clinical supervisor / preceptor. The clinical supervisor / preceptor needs to select a few key areas to focus on during feedback to ensure the student is not overwhelmed. So although you may have found the whole performance to be sub-optimal, identify just a few things to concentrate on.

"I'm really pleased you identified communication as being something you could work on. I think if you approached the patient using different body language and tone, you would be able to connect with the patient and uncover so much more than you did today".

Ask for clarification to ensure comprehension and ensure that you offer solutions. Never put off giving feedback to the end of the shift or next shift as it will lose its impact / effectiveness. Always ensure the student knows there are solutions and a pathway through their problems to ensure they remain positive and focused. The Golden Rule of feedback: "if I have done well, reward me. If I have done badly, tell me but let me know I have the capacity to make it next time" (Hunt as quoted in Horner 1995)

ACTIVITY: YOUTUBE CLIP: MOTIVATE OTHERS WITH FEEDBACK DURATION: 4.25 MINUTES

Management trainer Judi Clements shares some of the characteristics of effective motivation.

http://www.youtube.com/watch?v=cClQMsEY0qI&feature=related

REFLECTIVE EXERCISE: Recall a situation where giving feedback to someone was not received well. Can you describe how this may have been done to achieve a different outcome?

ACTIVITY: YOUTUBE CLIP: ASSESSMENT FOR LEARNING- EFFECTIVE FEEDBACK DURATION: 5.07 MINUTES

A short video by Ian Garfield portraying a supervisor giving feedback to a student.

http://www.youtube.com/watch?v=BWrUcWA0UGY

REFLECTIVE EXERCISE: How was the student guided to reflect upon her performance? How was this received by the student?

Performance counselling:

Performance counselling involves talking with a learner after ongoing feedback has been provided about issues relating to their performance or behaviour. It is a means of problem solving and working out alternative approaches that may assist the learner to improve performance. It is not a disciplinary procedure and should not be confused as such.

There are 3 phases of performance counselling:

1. Preparation: Gather all facts and any evidence. Consider how the person will react and think of possible rebuttals and responses they may offer and then provide possible solutions to these. Ensure you have identified any personal bias that may cloud your judgement.

2. Interview: Ensure that interruptions are minimised for the duration of the interview. Allow the learner to describe what went well and why? What was challenging and why? What they might do differently next time? Help them to establish the learning / knowledge gap and the possible causative factors. Help the learner make the necessary links to previous lessons learnt and identify possible solutions that may help the situation. Document them clearly and objectively.

3. Follow-up: Ensure you arrange to meet with the learner again to establish the effectiveness of your plan.

Common counselling errors include:

- Not clearly defining the behaviour required
- Neglecting to provide regular or effective feedback to the learner
- Delaying performance counselling
- Lack of preparation
- Not having control of the interview
- Being aggressive or compliant rather than assertive
- Not allowing the learner to talk
- Failing to actively listen
- Not establishing the cause of the problem
- Not setting an agreed plan of action.

The take home message for the delivery of constructive feedback is:

Remember to assume an empathetic approach to your role. Give regular constructive feedback and be clear in your language.

Delivering constructive feedback is difficult and not always fun. However, it can be rewarding. People will surprise you. Some will react more negatively than you anticipated. Others will surprise you by being grateful for the feedback, and you will feel proud when you see them grow. You are responsible for all learners and for them being able to work successfully as a team. It is important to give individuals feedback and hold all of them to the same standards. When you don't address behavior or performance issues, not only can staff lose faith and trust in you as a leader, they may think it's OK to behave that way as well (Blatchley, 2017).

There are three types of conversations to effectively feedback to students depending on the type of engagement required.

- Non-confidential directions requires a low energy level, requiring a casual conversation or short comment. It can be a brief exchange in a relatively public area and is useful for highlighting a possible clarification of policy or clarification of a question.
- Confidential discussions require a private area to discuss an underlying problem or behavior. The exchange is initially information gathering followed by an attempt to offer perspective for the student in relation to their understanding of the problem/behavior being discussed.
- A Supportive conversation is a discussion to identify whether the student is working in the correct environment and to provide them with more satisfaction. This can be particularly useful when the student may need another working environment because of perceived or real conflict in the workplace. Finding a satisfactory solution will help the student strive in the workplace and is necessary for their professional growth (Blatchley, 2017).

