Tasmanian
CLINICAL SUPERVISION PROGRAM

LEARNING PACKAGE

Contents

INTRODUCTION:

Welcome to the Tasmanian Clinical Supervision Learning Package for Health Professionals that 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 which aims to promote high standards of clinical supervision to all health professionals, across all disciplines and healthcare sectors. This package was first developed as part of the Tasmanian Clinical Placement Partnership Project (TCPPP) during 2012 and has been further enhanced to reflect inter-professional practice and the scope of the TCEN.

HWA is 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 that meets the needs of the Australian community, now and into the future (National Clinical Supervision Support Framework, 2011). The Tasmanian Clinical Education Network (TCEN) is Tasmania's response to the HWA directive and plays 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, is the Tasmanian Clinical Supervision Support Project (TCSSP). The TCSSP aims 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 the healthcare setting.

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; not-for-profit organisations.

HOW TO USE THE LEARNING MODULE

The learning module covers the following key areas:

- Effective Communication
- Learning styles / Adult Learning Principles
- Principles of Assessment
- Constructive Feedback
- Creating Positive Learning Environments

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. This can be kept in your professional portfolio as evidence.

The 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 that staff 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

MODULE 1: EFFECTIVE COMMUNICATION

OBJECTIVES:

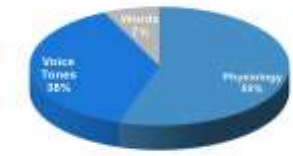
- To understand different methods of communication
- To develop an understanding of how information is interpreted
- To explore ways of improving your own communication skills

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: (http://www.maximumadvantage.com/demonstration-of-non-verbal-communication.html)

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



Perception:

Perception versus reality! (http://coa-debate.blogspot.com.au/2012/03/perception-reality.html#!/2012/03/perception-reality.html)

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
(http://www.councilofexmuslims.com/index.php?topic=18117.0)

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? (http://blog.drstankovich.com/blog/2011/04/uncategorized/perception-and-what-we-see/)

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.

YOUTUBE CLIP: EFFECTIVE COMMUNICATION BY INTEGRATION TRAINING

DURATION: 7.21 MINUTES

A short video by Mark Walsh giving 10 tips for effective communication.

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 occurred and why. How could this situation have been prevented?

YOUTUBE CLIP: VERBAL AND NON-VERBAL COMMUNICATION

DURATION: 4.38 MINUTES

A short video describing verbal and non-verbal communication with some cultural sensitivities.

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.

ACTIVE LISTENING:

Active listening is a way of listening and responding to another person that improves mutual understanding. Often when people talk to each other, they don't listen attentively. They are often distracted, half listening, half thinking about something else.
http://www.colorado.edu/conflict/peace/treatment/activel.htm

The following can be utilised to assist with the development of your active listening skills:

- Attending – pay close attention to what the speaker is saying and for non-verbal communication cues. Use minimal encouragers e.g. mmm or yes
- Open ended questions – use open ended questions that ask for an explanation or discussion; not closed questions which only elicit yes or no responses
- Reflection – reflect the speakers thoughts back to them to demonstrate understanding and comprehension
- Positive affirmation – positively affirm the speaker's actions and efforts. This helps build a positive, trusting relationship and will increase the speaker's confidence
- Summarise – summarising what has been discussed helps the speaker and listener agree on what has been said and prevents any misunderstanding

Barriers to effective communication:

- Insincere praise – can be seen as manipulation
- Diagnosing - not listening, or jumping to conclusions
- Ordering ("bossiness") - causes resentment or resistance, sabotage or non-compliance
- Threats (as above)
- Moralising - these are the 'you should do' comments backed up by reference to senior staff
- Advising – can imply a person is incapable of problem-solving
- Diverting - autobiographical takeover e.g. that happened to me
- Logical argument - focus on facts and avoids feelings when this is central to a problem
- Criticising – judgmental
- Pretending to listen- thinking of the answer while speaker is talking
- Generalising - can invalidate the speaker's feelings

Assertiveness:

Clinical Supervisors are often given complex clinical loads, because of their comprehensive understandings of their environment. Even the most competent supervisor may feel overloaded and needs to communicate this effectively.
Being assertive is an important method of communicating your message. Many people however find being assertive difficult. They want to be 'nice', 'helpful' and hate to let people down. When someone is crossing over the boundaries, use the 'I' message- e.g. **when you**… (the behaviour that annoys you) **I feel**… (how you actually feel) **I'd prefer**…(how you want things to be different).

Ensure you say 'no' upfront – do not hesitate or use tentative language. Be clear. Use a pleasant tone of voice and give a brief reason for your assertion. This will ensure the outcome prevents any misunderstandings and you do not feel like you are performing tasks that you are uncomfortable doing (Partners in Health, Preceptorship Package, 2005).

MODULE 2: LEARNING STYLES / ADULT LEARNING PRINCIPLES

OBJECTIVES:

- To understand adult learning principles
- Knowledge of how to appropriately situate learning for the adult learner using the Critical 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.

Characteristics of Adult Learners

- Adults are independent and able to self - direct their learning
- Previous experience informs their decisions
- Life experience provides a rich source of learning and experiences on which to draw
- Readiness to learn
- Adults base new learning on old frameworks
- Adults want to learn what they can use today (Knowles 1980)

Characteristics of Adult Learners	Implications for Preceptors / supervisors
1 Have established beliefs and values	1 Takes longer to change beliefs and values
2 Are less flexible in thinking	2 Reluctant to change practices
3 Have rich reservoir of experiences	3 Provide sharing of experiences
4 Learn by own and others experience	4 Teach through actual experiences
5 Have mixed motives for learning	5 Keep expectations realistic
6 Are accustomed to responsibilities	6 Are actively involved in learning
7 Are busy with many obligations	7 Avoid wasting their time
8 Less secure in learning situations	8 Ensure chances for success
9 Fear inadequacy and failure	9 Provide support and guidance
10 May need more time to learn	10 Give learner control over pace
11 Don't see supervisor as all knowing	11 Make learning useful to work
12 Are problem-centred learners	12 Relate as helpful colleague
13 Are reality-centred learners	13 Address perceived problems first
	14 Must be applicable to practice

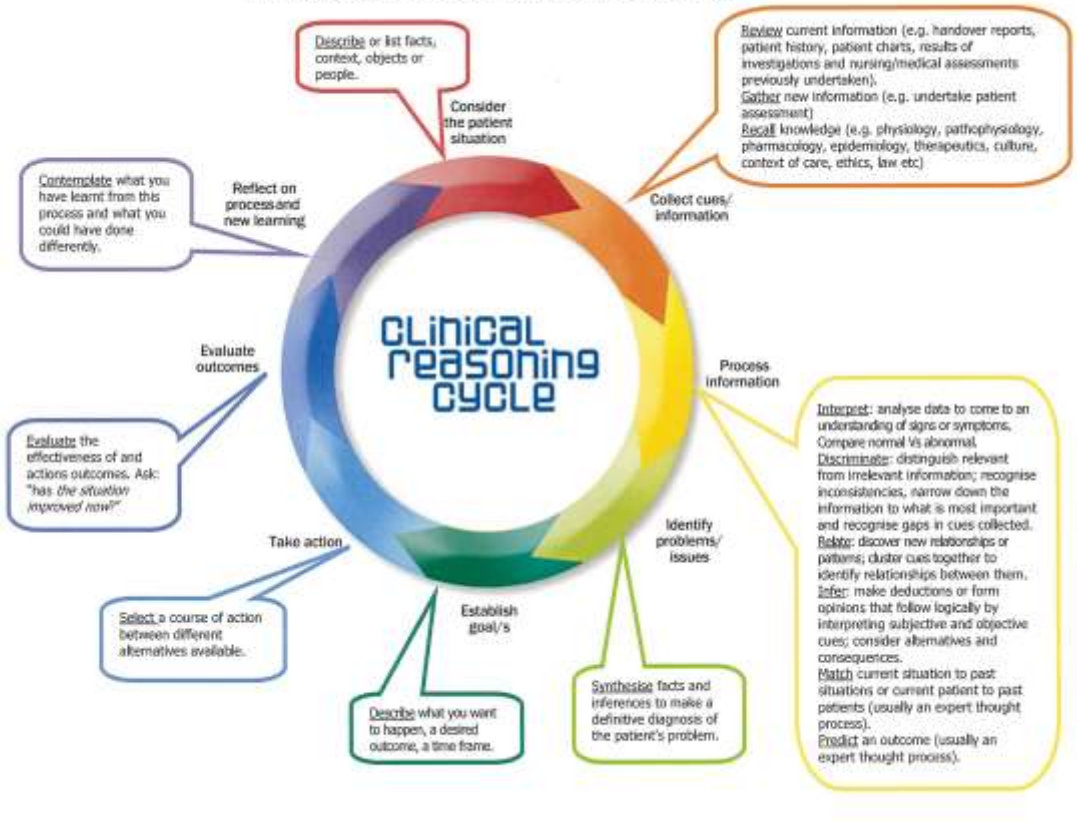
(Partners in Health, Preceptorship Package, 2005).