LEARNING ENVIRONMENTS (Module 5)

OBJECTIVES

- To understand the importance of creating a positive learning environment
- To reflect upon your role as a positive role model for your profession and organisation

A positive working environment is essential to effective learning. If staff provide a welcoming environment and have a positive cheerful attitude, the learner will feel accepted and therefore may integrate into the ward well, making the clinical placement a much more enjoyable experience for everyone. It is important for clinical supervisors / preceptors to:

- Learn the student's name and ensure it is placed on the allocation list so that everyone knows they are part of the team
- Introduce the student to staff and ensure they receive an appropriate orientation

Clinical environments provide myriad opportunities for learning. To the experienced clinician, these may not be obvious, but to a learner, the opportunities to expand knowledge are abundant. It is however essential that the connections between theory and practice are realised, and that part of the role/function of the clinical supervisor / preceptor is to recognise and facilitate these opportunities.

ACTIVITY: Read the Centre for Research on Learning and Teaching article by Thomas Schwenk titled "Clinical Teaching" in the link below (Schwenk, 1987)

http://www.crlt.umich.edu/publinks/occ1

REFLECTIVE EXERCISE:

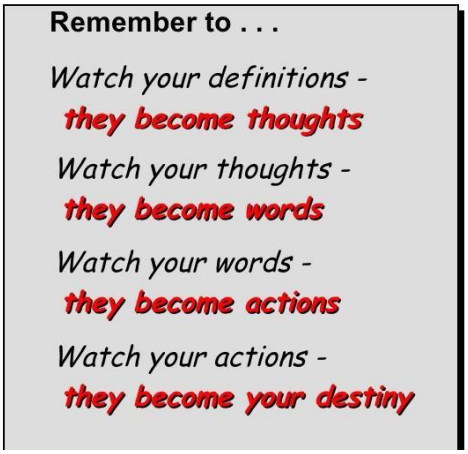
Schwenk discusses the transition process from unconscious incompetence to unconscious competence. Can you recall an example of when you made this transition when performing a certain skill, for example, venepuncture?

Can you recall who assisted you in this process and what assisted and hindered you in meeting competence? Describe this below.

As a clinical supervisor / preceptor, you are an important role model for both your profession and organisation. Students will imitate the behaviour that you exhibit and the professionalism that you display. Showing respect for students, your colleagues, management, patients, family… everyone is essential to maintaining positive working relationships.

Can you remember your very first day in a new workplace? How you felt? How people reacted to you and how that forged the way that relationship grew?

For students, entering the clinical environment may be a daunting experience. Fear of the unknown and lack of familiarity with the culture of the workplace may lead to a student feeling anxious and doubting their own capacity to learn. Clinical supervisors / preceptors provide assistance at this time to enable students to learn and achieve while undertaking their clinical placement. There are many different personalities in any workplace but the only personality you can change is your own. The clinical supervisor / preceptor relationship needs to be supported by clear objectives, expectations and guidelines can help design and deliver a preceptorship program which is likely to bring about more consistency, standardized training and positive outcomes for both preceptor and student (Valizadeh, Borimnejad, Rahmani, Gholizadeh, & Shahbazi, 2016).



Resources:

In the 2014 Budget the Australian Government announced the closure of Health Workforce Australia (HWA) and the essential functions were transferred to the Department of Health (DoH). The learning package *National Clinical Supervision Support Framework (HealthWorkforce, 2011)* is now located on the DoH website:

http://www.health.gov.au/internet/main/publishing.nsf/Content/work-prog.
http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Health_Workforce_Data
http://www.health.gov.au/internet/main/publishing.nsf/Content/publications-Health%20workforce

Additionally, the *National Clinical Supervision Competency Resource (Australia, 2014)* outlines the roles and responsibilities at a foundational, intermediate and advanced level supervisor. This learning package provides foundational level knowledge required of a clinical supervisor / preceptor in the healthcare environment. Whereby it is accepted that every competent health practitioner has a professional responsibility to undertake supervision activities, this package aims to further expand your capability to supervise and engage with learners. All health professionals responsible for the supervision of learners should become familiar with this document.

The content of this package is intentionally generic and is appropriately positioned to inform all health disciplines. It is however the responsibility of each practitioner to have an awareness of their discipline specific competency standards and understand how these standards may be applied to undergraduate student activity in their workplace. Each individual professional body has the code and guidelines available at the following web address. https://www.ahpra.gov.au/ or contact the professional body directly for their professional codes and guidelines of practice.