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 four categories of action: clinical skills, clinical knowledge, problem solving and reflection, (Jeffrey & Bourgeois, 2010).
Clinical reasoning is a way clinicians can think about the issues they encounter in clinical practice.

(http://www.utas.edu.au/__data/assets/pdf_file/0003/263487/Clinical-Reasoning-Instructor-Resources.pdf (Levett-Jones et al, 2009)

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.

The following chart outlines how CR may be used in the practice setting. It is extracted from the nursing context but the process is relevant to any discipline and setting.

Process	Description	Example
Consider the patient situation	Describe or list facts, context, objects or people.	This 60 year old patient is in ICU because he had an abdominal aortic aneurysm (AAA) surgery yesterday
Collect cues/ information	Review current information (e.g. handover reports, patient history, patient charts, results of investigations and assessments previously undertaken)	He has a history of hypertension and he takes beta blockers His BP was 140/80 an hour ago
	Gather new information (e.g. undertake patient assessment)	I've checked his BP and it is now 110/60, Temp 384. Epidural running @ 10ml/hr
	Recall knowledge (e.g. physiology, pathophysiology, pharmacology, epidemiology, therapeutics, culture, context of care, ethics, law etc)	BP is related to fluid status. Epidurals can drop the BP because they cause vasodilation. In ICU we have standing orders for epidural management.
Process information	Interpret: analyse data to come to an understanding of signs or symptoms. Compare normal Vs abnormal.	His BP is low, especially for a person who is normally hypertensive.
	Discriminate: distinguish relevant from irrelevant information; recognise inconsistencies, narrow down the information to what is most important and recognise gaps in cues collected.	His temp is up a bit but I'm not too worried about it – I'm more concerned about his BP and pulse. I'd better check his urine output and his O2 sats.
	Relate: discover new relationships or patterns; cluster cues together to identify relationships between them.	His hypotension, tachycardia and oliguria could be signs of impending shock. His BP went down after we increased the epidural.
	Infer: make deductions or form opinions that follow logically by interpreting subjective and objective cues; consider alternatives and consequences.	His BP could be low because of blood loss during surgery or because of the epidural
	Match current situation to past situations or current patient to past patients (usually an expert thought process)	Patients who have undergone an AAA repair often have hypotension post operatively
	Predict an outcome (usually an expert thought process)	If I don-t give him more fluids he could go into shock
Identify problem / issue	Synthesise facts and inferences to make a definitive diagnosis of the patient's problem.	He is hypovolaemic and the epidural has worsened the BP by causing vasodilation.
Establish goals	Describe what you want to happen, a desired outcome, a time frame.	I want to improve his haemodynamic status – get his BP up and urine output back to normal over the next hour.
Take action	Select a course of action between different alternatives available	I will ring the doctor to get an order to increase his IV rate and to give aramine if needed.
Evaluate	Evaluate the effectiveness of outcomes and actions. Ask: "has the situation improved now?"	His BP is up for now but we will need to keep an eye on it as he may still need aramine a bit later. His urine output is averaging > 30mL/hr now.
Reflect on process and new learning	Contemplate what you have learnt from this process and what you could have done differently.	Next time I would … I should have … If I had … I now understand …

Adapted from Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them. Academic Medicine. 78(8), 1-6.

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?

Adapted from Rubenfeld and Scheffer (2006, p. 83)

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 conditions.
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.

Adapted from Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them.* Academic Medicine*. 78(8), 1-6.

Learning styles:

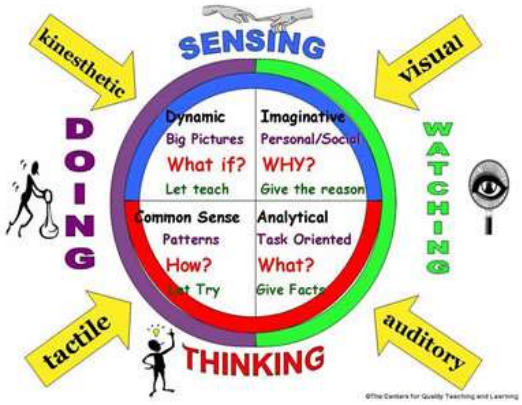
Many people recognise that each person prefers different learning styles and techniques. Learning styles group common ways that people learn. Some people may find that they have a dominant style of learning, with far less use of the other styles. Others may find that they use different styles in different 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 (http://www.learning-styles-online.com/overview/).

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. (http://www.learning-styles-online.com/overview/)

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 (http://www.learning-styles-online.com/overview/)

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



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

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

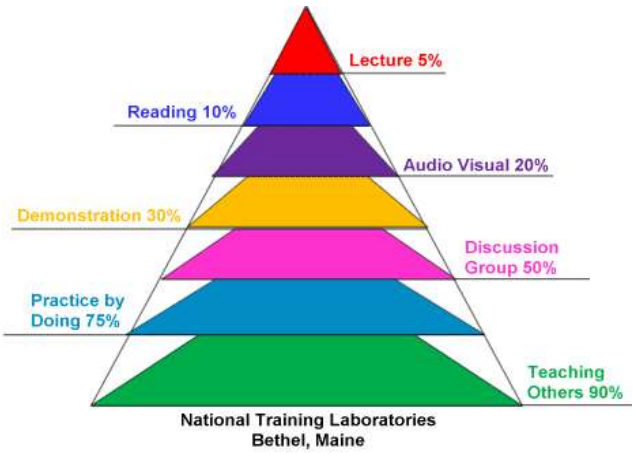
WEBSITE: FREE ON LINE LEARNING STYLE IDENTIFICATION

DURATION: 16 QUESTIONS

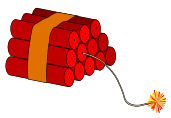
A quick free on-line questionnaire that helps you to identify the way you learn the best.

http://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?



Tip: To consolidate learning, have a student present a patient case study to the unit or another staff member to help reinforce knowledge!



Common Problems in Student Learning Experiences:

These are some of the more common problems that you may encounter as a clinical supervisor / preceptor:

1. Lack of learner focus:
   - The learner attempts to do too many things at one time - the result can be failure to make a useful amount of progress in any one area
   - Focus may be reduced by lack of logical progression 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. Supervised practice:
   - Supervised practice can be an intimidating experience
   - Few of us are truly at ease when someone is looking over our shoulder
   - Find ways to help without interfering (unless the actions have the potential to cause harm)

Emotional intelligence:

Salovey & Mayer (1990) 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" (cited in Cherniss & Goleman 2001, 'The emotionally intelligent workplace').