The University of Tasmania College of Health and Medicine has some very useful tools on their website that guide supervisors / preceptors when performing their role:

http://www.utas.edu.au/health/professional-experience-placement

http://www.utas.edu.au/health/professional-experience-placement/supervisors

http://www.utas.edu.au/health/professional-experience-placement/supervisors/online-learning-modules/jack-and-the-beanstalk

References

Bittner, N. P., Gravlin, G., MacDonald, C., & Bourgeois, D. (2017). A Newly Licensed Nurse Orientation Program Evaluation: Focus on Outcomes. *Journal of Continuing Education in Nursing, 48*(1), 22-28. doi:10.3928/00220124-20170110-07

Blatchley, A. (2017). A Nurse Manager's Guide to Giving Effective Feedback. *Nurse Leader, 15*(5), 331-334. doi:10.1016/j.mnl.2017.06.005

Carnegie Mellon University, E. C. (2016). Design and Teach a Course, Articulate your learning objectives. Retrieved from https://www.cmu.edu/teaching/designteach/design/learningobjectives.html

Catherine Garrison, M. E. (2018). Formative and Summative Assessments in the Classroom. Retrieved from https://www.amle.org/BrowsebyTopic/WhatsNew/WNDet/TabId/270/ArtMID/888/ArticleID/286/Formative-and-Summative-Assessments-in-the-Classroom.aspx

CEMB-Forum. (October 11, 2011). Freedom of Conscience - Freedom of Speech. Retrieved from https://www.councilofexmuslims.com/index.php?topic=18117.0

Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them. *Academic Medicine, 78*(8), 775-780. doi:10.1097/00001888-200308000-00003

Goleman, D., & Cherniss, C. (2001). *The emotionally intelligent workplace : how to select for, measure, and improve emotional intelligence in individuals, groups, and organizations*: San Francisco : Jossey-Bass, 2001.

Graduate Students, F. o. E., University of Windsor, Ontario, Canada. (2018). Assessment in the Inquiry Classroom. Retrieved from http://learninginscience.blogspot.com.au/

Grubbs, A. B. (2017). Boot Camp: Enhancing Clinical Reasoning Skills in MedVet to BSN Students. *Kentucky Nurse, 65*(2), 18-18.

Health Workforce. (2011). *National Clinical Supervision Support Framework*. Retrieved from http://www.ntrtn.com.au/sites/default/files/hwa-national-clinical-supervision-support-framework-201110.pdf

(HETI) (April 2012). The superguide: a handbook for supervising allied health professionals/Health Education and Training Institute. 88 pages.

Australia, H. W. (2014). *National Clincial Supervision Competency Resource*. Retrieved from March: http://www.heti.nsw.gov.au/Global/Clinical%20Supervision%20Series/HWA_National-Clinical-Supervision-Competency-Resource_FINAL.pdf

HETI. (May 2012). The Learning Guide a handbook for allied health professionals facilitating learning in the workplace. *Health Education and Training Institute)*, 104 pages.
http://vark-learn.com. (2018). How do I learn best? Retrieved from http://vark-learn.com/the-vark-questionnaire/?p=questionnaire

Knowles, M. (2011). The adult learning theory.

Levett-Jones, T., Hoffman, K., Dempsey, J., Jeong, S., Noble, D., Norton, C., . . . Hickey, N. (2009). *The 'five rights' of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically 'at risk' patients* (Vol. 30).

Levett-Jones, T., Hoffman, K., Dempsey, J., Jeong, S. Y.-S., Noble, D., Norton, C. A., . . . Hickey, N. (2010). The 'five rights' of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically 'at risk' patients. *Nurse Education Today, 30*(6), 515-520. doi:https://doi.org/10.1016/j.nedt.2009.10.020

maximumadvantage.com. (2013). Non-Verbal Communication. Retrieved from http://www.maximumadvantage.com/nonverbal-communication/

Roberts, B. (October 17, 2008). Non Verbal Communication.

Salovey, P., & Mayer, J.D. (2009) Emotional Intelligence, *magination, Cognition and Personality, 9*(3), 185-211. doi:10.2190/DUGG-P24E-52WK-6CDG

Scheffer, B. K., & Rubenfeld, M. G. (2006). Critical thinking: a tool in search of a job. *J Nurs Educ, 45*(6), 195-196.

Schwenk, T. L. (1987). *Clinical Teaching*. Paper presented at the CRLT Occasional Paper No. 1. http://www.crlt.umich.edu/publinks/occ1

Stankovich, D. C. (April 15 2011). Perception and What We "See" Varies from Person-to-Person.

Valizadeh, S., Borimnejad, L., Rahmani, A., Gholizadeh, L., & Shahbazi, S. (2016). Challenges of the preceptors working with new nurses: A phenomenological research study. *Nurse Education Today, 44*, 92-97. doi:https://doi.org/10.1016/j.nedt.2016.05.021

Walsh, M. (Feb 28, 2011). Commincation tips and skills - How to communicate effectively. *Communication Skills Training*.

www.learning-styles-online.com. (2018). Overview of Learning Styles. Retrieved from https://www.learning-styles-online.com/overview/

www.theodysseyonline.com. (2018). Our understanding of self. Retrieved from https://www.theodysseyonline.com/understanding-self