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

DURATION: 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. --

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MODULE 3: PRINCIPLES OF ASSESSMENT

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

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, helps 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 *learninginscience.blogspot.com* collected during placement-

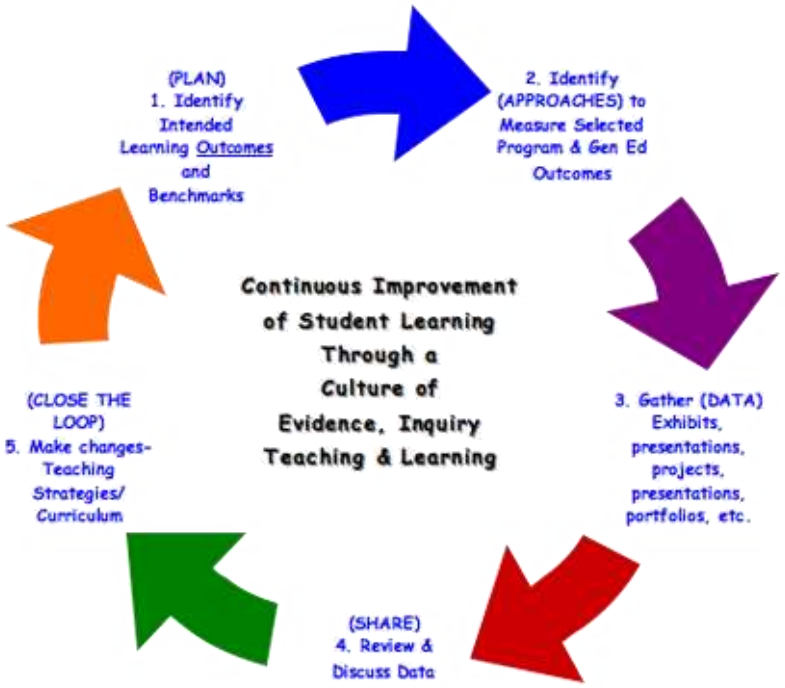
(For more information, Ctrl and click here)

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 (2013, Garrison and Ehringhaus, Formative and Summative Assessment).

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 referred to regularly and adjusted accordingly during feedback sessions with the student. (http://www.oaklandcc.edu/assessment/Definition.htm).

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

Most professions have national competency standards that are the benchmark against which performance is assessed. These exist to ensure a minimal professional level of competence 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.

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

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 EXERCISE: 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 ----------
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MODULE 4: CONSTRUCTIVE FEEDBACK

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

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?

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 staff
- 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.

MODULE 5: CREATING POSITIVE LEARNING ENVIRONMENTS

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 (right mouse click, open hyperlink).

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

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 with learners is key to the successful functioning and socialisation of the learner into the practice environment (Paternitti T 2006).

SUMMARY:

The learning package sits within the boundaries of the HWA *National Clinical Supervision Support Framework* which is located on the HWA website: http://www.hwa.gov.au/publications. HWA have just recently released the *National Clinical Supervision Competency Resource* which outline the roles and responsibilities at a foundational, intermediate and advanced level supervisor. This can be accessed via the hyperlink above. All health professionals responsible for the supervision of learners should become familiar with this document and reflect upon where they are situated within the structure outlined.

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.

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.

Further information relating to Supervision Support activities within Tasmania is available from the TCEN website: http://www.tcen.com.au/

The University of Tasmania (UTAS) School of Nursing and Midwifery (SNM) have some very useful tools on their website that guide supervisors / preceptors when performing their role:

Appendix 1: Situation, Action, Outcome form – this is an assessment tool used during student nursing placement to help direct the student towards critical thinking. UTAS SNM has provided a completed SAO form to help guide your writing.

Appendix 2: Clinical supervisor / Preceptor evaluation tool- To help inform and further develop your role as a clinical supervisor / preceptor we are encouraging you to seek feedback from your student. This form is to be completed at the end of a student placement and retained as part of your personal portfolio.

Appendix 3: Feedback template- This tool was developed by the UTAS SNM as a tool to identify areas for competency development. It is very useful when guiding a struggling student but is also useful to help guide feedback sessions.

This information is available from the following link:

http://www.utas.edu.au/nursing-midwifery/professional-experience-program/preceptors

Situation, Action, Outcome (SAO)

Name:_____ Date:_____

Situation (Briefly describe what happened)
Action (Clearly outline what you did and why)
Outcome (Briefly include what the outcome was and why)
Signature of RN Preceptor (thus validating SAO as a true and accurate account)
Name in Full: Signature: Designation: Date:

Feedback from practice/preceptor (if applicable)
Learning Plan (Based on this episode, where do you need to focus your learning?)
Competencies met
Progress/Completion review comments (Clinical Facilitator only-if applicable)

Example - Situation, Action, Outcome (SAO)

Name:__George Green_____ Date:__14th January, 2010___

ANMC Competency Domain of focus:___ Provision and Coordination of Care_____

Situation (Briefly describe what happened)

Yesterday I had a really challenging experience on the busy respiratory ward that I have been in practice on.
I was looking after Mr Jones on a late shift (pseudonym), who had been admitted with exacerbation of COPD and had very poor exercise tolerance. I had noticed the day before when I looked after him that he would even get very short of breath going to the toilet etc. On this particular shift at about 2130pm, I was writing notes at the nurses station when I heard his call bell. I had only been in his room about 20 minutes earlier to undertake his vital signs (which had been stable), so I wasn't expecting to see what I saw.
When I entered the room, I could see straight away he was visibly distressed and anxious. As I walked towards his bed, Mr Jones grabbed my arm tightly and said *"Help me, I….. can't…… breath ……properly!"*.
Instantly I could feel my heart thumping and I had no idea what to do, so I reassured Mr Jones and went and got my preceptor straight away.

Action (Clearly outline what you did and why)

I knew immediately that I needed support so I went and got my preceptor who came and managed the situation. Within 3 minutes, the patient's anxiety and shortness of breath had settled down.
I really wanted to help but I did know what to do, so I stood in the background and watched as my preceptor carried out the following:

- Reassured the patient
- Increased Oxygen
- Sat patient up
- Made patient sit forward
- Provided Salbutimol Nebuliser
- Undertook vital signs (SAO2 -87%, RR 32, HR 110bpm, BP 140/70)

My preceptor was talking me through his actions, but I couldn't pay attention as I was constantly thinking, 'had I really assessed him properly 20mins earlier?'

Outcome (Briefly include what the outcome was and why)

As mentioned, the patient recovered well in response to a Salbutimol nebuliser and some simple repositioning to facilitate breathing.
I was still concerned about the accuracy of the vital signs I took earlier, but my preceptor reassured me that in the short time period since doing them, the patient had began to deteriorate. - Which is not unknown in these type of patients.
The patient later said to me 'Sorry to scare you before mate', as I think he could see that I had been shaken by what had happened. But to be honest I was more 'shaken' by the fact that I should have known what to do and those interventions my preceptor initiated seem so simple and effective.

Signature of RN (thus validating SAO as a true and accurate account)

Name in Full: Anna Stamosis Signature:
Designation: Level 2 RN Date: 16th Jan, 2010

Feedback from practice/preceptor (if applicable)

I read with interest Georges comments above and did not realise the affect this episode had on him. I think it is important to acknowledge that he sought assistance as soon as possible which resulted in successful interventions being initiated for this patient. George feels this episode highlighted his lack of assessment skills and I

encourage him to practice physical assessment on consenting patients to build up his knowledge and understanding around this important aspect of nursing care. I am confident that he will be able to achieve this over the next few weeks.
I think George should consider this a positive learning experience as it has highlighted to him areas of his practice which require additional focus. Therefore, providing more opportunity to demonstrate competence.

Learning Plan (Based on this episode, where do you need to focus your learning?)

I agree with Anna's comments. I felt really uncomfortable with this situation and it is clear that I was not confident in my response. Additionally, I am due to start my graduate position in 6 weeks, so I need to ensure that I really improve my practice.
Therefore, I have decided I need to focus on the following areas:
Physical Assessment Skills
Review my understanding of physical assessment, particularly respiratory assessment, so I am able to better recognise a deteriorating patient.
Prioritisation
Discuss with my clinical facilitator about increasing my patient load to challenge my prioritisation and time management skills
COPD
I need to research more into this illness to gain a better understanding of why this population of patients have such poor exercise tolerance and look at the importance of positioning and chest physio in facilitating gas exchange.

Competencies met

Professional Practice
1.1, 1.2, 1.3, 2.1, 2.3, 2.5, 2.6.
Critical Thinking and Analysis
3.5, 4.1, 4.2, 4.4.
Provision and Coordination of Care
5.1, 5.2, 5.3, 6.1, 6.2, 6.3, 6.4, 7.1, 7.2, 7.3, 7.4, 7.5, 7.7, 7.8, 8.1, 8.2.
Collaborative and Therapeutic Practice
9.1, 9.2, 9.3, 9.5, 10.2, 10.3.

Progress/Completion review comments (Clinical Facilitator only-if applicable)

Clinical Facilitator:
George and I have reviewed this SAO many times over the last few weeks to ensure he is achieving the goals he set himself in his learning plan.
Since this incident, I have felt his skills around oxygen therapy have required further development. Therefore, I have set some additional tasks around this area to further benefit his learning.
George has really turned his focus towards working on his assessment skills and knowledge base around COPD. This has also been reflected in the feedback from his practice area where it has particularly highlighted the attention to detail he applies in determining his patient's respiratory status.
I feel it would be beneficial now to broaden this focus from respiratory assessment to encompassing whole body assessment as this will help George to improve his understanding of the 'big picture' about the patients' overall condition and therefore further improve his time/patient management.
Well done.

CLINICAL SUPERVISOR EVALUATION TOOL:

Please ask your student to complete this form so that it may help to inform your further development as a Clinical Supervisor.

Clinical Supervisor Name:	
Student Name:	
Date:	

How much do you agree with the following statements? (Please Circle)

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I felt welcomed and accepted by my clinical supervisor (CS)	1	2	3	4	5
My CS demonstrated enthusiasm in their preceptor role	1	2	3	4	5
My CS communicated in a manner that displayed respect for me as a student	1	2	3	4	5
My CS communicated to me in a clear and helpful manner	1	2	3	4	5
My CS was professional in attitude toward patients, relatives and other health professionals	1	2	3	4	5
My CS functioned as a role model during my Professional Experience Placement	1	2	3	4	5
My CS functioned as a resource person during my Professional Experience Placement	1	2	3	4	5
My CS assisted in providing opportunities to optimise my learning	1	2	3	4	5
I received an appropriate level of support and supervision from my CS	1	2	3	4	5
My CS provided guidance without taking over the experience	1	2	3	4	5
My preceptor provided explanations and rationales for procedures	1	2	3	4	5
My CSencouraged extension of my knowledge base and to make links between theory and practice	1	2	3	4	5
My preceptor encouraged me to use problem solving skills independently	1	2	3	4	5
My CS challenged my knowledge and reinforced learnt principles	1	2	3	4	5
My CS encouraged me to ask questions and seek assistance	1	2	3	4	5

My CS clearly stated expectations regarding my work and performance	1	2	3	4	5
My CS was realistic regarding expectations of my ability	1	2	3	4	5
My CS demonstrated an understanding of my learning needs	1	2	3	4	5
I received constructive feedback	1	2	3	4	5
Feedback regarding practice was timely and specific	1	2	3	4	5
Information regarding progress was treated with confidentiality and respect	1	2	3	4	5
My CS demonstrated a sound knowledge of policies, procedures, practices and unit routines	1	2	3	4	5
My CS utilised available resources, and promoted an evidence based approach to nursing	1	2	3	4	5
Time spent with my CS was educational and beneficial to my development	1	2	3	4	5
I felt positive about working with my CS	1	2	3	4	5

General Comments:

What did you find was the most helpful/enjoyable learning experience?

What did you find was the most challenging learning experience?

Do you have any suggestions for improving support for our students?

Thank you for taking time to complete this evaluation ☺

Feedback template for identifying areas of competency development (form designed by Mark Zasadny, UTAS).

Concern relating to area of practice	Level of competency	Action / strategy to be implemented	Outcomes
Knowledge	Safe		
	Effective		
	Proficient		
Skills	Safe		
	Effective		
	Proficient		
Attitude / Behaviour	Safe		
	Effective		
	Proficient		

1. Safe: taking no risks; prudent; cautious: said of persons
2. Effective: producing a definite or desired result; efficient
3. Proficient: having or marked by an advanced degree of competence, as in an art, vocation, profession or branch of learning

Clinical reasoning:

Student strategies and reflections: